

Chapter 2

Traditional Approaches to Ethical Decision Making

2.1 What Can History Tell Us?

The 3000 page, 5 volume *Encyclopedia of Bioethics* notes that ‘bioethics as a discipline cannot expect intellectual respect, much less legitimately affect moral behaviour, unless it can show itself to be grounded in solid theory justifying its proposed values, principles, and rules’ (Post 2004). Hence, we begin with an overview of that ‘solid theory’.

The ethical and moral judgements we make are necessarily situated in an historical context. A system of morals may be codified in different ways, in different cultures, and at different times. Homosexuality is an obvious historical example. Historically, in the Western tradition, it is possible to apportion the development of moral philosophy into four epochs. In each of these, appeal was made to different ethical systems or frameworks.

In the *Classical* (or *Ancient*) period are located the societies clustered around the Mediterranean—the polytheistic Hellenistic, and, to a lesser extent, Roman traditions, especially of Plato, the ‘Sophists’, and Aristotle. This period ended between the third and sixth century, after the sack of Rome in 410 CE, the closure of Plato’s Academy in 529, and the plague which began in 542. In this era, appeal for ethical guidance was made to either the *polis* (the Greek city-state) or to one or more of their several gods.

In the *Medieval* (or *Middle*) period, classical ideas were re-cast in the light of monotheistic traditions of Augustine, Maimonides, and Aquinas. Appeal for ethical guidance was made to God (be that Islamic, Judaic or Christian). Its time span is from around the time of the fall of Old Rome in 410 CE, to around the time of the fall of New Rome—Constantinople, in 1453 CE.

In the *Modern* period, commencing sometime after the Renaissance and the Reformation, rationality, reason, impartiality, empiricism, subjectivity, secularity, humanism and individualism began to replace religious duty. Science and reason replaced religious dogma as authority (hence “the enlightenment” as a descriptive

term). A morality of ‘law, command, duty and obligation’ (McCoy 2004), came to replace the external motivations originating in the Classical and Medieval periods. It was in the modern era of rationalism that, in deciding what I should do, there developed three ethical frameworks or groups of guidelines. The origins of each can however be traced to the Classical and Medieval eras (Walker and Lovat 2016). They are the *deontological* framework, the *teleological* framework, and the *virtue ethics* framework. They are considered *substantive*—that is, they are stand-alone sets of guidelines. In brief, deontological ethics focuses on the nature of the Act, and thus its framework is largely independent of situation or context. Teleological ethics focuses on the consequences of the Act, and thus its framework is at least in part conditional upon the situation or context. Virtue ethics focuses on the character of the agent. As well, there persisted a theist framework in the Islamic-Judaeo-Christian tradition. The theist frameworks are aware of an hereafter.

Principles derived from these frameworks, and modifications proposed to them, are foundation stones which have guided ethical decision making, including in clinical situations. Specifically to guide decision making in medical ethics, four principles were distilled from deontology and teleology. These are autonomy, beneficence, non-maleficence, and justice. They are considered in Chap. 3.

To illustrate and explain the ethical frameworks of deontology, teleology, and virtue ethics, we will consider trolley cars (trams) speeding out of control.

2.2 The Ethics of Trolley Cars Speeding Out of Control

Consider a runaway trolley car (tram), which is heading towards five workers on the track ahead, all of whom will be killed if it crashes into them (Foot 1967).

Scenario A: There is a side-track upon which one worker is standing. You are beside the switch which diverts the tram to the side track, which will kill the one worker. Would you flip the switch?

Scenario B: You are on a bridge over the track which the runaway tram must pass under on its way to the five workers. Standing beside you is a large worker, who, if he was pushed off the bridge in front of the tram would himself be killed—but would stop the tram before it reached the five workers. Would you push him off the bridge?

A large number of studies suggest that, regardless of age, ethnicity, religious background, general knowledge and specific moral philosophical knowledge, in Scenario A 89% of respondents would flick the switch. Yet in Scenario B 89% of respondents would not push the large man off the bridge (Hauser et al. 2007).

