When the subject of ethics is raised perhaps professionals overlook the fact that medicine is a moral endeavour. It is understandable human nature that the familiar is often forgotten. Ethical decision making is the bread and butter of burn care. Therapeutic advances and changes in society should impel those that care for burn victims to reexamine and reapply the established medical ethical principles.

In recent years the impact of scientific progress and the refinement of existing techniques has led to a tremendous improvement in the ability to save the life of most burn victims. In the very old and the very young severe burns are still associated with a high mortality [1, 2]. For some patients advances in the ability to save life may have outstripped progress in the ability to reconstruct and rehabilitate the burn victim. The premise that one should do all that one can is no longer accepted as universally valid. The professional must often take the role of gatekeeper [3], making decisions with the patient, on when particular treatments should be implemented, withheld or discontinued. An understanding of the ethical issues inherent in burn care helps carers and patients to make confident judgements under demanding circumstances [4]. The implementation of burn care in an ethical environment [5], one in which ethical issues are openly raised and understood by patients and staff, helps to lift from the individual professional some of the burdens associated with challenging decisions [6].

Health care as a whole is undergoing a transition. For over three hundred years health care in the West has been associated almost exclusively with medicine and medical establishments. Well-defined hierarchies have generally run such establishments. The patient carer interaction has been to a large extent paternalistic. In recent years however, new trends and forces have emerged. There are numerous signs that herald the arrival of this new order. There is a rising interest in alternative medicine and holism. Patients now increasingly want to be better informed and to have a greater involvement in their own care. Patients want to know what is written in their notes and increasingly want to know relative worth of different treatments and the track record of different clinicians. Traditional roles and hierarchies are being eroded. A team approach to patient care incorporating a range of personnel and skills is already well accepted in most specialties. The role of the doctor has changed. A public debate has been conducted into the funding and cost effectiveness of health care services. A doctor not only now needs to be aware of how effective a treatment is but also of its cost implications within controlled or managed budgets.

An understanding of the ethics inherent in the provision of burn care provides some stability during this potentially turbulent shift from one paradigm to another [7]. A comprehension of the relative ethical value of different actions can smooth the integration of new medical science, patient choice and cost management.

1. What are ethics?

Ethics is the study of how men and women ought to live their lives. It is interchangeable with the term morals. Contemporary medical ethics can be traced back to the 5th century BC, to the writings on the Island of Cos of the Greek physician and teacher Hippocrates. It can be argued that there is no single objective, expert, body of opinion concerning what is right and
what is wrong, but for the medical profession there are several universally accepted principles.

For those working in health care, ethical principles provide a code of behaviour for the profession, just as ethical principles do for other professions such as the law, the church, or government.

Medical ethics and medical law share a common foundation. In most societies legal duties are derived from moral obligations. An understanding of the ethical issues in burn care is helped by a working knowledge of medical law. It would be expected that health care professionals will be influenced in their decision making, not only by the constraints of the law or those of professional bodies such as the General Medical Council (GMC), but also by their own moral principles and values. One would expect such values to be derived from the values of the profession and from the values of society as a whole. Given that medical law is derived from accepted moral obligations, any conflict that an individual doctor has with established law should be the result of unprecedented circumstances, or personal values held by the doctor which are at conflict with those of society as a whole.

2. Intuitive ethics

We cannot help but make intuitive or spontaneous ethical decisions during our working lives. These judgements may be sincere, but are not the result of deliberation. They are inevitably prone to non-rational influences and are thus prone to inconsistency. For example the dictum that “all patients should be given equal attention” is not adhered to in all circumstances. The scalded child, who happens to be the son of the burns unit senior staff nurse, will receive more attention on the ward round than his injury might normally warrant. Such disproportionate attention is justifiable on the grounds of the need to maintain good morale within the burns care team. Ethics requires more than common sense judgement, deliberation is a necessity, intuitive ethics are inadequate for all the dilemmas inherent in the provision of care to the burn victim. An understanding of the various ethical theories and an appreciation of their individual difficulties should help health workers carry out a process of moral reasoning when faced with an ethical dilemma.

