# An examination of moral decision-making in Medicine, informed by a Habermasian paradigmatic approach: implications for medical education

Paul Jerome Walker

MBBS FRACS FACS

Submitted for the degree of Doctor of Philosophy,

Faculty of Education and Arts,

University of Newcastle

July 2015

This thesis contains no material which has been accepted for the award of any other degree or diploma in any university or other tertiary institution and, to the best of my knowledge and belief, contains no material previously published or written by another person, except where due reference has been made in the text. I give consent to the final version of my thesis being made available worldwide when deposited in the university's Digital Repository, subject to the provisions of the Copyright Act 1968.

Paul Walker

…….

**ACKNOWLEDGEMENTS**

Preparing a thesis by research, prompts reflection upon the sources from which the intellectual journey of one's life arise. Clearly parents, school, and university, have an influence. However, as an on-going stimulus, crucially significant contributions and insights come from our life-partner, as well as the prompting of our children as they themselves reflect upon their values.

As mentors on this journey, I record profound thanks to my supervisors, Professor Emeritus Terry Lovat, and Professor Ron Laura.

Terry, it was your address at my wife's graduation ceremony to receive her BSocSci which unexpectedly focused my thoughts on medical science and its relationship with the humanities. You have been an utterly indefatigable, unerring guide through the process which ultimately becomes a Doctor of Philosophy thesis, as well as a confidently insightful wordsmith in our several papers together. What follows is a reflection of your unwavering belief that I could do this. It has been a wonderful, perspective-changing, experience. You are an outstanding supervisor, in every possible way. I will always be grateful to you.

Ron, thank you for welcoming me into your Community of Enquiry. Your commitment is extraordinary. It was here that I learnt about empathic connectivity leading to participatory consciousness. This resonates for me, and has been a perspective-changing experience. I feel privileged to have met wonderfully thought-provoking colleagues in that Community, who share the burden of the PhD journey in a way which is difficult to put into words, set on a background of fabulous meals together.

I also thank my colleagues in otolaryngology who graciously and generously encouraged me in terms of taking time off from my clinical load. Nor must I forget the Riverwood group who discussed, with such animation, the various philosophical frameworks and problems we explored; and James, the great conversationalist.

However, it is to my wife Krysia, and our children Tom, and Ally, that I owe the greatest thanks for their stimulating discussions, their insights, their questions and their helpful comments; but far more so, for their forbearance, patience, and understanding, as I travelled this road.

**TABLE OF CONTENTS**

ACKNOWLEDGEMENTS ..... 3

TABLE OF CONTENTS ..... 4

ABSTRACT ..... 7

CHAPTER 1 INTRODUCTION ..... 8

1.1 The purview of moral philosophy ..... 8

1.2 *Ethics* or *morals*? ..... 9

1.3 Decision-making in ethical conflicts ..... 12

1.4 Medical morality ..... 15

1.5 Thesis outline ..... 18

CHAPTER 2 FOUNDATIONS OF ETHICAL AND MORAL DECISION-MAKING ..... 24

2.1 Introduction ..... 24

2.2 Epistemology, truth and language ..... 24

2.3 Historical contexts ..... 34

2.4 Summary ..... 40

CHAPTER 3 SUBSTANTIVE NORMATIVE ETHICAL FRAMEWORKS ..... 41

3.1 Introduction ..... 41

3.2 Normative ethical frameworks ..... 41

3.3 Deontological frameworks ..... 46

3.3.1 Deontology as originally formulated - Kant ..... 46

3.3.2 Contemporary deontology ..... 49

3.4 Teleological frameworks ..... 70

3.4.1 Teleology as originally formulated – Bentham and Mill's Utilitarianism ..... 70

3.4.2 Contemporary Teleology ..... 72

3.5 Virtue ethics ..... 86

3.5.1 Virtue ethics as originally formulated - Aristotle ..... 86

3.5.2 Contemporary virtue ethics ..... 89

3.6 Islamic-Judaeo-Christian influences ..... 104

3.6 Summary ..... 113

CHAPTER 4 PRINCIPLISM AND THE DYNAMICS OF THE DOCTOR-PATIENT RELATIONSHIP ..... 114

4.1 Introduction ..... 114

4.2 Four principles relevant to medical ethics ..... 114

4.2.1 Autonomy ..... 115

4.2.2 Non-maleficence, Beneficence, Justice ..... 122

4.2.3 The four principles in practice ..... 124

4.3 The dynamics of the doctor-patient relationship ..... 128

4.3.1 Traditional models ..... 128

4.3.2 The shared decision-making continuum ..... 132

4.4 Summary ..... 133

CHAPTER 5 THE PROPORTIONIST APPROACH ..... 134

5.1 Introduction ..... 134

5.2 Development of the Proportionist approach ..... 136

5.3 Summary ..... 141

CHAPTER 6 HABERMAS' DISCOURSE THEORY OF MORALITY AND COMMUNICATIVE ACTION ..... 142

6.1 Introduction ..... 142

6.2 Discourse theory of morality ..... 143

6.3 Communicative action ..... 146

6.4 Summary ..... 154

CHAPTER 7 APPLICATION OF THE HABERMASIAN PARADIGM IN CLINICAL PRACTICE ..... 156

7.1 Introduction ..... 156

7.2 A clinical example employing the Proportionist approach, discourse theory of morality and communicative action ..... 156

7.3 Practical difficulties with the Habermasian paradigm in clinical practice ..... 160

7.4 Confounding factors in moral decision-making in medicine ..... 175

7.4.1 Philosophical aspects of personhood ..... 175

7.4.2 The 'rule of rescue' and insights from neurobiological studies ..... 181

7.5 Summary ..... 186

CHAPTER 8 PRAXIS ..... 187

8.1 Introduction ..... 187

8.2 Rationale for practical action ..... 187

8.3 Theoretical implications for medical education ..... 190

8.4 Practical implications for medical education ..... 201

8.5 Summary ..... 206

CHAPTER 9 CONCLUSIONS ..... 207

REFERENCES ..... 213

**ABSTRACT**

This thesis explores how individual medical practitioners might make morally good decisions in clinical practice. It is predicated on the understanding that clinical encounters between clinicians and patients should be seen primarily as inter-relations among persons and, as such, are necessarily moral encounters. The thesis proposes therefore that moral decision-making in clinical practice needs to be based more consciously in an inter-relational framework, referred to within as intersubjectivity. The epistemological paradigm of Jürgen Habermas is proposed and justified as offering suitable theoretical grounding for such an approach to moral decision-making in clinical practice. This paradigm consists of Habermas' "ways" of knowing theory, his discourse theory of morality and his principles of communicative action, emanating in the kind of intersubjectivity that can be described as 'consensus-seeking'. It is argued that the relevance of such a consensus-seeking approach is especially apparent in an era in which there is greater cognizance of a plurality of values than has been the case in earlier eras. In addition, such an approach has potential to embed clinical decision-making in the concrete realities of the illness at hand, including the nature of the disease itself and its prognosis, as well as contingent circumstances and cultural values.

Thus, this thesis argues that moral decision-making in clinical situations should look beyond established normative ethical frameworks towards an approach more aligned to Habermasian principles. A Habermasian-inspired approach, framed in this thesis as Proportionism, is built around the need to balance intrinsic, *a priori* rules with the pragmatics of considering empirical consequences.

Given that our contemporary era is characterised by pronounced value pluralism, it will be argued that the Proportionist approach can be applied to moral decision-making in clinical settings through an inclusive, non-coercive and self-reflective dialogue within the community affected. This is effectively the *praxis* (practical action) that results from the Habermasian paradigm in clinical settings, wherein the clinician aims to maximise the good(s) of the patient. The aim is to reach an unforced consensual decision among the participants, consistent with Habermas' discourse theory of morality and principles of communicative action.

Finally, application is made of the Habermasian paradigm to the pedagogy of medical education. Thus, an emancipatory change is proposed for medical education, one which is designed to instil in student doctors the need to minimize power differentials between them and their patients in order to ensure optimal empowered dialogue, with all stakeholders, around moral decision-making.

## CHAPTER 1 INTRODUCTION

### 1.1 The purview of moral philosophy

Amongst the several branches of philosophy, moral philosophy is especially important. Certain customs or behaviours are recognised as Good and others as Bad. These normative behaviour customs collectively comprise morality.[1] Morality is arguably the summation of our value system as human beings, and is 'what all impartial rational persons would choose as a public system that applies to all rational persons'.[2] In a holistic understanding, morality concerns *all* that which is significant, or which matters, with no distinctions between moral and other practical considerations.

The aim of moral philosophy has been given as 'to find a way of thinking better ... about moral questions',[3] 'the systematic study of reasoning about how we ought to act',[4] 'the teaching of freedom and critical reasoning',[5] and 'the general enquiry into what is good'.[6] The purview of enquiry is informed by the question "how should I act?"; but should also look to 'the inner sources of our outward actions, namely, intention, motivation, disposition and character'.[7] Hence, this thesis views, as a more apposite formulation, that question posed by Socrates concerning 'the way we ought to live'.[8] This was a question wherein he recognised that 'no light matter is at stake, nothing less than the rule of human life'.[9]

Philosophy in general,[10] and moral philosophy in particular,[11] have been characterised by the seeking of wisdom; and as 'nothing else but the study of wisdom and truth' (in turn leading to 'calm and serenity of mind, a greater clearness and evidence of knowledge … less disturbed with doubts and difficulties').[12] Wisdom may be defined as 'striving to understand one's own life, others' lives,

---

[1] Beauchamp (1994). The 'four-principles' approach *Principles of health care ethics* pp.3-12.
[2] Clouser and Gert (1990). A Critique of Principlism. Journal of Medicine and Philosophy 15(2): 234.
[3] Hare 1989) The structure of ethics and morals, Essays in Ethical Theory, 175
[4] Singer (1994). *Ethics* p.4.
[5] Matsuura 2007) Philosophy: A School of Freedom (Teaching Philosophy and Learning to Philosophize. Status and prospects). Preface: viii
[6] Moore (1903, 1903) Principia ethica., Chapter 1 Section 2:
[7] McCoy (2004). The subject matter of morality *An Intelligent Person's Guide to Christian Ethics* p.14.
[8] Plato (c390 BC, 1997). Republic *Plato: Complete works* p.996.
[9] Plato (c390 BC, 1952). The Republic *The dialogues of Plato, The seventh letter* p.309.
[10] Gayle (2011). Befriending Wisdom. Analytic Teaching and Philosophical Praxis 31(1): 70.
[11] Gaita (2004). Moral understanding *Good and Evil: An Absolute Conception* p.265ff.
[12] Berkeley (1710, 1952). A treatise concerning the principles of human knowledge *John Locke, George Berkeley, David Hume* p.405.

and the relationships between [*sic*] us, in full moral seriousness, and in full humility',[13] or more simply, 'the power to choose well'.[14] Philosophy has been described as that which 'aims at the logical clarification of thoughts ... [it] is not a body of doctrine but an activity'.[15] Put another way by phenomenologists, it is understood to be 'an optics – a way of seeing things'.[16] Philosophers themselves have been characterised as being more than the etymological 'lovers of wisdom', but as 'lovers of the vision of truth'.[17] Aristotle suggested that, because the 'philosopher is … dearest to the gods … the philosopher will more than any other, be happy.'[18] If any doubt remains, Plato posited that only philosophers will go to heaven.[19]

Thus, in view of 'the central role that morality plays in the constitution of human nature',[20] and acknowledging that, 'it is the task of philosophy to engage hard questions',[21] critical debate about morality and moral decision-making are essential. There is no cogent reason to argue that moral decision-making, or enquiry into the underlying truths of moral philosophy, should be conceptually either easy or simple.[22] Moral philosophical reflection determines the procedures for normative validity. An investigation of moral philosophy, as well as empirically collecting data about what we *do* strive after, should seek to understand what we normatively *ought* to strive after. Of this word *ought*, there will be more later but let it be said here that moral philosophy should be prescriptive as well as descriptive.

### 1.2 *Ethics* or *morals*?

The etymological origins of the words *ethics* and of *morals* derive, respectively, from the words in Greek (*êthos*, *ethos*) referring to 'character', and Latin (*mos*, *mores*, *moralis)* referring to 'customs'.[23] However, in contemporary usage, the words are employed interchangeably. Consideration of their respective Greek and Latin origins and uses is ambiguous. In the Greek, as noted in 3.5.1 Virtue ethics as originally formulated – Aristotle, Aristotle attributed his ê*thos* as referring to 'character',

[13] Cowley (2011). Moral philosophy and the 'real world'. Analytic Teaching and Philosophical Praxis 31(1): 26.
[14] Gayle idem Befriending Wisdom. 72.
[15] Wittgenstein (1918, 2011). *Tractatus Logico-Philosophicus* p.34.
[16] Fleming (2013). Ethics is an optics: The Levinasian perspective on value as primary *The Routledge international handbook of education, religion and values* pp.362-372.
[17] Plato (c390 BC, 1952). The Republic *The Dialogues of Plato, The Seventh Letter* p.370.
[18] Aristotle (c340 BC, 1952). Nicomachean Ethics *The Works of Aristotle Volume II* p.434.
[19] Plato (c390 BC, 1952). Phaedo *The Dialogues of Plato, The Seventh Letter* p.233.
[20] Moll, Oliveira-Souza and Zahn (2008). The neural basis of moral cognition. Annals New York Academy of Science 1124: 161.
[21] Bishop (2011). Acknowledgements *The Anticipatory Corpse: Medicine, Power, and the Care of the Dying* p.xi.
[22] Williams (1985, 2006) Ethics and the limits of philosophy,
[23] Cassin, Crepon and Prost (2004, 2014) Morals/Ethics, Dictionary of untranslatables: A philosophical lexicon, 691-700

which he derived from *ethos,* referring in the singular to 'habit', by lengthening the initial vowel from *epsilon* (εῖ) to *eta* (ῆτα).[24] Thus, Aristotle contended that our virtue is perfected in us by habitual practice.[25] Similarly, Plato contended that character is ingrained by habit.[26] That is, in usage, the Greeks anchored ethics in habit (culture and practice) more so than in character.[27] In the Latin, Cicero chose *moralis* to translate the Greek *êthos* - 'because it relates to character, which they (the Greeks) call *êthos*, while we usually call this part of philosophy "concerned with character" (*mores*). It is appropriate nonetheless to enhance the Latin language and call (this) "moral"'.[28] While in its singular form, *mos* refers to 'habit', in the sense of tradition, or a system of reference, in its plural form, *mores* refers to 'character', with no consistent differentiation between internal motivation (character) and external action (conditioned by institutions).[29]

Interpreting this etymological ambiguity, Cassin *et al*. recognise 'a paradoxical chiasmus' in current usage when they note that, contemporaneously, ethics may be used with reference to social norms and conducts, and morals may be used with reference to the individual.[30] From another perspective, in terms of their use by Greek and Latin writers, morality has a prescriptive dimension. Hence, morality may also be conceived of as applied ethics, as 'the praxis of the theory (ethics)', or, that 'morality actualises the theory'.[31]

Etymological ambiguities aside, important differences are consistently able to be recognised in the philosophical literature. Here, *ethics* refers to 'character, personal disposition',[32] the 'more subjective individual or organisational understanding of right and wrong',[33] is 'a matter of personal worldview',[34] 'come from within … a personal sense of right and wrong',[35] is 'a region in which there

[24] Sachs (2002). *Aristotle: Nicomachean Ethics* pp.22, footnote 25.
[25] Aristotle (c340 BC, 1952). Nicomachean Ethics *The Works of Aristotle Volume II* [1: 13 1102b 5]
[26] Plato (1997). Laws *Plato: Complete works* [VII: 792]
[27] Cassin, Crepon and Prost (2004, 2014) Morals/Ethics, Dictionary of untranslatables: A philosophical lexicon, 691-700
[28] Cicero (44 BCE, 1991) *De Fato*, On Fate, [1: 1]
[29] Cassin, Crepon and Prost (2004, 2014) Morals/Ethics, Dictionary of untranslatables: A philosophical lexicon, 691-700
[30] Ibid.
[31] Babor (1999, 2006) Ethics: The philosophical discipline of action, https://books.google.com.au/books?id=qzETCc5fhkkC&printsec=frontcover#v=onepage&q&f=false
[32] Onions 1966) *The Oxford dictionary of English etymology*, 329
[33] Kerridge, Lowe and Stewart (2013). What is ethics *Ethics and Law for the Health Professions* p.3.
[34] Ormerod and Ulrich (2013). Operational research and ethics: A literature review. European Journal of Operational Research 228(2): 291-307.
[35] http://www.grammarphobia.com/blog/2012/02/ethics-vs-morals.html 1 January

are truths which are incompatible with each other',[36] and within which is found 'incompatible ideal images of forms of life according to which individuals assess the good life for themselves'.[37]

On the other hand, *morals* refers to 'rules or principles governing human behaviour which apply universally within a community',[38] is 'social in the sense that its point of view involves a consideration of other persons as such and not just as things',[39] emphasises 'more the sense of social expectation',[40] is 'the universal constituency',[41] the 'widely shared public or communal norms about right and wrong actions',[42] 'what is acceptable and right to all the parties concerned',[43] 'the complex of norms, behavioral models, virtues, and values which characterize society',[44] 'values determined by the surrounding community',[45] normatively refers to 'a code of conduct that is put forward by a society … a public system'.[46]

This thesis emphasises the understanding that ethics refers to a more individual or organisational assessment of values as relatively good or relatively bad, while morals connotes a more collective and intersubjective assessment of what is Right or Just for all affected.

For Sarah Harper, several contrasts are thus implied:

> (1) Ethics is a matter of convictions, whereas morality is a matter of principles or rules. (2) Human lives make up the subject matter of ethics, while morality is concerned with treatment understood in terms of action. (3) Ethical evaluations are scalar, while moral evaluations are non-scalar. (4) The convictions of ethics are self-regarding, whereas the principles of morality are other-regarding.[47]

There is a need in a post-modern setting, for a moral philosophical framework which contains principles of conduct towards other persons. Predicated upon intersubjectivity and alterity, this

---

[36] Strawson (1961). Social morality and individual ideal. Philosophy 36(136): 3.
[37] Forst (2007, 2014). Ethics and morals *The right to justification: Elements of a constructive theory of justice* p.64.
[38] Strawson (1961). Social morality and individual ideal. Philosophy 36(136): 1-17.
[39] Frankena (1980). *Thinking About Morality* p.32.
[40] Williams (1985, 2006). Socrates' question *Ethics and the Limits of Philosophy* p.6.
[41] Williams (1985, 2006). The Socrates question *Ethics and The Limits of Philosophy* p.16.
[42] Kerridge, Lowe and Stewart 2013) Ethics and law for the health professions,
[43] Ormerod and Ulrich (2013). Operational research and ethics: A literature review. European Journal of Operational Research 228(2): 291-307.
[44] Besio and Pronzini (2014). Morality, ethics, and values outside and inside organisations: An example of the discourse on climate change. Journal of Business Ethics 119: 289.
[45] http://www.grammarphobia.com/blog/2012/02/ethics-vs-morals.html 1 January
[46] http://plato.stanford.edu/archives/fall2012/entries/morality-definition/; Sep 30
[47] Harper (2009). Ethics versus morality: A problematic divide. Philosophy and Social Criticism 35(9): 1063-1077.

should recognise that principles of conduct towards others can be determined, no matter how one's own ethical values, conceptions of the good, or life-choices differ from those of others.

This distinction between ethics and morals is introduced early in the development of the argument of the thesis because it recognises that the clinical encounter is grounded in intersubjectivity amongst the clinician, the patient, and their community. The significance of potential differences between ethics and morals will be re-visited in the Introduction to Chapter 6 Habermas' Discourse Theory of Morality and Communicative Action, where it will be argued that the clinical encounter is appropriately situated in a space wherein a dialogue amongst the parties concerned is held, and hence should be viewed as a moral decision-making process, rather than as an ethical monologue.

**1.3 Decision-making in ethical conflicts**

An ethical conflict may be said to exist when, faced with a decision-making situation, two (or more) actions are available, each of which has some ethical evidence to support it. An ethical dilemma exists when a moral agent's reasoning appears to require that she do each of the two (or more) actions, which are opposing and mutually exclusive, at the same time.[48]

One example of an ethical dilemma is that of an impoverished father who steals food only to feed his starving family. He both ought not to steal and he ought to prevent his family from starving to death. A second example is provided by Plato - that borrowed arms should not be returned to an owner 'when he is not in his right senses', despite the existing duty to repay a debt.[49] Ordering or ranking of 'oughts' to constitute a hierarchy may be a helpful action in this situation. A third example, in a clinical setting, is when a clinician, who does not believe in deliberately shortening a patient's life, considers prescribing an opioid for the relief of pain and suffering, but which may also shorten that patient's life. This particular dilemma is explored in 3.3.2 iv Natural law theories.

A more difficult dilemma arises when a moral agent is in a situation where two (or more) opposing and mutually exclusive actions are available, but the evidence for each is incomplete or inconclusive. Ordering or ranking these actions into a hierarchy is less helpful here, partly because there is uncertainty about what the moral imperatives are. An example was offered by Jean-Paul Sartre, of a son in World War II who must choose between staying with his mother because she needs him, or joining the Free French to fight the Germans who killed his only brother but with whom his father is

[48] Beauchamp and Childress (2009). Moral norms *Principles of Biomedical Ethics* pp.10-11.
[49] Plato (c390 BC, 1952). The Republic *The Dialogues of Plato, The Seventh Letter* p.297.

collaborating.[50] There is great ambiguity between his obligations to his mother as her only surviving son, and to his country, made more difficult by the collaboration of his father and the uncertainty of whether he could actually achieve anything by leaving because he may not successfully join the Free French. When making a choice based upon incomplete practical and moral information, we cannot know which higher duty is more likely to result in the greater utility for the greater number or, indeed, which reflects the greater charitable love for others.

*Moral distress* is a term applied to situations where, for example, the clinician knows the right action to take but extraneous constraints outside the control of the patient or the clinician make it impossible to take that action. An instance would be seen when a patient with disseminated malignancy does not have health insurance or sufficient personal resources to pay for chemotherapy. The clinically best course of action is for the clinician to recommend chemotherapy treatment however the patient cannot afford this treatment. *Moral residue* is the term applied to the cumulative stress associated with compromises in morally dilemmatic situations like these. Reports suggest that nursing staff with greater levels of experience suffer higher levels of moral distress, and that this is associated with burnout. Nonetheless, reports also suggest that education can improve coping strategies.[51]

It is the understanding behind this thesis that moral conflicts and dilemmas are inevitable. As will be iterated, this is at least partly because of the pluralistic and fragmented character of contemporary society.[52] Dialogue or discourse seeks to clarify the ethical imperatives in the situation at hand, as each participant perceives them. This dialogue lays the groundwork for the resolution of those differences which remain.

Reflecting upon making ethical decisions, Habermas paraphrases Charles Taylor:

> Modern identity draws upon three different moral sources simultaneously: the Christian notion of the love of God, of whose goodness all creation partakes; the Enlightenment notion of the self-responsibility of the subject, who in virtue of his reason is capable of acting autonomously; and, finally, the romantic belief in the goodness of nature that finds expression in the creative accomplishments of the human imagination.[53]

---

[50] Satre (1957, 2010). Existentialism and Human Emotion *Ethics: the Essential Writings* pp.330-331.
[51] Jessica Schluter, Sarah Winch, Kerri Holzhauser and Henderson (2008). Nurses' moral sensitivity and hospital ethical climate: A literature review. Nursing Ethics 15(3): 315.
[52] Loewy (1989). Physicians and patients in a pluralist world *Textbook of medical ethics* pp.85-87.
[53] Habermas (1993). Remarks on discourse ethics *Justification and Application: Remarks on Discourse Ethics* p.73.

Habermas posits here that '[t]here is indeed broad consensus concerning the fundamental values of freedom, justice, welfare, and the eradication of suffering',[54] but 'there are profound rifts when it comes to the constitutive goods, and hence moral sources, which underpin these'.[55]

How individuals make ethical decisions is not well documented. We have inherited a fractured collection of conflicting traditions which we dip into as circumstances vary:

> We are Platonic perfectionists in saluting gold medallists in the Olympics; utilitarians in applying the principles of triage to the wounded in war; Lockeans in affirming rights over property; Christians in idealizing charity, compassion and equal moral worth; and followers of Kant and Mill in affirming personal autonomy.[56]

As for individuals in general, confusion exists about how senior clinicians make ethical decisions. Perhaps they apply a smorgasbord of ethical frameworks or, more generously, perhaps they deliberatively choose from amongst their ethical toolbox as different situations arise. This is not simply 'intellectual and moral vacuity'.[57] During the gestation of this thesis, the analogy with a surgeon needing to select the right instrument for the planned operation was reflected upon as an explication. Scalpels come in a variety of designs, each suited to a particular purpose or context – for example, incising a broad area of skin, a deep layer of fat, or a delicate cornea. In the same way that medical students and junior clinicians should be taught about scalpel designs, so they should be taught about the ethical frameworks that are available for clinical decision-making. Even if so, this is not sufficient in itself: trainee surgeons require further education concerning which scalpels may be the appropriate choice for different steps within an operation, aware nonetheless that a unique choice is not obligatory.

