The Journal of the Society for the Study of Medical Ethics

The *Journal of medical ethics* was established in 1975, with a milti-disciplinary Editorial Board, to promote the study of contemporary medico-moral problems. The Editorial Board has as it aims the encouragement of a high academic standard for this developing subject and the influencing of the quality of both professional and public discussion. The *Journal* is published quarterly. The *Journal* includes papers on all aspects of medical ethics, analyses ethical concepts and theories and features case conferences and comment on clinical practice. It includes book rviews and details of lectures and symposia on issues raised by the practice of medicine.

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Papers submitted for publication should be sent in triplicate to: The Editor, *Journal of Medical Ethics*, Tavistock House North, Tavistock Square, London WC1H 9LG. Rejected manuscripts are not returned unless accompanied by a stamped addressed envelope, or international reply coupon. Papers should be in double-spaced typewriting on one side of the paper only. On a separate sheet a brief entry for 'Contributors to this issue' should be supplied, containing the title of the author's present post, degrees and/or professional qualifications, and any other relevant information.

Four copies of the *journal* will be sent to authors free of charge after their papers are published. Offprints of individual papers may be bought from The Publisher, *Journal of Medical Ethics*, Tavistock House East, Tavistock Square, London WC1H 9JR.

In March 1981 the *JME* adopted a simplified 'Vancouver style' for references: details are given in various issues including December 1983, p 234. They are also available from the editorial office. The full text of the 'Vancouver Agreement' was published in the *British Medical Journal* in 1982; Volume 284; 1725/1814. As the 'Vancouver style' is incompatible with the long established style of references for legal articles, lawyers should use their own standard style, but avoid abbreviations so as to facilitate reference by others. The *journal* is multidisciplinary and papers should be in clear jargon-free English, accessible to any intelligent reader.

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Thematic review and index

The thematic review of past issues appears in the June issue each year and an index to each volume appears in the December issue.

way, a doctor may disapprove of issuing, say, contraceptive advice to 15-year-olds without their parents' knowledge, or of certain sorts of genetic counselling, but as a doctor he should still attempt to express the moral consensus of his society on such matters.

If a view of this sort were to be adopted – and I am not maintaining that it is exactly the view advocated by Dr Young – it would have several implications. The first is that surveys of ethical opinion ought to extend beyond the population Dr Young has in mind ('medical, nursing and student staff' p73) and include – predominantly include – the views of the *consumers* of health care. (Whose life is it anyway? Who will need to undertake the day-to-day care? Who will in the end need to pay for it all?) To this end, programmes about ethical dilemmas, such as those initiated by Ian Kennedy, G F Newman and others, are to be welcomed, since thereby the public is involved and informed, and, what is even more important, a little public opinion may penetrate that cocoon which is medical education.

The second implication is that such a policy imposes some limitations on the ethical autonomy of the doctor. The distinction between autonomy in medical judgement (where the doctor is supreme) and autonomy in ethical judgement (where there are no experts) must be noted here, and of course there must always be escape clauses on conscientious grounds for the doctor. But since we (the general public) pay the medical piper perhaps we should be involved rather more than hitherto in calling the medical ethical tune. That is why I agree with Dr Young when he writes in his introduction 'that ethical values are . . . for contemporary discussion and that the views of caring intelligent citizens may be sought in formulating acceptable standards', but would strongly urge him to cast his net wider than 'the opinions of medical, nursing and student staff'.

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News and notes

Aim to double kidney transplants this decade

'There are still 2,500 people waiting for a kidney transplant and many more waiting for corneas, hearts, liver and other organs', said Norman Fowler, Secretary of State for Social Services, speaking at the launch of a campaign to distribute 10 million organ donor cards.

Mr Fowler said: 'In 1983 there was a record number of 1,160 kidney transplant operations and I want to double this number before the end of the decade. Now transplantation is acknowledged as the preferred form of treatment for many kidney patients. Corneas play a valuable part in helping people to see better. Recent medical advances in the transplantation of hearts, livers and other organs are encouraging. So now is the right time to get more people to carry an organ donor card.

'Doctors find it much easier to ask shocked or distressed relatives about possible organ donation if they know the patient carried a signed donor card. Many cards have been distributed and recent research shows that 66 per cent of people agree to have their kidneys used for transplantation purposes after their death and only 20 per cent object. But only 20 per cent actually carry the card. Over 40 per cent of those who don't carry the card said they didn't because they couldn't be bothered or had never thought about it. We must convince them to bother.

'When someone decides to sign a donor card, they should ensure their friends and family know. It is important that they know so that the organs can be transplanted quickly in case of death.

'The money for the eight children's centres designated to treat children with kidney diseases will be increased by the Government by £310,000 in 1984/85. This is a 15 per cent increase in services. These services have been helped considerably by the BBC TV Blue Peter Treasure Trove appeal last year which raised over £2 million – a magnificent achievement by that programme's viewers.'