3. Ethical theories

3.1. Ethics defined by rights

Rights based ethics is the dominant principle of contemporary medical ethics in our society. Rights based medical ethics places the patient at the centre of the moral equation. An action is of moral worth only if it enhances and does not inhibit the rights of the individual patient. The accepted rights of an individual patient include:

- **Autonomy.** The patient should be able to think and act without influence or control by others.
- **Nonmalificence.** The patient should come to no harm.
- **Beneficence.** The patient should receive the benefit of an intended treatment.
- **Justice.** Treatments should be implemented in a fair and impartial manner.

3.2. Ethics defined by duties

Deontology (derived from the Greek deon; that which is binding) the study of duties, proposes that what matters most is not the actual consequences of our actions, but that a person acts according to a perceived duty or moral code. A deontologist might adopt a single overriding duty or might adopt a range of duties all making some moral claim upon him or her. In health care deontology places the professional at the centre of the ethical equation. One duty of a health care worker is to tell the truth. Consider the example of a man severely injured as the result of a house fire. Most doctors would argue that whilst his condition was still critical they would have a duty not to tell him the truth concerning the magnitude of his own injuries and the nature of injuries sustained by his family. A deontologist would insist that the patient be told the truth even if his life is endangered as a result of receiving such news whilst still seriously ill. The application of duties based ethical theories to health care imposes the values of the professional on to the patient. If health care is concerned with the health of the patient rather than the personal standing of the doctor or other carer, then it is the patient and his or her rights that must be at the centre of any ethical equation.

3.3. Ethics defined by consequences

Utilitarianism judges the worth of a decision on the basis of its actual results. The most moral actions are those that bring about the greatest sum or total happiness for mankind as a whole. The relative morality of a decision, from the most seemingly trivial to those incorporating whole societies, is dependent upon the resultant final balance of good or bad in the world. Morality is assessed retrospectively or by calculating the likely outcome of a decision. Utilitarianism does not however consider the distribution of good and bad
between the actual individuals that constitute mankind. Consider the example of a patient whose burn injury is associated with a poor prognosis, who is mechanically ventilated on the burns intensive care unit. The patient has some chance of survival and therefore his treatment can not be considered futile. According to utilitarian principles however, to assess the moral worth of the treatment, one must consider the good that would be potentially achieved by redirecting elsewhere in society the one thousand pounds or more a day that it costs to treat such a patient. Most of us not unreasonably feel uncomfortable with such judgements, which appear brutal and simplistic. On closer examination utilitarian equations have several components which at first are not apparent. If one considers the patient in the burn intensive care unit. Our society regards the individual as inherently valuable. Society would be spiritually impoverished, and therefore less good, if we denied to those in most need, treatments that can be comfortably or reasonably afforded. Within our society the defence of individual rights can be generally recognised as enhancing the long term cohesion and good of society as a whole. In an altruistic society which values the individual, modern utilitarianism can be made to accommodate to a large extent the principles of rights based ethics.

3.4. Ethical decisions require deliberation

Aristotle proposed that deliberation is the essence of ethics [8]. One should decide what one’s goal is in any circumstance and then carry out a process of deliberation on the best means to achieve that goal. The nature of health care and burn care provision is changing. It is useful to think of the goal of the profession not to be the diminishment of disease, but to be the fulfillment of the human condition. The goal is to allow each human to achieve more or to maximise his or her potential, be that in body or mind. When caring for burn victims any ethical decision will require some deliberation, consideration of the rights of the patient, the duties of professional and the good of society, in order to achieve the goal of maximised human potential.

4. Specific issues in burn care

In the provision of care to the burn victim there are several prominent individual issues which require potentially challenging ethical judgements. To a large extent, components of each issue overlap, for example the issue of whether it is justifiable to with-hold treatment from those patients with no predicted chance of survival, requires a comprehension of patient consent and of concepts of medical futility. In each circumstance one must consider the boundaries of medical law, the values of the medical profession, and ethical theories.

4.1. The patient/carer relationship

In burn care the interaction between the doctor (or other carer) and the patient can be characterised by several different models [17]. The relationship inevitably may be prone to dominance by the health care professional. It is the care-giver that has command of the knowledge and skills relevant to the patient’s predicament.