An epistemological analysis of decision-making in situations of ethical conflict, and three dominant normative frameworks extant in the secular Western tradition, helps to explain why clinicians might appropriately choose an ethical framework, depending upon the clinical context. The plurality of culture, tradition, and moralities which characterise contemporary secular society, however, results in a moral collage 'woven haphazardly out of pieces of diverse moral visions'.[58] Thus, it is the contention of this thesis that the nature of our contemporary society should impel a different moral

[54] Ibid.
[55] Taylor 1989) Sources of the self: The making of the modern identity, 495
[56] Pence (1993). Virtue theory *A Companion to Ethics* p.251.
[57] Paola, Walker and Nixon (2010). Theory in bioethics *Medical Ethics and Humanities* p.32.
[58] Engelhardt (1996). The intellectual bases of bioethics *The Foundations of Bioethics* p.34.

paradigm for determining moral truth, one built around a process of inclusive, non-coercive and self-reflective dialogue within the affected community.

From the perspective of medical education, the study of moral philosophy is an important way for those who must make important moral decisions to reflect upon and, where appropriate, re-calibrate their decision-making compass – 'a critical reflection on uncritically accepted moral discourse'.[59] Medical students inevitably bring an inchoate morality to their decision-making. This is based upon exposures to their family, secular and perhaps religious education, and to the media and the internet. Medical students and junior clinicians should be educated about which ethical frameworks may provide the basis for decision-making in clinical situations, but also which is the most apposite process for making moral decisions in the particular clinical consultation in question. Life-long reflective practice allows us to clarify and refine our moral decision-making paradigms as our wisdom grows.

At least one rationale for this is a report from a panel of bioethicists which sought to determine the top ten ethics challenges facing the public in 2005. It identified the top challenge as 'disagreement between patients/families and health care professionals about treatment decisions'. The top suggested response from the panel was education: that is, health care professionals should be provided with training in the negotiation and mediation skills needed to address serious disagreements.[60]

**1.4 Medical morality**

The first international conference devoted to medical ethics, in France in 1955, used the term *medical morality.* "Bioethics" was a neologism coined in North America in the 1960s to refer to 'the rise of professional and public interest in moral, social, and religious issues connected with the "new biology" and medicine'.[61] Bernard Gert makes the observation that this was not aimed at inventing a new ethical framework. Rather, he says, 'everyone subject to moral judgement knows what kinds of actions morality prohibits, requires, discourages, encourages, and allows' but 'what moral agents sometimes do not know is how a particular action ought to be described' so that a moral framework

[59] Paola, Walker and Nixon (2010). *Medical Ethics and Humanities* p.6.
[60] Breslin, MacRae, Bell, Singer and University of Toronto Joint Centre for Bioethics Clinical Ethics (2005). Top 10 health care ethics challenges facing the public: views of Toronto bioethicists. BMC Med Ethics 6: E5.
[61] Fox and Swazey (1984). Medical morality is not bioethics - medical ethics in China and in the United States. Perspectives in Biology and Medicine 27: 336.

can be applied to it.[62] Sebastien Tassy recognises that 'physicians frequently face moral dilemmas when caring for patients. To help them cope with these, biomedical ethics aims to implement moral norms for particular problems and contexts'.[63] H Tristram Engelhardt writes that the answer to the intellectual question "How can I consistently understand what is right conduct in the health care professions … and justify it to others"? is to be found through philosophical enquiry rather than empirical anthropology or sociology.[64] Joseph Fletcher wrote that it is 'precisely the business of rational, critical reflection (encephalic and not merely visceral) about the problems of the moral agent'[65] which is the concern of biomedical ethics.

The term 'clinician' is used in this thesis to mean medically-qualified doctors active in the practice of clinical medicine. By clinical medicine is meant 'the use of medical knowledge for healing and helping sick persons here and now, in the individual physician-patient encounter'.[66] Clinicians are sufficiently beyond their training programmes to be making moral decisions most often on their own, rather than deferring to a supervising senior colleague. Importantly, aspects of the decision-making process articulated here may be viewed favourably by non-medically qualified health care providers and educators who also provide clinical face-to-face care for patients. These would include, for example, nursing staff and allied health workers acting relatively autonomously, as well as psychologists, social workers and chaplains.

The focus of this thesis is not upon specific 'bioethical' conflicts based, for example, around abortion, euthanasia or test-tube embryos. Nor is it primarily about the allocation of scarce resources in medical settings, cognizant however of the reality of acute resource-limitations. Nor is its primary focus on professional ethical standards or research ethics committees. Nor is it primarily casuistic in its method. Rather, it argues that since each clinical doctor-patient contact inherently involves dealing with another human being, the clinical doctor-patient relationship has a necessary foundation in moral philosophy. Clinical interactions are, properly speaking, moral-decision making situations. These moral decisions should be based more consciously on an inter-relational theory.

---

[62] Gert, Culver and Clouser (2000). Common morality versus specific principlism: Reply to Richardson. Journal of Medicine and Philosophy 25(3): 310.

[63] Tassy, P Le Coz and Wicker (2007). Current knowledge in moral cognition can improve medical ethics. Journal of Medical Ethics 34: 679.

[64] Engelhardt (1986). The emergence of a secular bioethics *The Foundations of Bioethics* p.9.

[65] Fletcher (1972). Indicators of humanhood: A tentative profile of man. Hastings Center Report 2(3): 1.

[66] Pellegrino (2001). The internal morality of clinical medicine: A paradigm for the ethics of the helping and healing professions. Journal of Medicine and Philosophy 26(6): 563.

Put another way, this thesis aims to explore moral decision-making 'related to the phenomenology of the clinical encounter'.[67]

Initially, the thesis will explore how individual clinicians might use normative ethical frameworks, and principles derived from them or modifications proposed for them, to make morally good decisions in clinical situations. Recognising, however, that we are in a post-modern society, insights derived from post-modern philosophers are considered in order to view moral decision-making in clinical contexts in a different light, one that looks beyond the established normative frameworks yet builds upon them to seek a balanced or *Proportionist* approach. Cognisant of the plurality, fragmentation, and tensions within our contemporary era,[68] arguments are advanced in favour of a *process* for making moral decisions, and thus imbuing normative force. Practical difficulties notwithstanding, this approach is seen as most apposite to moral decision-making in clinical contexts. Arguing that knowledge or meaning or truth, properly understood, must impel *praxis* (from the Greek, *practical action*), it then seeks to apply that knowledge to medical education.

Jürgen Habermas is of the second generation of the Frankfurt school (the Institute for Social Research, Goethe University Frankfurt). His expertise straddles protean disciplines, but especially sociology, political science and philosophy. His concentration was upon principles and his work is characterised by constant interaction with his peers and critics. Derived from the vast oeuvre of Habermas, four insights are critical to the exposition presented here.

The first derives from an understanding of Habermas' epistemological approach to our belief systems, culminating in his three "ways" of knowing. These impel 'the conjunction of self-reflectivity and *praxis*'.[69] The second is Terence Lovat's attempt to find the balance between the extremes of secular Western moral philosophical frameworks, proffered as a Proportionist approach. This approach seeks the highest good for the patient, based upon a balance between *a priori* rules and empirical "greatest good for the greatest number"[70] utilitarian calculations. The third is the importance for the doctor-patient relationship, and hence moral decision-making in clinical settings, of Habermas' discourse theory of morality and his theory of communicative action. Implicitly cognizant of intersubjectivity, they are the basis for a *process* for making morally-good decisions. Intersubjective consensus, after dialogue within the community involved, imbues the decision with

[67] Pellegrino idem: 577.
[68] Loewy (1989). Physicians and patients in a pluralist world *Textbook of medical ethics* pp.85-87.
[69] Lovat (2006). Practical mysticism as authentic religiousness: A Bonhoeffer case study. Australian eJournal of Theology 6: 3.
[70] Priestley (1768, An Essay on the First Principles of Government, and on the Nature of Political, Civil, and Religious Liberty,

normative force, in turn rendering the process action-guiding. The fourth is the application of Habermas' insights to the pedagogy of medical education, illuminated by Lovat and by Ronald Laura.

This thesis deliberately uses the term "discourse theory of morality" for what may be more commonly known as "discourse ethics". Habermas identified his *Justification and application: Remarks on Discourse ethics*,[71] as continuing the themes of his foundational *Moral consciousness and communicative action*.[72] In his Preface, while recognising that "discourse ethics" is in more established usage, he writes that, following his 1988 Howison Lecture,[73] 'it would be more accurate to speak of a "discourse theory of morality"'.[74] Others also prefer the term discourse theory of morality,[75] and one commentator attributes the term "discourse ethics" to Karl-Otto Apel.[76] More importantly for this thesis, however, the term discourse theory of morality is congruent with the conception that, while ethical decision-making involves a relativistic and essentially subjective monologue, moral decision-making involves a process-driven universally-applicable construct. This conception, wherein moral decision-making is relocated into a social space cognizant of the other, and so one in which we need to have an inclusive and non-coercive reflective dialogue, as introduced in 1.2 *Ethics* or *morals*?, is further exposited in 6.1 Introduction. Although the words, ethics and morals, are interchangeable in common usage, Habermas recognises the 'explicit distinction between moral and ethical discourses'.[77]

In order to constrain this thesis to manageable proportions, discussion is confined to the Western tradition, in order to seek to do justice to that tradition. The author of the thesis is very much aware, however, of important contributions to the issue at hand coming from other traditions.

**1.5 Thesis outline**

The thesis is presented in nine Chapters. This first, introductory, chapter introduces the thesis. It considers words including *ethics* and *morals, conflict* and *dilemma*, why there are difficulties with ethical and moral decision-making in medical situations, and why this prompts a re-evaluation of medical education. It introduces the premise that decision-making in the clinical encounter should be approached from the perspective that the decision being made follows a process of moral

[71] Habermas (1994, 2001) Justification and application: Remarks on discourse ethics, 197: .
[72] Habermas (1981, 1990) Moral Consciousness and Communicative Action, 225
[73] Habermas (1994). On the pragmatic, the ethical, and themoral employments of practical reason *Justification and Application: Remarks on Discourse Ethics* pp.1-8.
[74] Habermas (1994). *Justification and Application: Remarks on Discourse Ethics* pp.vii-viii.
[75] Finlayson (2005). Habermas's Moral Cognitivism and the Frege-Geach Challenge. European Journal of Philosophy 13(3): 319-344.
[76] Heath (2014). Rebooting discourse ethics. Philosophy and Social Criticism 40(9): 838-841.
[77] Habermas (1994). *Justification and Application: Remarks on Discourse Ethics* pp.vii-viii.

dialogue by way of an inclusive and non-coercive reflective consensus, as distinct from what might be termed an ethical monologue.

Chapter 2, Foundations of Ethical and Moral Decision-Making, considers foundational concepts important in ethical and moral decision-making. Understanding these concepts helps to explicate moral decision-making in clinical settings.

Epistemology considers how we know what we know, and whether it can be justified. Language relates knowledge to truth, and is necessary for moral dialogue. Language acts as a moral intermediary. We cannot have a discussion about morals if we do not have the words for the concepts and if we do not agree about the meaning of the words.

Meaning and values are explored as they might be applied to moral decision-making. "Ways" of knowing are explored in the paradigm of Habermas, who based his epistemic conceptions on aspects of human cognition. Thus, he determined three "ways" of knowing – empirical-analytic knowing (data collection), historical-hermeneutic knowing (understanding of meanings), and self-reflective critical knowing. It is through the latter that *praxis* is achieved. Habermas' concepts of intersubjectivity, exposedness and vulnerability in morality are introduced. Thus, the argument begins that normative force for a moral decision properly derives from a process based upon discourse which, in turn, depends upon language.

The purview of moral philosophy relates to its historical context. Four epochs of moral philosophical development are recognised. These are the Classical (or Ancient) period, the Medieval (or Middle) period, the Modern period, and the Post-modern period. Aspects of the Post-modern epoch, wherein the arguments proposed in this thesis are located, are explored in further detail, since it is argued that a moral decision-making *process*, involving the reflective consensus of the community, is apposite to moral decision-making. Phenomenology is introduced here because it is founded on awareness of others, recognition of patients' actual reality, and embodiment of the patient in their reality. Recognizing the importance of these concepts will impel a re-balancing of medical education.

Chapter 3, Substantive Normative Ethical Frameworks, evaluates secular normative frameworks in the Western tradition, namely, deontology, teleology, and virtue ethics.[78,79,80,81,82,83]

[78] Childress (1989). The normative principles of medical ethics *Medical ethics* p.31.
[79] Loewy (1989). Theoretical considerations *Textbook of medical ethics* pp.18-22.
[80] Habermas (1994). On the pragmatic, the ethical, and the moral employments of pratical reason *Justification and Application: Remarks on Discourse Ethics* p.1.
[81] Solomon 1995) Normative ethical theories, Encyclopedia of bioethics, 812-824

They are considered in terms of how we might make morally correct decisions based upon these substantive (stand-alone) frameworks. Each is articulated as originally formulated in the writings of their progenitors. More recent interpretations are then discussed, including their strengths and weaknesses in terms of their applicability in clinical contexts. In considering deontological principles, attention is directed to philosophical principles which might guide moral decision-making at the end-of-life in Intensive Care Units (ICUs). In considering teleological principles, aspects of triage and of medical futility are discussed. The virtue ethics framework derives its epistemic development from the Classical Greek lines of Plato, Protagoras, and Aristotle, by way of Aquinas and the scholars of Islam. Contemporary re-formulations look at the process of making morally-correct decisions, and the role of self-education and reflective self-evaluation in that process. The Good of the patient is the ultimate *telos* (from the Greek, *end*, *fulfilment*, *final purpose*) of moral philosophical decision-making in clinical situations. Edmund Pellegrino proffers a hierarchy of four interpretations. In clinical practice, empathy and wisdom as examined by Pellegrino, and empathy, compassion and care as posited by Petra Gelhaus, are proposed to guide normative moral decision-making in clinical situations. Further insights are drawn from phenomenology in terms of awareness of others, awareness of the suffering of patients, and of the inherent vulnerability of patients. The theistic frameworks of the Islamic-Judaeo-Christian traditions are then considered, in both historical and contemporary terms. A case study (Baby 'W') is offered as being illustrative of the practical application of these frameworks.

Chapter 4, Principlism and the dynamics of the doctor-patient relationship, assesses contemporary moral decision-making considerations specific to the clinical dyad. The four discrete *prima facie* principles relevant to medical ethics proposed by Thomas Beauchamp and James Childress, which can be distilled from the normative frameworks, are considered in some detail. These are respect for autonomy, non-maleficence, beneficence, and justice.

Attention is given to these four principles because they have great influence on moral decision-making in clinical situations, and because, at a minimum, they offer a common ethical language amongst clinicians. Shortcomings in their theoretical and practical application will be identified. Various understandings of autonomy – considered to be first amongst the four principles - will be considered. Critical re-examination suggests that our traditional understanding of autonomy is impoverished and requires re-evaluation.

---

[82] Baron (1997). Introduction *Three methods of ethics* pp.3-5.
[83] Heath (2014). Rebooting discourse ethics. Philosophy and Social Criticism 40(9): 836.

It is a fundamental premise of this thesis that clinical encounters between clinicians and patients should be seen firstly and primarily as ones of inter-relations between persons; as such, they are necessarily moral encounters. Amongst the various models for this doctor-patient relationship, this thesis favours it being seen as a shared decision-making continuum.

Chapter 5, The Proportionist approach seeks a balanced approach to moral decision-making. The deontological framework predicates moral permissibility upon the intrinsic nature of the Act. The teleological framework predicates moral permissibility upon the consequences of the Act. The virtue ethical framework focuses on the character of the agent. For the clinician in her role as Agent, the *telos* of medicine is the good of the patient. This is articulated as empathic compassionate caring. To practically actualise this in clinical situations, the Proportionist approach has much to offer to moral decision-making. This is seen in its capacity to balance rules and consequential circumstances, hence utilizing but also going beyond the bounds of deontological and teleological frameworks. Its starting point is the actual reality of the patient in their situation. The historical development of the Proportionist approach is considered, as well as its applicability in our current epoch.

Chapter 6, Habermas' discourse theory of morality and communicative action, revisits the distinction between ethics and morals, by moving the perspective of moral decision-making from *ego* to *alterity*. This chapter, and the previous one, draw on the Habermasian epistemological paradigm of his "ways" of knowing, his discourse theory of morality and the principles of communicative action. Its starting point is the reality of the patient's situation in its actual medical and cultural context.

Recognition of intersubjectivity is important for Habermas in that it is a contributing factor to normative validity, within a system of morality. His discourse theory of morality requires that the consequences for all persons affected must be considered. His principles of communicative action imply that the discourse is based upon consensus, subsequent to inclusive and non-coercive reflective dialogue. Intersubjective consensus after dialogue within the relevant community imbues the decision with normative force which, in turn, renders the process one which is action-guiding. Habermas' discourse theory of morality generalises and expands the Kantian categorical imperative, as determined by ethical monologue, to a wider consensus-seeking dialogue. Thus, consensual agreement is reached about what constitutes morally-correct action. Relocating ethical decision-making from a monological space, into one characterised by dialogue, is especially appropriate to the clinical encounter.

Chapter 7, Application of the Habermasian paradigm in clinical practice, describes a further practical example (Baby 'H'). By way of this example, how the Proportionist approach, being true to

communicative action and its attached discourse theory of morality might be applied to a clinical case-conference, is described. The clinical example also underlines the way that, from the virtue ethics perspective, this approach seeks to maximize the good of the family, of which the child is a part. Practical difficulties and limitations of communicative action and the discourse theory of morality are then explored in detail. It will be argued that, practical difficulties in achieving the ideal dialogue notwithstanding, the process described here has both applicability and great merit for moral decision-making in clinical contexts.

Nonetheless, several confounding factors in moral decision-making in clinical situations remain. These include contention about the philosophical basis for assigning *personhood*, and the psychological impact of the 'rule of rescue', as well as insights from neurobiological imaging studies.

Chapter 8, Praxis, considers the important implications for medical education which necessarily follow from understanding the epistemology of moral decision-making in clinical settings. Limiting clinical medicine to its technical aspects alone misses the intimate intertwining of the moral motivation to be a good physician, aiming towards the Good of the patient. The virtues which lead the clinician to the *telos* of medicine are both intellectual and moral. Although David Seedhouse argues in a provocative paper that 'medical ethics' courses have no place in undergraduate medical education, there is a palpable need to address methods of good moral decision-making in undergraduate curricula, on postgraduate ward rounds, theatre sessions, and similar contexts, as well as in post-Fellowship contexts. This chapter borrows from Habermas once again in order to re-cast his ways of knowing into a medical education framework. His paradigm should inform a re-balancing of the role of medical morality in medical education. Practical methods, emphasising a holistic approach, are explored. As underlying principles for medical education, Habermasian paradigms articulating ways of knowing, and Ron Laura's concepts of coming to know truth via empathic connectivity and participatory consciousness,[84] are seen as fundamental. Self-reflective or 'critical' knowing derives from cognitive interest in emancipation - the drive to discern truth. Thus follows a medical education pedagogy which fosters life-long, self-reflective clinical practice.

Chapter 9 concludes and summarises the arguments presented in the thesis. Clinical encounters are understood as inter-relationships among persons. The final purpose of the clinical encounter is to maximise the goods of the patient. The setting for the provision of empathic compassionate care is the one most suited to our current era. This era is characterised by pronounced value pluralism. The Proportionist approach seeks the highest good, based upon a balance between *a priori* imperatives

[84] (Laura, Tim Marchant and Smith,2008) 9 pp.149-153

and empirical utility. It begins from the concrete reality of the patient in the broad situation of their illness. The practical application of the Proportionist approach in clinical practice requires application of the principles contained in Habermas' discourse theory of morality and his principles of communicative action. Thus, a cooperative search for truth, in order to make a properly shared decision, is undertaken. This paradigmatic approach, and the epistemic understandings it is based upon, impel practical change in medical education.

## CHAPTER 2 FOUNDATIONS OF ETHICAL AND MORAL DECISION-MAKING

### 2.1 Introduction

This chapter focuses on consideration of foundational concepts important in moral decision-making in clinical situations. These include an understanding of epistemology - how we know what we know, and how that relates to truth constructs. Epistemology is intimately related to language, which is the necessary intermediary for moral dialogue. Language relates to truth, meaning, and value. It is not possible to have a discussion about morals if we do not have the words to articulate the concepts, and if we do not agree about the meaning of the words. If the dialogue is to be unforced, then participants need to understand how the use of language can result in a coerced agreement rather than a consensual one.

Self-reflection is one of the driving motivators towards lifelong medical education. Habermas draws these threads together in his three "ways" of knowing. The perspective of phenomenology, based on alterity and intersubjectivity, offers much to moral decision-making in situations of clinical care. Historical perspectives contextualize and condition our approaches to moral decision-making.

### 2.2 Epistemology, truth and language

*Epistemology* (from the Greek *episteme* or *knowledge*, and *logos* or *theory*) is concerned 'about knowing and is about knowing how we know'.[85] Thus, it explores the sources, structure, and limits of knowledge. Epistemic justification relates belief to truth.[86] As such, it is important in understanding the basis for a morality (normative behaviours) and for moral philosophy (the study of morality). Language underpins discourse and is arguably the basis for assigning truth values. *Discourse* refers to its linguistic locus as blocks of contextually-situated 'written and spoken language produced as part of the interaction between speaker and hearers and writers and readers'.[87]

In everyday usage, the language of morality is often characterised by words such as *ought* and *should*. These words are important to conceptions of moral behaviour, and are considered 'decisive-reason-implying concepts'[88] by Derek Parfit. First, they assert an obligation.[89] That is, there is a logical inconsistency if individual A *ought* to do something, but individual B, in a similar situation, is

[85] Lovat (2004). Aristotelian Ethics and Habermasian Critical theory: A conjoined force for proportionism in ethical discourse and Roman Catholic moral theology. Australian eJournal of Theology 3(1): 4.
[86] Moser (1987). *A Priori Knowledge* p.2.
[87] Candlin, Maley and Sutch (1999). Industrial instability and the discourse of enterprise bargaining *Talk, Work and Institutional Order: Discourse in Medical, Mediation and Management Settings* p.321.
[88] Parfit (2011). *On What Matters* p.165.
[89] Ross (2002). *The Right and the Good* p.105.

not expected to respond to the 'ought' and do the same thing.[90] The action which *ought* to be taken can be generalised to others in precisely the same situation. Second, it is expected that its use can be justified – an action *ought* to be done, because of some reason which exists *a priori*, or else is able to be articulated, or because in that situation acting in a certain way is right, just or good, or it satisfies a truth construct. Third, *ought* implies *can* – in the sense that it is generally a precondition to an obligation that we ought to act in a certain way only if we can actually act in that way[91] Fourth, obligation does not attach to supererogatory actions.

O*bligation* and *duty* are also important words in moral enquiry. Both words look to a future event which a moral agent is required to do. Importantly, though, both are predicated upon a past event,[92] for example, making a promise, giving one's word, professing belief in the tenets of a religious or secular way of life. Obligations may be agent-relative or agent-neutral. Agent-relative obligations imply some reference to self, including the skill-set possessed (for example, a skill-set enabling an agent to resuscitate an injured person) in the context or circumstances at the time. Agent-neutral obligations are independent of self.

According to the understanding taken by this thesis, *normative* questions concern *ought* in the sense of goodness and rightness. More than a merely descriptive concept, normative constructs motivate action, they 'make *claims* upon us; they command, oblige, recommend, or guide [original emphasis].'[93] James Olthius has intimated that a more narrow definition of "ought" in the moral sense will eventually be required, and that this will focus more on truth than either goodness or rightness.[94]

There is a relationship between knowledge and truth. It is perhaps understandable if medical and surgical clinicians tend to view the only 'real' knowledge as that which is derived from empirical science. Contemporarily, "science" is popularly associated with the mantles of objectivity, universality, knowable truth, and apparent cognitive superiority to moral opinion.[95] In contrast, moral beliefs are associated with subjectivity, privacy, uncertainty, and are seen to lack 'authority to claim deference'.[96] In medicine, the double-blind randomised controlled trial is the gold standard for

---

[90] Hare (1993). Universal Prescriptivism *A Companion to Ethics* p.460.
[91] Kant (1788, 1952). The Critique of Pure Reason *The Critique of Pure Reason, The Critique of Practical Reason and other ethical treatises, The Critique of Judgement* p.168.
[92] Williams (1985, 2006). Socrates' question *Ethics and the Limits of Philosophy* p.8.
[93] Korsgaard (1996). The normative question *The Sources of Normativity* p.8.
[94] Olthius (1990). An ethics of compassion: ethics in a post-modernist age *What Right Does Ethics Have?: Public Philosophy in a Pluralistic Culture* pp.126, footnote 122.
[95] Paola, Walker and Nixon (2010). Theory in bioethics *Medical Ethics and Humanities* p.10.
[96] Ibid. 9

clinical decision-making, and is accorded the highest grade or level of evidence in what is the much-sought-after "Evidenced Based Medicine". Empirical scientific knowledge is only one form of knowing, however, and is arguably not the highest form.