Mr Fowler also announced a further £1,000,000 to be spent on renal services. 'This money will be given to health authorities where a small sum of money could get a new or experimental project off the ground.'

have this potential only after they are united and become the embryo. To say that flour, yeast and water have the potential, if mixed; kneaded and placed in a hot oven, to become bread, is not to utter the irrelevancy or triviality that bread has the potential to become bread.

So our argument stands. If it is legitimate to destroy eggs and sperm, when one has both of them and could unite them, it is also legitimate to destroy early embryos.

Contributors to this issue

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identified.

The problems related to the distinction between killing and allowing to die have been considered in the context of medical practice. What a right to the means to life should include was discussed in the context of problems such as suicide threats, abortion and euthanasia and the example of the two men requiring transplants; the latter example illustrated clearly many of the problems in determining whether allowing to die is less culpable than killing.

The last section of this paper compared the views of those who advocate and those who oppose the practice of selective treatment of handicapped children. It argued that the reasons given for this practice were utilitarian in character whilst those who opposed it generally based their arguments on belief in human rights. However, the acceptance of selective treatment did appear to depend on a moral distinction between acts and omissions, a distinction which is rejected within the context of utilitarian ethics. Both ethical views then led to the conclusion that selective treatment was morally equivalent to infanticide.

I conclude then that although the utilitarian can argue persuasively that the acts and omissions doctrine should be abandoned, especially in cases where we consider failure to save life, it is much more difficult to accept this in cases where it is argued that we should kill to save life, as in Harris's example of the two men who required transplants.

It may be that the move to abandon this doctrine stems from dissatisfaction with a human-rights-based moral theory which tends to emphasise only negative duties. A stronger theory of human rights which stresses the positive duties to provide at least some of the means to life, will yield more satisfactory responses to the many cases where failure to save life appears to be morally culpable.

Utilitarian moral theory concentrates on maximising goods whereas traditionally the moral theory based on human rights emphasises not doing harm. The development of a more positive interpretation of belief in human rights will mean that in applying theory to practice there will be more agreement between utilitarians and believers in human rights.

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News and notes

Congress on ethics in medicine

Beth Israel Medical Center, New York and Ben Gurion University of the Negev are sponsoring their first joint International Congress on Ethics in Medicine. The congress will take place at Beersheva, Israel from March 10–13, 1985.

For information, please contact: Office of Medical Education, Beth Israel Medical Center, 10 Nathan D Perlman Place, New York, NY 10003: (212) 420–2849.

should have taken place.

All felt that some more structured follow-up, in which an unobtrusive and benevolent eye could be kept on the family and on Janey's safety, was desirable and should not end now, just because the police investigation had been abandoned. The paediatrician felt the family had strengths which enabled him to allow Janey to be discharged back into its care. The GP felt it came down to a balance between two judgements: was Janey assaulted and if she was how was she harmed by both the event and the subsequent investigations? It was most probable that she had indeed been assaulted, but whether her best interests had been served by either the police involvement or the ease with which all the participants accepted an alternative, innocent explanation was doubtful. That she had been harmed was beyond doubt since even if caught from her mother, the gonococcal infection might well ultimately affect her fertility. Also, the GP added, the investigation and examinations would have left their mark. Certainly Janey's interests were not served by the failure to hold a case conference.

News and notes

Research spending on disease and its treatment reaches £600 million

Expenditure on medical research has reached £600 million. According to a recent Office of Health Economics report: *Pharmaceutical Innovation: Recent Trends, Future Prospects*, more than £600 million was spent on investigating disease and potential new treatments in Britain in 1982. The report also identifies the pharmaceutical industry as the major contributor to today's record level of spending: in 1982 the industry allocated £419 million to its research and development programme.

Yet in spite of sustained increases in research funding, the OHE analysis shows that there has been no corresponding growth in the output of new medicines. Indeed the reverse has been the case. An average of only 20 new chemical entities now become available each year compared with twice that number in the early 1960s. The report notes that this trend has been a world-wide phenomenon.

The OHE argues that the primary explanation for this development is the soaring cost of transforming a laboratory chemical into a prescribable medicine. Today the average cost of developing a new medicine by a pharmaceutical company is between £50 million and £90 million over a period of 10–12 years.

The OHE emphasises, however, that despite this trend, a number of highly innovative new medicines have appeared in recent years. In the cardiovascular field – which accounts for 22 per cent (or £260 million) of the total cost of drugs prescribed by family doctors – the development of calcium antagonists and special enzyme inhibitors represent major advances in therapy for heart disease and high blood pressure. New medicines are available for treating ulcers which can avoid the need for hospital admission, now costing as much as £500 per week. Finally, without drugs such as cyclosporin, the new era of life-saving transplant surgery would not be possible.

