The Roman Catholic Church and embryonic stem cells

Skene and Parker raise a number of concerns about religious doctrine unduly influencing law and public policy through amicus curiae contributions to civil litigation or direct lobbying of politicians. Oakley picks this up in his letter with an emphasis on the Roman Catholic Church's interest in preventing the destruction of embryos for embryonic stem cell research. Skene, Parker, and Oakley seem to be concerned mostly with religious views having undue influence on public policy. My concern is the negative effect that such Church influenced public policy may have on the progress of the biomedical research that is itself foundational to the debate. Oakley seems to be particularly incensed that, as he puts it: “Those who support a total ban on embryonic stem cell research sometimes talk as if theirs are the only views based on moral principle”. What seems to be at issue here though are not the moral principles of the sanctity and dignity of human life, but the application of those moral principles to biomedical research.

The Roman Catholic Church has historically defended the sanctity and dignity of human life to varying degrees at different times. Human life for much of the past 2000 years was defined by the Church as the presence of the soul, which was thought at different times to appear at various different stages during development. Only recently, with the advent of modern biology, has the Roman Catholic Church shifted its position to claim that the fertilised egg also qualifies as the right sort of human life. It should be noted that this doctrinal change was fundamentally driven by developments in our understanding of embryology and not the process of ensoulment.

The current position on the embryo is thus based not solely on Church doctrine but also on a specific interpretation of our empirical observations of human development. It is the Church's interpretation of the biology of early human development that is foundational to their current stand against experimentation on early embryos. However one of the reasons we may wish to experiment on early embryos is that we know surprisingly little about them. In fact any position that claims to be based on a solid, empirical understanding of the embryo is essentially misleading, as we simply do not have the data available. The reply to this will inevitably be that we know enough about embryos to make certain claims. For example the Roman Catholic Church likes to point out that the early embryo is obviously the earliest stage of a human life, and thus attributes to it many of the rights associated with actual people. Many would disagree with this on the grounds that the Church has confused being merely human with being a person. I am concerned by the claim that the early embryo is obviously the early stages of a human life.

My concern is not that the claim isn't obvious to some people but that obviousness is a dangerous thing when it comes to science. It is, for example, quite obvious to me that I am currently sitting at my desk. Empirically my senses seem to confirm that I am more or less stationary. I may well believe that I am stationary. For much of human history we believed the earth to be stationary at the centre of the universe. This assumption was confirmed in the Western world by the Church itself. Church doctrine confirmed that the earth was at the centre of the universe with the heavens above and hell below. When Galileo challenged this view by promoting the sun centred Copernican system of cosmology the Roman Catholic Church attempted to silence him. The Church's attack on Galileo and Copernicism was tripartite. Firstly, the Copernican system appeared to contradict some scriptures. Secondly, the Copernican system contradicted the Church sanctioned science of the day represented by Aristotelian physics. Thirdly, was the appeal to obviousness or the immediate evidence of the senses. Of the three, only the scriptural objections were undetermined in nature. The Church appeals to science and obviousness were able to be settled by empirical evidence. We now know that we are not stationary at the centre of the universe although this is still far from obvious to many people.

Any position that claims to be based on a solid, empirical understanding of the embryo is misleading: we simply do not have the data. The situation 400 years ago regarding Copernicism thus seems to be very similar to that today regarding the status of the early embryo. The Roman Catholic Church tried to prevent Galileo from collecting empirical evidence using his telescope and disseminating his empirical evidence by banning his books. Similarly the Church today has attempted to prevent the gathering of empirical data on the embryo by promoting a ban on all experimentation on early embryos. The Copernican revolution itself has become a paradigm for the process of theory change in science. Science is not simply a collection of results from experiments (or facts) but perhaps more importantly science is the interpretation of those results and the planning of further experiments. For all its claims of objectivity science is, so the philosophers of science tell us, essentially a theoretical construct. The practical and theoretical sides of science are of course intimately connected. In fact it is well known that a researcher's actions and observations are most likely guided to some degree by their own hopes and expectations. These same researchers develop the theories that they use to interpret their data. These theories fit the results (or facts) that have been previously observed and predict new experiments to be done. The role of theory at this stage of the process is often underestimated. Theories do not fall out of results. In fact in biology especially theories are often essential to making sense of what is observed (result) and what is noise (artefact). Theory then is not just a bridge to the next fact or experiment but arguably the very heart and soul of science. Theories that do not fit the facts are of no use and should be discarded. But in biology especially, theories can define what counts as a fact and what does not. Sooner or later a startling new observation is made that cannot be accommodated within the existing theoretical framework. New theories are developed and past observations are re-categorised. What was written off as noise at one time is heralded as fact. Thomas Kuhn called this paradigm shift and his paradigmatic case was the Copernican revolution. One overarching theoretical construct is replaced with another—our understanding of the world is literally changed forever.