For Bystander A, the decision to flick the switch so that the out-of-control tram is diverted away from the five workers on the main track, towards the one worker on the side track, arguably, means that Bystander A chooses to save the five workers, at the expense of the one worker. This is the ethical decision making framework known as utilitarianism, consequentialism, or teleology. Bystander B considers the same potential end—the death of the one but preservation of the

five—but achieved by different means. When Bystander B chooses not to push the large man onto the tracks, and so sacrifice him in order to save the five workers, this arguably means that for Bystander B, there is something intrinsically or inherently wrong in deliberately pushing the one onto the track below. This is the ethical decision making framework known as intrinsic, categorical, duty-based, or deontological.

2.3 Deontology

The name of Immanuel Kant is associated with the development of the framework of deontological ethics, which as just noted, is also known as categorical, intrinsic, duty-based. Under this framework the moral permissibility of an Action depends upon the intrinsic nature of that Action. Whether an act is morally good or not is dependent upon its concordance with a set of rules or principles, independent of its consequences. For example, torturing a terrorist who knows the location of a large explosive device under a city, is always morally wrong, no matter what the potential consequences of the bomb exploding are.

More formally, two components are important. First, we may make choices to act, only if the rule on which we base our decision to act, can be generalised so that it universally applies to all persons in all circumstances. This is known as Kant's categorical imperative. Second, we should act so that we treat persons always as an end, never merely as a means to an end. This is known as Kant's practical imperative. This means that humans should be considered as intrinsically valuable, with intrinsic dignity. Persons are unable to be compared (that is they are said to be incommensurable) in terms of their physical infirmity, their intellectual incapacity, or their contribution to society. The intrinsic value of a person precludes comparison with any other person, or indeed within oneself at different times or in different states of illness or infirmity.

Deontological frameworks make personal moral integrity paramount. Whatever the consequences, we cannot lie, despite the fact that innocents might thus be saved. In moral conflicts (for example, stealing), Kant would apply both his categorical imperative (stealing another person's property cannot be generalised) as well as his practical imperative (others should be treated as ends in themselves, not as a means to *our* ends). In clinical practice, an example could be that of a transplant physician who has tested an extended family for suitability for bone marrow transplantation for a 3 year old child's incurable leukaemia. He finds one uncle a perfect match. He is the only match. However the uncle is HIV positive after unprotected male sex, about which his wife knows nothing. The family of the child ask the physician whether he has found a match. Under the deontological framework as originally conceived, it is the clinician's duty never to lie—to always speak the truth, regardless of the situation or of the consequences of speaking the truth. Consequences here might well include marital break-up, family fragmentation, job loss and social isolation. A second example is that if some parents choose not to

immunise their children, they avoid all potential risks from immunisation of their children, but will still share the ‘herd immunity’ deriving from the vast majority of parents taking the risks of immunisation. While clearly rational for some to act this way, nonetheless, is it morally permissible? Arguably such parents are using other children (who take the risks) as a means to their own ends (protecting their own child). As a third, more troublesome example, consider the situation when a case of non-paternity in a traditional Muslim family is discovered via genetic incompatibility of the child with the father. While truth-speaking is a deontological maxim, in this situation the consequences of speaking the truth will likely include execution of the mother, abandonment of the daughter, and marriage ineligibility for the mother’s sisters (Gray 2015).

Deontological constraints are often framed in the negative, and are narrowly-framed. While you must not lie, you may withhold a truth. The crux is that you, as a morally good agent, must not do an act—not that the act must not happen. Consequences need not be considered in moral decision making under this framework. Consequences may be reasonably foreseeable, but if they are not the means or the end which the agent aims at, then no deontological constraints are breached (Davis 1993). Consider again the deontological rule “do not lie”. A murderer comes to the door and asks you whether the victim he is seeking is hiding in your house. The victim is, and under this framework, you must not lie, so you agree that the victim is hiding inside. Since harming the victim is not your chosen end, no deontological rule is breached.

At this point it is important to recognise that there exist in many ethically dilemmatic situations, a hierarchy of duties. It is entirely consistent from a deontologist’s perspective that conflicts of *prima facie* duties (that is, obligation/s that, ordinarily, must be fulfilled) exist, and should be resolved by using our best judgement to choose the actual action through which the most-good will be achieved. Stopping to assist at an accident is a higher duty than having coffee (especially if we have a skill-set useful to render medical assistance), despite promising to meet to have coffee. Another example would be the decision to over-ride the moral precept ‘thou shalt not kill’ in order to shoot a soldier who is burning to an inevitable death in unimaginable pain, but whom we cannot physically approach to give morphine to relieve that pain. It is in fact the duty of non-maleficence to which WD Ross ascribes the primary responsibility for us to follow. It is the only duty expressed in the negative, but in this form, recognition of our duty not to harm others is the basis of the secondary duty of beneficence. From this perspective, non-maleficence is more binding than beneficence. It is not good to steal from one in order to give alms to another, or to kill one in order to keep another alive (Ross 2002). Similarly, familiar to all medical clinicians, *primum non nocere*—first do no harm.

