

Correspondence

Composition and function of ethical committees

SIR,

In his paper on the composition and function of ethical committees, William May (1975) sets out an argument that such committees should be concerned with both moral and scientific aspects of medical research. Poorly designed research is, *a priori*, unethical since it exposes subjects to an unnecessary risk for an unrealizable benefit. The ethical committee's first response to a submitted project should, then, be, 'Is this good science?'. May elaborates some criteria for identifying scientifically valid work.

While we accept his view of the importance of ethical committees both in monitoring standards and promoting ethical awareness and accept that the considerations he sets out are both important and relevant for clinical experiments, we feel that it is necessary to go beyond these. If ethical committees are to be really effective they must concern themselves with *all* research in their institutions. While May's model for judging scientific acceptability is fairly easily generalizable to most natural scientific investigation, it could present real problems for social scientists engaged in medical research. In this, a certain tension between the programmes of the social and natural scientist is exposed.

As Illsley (1975) observes, medical sociology is gradually beginning to shake itself free of its domination by medical practitioners. In the past, sociologists tended to study problems defined for them by doctors in terms set by doctors. They looked at the social and economic correlates of disease incidence, at the failure of patients to make use of services and the inability of auxiliary and paramedical workers to execute physicians' instructions. These investigations were carried out within a model of inquiry which consciously aped that of the natural sciences. The

mathematical techniques and drive towards the quantification of phenomena and their properties which had served the natural scientists so well were adopted, often with their assumptions about causal determinism.

Over the last few years, however, sociologists have become increasingly disenchanted with such models of human conduct. In particular, it is argued that conduct is not causally determined behaviour but, rather, intentional action which is to be explained by reference to the purposes and motives of the actor. The language is one of reasons rather than causes. For example, sociologists are coming to suggest that patients do not take up available services because they have what they find to be entirely adequate reasons for not using them rather than assuming that they have some defective form of rationality or viewing their actions as determined by some occult force, while the researcher is, of course, a 'free actor'. If we want to understand patients' actions, we need to be able to tap the reasons which the patients recognize themselves, since it is those reasons which are responsible for the observable conduct. This can only be done by adopting methods of research which allow the investigator access to the cognitive framework through which the subject of the research interacts with his social environment.

In consequence, sociology has adopted a less rigid view of what is acceptable scientific enquiry. Research is relying a great deal more on the observation of naturally occurring social action and conversation-like free interviewing. The true objectivity of the scientist is seen to be his dispassionate, disinterested and sceptical state of mind rather than some particular bundle of techniques or quantitative procedures. Thus, while the sociologist may have a clear idea of what he wants to do, it may not be possible

to present it to an ethical committee in a fashion which corresponds to the procedural canons of orthodox science. Two important consequences follow. First, ethical research may be turned down because the scrutinizing committee are unable to recognize its scientific quality, since they may be judging it by inappropriate standards. Secondly, and more seriously, unethical research may slip through because scrutineers lack the knowledge to pick up its defects.

At the end of the day, the only true safeguard is the integrity of the researcher. This can be developed in undergraduate and graduate training but it is most important that integrity is sustained throughout the institutions in which researchers actually work. All the training in the world is likely to be rather ineffective if it is not supported by the everyday attitudes and practices of colleagues. The role of an ethical committee needs to be a positive one of actively promoting ethical awareness rather than merely inhibiting the slipshod. If it is to be successful in this enterprise, the committee must enjoy the whole-hearted confidence of every researcher coming under its auspices. It must be seen to accord fair representation to all disciplines, specialties and levels of experience and prestige and to be taken seriously by all members of the institution. Otherwise one merely creates a climate in which the tacit cover-ups described by Barber *et al* (1975) flourish. Such confidence can hardly be said to exist among medical sociologists at the present time, and this view is probably shared by other non-clinical researchers with interests in medical practice. The situation is unlikely to change while the ethical committees have, and are seen to have, in their philosophy and membership, the relatively narrow remit of reviewing only clinical research along the lines suggested in May's article.

The remedies are twofold. First,

ethical committees should draw on both clinical and non-clinical disciplines for their membership. The committees cannot hope to evaluate the scientific merits of research without the benefit of informed opinion. Without an adequate evaluation, the ethical may be excluded and the unethical slip through. But the committees would be hopelessly unwieldy if all possible disciplines and grades were represented. This might suggest some kind of division into constituencies which could nominate representatives. However, secondly, where a discipline is not represented directly it is important that the investigator be allowed to present his case in person and that a representative of that discipline who is fully conversant with the investigator's approach should join with the ethical committee and participate fully in the discussions which precede their decision.

