

I am writing this page while attending the International Association of Bioethics biannual congress in Singapore and I am happy to be able to report that bioethics is still a thriving field worldwide. The congress is attended by scholars from more than 55 countries. The breadth of topics covered is truly amazing and the approaches often novel and illuminating. We hope that this vitality of the field will continue to be reflected in the JME in the future and that it is already to some extent reflected in the current issue of the journal which contains contributions from a range of countries covering a wide range of issues and methodologies.

Where should my samples go?

The future research use of blood and tissue samples taken as part of clinical care is a currently contested question in medical ethics. Abou-Zeid and colleagues have investigated the views of Egyptian patients on this issue using survey methods (see page 539). The results show that many do not favour future research use of samples at all, and that among those who accept future use most favour an explicit consent model. The researchers also asked their respondents whether they were willing to have their samples exported to other countries. This question is important because modern biomedical research is an international enterprise and there is already considerable exchange of data and materials. It was found that Egyptian patients are significantly more willing to let their samples be exported to other Arab countries than to Europe or the USA. This interesting result can be interpreted in a number of ways, and may for instance reflect a belief that other Arab researchers are more likely to treat the samples in a culturally appropriate way.

From DNR to TEP

It is generally recognised that current approaches to end of life treatment planning for non-terminal patients are unsatisfactory. In the UK much attention has in the past been focused on Do Not Resuscitate or

Do Not Attempt Resuscitation orders. However, such orders only cover one potential intervention and they have furthermore been shown to be liable to misinterpretation. The paper by Obolensky *et al* reports an evaluation of a possible replacement for the Do Not Resuscitate order, the Treatment Escalation Plan (TEP) (see page 518). The TEP is a form and a process for filling out the form involving the doctor, the patient, and potentially relatives. The TEP covers cardio-pulmonary resuscitation, ventilation, renal replacement therapy, intravenous fluids and use of antibiotics. In the evaluation it was found that 96% of patients or relatives interviewed found the TEP process to be 'a good idea'.

Teaching practical wisdom

Practical wisdom or *phronesis* is a central Aristotelean concept. A person can only be a good practitioner of a *techné* if he or she possesses practical wisdom. Given that medicine is a *techné* the good doctor should therefore possess practical wisdom. But practical wisdom rarely occurs explicitly on the medical curriculum or in post-graduate training of doctors. Kaldijian compares practical wisdom to the more commonly used concept of 'clinical judgement' and argues that this comparison allows us to get a better or more complete understanding of clinical judgement (see page 558). In routine clinical judgement goals of care and ethical values are often implicit, but the wider focus of practical wisdom allows us to see that this taken for granted of goals and values is not always warranted. The relevant goals and values are those of the particular patient. Training in clinical judgement must therefore always be sensitive to the risk of conflating clinical judgement with 'the clinician's judgement'.

Routinisation of genetic services and practical knowledge

Genetic knowledge is becoming increasingly important to routine medical practice

and one effect of this is that many more healthcare professionals will have to engage with patients in discussions concerning genetic tests, genetic test results and other genetic matters. Genetic counselling in this sense will thus no longer be the exclusive province of geneticists or genetic counsellors. We therefore need to consider whether other healthcare professionals are ready to take on this role. There is a considerable literature on whether general practitioners and other healthcare professionals possess the necessary theoretical knowledge of genetics, and the answer to this question is generally sceptical. But, in a very interesting paper in this issue of the JME Dagmar Schmitz argues that focus on another type of knowledge is also necessary if the routinisation of genetics is to be successful and ethical (see page 529). Genetic practice involves many types of practical knowledge that are obtained primarily through repeated practical, clinical experience, for example knowledge about the proper focus of clinical action, the relevance of therapeutic action or the proper normative framework. Schmitz argues that non-geneticists need a chance to acquire both the relevant theoretical and practical knowledge in order for the routinisation of genetic services to secure the important interests of clients and patients.

Do you want more from Erewhon academic hospital?

This issue contains the eleventh instalment of the story of the events at Erewhon academic hospital (see page 516). We know that some people have started using the series for teaching purposes, but would like your input to the future developments. Do you want to hear more about our ethicist friends, healthcare workers and patients? And, if so what direction should the story take?