We now turn to a consideration of the question as to how, from a philosophical perspective, people may be allowed to die in Intensive Care Units. Since modern life support technologies are very effective in maintaining our physiological functions, as we have argued elsewhere (Walker and Lovat 2014) there needs to be a robust philosophical basis for decision making in relation to the discontinuation of

life-support technology. We approach this via first considering what it is to be a human person.

2.3.1 Personhood

Issues around life, moral agency, and personhood are fundamental moral philosophical predicates to decision making in clinical situations. Life can be understood at two levels. The first is biological or physiological life—characterised by beating of the heart, ventilation of the lungs, digestion, nervous activity, *inter alia*. The second is life in the sense of personhood, and what may be termed the meaningfulness of life. Jeff McMahan posits that we must thus have two corresponding understandings of death (McMahan 2003). The first is the death of the human biological organism. The second is the death, as ceasing-to-exist (here on earth at least), of the human person.

Criteria vary by which to assign personhood to a human being. Some would suggest that ‘the mere fact that a being is “human born” provides a strong reason for according it the same status as other humans’ (Scanlon 1998; Krishna and Kumar 2013), in which case physiological human life innately confers personhood. Against this is the traditional understanding of personhood that entails moral agency, autonomy, rationality and cognition, linguistic ability, and self-awareness. The traditional emphasis on what we will loosely proscribe as “rationality” is based largely on the Cartesian duality between mind and body—in the sense here, of regarding rationality (especially in the Kantian sense of autonomy) as a separable notion from that denoting a biological human being. Under these criteria, certain members of the species, *Homo sapiens*, can be denied personhood. These include anencephalics (those with absence of a major portion of the brain), infants, young children, the intellectually handicapped, those psychotic, demented and those in a persistent coma (Gert 2004; Engelhardt 1996; Fletcher 1998; O’Donovan 1998; DeGrazia 2006; Warren 1973; Hellston 2000). This approach, however, fails to recognise that even ‘our most intellectual thoughts are not independent of either our emotions or our relations to other people’ (Mathews 2012). First, we argue that our person is something which develops in the course of our life, predicated upon experiences which, even when not consciously recollected, are incorporated into our habitual bodily responses. We rely on intersubjective bonds which follow from the phenomenological understanding touched upon in Sect. 1.4, of our inter-connectedness, of being in the world of lived experience. We are embedded in a shared world—our experience of which results in our existence in a socio-cultural habitus even when we may not be explicitly aware of it. In other words, our ‘humanity which is worthy of moral respect ... is located not only in our rational capacities, but in all levels of our being as embodied human subjects’ (Mathews 2012), and thus our identities exist within the context of relationships. Second, a mature understanding of self-awareness recognises an empathic relationship with others. ‘[T]he Cartesian (and Kantian) conception of a person, as a kind of

disembodied ... thinker and decision-maker' (Mathews 2012) is a limited and partial abstraction from the whole human person. Recognition of vulnerability should be as much a focus of moral concern as our rationality. Rather than a metaphysical derivation, clinical moral decision making requires a reflective phenomenological understanding of human beings as persons, 'which, in Husserl's words, gets "back to the things themselves" as we actually experience them' (Mathews 2012). Martin Heidegger too points to an understanding of our personhood, our essence, as situated-in-the-world with others. More directly, Tom Kitwood argues that personhood is a standing or status bestowed upon human beings, by other human beings, in the context of relationships (Kitwood 1997, 2001). There is also a temporal element to personhood. Paul Ricoeur understands that we are who we are, despite the fact that thoughts, memories, and character traits change over time, because we are 'anchored in sameness by virtue of the temporal connections between past, present, and future' (Mackenzie 2001). This is a more nuanced understanding of the reality of our human condition, allowing the neurologically damaged to be treated in morally good ways by staff (acting as moral agents themselves), caring for them because these staff empathise with their shared humanity as fellow-sufferers.