4.1.1. Models of patient/physician interactions

In Table 1 models of patient/physician interactions are presented (after Zawacki [17]).

It is generally acknowledged that the models of an engineer and machine, or that of a father and child should be avoided. Benevolent paternalism is only accepted as justifiable in defined circumstances. For example when rapid deterioration of the patient’s condition, negate the patient’s ability to make a thoughtful decision. In such exceptional circumstances a carer may not be able to obtain consent, or be able to enter into a full dialogue with the patient. In normal practice in order to respect the patient’s rights of self-determination, he or she must become engaged in a dialogue with the doctor or other carer. The patient carer interaction may pass through different models over time or as the patient’s perception of his or her condition changes. The model of a contract between partners gives the patient appropriate respect and as such is the least likely to precipitate conflict.

4.2. Consent to treatment

Health care professionals have a duty to explain the nature, the purpose and the risk of a proposed treatment. Failure to obtain consent is a breach of the professional’s duty of care to the patient. The UK Patient’s Charter [9] requires that a patient be given “a clear explanation of any treatment including any risks or alternatives”. Professional defence organisations report that the foremost cause of complaint is a failure of communication between doctor and patient [10]. If the patient suffers any harm as a result of the treatment he or she is entitled under medical law to claim for compensation. One would hope that consent is not

| Table 1 |
| Engineer & machine | Parent & child | Contract between partners |
| Presumption & compliance | Paternalism & acquiescence | Negotiation & contract |
perceived by professionals merely as a mechanism to avoid litigation or challenge by patients and their relatives. The manner in which consent is obtained dictates the balance of the relationship between the doctor, (or other carer) and the patient.

4.3. Informed consent

The concept of informed consent originates from a ruling in 1914 in America by Judge Benjamin Cordova [11]. His declaration was that, “Every human being of adult years and sound mind has a right to determine what shall be done with his body, and a surgeon who performs an operation without the patient’s consent commits an assault for which he is liable.” In order to satisfy the moral and legal obligation of informed consent three principles must be fulfilled.

- **Competence.** The patient must be able to think rationally and thus make a personal discerning decision.
- **Absence of coercion.** The patient has the right to give or refuse consent without influence from others.
- **Provision of adequate information.** The patient must have enough relevant information to make a valued judgement on the proposed treatment.

Consent is often sought when patients are anxious or in distress. This is particularly relevant to the acute care of a burn victim. Under such circumstances it is insufficient merely to provide the patient with copious information. A doctor or carer has a moral obligation to try and help a patient to think rationally [12]. The patient’s rights of self-determination need to be respected, yet when seeking consent patients should be helped to deliberate effectively. Health care workers have a duty to make every effort to prevent patients becoming abandoned to irrationality. Where possible it is advisable to allow a reasonable interval between obtaining consent and starting a treatment, in order that a patient can reflect calmly on the relevant issues.

British case law clearly defines the legal responsibility of the professional when obtaining consent. The seminal case dealing with standards of consent in the United Kingdom is that of Sidaway vs. the Bethlem Royal and Maudsley Hospitals [13]. Mrs. Sidaway suffered spinal cord damage after elective orthopaedic surgery. She brought a case on the grounds that she had not been informed of the 1–2% risk of such a complication during surgery. The judge dismissed her claim of negligence by applying the established test of medical negligence as defined in the case of Bolam vs. Friern Hospital [14]. “The standard of treatment she received, (or standard of disclosure) was in accord with the accepted practice at the time as performed by a responsible body of medical practitioners”. In conclusion one must at the very least conform to accepted practices when obtaining consent, it is indefensible not to inform a patient of any complication with an incidence of more than 1%. The Bolam principle of standards of ‘accepted practice’ may yet be successfully challenged in the British courts. In Australia in the case of Rogers vs. Whittaker [15], the judge found an ophthalmic surgeon negligent for not warning of a 1:14,000 risk of sympathetic ophthalmia. In the USA standards of disclosure required are much higher than in the UK. Consent forms run to several pages. This may satisfy a legal imperative, but many doctors suspect that it provides too much information of uncertain worth and actually hinders the patient’s decision-making capacity.

