configure reasons to respond to my colleague's worries about Mr A? Dr B's responses to questions like these might suggest to Dr Rad that Dr B is significantly motivated to have her perform a CTA because he is unfamiliar with D-dimer. Such a thread of conversation might give Dr Rad an opportunity to recognise this and try to familiarise Dr B with the appropriate scope of use of D-dimer and CTA as diagnostic tests. As a result of having pursued these questions and having exchanged responses, Dr B might become more comfortable with both these diagnostic tools as she cares for future patients in similar situations.

I have tried to show that if Dr B and Dr Rad can articulate responses to the questions I have listed, they can begin to understand what the other doctor sees at stake in Mr A's situation. Together, and in their responses, they exchange reasons, open avenues for subsequent questioning and clarification, and create opportunities for each to propose modifications to plans for what should be done for a patient. The practice of reason exchange cultivates a narrative that adumbrates possible consequences and enables the canvassing and consideration of possible justifications for doing something not doing something, or doing something in different ways. When reasons and the patterns of perception that illuminate those reasons are rendered explicit through conversation and questioning, they can be identified, evaluated, problematised and challenged. Then, communication between colleagues—consulting and consultant doctors—can become clearer, more open and more collegial.

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CORRECTION

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Several errors occurred in the paper titled, Trasplants save lives, defending the double veto does not: a reply to Wilkinson (*J Med Ethics* 2007;**33**:219–20). A corrected pdf is available as a supplementary file to this correction, available at http://jme.bmj.com/supplemental. The journal apologises for these errors.