George Berkeley argued that the sole aim of language was to communicate our ideas.[97] Emile Beneviste posited that language must be the vehicle for thought,[98] and that language must itself be set in context.[99] The pronouns 'I' and 'you', and 'here' and 'there', are meaningless out of context. 'I' and 'you' signify unique persons in the present specific discourse. Ludwig Wittgenstein argued that 'language can only make sense, or have validity, within the context of its peculiar purpose'.[100] Some use the phrase "the linguistic turn" to mean that, 'in metaphysics, epistemology, or value theory, the philosophy of language has become a keystone of conceptual analysis'.[101]

However, it is not possible to test each and every statement for truth. Laura argues that, at the base of any system of well-founded and reasoned beliefs, there must be certain 'givens' or untestable precepts or beliefs, which must be exempt from doubt analysis. In this respect, science is no different from theism. For religion, the given comprises faith in a God, whereas, for science, it is faith in the uniformity or repeatability of nature.[102] These beliefs he terms *epistemic primitives*. Others use the word *axiom* (from the Latin and Greek *axioma* and *axios* or *dignity, weight, value, that which itself is evident*) in the sense of an immediately self-evident truth, the starting point or basis from which a reasoned argument can be developed. Furthermore, if one does not believe the words (language) being used mean what one believes them to mean, then one cannot formulate doubt in order to test it; this itself being a precondition of testability.[103] Thus, the basis for knowledge is certain beliefs, existing at such a fundamental level that it is not possible to adduce evidence to disprove them. Hence, they are termed epistemic primitives. For example, Kant's *a priori* precepts do not require justification; nor does the uniformity of nature, in the sense that the future replicates the past (which also has an ontological basis).

---

[97] Berkeley (1710, 1952). A treatise concerning the principles of human knowledge *John Locke, George Berkeley, David Hume* p.410.
[98] Benveniste (1966, 1971). Categories of thought and language *Problems in General Linguistics* p.63.
[99] Benveniste (1966, 1971). The nature of pronouns *Problems in General Linguistics* p.218.
[100] Lovat and Smith (2003). Curriculum and philosophy *Curriculum: Action on Reflection* p.81.
[101] Fultner and Habermas (2001). *On the Pragmatics of Social interaction: Preliminary Studies in the Theory of Communicative Action* p.vii.
[102] Laura (1978). Philosophical foundations of religious education. Religious Education 28(4): 313.
[103] Laura and Chapman (2009). The philosophical principles of unfolding consciousness *The Paradigm Shift in Health* pp.158-159.

Importantly, access to data alone cannot assert the importance of concepts such as value, goodness or wisdom. *Knowledge*, *meaning* and *truth* are concepts necessary for *value* to be conceptualised, as a basis for a moral judgement; and, it is contended here, they necessarily impel Action. Knowing (especially in an empirical sense) is not the same as understanding. As Koichiro Matsuura writes, philosophy implies freedom, in and through reflection:

> because it is a matter not just of knowing, but of understanding the meaning and the principles of knowing, because it is a matter of developing a critical mind … a long process that is dependent upon enlightened instruction, upon rigorously putting concepts and ideas into perspective.[104]

Charles Sanders Peirce placed great emphasis upon a 'community of inquirers'[105] constituting members of an ideal community. These must surrender all self-interest to the community's interest in searching for the truth.[106] He argued that it is 'knowers' who seek truth. He proposed that discovering scientific truth first required a normative determination, which in turn pre-supposed an ideally conceived scientific community to make that determination.[107,108] Peirce also opined that reality depends upon the ultimate decision of the community[109] and that normative validity resides in 'communal adjudication of determinations regarding the nature of validity'.[110] Thus, he was the seminal writer about what was to become known as discourse theory of morality.

Apel further elaborated and proposed that knowledge and truth are related through three elements. They are: 1) consensus; 2) which is achieved through communication; and, 3) which is possible only when there is a commitment to public understanding of knowledge.[111] He combined an ontological technical interest in knowledge with a transcendental-pragmatic coming-to-know viewpoint, and then introduced a third knowledge-constitutive interest as a 'reflective opening of the way to the autonomous self-realization of human beings in the species'.[112] For Wittgenstein, language-as-meaning implies it is a public language. It is impossible to conceive of a meaningful private language. Apel reformulated this concept into that of language as the vehicle for communication, and, echoing

---

[104] Matsuura 2007) Philosophy: A School of Freedom (Teaching Philosophy and Learning to Philosophize. Status and prospects). Preface: viii
[105] Bernstein (1981). *Charle S Perice: From Pragmatism to Pragmaticism* p.xix.
[106] Apel (Der Denkweg von Charles S. Peirce, 1981). *Charles S Peirce: From Pragmatism to Pragmaticism* p.52ff.
[107] Rasmussen (1990). Discourse ethics *Reading Habermas* pp.58-59.
[108] Ibid. 59
[109] Peirce (1960). From Pragmatism to Pragmaticism *Collected Papers of CS Peirce* p.189.
[110] Rasmussen (1990). Discourse ethics *Reading Habermas* p.59.
[111] Hugman (2005). Discourse Ethics *New Approaches in Ethics for the Caring Professions* p.128.
[112] Apel (1984). *Understanding and Explanation: A Transcendental-Pragmatic perspective* p.217.

Peirce, required a 'communication community',[113] thus giving validity to 'all human actions claiming to be meaningful and ... philosophical arguments claiming to be valid'.[114] Apel observed that, in modern scientism, self-reflection plays no role. He noted that the methodology of logical empiricism as it underlies modern science does not need to 'take into account an empirically-relevant self-reflection'.[115] On the other hand, cognition in the hermeneutic sciences does allow for the possibility of self-reflection. By this, he meant finding oneself in the other, and what he described as the reciprocity between self-understanding and 'interpretive self-transposition … into all humanity'.[116] Hubert Dreyfus suggests that understanding another involves making a translation of the other person's behaviour or language into one's own language.[117] This effectively means approaching all understanding as an epistemological question.

At least in part as an early reaction to logical positivism, which he derides as 'epistemologically the severance of knowledge from interest',[118] and an approach to understanding in which 'we disavow reflection',[119] Habermas apportions *knowing* into three "ways" based on connections he identified 'between logical-methodological rules and knowledge-constitutive interests'.[120] These are empirical-analytic knowing, historical-hermeneutic knowing, and self-reflective 'critical' knowing.[121] These 'knowledge-constitutive interests' guide the search for knowledge, and are universal, transcendent, and exist *a priori*.[122] They are fundamental, invariant, and they can be ordered. Empirical-analytic knowing derives from cognitive technical control and focuses on data capture of what is known. Truth is about facts - derived from ontological realities or from empirical observation of scientific data. In other words, empirical-analytic knowing involves capturing intrinsic and empirical 'facts'. Historical-hermeneutic knowing is derived from cognitive interest in understanding meanings, which is in turn impelled by inter-subjective human communication, rather than by empirical data collection. Put another way, historical-hermeneutic knowing involves understanding what the facts mean. Self-reflective or 'critical' knowing derives from cognitive interest in emancipation - the drive to discern truth. Epistemically, the Hellenistic Aristotle and the medieval Aquinas become conjoined

[113] Apel (1976). The transcendental conception of language communication and the idea of a first philosophy *The History of Linguistic Thought and Contemporary Linguistics* p.57.
[114] Ibid.
[115] Apel (1984). *Understanding and Explanation: A Transcendental-Pragmatic perspective* p.213.
[116] Ibid.
[117] Dreyfus (1980). Holism and hermeneutics. The Review of Metaphysics 34(1): 6.
[118] Habermas (1972). *Knowledge and Human Interests* p.303.
[119] Habermas (1972). *Knowledge and Human Interests* p.vii.
[120] Habermas (idem p.308.
[121] Ibid.
[122] Scambler (2001). Introduction: Unfolding themes of an incomplete project *Habermas, Critical theory, and Health* pp.5-6.

with Habermas in making a fundamental appeal to knowing oneself as being essential to the living of a morally Good life. The essence of this third way of searching out the truth is reflection upon the knowledge gained as the basis for *praxis* (practical action). Habermas incorporates both empirical-analytic knowing and historical-hermeneutic knowing while, at the same time, superordinating both of them in his third way of knowing – self-reflective 'critical' knowing. This third way is impelled by cognitive interest in emancipation in one's knowing. As part of this, Habermas argues that there is no knowing truth without one's knowing the knower – that is oneself – and therefore being changed, and, in turn, acting as an agent of change.[123] Without *praxis* – practical action for change, data can only be collected and understood outside of oneself. They cannot serve to initiate beneficent action which, in clinical settings, means the type of practice that, 'having reflected upon the knowledge gained from the human cognitive interests, sets out to be a participant and actor in change'. It is not sufficient to have right thoughts, or even to have good communication – '[o]ne must act for the good if good is to be done'.[124]

Aware of the risk of over-simplifying Habermas' considerable epistemological insights, it may be possible to use an artwork as an analogy. Empirical-analytic data collection may relate to recognising oil of different colours on stretched linen. Historical-hermeneutic understanding may recognise lilies floating on a pond and prompt discerning what the meaning intended by the artist might have been. Self-reflective and critical knowing is concerned with how the artwork moves me, what it reminds me of, in order to recognise its impact upon me, proffer an insight into myself or perhaps move me towards an action.

In a sense, empirical-analytic knowing of facts relates more towards the deontological way of thinking than the teleological – the search is for 'givens' or 'facts' of ethics which can regulate the course of moral activity in humans. In a similar sense, the historical-hermeneutic knowing of meaning, with its relegation of 'givens', relates more to the teleological way of thinking than the deontological – the search is based upon inter-subjective contestation, or the power to convince. There is some overlap. Although the search for 'givens' is relativized by teleology, empirical (data) calculations are inherent and the empirical-analytic way has some applicability to teleology; furthermore, to the extent that facts are filtered through language, the historical-hermeneutic way has some applicability to deontology. The search for facts and for meanings has its place, but needs to be reflected upon by oneself before the truth can be known to oneself. Self-reflectivity is more

[123] Lovat (2004). Aristotelian Ethics and Habermasian Critical theory: A conjoined force for proportionism in ethical discourse and Roman Catholic moral theology. Australian eJournal of Theology 3(1): 6.
[124] Terence Lovat and Gray (2008). Towards a proportionist social work ethics: A Habermasian perspective. Britis Journal of Social Work 38: 1104.

than a compromise between the first two ways of knowing; it constitutes a separate and authentic third way, a 'critically-balanced' way of knowing necessary for the highest order of moral decision-making.

Since language underpins the discourse which Habermas proposes is necessary in order for moral decisions to be made, he evolved a system of linguistics. He distinguishes 'communicative rationality' *illocutionary* language (reflecting its emancipatory ontology), from 'instrumental rationality' via *perlocutionary* language (reflecting its instrumental ontology). Following JL Austin, the illocutionary aspect of an utterance refers to 'what we do *in* saying something'[125] or the act the speaker performs via the utterance – for example, "I promise not to be late". The perlocutionary aspect refers to 'what we do *through* or *by* saying something'[126] or the effect produced via the utterance – for example, "if you are late, I won't wait", so expressing coercion. Communicative rationality is reflecting upon our background assumptions about the world, background assumptions which instrumental reality takes for granted as it considers the choice amongst means to obtain a given end. In an ideal dialogue of genuine communicative action, illocutionary goals are followed, and thus the foundations are put in place for a normative relationship between or amongst the speakers. For Habermas, communicative action is orientated towards reaching consensus via mutual understanding - which he regards as the *telos* of language.[127] Habermas identifies two inextricably linked constituents of language. These are, first, the communicative dimension, that is, the illocutionary force of the utterance, and, second, the cognitive dimension, namely its propositional content, about which consensual understanding is to be reached.[128] The illocutionary component simultaneously expresses three validity claims; these are 'truth, normative rightness, and sincerity [or authenticity]'.[129] Intelligibility was initially a validity claim, but it was subsequently discarded by Habermas.

At an epistemological level, Habermas holds the view that 'normative rightness must be regarded as a claim to validity that is analogous to a truth claim'.[130] Normative force is traditionally derived from a framework of ethical behaviour or beliefs, secular or theistic. Parfit summarises his belief in normative truth by claiming:

---

[125] Thomassen (2010). Communicative action and reason *Habermas: A Guide for the Perplexed* p.63.
[126] Ibid.
[127] Fultner and Habermas (2001). *On the Pragmatics of Social interaction: Preliminary Studies in the Theory of Communicative Action* p.ix.
[128] Fultner and Habermas (2001). *On the Pragmatics of Social interaction: Preliminary Studies in the Theory of Communicative Action* p.xiii.
[129] Ibid. xiv
[130] Habermas (1981, 1990). Morality and ethical life: does Hegel's critique of Kant apply to discourse ethics? *Moral Consciousness and Communicative Action* p.197.

> (A) There are some irreducibly normative reason-involving truths, some of which are moral truths. (B) Since these truths are not about natural properties, our knowledge of these truths cannot be based on perception, or on evidence provided by empirical facts. (C) Positive substantive normative truths cannot be analytic, in the sense that their truth follows from their meaning. Therefore (D) Our normative beliefs cannot be justified unless we are able to recognize in some other way that these beliefs are true.[131]

Parfit points to intuitively credible beliefs such as '[t]orturing children merely for fun is wrong'.[132] If not intuitive however, Parfits 'some other way' must suggest a process of discourse within the community affected.

Habermas has recourse to anthropology when he argues that morality is a protective safety device for people, both as individuals and collectively, who co-exist through inter-dependency within society – 'a densely woven fabric of mutual recognition, that is, of reciprocal exposedness and vulnerability'.[133] The essential intersubjectivity of the shared lifeworld is mediated through language. In this understanding, the vulnerability of human beings requires a system which points to mutual consideration – defending the integrity of the individual but also the collective 'through which individuals *reciprocally* stabilize their identities [original emphasis]'.[134] Habermas cites suicide as both an individual failing and a collective failing of an inter-subjectively shared lifeworld. He summarizes by saying that systems of morality must simultaneously 'emphasize the inviolability of the individual by postulating equal respect for the dignity of each individual. At the same time, however, they must also protect the web of intersubjective relations of mutual recognition by which these individuals survive as members of a community.[135] These principles correspond to justice, coequal respect and rights and to what Habermas refers to as solidarity, but which others may refer to as beneficence or compassion, empathy and care for our neighbours. Habermas finds roots for both of these concepts in the 'vulnerability of the human species, which individuates itself through sociation'.[136] Intersubjectivity is fundamental to Habermas, and this is necessarily based on language which, in turn, is constitutive of *homo sapiens*. Hence, his theory of language and communication was the precursor to his universal pragmatics and thence his expositions of discourse theory of

---

[131] Parfit (2011). *On What Matters* p.543.
[132] Ibid. 544
[133] Habermas (1981, 1990). Morality and ethical life: does Hegel's critique of Kant apply to discourse ethics? *Moral Consciousness and Communicative Action* p.199.
[134] Ibid. 200
[135] Ibid.
[136] Ibid.

morality and communicative action.[137] Thus, '[i]f language is what defines us, then we must look to our use of language for an account of morality'.[138]

Thus, the argument is beginning to emerge that normative force for a moral decision properly derives from a *process* based upon discourse which itself depends upon language. Language allows adjudication of competing truth claims[139] which, it will be argued, is a feature characteristic of the value pluralism characteristic of contemporary society. A process of discourse, within a community, aware of the principles of discourse theory of morality and communicative action, is the basis for a philosophy of intersubjectivity. It is not associated with an empirically factual justification, nor does its normativity appeal to moral intuitions. Habermas argues that in our contemporary epoch, arguments need to be set in appropriate 'world-disclosing' language in order to 'open the eyes of the "value-blind" children of Modernity' to the *Good*.[140] Without language, without words such as *ought*, *should*, *good*, *right*, and *justice*, amongst many others, there can be no moral enquiry.

Intersubjectivity underlies another approach to knowing, one with significant potential to impact on moral decision-making in medicine; this is *phenomenology*. Phenomenology has been described as the study of the lived experience 'from which the essential and universal truths of all experience can be derived';[141] it attempts to 'come into contact with the matters themselves, with concrete living experience.'[142] It is introduced at this point of the thesis because it flows from the present discussion of knowing, and because three inter-related components are especially relevant to moral decision-making in clinical contexts. The first is awareness of others. The second is recognition of patients' actual reality. The third is Maurice Merleau-Ponty's understanding of embodiment which stresses the solidness of the human encapsulation within reality. Edmund Husserl had a conception of what he termed the Life-world, as encapsulating 'the historical river of individual human existence. What is thus revealed is the *ontological* dimension of human existence, prior to (because a grounding condition of) the *epistemological*. This ontological dimension is the human being-in-the-Lifeworld [original emphasis];[143] in shorter form, this might be 'in the 'world of lived experience'.[144] In clinical medicine, phenomenology takes as 'its starting point – seeing patients' ethical dilemmas as

[137] Thomassen (2010). Introduction *Habermas: A Guide for the Perplexed* pp.5-9.
[138] Ibid. 10
[139] Bertens (1995). Theorizing the postmodern condition *The Idea of the Postmodern: A History* p.117.
[140] Habermas 1993) Justification and application: Remarks on discourse ethics,
[141] http://royby.com/philosophy/pages/levinas.html 8 April 2014
[142] Moran (2000). *Introduction to Phenomenology* p.xiii.
[143] Heelan (2001). The lifeworld and scientific interpretation *Handbook of Phenomenology and Medicine* p.50.
[144] Warnock (1970). Edmund Husserl *Existentialism* p.44.

grounded in concrete existential situations'.[145] Emmanuel Levinas 'never ceased to emphasise that the Other arises in relation to others and … [t]his relation is the unique relation of ethical responsibility … the practical relation of one to an other'.[146] This will be further explored in 3.5.3.iv Metaphysical empathy and phenomenology

Finally, there exists what could be termed an *epistemology of power*. By this is meant the clear power-imbalance between clinicians and patients, and between clinicians and students. This is based upon differences in the level of knowledge held by clinicians, compared with that held by patients and students, but is further encouraged by the importance accorded to quantitative knowledge, traditionally at the expense of meaning and value. Habermas, and Auguste Comte before him, argued that empirical scientific knowledge leads to predictability, and hence to power.[147] Laura proposes that 'because the epistemic goal of science is to make the world as predictable as possible, the world is stripped of its qualitative dimensions so that only the more predictable quantitative aspects remain'.[148] Linnie Price notes that medicine's choice to locate itself in science requires that non-observable phenomena be excluded.[149] A treatment paradigm which cannot be tested by determining its causal basis is rejected. Laura argues that modern medicine's reductionism recognises only a model of causation, crystallised into what he names 'the "theory of specific etiology"'.[150] This, in turn, has developed historically from Galileo Galilei's, Isaac Newton's and William Harvey's mechanistic world-view[151] 'fossilised into a metaphysical postulate',[152] dogmatically favouring an interventionist paradigm in medical decision-making. Jeffrey Bishop, in his provocatively titled *The Anticipatory Corpse*, writes that modern medicine is characterised by 'practices aimed at their own practicality ... deploy[ing] a metaphysics of control, of efficient causation';[153] scientific knowing is an act of power.[154] This follows upon modern medicine's propensity to definitively categorise objects unambiguously, which removes them from further

[145] Carel (2011). Phenomenology and its application in medicine. Theoretical Medical Bioethics 32(1): 33-46.
[146] Lechte (2008). Emile Benveniste *Fifty Key Contemporary Thinkers: From Structuralism To Post-Humanism* p.62.
[147] Outhwaite (1994). Scientism in theory and practice *Habermas: A Critical Introduction* p.35.
[148] Laura, Tim Marchant and Smith (2008). *The New Social Disease: from high tech depersonalisation to survival of the soul* p.10.
[149] Price (1984). Art, science, faith and medicine: the implications of the placebo effect. Sociology of Health & Illness 6(1): 69.
[150] Laura and Chapman (2009). *The Paradigm Shift in Health* p.xiii.
[151] Laura and Chapman (2009). The epistemological evolution of reductionist medical science *The Paradigm Shift in Health* pp.11-15.
[152] Laura and Chapman (2009). *The Paradigm Shift in Health* p.xiii.
[153] Bishop (2011). Transition one *The Anticipatory Corpse: Medicine, Power, and the Care of the Dying* p.89.
[154] Ibid. 90

evaluation, and 'is the power to control, to bring about the effects one desires in the world'.[155] Laura agrees: where knowledge should lead to empathic connectivity, it in fact leads to an epistemology of power.[156] The epistemology of power is re-visited in 7.3 Practical difficulties with the Habermasian paradigm in clinical practice.

**2.3 Historical contexts**

Moral judgements 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. The Diagnostic and Statistical Manual (DSM) of the American Psychological Association classifies mental and behavioural diseases. Thus it legitimises certain acts, behaviours, and attitudes by determining whether they are evidence of recognisable psychiatric disease. Legal ramifications aside, it also prevents the perpetrator from being labelled morally good or bad, or even owning moral responsibility for actions taken - at least during the time that the edition is current. The DSM has altered its classification of homosexuality, from a 'sociopathic personality disorder' in DSM-I (1952), through a 'personality disorder' in DSM-II (1968), and a 'sexual disorder Not Otherwise Specified' in DSM-III-R (1987), to a mental disorder only if the person has a 'persistent concern to change sexual orientation' in DSM-IV (1994).[157]

At the practical level of an individual making a moral decision, RM Hare proposed that moral thinking occurs at two levels – the *intuitive* and the *critical*. He postulates that the intuitive level is where one's personal historical-culturally influenced moral compass is to be found, whereas the critical level is from whence comes critical thought derived from reflection upon prior moral decisions. The critical level requires consideration of prescriptivity (normative concepts of *ought* and *should*) and impartial universalizability.[158] Thus, moral decision-making "practice" should be a fundamental tenet of medical education. As will be discussed In Chapter 3 Substantive Normative Ethical Frameworks, and also in 5.2 Development of the Proportionist approach, medical students can be facilitated to understand that certain *prima facie* principles can be recognised, and arranged in a hierarchy of relevance and importance, and thus ordered for the context of the particular situation at hand. In specific, difficult, morally-dilemmatic situations, assessment of the choices available should include consideration of the ethical frameworks available to us. Once a decision is

---

[156] Laura, Tim Marchant and Smith (2008). *The New Social Disease: from High Tech Depersonalisation to Survival of the Soul* pp.149-153.
[157] Engelhardt (1996). The languages of medicalization *The Foundations of Bioethics* pp.192-193.
[158] Crigger (1994). Universal prescriptivism: traditional moral decision-making theory revisited. Journal of Advanced Nursing 20(3): 540.

made, it should be reflected upon to ensure it is in coherent equilibrium with our intuitive moral decision-making compass, as an active process. The term *Reflective Equilibrium* was used by John Rawls in 1971 as he applied it to Justice.[159] The concept was however introduced earlier by Nelson Goodman in 1955 in the evaluation of the validity of one's internal processes of reasoning,[160] via actively reasoning backwards and forwards, determining and weighting the relevant moral aspects, principles used to make moral decisions, context, considering the consequences of possible moral decisions, and revisiting any elements which needed to be revisited, before reaching a decision. Christine Korsgaard holds that reflective scrutiny can be used to discriminate moral from immoral ways of acting, and that this 'constitutes a significant source of normativity'.[161] This approach also allows for evaluation of future moral dilemmas brought up by technology as it evolves. Different starting points for ethical deliberations, for example, the definition of life and when life begins, will however result in different reflective equilibria points.

Morality, and what is included in its purview, evolves as the questions asked by, and of, society change. The study of morality is necessarily contextualised by the historical reality of the times.[162] In the Western tradition, it is possible to apportion the development of moral philosophy into four epochs.[163,164]

The concept of epochs of philosophical thought is significant for several reasons. First, each epoch develops the thought of preceding epochs, and is in turn re-evaluated by succeeding epochs. Second, the appeal to logic of a philosophical approach will be more clearly understood when predicated upon knowledge of the historical conditions (for example, the civic and religious structures) extant at the time. Third, philosophers themselves are both effects and indeed can be causes.[165] They are 'effects of their social circumstances and of the politics and institutions' extant in their time but some are also sufficiently influential to be causes of the formation of mores in their milieu, or in those following. Fourth, there is a relationship between our circumstances and our philosophical beliefs - with circumstances influencing their philosophy, and their philosophy influencing their circumstances.[166] Richard Rorty writes that 'all of the different elements of human nature that help to build up the culture of a certain epoch or nation mirror themselves in one way or

[159] Rawls (1971, 1971). *A Theory of Justice (Original Edition)* pp.46-53.
[160] Pigliucci (2012). Reflective Equilibrium. Philosophy Now January/February(88): 27.
[161] O'Neill (1996). *The Sources of Normativity* p.xiii.
[162] MacIntyre (1998). *A Short History of Ethics* pp.89-90.
[163] Hugman (2005). Contemporary professional ethics *New Approaches in Ethics for the Caring Professions* pp.2-10.
[164] Engelhardt (1996). Introduction: Bioethics as a plural noun *The Foundations of Bioethics* pp.20-23.
[165] Russell (1946, 2004). *History of Western Philosophy* p.16.
[166] Russell (1946, 2004). *History of Western Philosophy* p.19.

another in the philosophy of that epoch'.[167] Foucault, in fact, speaks of 'the genealogy of ethics'.[168] Hence, there should not be an immutable *a priori* conception of moral goodness. Rather, there should be a conversation, a dialogue or dialectic, a process, of evaluation and re-evaluation, to determine what is morally Good, Right, and Just, in the situation under consideration. Dialectic (from the Greek *dialegesthai*, to converse, and *dialegein*, to sort or distinguish) has been defined as meaning 'to pass from one part – an object, a notion, a problem – to another by the means of language and reason'.[169] As will be exposited at length in this thesis, this process is especially important in our contemporary era, wherein, more so than in any previous era, the explosion of world travel and migration has brought a plurality of peoples from widely disparate cultures and belief-systems into our community. In clinical medicine, this understanding of a process of dialectic is especially apposite in coming to an understanding of wherein lie the best-interests of this patient in their situation. This thesis also argues that the process of dialectic, or discourse, has, of itself, a distinct moral dimension.