It was the practice in many institutions to delegate the chore of obtaining consent to the most junior staff members. Despite their earnest endeavours the quality of information provided by these juniors, especially concerning alternative options, may have been less than ideal. When ever possible, consent should be obtained by the person implementing the treatment. The Clinical Negligence Scheme for Trusts established by the NHS Executive in 1995 [16] recommended that consent should be obtained by, “a person capable of performing the procedure”.

4.4. Consent in the incompetent adult

In order to consent to treatment an adult must have the capacity to make decisions on his or her own behalf. To be considered competent the patient must satisfy the following criteria:

- He or she must comprehend and retain the relevant information
- He or she must believe that information
- He or she must be able to deliberate rationally in order to achieve a final decision.

A diagnosis of mental illness or of learning difficulty is not in itself sufficient grounds to determine that a patient be considered incompetent. One recent case [18] concerned a patient diagnosed as suffering from schizophrenia who in addition to having persecutory delusions, also believed himself to be an internationally respected physician. Despite his irrefutable mental illness the High Court considered him competent to make decisions on his own behalf concerning his own treatment.

The Law Commission has published proposals for new legislation that may allow the appointment of a proxy medical decision-maker on behalf of an incompetet adult [19]. There is however at the time of writing, no mechanism in English and Welsh Law that allows any person or court, to authorise or consent to
treatment on behalf of another adult, be he or she competent or not. Under Scottish law an application can be made to the Court of Session who can appoint a third party to deal with issue of consent on behalf of the incompetent adult.

The incompetent adult is entitled to proper medical treatment as defined by a responsible body of medical opinion. A doctor can treat such a patient without consent provided that the treatment is in the patient’s best personal interests. In the case of F [20], an adult with severe learning difficulties, the House of Lords considered an application to carry out therapeutic sterilisation lawful, on the grounds that the procedure was in the patient’s own best interest.

In the case of Tony Bland [21], who sustained crush injuries in the 1989 Hillsborough Stadium disaster, a diagnosis had been made of persistent vegetative state (PVS). He was believed to have no hope of recovery, and was fed via a percutaneous gastrostomy tube. Three and a half years after the initial injury Tony Bland’s parents were successful in their appeal to the House of Lords, to allow tube feeding to be discontinued. The House of Lords considered artificial feeding and hydration to be actual treatments, and decided that they could be discontinued in that particular case on the grounds of being medically futile and therefore no longer being in his best interests. A declaration from the court must be obtained in any case where it is proposed to withdraw life-sustaining treatment from an incompetent adult.

The House of Lords select committee on medical ethics report [22] published a year after the Tony Bland case acknowledged the need to respect the ‘living will’ of an incompetent adult. A medical practitioner should only contradict a living will if events take a different course to those that were expected by the patient, at the time that the will was drawn up.

4.6. Refusing treatment

A small but significant proportion of those injured with serious burns will be infected with potentially transmissible diseases such as hepatitis B or HIV. Many of these patients will be asymptomatic, others will symptomatic or be known to belong to groups in the society with a well-documented increased incidence of such diseases. Serious burns have a greater prevalence within disadvantaged groups such as IV drug abusers. A health worker might believe that when treating such a patient he or she would be placed under an extremely small, but very real, risk of inoculation and infection [24]. I know of no surgeon who will not admit to having suffered a needlestick injury during the treatment of a patient [25]. Can a patient who is for example known to be infected with hepatitis B or HIV, be refused treatment on the grounds of real or apparent risk to the surgeon or other health care workers?

On this issue the GMC unambiguously asserts that [26] “it is unethical for a registered medical practitioner to refuse a treatment or investigation for which there are appropriate facilities, on the grounds that the patient suffered or may suffer, from a condition that exposes the doctor to personal risk”. In the case of HIV the view of the British Medical Association is that [27] “It is unreasonable and unethical to insist that a patient be screened to identify the level of risk to a health care workers.” Patients can only be screened for diseases such as HIV in-order to identify risk to themselves or other members of the society, and then only with their consent.

