Medical ethics

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That an issue of a continuing *medical* education journal is devoted to ethics, is one manifestation of a recent surge of interest in ethical issues in medical practice. This increased interest is welcomed by those of us who are convinced of the importance of analysing and deliberating about moral values and views. However, there are some worrying features about the current 'ethics vogue'.

First, it may be prompted, at least to some extent, by an erroneous belief — the belief that including ethics in a curriculum (whether of undergraduate, postgraduate or continuing education) will prevent the all-too-frequent and sometimes scandalous moral lapses of which we are all aware. Although ethics has an important role to play in a medical curriculum, it is not a cure for all the moral ills in medicine. Instead, the role of ethics is to enable people to think more clearly about moral issues. This can have some positive impact on practice, but it cannot do everything necessary to make medicine moral.

Second, the demand for ethics contributions to formal and continuing medical education programmes, which has escalated further with the introduction of CPD points in ethics, has exacerbated the shortage of 'ethics expertise'. The result is that many people with (only) an interest (but not expertise) in ethics have been called upon to supply that which is being demanded. This has contributed, in turn, to the already very uneven scholarly standards in the area of bioethics.

We can discern a contemporary moral 'snake oil' phenomenon in these two problems. Bioethics is being imbibed often in the mistaken belief that it will constitute a quick moral fix. And no qualifications seem necessary to become a purveyor. In other words, bioethics is being peddled as much as prescribed.

Many people take exception to the notion of 'ethics expertise'. This objection would have force if the claim being made was that those trained in ethics have moral authority — a claim I have implicitly rejected. However, the objection is without foundation if what is being spoken about is the academic activity of analysing and arguing about ethics. Just as first-year medical students cannot be turned into cardiologists by a quick course, so cardiologists cannot be turned into moral philosophers by a quick course. If there is an academic content to ethics, then there are academic standards that need to be met. And if there is no academic content, then there is little point in teaching ethics and offering CPD points for it.

Unless the 'snake oil' view of ethics can be eliminated, we may well experience a backlash against the bioethics enterprise when it becomes clear (1) that a significant proportion of it is substandard and (2) that even when done well it cannot do what many hoped it could. The obvious prophylaxis here is to adjust one's expectations about what ethics can do for medicine, and to be as attentive to academic standards in ethics as one is in medicine.

I asked authors in this issue of *CME* to write on topics that would be of relevance to practitioners rather than on more esoteric matters in ethics. Although three of the papers deal with the important issue of confidentiality, they complement one another nicely. My paper provides an account of the importance and limits of confidentiality and shows how this grounds principles about when and how to breach confidentiality. I also highlight some unfortunate threats to confidentiality. Lesley Henley's paper takes up the issue of confidentiality in the context of adolescent medicine and examines the question of when a health care professional is justified in breaching the confidentiality of those patients in the twilight zone between childhood and adulthood. Jens Mielke's paper focuses on three cases

that raise problems in the care of HIV-positive patients. Confidentiality features in one of these cases. The other two cases raise issues of futility and resource allocation.

Susan Parry and Carl Elliott discuss the problem of inappropriate requests from patients. They provide a helpful taxonomy of such cases and list some questions for doctors to consider.

John Stone writes about the importance of collaboration between HIV/AIDS researchers and the communities in which they work. Although writing from his knowledge of the experience in the USA, his ideas have obvious application to the African context. He defends a 'deliberative democracy' approach to achieving the researcher-community goals and highlights some ways in which disadvantaged communities could be empowered.

Martin Perlmutter discusses the principle of truth-telling in medical practice, highlighting both its importance and its limitations.

This issue of *CME* includes articles not only on ethics, but also on two medico-legal topics. Theodore Fleischer argues that the current law on end-of-life decisions is inadequate. He discusses the South African Law Commission's proposals for changing this law and suggests why these proposals have not been taken to the next stage of deliberation. He proposes a way forward. In another medico-legal piece, Anne Pope, taking a recent legal case as a springboard, discusses the question of judicially sanctioned surgery without the consent of the patient.

