The Journal of the Institute of Medical Ethics

The *Journal of Medical Ethics* was established in 1975, with a multidisciplinary editorial board, to promote the study of contemporary medico-moral problems. The editorial board has as its aims the encouragement of a high academic standard for this developing subject and the influencing of the quality of both professional and public discussion. The journal is published quarterly and includes papers on all aspects of medical ethics, analyses ethical concepts and theories and features case conferences and comment on clinical practice. It also contains book reviews.

Editorial Board

Submitting manuscripts for publication

Papers submitted for publication should be sent **in quadruplicate** to: The Editor, *Journal of Medical Ethics*, c/o Imperial College of Science, Technology and Medicine, 14 Prince's Gardens, London SW7 1NA. Rejected manuscripts are not returned unless accompanied by a stamped addressed envelope, or international reply coupon. Papers should be in double-spaced typewriting on one side of the paper only. **The preferred maximum length of papers is 3,500 words – absolute maximum 5,500** (including references). A total word count is appreciated. On a separate sheet some brief biographical details should be supplied, including the title of the author's present post, degrees and/or professional qualifications, (if any) and any other relevant information.

Four copies of the journal will be sent to authors free of charge after their papers are published. Offprints of individual papers may be bought from Professional and Scientific Publications, Tavistock House East, Tavistock Square, London WC1H 9JR.

In March 1981 the *JME* adopted a simplified 'Vancouver style' for references: details are given in various issues, including December 1986. They are also available from the editorial office. The full text of the 'Vancouver Agreement' was published in the *British Medical Journal* in 1982; volume 284; 1766–70. As the 'Vancouver style' is incompatible with the long established style of references for legal articles, lawyers should use their own standard style, but try to facilitate reference by others. The journal is multidisciplinary and papers should be in clear jargon-free English, accessible to any intelligent reader.

Notice to subscribers

The *Journal of Medical Ethics* is published quarterly. The annual subscription rates are £38.00 in the United Kingdom and Irish Republic, and £53.00 in all countries overseas. US direct $85.00. Payment for overseas subscriptions should be made in sterling, payable to Professional and Scientific Publications/JME A/c. Orders can also be placed locally with any leading subscription agent or bookseller. (For the convenience of readers in the USA subscription orders, with or without payment, can also be sent to: Professional and Scientific Publications, *British Medical Journal*, Box No 560B, Kennebunkport, Maine 04046. All enquiries, however, must be addressed to the publisher in London). All enquiries regarding air mail rates, single copies, advertisements, etc, should be sent to: Professional and Scientific Publications, Tavistock House East, Tavistock Square, London WC1H 9JR.

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Thematic review and index

The thematic review of past issues appears in the June issue each year and an index to each volume appears in the December issue.

to God and in God's eyes. But the report explicitly disclaims any reliance on theological premises [148] and without that support the questions must be faced, and they are not always easy to answer.

Most people cling to their own lives even when those lives seem to others, and even to themselves, starkly miserable. But some do not; there comes a time when they find life insupportable and they long for release. If the autonomy of the patient is to be paid more than lip-service we must allow people to answer questions about the value of their lives for themselves. Certainly there are cases in which a person's life is of value to others, for example if he is the sole breadwinner of a family which will be left destitute at his death. But this type of case must be very rare in the circumstances envisaged by the legislation proposed by the VES. Certainly too, survivors grieve when someone dies; but that grief is coming to them in any case, and the tragedy lies, not in the AVE but in the conditions that led to its request.

The report even goes so far as to suggest that life should be prolonged against a person's will because doctors themselves may get something out of it. That, at least, seems to be the meaning of the following sentence taken from Section 62 on the disabled who are not terminally ill. 'It is a far more demanding and challenging task to attempt to discover value in the terrible situation that exists, but it is more in accord with the ethos of medicine to make that attempt than to kill the patient'. That the working party can refer to *voluntary* euthanasia as 'killing the patient' is a measure of the open-mindedness and sensitivity with which it approached its task.

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(5) *Sunday Telegraph* 1986 Nov 30.

(Continued from page 116)

be (with correlative debate about what counts as a health-care need and what as a mere health-care *want;* and how can satisfaction of such needs best be *measured)*; how much tax for health care can Government justifiably levy?; what are the proper principles whereby Government should undertake the macroallocation of the overall 'tax cake' between competing State objectives such as education and defence – and given some overall Government allocation to health care, how should it be distributed equitably in the face of competing health-care needs, if it is agreed that not all those needs can be met. In the face of the inexorable – and indeed often literally wonder-ful – development of new and effective health-care techniques, such a debate and a proper mechanism for encouraging and sustaining it – becomes ever more necessary.

