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# Making the evidence (and arguments) count

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doi:10.1136/medethics-2014-102642

The academic field of medical ethics continues to evolve. One of the starkest features of this ongoing evolution is the increase in research studies that incorporate an empirical component. Although this trend is not new (Borry *et al.*, 2006),<sup>1</sup> empirical papers in the *Journal of Medical Ethics* now constitute a significant contribution to each and every issue.

Disciplinary turf wars were a feature of the early days of this 'empirical turn' in medical ethics as philosophers and social scientists sought to articulate and defend why their different contributions were necessary to the advancement of the field. Crudely characterised, these battles were pitched over philosophers' perceptions that social scientists lack rigour in articulating how the study of ethical attitudes and practices could inform normative reasoning, and by social scientists' perceptions that philosophers' analyses were blind to salient features of the real-world settings in which moral problems arise in health care practice and policy-making.

As empirical contributions to medical ethics have expanded, these debates and disagreements have also evolved. One relatively new feature of the medical ethics and bioethics literature is the tendency to contrast 'analytical' medical ethics with 'empirical' medical ethics, as another of the journal's Associate Editors does in a recent piece in this column (Wilkinson, 2014).<sup>2</sup> This distinction has some advantages. It can help to avoid some of the cheap shots that were a feature of the earlier disciplinary disagreements. In particular, differentiating medical ethics research in terms of its methodological orientation can help to avoid common misrepresentations of the contributions of different scholars, and it explicitly recognises that both theoretical and empirical contributions have merit in advancing the field.

There are, however, problems with dividing up academic medical ethics in this way. One concern is the risk that, as the field matures, it will bifurcate between those who are more inclined to undertake empirical research and those who are not. Placing scholars in one of two camps may increase the risk that the field fragments as those medical ethicists advocating for one of these two approaches fail to

engage in substantive terms with those pursuing and advocating for the alternative. This 'silo' problem is not one to be taken lightly in a relatively young field that is only now becoming established in many parts of the world.

Another, perhaps more important, concern is that differentiating between 'analytical' and 'empirical' contributions simply fails to recognise the interconnections in research between philosophical argumentation and the empirical study of ethical problems in real-world health care contexts, as well as the nuances that exist within each broad approach. Contributions to the medical ethics literature that involve empirical work, for example, are not a single category and they do not share the same kinds of aims or objectives. Many, indeed, are conceived with the sole purpose of interrogating practical normative questions, and do so by adopting novel methodological approaches that seek to avoid common fallacies of reasoning (e.g. Dunn *et al.*, 2012; Ives, 2014).<sup>3, 4</sup> Equally, those contributions that involve philosophical argumentation can be embedded in, or stimulated by, real-world experiences or new empirical insights. As such, the quality of the analysis can stand or fall not just on the soundness of the arguments, but on how the underlying ethical problem has been characterised, and how the normative claims that are being articulated and interrogated connect to the world in which they are designed to take effect.

A number of the papers in this issue of the journal are illustrative of this nuanced and interconnected relationship between analytic and empirical contributions to the field of medical ethics. Raijmakers *et al.*'s (see page 145) large cross-sectional survey of the Dutch population reveals that a minority of people in the Netherlands are supportive of physician-assisted dying in situations where patients do not have a serious medical condition, but are expressing the wish to be helped to die. The authors are clear that these results do not constitute an argument for extending the reach of physician-assisted dying in the country. However, they do suggest persuasively that such insights about the population's attitudes justify a re-orientation in the field towards scrutinising the arguments for and against assistance in dying in this situation.

In contrast to Raijmakers *et al.*'s attempt to present data in order to shift the locus of the ethical debate in end of life care, Kitinger and Kitinger (see page 157, Editor's choice) draw upon interviews with family members of individuals in a vegetative or minimally conscious state to countenance against implementing certain arguments for the withdrawal of artificial nutrition and hydration (ANH) in familial decision-making situations. Motivated by the recent case of *W v M* in the English Court of Protection in which the withdrawal of ANH was considered, the authors reveal that relatives' primary concern is not whether their loved ones should live or die, but how they should die. In the face of familial refusals to consider 'causing death by starvation and dehydration', Kitinger and Kitinger are right to invite us to reconsider how life-ending interventions or withdrawals for patients in these conditions should be evaluated. This question is a different but, arguably, equally important question to the permissibility issue that medical ethicists have focused on following the case of *W v M* and others.

