should be effective; multiaxial, to consider the various views by which an intervention is considered effective; and specific, to consider the subjects and the conditions in which an intervention is effective' (5). These laudable suggestions raise for me the question whether actually we can provide such a comprehensive study of outcome. Ruggeri and Tansella (5) highlight the need to consider outcome (biological, psychological and social) from everyone's perspective. But what if those perspectives differ? What if a family and GP want an elderly person with dementia to be placed in a home, whilst the specialists and social services do not (or vice versa)? What evidence will then count? Some facts will seem pertinent, no doubt; but perhaps different facts to different families or different specialists. And what is pertinent seems like an evaluation: the facts (the evidence) will not always decide the matter.

This thought, emphasizing the importance of judgments of value, can only be circumvented – it seems to me – by the claim that (at least potentially) we *can* know *all* the facts and when we do there will be no issues of value to interfere with the evidence. I think that this is why evidence based medicine seems fishy, for it holds out the promise of a perfect clinical science. The corollary is that it threatens anything which we feel is not amenable to scientific scrutiny.

Nevertheless, since all that can be scrutinized scientifically should be, this is not to take a stance against evidence based medicine. It is, however, to note that there is more to medicine than the physical. Now, to some, talk of *meta-physics* will seem Luddite. But I should have thought that the exclusion of metaphysics from medicine would ensure the death of medical ethics as a discipline concerned with (specifically) moral values.

References

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Evidence based medical ethics

SIR

As Hope discussed in his editorial (1), evidence based medicine is now fashionable. The main principle, hardly new, is that clinical decisions and procedures, for care, comfort or cure, should be based on the best available evidence, founded whenever possible on randomized clinical trials, and not applied just because they are received wisdom. Hope briefly raises an example where medical ethics might benefit from such an approach. Is keeping information about an epileptic driver from the licensing authority less or more helpful to other road users at possible risk, than breaking the principle of confidentiality without consent would be in deterring other epileptic drivers from seeking medical advice? However, he does not discuss the logical next step which is to propose a method of seeking evidence to try and clarify this particular ethical problem. A parallel problem of balancing confidentiality against possible harm to others, much discussed at present, is the desirability of unknowing consents of HIV-positive subjects being informed of the risks that they run.

I take the example of informed consent to surgery – though I prefer the term valid consent, as merely informing is often not sufficient for adequate understanding. In our current rights-based society it is now taken as axiomatic that the doctor has the responsibility to inform the patient, who as an autonomous person has the right to know and understand *all* possible benefits and hazards of the

procedure. This applies even if patients may not want the worry of knowing everything, but consider that their autonomy, value as persons, and freedom of choice are sufficiently respected by being given the basic information. But going through the *full* procedure of obtaining and checking such valid consent, with detailed explanations, takes much time and effort that could be devoted to other patients. My argument is that we have no *evidence*; this procedure does not fit with evidence based medicine; we do not know whether the consenting patient actually benefits, except philosophically. A utilitarian approach can be taken, that the benefit to the consenting patient is outweighed by the lessened opportunity of care for others.

No doubt it is a generation too late to do a controlled trial: patients who expressly wish only for basic information, or for full information and explanation, would be excluded in the same way as in a clinical trial. Randomized patients will either be subjected to the full consent procedure, or be treated as Sir Lancelot Spratt treated them when I was a student 50 years ago. 'What do you mean, you now want to know *all* about how I do the amputation and every possible hazard. You trusted me enough to come to my outpatients when I told you the choices and you agreed to surgery, so you can rely on me to do what is best for you'. 'Of course doctor, I leave it to you'. 'Seven o'clock in the morning'. One could then measure if there were any difference in mortality, morbidity, and happiness between the groups; and be able to balance this against the time and opportunity gained by not going through the full consent procedure. If this approach is Politically Incorrect – the deontology thought police and rights activists will get you (presumably in these columns) if you don't watch out – then perhaps we could work out a thought experiment as done by the cosmologists. What if ...?

Reference

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