Thus we need a robust philosophical underpinning for how to approach end-of-life decisions in ICU. It is insufficient to deny personhood solely because the criteria for "rationality" have been lost. Our understanding of autonomy, in a properly authentic sense, should not focus on an egotistical individualist autonomy but should include an awareness of relationships. By doing so, autonomy should be strengthened, not weakened, by the reality of our existence in a world of others. A significant part of the reality for the relatives may well be an emotional clouding as to what the best course of action is. ICU staff, who bring valuable expertise about the clinical condition and its prognosis, may be trained in dialogical methods, and when they recognise the fragility of the critically-ill patient, as well as the wider community of others, are then well-positioned to offer guidance. Thus, we contend, based upon these relational conceptions of personhood and autonomy, that the moral decisions to be made, as the end-of-life approaches, are set in the context of this particular individual patient, considering their lived socio-cultural experience and the relationships they have, as well as the underlying clinical problem and stage of its natural history.

2.3.2 *Death in Intensive Care*

Traditionally, three constructs may be considered in making moral decisions at the end-of-life. These are the Principle of Double Effect, the Principle of Doing versus Allowing, and the Principle of Ordinary Care versus Extra-Ordinary Care.

The first principle, Double Effect, is derived from Aquinas' *Summa Theologica*. 'Nothing hinders one act from having two effects, only one of which is intended, while the other is beside the intention. Now moral acts take their species according

to what is intended, and not according to what is beside the intention' (Aquinas 1947). As a principle for moral decision making, double effect is applicable when a single action can have two (or more) outcomes—one (or more) good and one (or more) harmful. Examples include harming an attacker in self-defence, and wartime dropping of bombs on military targets with foreseeable but unintended civilian casualties. A commonly cited clinical example is minimizing suffering by giving opiate pain relief, which foreseeably depresses spontaneous ventilation and so shortens life (a scenario however for which of course the therapeutic margin in palliative care is actually not so narrow). The primary outcome aimed at is to relieve suffering. The secondary outcome is ventilatory depression. Now recall the trolley-car dilemma above. Some respondents to this problem call upon the principle of double effect. That is, they say that their primary intention is to divert the trolley away from the five; with the secondary unintended (albeit foreseeable) outcome being the death of the one. Consider for a moment that the Principle of Double Effect is active in the minds of both Bystanders A and B. Bystander A flips the switch, the train is diverted towards the one on the track so the five are saved, but then the one hears the train and steps off the track. The five are still saved. Whereas, if Bystander B pushes the large man and he survives the fall and jumps to safety, the train is not stopped by his body, and the five are lost. Even though both Bystanders A and B might both base their decisions on double effect, for Bystander A the one might escape after the five are saved; whereas, for Bystander B, the one must die in order to save the five—this death is, in fact, necessary, and so (arguably) is intended. Those who base their ethical decision making on the consequences which follow the Action (who are termed teleologists, and are discussed in the next section) would generally reject the notion that if two acts have the same actual or foreseeable outcome, they can vary in their moral permissibility. They therefore have difficulty with the principle of double effect.

The second principle has become known as Doing versus Allowing (Quinn 1989). As a basis for ethical decision making, it distinguishes between acting and not-acting. This distinction applies to, for example, killing someone by actively holding their head under water, versus failing to rescue a person who is drowning. A clinical example is active euthanasia by lethal injection, versus passive euthanasia by switching off life-support technology or by withholding antibiotics for pneumonia. In the context of euthanasia, James Rachels argues that once the decision to not prolong life and to avoid suffering has been made, there is no ethically significant difference between active euthanasia and passive euthanasia. Put another way, he sees no practical difference, ethically, between killing and letting die. Rather, the moral difference hinges on motive and intent.

Traditionally, the third principle is 'Ordinary' means versus 'Extra-ordinary' means. This can be summarised as: ordinary means are proportionate means, while extraordinary means are disproportionate means. This principle looks to the benefits which might accrue to the individual patient for whom it is being considered, compared with the difficulties and risks. This approach has been refined as 'Benefit versus Burden analysis'. It considers the potential benefits of a proposed treatment plan, and compares those with the potential burdens of the proposed treatment plan.