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News and notes

Ethical issues in *in vitro* fertilisation

A new 'scope note', Scope note 10, on Ethical issues in *in vitro* fertilisation, has been published by the Kennedy Institute in America. It lists important committee statements and offers an annotated bibliography on the legal, philosophical, public policy and religious aspects of the procedure.

Scope notes, the Kennedy Institute points out, are not designed to be comprehensive reviews, but to bring together recent information related to specific topics in biomedical ethics.

Copies are available from: the National Reference Center for Bioethics Literature, Kennedy Institute of Ethics, Georgetown University, Washington, DC 20057, USA. Cost is $3.00 prepaid and $5.00 outside the USA and Canada.

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(7) For a discussion of the change in public attitude towards the authority of the medical professional, see Starr P. *The social transformation of American medicine.* New York: Basic Books, 1984.
(8) Purtillo R B. Ethics consultations in the hospital. *The New England journal of medicine* 1984; 311, 15:983–986.
(9) See reference (2):166.
(10) See reference (2):450.
(11) Note that there is some question of breaching confidentiality by including lay members. For a general discussion of confidentiality see Cranford R, Hester F, Ashley B. Institutional ethics committees: issues of confidentiality and immunity. *Law, medicine and health care* 1985; 13, 2:52–60.
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(13) Allen P A, Waters W E. Attitudes to research ethical committees. *Journal of medical ethics* 1983; 9:61–65.
(14) See reference (12):48.
(15) Ross J W, Bayley C, Michel V, Pugh D. *Handbook for hospital ethics committees.* Chicago: American Hospital Publishing, Inc, 1986: 49–63.
(16) For example, a policy on resuscitation that requires a patient's consent prior to writing a 'Do Not Resuscitate' order tells physicians that patient participation in this decision is mandatory. For a further discussion of the role of policies in clinical care see Murray T. Where are the ethics in ethics committees? *The Hastings Center report* 1988; 18, 1:12–13.
(17) Weiden P. Ethics by committee? [editorial]. *The New England journal of medicine* 1987; 317, 22:1418.
(18) See reference (2):452.
(19) See reference (14):59.
(20) See reference (12):47.

News and notes

Death and the brain

There is now wide acceptance of the view that the irreversible loss of all brain function can be taken as a criterion of death. But this does not settle all arguments about death. Among the questions left open are: Is the use of brain death as a criterion of death a *scientific* decision or an *ethical* one? What implications does the use of the brain-death criterion have for our treatment of anencephalics, who are born with most or all of their brain missing? Does the use of the brain death criterion have any implications for the status of human embryos which have yet to develop a brain? Is there a sound basis for requiring the death of the whole brain, rather than "neocortical death" – that is, the death of those parts of the brain required for consciousness? Should we distinguish between the death of an *organism* and the death of a *person?* Can we contemplate the idea that a person has died while his or her body is still alive? If so, how should one treat such a body?

BIOETHICS invites contributions on any aspect of these issues, or on related ethical questions. Contributors who are in doubt about whether their topic will be suitable for the issue are invited to send us an outline of their work.

Submissions and/or enquiries should be sent to: Dr Helga Kuhse and Professor Peter Singer, Editors, *Bioethics,* Centre for Human Bioethics, Monash University, Clayton, Victoria, Australia 3168.

The deadline for submission of papers is January 15, 1990.

attributable to societal ills; therefore, an understanding of this state of affairs is essential as a therapeutic aim. US veterans of the Vietnam war who have failed to adjust to American society are deemed to be victims of the experience of participating in an unjust war with consequent perplexity, guilt, anger and torment (12). The therapist reveals his affinity with their plight by virtue of avowed political and ethical sympathies and corresponding preparedness to act on the veteran's behalf.

In these illustrations, particular groups of patients are identified with by an ethically committed therapist. But this sort of position may apply more generally. A therapist may wish to disclose certain values he espouses as an ingredient of his therapeutic approach, this on the premise that values are relevant to *all* social encounters and therefore to the therapist-patient relationship.

I suggested earlier that 'value-testing' and 'value-disclosure' are not necessarily contradictory options. A third position combines both options, albeit in a complicated way. The therapist, in accepting that values are integral to the therapeutic process, takes exceptional care to differentiate between those values which are entirely personal to himself and bear no relevance to the patient, and other values which are clearly crucial in the patient's efforts to achieve a more effective degree of autonomy.