In the *Classical* (or *Ancient)* period are located the circum-Mediterranean, polytheistic, Hellenistic, and, to a lesser extent, Roman traditions, especially of Plato, the 'Sophists' (including Protagoras), 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. Much of the foundation of moral philosophy can be traced to these times.[170]

In the *Medieval* (or *Middle)* period, Classical ideas were re-cast in the light of monotheistic Islamic-Judaeo-Christian traditions of post Augustinian Christian theology, through the likes of Maimonides, Aquinas and Islamic scholars. Allegiance of the people and their rulers to the Classical epoch *polis*, or city-state, was comprehensively replaced by allegiance to God. 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.[171]

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. Recognising the centrality of reason as the basis for philosophical enquiry is the term 'the enlightenment'. Science replaced religious dogma as authority. Compared

---

[167] Schlick (1967, 1992). The future of philosophy *The Linguistic Turn: Essays in Philosophical Method* p.43.
[168] Foucault (1997). *Ethics: Subjectivity and truth - the essential works of Foucault 1954-1984* p.253.
[169] UNESCO 2007) Philosophy: A School of Freedom (Teaching Philosophy and Learning to Philosophize. Status and prospects). Annex 3: 248
[170] Engelhardt (1996). Introduction: Bioethics as a plural noun *The Foundations of Bioethics* p.20.
[171] Ibid.

with ecclesiastical authority, science claims to be rational, is not associated with eternal penalties if its tenets are rejected, and offers piecemeal authority only. In this sense, it is not a complete system.[172] A morality of 'law, command, duty and obligation',[173] and a somewhat anti-Christian ethos, came to replace the external motivations originating in the Classical period and early Christianity. Somewhere too, between the medieval and modern periods, 'morals', in the sense of right and wrong or good and evil behaviour, came to be disconnected from the customary way of behaving, driven as they had been largely by adherence to the word of God and not thought of as being alterable by human will. Only if free will was deliberately exercised to turn away from God's notion of right and good, could a choice alternative to simply following custom, be made.[174] Perhaps to counter the suspicion that ethical theories tend to be unconnected to practical moral judgements, and to enhance a more rational 'scientific' basis for ethical decision-making, the modern epoch's normative ethical frameworks were placed 'prior to and the ultimate source of legitimacy for particular ethical judgements'.[175]

The contemporary era is here termed *Post-modern*. It may trace its origins to the completion of post-World War II reconstruction and the subsequent reflection upon modernity.[176] The later Modern period is characterised by self-doubt and a loss of hope in the anticipated social and scientific progress of the early twentieth century. The post-modern era is characterised by rapidly increased technology throughout the world, which especially impacted upon global communication via television and the world-wide web. This imparted a much wider knowledge of different cultures, ethics and ways of living. Together with widespread travel and immigration by the peoples of the world, a pronounced pluralism and fragmentation ensued, as well as increased tension related to devotion to the (often unilateral) rights and entitlements of the individual. This post-modern period is also post-traditional, in that it has reacted to and, in many areas, abandoned long-held traditional elements of culture, and is thus able to be characterised as having an 'incredulity towards metanarratives'.[177] A metanarrative 'provides a frame of reference in which people have faith; it is the basis for a 'credible' purpose for action … or society at large'.[178] In the post-modern era, these over-arching guidelines or 'macro goals'[179] (for example, a faith narrative based upon a religious

[172] Russell (1946, 2004). General characteristics *History of Western Philosophy* p.454.
[173] McCoy (2004). The subject matter of morality *An Intelligent Person's Guide to Christian Ethics* p.16.
[174] Bauman (1993). *Postmodern Ethics* p.4.
[175] Paola, Walker and Nixon (2010). Theory in bioethics *Medical Ethics and Humanities* p.11.
[176] Engelhardt (1996). Introduction: Bioethics as a plural noun *The Foundations of Bioethics* p.22.
[177] Lyotard (1979, *The Postmodern Condition: A Report on Knowledge* p.xxiv.
[178] Lechte (2008). Jean-Francois Lyotard *Fifty Key Contemporary Thinkers: From Structuralism To Post-Humanism* p.324.
[179] Ibid.

framework), are no longer accepted. This is the case especially as it encompasses our understanding of *knowledge*. Jean-Francois Lyotard aptly characterises this as an 'exteriorization of knowledge with respect to the "knower", at whatever point he or she may occupy in the knowledge process'.[180] 'Under conditions of irreducible pluralism, consensus concerning basic values and notions of the good life has permanently receded beyond the horizon of possibility'[181] and, therefore, attempts to rely upon substantive (stand-alone) frameworks as moral arbiters, 'fly in the face of historical reality'.[182] Aware of the diversity and fragmentation of a pluralist society in terms of life-views and value-constructs, contributors in this era do not seek a single (rational or otherwise) truth, but are cognisant of a multiplicity of truths. They de-emphasize any single moral framework as universally applicable independent of context.[183] In this, they deny the validity of the 'Enlightenment Project' which sought to establish a 'canonical, content-full morality in secular terms'[184] applicable to all. Thus, they rightly emphasise insightful self-understanding via critical self-reflection, and favour a *process* over a substantive framework, emphasising community consensus rather than subjectivity for normative force, using communicative language as the construct. The failure of rationality as a basis for moral force in the post-modern epoch means that it is not possible to dismiss those who disagree with a reasoned moral argument, as irrational.[185] The modern period may be characterised by an orientation towards Right Action. The post-modern era, as understood here, can be characterised by the need for dialectic, and thus consensus-seeking. The current era's constellation of religious beliefs, economic power or powerlessness, political ideologies and individualism only barely co-exist. The disparate ethics of ecological responsibility is useful to underline the fact that the pluralism of the multiparous societies of our world removes any automatic legitimisation across all societies. Post-modern rediscovery of Classical morality, articulated as the virtue ethical framework, has come to be seen as important for moral decision-making in medical and other caring professional settings. These realities impel the viewing of society as 'a network of meanings that are constructed by human beings through language, and so may only be understood through

[180] Lyotard (1979, 1984) The postmodern condition: A report on knowledge, Theory and History of Literature, 144
[181] Cronin (1993). Translator's Introduction *Justification and Application: Remarks on Discourse Ethics* pp.xx-xxi.
[182] Cronin (1994, 2001). Translator's Introduction *Justification and application: Remarks on discourse ethics* pp.xi-xxxi.
[183] White (1991). The postmodern problematic *Political theory and Postmodernism* pp.19-23.
[184] Engelhardt (1996). Introduction: Bioethics as a plural noun *The Foundations of Bioethics* p.23.
[185] Engelhardt (1996). The intellectual bases of bioethics *The Foundations of Bioethics* p.72.

language'.[186] Post-modernists argue that 'language constitutes, rather than reflects, the world, and that knowledge is therefore … specific [to the] environment in which it arises'.[187]

Although Habermas recognises himself as a modernist, albeit perhaps with some ambivalence, it is contended in this thesis that, under the understanding expressed above, he could also be seen as a post-modernist. At the very least, this is 'because his philosophical project … provides a constant and formidable background of which all postmodern theorizing cannot help being aware'.[188] Although some feel it is premature to speak of post-modernity, the appellations 'late modern' and 'postmodern modernity'[189] are awkward (allowing however that contemporary society may, itself, be awkward). This thesis does not agree that Habermas is orientated primarily towards 'a responsibility to act' in the world, and is therefore a modernist,[190,191] but argues that he is indeed orientated primarily towards 'a responsibility to otherness', open to difference, dissonance and ambiguity using language to disclose the world, and is therefore primarily a post-modernist. Stephen K White goes on to argue that post-modern ethics incorporates a virtue ethical framework focused upon caring, based upon individual particularities of the other – allowing 'sufficient time and attention for registering individual nuances and differences',[192] and requiring a strong '"injunction to listen" to the other, a willingness to hold open an intersubjective space in which difference can unfold in its particularity'.[193] The affinity with the concepts of Habermasian Communicative rather than Strategic Action is obvious. This thesis contends that the differences between Habermas and the postmodern era are over-stated, with less tension present than some commentators postulate.

Alasdair MacIntyre contends that philosophical comment upon morality should not be a mere abstract, action-neutral observance of mores extant at the time, but should be dynamically interactive with society and so impel action.[194] Habermas would likely agree that a trenchant dialogue between philosophically-enquiring minds and members of society at-large is fundamental to today's society. This thesis argues for a greater emphasis on communication and discourse, partly as a reflection of a migration from a substantive conception of moral (and also political) philosophy,

---

[186] Hugman (2005). Contemporary professional ethics *New Approaches in Ethics for the Caring Professions* p.8.
[187] Bertens (1995). Introduciton *The Idea of the Postmodern* p.6.
[188] Bertens (1995). Theorizing the postmodern condition *The Idea of the Postmodern: A History* p.114.
[189] White (1991). The postmodern problematic *Political theory and Postmodernism* p.13.
[190] d'Entreves (1997). Habermas and the Unfinished Project of Modernity: Critical Essays on 'The Philosophical Discourse of Modernity' p.2.
[191] White (1991). The postmodern problematic *Political theory and Postmodernism* p.x.
[192] Honneth (1995). The other justice: Habermas and the ethical challenge of postmodernism *Cambridge Companion to Habermas* pp.299-300.
[193] White 1991) Political theory and postmodernism, Modern European Philosophy, xiv, 153:
[194] MacIntyre (1998). *A Short History of Ethics* p.3.

towards a procedural conception.[195] This may be characterised as emphasising values and norms reached by active and reflective communicative consensus, and tested for universalizability, thus possessing both cognitive and normative force.

**2.4 Summary**

Understanding foundational conceptions of moral decision-making allows moral decision-making in clinical settings to be appropriately situated. These conceptions include knowing, how we know, values, meaning, and truth; with language as the moral intermediary. Cognizant of an historical perspective, characteristics of our current epoch, wherein the arguments advanced in this thesis are located, prompts consideration of a process by which clinicians make moral decisions. It will be argued that this process is based upon paradigms of discourse and reflective consensual agreement, and thus, a re-evaluation of medical education is impelled.

Before that, however, the three substantive (stand-alone) frameworks of deontology, teleology, and virtue ethics need to be considered, as they might apply to clinical moral decision-making. The Good of the patient is the ultimate *telos* of moral philosophical decision-making in clinical situations. A hierarchy of four interpretations will be proffered, with the guiding principles of empathy, compassion and care posited as an appropriate framework for normative moral decision-making in clinical situations. Notwithstanding the secularisation of moral philosophy, it is incomplete to explore moral decision-making without taking account of the importance of the Islamic-Judaeo-Christian tradition in both historical and contemporary terms.

[195] Moon (1995). Practical discourse and communicative ethics *The Cambridge Companion to Habermas* p.143.

## CHAPTER 3 SUBSTANTIVE NORMATIVE ETHICAL FRAMEWORKS

### 3.1 Introduction

In Chapter 2, foundational concepts of language as a moral intermediary, and the necessary underpinning of epistemology as explicating how we know what we know, and whether what we know is justified, were considered. This then segued into exploring knowledge as an emancipatory drive to elucidate how clinicians might make morally good decisions. Historical perspectives are important in understanding from whence our moral philosophical frameworks have derived, and, as importantly, what insights can be gleaned about clinical moral decision-making in our current epoch. Thus a re-evaluation of contemporary medical education can be based on firm foundations.

This chapter begins by considering several approaches to normative moral philosophy in the secular Western tradition. Three frameworks or groups of guidelines are recognised, and are considered *substantive* – that is, they are stand-alone sets of guidelines. These are the *deontological* framework, the *teleological* framework, and the *virtue ethics* framework. [196,197,198,199,200,201]

Principles derived from them, and modifications proposed to them, are foundation stones which guide ethical decision-making, including in clinical situations. Clinically-relevant applications will thus be emphasised. Against this background, the Islamic-Judaeo-Christian tradition is then examined.

### 3.2 Normative ethical frameworks

Three normative frameworks examine how we ought to act from a morally good perspective, and how to make morally good decisions. Though formulated in the modern epoch, they are sympathetic to lines exposited in the classical period.[202,203] As will be shown, 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.

---

[196] Childress (1989). The normative principles of medical ethics *Medical ethics* p.31.
[197] Loewy (1989). Theoretical considerations *Textbook of medical ethics* pp.18-22.
[198] Habermas (1994). On the pragmatic, the ethical, and the moral employments of pratical reason *Justification and Application: Remarks on Discourse Ethics* p.1.
[199] Solomon 1995) Normative ethical theories, Encyclopedia of bioethics, 812-824
[200] Baron (1997). Introduction *Three methods of ethics* pp.3-5.
[201] Heath (2014). Rebooting discourse ethics. Philosophy and Social Criticism 40(9): 836.
[202] Lovat (2004). Aristotelian Ethics and Habermasian Critical theory: A conjoined force for proportionism in ethical discourse and Roman Catholic moral theology. Australian eJournal of Theology 3(1): 2.
[203] Lovat and Gray (2008). Towards a proportionist social work ethics: A Habermasian perspective. British Journal of Social Work 38: 1102.

Deontological Ethics (from the Greek *deon* or *duty*, *obligation*) had as its earliest classical period champion, Plato, who in part built upon the earlier thoughts of Pythagoras.[204] Plato's understanding, developed throughout his various *Dialogues*,[205] was based upon the dichotomy between human sense perception and his Doctrine of Forms. Forms are perfections, existing in the mind of God. What we humans perceive are imperfect representations. Thus, he believed that knowledge, including that of Goodness, Justice and Right, come to us from above. Platonists therefore tend to rely on the rules which determine ethical behaviour.[206,207] Ideas are tested 'according to their intrinsic value, independently of the judgement of the crowd';[208] and 'virtue is worthwhile without utility, worthwhile in itself … by its relation to the absolute'.[209] This provided the epistemological framework for the philosophical tradition known variously as *absolutist*, *ontological*, *prescriptivist*, *intrinsicalist*, *categorical* or *deontological* (the term coined, interestingly, by Bentham). The progenitor medieval Christian philosopher in this framework was Augustine, who extended Plato's thesis that human sense perception was too inadequate to be trusted, to argue in *City of God*[210] that human senses and intuition were too corrupt to discern moral truth.[211] Thus, he dichotomised the world of natural desires with the realm of divine order.[212] In the modern era, Kant is associated with the original formulation of the deontological framework. Whether an Act is morally good or not is intrinsic to the Action itself, dependent upon its concordance with a set of rules or principles, independent of its consequences.

Teleological Ethics (from the Greek *telos* or *end*, *fulfilment*, *final purpose*) has as its earliest classical period champion the sophist Protagoras, who, as portrayed by Plato in various of his dialogues, believed that there were no absolutes with respect to knowledge, and that knowledge is derived empirically. He is credited by Plato as saying that 'man is the measure of all things, and that things are to me as they appear to me, and that they are to you as they appear to you'.[213] Truth is relative to the perceiver and the context. If one could convince another of the truth of a thing, then it was

[204] Russell (1946, 2004). Pythagoras *History of Western Philosophy* pp.73-74.
[205] Plato (c390 BC, 1952). The Dialogues of Plato *The Dialogues of Plato, The Seventh Letter* p.439.
[206] Lovat and Mitchell (1991). The history of ethics: trends and directions *Bioethics for Medical and Health Professionals* pp.3-4.
[207] Slote (1995). Task of ethics *Encyclopedia of Bioethics, Revised edition* p.722.
[208] Maritain (1964). The discovery of ethics: Socrates *Moral Philosophy: An Historical and Critical Survey of The Great Systems* p.5.
[209] Maritain (1964). The discovery of ethics: Plato *Moral Philosophy: An Historical and Critical Survey of The Great Systems* p.23.
[210] Augustine (413-426, 1952). The City of God *The Confessions, The City of God, On Christian Doctrine* p.331.
[211] Lovat (2004). Aristotelian Ethics and Habermasian Critical theory: A conjoined force for proportionism in ethical discourse and Roman Catholic moral theology. Australian eJournal of Theology 3(1): 3.
[212] MacIntyre (1998). *A Short History of Ethics* p.113.
[213] Plato (c390 BC, 1952). Cratylus *The Dialogues of Plato, The Seventh Letter* p.86.

true; in that context – 'the verdict of the bystanders was the final judgement'.[214] Since there was no objective truth, this 'makes the majority, for practical purposes, the arbiters as to what to believe'.[215] There were no absolutes, only relativities; consequently, there could be no absolute knowledge, only knowledge based on sense experience. Thus, opposite to Plato's Socratic conceptions of *the* Good/Just/Right, Protagoras conceived of *pragmatic* good/just/right in the circumstances given.[216] This provided the epistemological framework for the philosophical tradition variously known as *utilitarianism*, *consequentialism*, or *teleology*. The seminal (late) medieval philosopher in this framework was Niccolo Machiavelli. He believed that actions are of no moral relevance and should be judged entirely in terms of their consequences, and that the study of history and its lessons was a means to influence other people towards certain outcomes[217] In the modern era, Bentham and Mill are associated with the original formulation of the teleological framework, which is concerned with making moral decisions based upon the outcome or potential outcome which follows upon the morally relevant 'Act'. In other words, whether an Act is morally good or not depends upon whether it brings about the best consequences, independent of the reasons for acting.

Virtue, or Aretaic, Ethics (from the Greek *arête* or *virtue*, *excellence*) developed as a synthesis of Plato's exposition of morality as based upon fixed knowledge from above, and partly from that of Protagoras as based upon experiential knowledge derived empirically in the thinking of Aristotle, who, it might be said, corrected the over-corrections by Plato of Protagoras.[218] While in practical terms balancing the two views, which constituted more than mere compromise, Aristotle was offering a transcendent moral framework surpassing both.[219] In his *Nicomachean Ethics*[220] he proposed the knowledge and practice of the Good as the basis for *eudaimonia*, a flourishing life, as the final purpose of a well-lived life. Put another way, 'the art of morality is not the art of living morally *with a view* to attaining happiness; it is the art of *being happy* because one lives morally

[214] Maritain (1964). The discovery of ethics: Socrates *Moral Philosophy: An Historical and Critical Survey of The Great Systems* p.5.
[215] Russell (1946, 2004). Protagoras *History of Western Philosophy* p.124.
[216] Lovat (2006). Practical mysticism as authentic religiousness: A Bonhoeffer case study. Australian eJournal of Theology 6: 3.
[217] MacIntyre (1998). *A Short History of Ethics* pp.123-124.
[218] Lovat and Mitchell (1991). The history of ethics: trends and directions *Bioethics for Medical and Health Professionals* p.5.
[219] Lovat (2004). Aristotelian Ethics and Habermasian Critical theory: A conjoined force for proportionism in ethical discourse and Roman Catholic moral theology. Australian eJournal of Theology 3(1): 9.
[220] Aristotle (c340 BC, 1952). Nicomachean Ethics *The Works of Aristotle Volume II* p.431.

[original emphasis]'.[221] Aquinas represents a seminal medieval era Christian interpretation, albeit influenced by Islamic writings brought to the West partly as a result of the Crusades. Hence was laid the epistemological foundations for a *relativist*, *proportionist*, *deonto-teleological*[222] or *classical-medieval synthesis*[223] approach, ultimately to align and become identified with *virtue ethics*. The virtue ethical framework is concerned with making moral decisions in the Aristotelian sense of according with virtue, rather than according to rules or consequences alone. Thus, one can be said to be authentic in living the morally good life.

Critics of different normative frameworks can muddy the waters of comparison somewhat if they ascribe to their opponents either the most extreme or the most simplistic interpretation while, at the same time, ascribing to their selves a more moderated interpretation. The frameworks do share similarities. 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. An abstract theory of right action is not inherent. On the other hand, the rationalist streams of deontological ethics and teleological ethics are more prescriptive, more concerned with what should be done in given scenarios. They, for the most part, do inherently incorporate a theory of right action. In another sense, however, virtue ethics and deontological ethics value a Good Act for what it is in itself (to an Aristotelian as 'a constituent of human ... happiness',[224] to a Kantian as a rational application of duty independent of motive), and tend towards agent-relativity. In contrast, teleologists value an action to the extent of its real or potential consequences, and so tend towards agent-neutrality. Hence, personal integrity is not an inherent concern in their ethical framework. Aristotle, though, did place significant emphasis on the need to consider the best choice amongst competing means to achieve the virtuous end.[225] In similar fashion, Aquinas emphasises that 'in order to do good deeds, it matters not only what a man does but also how he does it'.[226] Under a teleological framework, right (in the sense of morally correct) is that which maximises the Good. In contrast, under a deontological framework, right (acting in a

[221] Maritain (1964). The discovery of ethics: Socrates *Moral Philosophy: An Historical and Critical Survey of The Great Systems* p.14.
[222] Lovat and Mitchell (1991). The history of ethics: trends and directions *Bioethics for Medical and Health Professionals* p.5.
[223] Pellegrino (2005). Toward a virtue-based normative ethics for the health professions. Kennedy Institute of Ethics Journal 5 (3): 254.
[224] McCabe (2005). *The Good Life: Ethics and the Pursuit of Happiness* p.6.
[225] Aristotle (c340 BC, 1952). Nicomachean Ethics *The Works of Aristotle Volume II* p.358.
[226] Aquinas (1265–1274, 1952). Summa Theologica *Thomas Aquinas II* p.39.

morally correct manner) is prior to the Good.[227] In its simplest utterance, we can only comply or not with a deontological *rule*, while we can only seek to maximise a teleological *value*.[228]

The abiding import of the three frameworks is noted by Habermas when he writes '[c]contemporary discussions in practical philosophy draw, now as before, on three main sources: Aristotelian ethics, utilitarianism, and Kantian moral theory'.[229] Yet Schopenhauer wrote that he found philosophy 'to be a monster with many heads, each of which speaks a different language',[230] and each of which asserts its own authority. It is perfectly clear to Engelhardt, a self-described 'born-again Texan Orthodox Catholic' as well as physician and bioethicist, that the impossibility of discerning a 'canonical content-full secular morality' - a concrete universal morality, or 'an account in general of what individuals … ought to do'[231] - reflects the post-modern recognition of the failure of the Modern philosophical, or Enlightenment, project.[232] He believes that this failure, despite over two thousand five hundred years of intellectual reasoning, 'constitutes the fundamental catastrophe of contemporary secular culture', and that this 'frames the context of contemporary bioethics'.[233] This thesis however does not hold such a pessimistic view. It argues that the classical, medieval, and modern epochs are the sources of the necessary building blocks upon which we develop an understanding of ethical decision-making in our contemporary era.

In the discussion that follows, initially the originally-formulated version of each normative ethical framework is described, usually in terms of the writings of one or two progenitors. Then, there follows discussion of more recent interpretations of the frameworks as originally formulated. Aspects which may be relevant to moral decision making in clinical settings are posited.

As an illustrative case study for each of the secular normative frameworks to be discussed below, consider Baby 'W'. He is a five and a half month old child, born to Chinese parents on a student visa, diagnosed with a syndrome of progressive neuro-muscular weakness (Spinal Muscular Atrophy). This condition is characterised by inevitably progressive weakness, with eventual development of seizures, inability to feed, failure of breathing, and, after several years, a fatal outcome. Treatment requires a home breathing mask (Continuous Positive Airway pressure, CPAP) titrated to breathing effort, eventually progressing to life-long mechanical ventilation. Also required will be enteral tube

[227] Rawls (1971, 1999). *A Theory of Justice (Revised Edition)* p.24.
[228] Singer (1994). *Ethics* p.11.
[229] Habermas (1994). On the pragmatic, the ethical, and the moral employments of pratical reason *Justification and Application: Remarks on Discourse Ethics* p.1.
[230] Schopenhauer (1818, 1844, 1969). *The World as Will and Representation* p.95.
[231] Engelhardt (1996). Introduction: Bioethics as a plural noun *The Foundations of Bioethics* p.3.
[232] Ibid. 8
[233] Ibid.

feeding, and anti-epileptic medications titrated to therapeutic levels. The family are to return home to China once their student visas expire. Their home town is of reasonable size and it is likely that this medical technology is available. The ethical dilemma is whether to commence treatment before they return home.

The chosen example is vulnerable to criticism, but is proffered here as a vehicle to allow explanation of the normative ethical frameworks, and to allow questions about the frameworks to be raised.

