

CROSS-CULTURAL ISSUES IN EUROPEAN BIOETHICS

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ABSTRACT

European biomedical ethics is often contrasted to American autonomy-based approaches, and both are usually distinguished as 'Western'. But at least three 'different voices' within European bioethics can be identified:

- *The deontological codes of southern Europe (and Ireland), in which the patient has a positive duty to maximise his or her own health and to follow the doctor's instructions, whilst the physician is constrained more by professional norms than by patient rights*
 - *The liberal, rights-based models of Western Europe, in which the patient retains the negative right to override medical opinion, even if his or her mental capacity is in doubt*
 - *The social welfarist models of the Nordic countries, which concentrate on positive rights and entitlements to universal healthcare provision and entrust dispute resolution to non-elected administrative officials*
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It is salutary for bioethics to bear in mind the contrasts between West and East, but we also need to remember that 'Western medical ethics' is not a unified field. North American approaches, archetypically based on autonomy, may well differ from European values encompassing solidarity; but even within Europe, three possible models of rights and justice spring to mind:

- The *deontological* codes of Southern Europe
- The *liberal*, rights based models of Western Europe (of which the Netherlands represents a strong version and the UK a weaker one)
- The *social welfarist* model prevalent in Nordic Europe.

There is also a fourth model, which I shall mention only briefly:

- The *imperial* concept of justice as the gift of the emperor, a model identified by some Eastern Europeans as dominant in the former USSR satellites.¹

The fourth model suggests interesting parallels with Confucian ethics: perhaps West and East are not so very different after all?

Despite the speculative attraction of that question, however, this article concentrates on the first three approaches, as identified and delineated by participants in the European Biomedical Ethics Practitioner Education project: a series of twelve workshops funded by the European Commission and devoted to the question of whether Europe can achieve any consensus on method and content in bioethics teaching. There are other differences which my tripartite model ignores: the prevalence of phenomenological theory in many Continental philosophical systems and its spillover into bioethics is the most obvious. I am not so much concerned, however, with the ontological bases of the different models as with what they have to say about dispute resolution between doctors, patients and families. Essentially I shall argue that the three models' answers to such conflicts are:

- The patient has a *positive duty* to follow the doctor's instructions, and to maximise his or her own health and wellbeing, often enshrined in constitutional provisions (Southern Europe)
- The patient has a *negative right* to override medical opinion and to pursue his or her own notion of individual wellbeing (Western Europe)
- Disputes are unlikely to arise in the first place if a proper social welfare system is in place; if they do come up, they should be resolved in an *administrative* manner by appointed officials, not by favouring either doctors' duties or patients' rights. (Nordic countries) Another way of conceptualising this third way, however, is in terms of *positive rights* and entitlements.

Of course these three models are caricatures of much more complex realities, but like all models, they have their analytical uses. It is particularly interesting, I think, to disentangle the Western European rights-orientated models from the Nordic administrative one, since the two are often confused.

¹ Valder Parve, 'The starving patient at the hospital's doors', paper presented at the sixth European Biomedical Ethics Practitioner Education conference, Naantali, Finland, September 1996.

'Medical deontology' is the term which the professional codes of southern Europe typically use to describe their approach.² Adapted in 1845 as the term 'déontologie médicale', the phrase does not necessarily denote Kantianism or any variant thereof: rather what Americans and northern Europeans would probably term 'professional ethics'. In one article on the Italian code, medical deontology is defined as 'the discipline for the study of norms as well as those pertaining more strictly to professional performance'.³ This is actually rather close to the vocational model of medical ethics which prevailed in America and Western Europe until recently, in which 'medical ethics [is seen as] a matter of right attitude and certain proscriptions of behaviour'.⁴ This is the doctor's side of the bargain; the corresponding virtue in patients is to obey the virtuous doctor. In Italy, for example, where codes of medical ethics date back to the Fascist period, there is a positive duty in the name of the collectivity to maximise one's own health and to allow the doctor free rein in the exercise of his or her beneficence. To the extent that this duty is positively enjoined on doctors, for example by article 28 of the Deontological Code, it would actually be morally wrong and legally dubious to stand in the doctors' way. Thus if relatives of a handicapped person or a child refuse consent to treatment, the doctor has a duty of beneficence to proceed regardless. Although the same article deals extensively with the patient's right to informed consent, 'in actual clinical practice doctors are given substantive discretion to resolve potential conflicts between the right of patients to be informed and the need to ensure their compliance.'⁵ Despite formal guarantees against enforced treatment in Article 32 of the Italian constitution, physicians tend to rely on implicit consent except in surgery, when formal written consent will normally be obtained. Overall, the aim of the 1995 code is to promote compliance with medical advice rather than patients' rights.

² For France, see: Decret no. 95-1000 du 6 septembre 1995 portant la code de déontologie médicale. Unlike the Italian code, the French is formally a legislative act.

