INTER-PROFESSIONAL ETHICS IN HEALTH CARE

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CONTENTS

1 Foreword: Inter-Professional Ethics In Health Care 5
The Hon Minister for Health, Dr. L. Deguara

2 Introduction: Inter-professional Ethics in Health Care 8
Prof. M.N. Cauchi, Chairman, Bioethics Consultative Committee

3 Teamwork and Training of Health Care Professionals 10
Dr. Sandra Buttigieg

4 Interprofessional ethics and pharmaceutical issues 18
Dr. Janet Mifsud

5 The Relationship between Private and State Health Care 30
Dr. Frank Portelli

6 Health Care and the Legal Profession 37
Dr. L. Schembri Orland

7 Celebrating Teamwork in Healthcare 47
Rev. Prof. Emmanuel Agius

Additional Papers:

8 The Relationship between State and Private Primary Care 60
Dr. Pierre Mallia

9 The Morality of Health Care Provision 65
Dr. Denis Soler

Biographical Information 75

1 FOREWORD

THE HON MINISTER FOR HEALTH, DR L DEGUARA

I would like to thank the Bio-ethics Committee for having organised this evening's seminar on Inter-professional Ethics in Health Care. Indeed an annual meeting that discusses ethical issues in health care is an important event for all health care professionals as well as members of the public.

Ethical issues pertaining to health and health care have been at the forefront of the topics of discussion in our country over the past few weeks, notably because of the case involving the operation on the Siamese twins. This episode has shown in no small way that the Maltese public has a keen awareness of ethical issues, and Malta, like many other developed countries, is facing tough challenges in the field of ethics in health and health care.

The theme chosen for this seminar may not raise an emotionally charged debate, and traditionally may not have been viewed as a priority for a Bioethics conference. I do feel however that this topic has not been given the attention it deserves in the past, and I hope that today's seminar will be the beginning of a serious discussion and further research on inter-professional ethics.

In the field of health care alone, there are around 20 regulated health care professions. This number is definitely set to increase. It must also be remembered that health care professionals interact with other professionals such as social workers, lawyers, engineers and insurers and accountants in their daily activities.

Modern codes of ethics place equal importance on the way in which a professional interacts with the patient as well as with peers. This is the description of professional and ethical standards being proposed in the new Health Care Professions Act.

The ministry of Health has been working intensively on the draft of the new Act to regulate Health Care Professions. This process has highlighted the importance of inter-professional ethics to ensure that patients obtain optimum care and professions work together in harmony.

I do believe that interaction between the different professions must be fostered at the earliest stages of training. The teaching of ethics is an ideal opportunity to encourage inter-disciplinary learning and discussion

Safeguarding ethical standards for health care professionals is the remit of the professional regulatory bodies. A system of dialogue should be established between the professional regulatory bodies in order to promote inter-professional ethics.

Gone is the era where one profession could dominate over the other members of the health care team. Real team-work means fulfilling one's own duties and responsibilities whilst acknowledging and respecting the expertise of other professions. At the same time, each profession must realise that professional status is bestowed by society onto a group of persons because their actions merit this. As such, professional status is hard earned and efforts are required to maintain it.

As health care professionals we must also seek to establish the appropriate form of dialogue with the legal profession. Whilst patients' rights should be upheld in every manner possible, encouraging a culture of litigation would ultimately be a disservice to patients since this would encourage the practice of defensive medicine.

The reality of health care in Malta is that the public and private sectors both play an important role. My government has always encouraged private sector activity and I believe that as long as a professional maintains strong ethical principles, concurrent public and private practice should not be barred on ethical grounds. Unfortunately, we do know ethical behaviour is sometimes lacking. It is a pity that a few dishonest professionals are allowed to tarnish the reputation of a whole profession through their actions. I appeal to all health care professionals to ensure

that in their daily practice, a multi-disciplinary approach is pursued. Ethical behaviour towards one's peers and towards other professions is necessary for the delivery of optimum care.

The Bioethics Committee has the important role of advising government on Bioethical issues, such as the recent Bioethics Convention of the Council of Europe. But its work in promoting debate and symposia for the health care professions and the public is to be applauded and encouraged. I thank Professor Cauchi and his team for their excellent work.

2 INTRODUCTION

M. N. Cauchi, Chairman, Bioethics Consultative Committee

There are few areas of human endeavour which loom so important to the average person than his or her own personal health. This in turn has become the domain of responsibility for several related professions, each jostling each other for recognition.

The Bioethics Consultative Committee organises regular conferences to discuss issues that bear on the ethics of health practice. Previous conferences have dealt with Informed Consent, Bioethics and Disability, Patients' Rights, Reproductive Technology, and Transplantation.

The current symposium deals with topics that are of interest to the various members of the health care team, and in particular, the unwritten rules that govern the relationships between them.

Dr Sandra Butigieg, Director Institute of Health Care will speak on the training of Health Care professionals. It is clear that the fostering of good inter-professional relationships should start during the years of training. Modern health care demands that patients are empowered and remain the focus of attention, and that all health care professionals should work as a team for their benefit.

Dr Janet Mifsud, Lecturer, Department of Clinical Pharmacology and Therapeutics, University of Malta will talk on Pharmaceutical Issues in Health Care. The link between the pharmaceutical and medical professions has always been a very important one in the provision of health. With the increasing complexity of medicinals available, there is more and more reliance of the medical profession on information to ensure that the best treatment is available for any particular patient. Issues discussed by Dr Mifsud include: the role of industry and medical representatives in providing unbiased information about medicinal products; inequity to access to medicines and pharmaceutical services for the patient; the role of non-healthcare professionals such as non-pharmacist pharmacy owners, managers, and economists.

Another broad area which will be looked into is the interface between public and private health care. To what extent should these two overlap within a community? What are the principles guiding medical practitioners in their efforts to supply good private medicine, particularly in a place like Malta where the same practitioner is often involved in both State and private medicine? What are the difficulties encountered by a family doctor in his or her dealings with the health centres? How should private and State health services be co-ordinated? A number of questions dealing with these aspects will be discussed by Dr Frank Portelli, who is well equipped to give us a clear picture relating to private practice in these islands.

It is also an unfortunate fact that very frequently, the legal profession is called in to investigate certain areas of medical practice. This ranges from the wide and increasing scope of forensic medicine, to the legal interpretation of difficult decisions taken by medical practitioners. In all cases, there is a borderline which needs to be looked into. Dr Lorraine Schembri Orland discusses these aspects of health care and the legal profession.

Finally, Professor Rev. Emmanuel Agius will examine the ethical principles that form the foundation of health care practice. His talk on "Celebrating Team Work in Health Care" will emphasize the fundamental principles involved in this area which has become such an important issue in recent times.

St James' Cavalier, Valletta
24 November 2000

3 TEAMWORK AND TRAINING OF HEALTH CARE PROFESSIONALS

DR SANDRA BUTTIGIEG

Health care is increasingly emphasising the team approach in which all the health care professionals adopt and develop new skills against a background of new forms of service delivery, a rise in patient expectations, staff shortages and a need for cost containment. This represents a paradigm shift from the paternalistic approach to the concept of shared care. Team-working is seen as a way of tackling the potential fragmentation of care and to widen skills. The main objectives of teambuilding training and teamwork are the continuous improvement in the quality of health care and patient satisfaction.

The UK Government White Papers, 'Working for Patients'[1] and 'Working Together'[2] put an emphasis on an integrated patient-centred approach in health care delivery, which can only be achieved through successful partnerships.

Paradigm Shift In Health Care From Individual Practitioners To Team Of Professionals

Over the past 150 years, healthcare delivery has expanded from what was largely a social service provided by individual practitioners, often in the home, to a complex system of services provided by teams of professionals, usually within institutions and using sophisticated technology. This has exacerbated many of the ethical tensions inherent in health care.

The new capabilities and demands of health care, the increased financial pressures, and the limited resources raise questions and require decisions about who will have access to care and the extent of their coverage. The complexity and cost of healthcare delivery systems have also added to the tension between what is good for society as a whole and what is best for the individual patient.

I would like to base this presentation on two important and challenging questions:
Should we promote teambuilding and interdisciplinary training for the health care professionals?

Should we promote a shared ethical code for all health care professionals?

I shall be considering these questions from my perspective as a member of the Bioethics Consultative Committee.

A health care discipline is an area of knowledge and research that is critical to patient care. In multidisciplinary practice, each member of a clinical group practises with an awareness and tolerance of other disciplines.

The Transition From Multidisciplinary to Interdisciplinary Practice Requires:

- *A Common Professional Interest*
- *A Common Knowledge Base*

In interdisciplinary practice, members of a team actively co-ordinate care across disciplines. Decisions are made by consensus and each discipline has an equal opportunity for input into decisions. To make the transition from multidisciplinary to interdisciplinary practice, all disciplines must have shared borders that represent a common professional interest and knowledge base. Such a practice model will lead to an increased level of trust among professions and a deeper level of understanding about what each profession can contribute. Barriers to interdisciplinary practice include historical factors such as different philosophies of practice and professional training, logistics of team implementation, and resource limitation.

To facilitate interdisciplinary practice, all the health care professionals must be competent, understand what a team is, and share common values and a common vision. Interdisciplinary patient care must be taught

Interdisciplinary patient care requires:

- competence
- common values
- common vision
- teamwork approach

in professional schools and postgraduate training programs. In this context it is important to mention that postgraduate programs at the Medical School (Masters in Public Health) and at the Institute of Health Care (Post-qualification Diploma and Masters in Health Services Management) are interdisciplinary in nature and are attracting health care professionals from different disciplines.

In the majority of academic institutions, including the University of Malta, students at undergraduate level, receive a traditional education, the content of which tends to relate specifically to their future roles as health care professionals. In essence, the curriculum for each course is designed independently of the others.

Inter-Professional Training Introduced in Universities In:

- *United Kingdom*
- *Canada*
- *United States of America*

The Faculty of Medicine at the University of Liverpool[3] studied the possibility of introducing inter-professional learning in the undergraduate medical curriculum. Two main themes emerged. These centred on the role of knowledge and inter-professional attitudes. Reported benefits included increasing professional empathy and awareness of other professionals' skills, as well as raising confidence and heightening awareness of the holistic nature of patient care. The results support the idea that inter-professional educational interventions must be tailored to specific learning goals to be implemented successfully, and that inter-professional education should be prolonged and widespread to have a real impact.

Over the last decade, in Europe and North America, interest has been accumulating in relation to inter-professional and multi-professional learning at student level. This enables health professional students to learn together in order to work together thereby encouraging and strengthening future collaboration in practice settings.

Several well known Universities have introduced inter-professional ethics as a first step towards initiating shared training that promotes teamwork.

