



Lorna Dyall

## Me Aro Ki Te Ha O Te Tangata Pay heed to the dignity of the people

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**T**his paper addresses what we believe are some of the critical questions in the current efforts to establish a system of ethical review in New Zealand. It draws on previous work we have done together, especially our work in analysing the submission to the Royal Commission on Social Policy, seeking to find what New Zealanders wanted for their social wellbeing in a fair and just society (Dyall and Keith, 1988).

### (a) What is ethics?

Ethical theory is a diverse set of ways of developing moral concepts and giving philosophical reasons that explain, augment and criticise the rules of social morality. Ethics is tikanga, the way we name the world, our values and beliefs.

### (b) Why is ethics important to health?

Health and wellbeing are one and the same. Wellbeing determines how you see the world. Ethical decisionmaking is based on tikanga, your beliefs and values. They are inseparable. We make ethical decisions every day of our lives, consciously or unconsciously. Sometimes we make them on behalf of others with whom we have a relationship.

When a child complains about a sore ear, for example, as a parent we consider whether or not to take her to the doctor. We may consider competing needs within the family, but our primary concern will be the welfare of that child. The doctor treating the child may consider whether to refer this particular child for grommets, possibly in relation to referrals for other children with similar needs. Those administering the service might consider what is safe and how to allocate resources within the service.

Yet the discussion about ethics and health to date has been heavily skewed towards the ethics of research.

### (c) What ethical frameworks are currently being used in New Zealand?

These are several and varied. The Code of Ethics for Nurses, for instance, is stated to be derived from values recognised by society as underpinning *any* code of ethical behaviour (our emphasis). The Code then lists as the values, justice, autonomy, confidentiality, beneficence, non-maleficence, safety, veracity and competence.

For a long time now, women have been questioning these values, arguing that they are male, Western, and individual values, overlooking and ignoring the vital role of relationships and the quality of relationships in determining behaviour. They argue that the ethical self exists only in relationships, with everyone, not just

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those with whom we have direct contact. This approach is increasingly referred to as "the ethics of care" (see, for example, Watson and Ray, 1988).

The Treaty of Waitangi provides another framework. Article One establishes governance and collective responsibility. Article Two acknowledges the special relationship between the Crown and Maori and the right of Maori to pursue tino rangitiratanga or self determination. Article Three ensures justice and equal rights of citizenship for both Maori and non-Maori.

Is it possible to combine the two to create a New Zealand framework which enables individual and collective values to stand tall?

When we sought the beliefs underpinning the thousands of submissions received by the Royal Commission on Social Policy we found three very consistent patterns which we named:

**voice** - *Mania o te reo, kia tu tangata,*  
**choice** - *Kia orite te tangata,* and  
**safe prospect** - *Hauora.*

The last, *hauora*, has three subsets - guardianship of the people resource, guardianship of the natural resources, and guardianship of the nation - thus coming close to the wider view of relationships being developed with the ethics of care. The other two, *voice* and *choice*, had elements of the so-called traditional Western values such as dignity, respect and confidentiality.

In the five years since completing that analysis, we have found these values extraordinarily consistent and we are including the summary as an appendix to this paper.

### (d) What valid questions may be asked of any piece of research being submitted for ethical review?

Some time ago we were challenged to consider research from a primary health care perspective. For us this can only mean "health by the people" care which is determined by people to meet their goals and which is grounded in their values and beliefs.

The questions, and the range of possible answers we generated, could enable ethics committees to determine whether the research is truly for the wellbeing of people:

- Who defines the research agenda? Is it providers or funders, especially drug companies with a product to sell? Overseas experts? Politicians? Individual academics with research careers to pursue? Or is it community groups?

- Who decides the actual problems to be addressed? We all know that whoever defines the problem also determines the answer.
- Who is to be involved in carrying out the research? Does it depend on volunteers? Do they get their expenses paid, including any time they are away from their job? What about a koha if the work is with a Maori community?
- Who owns the results of the research? Is it the researcher who can write it up in prestigious journals for personal academic acclaim and a secure future? What provision is there for feedback, for validation, for amendment and/or reinterpretation of the findings in keeping with the community's value system? Have comparisons been made with groups in other cultures with widely different value systems? Do all the variables carry the same meaning and have the same significance for both the researcher and those researched?
- How is the research to be evaluated? The word "evaluation" carries within it the word "value". Whose values? Do the results meet some norm, some objective standard or has the community itself established criteria which will measure success or failure?
- Finally, is the research a means to an end or merely an end in itself? Will the individual person benefit? Is it "public good" research? Or perhaps even "blue skies" research aimed at advancing human knowledge but with no immediate use at this time?

**(e) In considering a national system of ethical review, where should the emphasis be, on the structures, the processes, the content, or the value basis?**

The Director-General of Health appointed the Interim Taskgroup on Health and Disability Services Ethics to examine the current structure and working of ethics committees. The resulting Discussion Paper, which formed the basis for public consultation, focuses on optional structures, each reflecting a different focus of power, with the Health Commissioner, the Health Research

Council or the regional health authorities.

The processes almost invariably refer to research with an occasional acknowledgment that smaller centres may have to consider service ethics.

The content or value basis is invariably the hardy annuals, autonomy, beneficence, non-maleficence - but the focus of power is invariably with the health professional who is doing good or not doing harm to another.

There is a nod to Maori with proposals for Maori input into ethical review. There is no clear relationship with the Core Services Committee or the Public Health Commission which are also in the business of recommending priorities for health service delivery. The Core Services Committee publication *Best of Health 2* for instance, established four key principles as the basis for decision-making: what are the benefits? is it value for money? is it fair? is it consistent with the community's values and priorities? Yet no mention has been made of these forming the basis of the National Standard for ethics committees.

