What is it to do good medical ethics?
A kaleidoscope of views

Raanan Gillon,¹ Roger Higgs²

This special issue of the journal is a birth-
day issue. A fortieth birthday is usually
the time for more than pure celebration: a
rueful glance in the mirror at the begin-
ing to check on grey hairs, taking stock
about whether achievements come any-
where near those carefully laid plans, cau-
tious conversations with people who’ve
been around that long too (with a wary
look at the younger ones who might have
been expecting a lot more); and then a
long, deep breath about what comes next.
This anniversary is no different: 1975
was indeed a special year. Many will want
to know what happened then and since,
and why: Alastair Campbell, as the found-
ing editor (and writer of one of the first
modern books published on clinical ethics
in the UK) describes it clearly, and
Gordon Stirrat’s focus on teaching and
Roger Higgs’s on case discussion add
further dimensions. But equally important
questions for this birthday issue need to
be posed about what medical ethics in
particular, have achieved, and what
they haven’t; and where they should be
going from here.
It was the present editor-in-chief Julian
Savulescu who suggested that these ques-
tions might be addressed by making the
theme of JME40 the open-ended question
‘What is it to do good medical ethics?’ We
snapped up this idea. But who should we
invite to answer the question? We started
by asking the JME’s editors past and
present, and then we added our own
choices. There were far too many, even
for the bumper size of this special issue,
and we remain desperately aware that
many of us should have liked to have asked
haunter who has not been included. But as Kirkegaard
said, to start sewing you have to knot the
end of the thread, and we hope and
assume that other writers will forgive the
guest editors by engaging with the ques-
tion and responding to the challenge of
answers offered in this collection to give
the topic the thorough airing it deserves.
As its title makes clear the JME is pri-
marily (though not exclusively) concerned
with ethics in medicine, and we have con-
tinued that emphasis in this issue. The
breath of concern that this nonetheless
permits will be evident, and Sarah Chan’s
reflections on bioethics include an interest-
ing account of the distinction. Thus while
clinicians with a developed interest in
medical ethics are represented (some also
medical school teachers, members of
medical ethics think tanks, legislators, or
administrators), so too are patients and
managers, as well of course as a wide and
international range of professional bioethi-
cists with a background in philosophy. We
sought input too from sibling concerns
including medical law, medical economics
and medical humanities. We also explicitly
asked three clinician-ethicists to consider
‘good medical ethics’ from their specific
Christian, Islamic and Jewish religious per-
spectives. Conscious of the danger of too
narrow a focus on the doctor-patient inter-
change, we asked for contributions from
the perspectives of public health and
global justice: and we have responses to
our ‘set question’ from Argentina Australia
Denmark Egypt Holland Israel Norway
and Singapore as well as from the UK and
the USA. There is no shortage of criticism
amongst our older writers (including
ourselves) who look back, explain origins,
compare past and present; but as we
would expect younger contributors tend to
focus more on the present and future
states of medical ethics.

SOME EMERGENT THEMES
Unsurprisingly, many authors addressed
the issue of what ‘good’ in our question
might mean. The most extensive of these
analyses is by Jan Solbakk and his ideas
resonate throughout this issue. No birth-
day could be complete without celebra-
tion, and in view of its contribution to the
growth and development of medical ethics
and bioethics over the last 40 years this
journal does receive some plaudits for
having ‘done good’, in Art Caplan’s
phraseology. We were especially pleased to
read the praise of Julia Neuberger, a pre-
vious Chair of the Patients’ Association,
and a tireless campaigner on behalf of all
who use health services. By its support
over the years for the increasing focus of
medical ethics on the interests and
perspectives of the patients/clients/consumers/service users whose interests doctors
and other health care workers serve’ the
JME, she writes, ‘has itself made a signifi-
cant contribution to “doing good medical
ethics”’.
However as she and most contributors
make clear in this issue the glass of
medical ethics is nowhere near full.
Optimists and pessimists exist in all walks
of life, and while some contributors see it
as half full others emphasise that the glass
is certainly half empty, and maybe consid-
erably emptier than that, as in Julian
Savulescu’s very challenging assessment.
The warnings are there, in many places.
Brian Hurwitz searches in the attic and
reflects on the significance for medical
ethics of medical and nursing mass mur-
derers. Paquita de Zulueta warns that
without a major change of emphasis
towards an ethics of virtue and a concern
for compassion and human dignity
‘medical ethics risks becoming another
method for creating alienation, moral dis-
engagement and the reification of human-
ity, with all the dangers that this entails’.
Justin Oakley too recommends a virtue
ethics approach, arguing that it requires
both an empirically based moral psych-
ology and ‘sound action guiding prescrip-
tions’ if the virtues of physicians are to be
developed. Dan Callahan warns of danger
from without as well as within: good
medical ethics must tackle ‘a progress-
and technology-driven model of medicine
that is its basic or core value’ It is a drive,
he writes, ‘that knows no limits’ and
which is unsustainable. Medical ethics has
failed ‘to say that every technological
innovation should have to pass a test of
whether it will be good for humans’.
Rosamond Rhodes offers one explana-
tion of why a glass half empty perspec-
tive is needed when considering good
medical ethics. Appealing to a metaphor
of the philosopher J.L.Austin she writes:
‘to be more informative about what good
medical ethics is, requires explaining what
bad medical ethics is. In this case, bad
medical ethics wears the trousers’. There
is no question that there is plenty of
material to work on. While all contribu-
tors welcome the opening up of medical
ethics debate and the increase in moral
education in clinician’s training over the
last forty years, this alas is not a magic
that will chase away all bad actions and
tragedies caused by human inadequacy.
Scandals epitomised by the appalling
patient care in UK National Health