The authors of the main articles have devised some CPD questions based on their articles. The hardest moral questions, of course, are not ones that lend themselves to true and false or multiple choice answers. Readers are urged, therefore, not only to turn their minds to the CPD questions but also to those more difficult moral questions, the answers to which are not being rewarded with CPD points.

Due to the printer's devil, the October Guest Editorial was incomplete. The correct version appears below

Rural health matters

JANET GIDDY AND STEVE REID

A broad overview of international, historical and current rural health issues in South Africa

Rural health issues are not new, but in recent years the concept of rural health as an academic and advocacy issue has been evolving, and it is now defined as a distinct entity internationally as well as in South Africa. The issues of equity, access to health services, and quality of care are major concerns of the national Department of Health, and are receiving political attention that is long overdue.

During the last 10 years textbooks have been written and academic departments of rural health have been established at universities in Australia, Canada and the USA. Recently two senior academic appointments in rural health have been made in South Africa, and a body of knowledge is beginning to be published around the issues of rural health in this country, including this issue of *CME*!

The first international rural health conference was held in Shanghai in 1995, and has since become an annual event on the global calendar. It is striking that internationally the areas of common concern in rural health far outweigh the differences. Research and resources are being channelled into rural health issues and there is growing attention to issues such as recruitment and retention of rural practitioners.

Rural areas are characterised not only by their remoteness from cities, but by the relative scarcity of resources and alternatives. Rural people represent the majority of the world's population and universally have poorer health status than urban people. Despite this, rural health services command proportionally fewer resources than urban health services globally. The formidable challenge of making good quality health services available to people in rural areas is a worldwide one. Health care providers in rural settings must be generalists, often facing challenging situations with limited resources to provide high-quality care.

Poverty is a major determinant of health, and the health of poor people has been severely impacted on by the legacy of apartheid. Millions of people were forced to live in the homelands, which were deliberately underdeveloped rural areas. In South Africa, 52% of the total population, and 75% of poor South Africans, live in rural areas.

The health status of these rural inhabitants is similar to that in many developing countries: a higher infant mortality rate and a wide range of infectious diseases, nutritional deficiencies, chronic disease, HIV, tuberculosis and other diseases of poverty. Access to health care is difficult: the high cost of transport and large distances involved lead to late presentation of disease. The widespread use of traditional healers of varying levels of experience and skill compounds the morbidity and mortality.

There is a maldistribution of resources, with rural districts being significantly underfunded compared with urban areas. There is a shortage of doctors, with doctor-patient ratios in some rural areas of 0.9/10 000 compared with Gauteng province with a ratio of 9.1/10 000 patients.

The general practioners (GPs) who deliver private health care in small towns are predominantly South African. The service provided to 'cash' patients is inclusive of the consultation and medication, and is valued by patients not on medical aid. The decreasing income of GPs and depopulation of rural towns are leading to more one-doctor or no-doctor towns. GPs suffer from professional isolation, as many work on their own and have little contact with other doctors. The difficulty of obtaining locums means that rural GPs are unable to take holidays or attend CPD meetings, and it is stressful having to be available constantly. Many GPs do sessional work in state institutions, forming public-private partnerships from which both parties benefit. The district surgeon system, whereby GPs provided indigent patients with free health care in rural areas, was abused in some areas and is being changed amid much controversy.

Christian medical missionaries played an essential role in South Africa's rural health history, as they established and maintained an extensive rural health service for over 150 years. Most of the hospitals were taken over by the government in the 1970s and now form the infrastructure of the new district health system. Most rural hospitals offer a comprehensive service and are staffed by generalist doctors, the majority of whom qualified in foreign countries.

