The concise argument

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Cases for reflection from Médecins Sans Frontières

Sheather and Shah present four ethically challenging cases that healthcare professionals working with the humanitarian organisation Médecins Sans Frontières (MSF) have experienced (***see page 162***). The purpose of presenting these cases is to invite discussion and dialogue as an aid to ethical reflection within MSF and other humanitarian organisations. Each case is accompanied by ethical comment and by an explanation of what usually happens in the field.

We hope that our readers will engage in debate about these cases and will put them all up on our blog for discussion, but here is one of them to give you a head start:

> "Acting beyond competence
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> MSF aims to deliver high quality healthcare with professionals suited to their tasks. Doctors and nurses will inevitably be asked to act above their competence level as resources, including specialist physicians, are limited. The following scenario and its variations are not uncommon.
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> MSF dilemma 4
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> Our doctor has previously assisted in caesarean sections but has never taken sole responsibility for one. The doctor who is responsible for surgery is on holiday and transport to the next surgical facility takes 7 h, which is too long for this mother who is clearly in obstructed labour. The doctor is confronted with doing something that she has never done before. She knows that she could do a lot of harm by doing the operation badly, but doing nothing guarantees that the baby will not survive and may result in dangerous complications for the mother. The staff are waiting for her plan of action. What should she do?"

Are transplanted ovaries organs or gametes?

It is now possible to transplant ovarian tissue between women and although the treatment is still at an experimental it requires our ethical and legal attention. Ovarian transplants can be used to treat infertility and (premature) menopause. One issue that transplantation raises is how we should classify ovaries used for transplantation, are they organs or are they gametes? This matters because the legal regulation of organ transplantation and the legal regulation of gamete donation and use often differ markedly within a given jurisdiction. In the paper by Lisa Campo-Engelstein she provides an in-depth analysis of this issue in a US context and reaches the conclusion that "… at least for the near future, we should treat ovarian tissue like gametes." She argues that the way we handle anonymity is different in the two contexts of donation and furthermore that ovarian tissue transfer engages the donor's reproductive rights (***see page 166***). The recipient may go on to carry the donor's genetic child and this requires a different consent and counselling regime than other kinds of organ donation which do not potentially involve reproduction.

Physician assisted suicide and vulnerable groups: what is the evidence?

An important argument in the debate about voluntary euthanasia and physician assisted suicide (PAS) is whether allowing these practices, either be legalisation or by social acceptance and non-prosecution will lead to members of vulnerably groups being at risk for non-voluntary euthanasia. Analysing data concerning these practices in the Netherlands, Belgium and Oregon may help to give us an answer. But data rarely speak for themselves. They have to be interpreted. In 2007 the JME published a paper by Battin *et al*[1] analysing the Netherlands and Oregon data and arguing that there was no evidence that vulnerable groups are at risk. In a paper in the present issue Finlay and George challenge that conclusion (***see page 171***). They argue (1) that Battin *et al*'s analysis of vulnerability is problematic, (2) that later data from Oregon shows PAS being most prevalent among the elderly and (3) that there is also evidence from Oregon showing that some patients had clinical depression at the time when they were assessed and cleared for PAS. Based on this Finaly and George argues that legalising PAS in Oregon has had negative effects for the vulnerable.

This is undoubtedly not the last word to be said in this debate.

Ethics and evidence based medicine

What ethical values are proponents of Evidence Based Medicine (EBM) espousing or integrating in their work? The paper by Watine tries to answer this question by a close analysis of the writings of the inventors of EBM, especially by Gordon Guyatt and of the discussion on one of the main EBM discussion lists (***see page 184***). The paper shows that all of Beuchamp and Childress' four principles are mentioned and recognised by EBM proponents, but often in a form that differs from the form they have in bioethics. Instead of insisting on respect for patient autonomy, EBM proponents for instance talk about 'taking into account patients' values and preferences when making medical decisions', but 'taking into account' is clearly different from and weaker than 'respecting'. Similar transpositions happen in relation to the other principles. Watine's paper is an excellent contribution to our understanding of what happens when ethical principles and values get transposed into specific clinical spheres and should be required reading for both ethicists and EBM evangelists.

REFERENCE

1. **Battin MP,** vander Heide A, Ganzini L, *et al*. Legal physician-assisted dying in Oregon and the Netherlands: evidence concerning the impact on patients in "vulnerable" groups. *J Med Ethics* 2007;**33**:591–7.