

Highlights from this issue

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Mark Sheehan, *Associate Editor*

Facing up to the ethics committee
Elizabeth Fistein and Sally Quilligan's experiences of research ethics committees (*see page 224*) provide us with a glimpse of the interesting set of ethical issues surrounding the ethical governance of research. The biggest and arguably most intractable of these is how to judge between respect for autonomy (through the process of consent), the potential harm or benefit to the participant, and the overall value of the research. These are the big three—the researcher is very likely to judge them differently from the ethics committee member.

Fistein and Quilligan's experiences also raise questions about the relationship between method and ethics. Methodological questions are clearly important for the ethics of research, but that does not help when non-experts in the research methodology make (ill-informed) judgements about that methodology. Their advice to the novice here seems to me to be spot on: 'Take great care explaining methodology'. The distinction between audit and research comes up too. I take it that the lesson again is that the distinction between audit and research cannot come close to tracking the distinction between research that has ethical issues and research that does not. At best, this may be a form of proportional review.

The central issue though is what we are to make of variation in decision-making between committees about these and the rest of the substantive research ethics questions. A fair system would surely not produce wildly inconsistent judgements about how to balance 'the big three'. However, different groups of people will justifiably value the big three differently. This would appear to mean that there is

much legitimate scope for research ethics committees to come to different judgements about the same or relevantly similar cases. A detailed articulation of the range of reasonable decisions might look helpful but must still run the risk of over-prescription.

Finally, there are general theoretical questions about the role that reports of experience should play in our understanding of arguments and their associated claims. There is no doubt much in this paper, in the experiences of these authors, that gives us pause for thought about the research ethics system, but there may also be questions about the extent to which these experiences are generalisable. I suspect that those on the research ethics committee side of the fence will have something to say in response.

Are four principles enough?

In a special editorial essay, William Richie Muirhead pushes against what is often taken to be the dominant paradigm in medical ethics—the 'four principles' (*see page 195*). I wonder whether this status as the dominant paradigm still holds. It is still many people's introduction to the subject, but, as the field comes of age, the nuances of practical contexts may make it difficult to see medical or clinical ethics as the simple application of these four principles. This essay and Raanon Gillon's commentary (*see page 197*) look at the clinical, practical significance of the four principles. Muirhead holds that professional integrity and 'the set of rules typically described in professional guidance and law' give clinicians the required action guidance that they need—unlike the four principles. Gillon points out in response that the four principles are acknowledged to need speci-

fication and that the route to action-guidingness requires such specification.

Communication and clinical ethics committees

Under the heading of clinical ethics in this issue, there are two important papers touching on different aspects of the clinical setting.

First, Charlotte Rosalind Blease (*see page 199*) examines the role that particular communication strategies adopted by clinicians play in beneficial outcomes—'positive care effects'. She argues that 'the medical community needs to deepen its understanding of the variety of components that give rise to such therapeutic benefits to patients'. The undisclosed adoption of particular communication strategies that are more likely to result in a positive care effect is ethically equivalent to prescribing sugar pills. Blease points to the clear inconsistency between permitting the former but not the latter.

Anne Marie Slowther *et al* report on the development of clinical ethics committees in the UK over the last decade (*see page 210*). In comparison with North America and Europe, these committees and their attendant clinical ethics services are relatively new. There are important questions that arise out of this research and the UK context, which are not so easily addressed in more entrenched systems. One crucial set of questions centres on the proper role of the committees in decisions about particular cases, in education and in policy formation. The data presented here tackle the current situation on this set of questions (among others) and so can ground the normative discussion about how it ought to develop further.