It adopts a teleological approach in that it determines utility and disutility, and then derives net utility. To be useful in guiding decisions as to whether treatments should be commenced or withheld, it should be contextualised to the individual patient's situation. Instituting potentially life-maintaining interventions in, for example, severely syndromal neonates (including mechanical ventilation or Extra Corporeal Membrane Oxygenation), may well place an unreasonable burden of discomfort on the neonate, and a burden of prolonged suffering on the family, not outweighed by the benefits likely to flow from that intervention in terms of the quality of life which the child might achieve. Inevitably, it involves both the clinician and the patient making their best estimation of the likely benefits and burdens attached to the proposed treatment. The balancing of benefits versus burdens can only be meaningfully approached by having a dialogue amongst those on whom the decision impacts—namely, the patient and their family, and also the clinicians who will be advising what the treatment options, and what the risks and benefits, are likely to be.

In approaching end-of-life decision making, we favour benefit versus burden analysis. This is because, not only is it necessary to anchor the end-of-life decision making in the unique context of the individual patient, but also because this framework looks to the Good which may accrue to the patient and their family in their actual situation. The aim is to maximise the patient's good as a priority, allowing for the actual real clinical situation they are in, and not in isolation from others who are in relationship with this patient.

2.4 Teleology

The names of Jeremy Bentham and John Stuart Mill are associated with the development of the framework of teleological ethics. Under this framework the moral permissibility of an Action is determined by its outcome. Consequentialists are concerned with making moral decisions based upon the outcome or potential outcome which follows the Act. Whether an Act is morally good or not depends upon whether it brings about the best consequences, independent of the reasons for acting. For example, torturing a terrorist may be morally right, depending upon the result. In a medical example, consider the situation where there is only one dialysis machine available in a hospital. Six patients need renal dialysis to stay alive—five patients need it daily but briefly but the sixth requires it for a whole day, precluding the use of the machine by the five. Under a teleological framework, the five are chosen for dialysis over the one—who does not receive dialysis.

Utilitarians focus upon the greatest good for the greatest number, so do not specifically consider distinctions among individuals. This framework requires summation of the degrees of tendency to goodness for each individual, in regard to whom there is goodness for the whole, then offsetting this by the summation of the tendency to badness for the whole, and then taking the resultant balance as the tendency to goodness of the act for the community as a whole. Focusing upon the

nett balance of utility relieves them of the need to concern themselves with individual allocations of good (or bad) things. Specifically, the greater gains of some can compensate for the lesser gains of others.

Returning to the runaway tram once more, there has now been a tram accident.

In Accident 1, the result is that 4 patients are moderately injured but will likely live with sufficient resuscitation; while 1 is severely injured and will likely take most of the resuscitative team's resources, with an uncertain outcome even then.

In Accident 2, 4 workers are severely injured needing transplants to survive, and 1 healthy patient is in the Outpatients Department next door, for a routine check-up.

Following Accident 1, the patients are triaged into categories of urgency for medical intervention. From its origin in military mass casualty situations, the principles of triage have been adopted for the medical management of disasters and emergency medicine. Although Kant (and others of course) have argued that humans should be seen, always as ends in themselves, and intrinsically valuable regardless of functional ability, principles of triage are inherently utilitarian, directing limited resources to salvage the greatest number of casualties. Triage in the civilian setting aims to separate those with a potential to be saved by immediate treatment, and prioritises these over others who do not appear as likely to be able to be saved whatever treatment is offered, and over those with lesser injuries. However, an exception is usually made for injured emergency staff who will be able to return to saving others—and so they will generally also be prioritised over non-medical personnel. Similarly, they may be given priority immunisations in a pan endemic in order to allow them to stay at work and continue to immunise others. Triage of the wounded in military situations however allows for, indeed encourages (Beebe and DeBakey 1952), prioritisation so that less-wounded soldiers may be treated first in order to get them back into their defensive positions, so as to prevent the perimeter being over-run. Military capability is seen as a greater good than individual patient care. Using these principles, in North Africa during World War II a decision was made to allocate scarce penicillin injections to those infected with gonorrhoea, rather than to those infected after war injuries, because those treated for gonorrhoea would return to battle much more quickly (Beecher 1969). Following Accident 1, it is likely that resuscitation will be offered to the four moderately injured patients, at the expense of the one severely injured patient. However, extending the principles of military triage to prioritise allocation of intensive care beds to those most quickly able to return to contributing to society, is not likely to be considered appropriate by most clinicians.