### 3.3 Deontological frameworks

#### 3.3.1 Deontology as originally formulated - Kant

For Kant, ethical decisions depended not upon God or upon subjective feelings, human communities, individual preferences, or any actual or potential consequence. Ethical choices depended entirely on reason. Rational creatures are governed not only by the physical laws which impel all material things, but, uniquely, by what he saw as moral laws, as well; laws imposed on us by our ability to reason. Acting from desire is no more than that which any natural creature does. Acting according to a good will, a duty imposed by our rationality, is the basis for Kant's morality.[234] Reason is 'given to us as a practical faculty, i.e. one which is meant to have an influence on the will', and the proper function of our reason is to produce a will which is good in itself.[235] Importantly, the Goodness of a volition (will) 'is Good not because of what it performs or effects' [236] and not because of its fitness-for-task; it is Good in itself. The Goodness of an action 'does not lie in the effect expected from it … nor motive from this expected event'.[237] Put another way, in ethical decision-making the right (will) and the good (outcome) have no necessary connection. For Kant, the Right is prior to the Good.[238]

The categorical imperative asserts that I 'am never to act otherwise than so *that I could also will that my maxim should become a universal law* [original emphasis].'[239] Kant gives several examples. 'May I when in distress make a promise with the intention not to keep it?'[240] An example would be in borrowing money with no intention of repaying it. This situation brings into conflict the maxim of prudence (making the promise is safer for me, and removes me from immediate peril), and the law

[234] Warnock (1998). *An Intelligent Person's Guide to Ethics* p.80.
[235] Kant (1785, 1994). Foundations of The Metaphysics of Morals *Ethics* p.125.
[236] Kant (1785, 1952). The Fundamental Principles of the Metaphysic of Morals *The Critique of Pure Reason, The Critique of Practical Reason and other ethical treatises, The Critique of Judgement* p.256.
[237] Ibid. 259
[238] Rawls (1971, 1999). *A Theory of Justice (Revised Edition)* p.24.
[239] Kant (1785, 1952). The Fundamental Principles of the Metaphysic of Morals *The Critique of Pure Reason, The Critique of Practical Reason and other ethical treatises, The Critique of Judgement* p.260.
[240] Ibid.

of duty (to speak the truth always). Although the borrowing of the money is very good for the borrower at the time, if non-repayment was generalised to all peoples, then trust and the economy as a whole would both break down. In clinical practice, an example could be that of a clinician who watches her patient suffer a painful, fearful, and distressing death. As she leaves the ward, the family ask whether their loved one suffered as he died. Under the deontological framework, it is the clinician's duty always to speak the truth, regardless of situation or consequences.

An absolute good will follows the categorical imperative.[241] To act morally is to perform one's duty, and one's duty is to obey the innate moral laws. In fact, Kant specifically says that in order to be morally good, actions need to be done *from duty*, rather than *in conformity* with duty, simply from a generosity of spirit.[242] Indeed, it may be that, in terms of moral credits, a disciple of Kant benefits from the absence of coinciding inclinations such as sympathy and, even better, the presence of opposing inclinations such as misanthropy.[243] This is not to say however that doing good acts out of a sense of beneficence, albeit of less moral worth to Kant, is wrong in any sense of violating 'ought' or 'should'.

Kant allowed that intelligence, courage, qualities of temperament, and self-control, are all testimonies to good character. Nonetheless, if there is not a good will working in tandem, then these attributes are meaningless in terms of moral virtue.[244] A good will is good in itself – independent of its actual or intended effects. In fact, even if a good will fails completely to achieve its purpose, for whatever reason, it maintains its absolute value ('like a jewel, it would still shine in its own light, as a thing which has its whole value in itself … its usefulness or fruitlessness can neither add to nor take away anything from this value'),[245] according with Kant's principle of volition.[246] Good character and good actions are devoid of moral worth unless they are motivated by a good will. It is the task of man's reason to produce just such a good will.

Kant posits a pure philosophy of morals, derived from *a priori* principles, completely free from empiricism. By 'empiricism' here, Kant means the 'interests, want, desires, and preferences people

[241] Kant (1785, 1952). The Fundamental Principles of the Metaphysic of Morals *The Critique of Pure Reason, The Critique of Practical Reason and other ethical treatises, The Critique of Judgement* p.280.
[242] Kant (1785, 1952). The Fundamental Principles of the Metaphysic of Morals *The Critique of Pure Reason, The Critique of Practical Reason and other ethical treatises, The Critique of Judgement* p.257.
[243] Langton (1992). Duty and Desolation. Philosophy 67: 481-505.
[244] Kant (1785, 1952). The Fundamental Principles of the Metaphysic of Morals *The Critique of Pure Reason, The Critique of Practical Reason and other ethical treatises, The Critique of Judgement* p.256.
[245] Ibid.
[246] Ibid. 259

have at any given time'.[247] By so doing, he reminds us that the principles of pure metaphysical philosophy are complete in themselves. They are not based on empirical properties of human nature (personal desires or preferences are an insufficient basis for moral decision-making). From these principles (a metaphysic of morals), it must be possible to deduce practical moral rules for man.[248] Thus, Kant sees a categorical imperative as arising *a priori* (from reason), while a hypothetical imperative is empirically based (from inclination), and so is of a lesser-order.

While Kant sought simple, justifiable formulations with universal applicability, and some accuse him of excessive rigidity, he offered as a *practical imperative* that we should 'Act so that you treat humanity, whether in your own person or in that of another, always as an end and never as a means only'.[249] In other words, humans should be considered as intrinsically valuable, with intrinsic dignity, and treated accordingly. This is also known as 'the formula of humanity'.[250]

In moral conflicts (for example, stealing), Kant would apply both his categorical imperative (stealing another person's property cannot, rationally, be generalised) as well as his practical imperative (others should be treated as ends in themselves, not as a means to *our* ends). This notion that we must not use other people, but should treat them with respect, recognising their intrinsic worth as human beings, is fundamental to moral human rights theories. It is not to be conceptualised however as a type of goodness. Rather, it confers a moral status.[251] Kant's practical imperative requires not treating another human as a *mere* means. It does, however, allow a person to voluntarily consent to be a means to an end by, for example, formally agreeing to take part in a medical experiment. Kant's proposition that persons should always be seen as self-existent ends in themselves is elaborated upon by David Velleman as meaning that they 'have a value that is incommensurable with other values and, indeed, incomparable with the value of other persons'.[252] The *value* of a person intrinsically precludes comparison with any other person or within oneself (at times or states of physical infirmity, age, intellectual incapacity, or contribution to society). Necessarily, the value of a person delimits the view we take of a person and the things we consider are permissible acts upon a person. Alex Voorhoeve cites, as an example, that if I view another person as an end, I cannot even begin to consider whether telling a funny story at his expense might

[247] Sandel (2009). What matters is the motive *Justice: What is the Right Thing to Do?* p.108.
[248] Kant (1785, 1952). The Fundamental Principles of the Metaphysic of Morals *The Critique of Pure Reason, The Critique of Practical Reason and other ethical treatises, The Critique of Judgement* p.267.
[249] Kant (1788, 1952). The Critique of Practical Reason *The Critique of Pure Reason, The Critique of Practical Reason and other ethical treatises, The Critique of Judgement* p.337ff
[250] Parfit (2011). *On What Matters* p.177.
[251] Ibid. 2
[252] Voorhoeve and Velleman (2009). Really seeing another *Conversations on Ethics* p.237.

result in a greater gain through people appreciating my wit, compared with the loss accruing from his embarrassment. This is because appreciating him as an end rather than a means completely precludes telling a story about him at all.[253] In a medical setting, a clinician motivated to see patients as ends rather than means cannot even begin to consider whether it is better to direct limited resources to a group of younger patients versus a group of older patients. Viewing a person as an end rather than a means possesses inherent moral motivation.

In the case-study of Baby 'W', since not treating all babies cannot be generalised as a categorical imperative, while treating all babies can be, and furthermore, because Baby 'W''s intrinsic dignity is independent of his potential achievements, he should be given maximal medical help, without concern about the consequences for others. Thus, it is appropriate to commence CPAP, enteral feeding, and anticonvulsants.

### 3.3.2 Contemporary deontology

Hegel was critical of the prominence which Kant ascribed to duty as the prime motivator of decisions for moral goodness. He was concerned that the 'preaching of duty for duty's sake' was entirely too abstract, had 'identity without content' and thus left ethical decision-making in a vacuum.[254] As well, Kant's categorical imperative necessarily abstracts itself from the context of the ethical decision to be made.

In their purest form, being derived *a priori* rather than empirically, as originally conceived, deontological rules are exception-less. In moral decision-making under this framework, we try to determine the general features of the particular problem before us, and then apply a principle, or rule derived from a principle, in order to know the morally good choice.[255] In complex moral situations, the 'rules' could be correspondingly complex or detailed. Critics argue that there is a risk that preconceived moral standards could be applied without any great aforethought. Equally, with absolutely exception-less rules, it is difficult to have a reasonable discussion or argument. While teleological frameworks allow no sense of personal moral responsibility, deontological frameworks make personal moral integrity paramount; whatever the consequences, we cannot lie, despite the fact that innocents might thus be saved.

---

[253] Ibid.
[254] Hegel (1821, 1952). The Philosophy of Right *The Philosophy of Right, The Philosophy of History* p.47.
[255] Held (1990). Feminist Transformations of Moral Theory. Philosophy and Phenomenological Research 50: 321-344.

Deontological constraints are often framed in the negative, and are narrowly-focused or 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. Nancy (Ann) Davis argues that 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.[256] An agent must not harm the one in order to save the five; but if the agent refuses to harm the one and the five are thus harmed, since the harm to the five is not the agent's chosen means or end, then no deontological rule is breached. In an obvious medical setting, the rule (or 'constraint') could be "the patient must not suffer". Thus, sufficient morphine is given to relieve pain. The consequent respiratory failure is not in the environs of the moral decision-making. Similarly, provided a clinician does not lie, it is permissible to withhold the truth from a patient.

Other difficulties with the framework, as originally formulated, include the challenge of knowing wherein our duty lies in any given situation. What actions are, in practice, impermissible? Traditionally, those nominated are derived from Judaeo-Christian teachings, or can sometimes be referenced to Kant's own writings. The exception-less rigidity of Kant, for example, his conclusion that veracity is an absolute duty, is no longer thought to be reasonable. It is not our duty to truthfully point out to the Gestapo (or to a hired killer) wherein hides a Jew (or the intended victim). This would be a denial of our common humanity, our humane sensibility, and our compassion. 'Whether or not an action is morally good depends on its motive, but whether or not it is right depends on what it does'.[257]

Barbara Herman reminds us that Kant had great concern for telling the truth, for very good reasons. Normal communicative speech amongst us carries (or arguably should carry) a truth presumption.[258] The world would indeed be different if everyone always spoke the truth. Although we could argue that the wrong-intention of the murderer seeking his victim negates the consequence of lying, Kant could not argue so. This is because, for Kant, the nature of the moral act precludes consideration of consequences. Barbara Herman argues that it is the murderer's 'demand on *our* speech that contravenes the core value of truthfulness … [f]or that reason his demand cancels, or has no claim on, the truth presumption'.[259] She goes on to say that, in addition, since the aim of the murderer is to commit a wrong-doing, it is for this reason that the lie becomes a permissible option. Finally, though, she says that 'if, without increasing the risk to the victim, we can manage without the lie, we

[256] Davis (1993). Contemporary Deontology *A Companion to Ethics* p.210.
[257] Frankena (1980). *Thinking About Morality* p.48.
[258] Herman (2011). A mismatch of methods *On What Matters* pp.106-110.
[259] Ibid. 108

should'.[260] This might be by, for example, speaking un-informatively or not at all. Nonetheless the deliberate lie itself may be justifiable, in her words, by 'something like preventative policing of our shared moral space in response to the aggressor's betrayal of the common end'.[261] Importantly, this and similar ethical dilemmas, underline the insight that there is commonly an hierarchy of values or duties which we need to order so as to discern what is more morally good (or less morally bad). This will be further exposited below.

In some situations, whether a maxim turns out to be morally wrong depends on how many people act upon it (Parfit's *threshold objection*).[262] Some maxims can legitimately be permissible for some to act upon, though not all. For example, one may choose to have no children so as to devote one's life to philosophy,[263] or to work for the future of humanity.[264] However, this could not be generalised to all people, since there would be no more children born. Most might accept however that it is permissible for some people. Indeed, it may be argued that it is indeed morally good for selected people to forego children in order to study philosophy or to better humanity. However, some maxims can legitimately be impermissible for some to act upon, because not all can. For example, if some fishermen use larger nets, they will catch more fish, but if all fishermen use larger nets, fish stocks will decline, and all will catch fewer fish.[265] 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. Most would not rationally agree to will either of these situations to be true for all people, since there would be no fish, and rampant contagious disease. While clearly rational for some to act this way, nonetheless, is it morally permissible? The concern here is that exempting the few who wish to give up having children for philosophy or to better humanity, from Kant's categorical imperative, seems reasonable. Is it similarly reasonable to exempt the latter group of fishermen and non-immunisers? Or should there be no exemptions – as Kant intended?

Thomas Pogge suggests that Kant's imperative should be re-cast to something along the lines of the maxim in question being available to all, though not necessarily acted upon by all.[266] In the first group considered above, there are not so many people giving up children in order to become philosophers, or to better humanity, that the birth rate has declined. Fishing with bigger nets and

---

[260] Ibid. 109
[261] Ibid.
[262] Parfit (idem p.308ff.
[263] Ibid. 308
[264] Parfit (2011). *On What Matters* p.282.
[265] Parfit (2011). *On What Matters* p.303.
[266] Pogge (1997). *Kant's Groundwork of the Metaphysics of Morals: Critical Essays* p.190.

non-immunisation, though, are more difficult – since there is a natural temptation to use a bigger net, and others will then join in; and there is still much written about links between autism and immunisation despite the link being disproven.[267] 'Herd immunity' requires quite high compliance rates (70-95%)[268] to be successful for an individual unimmunised child. As well, not immunising one's own child contravenes Kant's practical imperative if the view is taken that other children are being used as a means to maintain herd immunity for the benefit of one's own child.

Clearly, Kant's drive to found principles of morality in abstract principles has great intellectual appeal. For Schopenhauer, however, it had little practical relevance to ordinary people. 'Difficult combinations, heuristic rules, propositions balanced on a needle point, and stilted maxims ... are certainly very well adapted for echoing in lecture halls ... but can never produce the appeal that actually exists in everyone to act justly and do good'.[269] This may be harsh perhaps, but it can be difficult to see what might motivate an individual to act purely out of Kant's notion of duty (assuming the individual knows what it is), with no concept of personally feeling good. Herbert James Paton offers a more generous interpretation when he suggests that taking an action 'does not demand that we should *renounce* all claims to happiness, but only that the moment the duty is in question, we should not *take it into account* [original emphasis]'.[270] In other words, we may feel good after the event provided that was not our motive in acting. Furthermore, since 'a natural inclination to that which accords with duty (for example benevolence) can greatly facilitate the effectiveness of the moral maxim, we have an indirect duty to cultivate natural sympathy as a means to that end'.[271] A Good will as Good in itself, discrete from outcome, is troublesome in clinical practice, and is not likely to be sufficient for a morally good decision. Consider, for instance, a benevolent but neophyte surgeon, who is so inexperienced that outcomes are poor. MacIntyre takes particular issue with Kant's preoccupation with reason and rationality as the basis for moral decision-making. He is unable to conceive how someone could be motivated to act except by emotional desire, and in fact proposes that the 'hard work of morality consists in the *transformation* of our desires, so that we aim at the good'.[272]

As will be re-visited in Chapter 6, Habermas' Discourse Theory of Morality and Communicative Action, in seeking normative truths, Habermas re-formulates Kant's universalizable normative

[267] Deer (2011). How the case against MMR vaccine was fixed. British Medical Journal(Jan 5): 342:c5347.
[268] Fine (1993). Herd immunity: History, theory, practice. Epidemiologic Reviews 15(2): 265.
[269] Schopenhauer (1841, 1965). *On the Basis of Morality* p.120.
[270] Paton (1947). *The Categorical Imperative* p.56.
[271] Ibid. 57
[272] MacIntyre and Voorhoeve (2009). The illusion of self-sufficiency *Conversations on Ethics* p.117.

predicate. This he does by going beyond asking an individual to decide whether the rule can be generalised to all others (while allowing that the norm should be teachable and be publically defendable and be non-discriminatory). He states, as a generalizability principle of his discourse theory of morality, that 'only those norms can claim to be valid that meet (or could meet) with the approval of all affected'.[273] 'Subjects capable of moral judgement cannot test each for himself alone whether an established or recommended norm is in the general interest and ought to have social force; this can only be done in common with everyone else involved'.[274] This is cast another way by McCarthy as 'rather than ascribing to all others any maxim that I can will to be a universal law, I must submit my maxim to all others for purposes of discursively testing its claim to universality'.[275] Habermas forces upon Kant a wider level of social engagement with others, via requiring dialogue and consensus in order to establish normativity. Habermas' basis for morality derives from a practical discourse within society as a whole. He echoes Kant in that he replaces notions of the Good with notions of a Good Will. Habermas and Foucault, while they may express opposing thoughts about morality based upon consensus versus morality based upon *realpolitik* power, both recognise the importance of Kant in contemporaneous philosophical (as well as moral, sociological, legal, and political) thought. Habermas takes Kant as his point of departure for discourse theory of morality. For Foucault, in abandoning the work of Kant, 'one runs the risk of lapsing into irrationality'.[276]

Kant's practical imperative – that we should not treat people as means to an end – is fundamental in Medicine, but needs to be interpreted with some care. Consider a situation where I have several organs available for transplantation.[277] Two patients, A and B, who need transplants, are on my side of the river (which I myself am too weak to swim across). Five more patients who will benefit from the organs are on the other side. If I transplant patient A, that patient is able to swim over to the other side with five organs. While if I transplant patient B that patient still cannot make that swim. In trying to avoid treating people as '*mere* means to my end', if I choose to transplant patient A then I am treating patient A as a means to the end of transplanting the five on the other side of the river. Patient A may well (and likely will) consent to being used as a means to my end. However, patient B is denied the transplant and perishes because s/he cannot, despite strong desire and willingness to give consent to be used as a means to my desired end of getting the organs across the river. The emphasis is upon 'mere' means.

---

[273] Habermas (1981, 1990). *Moral Consciousness and Communicative Action* p.66.
[274] Habermas (1987). *Theory of Communicative Action* p.95.
[275] McCarthy (1978). *The Critical Theory of Jurgen Habermas* p.326.
[276] Rabinow (1984). Space, knowledge, and power *The Foucault Reader* p.248.
[277] Kamm and Voorhoeve (2009). In search of the deep structure of morality *Conversations on Ethics* p.25.

Currently there exist a protean variety of deontological frameworks.

i) Kantian ethics

Kantian Ethics are extensions of Kant, sometimes divergent, but which claim moral authority in the writings of Kant.

ii) Rights-based deontology

The right of an individual to be repaid a debt is reciprocated with the responsibility of the other to repay the debt, independent of circumstance. John Locke argues that humans have absolute natural rights, for example, to not be harmed, to good health, to their own liberty, to possessions. The authority for this rests either in man's humanity itself, or in rights vested by God. They are not context-specific and thus are not able to be varied by location or physical geography, by race, colour or creed, gender or handicap. They are inalienable, and are articulated by Thomas Jefferson in the Declaration of Independence.[278]

Rights may be positive or negative. A positive right is a right to receive something – either goods or services. A negative right is a right not to be interfered with. Arguably, under this system of morality, there is a reciprocal obligation. If a person does have a right to something (for example, health care), then some other person in that society has an obligation to provide that something. Similarly, if someone has a negative right to avoid something (for example, physical violence), other persons have an obligation not to inflict that something upon them.

iii) WD Ross' deontology

William David Ross distinguishes the *Act* – by which he means 'the thing done', – from the *Action* – by which he means 'the doing of it'. He imputes *motive* to the Action but not to the Act.[279] He ascribes no intrinsic moral value to an Act, only to the motive. So there is no nett contribution to the totality of value in the universe coming from an Act, only from the motive to act.[280]

Both the frameworks of virtue ethics and of deontological ethics emphasise what *ought* to be the motivator in order that what is done is morally good. WD Ross maintains that, whether they are in agreement or in conflict, acting out of a sense of duty is of greater moral goodness than acting from

[278] Jefferson (1952). The Declaration of Independence *American State Papers, The Federalist, On Liberty, Representative Government, Utilitarianism* p.1.
[279] Ross (2002). *The Right and the Good* p.7.
[280] Ross (2002). *The Right and the Good* p.132.

a kind heart, because it is of a higher order as motive.[281] He discussed 'whether there is any general character which makes acts right, and if so, what is it'.[282] He favours the theory of GE Moore that 'what makes actions right is that they are productive of more *good* than could have been produced by any other action open to the agent'.[283] Ross assumes, explicitly, that some things are intuitively known to the "plain man" as Good. An example would be in keeping a promise by giving one's word, repaying a debt, telling the truth. Although one has promised to meet another, one has justification for breaking that promise if, by so doing, one can give relief instead to the victims of a serious accident. Despite a duty to honour a promise, there is also a duty to relieve suffering, and, in breaking the promise, I assign relieving suffering as constituting more of a duty in this instance. Conceptually, nonetheless, a promise was made to meet someone, while no promise was made to the victims of the accident.

Simplistically, Kant would argue that following duties of 'perfect obligation' (such as keeping a promise) admits 'no exception whatsoever in favour of duties of imperfect obligation' (such as the relief of suffering).[284] Moore (and Ross) argue that it is entirely consistent from a deontologist's perspective that conflicts of *prima facie* duties (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. He proposed a plurality of intuitively-known *prima facie* moral principles, which may well conflict, and thus their relative importance must be considered as a hierarchy.

Plato agreed. In his *Crito* and the *Apology*, Socrates articulates his several duties. To not harm the State by escaping, to respect the rules of the State one chooses to live in, but also to teach (a duty given him by god, the giving up of which in Athens was a precondition to his release). Knowing, at the same time, that his teaching was for the good of the State, Socrates argued that his duty to teach took priority over his duty to obey the State.[285,286]

Ross speaks of the *duty* that the agent has, and the *claim* that the other has. From the point of view of the agent, he enumerates certain *prima facie* duties as those which should ordinarily be followed before any other considerations. These are duties of fidelity (telling the truth, keeping promises, fulfilling contracts), duties of reparation (correcting or making up for wrongs done to others), duties

[281] Ross (2002). *The Right and the Good* p.164.
[282] Ross (2002). *The Right and the Good* p.16.
[283] Ibid.
[284] Ibid. 18
[285] Plato (c390 BC, 1952). Apology *The Dialogues of Plato, The Seventh Letter* pp.208-212.
[286] Plato (c390 BC, 1952). Crito *The Dialogues of Plato, The Seventh Letter* pp.216-219.

of gratitude (recognising and extending our gratitude), duties of justice (allocating resources as they are merited), duties of beneficence (helping to improve the conditions of others in terms of virtue, happiness), duties of self-improvement (to improve our own virtue), and duties of non-maleficence (avoiding injury to others).[287] If a judgement is made amongst mutually-exclusive competing *prima facie* obligations, then there may well be a residual obligation associated with, for example, breaking the promise to meet another and instead rendering assistance at an accident, which impels a telephone call as soon as possible for a new date to meet. This is a further duty or continuing obligation. A variation includes, as our primary duty, following the less morally culpable action. An example would include 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.[288]

It is the *duty of non-maleficence* to which 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.[289] In the oft-quoted example of conflicting duties, as noted in 1.3 Decision-making in ethical conflicts, Plato argues that borrowed arms should not be returned to an owner 'when he is not in his right senses', despite the existing duty to repay a debt.[290] Amongst the conflicting duties one has of fidelity (obligating one to return the arms) and non-maleficence (avoid injuring others), the dictum of non-maleficence is of a higher priority.

iv) Natural law theories

Natural Law theorists propose that our moral guide as to what is right or wrong, good or evil, lies within us, centred in our own human nature, and is ordered providentially. These guiding precepts are necessary for us to achieve good, both at a personal level and at a societal level. Arguably, natural law theorists can trace their origins to Greek antiquity. Sophocles hinted at it in Antigone's moral conflict between obedience to King Creon and her appeal to a higher cause prompting her

[287] Ross (2002). *The Right and the Good* p.21.
[288] Douglas (2009). End-of-life decisions and moral psychology: Killing, letting die, intention and foresight. Bioethical Enquiry 6: 339-140.
[289] Ross (2002). *The Right and the Good* p.22.
[290] Plato (c390 BC, 1952). The Republic *The Dialogues of Plato, The Seventh Letter* p.297.

obligation to bury her brother.[291] Aristotle referenced Plato in describing natural justice as having the same force everywhere.[292] Marcus Tullius Cicero wrote:

> There is a true law, a right reason, conformable to nature, universal, unchangeable, eternal, whose commands urge us to duty ... This law cannot be contradicted by any other law ... this universal law of justice ... God himself is its author ... he who does not obey it flies from himself and does violence to the very nature of man.[293]

Elsewhere he writes, 'man is born for justice, and that law and equity are not a mere establishment of opinion, but an institution of nature'.[294] St Paul agreed when he argued that all created human beings have an understanding of natural law (Rom 2:14-15).

This tradition gained even wider acceptance through the writing of Aquinas. The Thomist account is embodied in his 'Treatise on Law' in *Summa Theologica*, wherein Aquinas posited a hierarchy of Law.[295] Eternal Law is that of the Supreme Being or Reason of the Universe, unchangeable and eternal. It is the Law from which all other Laws are derived, and to which we must conform. Natural Law is that which is understood by and participated in by all rational beings created by the Supreme Being, and therefore with consciousness of what is good and what is evil. Aquinas argues that this Law cannot be removed from our hearts. Human Law is that which is codified by humans, so enabling humans to follow Eternal Law and Natural Law, and is temporal. Divine Law is that revealed in the Scriptures, necessary because we cannot fully deduce Eternal Law.