The effective operation of ethical committees depends upon the consent of those they are set up to monitor. That consent cannot be imposed or demanded. It can only be acquired if the committee's decisions and justifications are seen to be fair, just and reasonable, based on a full and informed consideration of all the issues involved. Such confidence will be most readily accorded to a broadly representative committee with open procedures and a readiness to accept the diversity of scientific investigation.

MICHAEL BLOOR
R W J DINGWALL
GORDON HOROBIN
J MCINTOSH
M L SAMPHIER

*MRC Medical Sociology Unit,
Centre for Social Studies,
Westburn Road,
Aberdeen*

References

- Barber, Bernard, Lally, John J, Makarushka, Julia Loughlin and Sullivan, Daniel (1973): *Research on Human Subjects*, Russell Sage, New York.
- Illsley, Raymond (1975). 'Promotion to observer status' *Social Science and Medicine*, 9, 63-7.
- May, William W. (1975). 'The composition and function of ethical committees' *Journal of medical ethics*, 1, 23-9.

Active and passive euthanasia

SIR,

Dr Richard Nicholson in his article, 'Should the patient be allowed to die?' writes: 'Euthanasia, literally a "well, or good death", may be voluntary or involuntary; it may also be either active or passive, these terms in practice being used synonymously with positive or negative euthanasia. Active, or positive, euthanasia involves the use of treatments designed to promote death sooner than would otherwise be expected. Passive, or negative, euthanasia is a failure to use therapies that would prolong life in a patient with a terminal illness.'

We are writing to you jointly, one of us a supporter and the other an opponent of legalized voluntary euthanasia, in the hope of checking the spread of the expression 'passive euthanasia'. In this and other English-speaking countries the established usage of 'voluntary euthanasia' refers only and precisely to what Nicholson calls *active* voluntary euthanasia. Furthermore, 'good terminal care', which Nicholson regards as synonymous with passive euthanasia, is anything but passive or negative.

The effect of introducing his distinction must be harmfully divisive. If the avoidance of 'furore therapeutica' comes to be thought of as a form of euthanasia, then those who are against euthanasia will be inclined to support 'furore therapeutica'. This is a result which both the present writers, and Nicholson too, would deplore.

A. G. N. FLEW
University of Reading

R. G. TWYXCROSS
St Christopher's Hospice, London

Dialogue between Marshall Marinker and Ivan Illich

SIR,

As a lawyer surreptitiously present at the London Medical Group conference on iatrogenic disease, I was aware of partaking in a function not only of medical significance, but of a deeper philosophical, even theological, importance. The real dialogue of the day seemed to me to be between Marshall Marinker and Ivan Illich.

Illich I was prepared to be disappointed in or impressed with. Marinker I did not know of. Both their contributions were articulate and compelling, and I was impressed

with both. But it is only through the benefit of time for thought that I have identified, for myself at least, the area in which they are unable to meet. It is the area of priesthood.

Illich articulated the concept of the area of man's autonomous self control. As he was talking of medicine he was constantly in fear of appearing to glorify the miseries of human suffering. He carefully picked his way through the dangers of holding a brief for the ultimate value of human responsibility, whether for your bank balance or your death.

Marinker seemed to me the almost perfect apostle of enlightened contemporary society. He was concerned to justify historically what he called 'the clinical transaction'. The ghostliness of the term did not deter me from the intellectual substance of his position. He saw the doctor as something more than a mere technician: he saw him as the senior partner in an almost metaphysical relationship.

Now it is that point that identified for me, at least, the reason why Illich caused a greater spiritual empathy. Man does need to be cared for and to believe, but it is not the doctor but the priest who has traditionally fulfilled this role. Marinker was wrong when he said: 'History suggests that the fact of the dialogue will not be changed'. Even his delightful reference to the historical Ivan Ilyich betrays the point. This man's question whether his condition is 'dangerous or not?' does not indicate a man seeking a personal spiritual relationship. On the contrary, he is a man seeking information about the physical parameters of his existence. Certainly there is no indication from the reply of the doctor - 'mind your own business' - that he is aware of this need for a relationship. On the contrary he is aware of a purely technical superiority, independent of any transcendental spiritual communication. The Ivan Ilyich of history on hearing that his condition was fatal would be far more likely to satisfy his economic commitment to the doctor and then seek the priest for the arrangement of his deeper spiritual relationships.

As I understand Illich - and I don't pretend he is easy to understand - he is trying to assert the value of man breaking free from the institutionalized provision of his