These include the University of British Columbia[4], Vancouver and the Faculty of Health Professions at Dalhousie University in Halifax,[5] Nova Scotia, Canada; the University of Dundee[6], Scotland; and the University of Colorado Health Sciences Centre[7]. This decision was based on the conviction that every significant health care decision has an ethical component. These Universities reported major benefits in teaching ethics on an inter-professional basis. The challenges of diverse and divergent Faculty and student reactions helped the students to learn how to think about education in inter-professional rather than profession-specific ways.

Effective inter-professional collaboration depends upon establishing a deep understanding of the differences in values and beliefs, and thus differences in the response to the multiplicity of patient needs. Health and social care students need a formal knowledge of the meaning of values and the varieties of systems within which values are expressed.

The conceptual framework in the teaching of values to health and social care professionals is derived from key concepts such as tolerance, compromise and education for dialogue.

Teaching Hospitals that are focusing on interdisciplinary training that can be translated into organising the delivery of care around patients have shown that patient care and organisational efficiency can be improved. The challenge lies in meeting patients' needs and preferences, particularly in the areas of emotional support, co-ordination of care, discharge preparation, and the involvement of family and friends. Critical care and emergency medicine are areas where co-ordination and communication under stress between and among health care professionals and teams representing a number of disciplines are critical for optimal care of the patient. The speciality is characterised by uncertainty, complexity, rapidly shifting priorities, and a high dependence on teamwork. Another area is palliative care, where interpersonal relations between the group members and their patients is a satisfactory answer to the need for communication in the dispensing of health care.

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

Many groups of healthcare professionals have established separate codes of ethics for their own disciplines. The separate, discipline-based codes of ethics often mark the highest aspirations of the professions they guide, and provide moral platforms on which disciplines can enforce their own standards on their members, and from which they can lay claim to the trust of society.

Separate ethical codes for different health care professionals do not encourage a cohesive approach to patient care.

The importance of a shared ethical code for all health professionals has been recognised by the British Medical Journal. A BMJ[8] editorial entitled, 'An ethical code for everybody in health care,' drew attention to the importance of bringing all stakeholders in health care into a more consistent moral framework. The publication of this editorial led to the formation of the Tavistock group of a multidisciplinary nature that came together to prepare a shared code of ethics.[9]

Separate Ethical Codes For Different Health Care Professionals Do Not Encourage A Cohesive Approach To Patient Care.

A Shared Ethical Code Unifies Health Care Professionals.

The group also recognised the difficulties in formulating such a code and considered it to be too restrictive and ambitious to fit the many circumstances for potential use within and among nations. Therefore, the draft came to be a basic and generic statement of ethical principles rather than a code.

The five major principles that should govern healthcare systems are:

1 Health care is a human right.

2 Health care delivery should be patient-centred.

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

What needs to be done?

- closer co-operation and collaboration in the training of health care professionals
- formulation of shared ethical principles

4 Co-operation with each other and with those served is imperative for those working within the healthcare delivery system.

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

Recognising the importance of the co-ordination and collaboration between health care professionals, a workshop was organised to discuss whether this concept could be applied in the local context. The participants acknowledged the need to put inter-professional ethics on a sound footing both in training and in practice by means of effective team-working. Suggestions included the organisation of inter-professional case study workshops, conferences and seminars; multidisciplinary and interdisciplinary meetings in the clinical setting, as well as having a shared ethical code for health care professionals.

In conclusion I would like to propose closer co-operation and collaboration in the training of health care professionals and that inter-professional ethics be recognised as the first step towards the realisation of this objective.

I believe that the Bioethics Consultative Committee can function as a catalyst in formulating and promoting a set of common ethical principles for all the health care professionals.

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1 INTER-PROFESSIONAL ETHICS AND PHARMACEUTICAL ISSUES

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Introduction

A just health care system is concerned with promoting equity of care:

- to assure that the right of each person to basic health is respected
- to promote good health of all in the community.

Health care professionals are bound together by a common goal in order to promote the good of patients and society. Patients expect this co-operation in order to receive optimal treatment and care with respect to pharmaceutical therapies that are required to meet their needs.

However, a number of issues are curtailing the attainment of this goal and these will be addressed in this paper. The development of expensive

innovative medicines; financing of medicinal therapy under the Social Security Act (priority setting and rationing treatment), patient-centred care and continuity of patient care at state pharmacies, from which all free medicines under the Social Security Act are currently dispensed is steadily improving. An ever-rising demand for specific treatments by individual patients; and a trend to treat medicines as ordinary items of commerce form the backdrop to these issues.

A response to these issues necessitates a collective approach by doctors, pharmacists, pharmaceutical industries and the State to promote the good of patients, society and future generations. All health care professionals are educated to refrain from criticism or unsustainable questioning of the competence of other professionals. This is not only unethical but undermines patient confidence and is in most cases unfounded.

"The public places great trust in the knowledge, skills and professional judgment of pharmacists. This trust requires pharmacists to ensure and maintain, throughout their career, high standards of professional conduct and performance, up-to-date knowledge and continuing competence relevant to their sphere of practice whether or not they work in direct contact with the public." (Code of Ethics, RPSGB, 2000)

Pharmaceutical Issues in Malta

The pharmacy profession has found an important role in diverse aspects of modern working life such as industry, academia, community pharmacies, government agencies, and hospitals. As a direct consequence of this, the pharmacist works with members of other health professions – such as medical doctors, scientists, nurses, midwives and physiotherapists, and also non-healthcare professionals such as managers, economists, auditors, pharmacy owners etc., adopting a multidisciplinary approach, in order to promote a more holistic aspect of healthcare, thus providing the patient with the best possible therapy.

Hence, this necessitates a serene working environment, in which every health professional fully respects the others' decision but is also open to discussion on therapy and all aspects of patient care. Malta is in a unique position that many GPs meet community pharmacists on a daily basis because their clinics are close to or seen inside the pharmacy and clinical pharmacists have close contacts with other HCPs in hospitals.

Pharmaceutical Industry

Pharmaceutical industry interacts directly with physicians and pharmacists through their representatives. General Medical Council guidelines state: "The medical profession and the pharmaceutical industry have common interests in the research and development of new drugs of therapeutic value and in their production and distribution for clinical use. Medical practice owes much to the important advances achieved by the pharmaceutical industry over recent decades. In addition, much medical research and postgraduate medical education are facilitated by the financial support of pharmaceutical firms."

Large multinational pharmaceutical industries are merging to reduce R&D costs, involving billions of dollars and years of work. The industry and drug representatives have an important role in the provision of unbiased information about medicinal products (microlevel relationship). The latter provide important information to other health care professionals about new products on the market. Advertising and sales promotion are necessary for the pharmaceutical industry but prescribing health care professionals should choose, and should be seen to choose, the drug which is in the best interests of a particular patient, both from a therapeutic point of view and from a financial point of view. Any presentation to promote a drug should lead the health care professionals to critically analyse the literature provided. Drug trial reports, considered impartial, should be consulted together with evidence-based information.

Doctors and pharmacists must not accept any financial or other inducements from a pharmaceutical company which might compromise or be seen to compromise, the exercise of his/her professional

judgement. The doctor and pharmacist can however accept reimbursement of conference fees and sponsorship of postgraduate meetings, in the form of hospitality at a reasonable rate and at no compromise. The possible distribution of samples, inducing initiation of treatment, without ensuring the continuation of treatment, may pose problems and may not be in the best interest of the patient.

Medical representatives should exert basic truthfulness in information given that no medicine is perfect. The medical representative should use ethical behaviour with regards to competitors' products. Promotional techniques e.g. hospitality, gifts should not be out of proportion and should ideally be for medical education purposes.

Several influential techniques from the marketing literature, are thought to be commonly used by sales people. These have been termed the principles of reciprocity: samples, gifts, printed material, patient information leaflets or invitations are offered in all encounters. Appeals to authority figures, where promotional claims were supported by reference to professors or specialists, and Social validation acts, where reference was made to the peer group, were also common.

Commitment acts were observed to occur in two ways: the first as a direct request to use the product detailed and the second as a series of questions or statements which gradually moved from pre-agreed areas to solicitation of a commitment to prescribe the drug.

Medical and pharmacy practitioners may not be aware of the potential effect these techniques can have on their prescribing practices. Knowledge of these techniques must be incorporated into educational programmes designed to provide health care professionals with critical appraisal skills.

Equity of Access to Medicines

There may be the problem of inequity to access to medicines and pharmaceutical services that fit patients' needs. Theoretically a member

of the public can be appointed on the Drugs and Therapeutics Committee. Therapeutic decisions should be founded on protocols based on moral criteria and incentives for cost effective prescribing must be introduced. Pharmaceutical services must be expanded to meet patient's needs.

Issues Related to Drug Products Standards

Adequate structures and standards to ensure that medicines purchased by State and private health care systems are of good quality, safety and efficacy are still being developed in line with WHO schemes for certifications of pharmaceutical products and EU directives. Drug misadventure, medication errors, non-compliance and adverse drug reactions may be difficult to quantify, however they are a reality.

Relationship between Individuals in Health Care Team with Respect to Pharmaceutical Issues

Ethical issues may arise, as part of the normal functioning of the health care team - the person who takes a decision, and the reaction of other professionals, within the team (e.g., if the consultant decides not to tell the patient his/her diagnosis). At times patients and their relatives may ask questions in order to confirm something said by another healthcare professional. Pharmacists may not realise that this puts them in a difficult position.

Interactions with fellow professionals, usually in the complementary professions and with colleagues in different subspecialties of medicine, is common and allows a broadening of one's horizon. There is a marked difference in the amount of interactions with different professionals in the public health sector. Pharmacists are sometimes asked their opinion about the competence of other health care professionals or to recommend a professional in another speciality.

In a community setting, prescriptions should be adhered to and changed only if there is a just cause following consultation with the physician, in line with Medical and Kindred Ordinance, while in State pharmacies generic prescribing is the norm with some exceptions. Information, which the health care professional receives through prescriptions should be confidential. Pharmacists have a responsibility to patients for medicines they dispense and are guided by a code of practice in this relationship.

There should be effective utilisation of expertise, not competition with each other's competences.

Divergences of opinion between doctors and pharmacists are most likely to arise with regards to drug prescribing. Although legal responsibility for prescribing rests with the doctor who signs the prescription, the pharmacist has a professional legal liability to ensure that the patient receives the right medicine that is prescribed and the correct advice regarding dosage and administration. The question of dispensing generic substitutes is a controversial issue, even within the pharmacy profession itself.

Any major disagreement regarding a prescription should be resolved between the professionals and not involve the patient, who can only end up confused and lose confidence in the health care provider. Establishing a good working relationship between the doctor and the pharmacist facilitates communication and they can support each other.

Potential problems may arise when the pharmacist does not agree with the doctor's choice of prescription drug, because of potential side effects or interaction with other drugs that the patient is taking, maybe on prescription from another doctor or with non-prescription medication. Once aware of potential hazards, the pharmacist is obliged to inform the physician about the problem but may have a problem consulting the doctor due to the added responsibility of respecting patient confidentiality. The doctor has the responsibility of keeping up to date about therapeutic advances but should also be willing to learn from the pharmacist.