Nevertheless, the OHE is concerned that a continuation of recent trends might deny society the therapeutic promises suggested by current research efforts. Advances, for example, in understanding the role of the body's chemical messengers – neurotransmitters and regulatory peptides – herald the possibility of new therapeutic approaches to mental disorders (such as dementia and schizophrenia) as well as more effective control of pain. And immunological research is progressively unravelling the complexities of the body's natural defence system, thereby paving the way for devising treatments for a wide range of viral, autoimmune and other disorders.

The OHE report makes it abundantly clear that such progress is urgently needed: 30 per cent of the population suffers from long-term and frequently disabling ill-health. Among people aged 65–74 years this proportion rises to 50 per cent. In many instances cardiovascular, mental and arthritic disorders are the cause of impairment.

Focusing on mortality, the report notes that one death in four (that is, approximately 130,000 fatalities each year in England and Wales) is of someone who has not celebrated his or her 65th birthday. The OHE's analysis suggests the solution to premature mortality lies principally in healthier lifestyles. Yet it is clear that new medicines could play a valuable role. In cancer, new drug combinations, better understanding of cancer cell survival strategies and the discovery of oncogenes offer the prospect of new therapeutic interventions.

In addition some of the burden of premature coronary mortality – 35 per cent of adult male deaths before 65 years stem from this cause – might yield to pharmacological measures. Scientists are beginning to understand the chemistry underpinning the balance between free and restricted blood flow.

Looking to the future, the OHE argues that government has a major role to play in facilitating the evolution of innovative new medicines. It must make available adequate funds for medical research undertaken in academic centres. It must also ensure that the regulatory and economic environment within which the pharmaceutical industry has to operate is consistent with innovation as a realistic commercial objective. The industry is the essential vehicle of new drug development and without appropriate support the predicted therapeutic breakthroughs are unlikely to be realised.

Journal of medical ethics, 1984, 2, 104–111

Thematic review of past issues

Volumes 1–10/1 (April 1975–March 1984 inclusive)

As a service to our readers we are continuing to publish annually, a compilation under thematic headings of articles which have appeared in the *Journal* since its inception in April 1975. Although we already publish at the end of each volume (December issue) an index for that volume it is felt that such a list allows new readers and researchers to see at a glance the range of topics covered so far. Our aim is to show the main themes so far covered.

Readers will also appreciate that in some cases articles could easily have been classified differently. We have classified the articles into very broad categories which cannot always do justice to every aspect of their content.

Abortion, sterilisation and contraception

1975 VOLUME 1/1
Case conference: Abortion and sterilisation
Sir Dugald Baird, Hugh MacLaren and J E Roberts
Commentary: Raymond Plant

VOLUME 1/3
Editorial: The abortion issue
Main article: Induced abortion: epidemiological aspects
Sir Dugald Baird
Main article: A new ethical approach to abortion and its implications for the euthanasia dispute
R F R Gardner

VOLUME 1/4
Editorial: Sterilisation
Focus: Child sterilisation
BBC Discussion

1976 VOLUME 2/1
Main article: Issues of public policy in the USA raised by amniocentesis
Amitai Etzioni

VOLUME 2/3
Main article: Congenital abnormalities and selective abortion
Mary J Seller

1977 VOLUME 3/2
The parliamentary scene: The Abortion (Amendment) Bill
Tony Smith

1978 VOLUME 4/1
Main article: Sterilisation: the Aberdeen experience and some broader implications
Sue Teper
Main article: Recent and possible future trends in abortion
François Lafitte

VOLUME 4/2
The parliamentary scene: Abortion and pregnancy screening
Tony Smith

1979 VOLUME 5/3
Main article: Self-ownership, abortion and infanticide
Ellen Frankel Paul and Jeffrey Paul
Commentary: Gerard J Hughes SJ

VOLUME 5/4
Report from America: The trials of Dr Waddill
Bernard Towers
The parliamentary scene: Abortion (Amendment) Bill
Tony Smith

1980 VOLUME 6/1
Main article: The Marquis de Sade and induced abortion
A D Farr
The parliamentary scene: The Abortion Bill in committee
Tony Smith

1982 VOLUME 8/4
Main article: Ethical aspects of genetic counselling
Mary J Seller

1983 VOLUME 9/3
Main article: Abortion and euthanasia of Down's syndrome children – the parents' views
Billie Shepperdson

1984 VOLUME 10/1
Main article: Depo-Provera – ethical issues in its testing and distribution
Malcolm Potts and John M Paxman

Animal rights

1983 VOLUME 9/2
Symposium 1: Vivisection, morals and medicine
R G Frey

Symposium 2: Vivisection, morals, medicine: commentary from an antivivisectionist philosopher
T L S Sprigge

Response: R G Frey

Symposium 3: Vivisection, morals, medicine: commentary from a vivisecting professor of pharmacology
Sir William Paton