Following Accident 2, although the teleological framework allows harvesting 4 organs from the well patient in for a check-up, in order to benefit the 4 severely injured patients who need them, in clinical practice this is also unlikely to be acceptable. That is, there are clearly some things which, intrinsically, should not be done, even for the greater good. That is, the “greatest good for the greatest number” and the “ends-justify-the-means” ethics need to be evaluated with care. Minority groups may well be disadvantaged as the nett utility calculation benefits the numerically larger group. In another clinical example, consider the allocation of limited health care resources in the provision of acute care (for example, to treat

children with poliomyelitis) versus preventative care (immunisation of infants against poliomyelitis). The greater long term net gain will likely accrue from immunisation, but, according to the strictly adhered to principles of teleological ethics, those individuals needing acute care, must be refused that acute treatment in order to achieve the greatest good for the greatest number.

Consider also, a former Olympic skier who, because of financial hardships, has been unable to ski for several years. She is seven months pregnant when she and her husband win an all-expenses-paid holiday to go skiing for three months. She wants an abortion so she can have that ski holiday. These two outcomes cannot easily be compared. The outcome for the mother, following from the abortion, is that she can have a holiday. The outcome for the foetus is death. Thus, a hierarchical ranking of consequences (including present consequences versus future consequences) is just as important as a hierarchy of duties.

2.5 Virtue Ethics

Virtue ethics is concerned with making moral decisions in the Aristotelian sense of according with virtue, rather than according to rules or consequences. Under a virtue ethics framework, the development of personal moral virtue allows for morally Good decisions to be made. It could be said that this is an emphasis on *being* morally Good rather than on the specifics of *doing* Good.

Set against the adversarial background of debate between teleological ethics and deontological ethics throughout the eighteenth, nineteenth, and early twentieth centuries, virtue ethics has had resurgence in the latter half of the twentieth century. As currently iterated, most virtue ethical frameworks are neo-Aristotelian in spirit. Aristotle spoke to the virtuous mean between excessiveness and insufficiency. For example, consider courage. Too little is cowardice. Too much is recklessness. Consider 'pleasantness'. A deficiency in a person's state of character with regard to pleasantness leads to quarrelsome, surly, or unpleasant behaviour. An excess is obsequiousness, or flattery. A mean state of character is friendly or pleasant. Similarly, dignity lies between servility and selfishness; and so on. Virtue is the mean between these two extremes.

A virtuous person seeks preferentially after intrinsic goodness (beneficence, generosity, honesty, courage) rather than instrumental goodness (fame, money, power). This is combined with sensitivity as to when and where a moral issue exists and an inherent motivation to act in a virtuous manner. While there can be erudite discussion about what is virtue, what are the virtues, and how we might aspire to be virtuous, we suggest that the essence is that 'good character guides right action: the ethical aim is to form oneself as a good person, and a well-formed person both knows how to act rightly and will habitually choose to do so' (Balousek 2014). Under a virtue ethics framework, moral decisions are made by well-informed, habitually good people who consider the individual situation, allow for their earlier

experiences and knowledge, and make the morally best decision they can in that situation, learning from it for future situations, for intrinsically good reasons.

Darrin Balousek argues that a virtue ethics framework, in the context of guiding decisions about whether to allow performance-enhancing drugs in professional sport, would have us ask two questions (Balousek 2014). The first is whether a decision in favour or against would foster habits which are formative of good character in the athletes, the team owners, and the fans of the game, and which thus enhance *eudaimonia*—the Greek notion of *flourishing*. The second is whether the decision for or against promotes excellence in that sporting activity (which Balousek ascribes to excellence in performance, rather than to winning per se), and which thus promotes the intrinsic good of that activity.

Edmund Pellegrino restates the Aristotelian definition of Virtue in the setting of the physician *qua* (as being) physician, striving to maximise the Good of the patient via a right and good healing action or decision. He argues that the good of the patient has been the foundation of morality in clinical medicine since antiquity (Pellegrino 1985). It is the ultimate arbiter in clinical decisions from a moral perspective. He proposes a hierarchy of four Goods of the patient. The highest Good is the *summum bonum*. The least Good in the hierarchy is the biomedical or techno-medical Good. This is an instrumental good which follows from the correct diagnosis, the correct drug in the correct dose or the correct operation, all in a technical sense. Next in the hierarchy is the perceptual Good of the patient, how she understands the clinical situation and treatment options, and how she wants to proceed. While competent, only the patient can judge what is most perceptually good amongst treatment options. For example, one of the risks of radical prostatectomy for prostatic cancer is incontinence and erectile dysfunction. Although the statistical risks of progression of the cancer can be imparted, ‘the precise meaning of the cancer in [his] life will be unique to him’ (Cowley 2012). Next is the Good of the patient as a human person, which Pellegrino founds upon autonomy. If not competent to choose, then another acts as a surrogate.