Thus, in Sally's case, my own attitudes to academic pursuit, the writing of books, the issue of what constitutes authentic living, and the like, are not pertinent to treatment. They are however the agenda for Sally to wrestle with as she explores unconscious motivating forces that have hindered her so profoundly. On the other hand, I am obliged to stress my conviction to Sally that it is a necessary feature of treatment that she consider participating in an exploratory process whose objective is more enhanced autonomous functioning. This I clarify in the framework of obtaining informed consent at the outset but reiterate in the course of treatment whenever it is apposite. In this way, the purposes and practice of therapy are always available for scrutiny and appraisal.

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News and notes

Ethics centre

The Department of Philosophy of The University of Tennessee-Knoxville is pleased to announce the formation of the Center for Applied and Professional Ethics (CAPE) under the direction of Professor Glenn Graber. CAPE develops programs of education, conducts conferences, and consults on matters of professional and applied ethics. For more information contact Professor Graber at (615) 974-3255: University of Tennessee-Knoxville, Knoxville 37996-0480, USA.

warning for those in this growing area of concern.

Animals as a source of human transplant organs is an equally fascinating section, commencing with a superb chapter by Richard Werner, recounting the futuristic tale of the earth's occupation by a 'superior' race, the Bios. The diary of a human scientist unfolds in a dialectical discussion on whether humans can be sacrificed, as well as other animals in the cause of another race. Arguments of speciesism and the greater good of all 'nature' rather than parts come alive in this original presentation. After this, other chapters in this section seem rather heavy and philosophical, devoted in the main to arguments about sacrificing life for organs and assessing the quality of life for either healthy animals or very handicapped humans. All agree that healthy animals should not be made to suffer and that harvesting human organs after death is preferable when transplantation is necessary to save the life of another.

Finally there are two brief chapters on the nurse's role, which are rather prescriptive and uncritical. Nurses are seen to have a primary role as patients' advocates and this is accepted apparently because previous nursing authors have supported and written about this. The second author illustrates this principle with the case of Baby Doe, reminding the reader that the child (not the family) is the primary responsibility of the nurse, who acts as his advocate.

In summary this is a useful collection for those, such as students, who are interested in learning about medical ethics, and it may stimulate debate and help others to realise there are many ways of looking at ethical problems. A quote from Richard Werner captures the essence of this subject and is sadly in contrast with the message from some of my nurse colleagues:

'I do not see it as the job of the moral philosopher to draw moral conclusions, to tell other people what they ought to do, if for no other reason than they won't listen anyway... . The important point is for one to develop one's own reflective morality, not to receive someone else's conventional wisdom'.

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Human Life and Medical Practice

J K Mason, 161 pages, Edinburgh, Edinburgh University Press, £17.50, 1988

Professor Mason faces the harsh question head on: do we, should we, aim for quality or quantity of life? Is the sanctity of life paramount, or is the capacity for enjoyment of that life to be a prominent factor in the ethical equation? In this careful analysis of the problems raised by abortion (around 172,000 cases a year in this country), euthanasia, fetal and neonatal rights and the definition of death, he sets out the issues with clarity and gives his own views with the firmness and modesty to be expected from one who has over many years developed a strong philosophical stance, derived from experience and close study of the views of others.

The author could be said to have missed a trick over abortion. The real effect of the Abortion Act, 1967 is that it legalised abortion 'on demand', since the requirement that the mother will be at greater risk if the pregnancy goes to full-term is satisfied in every case by the statistics for maternal death and morbidity, at least in the first trimester. This was revealed by the gyrations of Professor Huntingford and the Attorney-General over the validity of certificates under the Act: a striking example of legislation unwittingly contradicting the intention of Parliament and flying in the face of current ethical views.

The great value of this book is its historical perspective, illustrated by specific examples which clarify the issues – (sometimes: whether the *Gillick* case cleared or befogged the air is open to argument.)

Not surprisingly, the *Arthur* case figures prominently in the discussion. While the case was directly concerned only with the rights of a neonate and its parents, it raised a number of issues which go to the root of medical ethics, many of which are still unresolved. The value of Professor Mason's analysis is that he gives us the reasoning behind the 'pre-Arthur' and the 'post-Arthur' approaches to the problems of the defective neonate, so providing a framework for the examination of other ethical problems. It might have been some comfort to the tragic Dr Arthur to realise that he had at least polarised the chaotic views of his profession.

The other great virtue of this short book is the full annotation, with reference not only to the literature (somewhat scanty and often tendentious) but, more important, to all the leading cases in English law, and to many from North America. This is probably the only way to make sense of the network of strands of thought in this changing area. One aspect he does not cover, nor could he do so to any effect is: what is the duty of the doctor faced with the 'need' to sterilise a girl unable to consent by reason of her mental state, but too old to be made a ward of court? The House of Lords grappled with this problem recently and permitted it 'in the existing circumstances'.