Response: R G Frey

Artificial insemination

1975 VOLUME 1/1
Main article: Donor insemination
M G Kerr and Carol Rogers
Main article: Problems of selecting donors for artificial insemination
R Schoysman
Main article: Cryobanking of human sperm
Max S Frankel
Main article: AID and the Law
D J Cusine
Main article: Ethical aspects of donor insemination
G R Dunstan

VOLUME 1/2
Focus: Our future inheritance
R V Short

1977 VOLUME 3/4
Main article: Artificial insemination with the husband's semen after death
D J Cusine

1978 VOLUME 4/2
Case conference: Lesbian couples: should help extend to AID?
Roger Higgs

VOLUME 4/4
Report from America: Louise Brown – a storm in a petri dish
Bernard Towers

1983 VOLUME 9/3
Main article: The right to lesbian parenthood
Gillian Hanscombe

1983 VOLUME 9/4
Editorial: In vitro fertilisation
Symposium 1: In vitro fertilisation: the major issues
Peter Singer and Deane Wells
Symposium 2: In vitro fertilisation: the major issues: a comment
G D Mitchell
Response: Peter Singer

1984 VOLUME 10/1
Main article: Bioethics of IVF – the state of the debate
The Hon Mr Justice M D Kirby
Main article: In vitro fertilisation: the major issues
Teresa Iglesias
Main article: The moral status of the human embryo: a tradition recalled
G R Dunstan

Clinical research

1975 VOLUME 1/1
Main article: The composition and function of ethical committees
William W May

VOLUME 1/3
Main article: Some observations on informed consent in non-therapeutic research
J C Garnham

VOLUME 1/4
Main article: The inherent paradox of clinical trials in psychiatry
H Helmchen and B Muller-Oerlinghausen
Main article: The ethics of clinical trials
J K Wing

1977 VOLUME 3/1
Main article: Ethical problems of repetitive research
Report of a working party

1978 VOLUME 4/2
Main article: Testing new drugs – the human volunteer
Duncan Vere

VOLUME 4/4
Main article: Problems in deceptive medical procedures: an ethical and legal analysis of the administration of placebos
Beth Simmons

1979 VOLUME 5/1
Main article: A follow-up neurobiological study: why volunteer?
Jane S Sturges, Donald R Sweeney and David Pickar

1980 VOLUME 6/2
Editorial: Ethics, surgery and clinical research
Main article: Ethics and randomised clinical trials
Gustav Giertz
Main article: World Health Organisation biomedical research guidelines and the conduct of clinical trials
Withold Rudowski
Main article: Taboos and clinical research in West Africa
O O Ajayi

VOLUME 6/3
Main article: Biological aspects of homosexuality
Malcolm MacCulloch

1981 VOLUME 7/1
Editorial: Huntington's chorea
Main article: Ethical aspects of plans to combat Huntington's chorea
C J Brackenridge
Main article: Medical experiments on human beings
Bernard Towers

VOLUME 7/3
Main article: Ethical aspects of plans to combat Huntington's disease – a response
Michael Kottow

1982 VOLUME 8/1
Editorial: Clinical research on children

VOLUME 8/2
Editorial: Research, consent, distress and truth
Focus: The drawbacks of research ethics committees
Peter J Lewis
Commentary: D J Weatherall
Main article: Are pseudo-patient studies justified?
Martin Bulmer
Main article: We need to take a fresh look at medical research
John David Simnett
Commentary: Sir Douglas Black

1983 VOLUME 9/2
Editorial: Ethics, philosophy and clinical trials
Debate: Basic problems in controlled trials
R Burkhardt and G Kienle
Commentary: Problems in controlled trials – a critical response
D W Vere
Response: R Burkhardt and G Kienle
Reply to response: D W Vere

Main article: Attitudes to research ethical committees
Pauline Allen and W E Waters
Main article: Experimentation with human subjects: a critique of the views of Hans Jonas
Arthur Schafer
Main article: Research on human subjects: Australian ethics committees take tentative steps
L W Osborne
Main article: The practical and ethical defects of surgical randomised prospective trials
Arnold Byer
Commentary: Michael Baum
Main article: Informed consent: what does it mean?
The Hon Mr Justice M D Kirby

Death and euthanasia

1975 VOLUME 1/1
Editorial: Euthanasia
Main article: Should the patient be allowed to die?
Richard Nicholson

1976 VOLUME 2/1
Focus: The Karen Quinlan case
Ian Kennedy

VOLUME 2/4
Main article: The case for a statutory 'definition of death'
P D G Skegg

1977 VOLUME 3/1
Editorial: On dying and dying well
Focus: Diagnosis of brain death
Bryan Jennett
Focus: The definition of death
Ian Kennedy
Main article: Attitudes towards euthanasia
Carolyn Winget, Frederick T Kapp and Roselee C Yeaworth