Patients often ask the pharmacist about the side effects of a prescribed drug, which have not been fully explained by the doctor or which they did not understand. Naturally, the product leaflet alone does not absolve the doctor from the duty of doing this. The pharmacist may have problems with 'prescriptions' not originating from authorized professionals, or problems with reading/interpreting prescriptions and how to deal with this. Legislation allows Health Authorities to ask pharmacists to provide information regarding abuse of prescriptions. This is in the interest of the medical profession as well as of individual patients. The over the counter (OTC) list should be updated and telephone prescribing must be avoided. The impact of virtual pharmacies on internet is still to be assessed.

Pharmacy Premises

The Medical Council still guides doctors in relation to financial arrangements with chemists and pharmacies as follows:

"A medical practitioner must not circulate professional cards to chemists or opticians; neither must he have any salary or commission or any other arrangement with a chemist or optician; he must not have financial interest either directly or indirectly in a local chemist's shop."

Moreover, in the subsidiary legislation about the licensing regulations of pharmacies, doctors and dentists or their spouses do not qualify for a licence and the pharmacy licence is not renewable if a doctor has any direct or indirect interest in the pharmacy.

The underlying concept is that there should be no financial or other inducements from the pharmacy that might compromise or be seen to compromise the exercise of the doctor's professional judgement. In particular, there should be no inducements to affect referral to that particular pharmacy or to a clinic in that pharmacy. The patient should be free to attend the place of choice.

These guidelines may seem rather harsh and in fact, due to changes in the provision of health services in the UK, in the early 1990's, the BMA withdrew similar guidelines but directed the doctor who has a direct financial interest in a pharmacy to tell the patient beforehand, and to particularly refrain from explicit or implied direction to that pharmacy.

It is interesting to note that the concept that a commercial setting might compromise the profession, is also felt by the community pharmacists. However, for the protection of the patient, there is legislation requiring the presence of a pharmacist in each pharmacy at all times.

Considered from another angle, the actual presence of doctor's consulting rooms within the pharmacy is the ideal situation for developing and strengthening communication and respect between the professionals. There is also the right of the patient to choose the pharmacy of his/her choice.

Collegial Collaboration

Definition of roles is vital resulting in a focusing on the patient within the healthcare team. It is important that there is minimisation of overlap and at the same time provide cover for all areas. The pharmacist is in a good position to fill-up areas of patient care such as education and information about medicines, to enable patients to make the best use of them.

There should be communication among all stake-holders, mutual trust and mutual respect in an inter-disciplinary approach to the setting up of national policies with respect to drugs (mesolevel relationship).

The increased emphasis on interprofessional working has highlighted the need for greater collaboration and sharing of client information. A number of tensions that arise from collaborative relationships, which are not conducive to supporting interprofessional working in an ethically sound manner, have been identified. The way forward within these

collaborative relationships is to set clear parameters to the professional-client relationship, paying full regard to the autonomy of both the clients and the professionals involved. This approach to working will place the client at the centre of care provision.

Research and Academia

Billions of dollars in R&D are invested each year in pharmaceutical research. Gifts to institutions for research purposes are considered acceptable. Payment must be specified in the protocol for any research project, e.g. for assessing the effect of a new drug, and should be approved by the relevant national body. The patients involved in research must be informed regarding the nature of the study, the risks and their alternatives and patient consent obtained.

In the research environment and in clinical trials for new drugs, several health care professionals such as physicians, pharmacists, nurses, statisticians, biochemists, physiologists, analytical chemists, pathologists, geneticists, form part of a mixed group of colleagues working together towards one aim.

The advances in the Human Genome Project (HGP) will transform health-related research and ultimately the practice of medicine. The HGP's findings will offer clear improvements in diagnosis and prevention, and eventually in treatments, and the relationship between the academic medical centre and the pharmaceutical industry will change — but remain good — as that industry applies the findings of the HGP. The public and health care providers must develop a greater understanding of genetic issues.

Health Care Policy and Research Advisory Committees should be developed in Malta in order to foster health care research e.g. health care outcomes, and disseminate to clinicians, pharmacists and other HCPs, the findings of such research. Academics and HCPs working in clinical practice should co-operate in these activities.

Role of Non-Healthcare Professionals

There is an increasingly large number of nonhealth care professionals such as non pharmacist pharmacy owners, managers, economists, auditors, politicians, policy makers, whose involvement in these issues is both appropriate and necessary in the current healthcare environment in order to promote a more holistic aspect of healthcare. There should be an ongoing debate at macrolevel between State, representatives of professions and pharmaceutical industry, both the small but expanding local industry and large multinationals and other stake holders.

This debate will help to avoid a number of tensions, related to oppressed group behaviour, inadequate communication and conflict, that arise from collaborative relationships, which are not conducive to supporting interprofessional working in an ethically sound manner both the clients and the professionals involved.

The Way Forward

Professional mentoring may ease difficult situations and promote self-awareness, personal and professional growth, and leadership behaviour. Also very useful are resolution skills, improved exposure to diverse academic and professional experiences, and a need to learn management of feelings in effective ways. To cultivate co-operation, health care professionals need to better understand and accept each other's evolving roles and responsibilities.

Ethical issues which could arise, should be addressed and studied minutely, keeping as sole aim the risk/benefit ratio to the patient. Regular meetings and joint workshops and projects should be encouraged, in order to increase awareness of difficulties and conflicts, which health professionals may have. Joint continuing of on going professional development and education are very important

Pharmaceutical issues need defined structures, processes, and outcomes which are necessary to improve practice and patient outcomes and further develop legal and ethical standards, and thus aid in health care reform.

Health care professionals are bound together by a common moral purpose: to act in the patient's best interest. Thus, each health profession is a moral community, which must determine and promote ethical behaviour among its members and examine its responsibilities for vulnerable patient groups such as children. This relationship is about the effective utilisation of valuable human resources to the benefit of the nation and should be addressed as a social partnership in these committees on pharmaceutical issues.

This review is based on the ethical guidelines laid down by the Medical Council of Malta, Maltese Legislation, the General Medical Council, Pharmacy Board of Malta, Royal Pharmaceutical Society of Great Britain and the British Medical Association.

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THE RELATIONSHIP BETWEEN PRIVATE AND STATE HEALTH CARE

DR FRANK PORTELLI

At present there appears to be a big divide between State Medicine and Private Medicine both at Primary Care Level, for instance in the relationship between the General Practitioner and the Health Centres, as well as in the relationship between Private Hospitals and State Hospitals.

General Practitioners lament the fact that at primary care level, a simple request for a chest x ray by the patient's general practitioner requires an endorsement by a doctor from a health centre before it is performed.

General Practitioners complain that they do not receive a copy of the report of the X-ray of their patient. GPs complain that patients referred to hospital are often not referred back to their GP, but are being referred back to a health centre. Minimal ethical standards would suggest that patients should be sent back to their referring general practitioner with all the relevant medical information.

The divide between the State hospitals and private hospitals is so wide that one could well say that at present little co-operation exists between State and private hospitals. This lack of collaboration between the two sectors renders both State and private systems inefficient. It is detrimental to the patient, and ultimately costs the country money we can ill afford to waste.

The NHS – a victim of its own success

The demand for medical services has increased and will continue to increase. It has been said that the NHS has paradoxically become a victim of its own success. In any open ended offer – and the NHS is an open ended offer par excellence – demand is bound to outstrip supply.

Add to this the realities of increased life expectancy, the increased medical needs of the elderly, the great expense involved in providing cardiac surgery, the demand for newer and ever more expensive drugs such as Taxol, Taxotere, and Gemcitabine (for treatment of cancer of the breast, ovary, lung and colon), and the NHS will respond in the only way possible - by rationing

Rationing

An elderly person presently may have to wait up to one year for a cataract operation in order to regain his or her eyesight. He/she may have to wait another 4 or 5 years to have a knee or hip replacement. Whether we like to admit it or not, long waiting lists are in fact a form of rationing – rationing of medical treatment.

When the NHS does not have the money or the facilities or the manpower to provide the treatment demanded from it, it will respond in the only way possible by increased rationing – longer waiting lists.

Needless to say drugs like Taxotere, Gemcitabine, Ironotecan are not readily available on the NHS because of the expense.

We must stop perpetuating the myth that the State – the NHS – is able to provide for all our medical and social demands.

The Way Forward

Once we recognise that the State cannot, on its own, provide for all our demands what is the best way forward? Forming a strategic partnership with the private sector – finding areas of collaboration between the NHS and the Private Sector could be one solution. However, we must first dismantle the barriers that exist between the Medical Private Sector and the NHS.

Duplication of Medical Equipment

Modern Medical Equipment such as MRIs, CT Scan, Gamma Cameras, Cardiac Labs require a huge initial capital outlay and are expensive to run. Medical equipment depreciates heavily and soon becomes outdated, and moreover it has little or no resale value. Does it make sense to duplicate expensive equipment in a small country like ours with a population of less than 400,000 inhabitants? We have to ask, does it make sense to have two MRIs and three CT scanners competing against each other in such a small population?

Would it not make more sense to establish collaboration between State and private hospitals so that investment in expensive medical equipment is co-ordinated? When duplicate medical equipment is placed in a small country with a limited population the market fragmentation that occurs renders the investment non-viable.

Proposals

I would like to propose that a co-ordinating committee be set up between the State and private medical enterprise in order to review the facilities presently available on the island, and to plan future investment in order to avoid duplication of expensive equipment.

The brief of this committee would be to establish collaboration between State hospitals and private hospitals so that future investment in medical equipment could be co-ordinated, and duplication of expensive equipment would be avoided, thereby reducing capital outflow from the country, and avoiding further fragmentation of the market.

Leasing of Facilities

State Hospital and Private Hospital should start to lease their facilities to each other. For instance the newly installed MRI at St Luke's Hospital

could be leased on a sessional basis to the private sector. The MRI could be leased at advantageous rates for use after hours or at weekends. This would ensure that such a piece of expensive equipment is utilised to its maximum potential, it would be run more cost efficiently, and it would generate revenue for the government – revenue which State hospitals could well utilise.

State Hospitals should in turn lease facilities from private hospitals

The State could lease operating theatre time from private hospitals, it could also lease a number of beds from private hospitals. In the private sector there are a number of operating theatres that are standing idle at least 50% of the time – whilst there is a lack of operating theatre availability in state hospitals.

Recently in Britain a concordat between the NHS and the Private Sector has been signed by Alan Milburn, Britain's Labour Health Secretary. The agreement aims to lease the spare capacity in the private sector for the benefit of NHS patients.The UK Government has realised that an agreement that ensures co-operation between the NHS and the private sector will certainly benefit patients and will solve a number of problems for the NHS.

Britain's NHS will not only utilise the spare capacity in private hospitals for patients on the NHS waiting list, but the spare capacity – the unutilised beds in private hospitals will be available also for patients who require rehabilitation and convalescence, the so called intermediate care facilities, the place between hospital and home, largely for the elderly patient who is not fit to go home following an acute illness or a surgical operation .

