

# Preface

Moral decision making in clinical settings, especially around life and death decisions, has never been easy. In our current context, we see life-prolonging technological advancements racing ahead of our reflection on when to employ those advancements. Hence, decision making which aims to truly maximise the good of the patient has become ever more complex. At the same time, societies themselves have become more complex, with the largely homogenous societies of the past giving way to increasingly multicultural, multifaith ones. Hence, the relatively predictable set of values that once might have defined the stakeholders involved in difficult moral decision making has been replaced by value pluralism. As a result, the lines of Western philosophical thought that have determined such decision making in the past need to be reappraised and recalibrated to take account of this new situation. These lines of thought have resulted in the *substantive* (that is, stand-alone) ethical frameworks of deontology (also known as categorical or intrinsic), teleology (consequentialism, utilitarianism), and virtue ethics. Traditionally, one or other or a combination of these three frameworks has guided ethical decision making in the Western clinical setting.

Deontology argues that some things must not be done. For example, any act that could be described as killing is impermissible because of the intrinsic nature of the act of killing. Teleology argues that what is permissibly done depends upon the consequences of the action. For example, killing might be permissible if it can be shown to be of greater benefit (in terms, for example, of relieving suffering) than not killing. Virtue ethics focus on the character of the person who is doing the act, rather than the act itself; in the clinical setting, moral decision making turns on maximising the good of the patient through empathic, compassionate caring.

Four principles distilled from these frameworks—autonomy, non-maleficence, beneficence and justice—have historically guided ethical decision making in clinical settings. In the context of value pluralism, however, recourse to these frameworks alone has potential to overlook the essential inter-connectedness within the community, which is necessary for moral decision making. Regardless of how one's own ethical values, conceptions of the good or life-choices might be reached, how do they differ from those of others, especially the stakeholders to any life and

death decision? Herein, we propose a *proportionist* approach as a way of balancing out the wisdom to be found in the substantive frameworks and principles above with the realities of the new context of advanced technological potential and value pluralism.

In order to put into practice an approach of proportionate balancing of rules and consequences, a moral decision-making *process* should be followed. This process involves having a conversation, a dialogue or a discourse, with collaboration, amongst all the stakeholders. The aim of the dialogue is to reach consensus in the decision, via mutual understanding of the values held by the patient and the patient's family and others whom they see as significant, set against the concrete reality of the situation at hand. From a virtue ethics' perspective, this process seeks to maximise the various Goods of the patient so as to actualise optimal care for the patient. This process of *dialogic consensus* is inspired in part from the writings of Jürgen Habermas, a continental philosopher, political scientist and sociologist. His concepts of discourse theory of morality and principles of communicative action together underpin a moral decision-making process of inclusive, non-coercive and reflective dialogue.

The central argument of this book is that in our contemporary era, characterised medically by an ever-increasing armamentarium of life-sustaining technology, an active process of moral decision making in clinical situations, rather than mere monological contemplation on the part of a clinician, is required. Reaching unforced consensus amongst the stakeholders of clinician, patient, family and relevant others renders the decision with what is known in moral philosophy as normative force. Normative force means that the decision has a sense of *oughtness* or *shouldness* associated with it. Additionally, if this process of non-coercive dialogic consensus is understood and reflected upon, the patient, family and others are less likely to have lingering doubts about whether the normatively right decision is being made.

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