Each participant in the decision-making process in a clinical dilemma is trying to make a decision for the Good of the patient, while allowing that the participants will have different understandings of the patient’s Good. This is similar to seeking the patient’s “best interests”. “Best interests” may be in common usage by clinicians, but this book argues that this term is both vague, and somewhat simplistic. It should be more rigorously restated in terms of the *Good* of the patient, allowing recourse to the four Goods proposed by Pellegrino.

In postulating a model for ‘the right moral attitude’ in clinicians, Petra Gelhaus has looked at (the capacity for) empathy (Gelhaus 2011a), compassion (the adequate professional inner attitude) (Gelhaus 2011b), and care (the active *praxis* of clinical medicine) (Gelhaus 2012). Thus she proposes what she terms the normative image of a good physician. This book argues that both empathy and compassion require three things from the clinician. These are: first, an awareness of others; second, an awareness of their suffering when they become patients; and third, recognition of the inherent vulnerability of patients *qua* patients. This awareness may be located in the metaphysical space, and underlines once again the insights

into moral decision making in clinical situations, which phenomenology offers. Phenomenology places the patient in their actual reality, as the starting point for their care.

This approach is also of relevance to clinical decision making as it applies to the care of children. Virtuous parents have a moral authority to make decisions for their children. This may be either as proxy decision-makers for their child (“which school would my child like to attend?”), or as autonomous decision-makers about parenting itself (“which school will the parent decide to send their child, considering cost, belief system, etc.”). In this understanding, parents have a right to raise their children in accord with their own values. For example, parents are able to over-ride their child’s best interests by enforcing their parental value of “share your toys with your siblings”, and in so-doing, seek the best interest of the whole family. In clinical situations where there is disagreement between clinicians and parents when, for example, parents choose not to allow blood transfusions or chemotherapy for their child, a more practical tool is required. Lynn Gillam draws upon the harm principle and proposes that while parents have an obligation to maximise the well-being of their children, they have an absolute obligation not to cause significant harm. She uses the term “Zone of Parental Discretion” to describe an ethically-protected range for decisions which, while they may not be the very best for their child, do not cause significant harm (Gillam 2014). It may be possible to grade parental decisions in clinical situations as optimal, sub-optimal but reasonable, and harmful. Decisions in this last group may be over-ruled. Parents are able to exercise their parental autonomy only up to a point, the point of significant harm.

Finally, although attractive, especially in medicine, we suggest that in actual clinical situations, no virtue ethicist could be expected to know what constitutes the multiple goods to be enhanced, without a dialogue amongst those affected.

2.6 Islamic-Judaean-Christian Influences

The question we pose here is whether the monotheistic Faiths of the Islamic, Judaean and Christian God constitute a substantive moral framework comparable to the secular normative ethical frameworks of deontology, teleology, and virtue ethics; or whether their importance is recognised solely in terms of their influence on the secular normative ethical frameworks. While historically a substantive moral code, which reached its zenith in the medieval era, arguably the Islamic-Judaean-Christian tradition is no longer a moral framework with normative force. Although no-one would be likely to suggest that these monotheistic Faiths have a monopoly on Good and Goodness, there has been a substantial body of work published which addresses the questions of why and how to make moral decisions from this perspective. Warnock posits that ‘though ... moral philosophy ... has been secularised, it is almost impossible to think about the origins and development of morality itself without thinking about its interconnections with religion’ (Warnock 2004).