A similar agreement would be beneficial to our patients in Malta. Such an agreement would reduce bed blocking by patients in our NHS hospitals.These patients need care and rehabilitation, but their place is not in an acute bed in an NHS hospital. It seems sensible for the NHS to lease the vacant beds in the private hospitals .

More than this, however, an agreement (concordat) between State and private sector would signal a new relationship between the two sides, a relationship which will ultimately be beneficial to both parties.

The Private sector has enough facilities – in terms of hospital beds, operating theatre time etc, that if a concordat were signed with the private hospitals, together we could rid the NHS of its waiting list in the next few years. The Government has declared in its manifesto that it "will work at finding ways of promoting co-operation between the private health sector and that of the State, to the greater satisfaction of doctors and patients" (Article 161). (Electoral Programme nationalist party, 1988) The Government had also declared that it " will also encourage the development of private hospitals. This will ease the workload of State hospitals and reduce the pressure on their budgets." (Article 165)

Both major political parties ultimately believe that co-operation between State and private hospitals is beneficial to the country – so that there should be no obstacles from present political philosophy.

It would be gratifying to see the Government work hand in hand in a real partnership for the good of the patient. The patient will remain an NHS patient, the doctors can be NHS doctors or private doctors, and most importantly of all, the patient will not pay for the treatment

Medical Insurance

Private Medical Insurance has an important role to play in the health sector. The scope of Medical Insurance is for the patient to benefit from the advantages normally associated with private medical treatment, to avoid waiting lists, to have planned surgical treatment at his convenience etc.

Private Medical Insurance also benefits NHS patients because it relieves some of the work load of NHS hospitals, and it therefore has the potential to reduce waiting lists.

Some medical insurance companies, however, have introduced so called 'cash benefit schemes' which defeat these scopes. Cash benefit schemes are schemes that reward the insured patient who elects to receive treatment in an NHS hospital with a daily cash benefit. These schemes reward the patient with a cash benefit of up to Lm25 for every day that he lingers in an NHS hospital – a not inconsiderable sum by any account. Insured patients therefore, are being lured away from the private sector back into NHS hospitals.

The insurance company clearly benefits most from these schemes, as their liability is limited to Lm25 per day. They do not have to pay for private hospital fees, nor do they have to pay doctors professional fees, nor for any pharmaceuticals or expensive consumables.

Instead of relieving the pressure from NHS hospitals, these insurance schemes are actually riding piggy back on the NHS compounding further the problems for the NHS and milking it further. One can argue that since the patient is accepting a cash benefit then he has in fact activated his insurance policy and the NHS should treat him as an insured patient. A claim for all medical expenses incurred by the NHS would be in order. It cannot be right for insurance companies to reap profits from premiums and expect the NHS to foot the bill when medical treatment is required, treatment which is covered by the insurance policy.

Tourists and non-Residents

Over the years Malta has become a popular tourist destination. Indeed over one million tourists come to visit Malta every year around 500,000 of whom are British. The majority of tourists travelling to Malta nearly always have in their holiday package medical insurance cover which costs them around Lm20 for a two-week stay – pre-existing conditions being excluded.

The medical insurance requirements of these patients are in the main managed by handlers – companies that essentially work for

commissions. These insurance handlers are now utilising the reciprocal health agreement that exists between Malta and Britain, and are admitting their insured patients to St Luke's Hospital when they require hospital treatment.

The dimension of the problem is not negligible. If half of one percent (0.5%) of these often elderly patients require hospital medical care averaging 4 days, a minimum of 25 beds daily would be required to look after their medical needs.

At present insurance companies abroad are collecting more than Lm1,000,000 in premiums from the British tourists alone - and then they enjoy a free joy ride on the backs of our State hospitals. I feel that action is required to remedy the situation.

First: The reciprocal health agreement needs to be reviewed since patients who require Cardiac Surgery and Cancer Treatment are now in the main being treated in Malta and not being referred to the UK.

Second: Non-residents and tourists covered by a medical insurance should not be treated in State hospitals but should be transferred to private hospitals – and when it is mandatory for them to be treated in a State hospital they should be charged for the treatment as private patients. Certainly they should not be allowed to milk the NHS dry.

Clearly a great deal needs to be done, and this is a good time to start. I would hope that some of my proposals are taken up so that a true and beneficial partnership can be established between the State and the private sector – a partnership that would seek to eliminate waiting lists completely, remove the indignity of putting patients in hospital corridors – a partnership that will benefit patients, State hospitals and the private sector.

5 HEALTH CARE AND THE LEGAL PROFESSION

L. SCHEMBRI ORLAND LL.D., M.JUR (EUR)

The medical practitioner today is faced with a myriad of laws and regulations which aim at bringing health issues within their scope and effect. For the most part, such laws cannot be interpreted in a vacuum but, rather, must respect and reflect the guiding principles of medical ethics. Thus, the rights of a Doctor are qualified by the rights of his patient. These rights are not antagonistic but complementary in, for example, the principles of professional secrecy, of access to recent medical technology and treatment, or the freedom to exercise one's profession. From another perspective, the medical practitioner owes his patient a duty of care and a breach of this duty renders the practitioner liable to damages.

A medical practitioner may (invariably) have contact with the law or legal institutions not only in the observance of rules and regulations affecting his practice, but also in the role of court expert, witness, or defendant.

The Duty of Care

The Maltese Civil Code lays down the basic principles of liability. An action for damages may arise from a contractual relationship between the parties, or a relationship in tort.

Section 1031 provides simply: *Every person shall be liable for the damage which occurs through his fault.* The standard of care is that of the *bonus paterfamilias* and no person can be liable for want of prudence or negligence to a higher degree. Any person is also responsible for the negligence of his servants if he has not exercised care in the employment of such persons or in their supervision. (section 1037 C.C.)

Section 1038 provides further: *Any person who without the necessary skill undertakes any work or service shall be liable for any damage which, through his unskilfulness, he may cause others.*

The same degree of diligence is required by our law in the performance of contractual obligations. (section 1132)

Basically, therefore, a medical practitioner owes a duty to his patient irrespective of any contract between them. The jurisprudence developed by the courts of the United Kingdom offers a useful source of reference and interpretation.

In *R vs Bateman* it was held that there was no need for a contractual relationship between the person undertaking the treatment and the patient to support an action for negligence, nor is it necessary that the services were rendered for pecuniary reward.[1] In general, whenever a person undertakes to provide a service for another person knowing that the latter reasonably relies on his professional competence and judgment, a duty of care arises, whether the loss suffered is physical damage or economic loss.[2] That there may be no contract between the parties would be relevant if, for example, the service was undertaken in the context of a special relationship.

Once a person has been accepted as a patient, a medical practitioner must exercise reasonable care and skill in his treatment of that patient. The standard of care demanded is that required of any professional person. The test adopted in the leading case, *Bolam* [3], can be divided into two parts:

a) The test is the standard of the ordinary skilled man exercising and professing to have that special skill. A man need not profess the highest expert skill; it is well established law that is it sufficient if he exercises the ordinary skill of a competent man exercising that particular art. – That art is judged in the light of the practitioner's specialty and the post that he holds. Thus a doctor who professes to exercise a special skill

must exercise the normal skill of his specialty. A general practitioner is not expected to attain the standard of a consultant obstetrician delivering a baby but if he practices obstetrics at all, he must attain the skill of a general practitioner undertaking obstetric care of his own patients.

b) In determining whether a defendant practitioner has fallen below the required standard of care, the **Bolam** test looks to responsible medical opinion. Thus a practitioner who acts in conformity with an accepted, approved and current practice is not negligent merely because there is a body of opinion which would take a contrary view.

Professional practice must be judged in the context of proper practice at the time of the alleged negligence – a practitioner cannot be condemned with hindsight. However, evidence that a practitioner departed from current practice will be some, but not conclusive evidence of negligence on his part. The reason behind this argument stems from the consideration that the inducement to progress in medical science would be otherwise dangerously stultified.

There is also a general duty to refer a patient to a consultant, as a practitioner cannot undertake treatment beyond his competence.

The *Bolam test* is applicable to every aspect of the duty of care owed by a doctor to his patient thus:

a) The duty to warn and counsel the patient of the inherent risks and side effects of the treatment enabling informed consent.

b) The duty of care in diagnosis

c) The duty of care in planning treatment and prescribing

These will be taken in turn:

(a) In assessing whether a patient has consented to treatment, the doctor's duty is satisfied if he has explained in broad terms the nature

and purpose of the treatment. There is a duty to warn and counsel on the inherent risks and side-effects of that treatment however. In one case, a patient was not warned of a 1% risk of partial paralysis inherent in surgery to free a trapped nerve root in her neck. Her allegation of breach of duty was rejected. The Courts looked to a reasonable body of medical opinion which would have elected not to disclose the risk to determine whether a breach existed. However, the Courts in this case reserved the ultimate authority of the Court where even though no expert witness condemned the non-disclosure, such information was so obviously necessary to an informed choice on the part of the patient that no reasonably prudent medical man would fail to make it.[4]

In order to determine whether a breach of the duty to care in this context has been made, the answers must be judged in the context of good professional practice rather than what the reasonably prudent patient might want to know.[5]

Of course, accepted practice in relation to disclosure must be judged by current practice at the date of the alleged non-disclosure.

(b) In determining the standard of competence to be achieved when considering an issue of care in diagnosis and treatment, no allowance is made for inexperience. The test is that a practitioner must attain the standard of skill to be expected from a person holding his post. In WILSHER V ESSEX AREA HEALTH AUTHORITY[6] it was irrelevant that the doctor was new to his post and still in training. A junior doctor may, however, discharge his duty to a patient by consulting senior colleagues. With reference to so called battle conditions the standard of what is reasonable in an emergency may be qualified by that emergency. However whether lack of resources and overwork may reduce the standard of care owed by junior doctors is dubious.

It must be established that the practitioner either omitted to carry out an examination or tests which the symptoms indicated as necessary, or the patient's history should have prompted, or that he reached a conclusion which no reasonably competent doctor would have arrived

at. For example, failure to test for malaria in the case of a patient recently returned from the tropics when the patient presented flu-like symptoms and the doctor was informed of the recent trip was held to be negligent.[6] Practitioners must also be ready to reassess their diagnosis.

c) With reference to the duty of care in treatment and prescription, there will be negligence for failure to check a patient's history and potential drug compatibility. In one case, a clinic was held to be liable for death resulting to a patient who had been injected with penicillin and died from a reaction to the drug. The clinic had failed to inquire of the deceased whether she had an allergy to penicillin and injected her with the drug.[7]

Where a patient is treated by more than one doctor, their failure to communicate with one another would breach the duty of care.

