

Highlights from this issue

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When I was an intern, I saw a patient whose heart transplant had failed. She was presenting for assessment for a second transplant. The heart had failed because of continued intravenous drug abuse. She was in a desperate state. "Are you going to retransplant her if she is a drug addict?" I asked my registrar. "We can't deny her a transplant for social reasons. But we can because her prognosis is poor."

Issues of justice weave throughout this month's issue of the Journal.

In the Feature article, Bærøe and Bringedal address the issue of how just allocation of resources should take account of socioeconomic status, (*see page 526*). Higher socioeconomic status (SES) patients have better health and life expectancy, and use more health services. Bærøe and Bringedal ask: should clinicians give priority to individual patients with low SES in order to enhance health equity? They distinguish between four versions of 'healthcare need' and approaches an acceptable conceptualisation of the notion supported by Norman Daniels' theory on health equity. They conclude that equitable healthcare requires considerations of the impact of socioeconomic factors on patients' capacity to benefit from the care. Remaining neutral towards patients' SES in this respect does not promote equal regard. They argue that priority setting on the basis of socioeconomic factors is required in fair clinical distribution of care, for example, through allocating more time to patients with low SES.

Perhaps then, paradoxically, the drug addict should have been given another

transplant, or even given priority among those seeking a second transplant?

Questions of justice are also raised in the fascinating microethical study of Seeman and Seeman, (*see page 518*). They reveal a host of ethical issues involved in the care of women with chronic psychosis in a Canadian clinic. They raise the important and underdiscussed issue of whether partiality towards one's patients by 'gaming the system,' by obtaining diabetic financial supplements for non-diabetic patients, represents a violation of principles of fairness and justice. The article is rich in real life detail, a feast for narrative ethicists but also those who wish to test principles and theories against the world as it is. Other issues raised relate to prescribing concealed medication, questionable billing practices, industry collaboration, limits of confidentiality, grounds for abandonment and the primacy of autonomy.

The spectre of justice also looms behind Snyder *et al*, (*see page 530*). This interesting, small empirical study of 12 Canadian facilitators of medical tourism gives a peep into one of consequences of Canada's approach to distributive justice in healthcare. Rather like the previous article, rather than dealing with large abstract principles and theories, this paper argues for a pragmatic approach, "a planned conversation between medical tourism stakeholders to define and shape facilitators' roles." I like it: the ethics of the facilitation of medical tourism. It could be the new niche area. Virtue ethicists will be able to construct an account of the virtuous tourist facilitator.

One area where science has been thought to be in conflict with justice is over race and categorising people according to race. For example, one of the few topics in biomedical ethics which can't be discussed in many parts of the world is the relationship between race and IQ. Yet race is routinely used, like sex, within medical practice and research for purposes of risk evaluation and other purposes in research and treatment. Lorusso controversially questions whether racial categories belong in biological explanations (*see page 535*). She argues that the concept of race cannot be justified in biology because it does not lead to successful predictions, and that genetic discontinuities are sufficient to explain differences in diseases but not needed in the explanation. She argues that "[t]he biomedical field should search for genetic patterns related to diseases, and should not assume racial discontinuities among human groups and use racial clusters as proxies for undetected genetic patterns." Science then would not be in conflict with justice.

Good science, I believe, is essential to good ethics.

I recently paid to have parts of my genome sequenced by 23andme. The most interesting finding was the ancestry. My mother's genome derived, around 15 000 years ago, from the Lapps, which is shared by the modern Basques. My father's, to my surprise, originated from a gene pool which has given rise to the Askenazi and Sephardi Jews, and the Lebanese, at least according to 23andme. This kind of science could show that we share more in common as human beings (and with 'minority' groups) than we think.