

Transition and Dialectic: A Farewell, A Big Thank You, Some Medical Ethics and Some Reproduction

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My first task is to say a few words of heartfelt appreciation about our outgoing EIC Leigh Rich. We have been very fortunate to have a rare individual leading the journal since 2011. Leigh is rare in many ways, but most of all she is at the same time an accomplished public health bioethicist, as well as a born writer, journalist, and editor. She has brought editorial precision, rigor, courtesy, good humour, and a genuine humanitarian optimism to the Journal. Unfortunately, academia has reclaimed her, but happily she has agreed to stay on in a consulting capacity in our editorial team. We wish Leigh every good fortune in her future life and career and also look forward to a new ongoing relationship with her, whereby the JBI can continue to benefit from her experience and knowledge.

Leigh's character is exemplified by the wonderful editorials that she has written over the last few years. I feel privileged to have been given a byline jointly with her in some of these pieces. It was a real joy to write with her. As you have seen, her pieces are grounded in everyday life, rich in literary and cultural range. With irony and wit, they have illustrated bioethical issues in

general and set the scene for the issue in question. They are executed with the academic's keen eye and a good journalist's heart. Leigh's shoes will be very hard to fill, but Bronwen Morrell our Managing Editor, and myself, will now attempt to do so.

The contents of this issue seem to have cleaved accidentally into two major themes: one centred on medical practice and normative medical ethics and the other around diverse aspects of reproduction.

Parker addresses the theoretical background decision-making in the hinterland between full capacity and the absence of it. This is an issue of international significance for disability but also as the incidence of cognitive failure as a result of dementia becomes a global health challenge (as well as a major cause of death). The article draws attention to the danger of flawed assumptions and definitions as guardianship regimes are changed by jurisdictions intent upon the transition from guardianship to assisted models of decision-making (perhaps the road to hell paved with good intentions?).

Balfé addresses the long-standing question of whether doctors should ever be involved in torture. Although the authors do not address medical participation in executions, the same issue is at stake, namely whether doctors can ever be associated with "cruel and inhuman treatment." Normative international medical ethics, peak bodies such as the World Medical Association, and Amnesty International all take an absolutist position and state that doctors should never be so involved.

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However, some doctors are not so lucky, as for example in the United States, where the profession can be under pressure to assist to for humane reasons (Sawicki 2014).

It is easy for most of us to observe this interdict but it becomes more difficult for doctors employed in military, police, and correctional service settings. The role conflict between caring and statutory employment requirements of the judicial or security systems can place colleagues in extremely difficult situations. No doubt also, for some practitioners, there will be agreement with the need for torture in extreme situations of national security, such as when the lives of citizens may be under clear and present danger. No doubt there are also doctors who approve the death penalty in certain situations. This article explores the moral tensions involved and dangers of any such participation, particularly with regard to the moral authority conferred on such practices, and the governments concerned, by the participation of medical practitioners. No person, including any prisoner, should be denied medical care, but instrumental medical participation in torture and execution should surely be the subject of global interdiction: a real categorical imperative if ever there was one? Medicine should campaign vigorously against torture, capital punishment, and all inhuman or cruel practices wherever they occur, and whatever the supposed justification.

One of the most important tenets of classical liberalism is the freedom of movement of capital and people. We see all too clearly on a day-to-day basis the tragic struggles of refugees who for both safety and economic reasons try to move from poor and troubled parts of the world to more prosperous or safer places. It was seen to be an issue of fundamental liberty to allow people opportunities to go and live in places where good opportunities are available for them. However, migration either free or forced has always been a regulated and contested issue. One small but important aspect of this freedom is the right for people with professional qualifications to seek better opportunities in other countries. Medicine has always been the subject of migration, and indeed even prosperous countries have been exporters of doctors to “new world” countries such as the United States, Canada, Australia, and New Zealand. Although heavily regulated and subject to controls, historically there has been a considerable degree of freedom for this to occur. Doctors from poorer countries, particularly from Africa and the Indian subcontinent as well as many other parts of the so-called developing world often seek postgraduate training opportunities in wealthier