In prescribing drugs, an erroneous overdose would lead to a finding of negligence. In another case, a doctor who intended to prescribe the right drug and dosage was still held to be liable when his appalling handwriting misled the pharmacist to dispense the wrong drug.[8]

d) Errors in Treatment: An injury resulting from errors in treatment must be shown to be the result of (i) an error on the part of the defendant rather than the materialisation of a risk inherent in the treatment and (ii) an error which a reasonably competent practitioner would have avoided.

A negligent error may be for example:

- Failure to follow a routine precaution – often resulting in leaving surgical materials in the body.
- Mechanical error.
- Failure to provide proper aftercare.
- Failure to deal with complications after treatment or surgery.

- Injecting the patient in wrong area.
- Failure to check anasthetic equipment.
- Use of wrong anasthetic gas or drug.

The duty of care is owed by all medical practitioners.

Nursing staff owes this duty to their patients. Such staff is usually employed by hospitals or clinics and a patient would probably opt to sue the authority employing them rather than the individual nurse. In assessing competence and skill, the same principle appears to apply to nurses - that they must attain the standard of competence expected from a person holding their post. As nurses undertake more and more skilled functions, so the standard of care rises. Very often, a nurse may discharge her duty by bringing a concern to the notice of the medical practitioner caring for the patient.

Obvious examples of breach of duty would be, if a nurse fails to take note and act on the instructions given to her by the attendant medical practitioner. Nurses responsible for equipment would be held liable if that equipment were to be contaminated due to their negligence.

In the case of allied professions, it is interesting that, for example, a pharmacist was not held to discharge the duty of care by dispensing as written a prescription presented him when such was for a dangerous dosage of a drug. The pharmacist had to check with the doctor prior to dispensing the drug.[8] In the case already reported of the pharmacist who misread the doctor's prescription, the pharmacist would still remain liable if he should have been alerted to the fact that the prescription was inappropriate for the patient.[9]

Liability of Health Authorities

The health authority that employs professionals responsible for medical negligence is vicariously liable for that negligence. In *GOLD VS ESSEX*

COUNTY COUNCIL the Court put paid to the heresy that because of the degree of independent judgement exercised by consultant surgeons and physicians, the hospital authorities were not liable, provided the practitioner was an employee.

A hospital authority must use reasonable skill and care in carrying on the hospital and is liable for: Pacts or omissions of its permanent staff – whether surgeons, physicians or nurses, in the course of their employment: In *Gold vs Essex County Council*[10] already cited, the Court of Appeal held the defendant hospital liable for the negligence of a full time radiographer. It seems that in the UK the position holds for full time staff in national health service hospitals. (The hospital authority would have a claim for indemnity against the negligent member of its staff).

In addition it seems that in principle a hospital authority is liable for the acts or omissions of any part-time staff or visiting consultants and specialists if they are employed as part of its organisation for providing treatment whether they are in law the servants of the hospital authority or not; for in such circumstances the hospital authority undertakes the obligation of giving to any patients who require it treatment of the kind which the consultants and specialists are employed to provide – *This statement of law is supported by REX VS MINISTER OF HEALTH* [11] where the Court of Appeal held that a voluntary hospital was responsible for the negligence of a visiting part time anaesthetist – the primary question being the scope of the obligation undertaken by the body providing the treatment.(Also supported by Lord Denning in Cassidy v Ministry of Health [12].) In *Macdonald v Glasgow Western Hospital Board of Management* however, there was a reservation as to the question of liability of the hospital for a visiting consultant who is not part of the hospital staff (1954 S.L.T. 226). A hospital authority is not however responsible for the acts or omissions of a consultant or specialist who is selected and employed by the patient. (See *Cassidy op cit.*).

The position of a patient treated privately thus appears to be rather different. In such case, the patient would normally have selected the

consultant to care for him and will contract with the consultant for the necessary treatment or surgery and will contract separately with the hospital or clinic for nursing and ancillary care. In such a case the consultant does not act as an employee for the clinic which is not liable for his negligence. Where an accident occurs during surgeon, it may be problematic to identify whether the fault was of the surgery or of the hospital staff and it may be difficult to raise an inference of negligence against a particular individual.

What of agency nurses for example? These are not in direct employment with the hospital but with the agency that provides them. The judgment of Lord Denning in *Cassidy vs Ministry of Health* contends that health authorities are directly and primarily liable to patients and that this liability does not depend on whether the contract under which the negligent professional was employed was a contract of service or a contract for services. Once it has accepted the patient for treatment, the health authority comes under the duty to treat the patient with reasonable care and skill. Consequently it is responsible.

It is not the scope of the present talk to discuss the quantum of damages that can be claimed. Suffice it to say that Maltese law provides for compensation on the basis of *lucrum cessans* or actual monetary loss and *damnum emergens* which requires a liquidation of future loss and would include a determination of the percentage of disability a patient may have suffered. There are no special rules applicable but general principles would apply to claims for medical negligence.

These issues raise the question of indemnity insurance.

Professional Negligence Insurance

As more and more private individuals opt for health cover, it becomes imperative for the health professional to cover his/her liability with adequate professional indemnity insurance.

An indemnity policy covers a loss resulting from claim made against the assured in respect of any act of neglect, default or error on the part

of the assured, his partner or servants in the conduct of his profession. A patient who has suffered damages as a result of negligence should be guaranteed proper compensation for that negligence. A successful claim can attract not only immediate costs of short-term treatment, but also costs of long-term therapy, nursing and assistance. As in other cases of damages, a plaintiff may be awarded costs based on the liquidation of the percentage disability resulting multiplied by the expected earnings over a calculated life span of 20 years. A court will consider age, earning capacity, the need for professional long term help and even expected costs if the plaintiff would have to engage domestic help or other assistance. Damages for pain and suffering are not admissible in Maltese law as yet. However, recent judgments have become more expensive in their awards.

For example, in one case, it was held that compensation should include physical and mental damages.[13] In another case, the Court adopted a multiplier of 30 in respect of a plaintiff who was 22 years old at the time of the injury and also considered loss of part time employment for this purpose.[14]

One has to bear in mind that a practitioner may not even be faced by the actual patient in an indemnity suit but, rather, by the patient's health insurance provider should, for example, the patient direct that no payment be made by the Insurer.

In the final analysis, one can conclude that on the issue of liability, the test adopted in *Bolam* is a fair one to both patient and practitioner alike and provides a sound guideline for the determination of professional responsibility.

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7 CELEBRATING TEAMWORK IN HEALTHCARE

REV. PROF. EMMANUEL AGIUS

The main objective of the local conference on *A National Agenda for Sustainable Health Care* organized in February 2000 by The Foundation for Medical Services and The Forum of Health Professionals was to discuss the future of health care in Malta. Keynote speakers participating in this conference referred several times to the need of partnership or teamwork in today's healthcare system. Many claimed that interdisciplinary collaboration is becoming increasingly important because of the current complexity and cost of health care. The workshops' reports presented at the concluding plenary session of this conference are replete with statements that reflect the participants' concern for the lack of an interdisciplinary approach in our local health care system.

The following concluding remarks taken from the workshops' reports provide ample food for thought both for healthcare professionals as well as for those responsible to formulate and implement the ongoing restructuring of our national health care service: 'no continuity between hospital and community health care – fragmented care', 'lack of inter- and intra-professional communication', 'professionals are working in isolation', 'public and private sectors must co-operate', 'incentives must be created for health care professionals to work together', 'little or no teamwork or participation', 'curricula do not include humanistic values, communication skills and inter-professional interaction', 'the patient must be part of the team', 'teamworking requires learning new methods of work', 'health professionals need to learn how to interact with and respect other professionals and patients', 'primary health care lacks a multi-disciplinary service', 'health professionals need to be trained in interdisciplinary and teamwork practice'.

1. Defining an interdisciplinary health care team

R.B. Reich, in an article published in the *Harvard Business Review,* stated that '[i]f we are to compete in today's world, we must begin to celebrate collective entrepreneurship, endeavors in which the whole of the effort is greater than the sum of individual contributions. We need to honor our teams more, our aggressive leaders less'.[1]

Teamworking, in particular interdisciplinary teams, is among today's challenges of health care. Teamworking is seen as a way to tackle the potential fragmentation of care, a means to widen skills; an essential part of the need to consider the complexity of modern care; and a way to generally improve quality for the patient.

According to Theresa J.K. Drinka and Phillip G. Clark, an interdisciplinary health care team integrates a group of individuals with diverse training and backgrounds who work together as an identified unit or system. Team members consistently collaborate to solve patient problems that are too complex to be solved by one discipline or many disciplines in sequence. In order to provide care as efficiently as possible, an interdisciplinary health care team creates formal and informal structures that encourage collaborative problem solving. Team members determine the team's mission and common goals; work interdependently to define and treat patient problems; and learn to accept and capitalise on disciplinary differences, differential power, and overlapping roles. To accomplish these they share leadership that is appropriate to the presenting problem and promote the use of differences for confrontation and collaboration. They also use differences of opinion and problems to evaluate the team's work and its development.[2]

The value of working actively with other professionals, as part of a single care team, is well-established in discussions on effective health care. Sir Charles George, former chairperson of the Education Committee of the British General Medical Council and former Dean of the Faculty of Medicine, Health and Biological Sciences in Southampton, described teamworking as 'an essential prerequisite to modern clinical care'. In his report[3] entitled 'Teamworking in Medicine' presented in 1999 to the British General Medical Council, he claimed that medical and clinical teams, in order to be effective, must:

- have a positive attitude to patients and listen to their wishes and needs
- make sure that patients and colleagues understand the roles and responsibilities of team members, their professional status and specialty
- make themselves aware of what patients think about the quality of their service; and
- have a clear understanding of their professional values, standards and purposes.

The same report states that team members should:

- be willing to learn
- be committed to providing good-quality service and effective clinical practice
- respect the skills and contributions of colleagues
- be open and honest about professional performances, both together and separately; and
- try to persuade other team members to change their mind when they believe a decision would harm a patient, failing when they should tell someone who can take action. As a last resort they should take action themselves to protect the patient's safety or health.

Moreover, the report claims that an effective team will show:

- **purpose and values** – for example, evidence of well-defined values, standards, functions and responsibilities, and strategic direction
- **performance** – which will involve evidence of leadership, competent management, good systems, good performance records and effective internal performance monitoring and feedback
- **consistency** – including evidence of thoroughness and a systematic approach to providing patient care
- **effectiveness and efficiency** – evidence that amongst other things, they are assessing the care they provide, and its clinical results
- **a chain of responsibilities** – demonstrating that responsibilities are well defined and understood

- **openness** – for example, willingness to let others see in, and evidence of performance presented in ways that people outside the team can understand and
- **overall acceptability** – including evidence that the performance and results achieved by the team inspire the trust and confidence of patients, employers, and professional colleagues.

To help maintain quality, the report of the General Medial Council states that clinical teams should normally use:

- an active and supportive approach to the professional development of each member
- the standard set by professional organisations
- recommended clinical guidelines
- detailed performance records
- internal and external medical and clinical audit
- regular review of individual members' performance and
- suitable procedures for looking into complaints and avoiding unnecessary risk.

