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Editorial

Ethics, surgery and clinical research

In this issue we are pleased to publish a set of papers delivered at a recent symposium on Ethics in relation to Surgery held during the annual meeting of the International Federation of Surgical Colleges. Surgeons, like other men of action, are not renowned for their tendency to philosophise, an activity which they often castigate for its tendency to waste time, divert effort from its proper end (doing things) and worst of all, raise doubts where there were none apparent before. The surgeons represented by the contributors to this symposium are clearly in a different mould. They pick out a wide range of important ethical problem areas and discuss them in often considerable detail. Some might have hoped that such lengthy discussion would have actually resolved the problems, at least to some substantial degree. But, as Dr Michael Lockwood (the lecturer for the Society of Apothecaries course on philosophy and medicine) makes clear, this is by no means the case.

The problem of controlled clinical trials provides a good example since it was the subject of one whole section of the symposium. Dr Giertz in a detailed and stimulating discussion of the problem tries to resolve it by arguing that so far as ethical considerations are concerned controlled trials are really analogous to 'patient care work' rather than to 'research experiments'. He says: 'In controlled studies there is – or at least there should always be – an effort to do the very best for the patient. The problem is that the doctor does not know and in most instances no one else knows what is the very best. Despite this the doctor has to make his decision. The scientific element is merely that he organises his decisions, making it possible to draw conclusions concerning the best therapy as soon as possible'. Now this may well be true in some types of controlled trial, but surely not in all. For example in trials involving placebo how *could* there be 'an effort to do the very best for the patient' when the doctor generally knows that fifty per cent of his patients will be receiving placebos only?

It may well be that trials involving placebo are designed so that in the long run the very best will be done for patients in general, but it is important to distinguish between the best interests of patients in a trial and the best interests of patients in general. Even if one adopts a simple utilitarian morality whereby benefit to *any* patient, one's own or another's, existing or yet to be born, counts as equally valuable (and there are of course notorious problems with such an ethical system) still there remains a clear ethical difference between the activities of 'mere patient care' and controlled clinical trials. The difference is that in patient care the primary objective is to make a particular patient well while in controlled trials the primary objective is to refute an hypothesis. Even if the secondary objective of the controlled trial is to make patients in general better, and even if (for the sake of argument) one does not particularly care which patients, present or future, one's own or others, are to benefit, still there remains an important moral difference stemming from the implicit contract between doctor and patient. Patients normally come to doctors to be made well. When a doctor takes on a patient there is an implicit assumption that the doctor is medically competent and will intend and endeavour to use this medical competence to provide medically appropriate treatment for that patient. To give a patient a placebo in a controlled trial is not usually to give a patient medically appropriate treatment.

Dr Giertz suggests an interesting solution to this problem. *All* medical treatment should be based on informed consent, whether it is part of normal patient care or of controlled trials. Provided informed consent is obtained there is no moral difference between the two cases. Unfortunately this answer merely provokes a fresh set of questions; for, it is by no means obvious that the same criteria should apply to consent to treatment as should apply to consent to clinical trials; and the vexed question of truly *informed* consent (so well illustrated in Ajayi's paper about clinical research in West Africa) remains a major worry when the patient-doctor relationship is altered to that of subject-researcher.

Thus Dr Giertz's paper provides an example of how difficult it is to find simple solutions to the truly vexing moral issues being faced in modern medicine. The same point may be made about many of the other papers in the symposium. (The reader will find in Lockwood's summary article a good review of the emergent issues.) Yet this is perhaps hardly surprising. Surgery has always demanded a combination of three qualities: knowledge, skill and judgement.[1] As its dramatic technical advances provoke a whole new set of moral problems, we must hope for an increasingly sensitive awareness of what

such judgement means. This can only mean an increase in the complexity of the decisions and a lack of easy answers.

The transsexual dilemma

One contentious area of surgical practice not discussed in the Surgical Colleges' symposium was that of sex change operations. As chance would have it, we are publishing in this same issue three papers on the topic, though none of them from a specifically surgical perspective. The centre of our attention is the experience of the transsexual, and the problems he or she encounters within the present framework of medical practice and legal requirements in Britain. The picture is not a cheerful one. It is understandably difficult for people to appreciate a dilemma so far removed from their own experience. Yet since there are now reasonably well established medical and psychological criteria for assessing the problems of sexual identity faced by a not inconsiderable number of people, through no choice or fault of their own, it is sad that social attitudes and outmoded laws continue to provoke unnecessary suffering. We hope that the descriptions of the difficulties faced by one female-to-male transsexual (writing pseudonomously) may help to increase understanding of the human dimensions of this problem.

Reference

[1]Welbourn, R B (1979) Science and surgery. *Australian and New Zealand Journal of Surgery*, **49**, 2, 179–186.