Each of Eternal Law, Natural Law and Divine Law, by their nature, embody Good. Human Law is legislated by man and, if ordered to the Common Good, it must be obeyed (the laws are binding upon one's conscience). However, if a legislated Human law is unjust because it is contrary to the Common Good … then it does not bind one's conscience and need not be obeyed.[296] This is applicable to the deposing of an evil tyrant and was used to good effect by Martin Luther King in his *Letter from a Birmingham Jail* to justify his own civil disobedience, as well as that of the Christian

---

[291] Sophocles (1952). Antigone *Aeschylus, Sophocles, Euripides, Aristophanes* pp.131-142.
[292] Aristotle (c340 BC, 1952). Nicomachean Ethics *The Works of Aristotle Volume II* p.382.
[293] Cicero (54BC, 1841). Treatise on the Republic (Cicero's Commonwealth) *The Political Works of Marcus Tullius Cicero* p.270.
[294] Cicero (54BC, 1841). Treatise on the Laws *The Political Works of Marcus Tullius Cicero* p.45.
[295] Aquinas (1265–1274, 1952). Summa Theologica *Thomas Aquinas II* p.208ff.
[296] Aquinas (1265–1274, 1952). Summa Theologica *Thomas Aquinas II* p.233.

martyrs, Socrates, and those families that protected Jews from the Holocaust.[297] Human law can only legislate external acts (which appear), not 'interior movements' (which are hidden).[298]

Aquinas argued that the first principle of the natural law is 'good is what all desire' and 'good is to be pursued and done, and evil is to be avoided'.[299] All other precepts follow this and are subject to one's rationality or reason. This may be speculative (applying to 'necessary things which cannot be otherwise than they are', that is, absolute truths) or practical (applying to 'contingent matters, about which human actions are concerned').[300] Thus, *synderesis* (practical wisdom) impels us to act in the right, good, or just way. Actions follow upon the recognition of the natural law within us. Analogous to the example above of the responsibility to return the borrowed arms, Aquinas allows that 'in certain matters of detail', natural law needs to be guided by reason.[301] Furthermore, although natural law applies equally to all, the more details that are supplied, the more practical reason and judgement must be applied. The Thomist vision of moral philosophy however goes beyond natural law (which would be sufficient if we were directed to a natural, rather than a supernatural, end) and embraces Christianity as a spiritual journey towards God.

Natural law theories, in association with Aquinas' Principle of Double Effect, can provide the philosophical basis for discussion of how people may die in Intensive Care Units. There needs to be a robust philosophical basis for decision-making in relation to the use of life-support technologies since these are very effective in maintaining our physiological functions. Three constructs are considered in making moral decisions at the end-of-life - the Principle of Double Effect, the Principle of Doing versus Allowing, and the Principle of Ordinary Care versus Extra-Ordinary Care.

Jeffrey Bishop and Louis Janssens employ an Aristotelian-Thomist distinction between ontic and moral good and evil when they note that in the traditional understanding of death due to disease, death is viewed as ontically evil, but only morally evil if caused by human action.[302,303] Since advanced life-support technologies are quite capable of maintaining biological or physiological life - construed by Bishop as merely 'matter in motion', there has arisen a potential to control death by

[297] King (1963, 2010). Letter from a Birmingham Jail *Ethics: the Essential Writings* pp.364-365.
[298] Aquinas (1265–1274, 1952). Summa Theologica *Thomas Aquinas II* p.211.
[299] Aquinas (1265–1274, 1952). Summa Theologica *Thomas Aquinas II* p.222.
[300] Aquinas (1265–1274, 1952). Summa Theologica *Thomas Aquinas II* p.224.
[301] Ibid.
[302] Janssens (1979). Ontic and moral evil *Readings in moral theology: moral norms in the Catholic tradition* pp.40-93.
[303] Bishop (2011). Embracing death *The Anticipatory Corpse: Medicine, Power, and the Care of the Dying* pp.122-123.

choosing to withdraw life-support. This prompts consideration of whether such actions *cause* death, and are thus morally culpable.

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'.[304] 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 the therapeutic margin between benefit and harm in modern palliative care is actually not so narrow).[305] The primary outcome aimed at is to relieve suffering. The secondary outcome is ventilatory depression.

In these situations, four conditions must all be satisfied:[306,307] 1) the act must be good or at least neutral in itself (not in itself immoral); 2) the agent intends only the good outcome not the bad, although the bad outcome can be permissibly foreseen and is then 'tolerated' though not willed-for; 3) the bad outcome must not be intended as a means to the good outcome; and, 4) the good outcome must be a proportionate reason to compensate for permitting the foreseen bad outcome (as originally applied to justify self-defence it becomes unlawful if the act is out of proportion to the end). Appropriate doses of opiate analgaesia satisfy these criteria because: 1) opiates are not in themselves immoral; 2) opiates are used with the intention of relieving pain, although respiratory depression is a known accompaniment; 3) respiratory depression and the death of the patient are not the means opiates use to relieve pain; and 4) relief of severe pain is a proportionately serious reason to accept the outcome of hastened death.[308]

Consider though an elderly patient, pain-free but severely disabled by arthritis and thus with very limited mobility, who is 'tired of life'. The outcome of relieving the patient's 'tiredness of life' by using barbiturates can only be brought about by rendering the patient unconscious and liable

[304] Aquinas (1265–1274, 1947) Summa Theologica, Treatise on the Cardinal Virtues, Second Part of the Second Part: Question 64, Article 67
[305] Sykes and Thorns (2003). The use of opioids and sedatives at the end of life. Lancet Oncology 4(5): 312-318.
[306] McCormick (1973). *Ambiguity in Moral Choice* p.1.
[307] Kerridge, Lowe and Stewart (2013). End-of-life care: palliative care, euthanasia and assisted suicide *Ethics and Law for the Health Professions* p.675.
[308] Sulmasy and Pellegrino (1999). The rule of double effect: Clearing up the double talk. Arch Intern Med 159(6): 545.

therefore to die.[309] The principle of Double Effect cannot be brought to bear in that situation. In palliative medicine, existential distress refers to non-physical refractory depression, anxiety, demoralisation, or a self-awareness of the gap which exists when one's present experiences do not meet one's hopes and expectations.[310] Treatment may involve palliative (or "terminal") sedation. Again, the principle of double effect is not applicable, since this sedation is more likely to aim towards altering the patient's state of consciousness, unlike the action of opioids on physical pain.

Teleologists 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. Warnock attributes an example to (Gertrude) Elizabeth Anscombe which questions 'how far one's intention may stretch, and how one may, nevertheless, cut it off at a particular point, with varying degrees of plausibility'.[311] Consider a man hired to be responsible for keeping a rental property's drinking water tank full. He has been warned that the water-supply has become polluted but continues nonetheless to fulfil his obligation to fill the water-tank, and thus the family is poisoned. It seems unreasonable for him to argue that his intention was only to fill the tank, not to poison the family, which was a foreseeable but not intended outcome. In this case, it seems inappropriate to separate the intention from the foreseeable consequence. From a deontological perspective, it may be argued, as Ross alluded to, that there exists a hierarchy of duties. In providing analgaesia which depresses ventilation, the more important duty is to relieve pain, rather than that the patient should live another month; the higher duty was to not poison the family, rather than continue to fill the tank.[312]

Another criticism is that, if patient autonomy is central to clinical decision-making, then the principle of Double Effect is morally irrelevant. Arguably, 'the patient's informed consent to an action that may cause death is more fundamental than whether the physician intends to hasten death'.[313] Consider, however, the patient suffering with advanced emphysema who makes an autonomous choice to discontinue ventilatory support. Is the patient's intention to try to survive without a mechanical encumbrance, or is the patient's intention to hasten her own death in order to relieve further suffering?[314] This area is confused by ambiguous intentions. As well, making ethically good decisions under this principle may be easier when there is no conflict between two parties. An

[309] Daniel P Sulmasy and Pellegrino idem: 547.
[310] Calman (1984). Quality of life in cancer patients - an hypothesis. Journal of Medical Ethics 10(3): 124.
[311] Warnock (2004). *An Intelligent Person's Guide to Ethics* pp.41-42.
[312] Warnock (1998). *An Intelligent Person's Guide to Ethics* p.30.
[313] Quill, Dresser and Brock (1997). The rule of double effect--a critique of its role in end-of-life decision making. N Engl J Med 337(24): 1770.
[314] Ibid. 1769

example would be in medication given to relieve pain and suffering which also hastens that patient's own death. Compare this with the situation where there is a conflict of interest between two parties, for example, a mum who is pregnant but also has cervical cancer. In this situation, chemotherapy or gravid hysterectomy (removal of a pregnant uterus) results in the unintended but foreseeable death of the foetus.

The principle of Double Effect is not simply a justification for choosing the lesser of two conflicting bad outcomes, arguing that one is less evil than the other, and thus merely an instrument for utilitarian calculation, by which a *prima facie* prohibition can be over-ridden.[315] Rather, the intention is to pursue a morally good motive – provision of analgaesia for severe pain, aware of the foreseeable consequence. Put another way, the central distinction is 'between the *intentional* causation of evil, and *foreseeing* evil to be a consequence from what one does [original emphasis]'.[316]

The second principle has become known as Doing versus Allowing.[317] 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. Another example is active euthanasia by lethal injection versus passive euthanasia by switching off life-support technology or by withholding antibiotics for pneumonia. Its essential argument is that it requires more to justify harm from acting (also termed direct harm) than is required to justify harm from inaction (also termed indirect harm). It does acknowledge that the harm resulting from the intentional inaction has been allowed to occur. A given outcome is more likely to come about if one is trying to accomplish it, than if one is not trying to accomplish it. Thus, in the context of a harmful outcome, a deliberate action requires greater justification. Moral agents seem to have an intuitive preference for indirect harm over direct harm. Negative duties (avoid maleficence) generally take priority over positive duties (beneficence).

Phillipa Foot distinguishes doing from allowing, by distinguishing directly initiating or continuing a sequence, from indirectly allowing a sequence already in progress to complete itself.[318] James Rachels however describes a thought experiment in which Smith and Jones, both equally evil

---

[315] Sulmasy and Pellegrino (1999). The rule of double effect: Clearing up the double talk. Arch Intern Med 159(6): 545.
[316] Kerridge, Lowe and Stewart (2013). End-of-life care: palliative care, euthanasia and assisted suicide *Ethics and Law for the Health Professions* p.675.
[317] Quinn (1989). Actions, intentions, and consequences: The doctrine of doing and allowing. Philos Review XCVIII(3): 287.
[318] Ibid. 297

characters, decide to kill their 6 year old cousins in order to inherit their wealth.[319] Smith succeeds, but just before Jones acts, his cousin accidentally slips in the bath, hits his head and drowns while Jones watches. There is a strong moral intuition that Jones' inaction in failing to rescue the drowning cousin is no less morally culpable than Smith's action in killing his cousin. Since both had the same motive (personal gain) and same end in mind (death of their cousins), the unqualified distinction between positively acting and negatively not acting is morally insignificant. Marc Hauser proffered a very similar scenario.[320] In the context of euthanasia, Rachels mounts an argument 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 difference hinges on motive and intent. He makes the point that if the clinician's decision is incorrect and the condition was in fact curable, either form of euthanasia is equally regrettable. If the decision was correct, then the actual method used is not of itself important. Many authors contend that since both the intention or motive and the outcome are the same, there is no difference between withdrawing ventilator support and providing a lethal prescription or giving a lethal injection. Rachels argues that, by virtue of its quickness, active euthanasia may well be preferable to a lingering death by passive euthanasia.

Daniel Callahan takes issue with Rachels' analogy. He argues that the actions of Jones and Smith are both wrong, and not applicable in clinical settings. Callahan argues that in clinical moral decision-making, there 'is and will always remain a fundamental difference between what nature does to us and what we do to one another'.[321] "Allowing" ("letting die") is only possible if there is an underlying disease which, untreated, is fatal. He cites the example of placing himself, with healthy lungs, onto a ventilator, and then notes the significant difference between switching off the ventilator (following which nothing terminal will occur; he will simply breathe on his own again) and giving a muscle paralysing agent to prevent breathing – an active act of "doing" ("killing").[322] Furthermore, often the decision to cease active treatment in ICU has been made, and then, at a subsequent stage, the life-support technology is removed, not with the intention of killing, but with the intention of allowing nature to take its course. He posits, 'we can hardly be said to "intend" death when we admit we can no longer stop it'.[323]

---

[319] Rachels (1975). Active and Passive Euthanasia. N Engl J Med 292(2): 79.
[320] Hauser (2006). *Moral Minds: How Nature Designed Our Universal Sense of Right and Wrong* p.xviii.
[321] Callahan (2000). Stripping death bare: The recovery of nature *The Troubled Dream of Life: In Search of a Peaceful Death* p.76.
[322] Ibid. 77
[323] Ibid. 78

Additionally, aware of the respect many relatives and patients attach to the sanctity of human life, it is important that relatives do not see patients in ICU at any practical risk of being killed by clinicians who see no philosophical difference between killing and letting die in terms of motive or outcome. There is a significant felicific utility associated with disallowing the permissibility of killing rather than letting die.

The third principle is 'Ordinary' means versus 'Extra-ordinary' means. For an intervention to be an 'ordinary' means, Kevin Wildes suggests that consideration should be given to four elements:[324] 1) it must offer some hope of benefit; 2) it must be part of normal standard of care, not experimental or unproven; 3) the social situation of the individual must be a consideration; and 4) the means must not be overly painful, anxiety-inducing, excessively expensive, dangerous, or involve travelling great distances, or dislocating a family. He argues that ordinary means are obligatory. For an intervention to be 'extra-ordinary' means and thus not obligatory, consideration should be given to the same four elements. Perhaps this can be summarised as: ordinary means are proportionate means, extraordinary means are disproportionate means.

Bishop may agree that these means should be judged as such, at least partly, for their proportionality to their ends – to the quality of human or spiritual life these means will bring about. '[W]hile oxygenation can be an ordinary measure, it can be considered extraordinary if not ordered to the spiritual end'.[325] If the resultant 'physiological life is not ordered to humankind's spiritual end, ... [or] is overly burdensome to the patient', then the means is disproportionate and is not required.[326] Maximising biomedical or techno-medical good in terms of physiological outcome alone, without considering the context of this individual patient, may violate higher levels of the patient's *Good*, as will be further discussed in 3.4.2 Contemporary Teleology. This is quite different from a mechanistic reductionist concept of life-support technology in Intensive Care Units solely or predominantly directed towards maintaining the physiological function of the organism.

Bishop paraphrases Pope Pius XII when he states that the 'life-at-all-costs mentality' is not part of the Christian ethos, and using advanced life-support technologies to maintain life at all costs is not morally required. He goes on to note that 'because life is good, one ought *usually* to assist in the preservation of life [original emphasis]', but, he argues, 'the goodness of life is only possible insofar

[324] Wildes (1996). Ordinary and extraordinary means and the quality of life. Theological Studies 57(3): 505-506.
[325] Bishop (2011). The sovereign subject and death *The Anticipatory Corpse: Medicine, Power, and the Care of the Dying* pp.208-209.
[326] Ibid.

as it is directed to the *summum bonum*, to a *telos*'.[327] Put another way referring to *Evangelium Vitae*,[328] 'life is a relative and intermediate good, not the highest good'. The code of conduct of the Medical Board of Australia agrees when it states that doctors 'do not have a duty to try to prolong life at all cost'.[329] It goes on to state that they '… have a duty to know when not to initiate and when to cease attempts at prolonging life'.[330]

In the understanding proposed here, extra-Ordinary Care is not simply high technology or high cost treatment. Instead, it looks to the benefits which might accrue to the individual patient for whom it is being considered. In this sense, it is a similar approach to what has become known as Benefit versus Burden Analysis. This approach attempts to consider 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 nett utility. Properly, it should be contextualised to the individual patient's situation, and thus aims to guide the decision as to whether 'treatments may be legitimately foregone (withheld or withdrawn).'[331]

Re-evaluating the three philosophical underpinnings of end-of-life decision-making, as they might assist moral decision making in Intensive Care situations, is useful for this thesis. Each of these three Principles has short-comings as guides for moral decision-making in ICU. As noted in 3.2 The normative ethical frameworks, in a teleological understanding of moral philosophical enquiry, causality is focused upon the effects of an action while, in the deontological understanding, causality is focused upon motive for action. In other words, it may be that only in a deontological framework can a justification for Double Effect exist and a distinction between Doing versus Allowing be allowed. Double Effect has limitations in that foreseeable effects are heavily discounted as morally significant events, and so may be prone to ambiguity as to the actual intention of treatment, rendering them therefore less appealing. Doing versus Allowing may be difficult to differentiate in terms of both motivation and outcome, in clinical settings, notwithstanding the underlying natural history of the disease in question. Both the situation of prescribing treatment to relieve suffering with the foreseeable death of the patient, and the withdrawal of life-support with the foreseeable death of the patient, are contended here to have an equally causal relationship, at the very least in

[327] Bishop (2011). Embracing death *The Anticipatory Corpse: Medicine, Power, and the Care of the Dying* p.123.
[328] John Paul II 1995) Evangelium Vitae, 4:2:
[329] http://www.medicalboard.gov.au/Codes-Guidelines-Policies/Code-of-conduct.aspx
[330] Ibid.
[331] Catholic Health Australia 2001) Code of Ethical Standards for Catholic Health and Aged Care Services in Australia, 5.9: 44

that an inevitable sequence of events is triggered. There is no need, at least from a moral philosophical perspective, to disguise this by appealing to either Double Effect or Doing versus Allowing.

This thesis favours Ordinary versus Extra-Ordinary Care distinctions over both. 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. Ordinary versus Extra-Ordinary Care distinctions seek to maximise the patient's Good as a priority, but not in isolation from others who are in relationship with this patient. Those who are in relationship with the critically ill patient include the patient's relatives, the staff working in ICU, and the wider community itself. Thus, it encourages a dialogue to elucidate the particular context of the particular patient in question at the stage of their end-of-life.

Recent biomedical advances raise further, even more problematic, questions around withdrawal of life-maintaining support which might invoke these three Principles.

Consider an elderly patient with a fully implanted permanent cardiac pacemaker (PPM).[332] The PPM senses whether there is a cardiac rhythm, and if not, it is programmed to generate an electrical stimulus. In this patient, there is no spontaneous rhythm. The PPM is required to keep the heart beating. Electrical cardiac rate is permanently set to some lower limit. The patient develops pneumonia. Neither she, nor her family, wish to persist with treatment, and all accept that death is the most beneficent way forward.

From the patient's perspective, what should the PPM be viewed as? It is unclear whether fully implantable biotechnology devices are viewed by patients (or clinicians) as part of the ontology of the person who is the patient, in the same way that transplanted biological organs might be understood.[333] Certainly, it seems intuitively to be part of their being-in-the-world. Utilising a property-law approach, Frederick Paola *et al*. suggested that these devices can be viewed as similar to fixtures, rather than chattels.[334] Ruth England *et al.* proposed that, in distinction to transplanted organs and external mechanical appliances, and located somewhere between the two, the term

[332] Walker, Lovat, Leitch and Saul (2014). The moral philsophical challenges posed by fully implantable permanent pacemakers. Ethics and Medicine 30(3): 157-165.
[333] Paola and Walker (2000). Deactivating the implantable cardioverter-defibrillator: a biofixture analysis. South Med J 93(1): 21.
[334] Ibid.

"integral devices" should be assigned to fully implanted devices.[335] This reflects their status as non-organic, but "integrated into the physical being" of the patient.[336]

Thus, on what basis might the PPM be legitimately discontinued? The implanted battery of the PPM will last at least several years, so passively awaiting battery discharge is not a practical option. Being fully implanted, to remove it would require operative intervention. There is no physical on/off switch. To non-invasively stop it functioning, it must be deliberately re-programmed so its output is below the threshold to capture the heart's rhythm. If re-programmed in a patient who is dependent upon the implanted PPM, death would occur within a few moments.

Compare this to withdrawal of antibiotic treatment, the cessation of enteral tube feeding, or a one-way trial of extubation. Each of these would likely be accompanied by a longer period of dying, however death is not inevitable. In these situations, the Principle of Double Effect can be applied. Whereas following re-programming of a PPM, death, in the dependent patient, is inevitable and so Double Effect cannot be applied. Similarly, in these situations there exists a distinction between Doing and Allowing. Doing versus Allowing is troublesome, however, because the PPM requires active re-programming. Leaving aside whether it is possible to differentiate motivation from outcome, "allowing" the battery to run down will take an excessively long time. "Doing" involves deliberate re-programming of the PPM so as to no longer capture the heart's rhythm. This dramatically reduces the distinction between Doing and Allowing. Given the technological sophistication of a fully implanted PPM and the fact that an operative procedure is required, appeal to the Principle of Ordinary versus Extra-Ordinary Care is attractive. However, the PPM is already *in-situ*. This Principle is of less use after the event. The construct of Benefit versus Burden, as a guide to withholding or withdrawing treatment, is also less useful in this situation. This is the case, first, because the PPM treatment cannot easily be withdrawn, since it either requires an operation or requires reprogramming with the inevitable and almost instantaneous death of the dependent patient. Second, even when the patient is not completely dependent upon the PPM, its reprogramming will inevitably bring about the recurrence of the symptoms that mandated the insertion of a pacemaker in the first place. These are commonly light-headedness, and a propensity to sudden episodes of loss of consciousness. This will likely re-impose a significant burden. Put another way, in the non-dependent patient, deactivation of the PPM will neither improve the

[335] England, England and Coggon (2007). The ethical and legal implications of deactivating an implantable cardioverter-defibrillator in a patient with terminal cancer. J Med Ethics 33(9): 538.
[336] Ibid. 540

patient's well-being nor will it hasten death. Arguably, this constitutes a negative double effect, and is an inappropriate action whatever the intent.

Another problematic concept in this example is that of patient autonomy, or the right to self-determination. This tenet is central to clinical decision-making, and will be further explored in 4.2.1 Autonomy.

A further consideration from a moral philosophical perspective is the fact that in the situations of cessation of antibiotic treatment, of tube feeding, or a one-way trial of extubation, the time frame for death, if it occurs, is unpredictable, albeit within a span of several days or weeks. Following re-programming of the PPM, the time span to death is instantaneous or within only a few moments. The nexus between the action of deactivation and the death of the patient is so immediate that the intent to hasten death is made explicit. While this may be emotionally unsettling, time-span to death does not have any moral (or legal) weight in itself. It does however offer some understanding of the moral unease in re-programming the PPM in dependent patients. There is an identifiable discomfort amongst clinicians,[337] and also amongst patients and care-givers,[338] in this setting. Presumably, there is a role here for education of clinical and technical staff, and for subsequent de-briefing.

Rapid advances in biotechnology have rendered the distinctions offered by these three principles less clear in practical clinical application, perhaps rendering all three as, at best, "thin" ethical constructs only. Clear and open dialogue between clinician and patient, about the nature and consequences of fully implantable devices, before implantation and when significant deterioration in health appears possible, are necessary pre-requisites to moral decision-making in this context.

To make a morally-correct decision, to take morally correct action, may require courage. This courage of conviction in turn points to the strength of our moral compass. In the context of a discussion on abortion, Judith Jarvis Thomson speaks of the Good Samaritan (Luke 10:30-35) and the Minimally Decent Samaritan.[339] The latter are persons who, while they will not risk their own life to pull someone from the rolled car which they have just chanced upon, they will stop and call emergency services and request their help. While presumably a Bad Samaritan would swerve around the accident and continue on their way.