In Western society, there is evidence to suggest that superior organizational performance may be directly attributed to effective teamwork. Perhaps the father of group work and research is Emile Durkheim, who attempted to show that society is based on fundamental solidarity among people. He advanced the theory that this solidarity derives from interpersonal relationships among members of primary groups, which he defined as a small group of people characterized by face-to-face interactions. These groups include families, peer groups and group of co-workers.

Teams may be portrayed as 'effective work groups' whose effectiveness rests in the degree of motivation, co-ordination and purpose and whose synergy produces energy and creativity which is beyond them as individuals. The team approach to patient care is viewed as a means of

building and maintaining staff morale, improving the status of a given profession (for example, nurses and allied health professionals may become team collaborators with the physician rather than working under the physician), and improving institutional efficiency.

All teams are groups, but not all groups are teams. The difference comes primarily from the fact that a team of people is brought together to work towards a common purpose. We all know that good teamwork does not happen by chance. It requires deliberate and well-planned actions to develop and sustain it. That means tolerance, co-operation, and building on each other's strengths. It means integration and adaptation. Teamworking is meaningless without a shared vision and common goals.[4]

There are various levels at which a collaborative approach can take place. At the micro level, relationships between individual health professionals who are collectively responsible for hospital patients are expected to reflect sharing of competencies, communication and cooperation. In clinical settings, there are usually good working relationships among health professionals. But too often at the policy and planning levels of health care, things are different. At the macro level, an interdisciplinary approach is also needed for the setting up of national policies on healthcare. Only an ongoing social dialogue between the government and representatives of professional bodies could achieve this goal. Moreover, co-operation between primary and secondary healthcare professionals needs to be strengthened. We need a good system of communication, collaboration and partnership between hospital consultants, healthcare centres and family doctors.

2. From Multidisciplinary to Interdisciplinary Care

Though taken for granted today, a team approach to health care has appeared only recently in the practice of medicine in Western society. The development of team approach in Europe and North America reflects the historical development of these two continents. In the first

period, between World War I and World War II, a multi-professional approach appeared in healthcare that later developed into the team model. The major sources of impetus which brought about the shift in emphasis away from multidisciplinary towards interdisciplinary care included the proliferation of medical specialties, an increase in expensive, complex technological interventions, and the new challenge of providing a coordinated and comprehensive approach to patient care management.

The concept of multidisciplinary care is based on the premise that health care is delivered by a team, each member of which has a different training and brings different skills for the patient's benefit. Because they were trained to practise autonomously, physicians and other disciplines worked side by side in a sequential and sometimes contradictory fashion. There is no interdisciplinary collaboration when healthcare professionals only work in close proximity with each other with no interaction and communication with each other. There is more to collaboration than simply working side by side. Working 'together' rather than working 'alongside' can energise people and result in new ways of tackling old problems.[5]

A second period of development occurred between the 1950s and the 1980s, where interdisciplinary teamwork became the norm: health care became increasingly hospital-based, enabling a large group of health professionals in one place to care for the patient. In addition, new professional groups were generated in the belief that health care should be attentive to patients' social as well as physical well-being.

Interdisciplinary care, although not denying the importance of specific skills, seeks to blur the professional boundaries and requires trust, tolerance, and a willingness to share responsibility. What characterises this new model of collaboration is the recognition that it is not what people have in common but their differences that make collaborative work more powerful than working separately. Working together means acknowledging that all participants bring equally valid knowledge and expertise from their professional and personal experience.

An effective interdisciplinary teamwork requires a common information base and shared values, as well as respect for professional roles. Partners work together to achieve common goals. Their relationship is based on mutual respect for each other's skills and competencies and recognition of the advantages of combining these resources to achieve beneficial outcomes. Successful partners share decision making and responsibility.

The third period, which continues to the present, has focused on the appropriate goals and functions of health-care teams and evaluation of the teams' effectiveness.

3. Teamwork and Quality of Care

All medical practitioners have one primary goal, namely to ensure measurable and positive outcomes of their medical treatment. With this commonality in mind, it is crucial that an interdisciplinary teamwork should be aimed at in order to provide optimal care for the patient.

Studies show that the quality of healthcare professionals' relationship affects the outcomes of care. Quality of care and teamwork are inseparable. Good teamworking aims to produce a better outcome for patients and to make each team member feel valued and fulfilled. Effective interdisciplinary teams can enhance the efforts of quality improvement. Unfortunately, when teamwork is not functioning optimally, patients may have a less satisfying experience, leaving them with little confidence in the process. Without a team approach and good communication throughout, a favourable patient outcome is jeopardized. Harmful health care often happens as a result of no communication or a breakdown in communication between several providers who may or may not be from different disciplines, or between providers and patients.

All health professionals have the same overriding goal, namely the restoration and/or maintenance of their patients' health. This calls for a co-ordinated effort from all of them. The input of team members can influence the treatment plan. There are two characteristics which the

members of health-care teams should consistently display: first, solidarity with and mutual respect for one another, and secondly, a willingness to co-operate with one another for the good of patients. Where these characteristics are absent, the well-being of patients may be put at risk.

Membership of a well functioning team – one with clear team and individual goals, that meets together regularly, and that values the diverse skills of its members – reduces stress levels and increases performance. Thus coherent teamwork is crucial for the delivery of good quality patient care both directly in terms of efficient and effective services, and indirectly via its effects on reducing stress. Teams need to be aware of all the responsibilities of a unit, with knowledge of each other's work, developed ways of working together and supporting each other[6].

4. Some Ethical Issues in Teamworking

Ethical issues regarding health care teams arise in three major areas:[7]

(i) challenges arising from the team metaphor itself

(ii) the locus of authority for team decisions

(iii) the role of the patient as team member

The team metaphor

It is generally agreed that the health care team idea arose from assumptions about sports and military teams. This metaphor is not completely fitting because a health-care team is not in competition with another team. However, it is fitting insofar as members experience their affiliation as entailing 'team loyalty', a moral obligation to other members and to the team itself. They may believe that they have voluntarily committed themselves to a type of social contract requiring a member

not only to perform maximally but also to protect team secrets, thereby promoting a tendency for cover-ups or protection of weaker members. In the military team, obedience to and trust in the leader is an absolute.

An ethical conflict may arise when a member's moral obligation of faithfulness to other team members or the 'captain' does battle with moral obligations to the patient. This may manifest itself in questions of whether to cover up negligence or a serious mistake by some or all of the team. Should health care professionals 'blow the whistle' on their colleagues by reporting them to higher authority? Clearly this problem arises not only when a health professional is the victim of another health professional's wrong action but also when she/he witnesses another health professional acting wrongly. Sometimes, holding peers morally accountable for incompetence or unethical behaviour may be made more difficult by the team ideal. Therefore, teams must foster rules that require and reward faithfulness to patient well-being, and balance the value of team membership with that of maintaining high ethical standards.

Sometimes a further breakdown of communication and effectiveness accrues because of the team leader's allegiance to scientific rigor and specificity at the expense of a personalised caring approach to the patient. Since many team leaders are physicians, problems may arise as a result of the serious differences in orientation between physicians and other health-care professionals. Whatever its cause, marginalization of some team members results in team dysfunction.

Locus of authority for decision making

Since interdisciplinary healthcare teams involve different roles with their specific identity and boundaries, expectations are created regarding the conduct of each member of the team. This may give rise to the question of whose role carries the authority for team decision making. The challenge applies to both unidisciplinary and interdisciplinary teams but is highlighted in interdisciplinary ones, particularly those involving physicians and other health professionals. Traditionally the physician

was the person in authority by virtue of his or her office. The team metaphor reinforces the non-movable locus of authority vested in one who holds such office.

At the same time, the team metaphor created expectations of more equality among members based on competence to provide input. Each member becomes an authority on the basis of professional expertise instead of office, and should be in a position to provide leadership at such time as expertise indicates it. In ethical decisions regarding patient care, the question of authority must be viewed in terms of who should have the morally authoritative voice. Technical expertise does not automatically entail ethical expertise. In both types of decision-making situations, the locus of authority is movable.

Since ancient times, the doctor was the sole dominant and authoritarian figure in the care of the patient. He has been supported in this position by traditional ethics. Today, doctors need to acquire new attitudes for they are not prepared for the negotiations, analysis, and ultimate compromise fundamental to group efforts. According to E. Pellegrino 'no current code of ethics fully defines how the traditional rights of the medical transaction are to be protected when responsibility is diffused throughout a team and an institution. Clearly, none of the health professionals can elaborate such a code of team ethics by itself. We need a new code of ethics which permits the cooperative definition of normative guides to protect the patient served by a group, none of whose members has sole responsibility for care.'[8]

A further complication arises because teams usually have several members. A critical question regarding such collective decision making is whether team decisions are the sum of individual members, with accountability allocated only to the individuals, or whether a team itself can be regarded as a moral agent.

Sometimes teams have difficulty coming to consensus about the appropriate course of action. The moral responsibility of the team members is to assume that further role clarification, further attempts at

consensus building, and other collective decision-making mechanisms are instrumental only to maximizing patient well-being. Negotiations strategies must be built into the team process so that the authority of any one or several members, or even the team as a whole, does not prevail at the cost of the competent, compassionate decision geared to the appropriate ends of that team's activities.

The patient as team member

There is much discussion about whether and in what respect patients/clients and their families are members of health-care teams. The doctrine of informed consent and its underlying legal and ethical underpinnings dictate that patients and families should have input into decisions affecting themselves and their loved ones. Patient empowerment is perhaps the ultimate expression of teamwork in response to health problems. Although I believe that patients should be actively involved in their care, I also believe that patients should be active according to their ability. Determining a patient's true mental and physical capability for participation can be very difficult and is one of the responsibilities of the highly skilled health care provider or health care team.

5. Educating health professionals for teamwork

We need a culture that values teamwork. Health professionals should be offered the opportunity to learn together in order to be prepared to work together and care together. Being a good team member requires excellent interpersonal skills. It is easier to evaluate technical skills than interpersonal skills. Health professionals should be taught the benefit of openness and teamwork. Emphasis should not be put on the ability to cope on one's own without recourse to colleagues.

Too often the health professionals have approached patient care in isolation from one another. It is essential that health professionals develop their programme of education, research and patient care in

close collaboration with each other from the outset. There is need for a process that promotes interaction among students from different health disciplines for the purpose of developing knowledge of themselves, their role and others, fostering collaborative skills and problem solving methodologies which result in better client care, and team interaction. By sharing training experience, future care providers will develop skills in interdisciplinary communication, understanding, and problem solving, even as they learn the particular stance and skills that mark their unique discipline[9].

Within many UK universities, former Faculties of Medicine have been enlarged to incorporate several Schools, providing training not only for doctors but also for nurses, midwives, pharmacists and other health care professionals. Consequently, opportunities have arisen to offer interdisciplinary education as an experience of teamworking, at a formative stage.