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Service hospitals in mid Staffordshire and described in the Francis Report cast doubt on the usefulness of medical ethics discussion and education. As Wing May Kong puts it: ‘If we look into the mirror post-Francis, surely those of us who champion the importance of medical ethics must admit that currently medical ethics is not good enough?’ To help remedy this she proposes three priorities: the building up of an ever larger ‘ethics community’ across health care—currently medical ethics is too much of ‘a minority language’; the necessity in teaching and implementing good medical ethics of ‘nurturing our moral imagination’; and ‘resisting tick-box ethics’.

But the contributors to JME40 show that medical ethics can be ‘not yet good enough’ in many other ways. Several of the professional philosophers point to what they consider to be poor reasoning, whether from ethicists or doctors. Savulescu leads the charge with a critique of organs from dead bodies should give for medical research or for transplantation of the poor thinking of rote moralism, in many other ways. Several of writers on this subject are often not writers of poor argument. In a perhaps related point Stirrat states that non-medical bioethicists sometimes fail to grasp clinical realities; and he adds that sometimes their reasoning and argumentation skills may actually make clinicians ‘feel inadequate, making them apprehensive about getting involved in formal ethics teaching’.

In a thorough review of arguments rehearsed in the JME since its beginnings concerning euthanasia and physician assisted suicide Soren Holm, a past editor, concludes, amongst other things, that writers on this subject are often not careful enough to distinguish between and be honest about their twin objectives of rigorous argument and political activism —a point also made by Solbak. This is an aspect of what Chan calls ‘the multiple hat problem’ in bioethics and of deciding and making clear ‘which hat we are wearing at any given time. Who are we talking to and for what purpose?’ And she adds: ‘Doing bioethics requires an awareness of the multiple roles that bioethics is called upon to play, and knowing how to balance them is a part of good bioethics’.

This theme is also pursued by Bobbie Farsides in reflecting on her work as an ethicist in a medical school where her hats include those of teacher, philosopher, social scientist and active participant in the surrounding community. Her summary perception of doing good medical ethics is that it is ‘practical in approach, philosophically well grounded, cross disciplinary’; and, she suggests, often done by good people.

TOLERANCE AND CONSCIENTIOUS OBJECTION

While rigorous reasoning is agreed to be necessary to do good medical ethics, few if any contributors would find it to be sufficient. The role of religion in their approaches to doing good medical ethics is discussed, in three fascinating and very different accounts, by John Saunders, Gamal Serour and Avraham Steinberg. Each considers the importance and limits of tolerance for conscientious objection and each discusses in this context the issue of abortion. Florenzia Luna also addresses the theme of conscientious objection to abortion and proposes an ethical response to conscientious objection in the ‘non-ideal circumstances’ (one of Solbak’s varieties of goodness) of what she regards as Argentina’s failures to uphold its own already restrictive law on abortion.

Several contributors emphasise the need to incorporate a variety of psychological factors when ‘doing good medical ethics’ including a concern to increase the use of imagination and compassion and to value people’s emotional responses more highly. While Higgs sees moral thinking often arising from response to difficulties in the emotional sphere, de Zulueta argues that ‘proficiency at moral reasoning, although important, does not necessarily translate into ethical behaviour’, and writes that the emotional dimension may be missing in much of the discourse and teaching of medical ethics. In this context, emotions are often viewed as a hindrance, rather than an aid, to making sound decisions. The revival of virtue theory, which incorporates emotions within rational ethical decision-making, the inclusion of philosophical emotion theory and neuro-scientific knowledge in clinical ethics are thankfully reversing this trend.