Mellor *et al.* (see page 151) go even further in the sense that they engage in ethical reasoning in order to directly scrutinise and interpret the implications of the empirical insights they offer. Examining treatment non-adherence amongst paediatric patients in renal failure and undergoing dialysis, the authors' interviews with nurses show that these nurses struggled to align the responsibilities of the minor, parent and practitioner in relation to treatment decision-making, as well as how to respond to the challenge of non-adherence in ways that uphold the child's best interests. Upon further analysis, the authors argue that, given the nature of the child's needs, the responsibilities for safeguarding the child's health should be shared between the health care providers and the parents. This is supported by the additional claim that their patients' non-adherence should not necessarily be accorded the status of a treatment refusal rendering the nurses' (and parents') use of coercive practices less ethically problematic than they might first appear.

Elsewhere in this issue, other authors undertake ethical analyses that are motivated by particular observations about the

world of health care practice. Minerva (*see page 170*) examines how access to abortions could be improved in Italy. Her thesis, which includes a number of practical solutions to improving access, is borne out of the observation that the percentage of Italian gynaecologists who conscientiously object to participating in abortions is approaching 70%. Whilst Trigg raises concerns about the potential real-world problems that might follow from enacting Minerva's strategies for reducing the number of conscientious objectors (*see page 174*), it is also important to recognise that further empirical study is required to explain whether the low percentage of doctors willing to be involved in terminating a pregnancy limits a woman's ability to have a termination in a timely and safe manner. Minerva carefully lays out a number of reasons to think that there is a causal connection here that justifies her proposed solutions to the 'conscientious objection problem', but the empirical premise that lies at the heart of her ethical argument is ripe for further scrutiny.

Rather than being inspired by population-level data, other more 'analytical' papers in the issue take one or more specific observations from the front-line of practice as their starting point for ethical argumentation. Spriggs and Gillam (*see page 179*) examine the ethics of deceiving children in research in situations where the children's parents ask the researchers not to reveal something about the research to their children. Their claim that non-disclosure of information to

children is very unlikely to be ethically justified emerges from their examination of three scenarios that are characteristic of their experiences of working in the paediatric research ethics context. In a similar vein, de Vos *et al* (*see page 195*) dissect a real clinical case to examine whether the parents' request for the withdrawal of treatment from their 3-year old son with acquired brain damage should be respected. In an accompanying commentary (*see page 201*), Isaacs extends de Vos *et al*'s arguments by drawing upon a case from within his own practice setting, and the broader qualitative research literature. Exploring real-life situations can, therefore, not only stimulate ethical analysis in their own right, they can also shape the content and direction of this analysis in order to scrutinise the validity of the arguments being developed.

To conclude, then, it is not whether the contribution is 'empirical' or 'analytical' in character that matters, but *how* the analysis presented functions to advance our understanding of the medical ethical issue under scrutiny. Different topics will demand different research strategies at different points in time and in different geographical settings. In some topic areas, the ethical problems arising in practice will be well-characterised and the broader social context in which the problem plays out will be clear; there will be no need for additional studies of stakeholders' attitudes or practices, nor any value in 'horizon-scanning' for a range of further ethical issues.

In other topic areas, there may well be a problematic mismatch between the focus of emerging philosophical analysis and the views or experiences of those who are tasked to resolve the moral difficulty, or who otherwise stand in relation to it. As such, normative claims may have limited real-world currency, or ethical analyses will proceed to address problems that are not comparable to those faced 'on the ground'. Here, research contributions that can better account for the ways that ethical issues arise in practice, that can explore how the implications of certain arguments connect to the world in which they are intended to be implemented, or that can integrate an explanatory account of individuals' attitudes or experiences with a rigorous ethical analysis, are likely to be of particular value. The journal welcomes papers that advance our understanding of the contemporary medical ethical issues in a relevant, timely and scholarly fashion – whichever camp they fall into, or whichever label they acquire.

## REFERENCES

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- 3 Dunn M, Sheehan M, Hope T, *et al*. 2012. Towards methodological innovation in empirical bioethics research. *Camb Q Healthc Ethics* 2012;21: 466–80.
- 4 Ives J. A method of reflexive balancing in a pragmatic, interdisciplinary and reflexive bioethics. *Bioethics* 2014;28:302–12.