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# Highlights from this issue

Russell Powell, *Associate Editor*

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## PUBLIC HEALTH, JUSTICE AND THE APPRECIATION OF CULTURAL VARIATION

The ethics of female genital modification is a more philosophically complex problem than it might seem at first glance. Not only does it raise potential conflicts between moral principles and implicate a range of pragmatic social considerations that must be taken into account in setting national and international policies, but also the practice itself varies substantially within and across societies, and these variations may have morally significant implications. This is perhaps the central message of Arora and Jacobs's Feature Article (*see page 148*, Editor's Choice), in which they argue that categorical condemnation of female genital alteration—and indeed the very use of the loaded term 'mutilation' in these discussions—overlooks the significant cultural variation in female genital alteration practices. The authors contend that since attempts to stop the practice wholesale have been relatively unsuccessful, it is now time to consider permitting some types of non-therapeutic female genital alteration, namely those that carry low risk of physical harm and that have minimal or no impact on reproductive capacities and sexual-satisfaction. Such low-risk alterations do not violate the human rights of girls, so the logic goes, because they are morally equivalent to other purely aesthetic procedures (such as mole removal or orthodontics) commonly performed on children in liberal societies in which female genital alteration is prohibited. Tolerating low-risk versions of the practice would not only make advocacy against severe forms of female genital alteration more successful, they argue, but also would show due respect for religious and cultural differences. In her commentary on Arora and Jacobs's paper, Macklin (*see page 155*) questions the ambiguous value of 'cultural sensitivity', arguing that even low-risk versions of the practice symbolize the subordinated social role of women and reinforce gender injustice, and thus are not cultural practices that are deserving of respect. Shahvisi's commentary (*see page 156*) underscores dis-analogies between female genital alteration and male circumcision and, like Macklin and Earp (below), expresses doubt that the author's compromise will be welcomed by many people who

are embedded in a culture that sanctions more extreme forms of female genital cutting. Earp (*see page 158*) is skeptical that we could adhere in practice to a legal taxonomy of genital alteration, and he argues in any case that child genital autonomy is the decisive ethical consideration in these cases. He further argues that the differential treatment of male circumcision and female genital alteration in liberal developed nations, rather than speaking to the moral permissibility of low-risk versions of the female case, gives us good reason to question the nonchalant attitude toward male genital alteration that is common in many developed nations.

## CONSENT, CONFIDENTIALITY AND THE PUBLIC GOOD

With the rapid expansion of medical genetics, questions about the ethics of disclosing the results of genetic tests to potentially affected family members are becoming increasingly pressing. The standard approach is to regard genetic information as confidential at the patient level, and to hold that disclosure is permitted only with consent save for exceptional circumstances (such as the risk of serious and imminent harm to others). In contrast, on a relational model of autonomy, genetic information may be regarded as confidential at the family rather than at the individual level, with the disclosure of genetic results to at-risk family members treated as the default (and non-disclosure permitted only in exceptional circumstances). In an effort to learn what patients think about the disclosure of genetic information to family members, Dheensa (*see page 174*) conducted a qualitative study in which she found that most patients viewed genetic information, unlike information about day-to-day medical concerns, as belonging to the family rather than to the individual, and as a result most patients concluded that at-risk family members had a right to know the results of genetic tests. These findings lead the author to recommend that a qualified relational approach to the disclosure of genetic information be implemented in clinical settings.

Organ donation is another area of bioethics in which principles of consent figure prominently. In a recent paper in

this journal, MacKay<sup>1</sup> argues that 'opt-out' systems of organ procurement, such as one recently proposed by Saunders<sup>2</sup>, violate individual autonomy because they are not (despite claims to the contrary) grounded in actual tacit consent. This is because most people, MacKay argues, do not understand that their silence constitutes actual consent—a failure of understanding that is due, in part, to limitations of government information campaigns. In response, Saunders argues (*see page 203*) that valid legal consent need not involve robust understanding, because our definition of valid legal consent must (unlike the ideal of autonomous authorization) take into account the practical population-level consequences of consent policies—such as the demands that heavy disclosure requirements would impose on healthcare professionals—and because patients bear some duty to become suitably informed. Saunders is right that ignorance of the law is no excuse for violating it; still, one is left wondering whether patients who have done nothing wrong can reasonably be expected to appreciate the ramifications of new organ donation opt-out schemes, such that their silence may be taken as legally valid consent. If this is not reasonable, then we must either vastly improve the efficacy of public information campaigns, or else find moral considerations supporting opt-out schemes that plausibly outweigh autonomy violations.

## THE MEDICAL ETHICS OF INDUSTRIAL ACTION

When if ever is it permissible for healthcare workers, in particular doctors, to go on strike in order to secure better pay and working conditions for themselves? It is normally presumed that healthcare worker strikes are not in the best interests of patients, especially in the context of socialised medical regimes. But is this assumption warranted? Might healthcare worker industrial action in some cases be morally obligatory? These are some of the questions taken up by Broome *et al.* (*see page 168*) in an analysis that focuses on the impending junior doctor strike in the UK. The authors argue that absolutist positions against doctor strikes are unwarranted, in part because the interests of doctors and

patients will often be aligned: Unacceptably low salaries and high workloads may cause the most talented doctors to eschew or leave the profession, thus harming the quality and availability of clinical care. Nevertheless, recognizing that doctors have special duties to patients even

where the State has failed to hold up its end of the bargain, the authors provide a stringent set of necessary and sufficient conditions under which industrial action by medical doctors is morally permissible and, in some circumstances, even obligatory.

### REFERENCES

- 1 MacKay D. Opt-out and consent. *J Med Ethics* 2015;41:832–5.
- 2 Saunders B. Opt-out organ donation without presumptions. *J Med Ethics* 2012;38:69–72.