

## Belated congratulations to Robert Edwards on his Nobel Prize

On the day I am writing this it has been announced that Robert Edwards has received the 2010 Nobel Prize in Physiology/Medicine for the development of in-vitro fertilisation (IVF). When this is being printed it will be old news. Nevertheless it is appropriate to congratulate him here, belatedly with his well-deserved prize. Not only has IVF created innumerable happy children. IVF and its later variants has also created years of work for medical ethicists across the globe, and will continue to create work for years to come. In that sense Bob Edwards is also one of the great, although possibly unintended, benefactors of medical ethics.

## Professor Paul Wainwright in memoriam

In this issue we publish a paper by Paul Wainwright and colleagues on methodological issues in empirical ethics (*see page 656*). Paul died suddenly earlier this year and as this paper shows his death was a great loss to the UK healthcare ethics and philosophy community. Paul had for years been in the vanguard of research and teaching in the areas of ethics and philosophy in relation to nursing and allied health professions, and had done much to get these subjects recognised as truly academic subjects. He will be sorely missed. The paper argues for the use of consensus methods instead of simple questionnaires in empirical studies aimed at understanding ethically charged practices in health care. It provides very useful guidance concerning how vignettes can be embedded within and can enrich a Delphi exercise.

## Students come to medical school prepared to cheat!

Apart from the exclamation mark this is the title of a very interesting and brave paper—Taradi *et al* (*see page 666*) reporting the results of an anonymous questionnaire study of all first year students in Croatian medical schools. The response rate of 67% is high, so the rather worrying results are (unfortunately) likely to be reliable. The main result is that of Croatian respondents 78% ‘admitted to having frequently cheated in at least one form of assessed academic misconduct’ before entering medical school. Academic misconduct is therefore not a behaviour that suddenly appears when students arrive at university, it is a behaviour pattern that has already been established during the school years. This finding has obvious implications for how academic misconduct need to be handled and may also partly explain why it can be difficult to root out.

## Self-inflicted illness and justice

Should people who have inflicted their illnesses on themselves have a lower priority for healthcare resources? This is a area of controversy in many healthcare systems. In the current issue we publish two papers on his topic. Sharkey and Gillam (*see page 661*) have systematically analysed the academic debate about the issue and identified 12 main arguments and rebuttals to these arguments (see table 1). They show that the debate has stalled without resolution because both sides believe that they have successfully rebutted the arguments of the other side. They argue that to move the debate forward new multidisciplinary input from stakeholders is needed. The paper by Ofra

Golan (*see page 683*) focuses on the idea that risk-taking behaviour could be the morally relevant inequality that allows us to give lower priority to those whose illness is caused by their risk-taking. It argues that whereas this idea is initially attractive it faces decisive counter arguments. The number of factual claims that has to be substantiated in order to show that someone’s illness was caused by their risk-taking is very large, and in most cases we cannot show this conclusively. We can then ask whether risky behaviour negates a right to societal support for health care, but given that no society applies, or is willing to apply, such a test across the board, this does not give us a compelling reason to discriminate against specific kinds of risk–illness pairs.

## The power of narrative: a MUST READ!

True life stories often convey important messages in a much more powerful way than academic analysis can ever hope to do. In this issue we publish an account by Pauline Thiele (*see page 646*) of her experiences when prenatal screening indicated that her baby was a increased risk of trisomy 18 and when this was later shown to be the case by amniocentesis. Pauline and her husband decided not to terminate the pregnancy and this was when their problems in relation to the healthcare system really began. I strongly recommend you to read her account. It vividly illustrates how patients not conforming to the norm have to fight their corner at every turn. We also publish two accompanying papers providing academic commentary on the story (*see pages 642 and 644*).

**Table 1** Map of the lower priority debate

Arguments	Counter arguments
Pro-lower priority	
The medical argument:	<ul style="list-style-type: none"> <li>▶ Counter 1: the no evidence argument</li> <li>▶ Counter 2: the no precedent argument</li> </ul>
The policy arguments:	
▶ The behaviour change argument	▶ No rebuttal
▶ The public support argument	▶ Counter 1: the rebuttal of the public support argument
The moral arguments (the harm argument and the self-respect argument):	
▶ Assumption 1: a link between unhealthy behaviour and responsibility	▶ Counter 1: the not responsible argument (the no control reason, the other causes reason and the value reason)
▶ Assumption 2: a logical connection between responsibility and lower priority	▶ Counter 2: the role of the healthcare professional argument (the trust reason and the non-judgement reason)
Anti-lower priority	
The impracticality of application argument (the time reason, the bias reason, the confounding factors reason and the foresight reason):	▶ No rebuttal
The universalisation argument:	▶ No rebuttal