countries. This then can easily lead to permanent migration requests. Historically, wealthy countries have often dealt with workforce shortages and rural staffing problems by recruiting overseas doctors, often to work in unpopular and unfashionable locations and roles. Mpofu questions the ethics of medical migration from poorer countries to the developed world. He points out that these countries cannot afford the loss of skills, especially after the costs of undergraduate training are taken into account. He makes a call for a more morally based approach by both individuals and the more prosperous countries. He pits Kant and Rawls against a more personal concept of liberty, seeing liberty and community need as being shared attributes rather than the property of the individual alone. Although Mill says that if your freedom hurts others it can be curtailed.

Samuel and co-authors employ a study of the issue of functional magnetic resonance imaging for people with brain damage, to illustrate the virtues of a sociological or anthropological way of studying ethics empirically from the “ground up” so to speak. This is contrasted with a more abstract approach to ethics from above the “ethical landscape” where issues are played out. The work really addresses a fundamental methodological tension in the study of ethical issues. It clearly shows the benefits of a more casuistic approach to ethics.

We know that treatments for male impotence have historically always been potentially lucrative regardless of biological mechanism or evidence. It is therefore perhaps no surprise that Boscolo-Berto et al find evidence of bias in the global literature on erectile dysfunction treatment, generated by financial conflict of interest. It seems that despite concerted efforts by the medical profession worldwide, it is hard to untangle and isolate financial interest.

Liao asks us to consider the possibility of intra-family gamete donation in China. The article shows the importance of bioethics as a global conversation that can explore different traditions, in this case Confucianism, to deal with issues that accommodate the intellectual and spiritual traditions of the countries concerned. In this case it is seen that the Chinese emphasis on family connection needs to be balanced against a more logical positive and scientific approach to avoid the dangers of consanguinity. Olesen shows that it is important to consider what religious scholars say about assisted reproductive issues in a multi-religious society such as Malaysia, as these opinions will carry weight in the communities concerned. These articles show the importance of analysing issues in a way that is relevant to the

societies concerned, without fear that international normative principles of scientific truth or human rights will be thereby necessarily violated. This is not to say that culture should always determine what happens, or that religion or customary practice be the sole determinates of how people are treated.

Belgian authors Raes and colleagues have undertaken a philosophically logical structured analysis of whether couples using donor insemination should be directed in counselling to inform the resultant children of their biological origins. They conclude that there are no sound arguments, nor is there a good evidence, to suggest that such an intrusion into personal liberty and into the privacy of counselling room can be justified. Nonetheless, sperm and egg donors should be made aware, regardless of jurisdiction, that there is a global trend toward allowing people to contact their biological parents on the basis of a person's right or entitlement to do so. The letter from Visser et al also draws attention to the assumptions that are made in this debate about what donor-conceived offspring need and want.

In Recent Developments, there is a case report by Michaela Okninski that deals with the challenges of courts overruling parental authority, in this case to mandate the administration of chemotherapy for a young girl with a brain tumour (CAHS v Kiszko & Anor [2016] FCWA 19). It shows that courts are likely to back evidence-based medical evidence as opposed to unproven alternative therapies and that the best interests of the child will override parental rights and autonomy.

However, from a clinical point of view it is surprising that the tumour details were not available to the court proceedings. If, for example, the histology was a diffuse pontine glioma (DIPG), which carries an appalling prognosis whatever you do, the best interests argument in favour of treatment would be weak (and the parental rejection of treatment would be a reasonable choice), whereas a medulloblastoma, ependymoma or lymphoma, tumours with a much more favourable response to treatment, might have a very different potential outcome and best interests would indeed warrant urgent treatment initiation.

Readers of the case from the field of bioethics, especially outside the United States, will be impressed by the weight given to the institutional clinical ethics committee. These are very variable and often fragile entities with a paucity of support and background policy and literature, certainly in Australia (Newson 2015). Maybe a reading of this case will impress upon health providers the benefits of establishing a viable clinical ethics framework, including clinical ethics committees, and perhaps the pitfalls of not doing so.

References

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