One area of potential controversy is that of non-essential therapy. A surgeon might for example argue that secondary reconstructive procedures, performed some time after the initial burn injury are non-essential supplementary treatments. Under these circumstances one might perhaps build a case for the right to defer treatment unless the patient consents to an appropriate screening test? Such an argument might be valid in other fields of surgery, perhaps when dealing with otherwise healthy individuals requesting cosmetic procedures. In the field of burn care, secondary reconstructive procedures, are components of the overall package of treatment. One cannot therefore ethically refuse to treat a patient, nor can one demand that the patient be tested for HIV or hepatitis B.

Some patients through their own deliberate life style choices place themselves at risk of illness and yet are still eligible for treatment. One thinks of the patient who repeatedly burns him or herself in acts of deliberate self harm, or in the field of cardiac surgery the patient who is referred for coronary artery

4.5. Consent in minors: the Gillick case

For children below 16 years of age criteria for consent is defined by case law, notably the case in 1985 of Gillick vs. West Norfolk and Wisbech Area Health Authority [23]. Mrs. Gillick brought a case after discovering that her daughter had been prescribed the contraceptive pill without the knowledge and consent of her parents. The Senior Law Lord, Lord Scarman ruled that a child could be deemed as having the capacity to consent if he or she has sufficient understanding, intelligence and maturity to make a reasoned decision. If the criteria of ‘Gillick competence’ are not fulfilled, then consent is not valid, and the parental right to determine consent must be exercised.
bypass grafting but will not stop smoking. The GMC is once more, adamant [26]: “It is unethical for a doctor to withhold treatment from a patient on the basis of a moral judgement that the patient’s activities or lifestyles have contributed to the condition”. The judgements of the GMC are unequivocal. Rather than constraining the health worker one could consider that these judgements liberate from him or her, the potential burden of making personal value judgements regarding the patient’s life style. Our society regards all individuals as inherently valuable and as having an equal social worth. Refusing to treat patients on the grounds of their lifestyles, even under the restraints dictated by limited resources, is at conflict with the egalitarian values of the medical profession and of our society as a whole [28].

4.7. Medical futility

For victims of major burns there is a relatively well-established relationship between the severity of the injury and the chance of survival. The burns doctor can with reasonable confidence identify a group of patients for whom medical intervention would be futile, and would be associated with no precedent of survival. This raises the question, should one resuscitate (i.e. give fluid therapy to) a patient whose burn is of sufficient severity to render the intervention futile? Opinion is divided on the issue. It is argued by Zawacki that to not initiate resuscitation on grounds of medical futility is paternalistic [17], however benevolent one’s motives are, the patient is deprived of control of his or her own destiny. The 1979 National Institute of Health Consensus Exercise in the USA [30] concluded that physicians have a duty always to give resuscitation and have the authority to do so without obtaining informed consent. Advocates of absolute patient autonomy would justify resuscitation on the grounds that, even if the patient does not eventually survive, resuscitation may restore to the patient his or her decision-making capacity. Herndon and others have argued to the contrary [31], that physicians have a duty not to treat burn shock in those patients with no established precedent for survival.

An analogy can be made between treating burns shock and cardiopulmonary resuscitation (CPR) in nonburned patients. If an intervention (particularly CPR) is deemed as futile by ‘consensus’, then the issue of ‘patient autonomy is irrelevant’ [32]. It is argued that such an intervention need not be performed, even if previously requested by the patient. A patient with a non-survivable burn injury is perhaps analogous to those patients referred to in the guidance on CPR issued by The Royal College of Physicians of London in 1987 [33]:

Resuscitation is not indicated for all patients… It is inappropriate to attempt to resuscitate those patients whose lives are drawing naturally to a close due to irreversible diseases.

