



Diversity of scholarship in medical ethics

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In their essay arguing for ethical review of social research, Sheehan *et al* write:

Inquiry and human life are intertwined and interdependent. To be human is to be curious, to ask questions about yourself, the world, and your place in the world. This process of inquiry is undertaken individually, but is a social activity.¹

As researchers in medical ethics, all the authors in this issue have chosen to ask a particular type of question about the world: questions about ethical complexity and justification. Their inquiries are rich and diverse. We can see each as an individual piece of scholarship, contributing to our knowledge of a specific topic. But we can also see medical ethics as a social activity—one undertaken by a community of authors and readers, debating and reasoning together.

What is striking when we think of medical ethics in this second way is the diversity of approaches to research that are useful in our discussions. Understanding ethics in healthcare is furthered by very different types of research, and this issue of the journal clearly illustrates this breadth of approaches to scholarship in medical ethics.

The three articles on transplant ethics provide an excellent example of this diversity of scholarship in medical ethics. All explore ethical aspects of transplantation but using different approaches. Ladin and colleagues² identify an ethical problem through empirical inquiry. Their research examines the requirement that a patient have adequate social support in order to be eligible for kidney transplant. They suggest that social support as a criterion ‘remains controversial because of its subjectivity, lack of uniform standards for assessment, and because its relationship to post-transplant outcomes remains uncertain’. Using a discrete choice experiment, they investigated how clinicians rank social support, compared with other factors, when choosing a candidate for kidney transplantation. They found that ‘respondents were 1.68 times more likely to choose a profile of a transplant candidate that had social support’, and argue that this has worrying implications for equity of access.

Their quantitative inquiry differs from the approach taken by Saunders, who has undertaken a conceptual analysis of altruism.³ Saunders interrogates the commonly held view that organ donation must be altruistic. Drawing on the philosophy of Aristotle and Hurka, Saunders argues that ‘having the proper amount of regard for one’s own interests is good’. He suggests that ‘[s]ometimes altruistic donations may exhibit the vice of self-abnegation’ and thus that we have reason to look critically at instances of altruistic behaviour. In contrast to Saunders’ conceptual analysis, Hedges and Rosoff⁴ use risk/benefit analysis as an approach to medical ethics inquiry. Their argument against paediatric hand transplantation explores the ‘risk/benefit ratio’ of this new intervention. They conclude that ‘children should not be considered for this surgery due to the substantial risks of immunosuppressive medication, the likelihood that the graft will need to be replaced during the patient’s lifetime and the lack of significant compensatory advantages over modern prosthetics’.

Further diverse approaches to medical ethics inquiry can be found in other articles in this issue. Lucivero and Jongsma⁵ undertake a critical analysis of claims being made about emerging mobile technologies for health, particularly wearable devices. They look at three ‘recurrent promises of mHealth’—fostering efficiency and prevention, increasing self-management and promoting access—and argue that, for mHealth technologies, ‘expectations often do not resonate with their practical use’. Akabayashi *et al*⁶ take a case study approach, providing a close analysis of a specific public funding decision to develop a stem cell bank. Blackstone and Youngner⁷ take the unusual but valuable approach of looking back at a particular slippery slope argument to assess it in light of current evidence. They suggest that ‘while such retrospective analysis... rarely appears in the literature, it can provide perspective and, perhaps, insight into other cries of danger that are greeting the growing legalization of physician-assisted death’.

There is a shared thread among these diverse approaches to scholarship in medical ethics. All the articles in this issue have in common a contribution that is

both theoretically interesting and practically important. This combination is exemplified in this issue’s editor’s choice article, ‘Substituted decision-making and the dispositional choice account’.⁸ In this extended essay, Andersson and Johansson engage in an innovative way with the substituted judgement standard: the view that surrogate decision makers ‘should attempt to reconstruct the decisions the patient herself would have made, if she were capable’. The authors question the dominant view that the substituted judgement standard only applies to patients who have previously had decision-making capacity. They investigate various explanations of how unconscious patients can have interests and argue that the most plausible explanation implies that ‘the substituted judgement standard can be coherently applied to patients while they are unconscious, even if they have never been conscious’. Their conceptual investigation is distilled into a practical question for clinicians: ‘what would this particular patient have reason to choose if she were capacitated?’. Andersson and Johansson argue that ‘viewing the patient as a dispositional “chooser”... helps us preserve a patient centred perspective’. Their work both furthers theoretical debate about the nature of interests and autonomy and contributes to ethical practice in patient care.

The extended essay on research ethics by Sheehan *et al*¹ similarly displays this mix of furthering theoretical debate and facilitating ethical action. These authors respond to recent critiques of ethical regulation for social science research. They tackle this topic in terms of two challenges: first, ‘to provide an account of the relationship between research and society that can ground a general claim for a system of research ethics governance across the social sciences’ and second, ‘to derive a form of governance arrangements from this account’. They argue that we need to understand ‘what kind of *stake* society has in social research’ in order to make claims about appropriate research ethics governance. Sheehan *et al* suggest that this stake relates to human flourishing. As highlighted above, they see ‘inquiry as a constitutive element of human flourishing’. They argue that inquiry is ‘embedded within the functioning of societies’ and

that formal research is the institutionalised form of this intrinsically valuable activity. They put forward an ‘understanding [of] research, via the idea of inquiry, as importantly associated with human flourishing, and so as something about which society ought to be concerned’. Like Andersson and Johansson, they then use this theorising in relation to a particular practical question: ‘the relevant question is about what specific piece of research ought to be conducted’. They articulate a ‘model of fair process’ for deciding on the appropriateness of particular research projects. Hammersley⁹, in response, highlights the ‘severe limits to the knowledge likely to be available to members of RECs’ and questions ‘mandatory, pre-emptive assessment’. Diverse views, topics and approaches to scholarship characterise

medical ethics, and this diversity is a undoubtedly a strength as we continue our process of inquiry both individually and as a community of authors and readers.

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