

Highlights from this issue

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As Tony Hope put it in an editorial for this journal 14 years ago, 'Philosophical medical ethics is the parent of empirical medical ethics'.¹ One the one hand, this means that philosophical ethics came before the empirical field, but more importantly it means that good progress on the theoretical side of things is constantly generating new questions for empirical work to answer. For example, once we have determined that public concern is one of the main barriers to post-mortem autopsies, we might wish for evidence regarding how real members of the public feels about the practice (see page 735). If we have a strong analytic argument about whether medication should continue after the end of a clinical trial, we might wonder what the opinions are of those who are actually involved with this question in the real world (see page 757). These empirical studies can in turn break philosophical roadblocks, allowing us to make progress on the ethics with full understanding of clinical realities and the preferences of stakeholders.

In this month's issue of the Journal we see an unusual wealth of empirical papers, both qualitative and quantitative, perhaps demonstrating that the discipline of empirical ethics has now come of age.

As an editorial team we try to strike a balance between the theoretical and empirical dimensions of medical ethics, as both sides have become crucial aspects of medical ethics discourse. However, at present we are developing a number of special issues, each focused on one particular medical theme. We expect these forthcoming themed issues to be substantially filled with philosophical analysis, and so we in order to retain balance between the two domains, we will also often find ourselves with issues that have a strong empirical flavour, like this month's issue.

Regret

In this month's Feature Article, *Abortion and Regret* (see page 705, Editor's choice), Kate Greasley addresses the moral significance of regret among women who seek and obtain abortions. Women sometimes express regret over a

successful abortion, but only very rarely express regret over bearing a child to term, and so this post-abortion regret is used to prop up a range of arguments against the practise of abortion. These arguments are made either on the grounds that regret (*qua* remorse) is positive evidence of moral wrongdoing, on the grounds that regret usually is felt following the commission of a morally dubious act, or on the grounds that the prevalence and unpleasantness of that emotional response gives pregnant women a prudential reason to avoid having an abortion.

In her piece, Greasley first reviews evidence suggesting that post-abortion regret may not be as prevalent as we might assume, and she points out that the opposite statistic—women who privately regret carrying their child to term—is currently unknown and largely uninvestigated in the empirical literature. With that as the background, she goes on to address the broader question of whether or not regret always goes hand-in-hand with moral wrongdoing or with a failure to meet one's moral duties. She gives a detailed discussion of Wallace's recent paper which shows how one may regret acts (including acts of conception) that are morally neutral or good, or events that one did not act to cause. If regrettable acts can be morally good, Greasley argues, then regret cannot be sufficient evidence that one has acted wrongly.

Wallace's earlier paper also shows that a parent might even fail to regret the birth of a child who was wrongfully conceived and wrongly brought to term, since births are subject to a socially (and perhaps even biologically) mandated celebration and affirmation, whereas abortions or other decisions not to conceive are never celebrated at all. If that, too, is correct, then it is not true that there is any reliable link between regret and wrongdoing. But it could still be true, as some claim, that 'where there's smoke there's fire', and acts that are very frequently regretted tend to be wrong.

Greasley approaches this point from a different angle, pointing out that there are numerous examples where commonplace actions are frequently regretted but not wrong—for example, buying a quickly depreciating car. Though not in themselves

unethical, of course these choices can still be imprudent, and that brings Greasley to the final regret-based argument against emotion: that the heavy toll of regret itself makes abortion an imprudent practise.

Regarding the toll that regret can take on the regretful, Greasley argues that future regret ought not to determine our choices unless we think that the regret will be justified by other considerations. If I expect to have an irrational or unjustified feeling of regret, then by Greasley's lights my expected regret should not influence my choices at all. In other words, regret does not provide a free-standing reason to avoid having an abortion, but instead ought to be weighed among the various downsides to making a choice that is truly worthy of regret.

She concludes that the best choices may frequently be those that will lead to the most regret, and that regret-based objections to abortion are thus unsustainable (or even regrettable) in their own right.

Default options

The use of default options in the clinic is back on the menu this issue in a paper by Haward, Murphy and Lorenz (see page 713). This empirical study investigates the question of whether changing the default treatment option would influence the choices people would make about whether or not to resuscitate a hypothetical, highly premature baby. When resuscitation was presented as the default option for the clinic, fewer people chose to opt out, and when palliative sedation was presented as the default option, fewer chose to resuscitate. Hence the authors conclude that the choice of a default option can become a subtle form of manipulation, especially since the patient is often unaware that the presence of a default is influencing their choice. This argument has been popular with those who are skeptical of the promise of 'libertarian paternalism', which claims to control public behaviour without compromising the autonomy of the controlled members of the public.

The discussion heats up, however, in the commentary of Alexander Kon (see page 719) and response of Halpern and Quill (see page 721). Kon suggests that

the process of gathering genuine informed consent is more involved than simply offering default options to patients and asking them to choose. To obtain truly informed consent a doctor must fully explore every option with the patient in a way that takes the patient's existing preferences into account. In that model of consultation, we might suppose that the effect of a default option on a patient's choice would be much weaker. But he goes on to point out that patients also generally prefer to receive directive advice from a doctor rather than a completely neutral list of informed choices, and that as a result the doctor's directive advice is also likely to dwarf the overall impact of default options in the clinic.

Halpern and Quill, by contrast, argue that defaults are indeed powerful instruments, but they are concerned about the experimental rigour and broad applicability of Haward's study. They go on to suggest that the influence of defaults in the clinic is likely to be highly domain-specific, and that we should resist the temptation to make broader conclusions about defaults as a general strategy, preferring instead to gather more data about their influence in specific cases.

Reproductive tourism

We are always pleased to be able to publish papers that highlight medical ethics issues arising in countries outside the first world,

and the paper by Deonandan *et al* in this issue is a perfect example (*see page 742*). The authors review and discuss eight distinct areas of ethical concern in the practice of 'reproductive tourism'; that is, when prospective parents travel 'from their country of residence to another country in order to receive a specific treatment or to exercise personal reproductive choice', for example to obtain IVF treatments or to find a cheap surrogate mother. These practices are becoming much more popular in countries such as India, and so this review paper is both timely and fascinating.

Responsibilities for research participants

While research ethics is overwhelmingly focused on the responsibilities that researchers have towards their participants, David Resnik and Elizabeth Ness argue in this issue that there is a dimension of responsibility that participants have towards researchers and towards the research they participate in (*see page 746*). By default, the project of medical research ethics focuses on the maximisation of the autonomy of participants, and this has been the case ever since atrocities like the Tuskegee syphilis experiment highlighted the vulnerability of patients who enrol as participants in research studies.

This paper, then, is both novel and controversial, since it suggests that patients who are enrolled in research may have a (weak or strong) moral obligation to follow the experimental protocols, and to remain enrolled until the project ends. According to Resnik and Ness, these duties are grounded partly in the duty to fulfil one's promises, and partly in the ethical obligation to maximise benefit and minimise harm both to others and to oneself.

Health care and the media

The last word in this issue goes to Wendy Lipworth, who provides a fascinating brief report on the question of whether members of the press are obliged to promulgate government messages aimed at improving public health (*see page 768*). While everyone shares an interest in promoting public health, Lipworth points out that the press also has its own set of norms and ethics, most of which are aimed at promoting a free and independent 'fourth estate'. She suggests that our shared interest in having independent news media should make us more forgiving of members of the press when they fail to disseminate the government's healthcare messages.

REFERENCE

1. Hope T. Empirical medical ethics. *J Med Ethics* 1999;**25**:219–20.