Each of the traditions of Judaism, Islam and Christianity begin with revelations originating from a divine source and recorded as sacred texts in the first five books of the Bible—the *Pentateuch*, and in the *Qur'an* and the New Testament. To the Hebrew *Tanakh*, is added the *Qur'an* by Muslims, and the New Testament by Christians. Equality before God is a tenet of all three traditions. Each tradition then allows, indeed fosters, interpretation of the divine scriptures in the practical moral decision making of humans by the respective community of the faithful. Each tradition is characterised by an ethical impact and, in turn, practical action, as the keystone of their faith, be it the practice of the Ten Commandments, Jesus' commandment to love God and neighbour as oneself, or the Five Pillars of Islam. For example, the Bible contributes to foci within Christian Ethics (or Moral Theology) concerned with two basic issues—'how to act from the right motive and how to find what is the right action in particular circumstances' (Preston 1993). Philip Hallie recognised two kinds of ethical rules spread through the Bible—negative rules and positive rules. The chief negative rules were those Moses brought down from Mt Sinai—'Thou shalt not make for yourself an idol ... You shall not murder, Neither shall you commit adultery, Neither shall you steal, Neither shall you bear false witness ..., Neither shall you covet your neighbour's wife ... house, or field' (Deuteronomy 5:8–21). The positive rules include 'learn to do good; seek justice, rescue the oppressed, defend the orphan, plead for the widow' (Isaiah 1:17) and in the Gnostic Gospel of Truth 'Steady the feet of those who stumble and extend your hands to the sick. Feed the hungry and give rest to the weary' (Gospel of Truth 33:1–2) (Valentinus 2007). The negative ethic forbids certain actions; the positive ethic requires certain actions. 'To follow the negative ethic is to be decent, to have clean hands. But to follow the positive ethic, to be one's brother's keeper, is to be more than decent—it is to be active, even aggressive. If the negative ethic is one of decency, the positive one is the ethic of riskful, strenuous nobility' (Hallie 1981).

The Golden Rule of Jesus is 'do unto others as you would have them do unto you' (Mathew 7:12, Luke 6:31). It has a similar existence in most moral traditions. It is aligned with universalizability, and hence in concordance with moral justice; furthermore, it implies reciprocity. One might possess a relatively unsophisticated understanding of ethical principles, yet intuitively apply these understandings successfully to oneself, at least as a sufficient starting point for them to become the basis of an ethical code which one then can apply impartially to others. It is an ethical code which explicitly requires empathically walking in the shoes of the other. It is included in *The Fellowship Pledge* of the American College of Surgeons in the words 'I promise to deal with each patient as I would wish to be dealt with if I were in the patient's position' (American College of Surgeons 2008).

Amongst the three cardinal virtues (1 Corinthians 13:13) *compassion* is most intimate to the Christian Ethic. In John's Gospel the concentration is upon a sophisticated *agape* or 'love' in the sense of unconditional love from God to Man, and amongst men, love of neighbour as oneself. As a motivation, *agape* does not give detailed content to ethical decision making (Preston 1993). Rulings were not given by Jesus in a wide variety of different situations which were ethically dilemmatic. The ultimate test for concordance with a Christian Ethic is whether it

accords with love of God and love of neighbour. What then is the practical mechanism by which a modern-day Christian might seek to make morally correct decisions? Dietrich Bonhoeffer has an understanding of the essence of the Christian Gospel message and the essential charter of Christianity as ‘a deeply personal commitment to strive for the good of others’ and to conform ‘one’s life to serving the betterment of the human race’ (Lovat 2012).

In certain clinical situations, for the parents who follow in the Islamic-Judeo-Christian tradition, this framework is very apposite. Consider end-of-life decisions centred on a child with a progressive neurological condition which will ultimately result in death. This child faces the alternative of being placed on a ventilator for several decades and then dying, or being allowed to die immediately. The choice for the parents could be seen as one between being in a better place (heaven) immediately, or prolonged lingering here on earth.

2.7 Summary

We have argued in this chapter that the frameworks we have traditionally appealed to as ethical guides—deontology, teleology, and virtue ethics, have significant shortcomings. Given the multicultural and multi-faith characteristic of our times, these approaches have limitations as substantive frameworks, especially in clinical situations. We propose that moral decision making in clinical contexts should look beyond the established frameworks towards a different approach, identified in the next chapter as Proportionism. The proportionist approach seeks the highest good based upon a virtuous mean or balance-point between a priori rules and an empirical “greatest good for the greatest number” utilitarian approach. Practical application to moral decision making in clinical situations is based upon a process of inclusive, non-coercive and self-reflective dialogue within the community affected. This in turn is founded upon Habermas’ communicative action incorporating his discourse theory of morality, aimed at reaching an unforced consensus, predicated upon language aimed at establishing an ideal speech situation.

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