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News and notes

Professorship in medical ethics for JME's first Editor

Dr Alastair Campbell, the first Editor of the *Journal of Medical Ethics*, has been appointed Professor of Biomedical Ethics in the Medical School of the University of Otago, New Zealand. He will also be the Director of the university's newly established Bioethics Research Centre. Dr Campbell was previously Senior Lecturer in the Department of Christian Ethics and Practical Theology, Edinburgh University.

Note from the Editor

Changes at the Institute

The Director of the Institute of Medical Ethics, Prebendary Edward Shotter, has been appointed Dean of Rochester. He will take up his appointment on January 1st next year. Dr Richard West, until recently Dean of St George's Hospital Medical School, London has been appointed General Secretary of the Institute.

The Institute is to establish a research centre in Edinburgh which will be the responsibility of the Institute's present Scottish Director and Research Fellow, Dr Kenneth Boyd.

The London Medical Group is being replaced by locally based Medical Groups in several London teaching hospitals; there will be a United Hospitals Medical Group for St Thomas's and Guy's and Medical Groups are being formed also at St George's, the Royal Free and at Charing Cross/Westminster. These groups will collaborate to arrange the 27th London Medical Group's annual conference in February 1990.

The London Medical Group originated in 1963 when four lectures on medical ethics were arranged. By 1970 it had establised a twice-weekly programme in the 12 London teaching hospitals. This programme, some 48 symposia, supported by conferences, study seminars, clinical rounds and overseas visits, led to the formation of similar Medical Groups in all of the British centres of medical education. The Nottingham Medical Group, the most recent and final group to be established, begins in January next year.

Since their inception the Medical Groups and the Institute itself have depended upon charitable funds. The *Journal of Medical Ethics,* started with the generous support of the late Sir Cyril and Mr Ernest Kleinwort, the merchant bankers, has become profitable and contributes towards the general expenditure of the Institute. For the past two and a half years however, the profits of the Journal have been applied to the monthly *IME Bulletin.* Unfortunately the Bulletin has failed to attract enough subscribers to become financially viable and, despite the generous support of the Honourable David Layton and Incomes Data Services the Institute could not meet the continuing loss. It was therefore decided to cease publication of the Bulletin in July.

Some of the financial difficulties referred to have been met by selling a half-interest in the *Journal of Medical Ethics* to the BMJ publishing group. This will consolidate 15 years of collaboration between the Institute and the BMJ. The editorial team, including myself as editor, will remain unchanged.

Institute of Medical Ethics

The Institute of Medical Ethics is a centre for research, education and information. It is financed by grants from charitable bodies, government sources and members' subscriptions.

It was established as the Society for the Study of Medical Ethics, and is an independent, non-partisan organisation for the multi-disciplinary study of medico-moral issues raised by the practice of medicine.

The institute aims to influence the quality of both professional and public discussion of medico-moral questions; to promote the study of medical ethics; to ensure a high academic standard for this developing subject; to encourage a multidisciplinary approach to discussion of the consequences of clinical practice; to stimulate research in specific problems, and to remain non-partisan and independent of all interest groups and lobbies.

The institute undertakes research on medico-moral questions, sponsors a major educational programme and provides an information service for members.

Two reports, *The Ethics of Resource Allocation in Health Care* by Kenneth Boyd and *Dilemmas of Dying* by Ian Thompson, were published, by the Edinburgh University Press, a few years ago.

In 1986 two more reports were published. One, on the ethics of clinical research investigations on children, *Medical Research with Children: Ethics, Law and Practice* by Richard Nicholson was published by the Oxford University Press and *Life Before Birth – the Search for a Consensus on Abortion and the Treatment of Infertility* by Kenneth Boyd, Brendan Callaghan and Edward Shotter, was published by SPCK. The *Pond Report on Teaching Medical Ethics*, a summary of which appeared in the IME Bulletin, was published in full in 1987.

The institute derives from the London Medical Group, a student group for the study of issues raised by the practice of medicine which, since 1963, has arranged a comprehensive programme of lectures and symposia on medico-moral issues raised by the practice of medicine. Similar groups associated with the institute have been established in university teaching hospitals at Aberdeen, Birmingham, Bristol, Cambridge, Cardiff, Dundee, Edinburgh, Glasgow, Leeds, Leicester, Liverpool, Manchester, Newcastle, Oxford, Sheffield and Southampton.

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