**Reference & footnote**
1. Hume D. A treatise of human nature (1739). Mossner EC (ed). London: Pelican Classics, 1969: 514.

[a]The phrase in the article is a paraphrase of Hume, who actually says:
 'Thus upon the whole, 'tis impossible that the distinction between moral good and evil, can be made to reason; since that distinction has an influence upon our actions, of which reason alone is incapable.'

**Philosophy for medicine: applications in a clinical context**
**Martyn Evans, Pekka Louhiala and Raimo Puustinen (eds)**
Radcliffe Medical Press, 2003
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ONE of the problems that modern medicine struggles with is that the facts don't tell you what to do. The problem is undiminished and perhaps even exacerbated by the rise of evidence-based medicine (EBM). EBM has given us more facts, and better facts about the work that we do. However, as David Sackett and others have cautioned, evidence always needs to be interpreted by a clinician for a particular situation conscientiously, explicitly and judiciously. Evidence, and derivations of evidence like guidelines, are not self-interpreting. It is not unusual now, at least in our area, for GPs to have to rescue the over-90s from the dubious benefits of drugs like statins and antihypertensives started injudiciously (although with best of intentions) by junior medical staff in hospital. Drug-induced iatrogenic problems are now a major cause of morbidity and admission to hospital, especially in the elderly, yet as doctors, we seem to have a persistent belief that, as far as drugs are concerned, more is better. We need to keep remembering that the patient in front of us, as Jonathan Rees says, was not in the trial. Or, as David Hume said in 1740, you can't derive an 'ought' from an 'is'.[1a]

Yet this Journal, like all of its kind in the glorious age of biomedicine, gives great prominence to studies of what 'is' (or may be), and less attention to the subtler question of 'ought', with all the problems of subjectivity that that word entails.

If the facts don't tell us what to do, then how do we make clinical decisions? This is one of several areas addressed in this commendable book. It benefits from a wide variety of perspectives by doctors and philosophers from Wales, Finland, Korea and the US. They show how philosophy can provide useful perspectives on the clinical encounter, the definition of the medical 'problem', guilt and shame in patients and doctors, culture and medicine, aesthetics, medicine and morality, and medical traditions. All in 157 readable pages. In particular, I found John Saunders' four categories of medical uncertainty — interpersonal, knowledge-related, application (as above) and moral — very helpful. I disagree with him, however, when he implies that we need to protect our patients from uncertainty. Respect for autonomy in 2004 may mean, at times, the sacrifice of beneficence.

Paul Wainwright's fascinating chapter on the aesthetics of clinical practice offers a way into the 'ought' issue. He reminds us that the root of aesthetics is *aisthesis*, the Greek for perception. Perhaps it is only in developing our perceptual capacity as clinicians that we can establish not only an aesthetic of medicine, but also decide what we ought to do with, or for, our patients.

**John Gillies**

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**The public understanding of science**

Genotypes and phenotypes, loci and foci —
these are the things that science is made of.
Joes and Bloggs, and odds and sods —
these are the things the public is made of.

Boffins and toffs, presenters and hacks
punt to the punters their digital lines,
deleting their errors, translating results
from test tube to mouse, to the man in the house.

And it's all in the name of human advancement,
the right to convenience, the pay in the packs,
the frontiers unbounded, the oceans unsounded,
the ivory towers, the grants in their pants.

For the man in the street is just one in a crowd
and his voice, as you've heard, is increasingly loud.
And the street is the lab, and the man in your view,
and the funder, the funded, the outcome are you.

**Blair H Smith**

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