VOLUME 3/2
Focus: On dying and dying well: extracts from the Edwin Stevens lecture
Donald Coggan
Case conference: Death my only love
Roger Higgs

VOLUME 3/3
Main article: Attitudes to death: some historical notes
Kenneth Boyd
Analysis: The right to live
D Hostler

VOLUME 3/4
Case conference: Officiously to keep alive
Roger Higgs

1978 VOLUME 4/1
Main article: Fetal survival – who decides?
Iain R McFadyen

VOLUME 4/2
Report from America: The impact of the California Natural Death Act
Bernard Towers

VOLUME 4/3
Case conference: After the first death there is no other
Roger Higgs

VOLUME 4/4
Main article: Dying while living: a critique of allowing-to-die legislation
Marc Lappé

1979 VOLUME 5/2
Main article: Deciding the care of severely malformed or dying infants
A G M Campbell and R S Duff
Main article: Learning about death
Una MacLean
Main article: The faces of death
G Popa and Ecaterina Hanganu

VOLUME 5/3
Debate: Selective non-treatment of newborns
Richard Sherlock
Response: A G M Campbell and R S Duff

VOLUME 5/4
Main article: Killing, letting die and euthanasia
Douglas N Husak

1980 VOLUME 6/2
Main article: The right to die and the chance to live
Jonathan E Rhoads
Report from America: A television triumph about death and dying
Bernard Towers

VOLUME 6/4
Editorial: Who shall die?

1981 VOLUME 7/1
Focus: On the death of a baby
Robert and Peggy Stinson
Commentary 1: R B Zachary
Commentary 2: A G M Campbell and D J Cusine
Debate: Even dying must be edited: further thoughts on Joan Robinson
Stephen Curry, Arthur Zucker and Joanne Trautmann
Response: Bernard Towers

VOLUME 7/2
Editorial: Ordinary and extraordinary means
Main article: Learning about death: a project report from the Edinburgh University Medical School
Ian E Thompson, C P Lowther, Derek Doyle, Jeremy Bird and Jane Turnbull
Debate: Extraordinary means and the sanctity of life
Helga Kuhse
Commentary: Gerard Hughes SJ
Response: Helga Kuhse
Main article: Can fluids and electrolytes be 'extraordinary' treatment?
Carson Strong

VOLUME 7/3
Editorial: Severely handicapped infants
Focus: Ethical problems in the management of some severely handicapped children
John Harris
Commentary 1: John Lorber
Commentary 2: G E M Anscombe
Commentary 3: D J Cusine
Main article: The right to life
Kenneth Boyd

1982 VOLUME 8/1
Debate: Reply to Lorber, Cusine and Anscombe
John Harris

VOLUME 8/2
Debate: Euthanasia – a physician's viewpoint
Robert G Twycross
Commentary: Nancy Ludmerer
Response: Robert G Twycross

VOLUME 8/4
Focus: Dealing with the brain-damaged old: dignity before sanctity
George S Robertson
Main article: The doctor-patient relationship and euthanasia
Gary E Jones
Report from America: Irreversible coma and withdrawal of life support: is it murder if the IV line is disconnected?
Bernard Towers

1983 VOLUME 9/1
Symposium 1: The Arthur case – a proposal for legislation
Diana and Malcolm Brahams
Symposium 2: Paternalism versus autonomy: medical opinion and ethical questions in the treatment of defective neonates
Peter Ferguson
Symposium 3: Legislation is likely to create more difficulties than it resolves
John Havard
Main article: Whole-brain death reconsidered
Alister Browne
Commentary: Whole-brain death reconsidered – physiological facts and philosophy
C Pallis
Case conference: Cutting the thread and pulling the wool: a request for euthanasia in general practice
Roger Higgs

1983 VOLUME 9/2
Report from America: Public debate on issues of life and death
Bernard Towers

1983 VOLUME 9/3
Main article: Abortion and euthanasia of Down's syndrome children – the parents' views
Billie Shepperdson
Main article: The right to be allowed to die
A G M Campbell
Main article: The hospitalisation of death: should more people die at home
Ann Bowling

Disputes in the Health Services

1976 VOLUME 2/1
Editorial: Industrial action by doctors

1977 VOLUME 3/2
Editorial: Strikes in the NHS
Main article: Strikes and the National Health Service: some legal and ethical issues
Gerald Dworkin
Commentary: Peter Zacharias
The parliamentary scene: Coming battles
Tony Smith

VOLUME 3/3
The Royal College of Nursing (RCN) code of conduct
Commentary: J D Dawson, A T Altschul, Chris Sampson and Alexander McCall Smith

1978 VOLUME 4/1
The parliamentary scene: Why doctors cause politicians trouble
Tony Smith

1979 VOLUME 5/2
Editorial: More struck against than striking
The parliamentary scene: Strikes by NHS workers
Tony Smith

VOLUME 5/4
Main article: The incentive argument for the unionisation of medical workers
Terrance C McConnell