A problem arises when an organisation such as the Roman Catholic Church erects its doctrinal structure on the shaky foundations of a specific theoretical construct. Biology and developmental biology in particular is a comparatively young sciences that are progressing rapidly and are thus quite theoretically diverse. By lending its support to a certain theory or position within biology the Church may well be able to distil the balance that exists in science whereby theories are valued for their explanatory power or instrumental use, not their doctrinal compatibility. External interest groups with political lobbying power may thus hijack the delicate process of progress in science with dire consequences for future advancement in science and medicine. The Roman Catholic Church's influence on science is indirect and usually through the medium of public opinion and public policy. As we have seen in the American debate over the status of the embryo with regards to the derivation of embryonic stem cells this influence may be decisive in the formation of public policy. Indeed President Bush's decision to effectively ban public funding of embryonic stem cell research in America is widely believed to have set back progress in the field worldwide by many years.

The Roman Catholic Church's input into the embryonic stem cell debate has not been simply moral or ethical as one might assume but it has openly defended a particular claim about the biology of the early embryo. Given the basic lack of empirical evidence regarding the embryo and such developments as the unexpected properties of stem cells the Roman Catholic Church's choice of position on the biology of the embryo seems to be chosen solely as a prop for its doctrinal position. This prop has then been introduced into the secular debate on the status of the embryo as a somehow obvious empirical claim.

I believe the Church's religious fervour for its preferred doctrinal and scientific position of the day is fundamentally at odds with the process and progress of science. Science is an exploration of the physical world that is characterised by continuous change and, historically at least, major shifts in understanding. Over the last 400 years the Roman Catholic Church has been slow to accept that science progresses at all and has proceeded to maintain its doctrinal position as a matter of faith even when it has been shown to be empirically unsound. My concern here is I think similar to that of Skene
and Parker. The Roman Catholic Church's contributions to public policy are based
not only on their moral or ethical principles, but on any effectively arbitrary and
dogmatic application of those principles that is backed by the full force of what is effectively a
very powerful lobby group in many countries.

Like Skene and Parker, I have no answer to
the problem I have raised. Historically one
thing is certain, in the future the Roman
Catholic Church's current position on the
embryo will be judged to have been right or
wrong with the wisdom of hindsight. Just as we
dudge the Church's persecution of Galileo
almost 400 years ago now.

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Non-compliance: a side effect of
drug information leaflets

The problem of non-compliance with treat-
ment and its repercussions on the clinical
evolution of different conditions has been
widely investigated. Non-compliance has
also been shown to have significant economic
implications, not only as a result of product
loss but also indirectly through the complica-
tion of disease management and its subse-
quent healthcare and social costs.

Non-compliance as a health problem

The term “non-compliance” might be taken
to refer both to the failure to follow a drug
regimen and to the failure to adopt other
measures that contribute to improvement in
health—for example, changes in lifestyle or
diet. This letter focuses on the former.
Non-compliance with a drug regimen can be
the result of a number of different factors
and a variety of techniques have been
developed in an attempt to control it. Of
these, the few techniques that have been shown
to be effective have only managed to solve the problem in specific situations over
short periods of time. The use of such
techniques to control non-compliance, partic-
ularly where these are effective, raises
interesting ethical questions about the extent
to which their application constitutes an
infringement of the patient’s right to decide
on how to manage their own health. Here we
suggest that in some cases one factor that
leads to non-compliance is the tendency to
provide extensive and exhaustive information
on side effects in patient information leaflets. Consider the following case.