In her characteristically quirky and amusing contribution Inez de Beaufort recommends to bioethicists, among many other suggestions, that ‘one should be personally involved in the issues one thinks and writes about and [try] to bridge the gap of ‘moral distance’.

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THE DEMOCRACY OF MEDICAL ETHICS

Even if only from a ‘glass half full’ viewpoint, most contributors would probably agree that a positive development in medical ethics over the last forty years has been the recognition that many different perspectives are needed for ‘good medical ethics’. They are likely to agree with Solbakk’s claim that ‘ethics represents a domain and a form of knowledge different from any expert knowledge, in the sense that everybody—and notably on equal terms—is entitled to partake in public debates, dialogues and deliberations about moral issues that might affect his or her life’. Savulescu’s concerns about lack of training of so called experts in medical ethics notwithstanding, Neuberger, Callahan, Caplan and Bowman all write about the importance of involving the public, and all four, like many others in this issue, are prolific contributors in the non-academic media. De Beaufort, on being told by her (academic) publisher about 200 downloads of one of her academic articles asks herself whether it would have been better in the time it took her to prepare that paper to ‘have written 5 contributions for the popular press?’. A shining example of interdisciplinarity in medical ethics and of the glass half full approach is Mike Parker’s account of the ‘genethics club’ and his emphasis that ‘the moral craftsmanship’ of doing good medical ethics is a cooperative rather than a competitive activity.

INDIVIDUALS AND POPULATIONS

One of the recurring tensions in this collection of papers is between good medical ethics that is concerned primarily with how doctors should interact with their patients and good medical ethics that expands the proper concerns of medical ethics to ever larger ‘spheres of justice’. Angus Dawson vigorously reminds doctors that good medical ethics is typically too orientated to individuals, arguing that it should instead incorporate far more concern for communities, as in public health ethics. Writing as the epidemic in west Africa was beginning to threaten to spiral out of control, he cites a WHO response to the Ebola crisis as demonstrating the faults of traditional individual-orientated medical ethics. Richard Cookson points out, as a good health economist should, that good medical ethics requires ‘consideration not only of the identified patients who benefit from decisions, but also the unidentified patients who bear the opportunity costs’.

In a similar vein Savulescu argues that preventing avoidable loss of life is a fundamental obligation of good medical ethics.

‘There is a moral imperative to perform good research and not unnecessarily impede it. To delay by one year the development of a treatment that cures a lethal disease that kills 100 000 people per year is to be responsible for the deaths of those 100 000 people, even if you never see them’.

The JME started publishing a full 30 years after the end of World War Two, but several others of our contributors are far from happy about how the consequences of the new ethical oversight of medical research that followed that war have worked out. Like Savulescu, Solbakk writes about the ‘dysfunctionality’ of sometimes ‘exploitative’ international medical research ethics. They both question the Helsinki Declaration’s ‘normative bedrock of clinical research’ – namely that the interests and welfare of the individual should have priority over the sole interest of science or society. Solbakk urges ‘concerned ethicists to join forces’ and move away ‘from the microlevel of informed consent and of quasi-consensual transaction procedures to a level of deliberation that grounds international medical research ethics ‘within a broader normative framework of social, distributive, and rectificatory justice’. More broadly still, Jennifer Prah Ruger argues that too little account is taken by medical ethics, bioethics and political philosophy of ‘the capability to flourish’ as being ‘the proper goal of social and political activity’. Crucially underpinning this goal are ‘health capabilities and specifically central health capabilities—freedom from avoidable morbidity and premature death’, for these are essential for human functioning and thus underlie all other capabilities.

Prah Ruger offers components of a global health justice framework based on this health capabilities approach that she calls ‘provincial globalism’. (Smug Brits may also be struck by her claim that a free national health service was provided over 3000 years ago by the ancient Egyptians!).

A different aspect of justice—legal justice— in relation to medical ethics is discussed by Emily Jackson, who teases out some of the puzzling and sometimes confusing relationships between medical ethics and law. That this directly affects publishers of medical ethics is discussed by Higgs, who thinks that legal restrictions including the UK’s strict libel laws and data protection laws run the risk of making case discussion in print about conflict situations well-nigh impossible, however well details are anonymised.

