- Toulmin S. The tyranny of principles. *Hastings Center report* December 1981.
- (4) We are, however, a bit puzzled by Swales's contention that the case of Leonard Arthur exhibits this 'shift from the ethical to the clinical domain'. If the practice of 'allowing the deaths' of anomalous newborns is not a moral issue, what is? If the crucial question raised by this case called for *clinical*, rather than moral, expertise, why did the members of LIFE press the issue in court? For a sensitive discussion of the Arthur case, see Glover J. Letting people die. *London Review of Books* 4-17 March 1982; Vol 4 No 4: 3.
 - (5) Veatch R M, Tai E. Talking about death: patterns of lay and professional change. *The annals of the American Academy of Political and Social Science* January 1980; 29-45; and Novack D H et al. Changes in physicians' attitudes toward telling the cancer patient. *Journal of the American Medical Association* March 2, 1979; 241: 897-900.
 - (6) Caplan A L. Ethical engineers need not apply: the state of applied ethics today. *Science, technology and human values* Autumn 1980; 6: 24-32.

Response

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I am flattered that my short piece drew forth such lengthy rejoinders. I am also delighted because in spite of the assertions made in these replies I believe that a debate between individuals of the widest range of backgrounds is a desirable and necessary precondition to finding a working provisional solution to the ethical dilemmas of medicine. My objection was not to such a debate. My objection was to the development of the 'ethical expert' and the discipline of 'medical ethics' as a discrete subject in the teaching of medical students analogous say to endocrinology or gastroenterology.

The implication of Arras and Murray that ethical value judgments and the inductive observations and testable hypotheses of medical science are qualitatively similar hardly stands up to critical examination (1). Do they seriously believe that the ethics of, for instance, the termination of pregnancy are testable in the same way as, say, those of clinical treatment? If ethical hypotheses were testable I would agree that analogous roles for the ethicist and endocrinologist could indeed be identified. Until I am convinced of this the arguments for 'professional ethicists' remain specious.

I might be persuaded by the more empirical approach of demonstrating benefit. I certainly am not persuaded by statements referring to 'Swales's conviction that all ethical questions in medicine are ultimately reducible to questions of technical expertise' or the statement that 'he [Swales] insists that non-scientific outsiders can contribute nothing to clinical decision-making . . .'. I recognise that it is easier to attack a stereotype of an intensively conservative medical position, but nowhere in my article or elsewhere have I objected to a wider debate with non-medical interested

parties. However, I would emphatically give primacy in such debate to patients rather than 'experts' or pressure groups with a particular viewpoint and it is depressing that both replies give so much space to the role of various experts and so little to the role of the patient which I emphasised in my original piece. I would have hoped that from their experience Arras and Murray could have produced evidence for the value of the 'bioethicist'. Unfortunately they have not. Indeed we are merely assured that 'it is hard to believe' that changes in doctors' approaches have not been influenced by bioethicists. The examples they quote do not support this view. The justifiable concern with human experimentation in the United Kingdom, for instance, does not follow from ethicists' investigation. It largely stems originally from Dr Pappworth's book (2) which meticulously chronicled published studies in the medical literature and explained for a lay public what was involved. Ethical judgment was clearly necessary but equally clearly no expert moral analysis was required to demonstrate the unacceptable nature of what was being done. The relevant previously unrecognised fact was that it was happening. It is as illogical to claim that public concern with the dilemmas of medicine follows from the evolution of bioethics as it is to maintain that the equally widespread concern with the modern epidemic of cardiovascular disease stems from the development of professional cardiologists. Post hoc non propter hoc.

Most disturbing of all in Arras and Murray's article is the description of an expansion of the role of the ethicist into a social worker/psychotherapist who knows 'about the patient's own hopes, fears, plans and problems in order accurately to predict what course will in fact maximise her welfare'. I am even more surprised to read that this is 'a more difficult undertaking than Swales would have us believe', since my original article expresses no views about this difficult area. Further, in the last paragraphs, a role in analysing organisational and personal problems of staff and patients is described which suggests quite different activities from those which the term 'ethical philosophy' would normally subsume. Such activities should be judged in their own right but have no bearing on my original contention.

Since the burden of my article has clearly escaped Drs Arras and Murray perhaps I could emphasise again the importance of an open debate. What I remain sceptical about is the role of the ethicist as an expert whose authority can resolve the dilemmas of medicine for ourselves and our students. Judging by the analysis presented by Drs Arras and Murray it cannot do this, it can however generate a considerable smoke-screen.

References

- (1) Popper K R. *The logic of scientific discovery*. London: Hutchinson, 1977.
- (2) Pappworth M H. *Human guinea-pigs: experimentation on Man*. London: Routledge & Kegan Paul, 1967.