1981 VOLUME 7/1
Main article: Consultants rule OK? the changing pattern of medical hierarchy
N F Coghill

VOLUME 7/4
The parliamentary scene: Struck off!
Tony Smith

Doctor-patient relationship

1975 VOLUME 1/1
Main article: Communication with the dying
J M Wilson
Commentary: C M Fletcher
Analysis: Determinism
R S Downie

VOLUME 1/2
Main article: Not quite what the patient ordered
Katherine Whitehorn

VOLUME 1/3
Analysis: 'Is' and 'ought'
Patrick MacGrath

VOLUME 1/4
Main article: Homosexuality and the medical profession – a behaviourist's view
John Bancroft

Analysis: Authority
C H Lesser

1976 VOLUME 2/1
Commentary on John Bancroft's article 'Homosexuality and the medical profession – a behaviourist's view'
Ruth A Schrock and Ian C Dunn
John Bancroft replies
Case conference: Limits of confidentiality
Roger Higgs

VOLUME 2/2
Main article: Interdisciplinary teamwork
M de Wachter
Main article: Some problems of confidentiality in medical computing
Barry Barber, R D Cohen, D J Kenny, J Rowson and Maureen Scholes

VOLUME 2/4
Main article: Medical practice: defendants and prisoners
Paul Bowden
Main article: Is geriatrics the answer to the problem of old age?
I P H Millard
II Brice Pitt
III David Hobman
Case conference: Retreat from death?
Roger Higgs

1977 VOLUME 3/3
Main article: False belief and the refusal of medical treatment
Ruth and Alan Faden
Case conference: Changing direction in general practice
Roger Higgs

VOLUME 3/4
Main article: Privacy, confidentiality and automated health information systems
H Vouri

1978 VOLUME 4/1
Case conference: Conflict of loyalties – Hippocratic or hypocritical
Roger Higgs

VOLUME 4/4
Case conference: Fain would I change that note
Roger Higgs

1979 VOLUME 5/1
Point of view: More blessed to receive?
Anthony R Moore

VOLUME 5/2
Main article: The nature of confidentiality
Ian E Thompson

VOLUME 5/3
Editorial: BMA Ethical Handbook
Case conference: 'There's naught but Care on ev'ry han' '
Roger Higgs

1980 VOLUME 6/1
Main article: The role of the doctor: technician or statesman?
R F Stalley

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Editorial: The transsexual dilemma
Main article: Limitations of the surgical contract
Folke Nilsson
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John Cook
Main article: The transsexual dilemma: being a transsexual
Nicholas Mason
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Joseph M Thomson

VOLUME 6/3
Main article: Homosexuality and freedom of speech
R D Catterall

VOLUME 6/4
Focus: Triage and the patient with renal failure
V Parsons and P Lock
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The parliamentary scene: Complaints and clinical judgment
Tony Smith

1981 VOLUME 7/1
Case conference: Where there's no will there's no way
Roger Higgs

VOLUME 7/3
Main article: The place of confinement – a question of statistics or ethics?
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Main article: The houseman and the dying patient
G P Adams and Marilyn Cook
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Roger Higgs

1982 VOLUME 8/1
Main article: Confidentiality: the confusion continues
D J Kenny
Main article: Changing practice on confidentiality: a cause for concern
Derek F H Pheby
Commentary 1: J M Jacob
Commentary 2: Michael Green
Main article: Selection of patients
H J J Leenen
Case conference: Truth at last – a case of obstructed death?
Roger Higgs

VOLUME 8/3
Editorial: On telling dying patients the truth
Main article: The ethics of telling the patient
Lawrence Goldie
Main article: Of gossips, eavesdroppers and peeping toms
Huw W S Francis
Case conference: Obstructed death revisited
Roger Higgs

VOLUME 8/4
Doctor/patient relationship
Main article: Changing practice on confidentiality: further points for discussion
Derek F H Pheby

1983 VOLUME 9/1
Editorial: On paternalism and autonomy
Main article: A defence of medical paternalism: maximising patients' autonomy
Mark S Komrad

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Editorial: Impaired autonomy and rejection of treatment
Symposium: Consent, competency and ECT: some critical suggestions
Richard Sherlock
Commentary 1: Consent, competency and ECT: a philosopher's comment
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1983 VOLUME 9/4
Case conference: Making up her mind: consent, pregnancy and mental handicap
Roger Higgs
Main article: Must doctors save their patients
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Comment: John A Davis