Several of the papers in this issue, including those by John Harris (another past editor) Kong and De Beaufort, discuss yet another aspect of ‘doing good medical ethics’, the importance of teaching and mentoring students and younger colleagues both in the medical context and within academic medical ethics and bioethics. Harris suggests several models—including a research lab model and a ‘renaissance studio’ model in which this teaching and mentoring might occur and help the ‘research-craft’ of younger colleagues to ‘dock safely at the big quay of academia’.

‘PRINCIPLISM’ AND MEDICAL ETHICS

An important tension emerges in this collection about the role of ‘principlism’ or ‘the four principles approach’ in relation to good medical ethics. Supporting their use are Macklin who concludes that ‘the “famous four” principles provide the best approach’, Raanan Gillon, another past editor, who argues that ‘they are a good moral framework’ that underpins a contemporary ‘moral mission statement’ for good medical practice and thus for good medical ethics, and Ilora Finlay who finds them a helpful moral framework both in her clinical work and in her legislative work in the United Kingdom’s House of Lords where ‘the core principles of the classical framework outlined by Beauchamp and Childress can be seen to come into play’. On the other side however are several contributors with Rhodes in the lead castigating principlism for being ‘incoherent’ (by which it is clear that she means that they do not cohere with good medical practice) and ‘not illuminating’ (because ‘the four principles do not provide a mechanism for resolving dilemmas’). She joins Kong in criticizing the approach for encouraging ‘tick box ethics’ and writes ‘A formulaic approach that requires rote-wise ticking off principles or topics can be inefficient and distracting without clarifying the issue or helping to resolve the problem’. De Zulueta also implicitly lays into principlism, arguing passionately for the necessity of a virtue-based approach. A virtue ethics approach that Gillon argues seems to be compatible with principlism is provided by Oakley, who stresses the importance of good empirical studies both for determining which aspects of ‘the internal morality of medicine’ actually serve the ‘central goal of medicine’ of ‘serving patient health’; and which professional and political norms and requirements actually promote that internal morality. In the context of the principles several writers
complain about over-emphasis of respect for autonomy though both Callahan and Boyd, in his excellent discussion of informed consent, detect movement in contemporary medical ethics towards what the latter describes as ‘a possible rebalancing’ of beneficence over respect for autonomy when these conflict.

Perhaps a final glass half full perspective is expressed by Caplan who summarizes a general agreement by contributors to JME40: that while there are many ways to do good bioethics and good medical ethics ‘One crucial way is to do good’.

This issue of the JME certainly doesn’t provide a canonical account of what it is to do good medical ethics: on the contrary it provides a wide range of different accounts in which are proposed many different ways in which medical ethics should be improved. Kenneth Calman proposes setting up a multidisciplinary committee or commission, national or perhaps international, which should include the perspectives of patient groups, to continue to look at the question and ‘enlighten the professions, the patients and the politicians’—a view succinctly endorsed by Bowman in recommending ‘actively seeking perspectives and contributions from people other than academics and clinicians’. Such a committee could do worse than start with the kaleidoscope of views presented in this volume—and referred to in the treasure house of their authors’ references.

Finally we must thank those who let us guest edit this 40th birthday issue in the first place: above all Julian Savulescu, who, when Roger originally suggested the idea of a special 40th anniversary issue at a meeting of the IME Governing Body, so readily accepted its proposal and allowed the two of us to be its guest editors. Julian has played a hands-off Editor-in-Chief’s role throughout, and we should emphasise that any brickbats must come our way! With him we should thank the IME/BMJ joint journal management committee for so generously (and we hope farsightedly) agreeing to the plans and to our request for a double issue for JME40.

We also thank all the ‘backroom’ staff who, as always, play such a vital role in production of the JME. Amongst them we particularly thank Miriam Wood, administrator extraordinary, Bernadette Berido, who has been tireless in support of us and contributors, production editor Emma Chan and journals manager Claire Weinberg for all dealing so effectively with the many problems as they arose, and without complaint (at least to us!). More broadly we thank all the people who have helped produce the JME over the last 40 years. It would be impossible to name them all and invidious either to try and fail or else to select just a few. Suffice it to doff a hat to the founder, the various editors, their many assistants, the board members, the unsung army of peer reviewers, the publishing staff, and above all the thousands of writers. Between them all they have built up the JME to become a splendid example itself of good medical ethics, recently ranked by Google Scholar as the top bioethics journal, and by ISI as no 2 on the basis of academic journal impact factor alone. Happy fortieth birthday, JME.

So ‘what is it to do good medical ethics?’ Please read on.


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