A true story

One morning Dr Smith woke up with a slight
cold—muscular aches, headache, chills, and
nasal congestion. He decided to take some

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medicine to counteract its effects. His initial
thought was to find something to combat his
runny nose, so he chose a product specially
indicated for that purpose: “StopSniff”. After
reading the product information leaflet, how-
ever, Dr Smith felt another kind of chill
run down his spine. He was struck cold by the
contraindications, warnings, interactions, precautions, and other matters listed
on the leaflet. If he used this drug, it said, he
would run the risk of suffering nausea,
anxiety, agitation, insomnia, hallucinations,
convulsions, amazement, weariness, arrhyth-
mia, dizziness … . Rather than risk all of this,
he thought, why not suffer a few bothersome
snuffles? For his muscular aches, Dr Smith
chose another drug. “Abatache”, but the
risks described in the accompanying informa-
tion leaflet seemed even worse. These
included baldness, skin blistering, apoplectic
meningitis, pneumonitis, fatal hepatitis, gas-
trointestinal perforation, blood in the urine,
jaundice, kidney disease, peptic ulceration,
mouth ulceration, visual abnormality … . So
in the end, armed with his clinical and
pharmacological knowledge, Dr Smith simply
opted to continue blowing his nose and suffer
a few muscular aches. He had no desire to
play Russian roulette with his health.

The principle of autonomy and the
right to information

The principle of autonomy in medical ethics
places the patient at the centre of medical
decision making about his or her care. It
places particular emphasis on the importance
of informed consent, and suggests that,
except in rare situations, no patient should
undergo medical treatment or surgical inter-
vention without his or her fully informed
authorisation. This is the basis of patient-
centred medicine.

To obtain valid informed consent, it is
argued that the patient must receive suffi-
cient understandable information to make a
fully informed choice. In practice this means
that someone undergoing a specific treat-
ment receives information from at least two
sources. First, they are given direct
information from their doctor or another
health professional about the drug to be
taken, recommended lifestyle changes, and
perhaps a warning of the hazards related to
non-compliance. They will also be provided
with information on some of the side effects
attributed to the drug being prescribed.
Individual patients will tend to understand
this information in a range of different ways,
and it is well recognised that they will respond with a variety of known
behaviour patterns.

Secondly, the patient will also receive
additional information on side effects from
the information given with the drug itself.
These leaflets tend to cite each and every one of the undesirable effects
related—note “related” —to the principle
active ingredient in the drug. The information can in some cases be so complete
or detailed that even any extremely unusual
syndrome described in relation to the use
of the drug will inevitably be listed in the
leaflet as a possible side effect.

This information can sometimes have
a significant effect on the likelihood that a
patient will take the drug in question and
may lead to significant “non-compliance”.
When patients with minor ailments read
about all the problems that may occur from
using the prescribed medication, they may
start worrying, to say the least. Some people

read the leaflet again and again. They may
then consult another source of medical
information such as a website and perhaps
decide to take only half the dose for half the
time prescribed, or simply decide not to
take the medicine at all.

In addition to the problem of non-compli-
ance, the so called nocebo effect1 needs to be
considered whereby the patient’s mindset
is often a key element in the appearance of
either physical or imaginary side effects, as has been
shown in various studies.2 Such an effect
may be caused by information leaflets.

Complete information versus sufficient
information

Practically any city dweller would refuse to
use transport services, work tools, or recrea-
tional facilities if they were supplied with
complete, absolute, and extensive informa-
tion on the hazards using these might entail.
Precautions and warnings are usually good
things, but they should be kept within reasonable limits to avoid creating outright
alarm. Too much information can sometimes
undermine autonomy and also lead to sig-
ificant harms through non-compliance.

It was shown some years ago that
information supplied by doctors can generate
side effects that cannot subsequently be
corroborated by physical examination. As
it happens all too often, the information was
not as exhaustive or complete as it might be.

In view of this, we believe that the kind of
information given in drug descriptions
should be reassessed. The information should
be true, accurate, and easy to understand in
as complete a way as possible, but it should
not generate alarm that can lead to deleter-
ious consequences in the healthcare sector or
in the economic sphere.

So what did the patient decide?
The patient, shocked and dismayed at the
drug’s side effects, finally decides not to follow
the doctor’s recommendation. He (or she) will
try to relax, perhaps by smoking a cigarette
laced with nicotine, tar, and a number of other
substances. True enough, doctors recommend
giving up smoking. But who will listen to what a
doctor says about smoking when they appear
to be prescribing drugs truly hazardous to
health? After all, a pack of cigarettes only says
that cigarette smoking seriously damages your
health. There is certainly no leaflet listing each
and every one of its possible side effects.
Tobacco kills, but it sometimes looks as if
medication is worse.