[337] Kramer, Mitchell and Brock (2012). Deactivation of pacemakers and implantable cardioverter-defibrillators. Prog Cardiovasc Dis 55(3): 297.
[338] Ibid.
[339] Thomson (1971). A Defense of Abortion. Philosophy and Public Affairs 1(1): 47-66, ibid.

v) Social contract theories

Social contract theorists base their moral philosophy upon achieving politico-social order and justice. In examining how we should live together as a cohesive society, Thomas Hobbes, Locke and Rousseau have contributed to abstract theories of justice wherein the initial position of equality is independent of social class or status, personal attributes, strengths or weaknesses, or personal wealth. The argument is that no one can thus be disadvantaged at the outset. Hobbes described a form which may be also characterized as rule-based ethical egoism. He believed man in his natural state is inherently selfish and driven to seek power over others. He writes that without a civil government, 'every man is enemy to every man … and the life of man, solitary, poor, nasty, brutish, and short'.[340] Therefore, as a result, for purely selfish reasons, for our own protection from the selfishness of others and to avoid anarchy, society is better-off with rules than without them. This may be paraphrased as mutually beneficial co-operation. Thus, humans are enabled to live together, via rules or laws enacted and enforced by government, which trade-off certain freedoms with protection by the law. This is his initial contractual proposition.[341]

Rawls uses the term 'justice as fairness' to describe his initial situation of fairness - rights given behind a 'veil of ignorance'.[342] Members are rational and disinterested in, or at least unknowing of, their own position in society, personal characteristics, race, abilities, sex, religiosity. They need to arrange society so that each member has equal wealth and opportunity. Aiming for the highest mean amount of wealth is not sufficient, principles of nett utility are not relevant, reciprocity is fundamental, and 'accidents of natural endowment and the contingencies of social circumstance' need to be countered.[343] Inequalities are permissible only if they are beneficial to everyone (medical practitioners are included here). From the perspective of morality, for Rawls what is morally good is that which unbiased impartial observers would agree with. Rawls himself maintains that the thrust of his work is towards a political theory of social justice, and that his theory is Kantian by 'analogy not identity'.[344] Thus he articulates two principles of justice.[345,346] The first and the more fundamental is that of liberty or freedom. This is required by all members of a just society, and includes freedom of conscience, freedom of association, dignity as a person, and an extant rule of

[340] Hobbes (1651, 1952). Leviathan *The Prince, Leviathan* p.85.
[341] Hobbes (1651, 1952). Leviathan *The Prince, Leviathan* pp.84-91.
[342] Rawls (1971, 1971). *A Theory of Justice (Original Edition)* p.12.
[343] Ibid. 15
[344] Rawls (1985). Justice as Fairness: Political not Metaphysical. Philosophy & Public Affairs 14(3): 224.
[345] Kerridge, Lowe and Stewart (2013). Ethical theories and concepts *Ethics and Law for the Health Professions* p.23.
[346] Kerridge, Lowe and Stewart (2013). Principle-based ethics *Ethics and Law for the Health Professions* p.127.

law. These are seen as fundamental because they are required by individuals in order to be social citizens, in order to be moral agents. The second principle is that of difference. This regulates permissible differences in wealth and power, and so defines the limits of inequality in a just society.

vi) Divine command theory

A single monotheistic God, or multiple polytheistic gods, decide what are the rules to be followed, and the morally-correct decision is to follow them, regardless of the consequences. This monotheistic deity, all knowing, creator of all, and perfectly unbiased, knows the consequences of all possible decisions and hence what is best. S/He sets morality, incontrovertibly. The deity is the paradigm of the all-encompassing truth condition. Coherence is perfect. In practice however, even amongst theists, there is considerable controversy about how to listen to the Deity, and what S/He actually says. Although secularists neither look nor listen here, it may be that another distinguishing feature of the post-modern epoch which, since it defaults to ignore any concept of a monotheistic God, inevitably recourses to a polytheistic system of multiple gods (or goddesses). Each of them portrays equally defensible, but quite different, perspectives.[347] Thus, we see the moral diversity of post-modern secular moral philosophy, each position clamouring for authority. Within this context is set medical morality. Thus this thesis reiterates that, in our current epoch, a *process* for making morally good decisions and also for adducing normative force, necessarily follows these insights.

vii) Derek Parfit's triple theory

In seeking a guiding principle of morality, Parfit, in *On What Matters*, seeks to combine the essence of Kant's categorical imperative with elements of Consequentialism. Rather than seek to define 'wrongness' itself (for example, deliberately causing pointless suffering), Parfit seeks to describe a 'single *higher-level* wrong-making property'.[348] This he proposes as a single umbrella for all other properties or facts which make an act wrong; this is his universal theory of morality. It is a three-step argument for him. Initially he revises Kant's categorical Imperative to 'Everyone ought to follow the principles whose universal acceptance everyone could rationally will', which he terms the *Kantian Contractionalist Formula*.[349] Next, he qualifies it with Scanlon's formula 'everyone ought to follow the principles that no one could reasonably reject'.[350] 'Reasonably' here means both 'rationally' and in the sense of needing to give some weight to the moral claims of others. Perhaps Scanlon's formula echoes William Frankena's reformulation of Kant that there is a '*duty* to act on a maxim if

[347] Engelhardt (1996). The intellectual bases of bioethics *The Foundations of Bioethics* pp.36-37.
[348] Parfit (2011). *On What Matters* p.414.
[349] Parfit (2011). *On What Matters* p.342.
[350] Parfit (2011). *On What Matters* p.360.

and only if one cannot will its *opposite* to be a universal law'.[351] Finally, he adds a version of *Rule Consequentialism* as 'everyone ought to follow the principles whose universal acceptance would make things go best' – what may be termed *optimific* principles.[352]

Thus follows his *Triple Theory* - an 'act is wrong just when such acts are disallowed by some principle that is optimific, uniquely universally willable, and not reasonably rejectable'.[353] Parfit goes on to say that, in cases such as rape, there is no need to refer to a triply-supported principle. Nor is there a need to refer to deontology or teleology. Rape is always wrong. However a triply-supported theory may be of great value in approaching moral conflicts in order to categorise acts as wrong or not. He cites as examples telling a lie for someone's good end, or stealing something its owner never uses.

### 3.4 Teleological frameworks

#### 3.4.1 Teleology as originally formulated – Bentham and Mill's Utilitarianism

For Bentham and Mill, decisions or choices for Goodness depend upon Utility – which Mill submits as his 'ultimate appeal on all ethical issues'.[354] Bentham originally described 'the principle of utility' but quickly accepted the alternative 'greatest happiness principle',[355] which he attributed to Joseph Priestley, who wrote that 'the good and happiness of the members, that is the majority of the members of any state, is the great standard by which everything related to that state must finally be determined'.[356] This principle aims for 'the greatest happiness of all those whose interest is in question, as being the right and proper, and only right and proper and universally desirable, end of human action: of human action in every situation'.[357] Utility means to Bentham 'that property in any object, whereby it tends to produce benefit, advantage, pleasure, good or happiness' or to prevent the opposite.[358] The concept however of 'the greatest amount of happiness altogether'[359] is that of nett happiness or goodness. In other words, 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

[351] Frankena (1973). Egoistic and deontological theories *Ethics* p.57.
[352] Parfit (2011). *On What Matters* p.410.
[353] Ibid. 413
[354] Mill (1859, 1952). On Liberty *American State Papers, The Federalist, On Liberty, Representative Government, Utilitarianism* p.272.
[355] Bentham (1789, 1988). *The Principles of Morals and Legislation* p.1 (footnote).
[356] Priestley (1768, An Essay on the First Principles of Government, and on the Nature of Political, Civil, and Religious Liberty,
[357] Bentham (1789, 1988). *The Principles of Morals and Legislation* p.1 (footnote).
[358] Ibid. 2
[359] Mill (1861, 1952). Utilitarianism *American State Papers, The Federalist, On Liberty, Representative Government, Utilitarianism* p.450.

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.[360]

We may deliberately make a choice which causes us pain (for example, Aristotle's boxer who sustains painful blows in order to ultimately achieve victory) or which involves sacrifice (Aristotle's soldier who chooses 'the noble deeds of war' at the cost of losing his life).[361] Alternatively, we might consider Mill's noble hero who voluntarily sacrifices himself 'for the sake of something which he prizes more than his individual happiness'.[362] However, from Mill's ethical viewpoint, there is absolutely no virtue attached to self-sacrifice which adds nothing to the happiness of all others in the world – while it 'may be an inspiring proof of what men *can* do' it is 'assuredly not an example of what they *should*' do.[363] More generally, for Utilitarians 'a sacrifice which does not increase ... the sum total of happiness, it considers as wasted'.[364] The probability of an outcome should be considered – a 'course of action that will certainly produce some benefit is to be preferred to an alternative course that may lead to a slightly larger benefit, but is equally likely to result in no benefit at all. Only if the greater magnitude of the uncertain benefit outweighs its uncertainty should we choose it.'[365]

Following on from his discussion of beneficence, David Hume argues that, in moral determinations, utility for the Common Good is a necessary consideration.[366] Wherever a moral or philosophical conflict arises with respect to where our duty lies, that conflict can be resolved by determining where the Common Good of mankind lies, mindful however that further experience or analysis may warrant altering the decision as to where lie the boundaries of moral Good. Hume gives the example of alms-giving to beggars. This at first appears to be Good, but when it occurs that 'the homely bread of the honest and industrious is often thereby converted into delicious cates [delicacies] for the idle and the prodigal',[367] then it no longer remains Good. Kant notes that, although 'the sovereign, as undertaker of the duty of the people, has the right to tax them for ... charitable or pious

[360] Bentham (1789, 1988). *The Principles of Morals and Legislation* p.31.
[361] Aristotle (c340 BC, 1952). Nicomachean Ethics *The Works of Aristotle Volume II* p.364.
[362] Mill (1861, 1952). Utilitarianism *American State Papers, The Federalist, On Liberty, Representative Government, Utilitarianism* p.452.
[363] Ibid.
[364] Mill (1861, 1952). Utilitarianism *American State Papers, The Federalist, On Liberty, Representative Government, Utilitarianism* p.453.
[365] Singer (2010). Rich and Poor *Ethics: the Essential Writings* p.525.
[366] Hume (1777, 1975). Concerning the Principles of Morals *Enquiries concerning human understanding and concerning the principles of morals* pp.178-182.
[367] Hume (1777, 1975). Concerning the Principles of Morals *Enquiries concerning human understanding and concerning the principles of morals* p.181.

foundations', it is important to be sure that 'the profession of poverty' does not become 'a means of gain for the indolent'.[368]

Utilitarians do not specifically consider distinctions among individuals. Focusing upon the nett balance of utility relieves them of the need to concern themselves with individual allocations of good (or bad) things. The possible exception is in a tie, where a more even distribution may be better. Specifically, the greater gains of some can compensate for the lesser gains of others. In a medical example, consider the situation where there is only one dialysis machine available. 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.[369] Under a teleological framework, the five are chosen for dialysis over the one – who does not receive dialysis.

In the case-study of Baby 'W', providing expensive resources after his return to China is clearly to his advantage. However, this would require re-allocation from other medical programmes, which may offer benefit to a far greater number of citizens, and so does not serve the greatest happiness (best nett consequence) for the Chinese community as a whole. Thus, it is not appropriate to commence CPAP, enteral feeding, and anticonvulsants.

### 3.4.2 Contemporary Teleology

Peter Railton paraphrases consequentialism (utilitarianism) as 'whenever one faces a choice of actions, one should attempt to determine which act of those available would most promote the good, and should then try to act accordingly … consciously aiming at the overall good and conscientiously using the best available information with the greatest possible rigor'.[370] As a substantive moral framework, consider the choice proposed by Engelhardt between two possible worlds, each populated by ten people.[371] In World A, all ten individuals have five 'utiles' (units of utility, happiness, goodness, or preference satisfaction); 50 utiles in total. In World B, nine individuals have five utiles each but one individual has ten; 55 utiles in total. Which is the morally better world? World B has more utiles. World A has greater equality. If one argues that World A is better, then one has 'recalculate[d] matters on the basis of a special value now given to average utility or equality'. Or should one, after the event, add a dis-utility component to World B on the

[368] Kant (1796, 1952). The Science of Right *The Critique of Pure Reason, The Critique of Practical Reason and other ethical treatises, The Critique of Judgement* p.443.
[369] McCoy (2004). Kant *An Intelligent Person's Guide to Christian Ethics* p.82.
[370] Railton (1988). Alienation, Consequentialism, and the Demands of Morality *Consequentialism and Its Critics* p.113.
[371] Engelhardt (1996). The intellectual bases of bioethics *The Foundations of Bioethics* pp.42-43.

basis of inequality? Or should one add further utility because of the moral excellence of a person with 10 utiles of goodness?

This type of dilemma is important in the allocation of limited health care resources. Consider decisions about the provision of acute care (for example Neonatal Intensive Care beds to treat congenital rubella) versus preventative care (immunisation of the female population against rubella). The greater long term nett gain may well accrue from mass immunisation but those needing acute care to survive will need to 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 (R Laura, 28 March 2013, Research Higher Degree Seminar, University of Newcastle). 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. A hierarchical ranking of consequences (present consequences, versus future consequences) is just as important as a hierarchy of duties. The 'Rule of Rescue,' regardless of consequences, as a confounding factor in acute moral decision-making situations, will be further exposited in 5.4.1 The 'rule of rescue' and insights from neurobiological studies.

Rawls suggests that it is the 'impartial sympathetic spectator'[372] who decides maximal global happiness. Hare suggests that, if available, we could appeal to an all-knowing archangel to determine ideal preference-satisfaction.[373] Both are implicitly agent-neutral. Utilitarians do not agree that an individual is able to be held responsible for what he or she does, so values such as personal integrity are more or less irrelevant.[374] There is no room either for unconditional commitment – however things turn out. For a Utilitarian, there are no absolute human rights – it can never be said 'whatever the consequences, nobody must ever be treated in this way'.[375]

The "greatest good for the greatest number" and the "ends-justify-the-means" ethics need to be evaluated with care. Under a teleological framework, minority groups may regularly be disadvantaged as the nett utility calculation benefits the numerically larger group. Indeed, rational moral agents in a dominant group may rationally require that others follow moral precepts they

[372] Rawls (1971, 1999). *A Theory of Justice (Revised Edition)* p.24.
[373] Hare (1989). The Structure of Ethics and Morals *Essays in Ethical Theory* p.189.
[374] Smart and Williams (1973). *Utilitarianism: For and Against* p.99, ibid.
[375] Finnis (1980). *Natural Law and Natural Rights* p.224.

have determined, without requiring that they themselves follow those same precepts.[376] Or they may rationally require moral behaviour within their dominant group, but not towards subordinate groups.[377] The dominant group depends upon force of numbers, or force *per se*, to protect its interests.

Thought experiments are popular in philosophical explorations. They aim to clarify how moral decisions might be made, and not uncommonly point to inconsistencies in our thinking, or question our assumptions. '[T]he use of artificial moral dilemmas to explore our moral psychology is like the use of theoretical or statistical models with different parameters; parameters can be added or subtracted in order to determine which parameters contribute most significantly to the output'.[378]

Two specific advantages of thought experiments as they are currently utilised have been enumerated as: first, compared with questioning about abortion, euthanasia, and other real-life situations, the subjects of thought experiments will have no personal attachment to the moral dilemma; and, second, they can be sequentially modified to examine particular aspects of the moral decision-making process by adding or subtracting parameters to determine which is contributing more or less to the output of the moral decision-making process.[379] This thesis is aware of Allen Wood's articulate criticisms of morally dilemmatic situations set upon lifeboats, trolleys, tunnels, bridges, or similar.[380] It accepts the criticism that losing any lives is a tragedy, and that the real-life reasons for, for example, insufficient numbers of lifeboats, needs to be vigorously pursued and corrected. Nonetheless, this thesis sees value in thought experiments for the reasons set out above. In clinical medicine, where this thesis argues decisions are predicated upon morality, understanding the intuitive and cognitive influences upon our moral thinking, is important. In educating both medical undergraduates and postgraduate clinicians, thought experiments seem very attractive and generally encourage quite animated responses.

A well-known philosophical thought experiment is known as the tram (trolley) thought experiment, initially in two parts. Consider a runaway tram, which is heading towards five workers on the track ahead, all of whom will be killed if it crashes into them.

---

[376] Gert (2004). The Moral theory *Common Morality: Deciding What To Do* p.81.
[377] Ibid. 83
[378] Hauser, Cushman, Young, Kang-Xing and Mikhail (2007). A dissociation between moral judgements and justifications. Mind and Language 22(1): 4.
[379] Ibid.
[380] Wood (2011). Humanity as end in itself *On What Matters* pp.71-82.

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?

B: You are on a bridge over the track which the runaway tram must pass under on its way to the five workers. 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?

This thought experiment provokes discussion about moral decision-making at several levels – moral philosophical, moral psychological, and neurobiological.

At a moral philosophical level, for Bystander A, the initial dilemma is teleological - whether to accept the greater utility of saving the five workers by sacrificing the one worker. Another appeal by Bystander A could be to the Principle of Double Effect - wherein the primary aim or intention, is to divert the trolley away from the five; with the secondary unintended (but foreseeable) outcome being the death of the one. Or perhaps that, under a hierarchy of duties, protecting the five is a higher duty for Bystander A than protecting the one. For Kant, however, the one worker should not ever be used as a mere means to save the five.

Bystander B considers the same potential end – the death of the one but preservation of the five – but achieved by different means. Appeal might be made to Kant's impermissibility of (literally) using another human as a means to an end, or to the negative duty to do no harm (non-maleficence) as being of greater moral force than the positive duty to aid (beneficence). An alternative appeal could be to Double Effect. 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 fat 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 is intended.

Thomson has suggested (based upon the doctoral thesis of one of her students)[381] that there is no universally satisfactory solution to the tram (trolley) problem,[382] albeit she leans towards the principle that negative duties are weightier than positive duties. Hume, in seeking to understand

[381] Friedman (2002). Minimizing Harm: Three Problems in Moral Theory, Massachusetts Institute of Technology,
[382] Thomson (2008). Turning the Trolley. Philosophy & Public Affairs 36(4): 359-374.

moral choices, discussed the 'combat of passion and reason' and the historical preference for reason as the dominant moral motivator impelling action. He goes on to argue, firstly, that reason alone is in fact insufficient as a moral motivator to an action of the will to make choices for Good and, secondly, that in directing the will, reason cannot overrule passion. He does not believe that reasoning alone will ever cause any action – since 'its proper province is the world of ideas', while that of the will is in reality.[383] Requiring, or implying as necessary, that an action must follow a decision-process, was important to Hume. He believed that, although reason can be a proximate cause of a morally Good decision, it is emotions or passions which in actuality impel actions. Thus, he suggests that it is not unreasonable 'to prefer the destruction of the whole world to the scratching of my finger' or to choose personal ruination in order to help a stranger.[384] It is erroneous to ascribe the calmer passions – benevolence, love of life, kindness, tendency to goodness – as evidence for rationality in moral decision-making.[385] 'Strength of mind' merely 'implies the prevalence of the calm passions above the violent'.[386] Clearly, mankind often acts contrary to reason or rationality – both to defer good to a later time or to redirect it to another person or persons, or to actively choose evil when the rational reasoned decision falls on the side of choosing Good. In his later work, Hume suggests that in more difficult choices for Good, both reason ('a chain of argument and deduction') and sentiment ('an immediate feeling and finer internal sense')[387] need to be applied in a complementary way. At the same time, he proscribes sentiment (passions) as the dominant ethical motivator. The final aim of moral speculation is 'to teach us our duty' and, once we understand the merits of virtue versus vice, then we should adopt habits which allow us to follow virtue rather than vice. Unless the truths which are discovered induce desire or aversion, 'they can have no influence on conduct and behaviour'.[388] Furthermore, what is Good 'takes possession of the heart, and animates us to embrace and maintain it'. What is reached by reasoning 'procures only the cool assent of the understanding'.[389] Thus, on this understanding, Bystander B's teleologically-rational desire to save the five over the one on a side-track is over-ruled by the aversive sentiment (further explored below) associated with personally pushing the large worker off the bridge and watching his certain death immediately below. Two things are nonetheless not clear from Hume's writings. First is whether or not he recognised that through education (religious, moral, or philosophical), 'sentiment'

[383] Hume (1739, 1994). A Treatise on Human Nature *Ethics* p.118.
[384] Ibid. 120
[385] Ibid. 121
[386] Ibid.
[387] Hume (1777, 1975). Concerning the Principles of Morals *Enquiries concerning human understanding and concerning the principles of morals* p.170.
[388] Hume (1777, 1975). Concerning the Principles of Morals *Enquiries concerning human understanding and concerning the principles of morals* p.172.
[389] Ibid.

as a moral motivator may be altered – one's moral compass becomes re-calibrated. Second is the problem posed in a morally dilemmatic situation by the question (assuming Hume would allow that it is valid to question a feeling) - '*ought* I feel like this?' This is unable to be answered by another feeling without recursion,[390] and so requires an answer from reason (or on an *a priori* basis).

William Godwin accepted the view of Hume that feelings rather than reason impel action ('the voluntary actions of men are under the directions of their feelings'),[391] but also the view of Locke that reason discerns moral distinctions ('reason ... is calculated to regulate our conduct, according to the comparative worth it ascribes to different excitements').[392] Thus, he synthesised these into an understanding that sentiment impels action, but only to right action if we have a rational understanding of the facts.[393] Beyond this concept, he perhaps foreshadowed *Proportionism*, as exposited below in 5.2 Development of the Proportionist approach, by allowing that in moral decision-making the consequences of our actions need to be considered, as well as the need to have, and the impermissibility of making exceptions to, general rules for the benefit of all. This is together with a belief that the happiness of a number is of more value than that of one, without impartiality.

Hauser's group studied trolley experiments and found 89% of more than 5000 respondents judged it morally permissible to flip the switch as Bystander A, but only 11% would push the large worker off the bridge as Bystander B.[394] This is independent of age, ethnicity, religious background, general knowledge and specific moral philosophical knowledge. In attempting to justify their decision, two-thirds of respondents were described as 'clueless' about why they made the decision they made. This uniformity of moral decision-making among disparate populations prompts thoughts about an innate moral sense within humans.

At a moral psychological level, there needs to be some explanation why 89% of people choose to flip the switch as bystander A but 89% choose not to push the man off the bridge as bystander B. Perhaps humans are indeed subconscious utilitarians (perhaps for the good of the species), but physically pushing an innocent to certain death is more psychologically abhorrent than flipping a mechanical switch because of the intuitive or emotional influence which acts upon moral decision-

[390] MacIntyre (1981, 2007). *After Virtue* p.170.
[391] Godwin (1793, 1985). *Enquiry Concerning Political Justice and its influence on modern morals and happiness* p.77.
[392] Ibid.
[393] MacIntyre (1998). *A Short History of Ethics* p.223.
[394] Hauser, Cushman, Young, Kang-Xing and Mikhail (2007). A dissociation between moral judgements and justifications. Mind and Language 22(1): 6.

making. In a thought experiment, a moral decision which goes against our intuitions may therefore be rejected. Some of these intuitions however may have only a biological basis in evolution, and therefore not constitute reasonable normative grounds on which to reject the response.[395] For example, if morals develop as a result of 'altruism failures',[396] primitive society likely had a strong taboo against killing an innocent member of one's own tribe with one's own hands and this acted as a natural selector. Hence, almost as an evolutionary biological residue, most people will not push the large man off the bridge, but will flip the switch. Our common intuitions do not necessarily have normative force. Another study utilising similarly morally dilemmatic thought experiments with identical outcomes but differing causes for the same consequences, suggested that solutions are more likely to favour teleological decisions when active intervention influences the path of the agent of harm (for example the trolley), than when the intervention influences the path of a potential victim (for example, the large man on the footbridge).[397]

Neuro-imaging correlates with decision-making are to be revisited in 7.4.2 The 'rule of rescue' and insights from neurobiological studies. Joshua Greene's group distinguished between 'personal' and 'impersonal' moral decisions.[398] A moral decision is personal if it is likely to cause serious bodily harm, to a particular person. This may be simplified to Me-Hurt-You. *Me* captures the agent, *Hurt* invokes harm, and *You* identifies the victim. Bystander B pushing the large man off the bridge in front of the tram meets all three criteria, and is personal. Whereas diverting a tram involves merely deflecting an existing threat, removing the crucial sense of Agency, and therefore is impersonal. Functional Magnetic Resonance Imaging (fMRI) studies from Greene's group found that evaluating personal moral dilemmas (as bystander B) produced increased activity in areas associated with emotional processing, while evaluating impersonal moral dilemmas (as bystander A) did not. Responding to a personal moral dilemma with a decision which was incongruent with the intuitive emotional response (bystander B pushes the large man off the bridge) took longer to reach because of interference from the intuitive emotional response. Many variations to the trolley experiment have been proposed in attempts to clarify the moral decision-making process.

It is very difficult to comprehensively consider, and incorporate into the moral decision-making process, all possible consequences of an action. This is the case especially if there is a time-

[395] Singer (2005). Ethics and Intuitions. The Journal of Ethics 9(9): 331-352.
[396] Kitcher (2011). The shape of things to come *The Ethical Project* pp.5-6.
[397] Waldmann and Dieterich (2007). Throwing a bomb on a preson versus throwing a person on a bomb: Intervention myopia in moral intuitions. Psychological Science 18(3): 247-253.
[398] Greene, Sommerville, Nystrom, Darley and Cohen (2001). An fMRI investigation of emotional engagement in moral judgement. Science 293(5537): 2105-2108.

constraint, and even if all of humankind will benefit. Consider the eloquently presented challenge of Ivan to Alyosha in *The Brothers Karamazov*, wherein to create a fabric of human destiny resulting in the ultimate happiness for all mankind, a baby must be tortured to death and the edifice built upon its tears.[399] While there would be disagreement, the question becomes moot since our concept of justice 'is superior to and more valuable than well-being or efficiency; it cannot be sacrificed to them – not even for the happiness of the greatest number'.[400] Charles Fried is perfectly clear that '[o]ur first moral duty is to do right and to avoid wrong. We must do no wrong – even if by doing wrong, suffering would be reduced and the sum of happiness increased'.[401] Additionally, 'there are things you must not do – no matter what. They are not mere negatives that enter into a calculus to be outweighed by the good you might do or the greater harm you might avoid'.[402] Anscombe[403] and Jonathan Bennett[404] also argue that certain actions are absolutely forbidden, regardless of what consequences threaten. For example, killing of the innocent for any purpose, whatever good may then follow. Robert Streiffer however disagrees that consequentialism should be regarded as a relativistic theory[405]. Rawls argues that Utilitarians cannot infringe upon the basic moral rights of individuals unless to prevent a greater injustice – not simply to bring about a greater benefit for a greater number of people. In his book of the same name, he argues the deontological precept that 'in justice as fairness the concept of right is prior to that of the good'.[406] He argues that the principle of equal rights for all has greater import than the greatest happiness or greatest nett value principle. Thus, minorities need some additional protection.