1984 VOLUME 10/1
Editorial: Medical confidentiality
Focus: Why patients should keep their records
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Main article: The use of narcotic analgesics in terminal illness
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Main article: Self-medication with mood-changing drugs
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Main article: What is barbiturate dependence and who is at risk?
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Case conference: Volunteers at risk
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Main article: 'Side' effects – a misnomer
C R B Joyce
Commentary: Andrew Herxheimer and Roger Higgs
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Editorial: Physician heal thyself
Main article: Do drug advertisements provide therapeutic information?
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Main article: Ethics and the professions
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Main article: Tacit components of medical ethics: making decisions in the clinic
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D D Clarke and D M Clarke

1978 VOLUME 4/4
Main article: A clinical model for decision-making
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Focus: Law and medical ethics
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VOLUME 5/3
Analysis: Acts and omissions
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Main article: Ethical aspects of clinical decision-making
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Main article: Professional ethics – for whose benefit?
Paul Sieghart
Words: Illegitimacy
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VOLUME 8/3
Symposium: Medical ethics: some reservations
J D Swales
Symposium: The ethics of society rather than medical ethics
Andrew Smith
Symposium: In defence of clinical bioethics
John D Arras and Thomas H Murray

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Main article: Medical ethics: who decides what?
Michael Kottow

1983 VOLUME 9/3
Report from France: Contemporary aspects of medical ethics in France
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Main article: Ethical aspects of clinical chemistry
Ezra BenGershôm

1984 VOLUME 10/1
Main article: Having a life versus being alive
Thomasine Kushner

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Case conference: The limits of informed consent
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Report from America: A long hard look at medicine
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Chuni Roy
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Hillel Steiner

1977 VOLUME 3/1
Analysis: Dignity
Elizabeth MacLaren
VOLUME 3/2
Analysis: Conscience
Eric D'Arcy
VOLUME 3/4
Main article: Human rights
Enoch Powell
Commentary: R S Downie
Main article: Gifts, exchanges and the political economy of health care
Part I – Should blood be bought and sold?
Raymond Plant

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Main article: Gifts, exchanges, and the political economy of health care
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Raymond Plant
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Focus: The 'no lose' philosophy in medicine
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Main article: Statistical lives and the principle of maximum benefit
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Carson Strong

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Editorial: Torture and philosophy
Focus: Self-help in health care
David Robinson
Main article: On the permissibility of torture
Gary E Jones
VOLUME 6/3
Editorial: Surgery for the mind
Main article: Doctors and torture: the police surgeon
Stanley H Burges
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Alfredo Jadresic
Letter from Australia: Coming of age
Anthony R Moore
VOLUME 6/4
Case conference: A solitary mister
Roger Higgs
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1981 VOLUME 7/1
Editorial: The 1980 Reith Lectures
VOLUME 7/2
Main article: The fragmented man
Margaret Blackwood
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Tony Smith
VOLUME 7/3
Words: Rights
Michael Lockwood
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William J Winslade

1982 VOLUME 8/1
Letter from Germany:
Michael Kottow
VOLUME 8/2
Main article: Nuclear power – is the health risk too great?
B E Wynne
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J M Thomson
Words: Nature and nurture
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Debate: What price excellence?
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Editorial: Risk
Main article: Risk and medical ethics
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Ilham Dilman

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Editorial: Medicine and moral philosophy
Main article: The ethics of resource allocation
The Rt Revd John Habgood
Commentary: The ethics of resource allocation
Kenneth M Boyd

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Main article: Jewish medical ethics – a brief overview
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Main article: The religious foundations of health care: a conceptual approach
Robert L Sevensky

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Main article: Nuclear weapons and medicine: some ethical dilemmas
Andrew Haines, Christopher de B White and John Gleisner
Comment: R J W Lambert

1984 VOLUME 10/1
Main article: Some ethical issues in dementia research
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1975 VOLUME 1/2
Main article: Transplantation
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Tam Dalyell MP
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Bryan Jennett
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John Mahoney
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1979 VOLUME 5/1
Main article: The donation and transplantation of kidneys: should the law be changed?
Ian Kennedy
VOLUME 5/4
Debate: Let's not opt out: kidney donation and transplantation
Robert A Sells

1980 VOLUME 6/1
Debate: Kidney transplants: a reply to Sells
Ian Kennedy

Pain

1977 VOLUME 3/2
Main article: Patients with protracted pain: a survey conducted at a London Hospital
Jennifer M Hunt, Thelma D Stollar, David W Littlejohns, Robert G Twycross, Duncan W Vere

1978 VOLUME 4/3
Editorial: Facing pain
Main article: The assessment of pain in advanced cancer
Robert G Twycross
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Mark Swerdlow
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Sheila Kitzinger
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Gilbert Lewis

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Focus: The hospital as a place of pain
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1976 VOLUME 2/3
Main article: Exorcism: a psychiatric viewpoint
W H Trethowan

VOLUME 2/4
Focus: The care of the mentally abnormal offender and the protection of the public
Henry R Rollin
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Alan Norton