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We read with interest the papers on informed consent published in a recent issue of the Journal of Medical Ethics. Whatever their differences, and however much they questioned some aspects of the duty to respect autonomy through attempting to obtain informed consent for therapeutic interventions, there was general agreement that competent adult patients are entitled to a core of basic information about their treatment options. There was also consensus that training in the process of obtaining consent is important. In experience, two dimensions of such training are of particular interest. On the one hand, students require good theoretical understanding of the ethical and legal aspects of obtaining informed consent. On the other hand, they need practical training in the relevant communication skills and how to apply them to obtain consent for specific clinical procedures. To do so, doctors must obviously also have a good understanding of these procedures. We recently encountered serious problems in cases such understanding in a study among junior doctors in England (Schildmann, Cushing, Aoyal, Vollmann). The laws and ethics of informed consent: knowledge, views and practice of pre-registration house officers (PRHOs), submitted for publication. No matter how good their philosophical and legal knowledge, preregistration house officers (PRHOs) will not be able to deliver the minimal standards of informed consent outlined by O'Neill unless, suffice it to say, they know what—practically speaking—they are talking about.

In contrast to Bravo et al.'s results (in the same issue of the journal), almost all the PRHOs who took part in our survey had good legal understanding of the differences between competent and incompetent patients. This may be interpreted as a positive result of the change in the curricula at their particular medical school, which includes extensive sessions about informed consent. These embrace ethics, law, and communication skills. However, despite their understanding, the junior doctors in our study still experienced problems about their role in the consent process. The problems pertained to time and lack of support by senior doctors, as well as pressure on them at times to obtain consent in circumstances where they had been taught that they should not. This gap between the standards of informed consent currently taught to medical students and the clinical realities they face, and into which they are thrust, is an ongoing problem.

If informed consent is to fulfill the purpose of respecting the autonomy and dignity of patients, sufficient resources are required to train young doctors to do the job properly, especially as regards their understanding of procedures for which they are providing information and their competence as communicators. One thing is clear: if they cannot complete the task in accordance with the guidance issued by the National Health Service Executive, the General Medical Council and the Department of Health, they should not be doing it at all. Trusts and colleges should ensure that all supervisory staff are aware of their responsibilities in this regard.

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Response to "Patient organisations should also establish databanks on medical complications"'

Gebhardt in his brief report1 pleads for patient organisations to establish databanks on medical complications. Given the references (for example, an article by Paans, a journalist, entitled "Medical errors to be kept secret"), it is not surprising that he thinks it is substantial danger of misinterpretation of the current situation, which in turn may frustrate the process of increased transparency. We would therefore like to respond to this by giving background information and reasons for some of the choices that were made with respect to the registry of complications mentioned by Gebhardt.

First, a distinction needs to be made between an error and an adverse outcome, which are often confused. From Gebhardt’s reference to the journalist’s article which discusses the same registry of adverse outcomes, but with the title referring to errors, both Gebhardt and the journalist think errors and adverse outcomes are the same thing. However, an error refers to the process in which something has gone wrong, a sub-standard performance, regardless of the outcome. It has been explained by others that such a judgment may have a degree of subjectivity.2 An adverse outcome refers to the outcome which is unwanted but does not necessarily imply that an error has been made. This is why the term “adverse outcomes” is used rather than the term “complications”, since the latter term is often confused with an error being made. The registration of medical complications that Gebhardt refers to is a registry that records adverse outcomes guided by an unambiguous definition of the term “adverse outcome”, of which only a small percentage is related to errors.3 Furthermore, some errors will be missed in this registration—that is, errors which have not led to adverse outcomes.

Secondly, with respect to confidentiality, this is relevant in particular for the initial years of such a registry during which it is thoroughly tested and accuracy of the registry may vary widely between participants. Nothing is gained by false positive signals with respect to the high incidence of adverse outcomes in some hospitals, except perhaps by flashing headlines in the newspapers. In this respect one may compare the development of such a national registry to the development of a new drug, in which case no one argues about confidentiality and thorough testing until proved safe. Moreover, a pharmaceutical company will probably be sued if it markets a new drug without proper research. It is intended that after this initial period, national adverse outcomes become available to the public with respect to probability of an adverse outcome given certain types of surgery.
**Box 1: Patients need information to make a well-informed choice**

Who is a good doctor and what is a good hospital? This simple question is not easy to answer for patients, who need information about good diagnosis and the best treatment. The NPCF (Dutch Federation of Patients and Consumer Organisations) and its member organisations have published several consumer guidelines for specific diseases to help patients find their way in the labyrinth of the healthcare system. Patients experience many difficulties in getting access to relevant information from doctors' organisations and insurance companies. Therefore the NPCF wants to cooperate with these organisations to create consumer information based on the important and relevant data that are available. A joint project for a database on best practices started in September 2003.

