The Tavistock Principles for everybody in health care

Richard Smith

Editor, BMJ

What I want to talk about

- The principles
- Why have such principles?
- How were they developed?
- The thinking behind each principle
- The principles applied to two cases
- How might they be used?
- Conclusions

Tavistock principles

- **Rights**
- People have a right to health and health care.
- **Balance**
- Care of individual patients is central, but the health of populations is also our concern.
- **Comprehensiveness**
- In addition to treating illness, we have an obligation to ease suffering, minimise disability, prevent disease, and promote health.

Tavistock principles

- **Cooperation**
- Healthcare succeeds only if we cooperate with those we serve, each other, and those in other sectors.
- **Improvement**
- Improving healthcare is a serious and continuing responsibility.
- **Safety**
- Do no harm.
- **Openness**
- Being open, honest, and trustworthy is vital in healthcare.

Why have such principles?

- The most fundamental problems in health care are ethical--Who will live? Who will die? Who will decide and how? How will we allocate resources?
- There are ethical codes for individual professions but not for everybody in health care (owners, health care workers, patients)

Why have such principles?

- Yet health care is multidisciplinary and has many players
- The codes of individual professions may be used as weapons rather than an aid to solving complex dilemmas
- Principles that were agreed and used by everybody might provide a moral compass and aid thinking

Ethics versus policy

- "The most unfortunate thing about the current debate on health care reform in the US is that a remarkable opportunity has been missed. What could have been a wide-open, far-ranging public debate about the deeper issues of health care - our attitudes toward life and death, the goals of medicine, the meaning of "health," suffering versus survival, who shall live and who shall die (and who shall decide) - has been supplanted by relatively narrow quibbles over policy.”
- Will Gaylin, president of the Hastings Centre

Ethics versus policy

- "It is a lot easier and safer for politicians and policymakers to talk about delivery systems, health product procurement procedures, and third party payments than about what care to give to a desperately ill child or whether a kidney patient over the age of 50 should be eligible for a transplant. The paradox of our current situation, however, is that unless we address such basic, almost existential questions, we stand little chance of solving our nation's health care crisis."

- Will Gaylin, president of the Hastings Centre

How were the principles developed?

- Three friends (2 US, I UK) had the idea--off the back of the BMJ theme issue on the Nuremberg trials
- They gathered together about a dozen other friends and drafted some principles
- They sent the principles to many friends and health groups in the US and UK and modified the principles in the light of the responses

How were the principles developed?

- They encouraged some health institutions to experiment with the principles
- A meeting was held in Cambridge, Mass to discuss the principles and hear experiences of trying to use them
- The principles were modified again
- The world can now do what it likes with them--which may well be nothing

Rights: People have a right to health and health care

- Relatively uncontroversial in Britain
- Health depends on much more than health care
- But how can people have a “right” to health?
- Jeremy Bentham argued that for every “rights holder” there must be an obligation provider
- Immanuel Kent distinguished between “perfect” and “imperfect” obligations
- Perfect obligations impose a duty on particular people and institutions
- Imperfect obligations do not

Rights: People have a right to health and health care

- Imperfect obligations can move to be perfect--through legislation
- The government in Britain has accepted an obligation to provide health care
- Making health and health care rights gains attention and puts them on the agenda
- The obligation might prevail beyond Britain

Balance: Care of individual patients is central, but the health of populations is also our concern.

- Has to be “but” not “and”--recognising the tension--around, for example, resources, use of antibiotics, immunisation
- Applies to everybody, including those who mostly treat individuals
- It gives us an obligation to think about the extreme inequity in health and health care around the world

Comprehensiveness: In addition to treating illness, we have an obligation to ease suffering, minimise disability, prevent disease, and promote health.

- Uncontroversial
- Again applies to everybody
- Many practitioners regard medicine as primarily a technical activity--but it’s much more than that

Cooperation: Healthcare succeeds only if we cooperate with those we serve, each other, and those in other sectors

- A truism, but it would be very powerful if we lived the principle
- “Each other” includes managers; “those in other sectors” includes politicians and the media
- “Cooperating” with “those we serve” could lead to profound change-”patient partnership”
- Patients might be seen as “coproducers” of health care
- “Nothing about me without me,” including in policy setting

Improvement: Improving healthcare is a serious and continuing responsibility.

- Means always aspiring to do better
  - Recognising underuse, overuse, and misuse of health care
  - Recognising the escalating rate of new knowledge, the rapid advances in technology, that patients want to be partners, and that our systems of health care are too complex, giving too much room for error and waste
- Means learning the skills of improvement
- Means not resisting change

Safety: Do no harm.

- Health care is harmful
- Policies and practices that seem inevitably to be benign may do harm (putting babies on their fronts to sleep, the Tavistock principles?)
- Harm is of course inevitable if you do anything (the principle implies being confident that the benefit you expect will outweigh the harm that is inevitable)

Openness: Being open, honest, and trustworthy is vital in healthcare.

- Again seems obvious
- But everyday people behaving differently--”softening the blow”
- “I won’t tell you any lies, but people want to know different amounts in different ways. You’ll have to help me to understand what you want.”

Case one: a patient is denied a new treatment

- *A doctor working in an NHS trust thinks it wrong that his patients will be denied a new treatment for cancer—despite the hospital formulary committee deciding that it should not be prescribed. Should he contact the local media? Should the trust punish him if he does?*

Applying the principles

- Principle 2 (balance) recognises that there is a tension between what's good for individuals and populations.
- It was probably on these grounds that the formulary committee decided that the new drug would not be made available.
- Principle 4 (cooperation) suggests that the doctor should cooperate with his colleagues and implies that contacting the media would not be helpful.

Applying the principles

- But principle 7 (openness) means that the committee should be open with the patient, the doctors, and the community, through the media perhaps, on why it is denying the patient the drug.
- The doctor might decide that the hospital is not living up to principle 7 (openness) and so contact the media himself.
- If he does that he should ensure that he abides by principle 7 (openness) and gives the whole story, not just his version.

Applying the principles

- If the trust has lived by the principles and the doctor hasn't then it might be legitimate to punish him.
- It clearly would not be if the doctor lived by the principles but the trust did not.

Case two: Sedating an awkward patient

– *A doctor and a nurse decide to sedate an awkward demented patient by slipping a sedative into his tea. The nurse is afterwards disciplined. The doctor is not.*

Applying the principles

- The doctor and nurse presumably sedated the patient because they judged the patient to be a danger to himself or others. The alternatives might have been restraint or isolation.
- Principles 1 (rights), 4 (cooperation), 6 (safety), and 7 (openness) suggest that to drug the patient would be wrong, but they would also weigh against restraint or isolation.
- Principle 2 (balance) suggests that some “harm” to the patient might be acceptable for a “benefit” both to the patient and the population.

Applying the principles

- The principles suggest that the sedation may be inappropriate. They certainly support very careful recording of all ethical considerations before action is taken.
- Principle 4 (cooperation) suggests that it makes no sense to treat the nurse and the doctor differently.

How might the principles be used?

- Simply to prompt discussion
- A board or trust might adopt them for an organisation and try to live by them
- There might be an organisation of those who agree to live by the principles (with the possibility of expulsion if people didn't live up to them)
- They might be incorporated into law

Conclusions

- It may be a good idea to have principles that could be used by everybody in health care
- Some such principles have been developed
- They can be used to think ethically about health care
- They might be adopted and used by health care organisations
- This talk is available on www.bmj.com, as is the articles that discuss the Tavistock principles