It is not sufficient to educate and promote team development training and then leave the team on its own to function or to try to deliver care as an interrelated system. It is equally important to develop and learn the team system, recognizing that such a sophisticated system needs to be maintained, and that team members must be allowed time and must take time to manage their team.

As a concluding remark, I venture to comment that we cannot face adequately the future of healthcare of our country without creating an ethos of teamwork and team management in our healthcare services. The road towards this goal is long and full of obstacles. Let us take the challenge and learn to plan together for it properly and to move slowly but gradually towards full implementation of interdisciplinary practice in our healthcare system for the benefit of both present and future generations.

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3 THE RELATIONSHIP BETWEEN STATE AND PRIVATE PRIMARY CARE

DR. PIERRE MALLIA, M.D., M.PHIL.

In Malta there is no uniform Healthcare system. There are government services divided primarily in State hospitals and health centres in the community; and there are private doctors – from primary to tertiary level. Although the system works somehow, it is by no means perfect and is confusing to the person trying to make use of both. Government doctors have on their contracts that they may work privately - this is one reason why many believe salaries have been kept quite low. Those who opt to work only in the private sector have a choice of making use of government services or using only private institutions for investigations etc. In primary care, it is impossible to always refer people privately for tests and specialist consultations. The private General Practitioner thus usually discusses with the patient whether she wishes to be investigated at hospital or privately and explains the pros and cons of each.

Invariably, many opt to be referred to hospital for further investigations. Since medical insurance is still in its infancy in Malta, and since they by no means gives comprehensive unlimited coverage to the insured, many who have tests done privately pay for them personally. In this respect the health centres have offered a number of tests which the GP may avail herself of and which will thus save the patient some money.

Tests offered by the department of health

Recently it was announced that GPs may order a limited amount of blood tests either through health centres or by taking blood themselves and handing it personally to the hospital laboratory. This was definitely a step in the right direction as not all people can afford to have tests done privately, and it thus saves a considerable amount of patient and staff time by avoiding unnecessary referrals for basic blood tests.

However the generosity stops here. For other specific tests doctors must refer either through a hospital firm or, rather unprofessionally, through another health centre doctor. For example, if I want to order a simple Chest X-ray I may send the patient to the health centre; but I must do this through another doctor, I do not get a copy of the X-ray (unless I am prepared to wait for about three months – I have tried this and till now have never managed to get hold of a copy), and it is only at the other doctor's discretion whether he will send me a note. The fact is that by referring the patient to the health centre, I have had to send the patient to another doctor who then decided whether that Chest X-ray was to be done. Although these are rarely refused, it is rather unprofessional that another doctor – usually junior to onself decides about my patients.

Co-operation with Health Centres

Patients are not registered with a doctor under our system. Yet when asked who their doctor is many will give you the name of their private GP. This occurs for example when someone unfortunately dies and the family calls in the health centre doctor. To avoid having to issue a death certificate for someone they have never seen before, the doctor asks the family who their doctor is. They are then instructed to call him or her – even if in reality he may not have seen the deceased for months or even years. Nevertheless, if the private GP is good enough to be involved in such situations, should he or she not be good enough to informed about the patient's history and visits to the health centres? It is definitely not in the interest of patients to have two files – one at the polyclinic and one at their private GP; both files having information which the other lacks.

Inter-professional co-operation and communication is something we owe our patients and is a requirement by any code of ethics. To date our ethical codes approved by the Medical Council do not stipulate such co-operation because in reality health centres and private doctors

owe nothing to each other and it is only at their discretion to co-operate. In effect health centres take away from the private GP his or her everyday bread and butter so it would seem ironic to many to co-operate at all. Nevertheless if we are to make a health system which provides optimal care, the government has to realise that it is only the private family doctor who provides a true family service and who provides continuity of care that no doctor in a health centre can provide. It is thus in the interest of everybody that the private GP should be helped and not hindered.

The role of the GP in hospital

Let us now tackle the relation between primary and secondary care. To date there is no protocol governing how the hospital team should deal with the family doctor. Indeed, even in discharge letters, although there is a space for the name of the family doctor being addressed, this is left unfilled even if the family doctor referred the patient to hospital. Patients may be seen again at Out Patients Departments and finally they are discharged. There is never any continuity of care, however, and I often get patients complaining that they have been ignored or abandoned, not realising that their private GP or the health centre is to take care of their continuing medical needs. Sometimes patients are told that they now have to continue seeing their doctor; or if the patient asks he is granted a note for his GP.

What should happen is that there should be continuity of care throughout the process, both as in-patients and as out-patients. There is a role for the family doctor to be included in the treatment plan of the patient throughout; and the least one can do is to have a good system of communication with the GP. As it is, it is at the discretion of the GP to chase the hospital doctors for information about his or her patients; and even in hospital the nurses may be reluctant to allow this stranger claiming to be the patients' GP to see the file. Who can blame them? They are responsible for the confidentiality of files.

Follow-up after hospital

Diabetic patients are often referred to the Diabetes Clinic for instruction and further tests. Once patients finish the secondary-care treatment of diabetes, they are never referred to their primary care doctor. Instead they are referred to the health centres in the community. I think this is the most unethical practice in our health care system. We are giving our patients the message that diabetes is something to be followed up by a specialist who works in the health centre, or in some instances, privately. But in an emergency, it is the GP who is called in, and who then must make sense out of a situation which he not only has not been following, but, in the case of a patient he has not seen for some time, may be unaware of.

Diabetes is to be looked after by the family doctor – unless the doctor feels he needs to share the care of the patient with a specialist. It is not only unethical for any doctors working in the diabetes clinic to take on patients without ever communicating with the family doctor, it is unprofessional for the government to lure people into thinking that they will not be entitled to free insulin unless they attend the polyclinic.

Conclusion

The government should seek to explore further possibilities of co-operation with doctors at primary care level – be they health centre doctors or private doctor. Only private doctors provide true Family Medicine Without them the government would have to invest more. People attend health centres; but only their family doctor provides them with an on-going security. If we want this to remain the government must not only stop competing with the family practitioners providing patients with services which only give a false sense of security, but it should seek to promote the family doctor who knows you from birth through to the age when you yourself have children.

Moreover, the government should commit itself to provide post-graduate education to doctors. I recently sought the help of the Department of

Radiology to learn ultrasound screening – a process which has started in Family Medicine abroad. Ultrasound screening is recommended as part of the general physical examination. It is cheap, it is easy and it can detect conditions, which are otherwise silent, much before patients present with symptoms. I was turned down. If anything this should increase referrals to radiologists for confirmation; but the point is, once the government does not provide ultrasound screening and once international standards suggest ultrasound for primary care, government should provide the training. Unless we are to scrap either private care or State care, the only road left is co-operation between the two. Professionally we owe this to our patients.

9 THE MORALITY OF HEALTH CARE PROVISION

DR DENIS SOLER

Medical ethics has been defined as "the analytical activity in which the concepts, assumptions, beliefs, attitudes, emotions, reasons and arguments underlying medico-moral decision making are examined critically."[1] This is a hot potato for debate, and anyone hoping that ethics will provide simple straightforward answers will be disappointed.

The goal of medical ethics is to improve the quality of patient care by identifying, analysing, and attempting to resolve the ethical problems that arise in the practice of clinical medicine[2].

The basic preconditions for health are well known, and many societies are willing to consider their equitable distribution. In spite of this, few societies are actively trying to redress inequalities in health. In choosing between policy options that concern such known preconditions for health as education, income, environmental safety, housing, and working conditions, policymakers should consider distributions as well as general average outcomes. But for that to happen, equity in health needs to remain on the political agenda.

Ethics and morality in health care are consequently not the sole domain of medical practitioners.

It is time to admit that we need a two-pronged approach to equity in health: a scientific and a political effort. These may not be synchronised and each has to be allowed to run its own course, but they need to happen simultaneously[3].

On the one hand we are confronted with a teasing scientific problem. Why are social inequalities in health so universal? They show a clear gradient for almost any health indicator by any measure of social position be it education, income, professional class, or social class in every

country where data have been collected, irrespective of the country's position on income distribution, access to education, regulations on working conditions, social benefits, or social housing policies. Why do health inequalities appear to affect almost all diseases, both the diseases of poverty and the lifestyle related diseases of more affluent societies? And, finally, with the limited evidence we have on interventions that seem to improve the health of deprived groups can we confidently recommend policies to governments eager to reduce inequities in health?

It might well be that equity is the most powerful concept to help not only developing countries in their growth towards health for all, but also western countries in trying to adapt health policies for the 21st century. One important opportunity to achieve as much equity in health as possible, given our limited understanding, may be in the daily practice of health care itself. Institutions and individual practitioners need carefully and continuously to ask themselves if their efforts produce equal benefits for those entrusted to their care. Such small-scale efforts are unlikely to resolve the inequalities in health we measure at population level, but a continuing effort at least not to add to these inequalities may well be the best way to preserve equity as a central value in our healthcare services.

The expansion in healthcare delivery over the past 150 years has exacerbated many of the ethical tensions inherent in health care and has created new ones.[4] To answer these problems, many groups of healthcare professionals have established separate codes of ethics for their own disciplines, but no shared code exists that might bring all stakeholders in health care into a more consistent moral framework. A multidisciplinary group last year came together at Tavistock Square in London in an effort to prepare such a shared code. Healthcare delivery everywhere has expanded from what was largely a social service provided by individual practitioners, often in the home, to a complex system of services provided by teams of professionals, usually within institutions and using sophisticated technology. As a result, problems develop, such as the following:

1. The new capabilities and demands of health care dispose providers and members of society to consume resources at an increasing rate.

2. The financial pressures on healthcare delivery have increased, placing the cost of many acute illnesses and chronic care beyond the reach of most individuals.

3. Financing for these services is therefore provided largely through private or public insurance or public assistance. Limited resources require decisions about who will have access to care and the extent of their coverage.

4. The complexity and cost of healthcare delivery systems may set up a tension between what is good for the society as a whole and what is best for an individual patient.

5. Flaws in healthcare delivery systems sometimes translate into bad outcomes or bad experiences for the people served and for the population as a whole. Hence, those working in healthcare delivery may be faced with situations in which it seems that the best course is to manipulate the flawed system for the benefit of a specific patient or segment of the population, rather than to work to improve the delivery of care for all. Such manipulation produces more flaws, and the downward spiral continues.

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

Cooperation throughout a healthcare system can produce better outcomes and much greater value for individuals and for society. Such co-operation requires agreement across disciplinary, professional, and organisational lines about the fundamental ethical principles that should guide all decisions in a truly integrated system of healthcare delivery.

Five major principles should govern healthcare systems:

1. Health care is a human right.

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

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

4. Co-operation with each other and those served is imperative for those working within the healthcare delivery system.

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

Clinicians often find themselves in the role of managers being required to set priorities, or they may be affected by the decisions of others about priorities. Priority setting was called "rationing" 20 years ago, and "resource allocation" 10 years ago and is nowadays being called "sustainability", as our language about this problem becomes progressively sanitised.

