The concise argument

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There is a world outside Verona walls

When talking to people at international ethics conferences, they sometimes label the *Journal of Medical Ethics* as an "English" journal. This is obviously true in the sense that the it is edited from and published in the UK and that it only publishes papers in English, but it is not true if it is taken to imply any particular bias against non-UK papers.

This is amply demonstrated in the current issue. The large majority of the papers come from outside the UK and add to discussions in ethics that are truly international. They thereby reflect what the Editors' want the journal to do—that is, publish relevant and interesting papers from all corners of the world that move current discussions in medical ethics forward.

A Canadian, a Norwegian, a Swiss, a Dutch and a US paper all investigate aspects of clinical decision making.

Epistemic humility

Anita Ho analyses a case of disagreement between family and physicians about the end of life care of an elderly patient (***see page 497***). The focus of the analysis is the fairly common assertion that families (and patients) make the decisions they do because they "don't get it". They don't understand the medical details as well as the medical expert and therefore make the wrong decision. But Ho's analysis of the concept of expertise and the kinds of knowledge relevant to medical decision making shows such assertions to be much too simplistic. There are also many relevant factors that medical experts don't get. Ho's prescription of "a commitment to epistemic humility" may be hard to swallow for some doctors, humility of any kind not always being a prominent feature in the personality of medical professionals.

Families in the intensive care unit

Halvorsen *et al* also focus on the role of the family, but this time in the intensive care unit (***see page 483***). Based on field observations and qualitative interviews with doctors and nurses, they explore both what role these professionals think the family should have in decision making and what role the family actually has. One very interesting finding is that, although justice and equality are prominent values in the Norwegian healthcare system and although the professionals are personally committed to these values, it is nevertheless the case that "When time and staff resources were scarce, clinicians gave priority to families who were persistent, which made more reserved families vulnerable to a lack of attention".

Identifying breaches of confidentiality–medical ethics teaching helps!

Bernice Elger reports on a questionnaire study among Swiss physicians assessing their ability to identify breaches of confidentiality and assess their severity (***see page 517***). It shows that this ability varies widely among the respondents. Because of the size of the study (n = 508), Elger is able to statistically test for the relation between ability to identify breaches and various demographic features of the respondents. She finds that training in health ethics or law (Hurrah!) is associated with a better ability to spot breaches of confidentiality, as is years of practice and being female.

When is suffering unbearable?

In the Netherlands, a physician can only accede to a patient's request for euthanasia if the physician is "satisfied that the patient's suffering is unbearable and that there is no prospect of improvement". Rietjens *et al* use a vignette design to study whether Dutch general practitioners, hospital consultants and members of euthanasia review committees agree in their judgements of when a patient's suffering is "unbearable" (***see page 502***). They find that, in what they call the "standard case" of a cancer sufferer in the terminal stage with uncontrollable pain and other symptoms, there is almost perfect agreement, but that, in other cases, general practitioners are significantly less likely to find a patient's suffering "unbearable". There are several possible explanations for this finding presented in the paper and also an interesting discussion of whether the finding is indicative of a problem or not.

The role of the organisation

All hospital work takes place within an organisation that, like all organisations, has a structure, a set of policies, a culture and a set of actual decision-making processes. Opel *et al* analyse 71 ethics consultation notes from an American academic children's hospital in order to investigate the role of organisational issues in cases where an ethics consult is asked for (***see page 477***). They find that organisational issues are pervasive and that there is mention of a median of two organisational issues per consult note.

The three most common issues relate to organisational culture, policies and procedures, and communication. They conclude that "Organisational issues contributed to the development of most ethical concerns that resulted in clinical consults. […] Ethics consultants and ethics committees may also find it useful to be explicit in conveying these identified issues to clinical administrators and quality improvement experts so that they can be addressed further." This is clearly right. Let us just hope that those to whom the issues are conveyed will also take them seriously.

And there is more

In this issue there is also a paper on the function of Chinese ethics committees (***see page 512***), a paper on priority setting in healthcare in Norway (***see page 488***), a paper on conscientious objection in the USA (***see page 471***), a neuroethics paper from Canada (***see page 469***) and of course the second instalment of our Dutch soap. So, next time you meet me at a conference, please don't tell me that the JME is English!

Conflict of interests: Søren Holm is proud to be Danish!