

Fallacies in pro-technology arguments

Some new possible treatment modalities come with theoretical rationales for why they should be better than the current treatments. This theoretical promise of improvement over current therapy is often used to argue that we should implement the technology now and bypass all or some of the usual requirements for rigorous testing of new treatments. In a meticulously argued paper, Bjørn Hofmann uses the example of proton therapy, a new type of radiotherapy for solid tumours, to show the many ways in which such arguments can fail by invalidity or unsoundness (*see p 684*). He builds on a previous JME article by Holm and Takala,¹ but extends the argument considerably by not only considering the ethical arguments that Holm and Takala considered but also considering epistemic and social arguments. It is impossible to mention all the many arguments that Hofmann dissects, but it is worth quoting his analysis of arguments built on the value of being progressive at some length to give a flavour of his analysis:

“Correspondingly, a frequent argument is that other countries that are comparable with our country have the technology in question, so we should implement it as well. Another version of the argument is that another country (or institution) which we compete with, or like to be ahead of, is on the verge of implementing a new technology, so we should do so quickly.

[...] one example is found in the Norwegian debate, where it is argued that the Norwegian health care system is endangered because Norway is one of the few countries that does not have proton therapy. The argument goes like this:

P1 For a long time Norway was the only country together with Iceland and Albania that did not have PET (positron emission tomography).

P2 Now we are on the verge of making the same mistake with regard to proton therapy.

C Thus we should have proton therapy (in Norway).

This argument can be interpreted in many ways. The form of some of these arguments is presented below:

P1 Only few countries do not have T (proton therapy).

P2 We do not want to be compared with the countries that do not have T.

C We should implement T.

This is partly an *argument from adverse consequences* (sometimes called *appeal to fear and scare tactics*). If we do not implement proton therapy, something bad will happen—that is, we will be in the class with those we would not like to be compared with.

However, the argument also hinges on the form:

P1 Most countries have T (proton therapy).

P2 Most countries cannot be wrong.

C Therefore we should have T.

This is an *appeal to widespread belief* (also called *argumentum ad populum*, *bandwagon argument*, *peer pressure* and *appeal to common practice*) because it refers to common practice or what everybody does or believes.”

Ethics in the infertility clinic: the power of a qualitative empirical study

What happens behind those doors in the fertility clinic that are marked “for staff only” when staff discuss the ethical issues that arise on a daily basis? The paper by Lucy Frith gives us an answer to that question and, in the process of giving that answer, also illustrates the power of qualitative research to provide ethically important insights about the work of clinicians (*see p 662*). Frith interviewed 22 infertility clinicians and found that 21 of the 22 would not take a decision on a difficult case alone. More importantly, she found that the clinicians believed that reflective group discussions

were likely to be better in the sense of being “less likely to be made on the basis of personal prejudice and bias”. What was sought by the clinicians was, however, not necessarily consensus on the substantive ethical issue, but consensus on a way of proceeding that “everyone could support and manage in practice”. Building on these empirical findings, Frith then provides an insightful discussion about the strengths and weaknesses of substantive and procedural accounts of consensus in the literature. She argues that, although we may have theoretical reasons to be sceptical about some aspects of the procedural accounts, it is still the case that consensus decision-making works in practice and that it, despite its flaws, may be the best option we have.

Should we enhance animals?

The JME rarely publishes work on animal ethics, but this issue contains an exception. There has for many years been a lively discussion concerning whether we should enhance humans, for instance by genetic modification. But what about animals? What does enhancement mean in the context of animals? What are the implications of the arguments in the human enhancement debate for the ethics of animal enhancement? And, what are the implications of this discussion when we then reflect back on the discussion of human enhancement? All of these questions are raised and answered in the paper by Chan (*see p 678*). She argues that enhancement should be cashed out as an intervention that “Enables greater fulfilment of the animal’s own interests”. And further that, unless we have reasons to completely discount the interests of animals, then there will be circumstances in which animal enhancement is the ethically right thing to do.

REFERENCE

1. Holm S, Takala T. High hopes and automatic escalators: a critique of some new arguments in bioethics. *J Med Ethics* 2007;**33**:1–4.