disadvantages. Among other possibilities are the introduction for interested undergraduates of an intercalated year of philosophy (specially tailored for medical needs) in the preclinical curriculum, along the same lines as those already developed in London University for sociology and psychology.

Philosophy departments might also consider taking up the Apothecaries' Society's idea of a diploma course for medical personnel in the philosophy of medicine, by providing an introduction, via a weekly or fortnightly series of lecture-seminars, to contemporary Anglo-American philosophical method.

Contacts between the relevant disciplines could also be profitably expanded by interdisciplinary lecturing, as already happens in Edinburgh University and King's College London, where philosophers, theologians and lawyers give lectures and seminars on medical ethics to medical students. And of course at an informal level the London Medical Group and associated student groups throughout Britain continue to provide valuable cross-disciplinary discussion. Imperial College (London, SW7) recently held the first British course on medical ethics for medical and nursing teachers and Oxford University External Studies Department (3–7, Wellington Square, Oxford) has begun to hold weekend seminars on morals and medicine.

One or two other opportunities for interested doctors to participate in philosophical activities are worth remarking. The Royal Institute of Philosophy, although its activities are aimed primarily at philosophers, also admits as members interested non-philosophers to whom its lectures and some of the papers published in its quarterly journal, Philosophy, will be accessible. The October 1982 issue for example, includes papers on 'The justification of morality', 'The choice between lives', 'Character, virtue and freedom' and 'Rationality and paternalism'. Membership of the Institute (14 Gordon Square, London, WC1) costs a mere £10 per annum and includes a subscription to Philosophy as well as access to the evening lectures.

A further opportunity for interdisciplinary discussion has been created with the establishment of the Society for Applied Philosophy, which holds conferences and intends to publish a journal of applied philosophy. The first medically orientated activity of the society is a workshop on philosophical and ethical issues in medicine and science policy, to be held on March 12 in London. Details of the society's activities are available from its Secretary, Brenda Cohen, Philosophy Department, University of Surrey, Guildford. Finally, other journals concerned with philosophical issues related to medicine include: The Hastings Center Report (bi-monthly - details from The Hastings Center, 360 Broadway, Hastings on Hudson New York 10706); The Journal of Medicine and Philosophy (quarterly; D Reidel Publishing Company, PO Box 17,3300 AA Dordrecht, Holland); Theoretical Medicine (formerly Metamedicine; quarterly; also published by D Reidel). And a new British journal called Explorations in Medicine which concerns itself with the philosophy of medicine is also planned.

Moral philosophy needs real moral problems to keep its thought nearer the ground. Medical practice needs more philosophical awareness if it is to cope adequately with its endless supply of real moral problems. It would be a tragedy if the obvious potential for a symbiotic relationship between the two disciplines were to be frustrated by reciprocated ignorance and distrust.

(for references see page 49)

On paternalism and autonomy

One feature of Mark Komrad's stimulating and broad-ranging paper in this issue defending a limited medical paternalism designed to restore or maximise a patient's autonomy requires comment. Komrad argues that 'all illness represents a state of diminished autonomy' and that it is this which justifies paternalistic medical interventions to restore or maximise this impaired autonomy even if these over-ride or ignore the patient's own desires. In considering this claim it is important to distinguish not only as Komrad does, between impairment of the ability to make autonomous choices (impairment of 'autonomy of will') Komrad puts it) and impairment of the power to implement one's choices (impairment of 'autonomy of action') but also between these concepts of autonomy and the quite separate issue of what are the morally appropriate responses to such impairments. It is the latter which is addressed by the principle of autonomy. Even if a person's autonomy or freedom of action is almost entirely eliminated (for example by quadriplegia) this fact in no way entails that his freedom or autonomy of will need not be respected (the theme of the play Whose life is it anyway?); and even if his freedom or autonomy of will is considerably impaired this in no way entails that what is left should not be respected.

Mill's principle of autonomy quoted by Komrad offers only two qualifications: we must not interfere with other people's freedom (or autonomy) of thought and action provided these do not harm others and provided that the people thus respected possess a rather basic level of maturity (a capability 'of being improved by free and equal discussion'). Komrad, in fact, is suggesting that we need fully respect the autonomy only of those enjoying some (probably mythical) state of maximal and/or unimpaired autonomy of will and action is proposing a radical modification of Mill's widely accepted principle of autonomy. By his arguments no patient need have his autonomy fully respected since this autonomy is always impaired and 'never maximal'.

There will be those who for other reasons reject Mill's principle of autonomy: but Komrad's alternative proposal, attractive as it will be to many, simply does not follow from the alleged fact that illness always represents a state of diminished autonomy.