Sustainability of health services does not merely equate with increased financing. It is a complex matter, which is riddled with hard choices, which have social, political and economic implications, all of which are in turn value laden.

The news that the new tal-Qroqq hospital is estimated to absorb the present health budget *in toto* must come as a shock to our politicians and health planners. While time and time again the value of a well organised system of Primary Care in curtailing ever spiralling costs of health services is mentioned, and although efforts and investment in this field have to date been substantial, they were directed at creating expensive buildings, which are proving increasingly difficult to man and which would operate under the same limitations prevailing at present if and when functional. No more money should be spent to further spread out, extend and clone the existing system, which everyone agrees is not the appropriate one. Rather, major consideration for investment should be given to ongoing training and continued professional development of family physicians. The country urgently requires a comprehensive system of primary health care, gatekeeper style offering continuity of care and expounding the fundamental principles of health education, promotion and prevention, as well as providing therapeutic services including palliative care. The bold decision that must be taken soon, if the much flaunted reforms in primary care are to be effective, is that the private sector must be dovetailed into that provided by the State, not only in open recognition of the invaluable social contribution this sector has made over the years, but more importantly, to provide a real choice to patients in determining who to entrust their health matters to.

The most important recent advance in priority setting has been the development of an ethics framework – accountability for reasonableness – for legitimate and fair decisions on setting priorities.

In October 1998, the BMJ sponsored an international meeting and published a special issue on "Priority setting: the second phase." The first phase had been based on "simple solutions," such as cost effectiveness analysis, on the assumption that it was possible to devise a rational priority setting system that would produce legitimate decisions. The second phase follows the realisation that the idea of devising a simple set of rules is flawed and focuses on the priority setting process itself.

Daniels and Sabin have developed a framework - accountability for reasonableness - for this second phase of priority setting[5]. To make legitimate and fair decisions on priorities, organisations must meet four conditions.

The four conditions of accountability for reasonableness are as follows:

1. *Publicity* – Decisions regarding coverage for new technologies (and other limit setting decisions) and their rationales must be publicly accessible.

2. *Relevance* – These rationales must rest on evidence, reasons, and principles that fair minded parties (managers, clinicians, patients, and consumers in general) can agree are relevant to deciding how to meet the diverse needs of a covered population under necessary resource constraints.

3. *Appeals* – There must be a mechanism for challenge and dispute resolution regarding limit-setting decisions, including the opportunity for revising decisions in the light of further evidence or arguments.

4. *Enforcement* – There must be either voluntary or public regulation of the process to ensure that the first three conditions are fulfilled.

The Maltese NHS has evolved as a compromise between key parties; it allowed those patients who could afford it to have access to both private health care and the NHS, and it permitted consultants to have access to income from private practice while working in the NHS. This safety valve for excess demand was developed contrary to the founding principles of equity, but it has been a feature of health care in Malta allowing more affluent patients to circumvent the periodic funding crises in the NHS while maintaining their support for health care funded by taxes. As a result the share of total healthcare spending contributed by the private sector keeps rising steadily.

It has been argued that the NHS is not sustainable, primarily because funding through taxation will lead to an increasing gap between the demand for and supply of health care. Alternatives to the NHS would involve requiring a larger private contribution to the costs of health care but such systems require complex regulation and seem to produce more inequities than what they propose to resolve. In contrast, expanding the funding of the NHS in line with increases in the gross national product appears to be affordable and broadly equitable.

The NHS continues to have high levels of public support, and close to 70% of the population support the principle of a health service available to all. Above all, Malta compares favourably internationally in terms of fairness of funding, equality of access, and efficiency as evidenced in a recent WHO commissioned study.

It would appear that a higher share of private funding in a mixed economy of public and private care is inevitable and desirable. Critics tend to argue that a publicly funded system, particularly one funded through general taxation, cannot provide the volume and standard of health care that an increasingly affluent, aged, and sophisticated population wants (despite the fact that we cannot determine objectively what level of spending is correct). The main difference between Malta and other comparable countries lies not in the amount of public funding for health care but in the lower level of private funding.

Irrespective of the merits of these arguments there is little doubt that a more mixed economy is emerging in Malta, albeit not always as a direct result of explicit reform of health policy.

Gazing into a crystal ball is rarely rewarding, but it seems that the NHS may move in a way where further changes could occur simply through the accumulation of seemingly separate smaller scale changes which would further reduce the contribution of publicly funded health services, as has happened so far.

On the other hand politicians have never been more aware than today that this is a risky path to follow as lack of foresight and planning could well send the whole system into chaos. Some indications as to the trend that the NHS may follow in future can be gleaned from the occasional ministerial slip or statement. Other possible directions may be deduced from what other countries, sharing the same funding problems have considered as possible options.

It would not be unreasonable to predict that the country may be faced with the following developments that may alter the mix of financing for health care:

- Removal of the tax payable on private insurance schemes in the short term – a yet unfulfilled electoral promise,
- Plans for compulsory private medical insurance in the long term,
- Changes in social security leading to a requirement for personal insurance against accident, sickness and retirement,
- Commercial funding for all major NHS capital schemes,
- Moving NHS dental care into the private sector,
- Government plans to charge insurers for the full cost of NHS treatment of motorists and passengers involved in road accidents.

The survival of health services lies largely in the hands of Government. Various governments have introduced different reforms aimed at making the system sustainable in the face of present and future challenges. Arguments about the adequacy of funding are likely to continue because it is a matter of value judgement, which of necessity is made by Government. However, Government also has the ability to modify the pressures on the health services and so how well it copes is, at least partly, a function of political choice. Government could try to reduce demands arising from increased expectations by encouraging informed

public debate about priorities and influencing the availability of private health care.

If Government wishes to sustain its health services then it needs to engage the public in deciding how to trade these values and brace itself for an ever-increasing financial allocation to this sector, with major internal re-distribution of funds where spending has been shown scientifically to contain overall health costs.

Maybe the most important development will be in our sensibilities. Having been told for so long that change is inevitable, the prospect of change does not seem quite so alarming, even though the evidence that it will solve the enduring problems of health care in Malta is lacking.

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Notes on Contributors

Rev Professor Emmanuel Agius studied philosophy and theology at the University of Malta and at the catholic University of Leuven, Belgium, where he obtained an M.A. and Ph.D. He pursued post-doctoral research in the field of bioethics at the University of Tubingen, Germany as a fellow of the Alexander von Humbolt Stiftung, at Georgetown University, Washinton, D.C. as a Fulbright scholar, and at the University of Notre Dame, Indiana. He is professor of Moral Theology and Philosophical Ethics at the University of Malta. He is a member of the National Bioethics Committee and co-ordinator of the *Future Generations Programme* which is supported by UNESCO. Prof. Agius is the author of three books and co-editor of five publications on future generations. His articles have appeared in a number of international journals.

Dr Sandra Buttigieg is the Director of the Institute of Health Care, University of Malta. Sandra Buttigieg graduated as a Medical Doctor from the University of Malta in 1987, later obtaining a Masters in Public Health Medicine. She is currently reading for a Masters in Business Administration. She is also a Fellow of the Salsburg Seminar, sessions 292 and 356, related to Health Care. Between 1987 and 1998, she served as Vice-President and later International Secretary of the Medical Association of Malta. Dr Buftigieg's previous post was that of Medical Superintendent at St Vincent de Paule. Dr Buttigleg is a member of the Bioethics Consultative Committee, the St Luke's Hospital Management Committee, and the Board for the Professions Supplementary to Medicine.

Professor Maurice N. Cauchi, A.M., M.Q.R., M.D., M.Sc., Ph.D, F.R.C.RA., F.R.C.Path Professor Cauchi graduated M.D. (Malta, 1991) and furthered his education at the University of London, Monash and Melbourne. He is professor of Pathology, University of Malta, and Chairman, Gozo Health Council. He is Chairman of the Research Ethics Committee (Medical School, University of Malta). He represents Malta on the Bioethics Committee of the Council of Europe. He has written and edited several monographs and papers of a scientific nature. He has also several articles relating to bioethics to the local press. He is currently Chair, Bioethics Consultative Committee.

Dr Pierre Mallia graduated M.D. in 1993 and M.Phil. (Bioethics) in 1998. for which he obtained a distinction. He is currently secretary to the Bioethics Consultative Committee and lecturers part-time in Bioethics at the University of Malta whilst being a fulltime GP He has written articles on Bioethics in a number of International journals and presented a number of papers in international meetings. Currently he is about to publish a book on patients' rights in Maltese. His M.Phil. thesis on Principles of Biomedical Ethics is also being published (Kluwer Academic Publishers). He is reading a PhD in Bioethics at the Catholic University of Nijmengen, Holland, under Prof. Henk ten Have with whom he also works on EU-related projects in Bioethics.

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Dr Mifsud is also expert evaluator for proposals submitted under the Quality of Life key action in Brussels. Locally, she chairs the Gender Issues Committee for the University of Malta, and is a member of the Public Service Commission. She has been a member of the BioEthics Consultative Committee since 2000, after previously having been member of the Research Ethics Committee of the Faculty of Medicine and Surgery.

Frank Portelli MD FRCS (Ed) A surgeon and presently Director and CEO, St Philips Hospital Malta, and Consultant in private Practice, Blue Cross Clinic. He has held several appointments, including,

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He was also appointed by the Council of Europe as an Official Observer for the first Elections in Yugoslavia, and by the Commonwealth Association as Official Observer for Elections in St. Kitts.

Dr Lorraine Schembri Orland was educated at the Convent of the Sacred Heart. She graduated to the Doctorate of Laws from the University of Malta (1982), and holds a Masters degree in European Law, as well as a Diploma to serve before the Ecclestiastical Tribunal. Her Doctorate thesis dealt with problems of carrier liability in container carriage whilst her Masters thesis dealt with "The Doctrine of Direct Effect" of the European Union." Dr. Schembri Orland was President of the National Council of Women(1988-1990), an elected member of the Executive of the Conseil International des Femmes(ICW), Chairperson of the Inter-govenmental Committee on Violence Against Women (1990-92), and Vice-Chairperson of the Commission for the Advancement of Women (1989-1996). She is co-drafter of the family law and adviser on amendments concerning Domestic Violence. She is also a Salzburg Fellow and a recipient of the USIA International Visitors Programme. She has represented Malta at the Council of Europe, at the UN General Assembly and at the 1995 UN World Conference in Beijing. She was an Expert advisor to the Commonwealth on women's issues (1993-1995). She was a Director of Middle Sea Insurance Co. Ltd. (1992-1996), a Committee member of the Camera Degli Avvocati (1998), and is currently a Director of Sea Malta Co.Ltd. She is married to George Schembri Orland and has one son, Kevin. She is partner in the Law firm Farrugia Schembri Orland.

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