

## Editorial

# Empirical medical ethics

Tony Hope *Editorial Associate, Journal of Medical Ethics*

Three papers published in this issue describe empirical studies of one kind or another.<sup>1–3</sup> A look through recent volumes of the journal reveals several further examples. And yet there has been little explicit acknowledgement of this developing field of empirical medical ethics. I hear people talking of it, but the textbooks and the standard writings see medical ethics as almost exclusively a branch of philosophy.

Is this empirical work unfortunate, taking medical ethics away from its true intellectual base in philosophy and leading to mediocre studies of little interest or significance? Is it a worthwhile activity, but not medical ethics? Or is it a healthy development in the maturing subject of medical ethics? I take the latter view. It is not that there is no more philosophical work that needs doing—quite the contrary—but empirical work will be an integral part of the development of the subject, perhaps in the same way that physics develops through a healthy relationship between theory and experiment.

Almost fifteen years ago Raanan Gillon wrote *Philosophical Medical Ethics*.<sup>4</sup> The title was chosen, I suspect, to contradict the idea, then prevalent amongst clinicians, that ethics was simply a matter of common sense and experience. Gillon wanted to emphasise the importance of a proper philosophical approach—a set of academic skills with a secure intellectual base—which needed to be brought to bear on the increasingly complex and sophisticated field of medical ethics. What is needed is a sister volume: *Empirical Medical Ethics*.

### Why is the field of empirical ethics developing?

I think there are several reasons why this field is developing now.

Some developments in the methods of philosophical medical ethics are sympathetic to empirical issues. Narrative ethics, for example, emphasises the importance of the empirical details of the case or situation under discussion. The material for ethical analysis tends to be the details of real situations.

Over the last thirty years a great deal has been done to clarify the contribution of philosophy to medical practice. This conceptual work has helped to delineate what are the relevant empirical issues. For example, the concept of advance directives raises important empirical questions to do with how such directives are best formulated, what their impact is, etc, etc.

The multidisciplinary nature of medical ethics has meant that many of those working in the field have their principal academic background in the empirical sciences rather than in philosophy.

Researchers interested in medical ethics who are working in departments of medicine need to find ways in which their work can be assessed and funded. Unless they are able to do this they will lose out in the research assessment exercise which is crucial to university funding at least in the UK.

### Six types of empirical study

Some philosophers may be sceptical of empirical work. Consider, for example, euthanasia. If empirical work in euthanasia means surveys of whether people believe euthanasia is right then what on earth is the use of it? Whatever the results, no light is shed on the issue. The question of whether euthanasia is right or wrong is a philosophical, not an empirical issue. If this were the paradigm of empirical medical ethics then I would agree with this view, but it isn't. I will give several examples.

Philosophical argument often depends on empirical issues. One reason, for example, why doctors should keep patient information confidential is in order to foster patient trust and ensure that appropriate help is sought. And yet the effect of specific breaches of confidentiality is an empirical issue.

Medical ethics has been shaped by empirical facts. These have rarely been collected in a systematic way. For example, the very issues that are the focus of medical ethics are taken from the experience of health professionals. A more systematic approach to the empirical base might lead to new issues and new perspectives. Studies of

ethical issues faced by patients or their relatives, for example, are likely to reveal important differences from the professional perspective.

Medical ethics is increasingly developing what are, effectively, interventions: advance directives; consent procedures; ethics committees (research or clinical). In this issue, Kent<sup>2</sup> examines the performance of research ethics committees; and Bjorn and colleagues<sup>1</sup> report the results of a randomised controlled trial of two different types of information sheet for possible participants in a research study. The use, in this field, of a methodology now standard in medical science is a significant development. Perhaps we may look forward to a Cochrane collaborative centre for empirical work in medical ethics.

The much derided survey can be sophisticated and important. For example, the question of capacity to refuse treatment in people with anorexia nervosa can be very problematic. Little research has been carried out into the beliefs of people with anorexia from the point of view of such capacity. An empirical examination of such beliefs is likely to help in developing a richer understanding of what capacity, or lack of capacity, means.

Some ethical theories lead directly to empirical work. An outstanding example is QALY (Quality Adjusted Life Year) theory. Three quite different types of empirical study follow from this theory. The first is the establishing of what quality adjustment should be made for different states of health. The second, which is becoming quite standard in analyses of health care interventions, is the cost per QALY. A third type of study would examine what resource allocation (or rationing) decisions have actually been made by some responsible body (such as a health authority). This would be followed by examining the extent to which such decisions are consistent with a QALY approach. Almost certainly they will not be entirely consistent. The question then arises as to whether, in those cases where the decisions are not consistent with QALYs, this is anomalous; or whether there are important values which are reflected in these decisions which are not captured by the QALY approach.

Health economists and statisticians are already used to providing input into empirical studies. Those with an expertise in ethics may be approached in a similar way. For example a

research study into genetic aspects of depression might be under development. Those developing the study may need to grapple with the issues of consent and confidentiality. Rather than seeing these as problems to overcome or set to one side, the researchers may seek ethical input in order to include some of these issues in the study itself.

### Conclusion

Medical ethics has been developed, at the philosophical level, to a stage where much valuable further research is, at least in part, empirical in nature. It is through the work of philosophers, in the main, that the subject is mature enough to have reached this stage. Philosophical medical ethics is the parent of empirical medical ethics.

It was said, in the late nineteenth century, that theoretical physics had developed as far as it could: all that remained in the physical sciences was to measure things to the next decimal place. It was anomalies between the theoretical predictions and the measurements made "to the next decimal place" which led to Einstein's theory of relativity. The results from empirical medical ethics may help to enrich the subject of philosophical medical ethics: parents can learn from their children.

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*Tony Hope is Editorial Associate of the Journal of Medical Ethics, a Psychiatrist and Reader in Medicine and Leader, Oxford Practice Skills Project, Oxford University, UK.*

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