Even more recently, the public has been asked to provide comment on the Ministry of health document *Consumer Safety in Health and Disability Support services*. This poses the following questions which set out the scope of the review:

- what is safety?
- what is treatment and care?
- what are health and disability and support services?
- who are the providers of these services? and
- how is safety currently protected?

Each of these involves value judgments and ethical decisions. Yet we have no indication of the ethical framework which is to be used.

**(f) What should be the status of the National Standard for ethics committees?**

The National Standard must be a dynamic document, kept alive and relevant by the communities it serves. It is *turangawaewae*, a basis for being and beliefs. Those administering it, reviewing it and monitoring it must be drawn from people with wide community networks. It must be based on the "health of the people" philosophy.

Its format and status must be that which best enables this to happen. Enshrining it in statute in a static form would be entirely inappropriate, although it may be rooted in statute if the law might require it, provide for its regular review and describe its functioning. Including it as a Schedule associated with a general statute would make it more accessible and more amenable to amendment.

Recognising that health is fundamentally about ethics, it would be even more significant to make an amendment to the Long Title of the Health and Disability Services Act itself. Such an amendment would mean that this would read:

An Act to reform the public funding and provision of health services and disability services in order to ...

(d) ensure that ethical review is fundamental to all health service activities and research.

**Conclusion**

After reading all those thousands of submissions to the Royal Commission on Social Policy, we concluded that in their quest for a fair society, the people of New Zealand wanted:

to be valued, to have a say in decisions which affect their lives. Not everyone wanted to be the same. The right to be different should be respected. People should have the opportunity to have a range of choices to meet their needs. All of them wanted a safe prospect for themselves, their families, their communities, and future generations. To achieve that safe prospect, they recognised that there needed to be a number of working partnerships.

The same is true here. Ethical discussion depends on effective relationships within and between the great variety of groups that make up this country. Research is part of that endless process, the constant testing of our understanding. But it must be the community testing its understanding. The researcher and the health professional, the law and national standards, must be servants not the master of that process.

Hutia te rito o te harakeke  
Kei hea te komako e ko  
Kii mai ki ahau  
He aha te mea nui i te ao  
Maku e kii atu  
He tangata, he tangata, he tangata.

## Appendix

The patterns identified in the submissions were:

### Voice:

#### Mana o te reo, kia tu tangata

- to be able to name the world
- to be heard, to be understood
- to have someone who will listen
- to have your say in matters which affect you directly
- to have your say in policy issues
- to be accorded respect when you speak
- not to be impeded from speaking, physically or spiritually
- to have someone act as your advocate/agent if necessary
- to have places where your voice can be heard
- to have access to information to make your case
- to have a fair hearing
- the weakest voice shall be heard "Value me".

### Choice:

#### Kia orite te tangata

- to be in a position to choose freely from amongst alternatives
- to have alternatives available
- to value diversity
- not to have majority views imposed willynilly
- to contribute to your own destiny
- to have your right to hold a particular belief respected
- to have a fair start
- partnership
- opportunities for independence

### Safe Prospect:

#### Hauora

- guardianship of the people resource
- guardianship of the physical resource
- guardianship of the nation.

### References

Dyall, L, and Keith, J. 1988 Let the People Speak, Me Aro Ki te ha o te Tangata. In *The April Report: Report of the Royal Commission on Social Policy*. Vol. III, Part One. Wellington, pp365-404

Watson, J., and Ray, M. (eds) 1988 *The Ethics of Care and the Ethics of Cure*. National League for Nursing: New York

## Readers' Views

Dear Editor:

I read with interest Professor Skegg's paper on "Medical Manslaughter and Medical Neglect" in the February edition of the *Otago Bioethics Report*. This area is of great importance to practising anaesthetists in New Zealand at the present time. There are two issues I would like to comment on.

In one particular region of New Zealand at present, a very zealous police team (for reasons best known to its members) reputedly investigates any theatre related death (in the majority of instances without any directive from the coroner and in contrast to any other area in the country). The manner of these investigations is said to be confrontational. Many of the affected anaesthetists find that this "hostile" attitude has a substantial impact on their ability to practise good medicine. Emotions are understandably running very high. While I cannot endorse or excuse "the refusal to provide operations" I can certainly understand it in this context.

The second issue I wish to raise is the crime of manslaughter itself. The following examples may illustrate why the scope of this charge/verdict is much too broad.

In one instance a doctor (an anaesthetist) while attempting to do his best for his patient in an emergency situation, makes an error (failing to check the labelling on a drug ampoule) and his patient dies. The verdict is manslaughter (R.V. Yogasakaran).

In another situation, a victim is killed during the course of an

armed robbery. The verdict is manslaughter (R.V. Green).

Our criminal justice system, would have it that these two crimes are equivalent (although Professor Skegg alludes to the lenient sentences for medical manslaughter, as though this somehow makes the verdicts reasonable.)

I contend that a legal system that equates these two crimes is ethically destitute.

Isobel Ross

Consultant Anaesthetist

### Professor Skegg's reply:

Dear Editor,

Thank you for your invitation to "write a rejoinder" to Dr Ross' letter.

I am in entire agreement with Dr Ross about the first issue she raises, and am in broad agreement with her about the second issue. (There would be advantages in amending the Crimes Act, so that people who negligently cause death could be convicted of an offence of causing death by negligence, rather than the broader offence of manslaughter.)

I am puzzled by Dr Ross' statement that "Professor Skegg alludes to the lenient sentences for medical manslaughter, as though this somehow makes the verdicts reasonable". I cannot think of any circumstance where a lenient sentence would make a verdict reasonable.

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