4.8. Withholding and withdrawing treatment

If it is ethically sound to withhold a treatment on the grounds of a living will, or on the grounds that such treatment is medically futile, then it can be argued that to withdraw a treatment is equally sound and justifiable [34]. Consider the example of the elderly unconscious patient who presents with a severe burn. Initial assessment indicates that the burn is potentially survivable and resuscitation with intravenous fluids is started. A few minutes later a background medical history is supplied by her General Practitioner (GP) indicating that she had recently suffered a severe stroke, and that her general condition over the previous weeks had been gradually deteriorating. If the telephone call from the GP had been made ten minutes earlier then knowledge of the patient’s general medical condition would have prevented resuscitation from being started on the grounds of medical futility. If a decision not to resuscitate this patient is ethically valid, then accidents of timing should have no bearing on that validity. It is understandable that stopping a treatment, for example discontinuing ventilation or resuscitation, requires a greater moral fortitude than merely not starting such a treatment. Those of us working in the provision of health care are not generally accustomed to considering our treatments as being of potentially no worth to a patient. For patients who are terminally ill as result of their injuries inappropriate aggressive treatments may actually worsen their quality of life.

4.9. Assisted suicide

No discussion of the ethical issues inherent in burn care would be complete without referring to the subject of whether it is ethically valid for a doctor to assist a patient who wishes to commit suicide. When a patient asks for help in ending his or her own life, it is imperative that any doctor or health care worker considers what has led the patient to make such a request. Is their pain control inadequate, is the patient able to make a reasoned judgement? Is the patient suffering from depression that could readily be alleviated? Is there any organic, treatable cause that has led the patient to abandon hope?

Many of the victims of a severe burn injury will die in the hours or days after the initial event. Some
patients will survive for a period of weeks before succumbing to sepsis or multi-organ failure. Some patients however may live on with a quality of life that would be considered by most of us to be insufferably poor. They may suffer from intractable pain and disability. Despite optimal medical care some of these patients may wish not wholly unreasonably to end their own lives.

The proponents of euthanasia ethically justify suicide on the grounds that if it is ethically valid for one to kill another in self-defence (perhaps in order to escape pain and torture), then why is it not valid to kill oneself (perhaps in order to be released from the pain and torture inflicted by a severe burn)? If a patient can request that a physician amputate a limb that is causing insufferable pain, why can he not ask the same physician to release his consciousness from the insufferable pain and disability caused by a burn covering 95% of his body? Another argument proposed by those wanting to legalise euthanasia, is that the practice of physician assisted suicide enhances the patient rights of self-determination and autonomy. This is a potentially flawed argument [17]. It is put forward as a way to give dying patients control of their own destiny. Euthanasia however is an irreversible action. By assisting in the patient’s suicide the doctor is prescribing an intervention which once implemented denies the patient any potential control or self-determination. For the patient there is only one destination.

Involvement in euthanasia brings with it undeniable potential dangers to the medical profession. It is uncertain what effect such an involvement would have on the patient’s perception of his or her relationship with the doctor. A patient might feel that not only does he or she have a right to die, but that when seriously ill, he or she has a duty to die.

With the consent of the patient it is ethically valid for a doctor to remove potential obstacles to the patient’s death, for example if a patient developed a chest infection or sepsis one could withhold the administration of antibiotics. There is an ethical and actual difference between omitting obstacles to death, and acting to precipitate death. One cannot intervene to bring about or speed up the patient’s death. At the time of writing physician assisted suicide is illegal in the UK. If a doctor is found to have acted with the express intention of helping a patient to die then he or she will potentially be found guilty of manslaughter or murder.

4.10. Research

It is imperative that the ethical characteristics of any proposed research project be considered. In the NHS, the Local Research Ethics Committee (LREC) must approve all research work involving patients. Advice can be sought from the professional associations and Royal Colleges [35]. The British Pharmaceutical Industry has recommended guidelines for its member companies when undertaking research [36]. If a patient suffers any harm as a result of the proposed treatment then the fact that the patient gave consent does not exclude him or her from being eligible for compensation.

For therapeutic clinical research, the patient’s informed consent must be obtained before the patient is enrolled. Issues of consent largely unique to research work include the absolute need to inform the patient of the motives and purposes of the project. The decision to consent should be made by the patient without real or implied pressure from the physician. The patient should not enrol in a research project due to a fear of being deprived of a potentially beneficial treatment. The patient has a right to be fully informed of standard or alternative treatments, and of the extent of the current knowledge of the proposed treatment.