Patients are not interested in black lists of doctors and malpractices, they prefer to know about good and best practices to make a well-informed choice for a doctor or hospital. They need consumer information on objective measures such as the risk of infection in a hospital, the specific skills of a doctor, how many patients with specific diseases a doctor treats a year, etc. Patients would also like to receive subjective information on a specific hospital or doctor: How is the communication between a doctor and his or her patients? Does the team give enough information and support when needed?, etc. This experience based information is often available from patient organisations.

The NPCF has chosen to work together with organisations of healthcare providers and insurance companies to use parts of their databanks as a basis for consumer information. One task of the NPCF is to translate the data into consumer information that meets the needs of the patients, based on research and experiences of patients. Joint efforts are needed to make this important information accessible for doctors and patients.

Dr I van Bennekom, Director, NPCF

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Finally, what does the patient want? (see box 1). International research has shown that patients do not use public information on performance of hospitals or doctors for participating in their own care. The literature suggests that patients do not use public information on research and experiences of patients. However, they suggest that by surveying patients' perspectives they will be able to capture one side of this equation, considered moral judgements or moral principles (they do not specify which), and in so doing contribute to the desired end: a consistent ethical framework to govern medical encounters, built (at least in part) from the principles and moral judgements of the patient community. Whatever the merits of this goal, however, Joffe et al fail to capture either the considered moral judgements or the moral principles of those they survey and so fail to contribute to the moral theory they seek to construct.

Ravels defines considered moral judgements as those judgements in which our moral capacities, which he considers analogous to our linguistic capacities, are most likely to be displayed without distortion—for example, those offered without hesitation, given without strong emotions like fear, and made in the absence of conflicting interests (p 47). The distinction between considered judgements and judgements generally is important. When constructing a moral theory for a particular community—for instance, the medical community—we want to use only those judgements that reflect the respondents' real moral sensibilities, and not those stemming from superficial prejudices or their mood on the day they happen to respond to certain questions. Important questions, however, for researchers, who, like Joffe et al, are using the concept of reflective equilibrium: (1) precisely how considered do considered judgements have to be if they are to count; and, more practically, (2) how can a researcher know whether he or she is collecting them—that is, what survey method, if any, is appropriate for the task?
Although it is difficult to give a positive answer to these questions (and I will not attempt to do so here), some survey methods, such as the mailed questionnaires that Joffe et al used, seem particularly inadequate. Rawls suggests that certain external conditions favour the formation of considered judgements: “the person making the [considered] judgement is presumed to have the ability, the opportunity and the desire to reach a correct decision (or at least, not the desire not to)” (p 48).1 Very likely, however, many of Joffe et al’s respondents lacked the necessary ability, opportunity, or desire to consider their moral judgements when responding to the questionnaire they received in the mail. Furthermore, even if a number of patients did offer legitimate considered judgements, there is no way to distinguish these from those made by respondents who lacked the requisite ability or desire. Although the size of Joffe et al’s study is of value for its ability more accurately to reflect a population’s response to its survey questions, because of the practical limitations that come with its size, the study falls short of capturing patients’ considered moral judgments.

Any empirical approach in reflective equilibrium, as Joffe et al, faces a second challenge: why do we want people’s considered moral judgements to influence our theories of ethics in the first place? In his influential critique of reflective equilibrium, D W Haslett writes:

… given the wide differences between people’s considered moral judgments, and given that these differences are, as we know, largely just a reflection of differences in upbringing, culture, religion, and so on, it would appear that, far from having a reason for giving people’s considered moral judgments initial credibility, we have instead a reason for initial skepticism (p 309).4

If moral judgements are liable to reflect superficial prejudices, one could argue, considered moral judgements are liable to reflect deep seated ones. Surely this prejudice is not only logically necessary for our holding that particular normative principle, the assumption that those findings must challenge the centrality of the mandatory autonomy view, the studies that Joffe et al cite, even if valid, can be interpreted variously as devaluing the mandatory autonomy view or as recommending that we better educate patients on the principle of respect for autonomy. This normative question cannot be settled empirically.