³ Fineschi V, Turillazzi E, Cateni C. (1997) 'The new Italian code of medical ethics'. *Journal of Medical Ethics* 23: 239-44. The most recent version of the code is that of October 1998; this article refers to the earlier version of 1995.

⁴ Ashcroft R. (1998) 'Teaching for patient-centred ethics'. Paper presented at the European Society for Philosophy in Mental Health conference, Marburg, 20-22 August.

⁵ Calzone C (1996) 'Consent or compliance? From informed consent to the right to informed guidance'. Paper presented at the sixth EBEPE workshop, Naantali, Finland, September 1996.

Nevertheless the 1995 code is also seen as an evolution away from paternalism towards a more equal form of doctor-patient relationship. Article 4, for example, specifically calls on the physician to 'respect the rights of the individual.' In specific areas such as medical confidentiality, the 1995 code also represents an advance towards the liberal model on its 1989 predecessor: the old practice of informing next of kin of a terminal diagnosis but withholding the information from the dying person is specifically prohibited.⁶ On many other vital questions, however, the code is silent, e.g. in relation to advance directives. Here the professional's duty of beneficence is presumed to fill in the gaps. Where assisted reproduction is concerned, the Code is quite explicit, particularly in proscribing commercial contract motherhood. The neo-liberal model emphasising freedom of contract is specifically rejected. Overall, the paramount values in the deontological codes are the professionalism of physicians and the dignity (rather than the rights) of patients⁷. It has been said, however, that dignity is what is allotted to those who are not in charge, and this would certainly be the outlook of the second model, the patients'-rights approach.

Whereas the Italian code of professional conduct is intended to be 'as free as possible from the strict confines of the law',⁸ the rights-orientated approaches of Western Europe rely on the law to enforce patients' rights. And whilst it has been said that in Greece the patient is in some sense defined as a defective person, not fully competent,⁹ Western European systems more typically refer to patients as 'service users' and uphold the assumption of competence (at least for adults) even in very extreme circumstances. In the 1994 English case of *Re C*, for example, a 68-year-old paranoid schizophrenic whose delusions included the belief that he was himself a world-famous vascular surgeon was judged competent to reject the preferred management plan of the real vascular surgeon who was treating him for a gangrenous leg.¹⁰

⁶ Compare the more paternalistic situation in Spain, as described by: Osuna E, Perez-Carceles MD, Esteban MA, Lune A. 'The right to information for the terminally ill patient'. *Journal of Medical Ethics* 1998; 24: 106-109.

⁷ For the paramountcy of the principle of dignity in French codes and the constitution, see: G. Lebeer, paper presented at the Second Unesco Conference on Medical Ethics and Medical Law, Copenhagen, June 1998.

⁸ Barni M (1991) 'La medicina legale e le etiche esterne alla legge'. *Rivista Italiana di Medicina Legale* 13: 375-80.

⁹ Peonidis F. (1996) 'A moral assessment of patients' rights in Greece'. Paper presented at the sixth EBEPE workshop, Naantali, Finland, September 1996.

¹⁰ *Re C* (1994) 1 All ER 819.

On the other hand, the standard for consent in UK law remains what a reasonable doctor would disclose¹¹ rather than what a reasonable patient would want to know; in this and other aspects of the law, the British model represents at best a weak form of the patients' rights approach, arguably closer to the professional-duties model of southern Europe. A strong version of the patients' rights model is to be found in the Netherlands, particularly in regard to mental health legislation.

As in the UK, the assumption of patient autonomy is not vitiated in Dutch legislation by a finding of mental incapacity. Where the Netherlands goes further, however, is in affording even compulsorily detained patients the right to refuse treatment for psychiatric disorders. In the Mental Health Act for England and Wales, a distinction is made between refusal of physical treatments, which is allowed, and refusal of treatment for mental illness, which is not¹². Dutch legislation dating from 1994, however, gives the compulsorily detained mental patient the right to accept or refuse the treatment plan which the psychiatrist draws up. The law thus makes no distinction between the rights and treatment decisions of a competent patient and an incompetent patient, which some Dutch commentators find an extreme version of the patients' rights position.¹³ A series of consultation rounds between physician and patient give even the compulsorily detained patient the upper hand in cases of conflict, unless he or she is a serious danger to himself or herself, or to others. Consent from family members cannot override the patient's own refusal, whereas in most Southern European systems, familial proxy consent is important. Dutch legislation is also scrupulous about requiring consent to admission, even from autistic, learning-disabled or senile patients, where English law and practice allow for informal admission.¹⁴ Unless the patient actively consents, formal mechanisms for treatment must be invoked, whereas English

¹¹ Sidaway *v.* Bethlem RHG (1985) 1 All ER 643.

¹² Mental Health Act 1983, s. 63.

¹³ R. Berghmans (1997) 'Protection of the rights of the mentally ill in the Netherlands'. Paper presented at the tenth EBEPE conference, Turku, Finland, June 1997.