In the field of surgery there are often two or more procedures available for the same condition. Inevitably individual surgeons will prefer one procedure to another. In order to discover if there is a significant difference in outcome between the two treatments one commonly conducts a randomised trial. The issue of consent is problematic. A surgeon would have to ask a patient to enrol in the study knowing that the patient might be allocated to a treatment that he or she does not favour. When obtaining consent from the patient he or she would be ethically obliged to inform the patient of this potential dilemma. Under such circumstances the patient should be free to request exclusion from the trial and to receive the established procedure preferred by the surgeon.

Non-therapeutic research projects involving healthy volunteers requires the same standard of informed consent as that required when carrying out therapeutic research. In the case of non-therapeutic research involving children the established view is that parents cannot authorise an intervention or treatment that is not in the child’s best interests. Non-therapeutic research involving children may be only be approved at the discretion of the LREC if the treatment is not against the interests of the child, and there is negligible risk of any discomfort [37]. For incompetent adults therapeutic research can be carried out without consent, if it is in the patient’s best interests [19]. Non-therapeutic research however can only be performed if strict guidelines are satisfied [19]. The research project must be directed toward an incapacitating condition that the patient is or may be suffering from. There must be no other means to carry out the research. The interven-
tion must be associated with no more than negligible risk.

4.11. Rationing and distributive justice

It is an inescapable reality of health care provision that resources have finite levels. Once this premise is accepted the concept of rationing is morally sound provided that it is done so in a manner deemed by society as fair. In the United Kingdom rationing occurs at almost every level of the provision of health care. The percentage of Gross National Product to be spent on health care by the state is decided by the cabinet. Rationing occurs when the Department of Health puts its case for the limited resources of the state in competition with other departments such as defence or education. As the money trickles down toward the patient it is rationed between specialities, and between different services such as those in the community, the hospital or specialist centres. Finally it is rationed between individual patients.

To manage resources in a fair manner it is helpful to use a goal based ethical model. The goal is that of maximised human potential. A compromise must be met between utilitarianism, considering the good of society as a whole, and rights based ethics respecting the rights of individual patients. When a treatment is of marginal or unproven worth to the individual, then the cost of that treatment and its impact on the rest of society must be considered. Given the high cost of surgery and Intensive Care therapy, those working in burn care can increasingly expect to be involved in dilemmas concerning resource allocation [28]. Doctors and other professionals have a duty to act as advocates for the rights of the patient, but should not shrink from participating constructively in the debate concerning health care rationing. Doctors should be aware of the financial implications of their actions. If treatments are withheld from patients on the grounds that they are economically unavailable then patients should be informed [29]. The argument that it is morally acceptable to hide or not disclose such information, on the grounds that doing so would be cruel and inhumane, is not valid. Patients increasingly are aware of potential treatments, and may with some justification feel that the doctor who withholds information from them is no longer a trust worthy ally. To minimise the potential for conflict the rationing of health care should be carried out unashamedly in public.

5. In conclusion

Tremendous therapeutic advances in the care of burn injury victims have been made. Heath care is in a period of transition, a public debate is being conducted into the funding of health care and the accountability of health care professionals. New treatments and working practices should stand up to ethical scrutiny.

In a society that values the individual, medical ethics has to be centred on the individual patient and the maintenance of his or her individual rights. The duties of a professional working in burn care must be directed toward the best interest of the burn victim and to protect his or her fundamental rights.

Patients have the right of autonomy, consent for treatment should, except under exceptional and defined circumstances, be obtained as a result of dialogue and negotiation with the patient. The withdraw or withholding of a medically futile and inappropriate treatment may potentially be considered to be in the patient’s best interest. Guidelines for consent in minors, in the incompetent, and for research purposes have been laid down by the professional bodies and are defined by medical law.

Health care resources are finite. The rationing of such resources is an undeniable reality. The majority of burn victims recover from their injuries and retake their place in society. In the case of the severely injured recovery may not be complete, treatments may be lengthy and very expensive, in the young and old such injuries are still associated with a high mortality. The rationing of health care resources should be done openly in a just and ethical manner. Health care workers, including those that care for burn victims, should contribute to the debate on the future of health care distribution. The care of burn victims is a worthy undertaking, professionals should have no fear and no reluctance to examine the moral basis of their decisions.

References