Empirical researchers have the potential to contribute substantially to bioethics, but their work needs the kind of empirical rigor that comes from truly interdisciplinary collaboration and must be informed by a careful reflection on the proper relationship between descriptive and normative ethics. Joffe et al take us part of the way down that path. An exciting research itinerary lies ahead.

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How to be a ‘good’ medical student

The public revelation in 2003 that medical students perform intimate examinations without patient consent has engendered much debate in the press and scientific journals. Using this case as a springboard for discussion, I will argue that medical schools should encourage students to raise their ethical concerns and call for a change of policy making it easier for students to do so. I will also address the question of medical students’ moral obligations towards their patients, and conclude that medical students ought to express their discontent when faced with unethical practices or attitudes.

In early January 2003, a study appeared in the British Medical Journal revealing that nearly a quarter of rectal and vaginal examinations on anaesthetised patients were performed by medical students without patient consent. Although the study did not generate the firestorm of controversy many expected, it engendered much discussion on ethical issues surrounding informed consent and patient autonomy, as well as stressing the need for greater ethics training for medical students. As an ethical problem, however, the case of intimate examinations involves the moral obligations of medical students towards their patients, and concludes that medical students ought to express their discontent when faced with unethical practices or attitudes.

Judging from some of the comments from students at Bristol, however, the growing emergence of medical ethics has not dispelled the awkward climate of unquestioned reverence towards teachers. Many of the students felt uneasy about the examinations, but were too intimidated to voice their concerns: “You couldn’t refuse comfortably. It would be very awkward, and you’d be made to feel inadequate and stupid”, commented a fourth year student who participated in the study. It seems clear that medical schools should strive to foster a climate more conducive to open discussion on ethical issues between students and teachers. Students should not have to perform heroic acts of courage to raise ethical concerns. In light of medical ethics’ place in the curriculum, the situation is deeply paradoxical. Students may be taught the importance of respecting the patient’s autonomy one day, but witness an obvious violation of this principle by their teachers the next. For the subject to be of any use, students must not only be allowed, but positively encouraged, to put into practice their knowledge without the fear of appearing “inadequate and stupid”. If a student’s ethical concerns remain unresolved after discussion with the teacher, there should be formal mechanisms for complaint, perhaps through a committee specifically set up for that purpose, or through the school’s medical ethicist, who would then investigate the matter thoroughly. Medical ethics is, after all, an applied discipline.

It is nonetheless all too easy to blame the medical establishment and individual teachers for the unethical behaviour of students, as if the appellation ‘medical student’ shielded individuals from moral fault. In Nick Hornby’s novel “How to be good”, the narrator, an adulterous GP and mother of two, resolves her moral conundrums by mechanically repeating “I must be good. I’m a doctor”. It is only later that she acknowledges that her justification is too facile: “it’s not enough to just be a doctor, you have to be a good doctor”. Students, however wide eyed or intimidated, are entitled to independent thought. Their personal values should not vanish as they put on the white coat, just as a patient’s rights should not evaporate as they put on the white coat, just as they put on the white coat. Indeed, far from absolving him from moral inquiry, these factors should encourage a process of ethical questioning. This exercise is, to my mind, crucial to a student’s flourishing as a morally responsible future doctor. To paraphrase Nick Hornby: “it’s not enough to just be a medical student”.

Acknowledgements

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JME editorial office has now moved

The JME editorial office has now moved to BMA House. The new contact details are: Journal of Medical Ethics, BMA House, Tavistock Square, London WC1H 9JR. Tel: +44 (0) 207 383 6439. Fax: +44 (0) 207 383 6668. The point of contact is Nayanah Siva, Editorial Assistant.

Institute of Medical Ethics Student Electives

The JME wishes to award 10 bursaries of up to £500 each to support Medical Student Electives, or exceptionally Special Study Modules, on issues in medical ethics.

Medical students, jointly with their supervisor, are invited to apply by 28th February 2005. Application is to be done via email, explaining the project’s relevance to medical ethics and the reasons why a bursary is requested. An outline study protocol and project budget should be included or attached. Applications should be sent to Mrs M Bannatyne, IME Bursaries Administrator, email: bannatyne@dial.pipex.com.

Successful applicants will be informed by 31st March 2005.