Part of the motivation for introducing the coercive and controversial community service for medical graduates was to improve the staffing of rural hospitals. Since 1999 staffing levels have improved, but the compulsory nature of the placements has caused resentment and negative attitudes on the part of some graduates, and in many cases there is inadequate supervision by senior doctors to ensure high-quality care. The impact of community service on rural health care would be far more substantial if it were linked to vocational training programmes.

There are various ways in which other countries have approached the problem of staffing in rural areas, but South Africa has done little in this regard. Community service and Cuban doctors are seen as the solution. Strategies to recruit and retain senior doctors with appropriate incentives, training, and career opportunities are urgently needed.

Rural doctors themselves have initiated programmes and started organisations aimed at providing support and overcoming the obstacles and isolation of rural practice. Healthlink, a project of the NGO Health Systems Trust, has linked rural doctors through electronic mail, which has improved communication and enabled discussion across geographical barriers of distance. The electronic discussion group 'mailadoc' makes it possible for rural doctors to obtain answers to clinical problems from urban specialists as well as rural colleagues. The Rural Doctors' Association (RUDASA), formed in 1995, has grown to a membership of about 300 and hosts a popular annual conference. The association has addressed a number of issues of importance to rural doctors and represents their interests at national level. The South African Academy of Family Practice has played a major supportive role for rural doctors, including the hosting of the 2nd World Rural Health Conference in Durban in 1997.

In spite of the high percentage of rural people in South Africa, undergraduate and post-graduate education has been focused on urban/periurban areas. Most medical schools have short rural medicine programmes for undergraduates, and although some attempts are now being made to equip doctors for rural practice, there is still a long way to go.

At present there is no specific post-graduate training for rural practice in South Africa. Undergraduate medical education still focuses on the traditional clinical specialties, while issues such as context, community and culture, along with strategies in primary health care (PHC) and public health, are beginning to be addressed by family medicine departments. Many rural doctors wishing to equip themselves better for their task have looked to family medicine master's programmes. Although most of these programmes are urban based and teach a traditional curriculum, certain medical schools (Stellenbosch, Transkei and Medunsa) have focused on the learning needs of rural doctors and tried to develop more appropriate programmes.

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A number of vocational training schemes have also been set up over the years in an attempt to develop the skills needed by rural doctors. There has been insufficient support for these and at present the only one still functioning is based at McCord Hospital in Durban.

The vision for providing health care equitably to the inhabitants of South Africa is framed by the concept of a functional district health system (DHS). A range of health services are offered within these districts, including private GPs, traditional healers, local and provincial government clinics, district hospitals and environmental health services. In many areas these role players have no relationship, despite serving the same community for years. The challenge is to build a health system that is equitable and inclusive of all players.

Thus far the role of the PHC doctor has been poorly defined within the DHS. To a large extent doctors in primary care have been marginalised in favour of nurse clinicians, despite the fact that nurses in many cases do not have adequate training or support. The pivotal role of the generalist physician in South Africa has not been recognised, as it has in the National Health System in the UK and many other countries. Unfortunately and erroneously, the skills of family medicine have been perceived as appropriate for private general practice only, with little relevance to PHC and the DHS.

It is crucial that the concept of the district medical officer receives more attention. This person needs to be part of (but not necessarily the leader of) the district health management team. There is a need for doctors who see their districts as populations at risk and who use every consultation as an opportunity for education and prevention. The public health service needs generalists who are caring, committed and competent, and understand their patients — their families, communities, cultural/traditional belief system, language, aspirations, and sources of stress. They also need to be effective teachers and should be actively involved in PHC nurse education.

Justice and equity are cornerstones of the new constitution, and since 1994 there is the political will for the redistribution of resources. The national health system policy is based on a foundation of PHC, but research shows that there has been very little shift towards an equitable distribution of health resources into PHC or from urban to rural. Appropriate attention and resources must be allocated to this historically deprived area of health care in the near future, so that it is recognised that rural health matters really do matter!

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FURTHER READING

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