1977 VOLUME 3/1
Editorial: Where are the promised secure units for the mentally ill?

1978 VOLUME 4/2
Editorial: Psychiatry, ethics and political intimidation
Declaration of Hawaii
Commentary: Clarence D D Blomquist
Main article: Political neutrality and international cooperation in medicine
H Merskey
Analysis: Mental disease
Antony Flew

VOLUME 4/3
Main article: Psychiatry as ideology in the USSR
Sidney Bloch

1980 VOLUME 6/1
Case conference: A volunteer by family choice
Roger Higgs

VOLUME 6/2
Case conference: Hallelujah, I'm a bum: a story from the post-Christian era
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VOLUME 6/3
Main article: Psychosocial aspects of homosexuality
Sidney Crown
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Larry O Gostin
Commentary: P K Bridges

1981 VOLUME 7/1
Words: Mental illness
Roger Scruton

VOLUME 7/3
Main article: 'Section 47'
J A Muir Gray

1982 VOLUME 8/1
Focus: Medical ethics and child psychiatry
Dora Black and Fiona Subotsky

VOLUME 8/4
Main article: Ethics in psychiatry: the patient's freedom and bondage
E K Ledermann

The 1980 Reith Lectures – some reactions

1981 VOLUME 7/4
Main article: Agreements and disagreements
Sir Douglas Black
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Anthony Clare
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P D Toon
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Ian Kennedy

Teaching medical ethics

1975 VOLUME 1/2
Editorial: Teaching medical ethics
Main article: Teaching medical ethics in Sweden and USA
Clarence Blomquist, Robert M Veatch and Diane Fenner

VOLUME 1/3
Main article: The teaching of medical ethics in Maastricht, The Netherlands
Paul Sporken

1976 VOLUME 2/2
Main article: The teaching of medical ethics in the Nottingham Medical School
J S P Jones and D H H Metcalfe

1977 VOLUME 3/3
Main article: Some practical results of the London Medical Group conference on iatrogenic disease
Sue Thorne and Andrew Herxheimer

VOLUME 3/4
Main article: The teaching of medical ethics at Southampton University Medical School
K J Dennis and M R P Hall

1978 VOLUME 4/1
Main article: The teaching of medical ethics: University College, Cork, Ireland
Dolores Dooley Clarke

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Main article: The teaching of medical ethics: University of Nijmegen, Netherlands
Maurice De Wachter

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Main article: The teaching of medical ethics: University of Edinburgh
Kenneth Boyd, Colin Currie, Alison Tierney and Ian E Thompson

1979 VOLUME 5/2
Main article: Teaching medical ethics in the Federal Republic of Germany
Eduard Seidler

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Main article: Teaching medical ethics: the cognitive-developmental approach
Stephen A Goldman and Jack Arbuthnot
Commentary: Raanan Gillon

1980 VOLUME 6/1
Debate: Philosophy and teaching medical ethics
Jack Arbuthnot

VOLUME 6/2
Main article: Teaching medical ethics: Ljubljana school of medicine, Yugoslavia
Janez Milcinski and Stefan Straziscar
Case conference: As the buds so the flowers: a discussion of medical education
Roger Higgs

1981 VOLUME 7/2
Focus: The wrong doctors: selection or training at fault?
Alison Munro

Main article: Students' attitudes to ethics in the medical school curriculum
Earl E Shelp, Michael L Russell and Nellie Grose
Case conference: How do we teach medical ethics?
Roger Higgs

VOLUME 7/4
Editorial: Medical ethics and medical education

1982 VOLUME 8/1
Main article: Five ethical doctrines for medical education
W T Tweel

1983 VOLUME 9/1
Focus: Teaching medical ethics as a practical subject: observations from experience
Alan G Johnson
Main article: Medical ethics education: a professor of religion investigates
David Belgum

1983 VOLUME 9/4
Focus: Can compassion be taught
Gregory E Pence

Violence

1979 VOLUME 5/3
Editorial: An end to violence?
Main article: The origins of violence
H J Eysenck
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Claire Russell and W M S Russell
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The Society for the Study of Medical Ethics is an independent, non-partisan organisation for the multidisciplinary study of medico-moral issues raised by the practice of medicine.

The Society aims to influence the quality of both professional and public discussion of medico-moral questions; to promote the study of medical ethics; to ensure a high academic standard for this developing subject; to encourage a multidisciplinary approach to discussion of the consequences of clinical practice; to stimulate research in specific problems; to remain non-partisan and independent of all interest groups and lobbies.

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In 1967 the Edinburgh Medical Group was established with similar aims, and subsequently medical groups have been formed in a majority of the British medical schools – currently Newcastle, Sheffield, Glasgow, Bristol, Birmingham, Manchester, Liverpool, Cardiff, Southampton, Aberdeen, Dundee, Cambridge, Oxford, Leicester and Leeds.

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