¹⁴ *R v. Bournemouth Community and Mental Health NHS Trust, ex parte L* (judgement delivered 25 June 1998). Shah A, Dickenson D (1998) The Bournemouth case and its implications for health and social services. *J Roy Soc Med* 91: 349–51. Livingston G *et al.* (1998) 'Treatment of patients who lack capacity: implications of the *L. v. Bournemouth Community Trust* ruling'. *Psychiatric Bulletin* (1998) 22: 402–4. Eastman N, Peay J (1998) 'Bournemouth: an indefensible gap in mental health law'. *BMJ* (1998) 317: 94–5.

practice heavily relies on informal admission in the absence of active resistance. In the Netherlands, where the 1994 legislation was strongly influenced by the patients' rights movement, the decision regarding compulsory admission must be a formal one, and it is entirely separate from the decision regarding compulsory treatment. Thus the onus is on the medical professional in both cases to prove that compulsion is necessary.

Giving rights to patients is only one side of the coin; they also need to be given the structure and facilities to actuate these rights, many Dutch commentators argue.¹⁵ The 1994 legislation also provides for patient advocates, a kind of ombudsman, in all hospitals; but the most complete version of the ombudsman model is found not in the Netherlands but in the Nordic nations, and the paradigm I shall examine is the Finnish Act on the Status and Rights of the Patient (approved in 1992 and enacted in 1993). Although one strand in the Finnish statute is strengthening legal guarantees of patient autonomy, the patient's rights are primarily conceived in the social context.¹⁶ Resources and social structures to support the rhetoric of rights, to transform them from negative liberties to positive entitlements, are part of statutory provision; dispute resolution is primarily through non-elective administrative channels, and the statute is rather vague in its drafting. For example, the provisions on competence and right to refuse treatment for children and young people are left very open, with the rather vague provision that a competent minor has to be treated 'in mutual understanding'; the model for resolving any conflicts does not involve recourse to the courts in adversarial fashion, but administrative intervention. There is no formal definition of competence or of informed consent. Instead, it seems to be assumed that conflicts can be resolved in the public health care system precisely because it is a public health care system, with the virtues of universality and solidarity built in. The act's principal drafter has described it as a 'soft law' aiming to avoid sanctions, concentrating instead on influencing practitioner attitudes. In contrast, representatives of the nascent Finnish patients' rights association describe the idea of the rights-aware patient as a foreign import, and look to the Netherlands

¹⁵ Berghmans *supra*; Ter Meulen R. (1996) 'Care for dependent elderly persons and respect for autonomy'. Paper presented at the fifth EBEPE workshop, Maastricht, June 1996.

¹⁶ R. Lahti (1996) 'The Finnish act on the Status and Rights of Patients'. Paper presented at the sixth European Biomedical Ethics Practitioner Education conference, Naantali, Finland, September.

for their model.¹⁷ This movement criticises the ombudsmen as mere officers of the 'system'; unless the liberal notion of separation of powers is preserved, patients' rights advocates argue, there can be no real accountability. But this view, typical of the second model, appears to remain a minority one.

In this paper I have argued that there are at least three different moral 'voices' in European bioethics¹⁸, not one. The schema I have offered is necessarily somewhat arbitrary, but it does highlight important differences which can otherwise be too easily ignored, particularly by those outside Europe. There are anomalies, of course: Ireland, though not part of southern Europe, rejects the liberal rights-orientated model of the person, enshrining a positive duty of seeking to promote one's own health in its constitution in the Italian fashion.¹⁹ Here the influence of the Catholic church is clearly important; yet that does not explain why the Netherlands, with a very substantial Catholic population, has embraced the individualist Protestant model so wholeheartedly. In the case of Ireland, the discourse of choosing one's own moral principles is comparatively new; yet the Irish do not entirely reject the Kantian notion of self-enacted moral principles. The Church is now coming under fire for failing to educate children in ethical skills, in the ability to stand back and reflect on one's own values. But although Ireland has never experienced Fascist rule — unlike the countries of southern Europe — there is a long-standing absence of pluralism, and the notion of negotiating solutions to conflict remains foreign, according to at least one Irish writer.

We tread a fine line in identifying cross-cultural issues in bioethics: our classification systems may either be too fine-tuned — leaving us with a welter of accurately observed but confusing detail — or too general — simplifying what are really important distinctions into false commonalities. But this is no more or less than the perennial difficulty of formulating hypotheses and constructing analyses.

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¹⁷ Carl-Gustav Sodergard (1996) 'Patients' rights in Finland'. Paper presented at the sixth European Biomedical Ethics Practitioner Education conference, Naantali, Finland, September.

¹⁸ Cf. Gilligan C. (1982) *In a Different Voice: Psychological Theory and Women's Development*. Cambridge, Massachusetts: Harvard University Press, 1982.

¹⁹ Dooley D. (1997) 'Autonomy, feminism and vulnerable patients'. Paper presented at the tenth EBEPE conference, Turku, Finland.