Peter Singer provides an illustrative example in a medical setting when he describes a surgeon who values human life above all else, on a ward round pre-operatively, reviews a patient who needs a heart transplant, but none is available in time to avoid death. The surgeon then reviews a patient who needs a liver transplant, but none is available in time to avoid death. He then goes to theatre to operate on a patient with a brain tumour but a healthy heart and liver. All have equally valuable family (and all other) situations.[407] Even though the nett human life value would clearly be greater if the surgeon facilitates the one brain tumour patient to die and then harvests both heart and liver to help the other two patients in need of transplants, to do so is not morally acceptable. Similarly, a

[399] Dostoevsky (1879-1880, 1952). The Brothers Karamazov *Dostoevsky* p.127.
[400] Comte-Sponville (2001). *A Small Treatise on The Great Virtues* p.62.
[401] Fried (1978). *Right and Wrong* p.2.
[402] Fried (1978). *Right and Wrong* p.9.
[403] Anscombe (1958). Modern Moral Philosophy. Philosophy 33(124): 10.
[404] Bennett (1995, 1998). Arguing for making/allowing asymmetry *The act itself* p.165.
[405] Streiffer (2003). Defining moral relativism *Moral relativism and reasons for action* p.98.
[406] Rawls (1971, 1999). *A Theory of Justice (Revised Edition)* p.28.
[407] Singer (1994). *Ethics* p.11.

medical experiment which might cause pain and be ultimately fatal for 100 children, even if it thus allowed 10 million children to benefit,[408] would not be permissible. Contrarily, consider organ donation after death. Choosing to become an organ donor involves no physical pain, no suffering, and yet confers very great benefit to others. A utilitarian cost-benefit ratio very much favours organ donation. Yet organ donation rates are low. As a further medical example,[409] a clinician may put the choices for treatment of a cancer as surgery, radiation, chemotherapy, a combination of modalities, or no treatment. The clinician may then explore the consequences of each choice for all involved. Consider however a couple seeking to have a healthy baby. Available choices include intercourse, artificial insemination, in vitro fertilisation, adoption, cloning, or kidnapping; not all of which are morally equivalent.

Articulating why the means which may be considered are morally Good, or not, requires intellectual rigour and is set firmly within the domain of moral philosophy. To borrow from Engelhardt, clinicians could endeavour 'to play the role of a geographer of values, mapping the various consequences of placing oneself at a particular place in the terrain of possible outcomes'.[410] In the face of medical uncertainty about actual outcomes in this individual patient, with uncertain probabilities, and considering the conceptual 'Risk of Unacceptable Badness' to be exposited below, empirical value theory principles are difficult to apply. As well, the magnitude of the poor outcome, and the proximity to oneself or a loved one, inevitably skew one's choice. Tools are available that can assist in explaining the 'terrain of possible outcomes'. In palliation of oesophageal carcinoma, for example, it is possible to calculate the area under the curve by the mathematical formula for integration, as the 'efficiency of palliation'. This allows comparison of radio-chemotherapy (associated with a longer duration of life but at a lower level of function), with surgical resection (associated with a shorter duration of life but at a higher level of function).[411] Thus, the consequences of differing choices can be quantified to aid in the contextual dialogue amongst those involved in the decision-making process.

Relevant to nett utility calculations, and also constituency within a community seeking consensus in making a moral decision, consider Care of the Land. Does the nett value equation, properly

[408] Thiroux and Krasemann (2007). Consequentialist (teleological) theories of morality *Ethics Theory and Practice* p.44.
[409] Paola, Walker and Nixon (2010). Theory in bioethics *Medical Ethics and Humanities* p.32.
[410] Engelhardt (1996). The principles of bioethics *The Foundations of Bioethics* p.125.
[411] O'Rourke IC, McNeil RJ, Walker PJ and CA (1992). Objective evaluation of the quality of palliation in patients with oesophageal cancer comparing surgery, radiotherapy and intubation. Australian and New Zealand Journal of Surgery 62(12): 922-930.

expressed, need to calculate the interests of posterity,[412] especially when they conflict with the interests of existing human beings? Calculating the denominator to perform the calculation of nett Goodness is problematic for at least two reasons. First, by most predictions the number of future people will vastly out-number current population counts, skewing the nett calculation in favour of future generations. Second, however, since we could actually influence future population numbers if there was a will for that – via contraception and other technologies - how do we incorporate the fact that we can influence the denominator ourselves, into an ethically moral nett Goodness calculation? Furthermore, as originally described, the amount of pleasure or happiness equates directly to value (Bentham's felicific calculus), independent of whether the activity is a simple game of pushpin or reading great poetry. If we turn the earth into a barren wasteland, however, the quality of life of future humans will be significantly less. As well, mere summation is not appropriate if the values are not roughly equal. This was alluded to above in considering the pregnant skier. If we can rescue one television technician trapped on a transmitter by turning off the power, then we must do this despite the fact that millions will miss the televised World Cup. This is because the viewers' inconvenience is trivial, no matter how numerous they are, compared to the life of the technician.[413,414] Finally, consider the dilemma of whether to limit active resuscitation of premature babies to those with a gestational age and birth weight above a certain mandated minimum in order to control costs, because of low survival rates, low quality of life of the survivors, and the very high costs involved. Does it make a difference to the moral decision if the monies saved are re-directed back into health care via a preventative programme of immunisation; or into tax rebates, or building formal gardens?[415]

Considering end-of-life decisions, under the teleological framework the aim is to maximise the nett Good or Happiness of the patient, often with pressure to add in the Good or Happiness of the family. Problems include how to weight the value of the patient compared with the family in the resultant equation; how to weight family members other than immediate family; and how to compare the physical suffering of the ventilated and mechanically-supported but unconscious patient, with the emotional suffering of the family seeing the patient that way. There is also the mathematical fact that the denominator increases by one if the patient is alive, but reduces by one if the patient is not. As well, the difficulty of assigning a value to the future Goodness or Happiness of the patient and the

[412] Sidgwick (1907, 1962). *The Methods of Ethics* p.p414.
[413] McNaughton and Rawling (2006). Deontology *The Oxford Handbook of Ethical Theory* p.438.
[414] Scanlon and Voorhoeve (2009). The kingdom of ends on the cheap *Conversations on Ethics* p.182.
[415] Engelhardt (1996). The intellectual bases of bioethics *The Foundations of Bioethics* p.32.

family, knowing that the value for the family that will go on living may inevitably be substantially greater than that of the patient who will die.

Triage is the sorting or prioritising of wounded or injured patients into categories of urgency for medical intervention. From its origin in military mass casualty situations, its principles have been adopted for the medical management of disasters and emergency medicine. Although Kant and others 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 that will be able to return to saving others and so they will generally also be prioritised over non-medical personnel.[416] They may also be given priority immunisations in a pan endemic in order to allow them to stay at work and immunise others. Triage of the wounded in military situations however allows for, indeed encourages,[417] prioritisation so that less-wounded soldiers may be treated first in order to get them back into their defensive positions, so to prevent the perimeter being over-run. This is despite the fact that some more-severely wounded may die during that time. 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.[418] In these situations, specific utility (as medical workers or soldiers) is entering into the calculation, not their general worthiness or intrinsic value as individual human beings. Extending the principles of military triage to 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.

The concept of 'medical futility', perhaps better understood in this thesis as 'medical dis-utility' from the perspective of the patient, is an important and still-evolving concept. It incorporates the twin concepts of 'substantial benefit' – an eventual outcome which the patient would view as worthwhile; and 'unacceptable badness' – an eventual outcome which the patient would not consider as worthwhile, and would not likely consent to if able to.

---

[416] Thiroux and Krasemann (2007). Consequentialist (teleological) theories of morality *Ethics Theory and Practice* p.45.
[417] Beebe and DeBakey (1952). Battle Casualites: Incidence, Mortality, and Logistic Considerations
[418] Beecher (1969). Scarce resources and medical advancement. Daedalus 98(2): 280.

Medical futility may usefully be sub-divided.[419] Physiological futility (also termed futile because ineffective) includes acts which cannot achieve their intended physiological outcome – for example, cardiopulmonary resuscitation (CPR) on a decapitated patient cannot fill the heart. Qualitative futility (also termed futile because non-beneficial) implies a physiological benefit but one which is of no benefit to the patient's personhood or human Goodness – for example tube feeding the patient in a permanent vegetative state. Quantitative futility (also termed futile because improbable) refers to an act which is very unlikely to result in a physiological or personal benefit – for example, topical camomile tea for intra-abdominal malignancy. Active treatment which will not meaningfully delay an inevitable death is also included in the category Quantitative futility.

Two areas of controversy arise. First, while there is general agreement that medically futile acts or interventions *need not* be undertaken, it is more controversial whether such interventions *should not* be undertaken. Second, is the controversy whether the assignation of 'medically futile' should be made exclusively by clinicians expert in the area, and therefore prior to considering patient autonomy or any teleological or deontological considerations. Perhaps inevitably, lawyers decry medical experts making sovereign futility judgements, arguing that these expert judgements should not be 'an exercise in … *normative closure* [original emphasis]'.[420] On the one hand, debating moral 'oughtness' fails to recognise that the fact that CPR cannot fill the heart of a decapitated patient. This is an amoral judgement. Tube feeding the long term comatose patient however, probably is a moral decision. Topical camomile tea for intra-abdominal malignancy is probably not. On the other hand, the argument that medical science alone cannot definitively unambiguously prove medical futility in the Qualitative and Quantitative categories might be predicated upon two issues. The first is the uncertainty of medical science in specifying the absolute outcome of an Action. Consider a trial of extubation (removing the endotracheal tube allowing maintenance of the airway and breathing) of a syndromic infant. Failure of extubation is thought very likely. If extubation fails, then the infant will need to be re-intubated. Previous intubations have been very difficult, with the risk of hypoxia (with further brain damage) during the attempt. Elective tracheostomy is therefore an option. If this option is taken, it will likely remain in place for several years. The likelihood of failure of extubation, may be set by the clinicians involved at 95% or 99.5%. Two issues follow. First, medical science cannot offer a 100% certainty as to the outcome. Thus, so the legal argument continues, clinicians should not have sovereign authority. Additionally however, lawyers argue that 'legal sovereignty

[419] Paola, Walker and Nixon (2010). Professionalism and the internal morality of medicine *Medical Ethics and Humanities* p.123.
[420] Stewart (2011). Futility determination as a process: Problems with medical sovereignty, legal issues and the strengths and weakness of the procedural approach. Bioethical Inquiry 8: 155-163.

overrides professional sovereignty … [e]ven a pure medical concept of futility must still remain open to questions about whether the correct legal standards of decision-making have been satisfied'.[421] Second, given this uncertainty, the parents need to be guided towards making a value judgement, about whether a 5% or 0.5% chance of success is sufficient for them to opt for a trial of extubation without a preliminary tracheostomy.

Following neurotrauma, there is a severity of head injury where decompressive craniectomy (removal of a large section of the cranium to allow for massive acute brain swelling) may maintain life, but at a near-vegetative level.[422] In calculating the utility of this intervention, mere life or death is insufficient. Properly, a qualitative value needs to be calculated for the life the survivor has – taking into account in the calculation the point where an individual would find the functional outcome unacceptable. This then becomes an added negative to the cost borne by the community to maintain the vegetative existence. In providing options in management to family members, it is not uncommon that outcome is seen as life or death. A third outcome category exists however, and one that is more difficult to discuss - the 'Risk of Unacceptable Badness'.[423] The treating clinicians' decision-making process, may also be under the influence of the 'Rule of Rescue' - 'the imperative to rescue identifiable individuals facing avoidable death, without giving too much thought to the opportunity cost of doing so')[424] – to be further discussed in 7.4.2 The 'rule of rescue' and insights from neurobiological studies. In practical discussion of a 5% chance of survival compared with a chance that if s/he does survive, there is a 10% chance of living in a state s/he considers acceptable, but a 90% chance of living in a state the patient would likely consider unacceptably bad, an analogy can be given of standing before two doors. The left hand door results in immediate death. The right hand door offers ten exit chutes. One of these ten offers a state of reasonable existence; nine offer a life 'demented, bedridden, with tubes in your nose and veins and bladder and unable to do anything for yourself'.[425] Which do you choose? This is especially difficult when a surrogate is choosing for a loved one.

As a counter to this negative, as noted when discussing Doing versus Allowing, there may be significant positive social utility in knowing that medical decisions are not made on the basis of scarce resource allocation, but rather, with compassion and an over-riding intent to protect and nurture injured members of society. Thus, teleological frameworks are intrinsically beneficence-

[421] Ibid.
[422] Honeybul, Gillett, Ho and Lind (2011). Neurotrauma and the rule of rescue. J Med Ethics 37(12): 707-710.
[423] Gillett (2001). The RUB. The risk of unacceptable badness. N Z Med J 114(27): 188-189.
[424] McKie and Richardson (2003). The Rule of Rescue. Social Science & Medicine 56(12): 2407.
[425] Gillett (2001). The RUB. The risk of unacceptable badness. N Z Med J 114(27): 188-189.

based, with the goal of maximising welfare. It is intuitively clear that consequences must in some way be incorporated into morally good clinical decision-making.

Currently, there exists a variety of teleological frameworks.

i) Ethical egoism and ethical altruism

Ethical Egoism maximises benefit for oneself. Although it has advantages in clarity of purpose, as an ethical framework it is not useful for ethical decision-making in the helping professions. Ethical Altruism maximises benefit for everyone except the agent (that is, for others). Thus an infirm elderly may choose to suicide to reduce their burden on society's resources.

ii) Consequentialism and its various forms

Anscombe suggested the term 'consequentialism' as a replacement for 'utilitarianism'.[426] Consequentialism exists in a plethora of forms contingent upon what is maximised. *Act* consequentialism argues that the ethically good thing to do is for an individual to calculate which action maximises the nett benefit for everyone. Significantly increasing the health standards of those in impoverished nations towards our own would likely reduce the living standards of wealthy countries. Some ethicists allow that 'our duty to help others is limited. There is some point, though its location is hard to determine, at which agents have done all that duty demands. At that point they have an option to decline to do more'.[427] Doing more is then supererogatory, but Act-Consequentialism appears to leave no room for this, in a sense demanding too much of us – for example, the active suicide of the infirm elderly maximizes value but can only be seen as supererogatory rather than in any sense morally obligatory. Furthermore, quantifying the consequences of an Action for others may well be difficult, as can be the time inefficiencies of having no established rules and so having to evaluate every moral situation anew. An attempt to speed this up may imply rules, albeit unstated. Presumably too, there is a learning curve, perhaps best avoided in medicine. *Rule* consequentialism developed as a response to Act consequentialism by arguing that certain similar patterns of moral conflicts can be identified, and so rules can be set up so that the nett consequences of adopting the rule are favourable to all. The rules thus derived could become quite complex in order to allow for similar but different situations. There are several other forms of consequentialism described.

[426] Anscombe (1958). Modern Moral Philosophy. Philosophy 33(124).
[427] McNaughton and Rawling (2007). Deontology *Princliples of Health Care Ethics* p.65.

### 3.5 Virtue ethics

#### 3.5.1 Virtue ethics as originally formulated - Aristotle

Aristotle begins his *Nicomachean Ethics* with 'Every art and every inquiry, and similarly every action and pursuit, is thought to aim at some good; for this reason, the good has rightly been declared to be that at which all things aim'.[428] In Books II-IV of *Nicomachean Ethics* Aristotle amplifies his discussion of moral virtue. His enquiry though is 'not in order to know what virtue is, but in order to become Good'[429] – an approach to achieving Goodness in actual practice rather than just theorising about it.

In the soul, are things of three kinds – passions (for example anger, fear), faculties (for example capability to become angry, to be afraid) and states of character.[430] States of character are positions by which we stand with reference to the passions, avoiding excess and insufficiency – standing appropriately in a middle-position, neither too far to one side nor to the other. Passions and faculties are neither good nor bad. It is our response to them – especially whether the response is moderate or appropriate rather than excessive or weak, which determines how we are judged as Good or not-Good – hence 'states of character' best describes them.

One's state of character arises out of practice (habit), but is a spectrum of response to passion from excessive, through an appropriate middle ground (or mean), to a deficiency in response. Aristotle argues that some responses do not have a spectrum of of passion associated with them because they are always morally wrong – for example, murder and rape. Most others do. For example, consider 'courage'. A person who flees from every threat tends towards insufficiency and is a coward. Yet, one who recklessly confronts a larger group of aggressors tends toward rashness. The mean behaviour between these two extremes is bravery. 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. Aristotle argued that moral virtue is that mean.[431]

It is however not a precise spot, and it can be difficult to find. For example, adultery will arouse justified anger in a husband but how long to maintain this anger and how to express it is a difficult

[428] Aristotle (c340 BC, 1952). Nicomachean Ethics *The Works of Aristotle Volume II* p.431.
[429] Aristotle (c340 BC, 1952). Nicomachean Ethics *The Works of Aristotle Volume II* p.349.
[430] Aristotle (c340 BC, 1952). Nicomachean Ethics *The Works of Aristotle Volume II* p.358.
[431] Aristotle (c340 BC, 1952). Politics *The Works of Aristotle Volume II* p.477.

judgement. Aristotle argues that moral virtue is determined by our choice, and therefore that moral virtue is an active state, in distinction to the passive passions and faculties.[432] Furthermore, by being habituated to find the mean and so be virtuous (for example to stand our ground against bad things), we become brave (virtuous), and are then better able to stand our ground, and so on.

For Aristotle, decision-making about an end is embodied in practical terms by identifying the means to achieve that end. If Aristotle's virtuous man is one who acts according to the right rule, then framing that rule is an intellectual operation. In Book VI, Aristotle explores the five states of mind (intellectual virtues) by which we reach truth.[433] These are: science (inferential deduction from known truths); art (making useful, more so than beautiful, things); *phronesis* or practical wisdom (deliberations as to how a satisfactory state of being can be brought about); intuitive reason (correctly knowing the premise from which conclusions are inferred); and, theoretical wisdom (the union of science and intuitive reasoning).[434] *Phronesis* may also be thought of as prudence. Prudence is looking forward and rearward before making a rational decision about whether and how to Act, so that a Good will can achieve a Good outcome, mindful of whether we have the personal or professional resources to perform a good act, and then whether the foreseeable outcome is likely to be achievable, and still remain good; 'good sense, but in the service of goodwill'.[435] Aristotle views the perfection of virtue as combining both the will, and action (the deed).[436]

Aristotle observed that one of our human needs is to be social, to live in a community. To be part of a community requires concern with and commitment to virtue; otherwise, it is simply an alliance of people, not a true community ultimately achieving union 'in a perfect and self-sufficing life'.[437] The success of that society's education system may be judged by the extent to which it fosters virtue in its members.[438] Plato agreed – described in ***Laws*** is his premise that virtue is based upon sound education.[439] For Aristotle 'ethics is the study of education … [or the process by which] it becomes possible to study ethics'.[440] Only the man who has been educated to recognise what Goodness is, can be virtuous. Kant too argued that while animals have instinct to guide them, man must be

[432] Sachs (c340 BC, 2002). *Aristotle: Nicomachean Ethics* p.xiii.
[433] Aristotle (c340 BC, 1952). Nicomachean Ethics *The Works of Aristotle Volume II* pp.388-391.
[434] Ross (1998). *Aristotle. Nicomachean Ethics* pp.xv-xvi.
[435] Comte-Sponville (2001). *A Small Treatise on The Great Virtues* p.32.
[436] Aristotle (c340 BC, 1952). Nicomachean Ethics *The Works of Aristotle Volume II* p.433.
[437] Aristotle (c340 BC, 1952). Politics *The Works of Aristotle Volume II* p.478.
[438] http://www.markvernon.com/friendshiponline/dotclear/index.php?post/2007/01/07/484-what-is-the-good-life
[439] Plato (c390 BC, 1952). Laws *The Dialogues of Plato, The Seventh Letter* p.649.
[440] McCabe (2005). *The Good Life: Ethics and the Pursuit of Happiness* p.9.

educated in how to conduct himself well.[441] Indeed '[m]an is the only being who needs education',[442] and '[h]e is merely what education makes of him'.[443] Aristotle contends that although virtue arises in us by nature, it is perfected in us by habitual practice – habitually behaving virtuously.[444] 'Character' (ê*thos*) derives from 'habit' (*ethos*) only by lengthening the initial vowel.[445,446] Thus, he contends, we become just by doing just acts, temperate by doing temperate acts.[447]

Importantly, Kant, in his Introduction to *The Metaphysical Elements of Ethics*, proposes that 'Virtue considered in its complete perfection is, therefore, regarded not as if man possessed virtue, but as if virtue possessed the man'. This is because the former allows for virtue to be only a *part* of one's motivation rather than the complete motivator, and implies an ability to choose whether to follow a virtuous path, thus requiring another virtue to select that path, and hence resulting in a plurality of virtues.[448]

In Section II of Part I of *An Enquiry Concerning the Principles of Morals*, Hume discusses benevolence.[449] Similes he proposes include 'humane', 'good-natured', 'merciful', 'generous', and 'beneficent'. Hume may summarize the concept of benevolence as that feeling which 'proceeds from a tender sympathy with others'.[450] Perhaps 'empathy', rather than reason, underpins his morality. For Hume, contribution to the general Good of society constitutes an integral part of benevolence.[451]

Aristotle posits that, unlike grammar or music, to be virtuous requires that the Good thing be done with a right frame of mind. In other words, it is done 1) with knowledge, 2) choosing the acts for their own sake, and 3) from a firm and unchangeable nature.[452] In order to be virtuous, a just person must do just acts *as* a just person would do them. Acts which to outward appearances appear just,

---

[441] Kant (1903, 1906). *Kant on Education (Ueber Padagogik)* pp.1-6.
[442] Ibid.
[443] Kant (1903, 1906). *Kant on Education (Ueber Padagogik)* p.6.
[444] Aristotle (c340 BC, 1952). Nicomachean Ethics *The Works of Aristotle Volume II* p.348.
[445] Ibid.
[446] Sachs (2002). *Aristotle: Nicomachean Ethics* pp.22, footnote 25.
[447] Aristotle (c340 BC, 1952). Nicomachean Ethics *The Works of Aristotle Volume II* p.349.
[448] Kant (1796, 1952). Metaphysical Elements of Ethics *The Critique of Pure Reason, The Critique of Practical Reason and other ethical treatises, The Critique of Judgement* p.377.
[449] Hume (1777, 1975). Concerning the Principles of Morals *Enquiries concerning human understanding and concerning the principles of morals* pp.176-178.
[450] Hume (1777, 1975). Concerning the Principles of Morals *Enquiries concerning human understanding and concerning the principles of morals* pp.178-182.
[451] Ibid.
[452] Aristotle (c340 BC, 1952). Nicomachean Ethics *The Works of Aristotle Volume II* p.351.

are not just unless done in the knowledge that they are just, with the desire to do them because they are just and with the good character that a just man has.

### 3.5.2 Contemporary virtue ethics

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. This has been a reaction to both a primarily rights-based ethic, and to an emphasis upon morality as a merely personal choice or social preference, perhaps, in turn, responding to an increasingly fragmented, pluralistic society. As currently iterated, most virtue ethical frameworks are neo-Aristotelian in spirit.

Moore offers as a definition of moral virtue that it is 'an habitual disposition to perform certain actions, which generally produce the best possible results'.[453] He characterises virtue as having three attributes. The first is that, as an agent, one's mindset is habitually orientated towards performing one's duty. The second is that good motives habitually bring about the performance of one's duty. The third is that one distinguishes between one's motive to act solely for duty's sake, and other motives based on, for example, benevolence.[454]

For Michael Slote, a virtue is 'an inner trait or disposition of the individual'[455] which is needed for *eudaimonia.*[456] 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, Aristotle favoured seeking after *eudaimonia* or 'flourishing', by which he meant living in accord with one's unique nature.

For MacIntyre, to act virtuously is to act from 'an inclination formed by the cultivation of the virtues', to act in accordance with the virtues, to determine what the morally virtuous agent would do in a situation involving moral choice, and then just *do* that - 'the immediate outcome of the exercise of a virtue is a choice which issues in right action',[457] and to reflect upon the decision afterwards. Or, put

[453] Moore (1903, 1903) Principia Ethica, Chapter 5 Section 106:
[454] Ibid.
[455] Slote (2001). *Morals from Motives* p.4.
[456] Hursthouse (1999). *On Virtue Ethics* p.20.
[457] MacIntyre (1981, 2007). *After Virtue* p.149.

another way, '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'.[458]

Both deontological and teleological frameworks offer important insights, albeit emphasising different aspects of an ethical conflict. A virtuous person may be one who is able to choose wisely between them, in different situations, so constituting a 'virtuous mean'. The virtue ethical framework seeks *phronesis* in order to induce virtuous action, which is self-reinforcing and insightful. Virtue ethics, as a framework for moral decision-making, has a claim to primacy because 'a theory that is adequate to the subtle experience of a mature moral agent must take moral character to be the most basic moral concern'.[459] Importantly, it implies that an agent has gone through a process of personal reasoning, evaluation and re-evaluation, and education about virtue, captured by Habermas in his self-reflective self-knowing epistemology. Thus, older members of Society are responsible for instilling Virtue in younger members – with clear implications for education. It does not seem unreasonable for moral philosophy and Education to shift their emphases away from frameworks focused upon either prescribed rules, regulations, or consequences, accepting that our world is becoming less moral and more superficial; and focus instead upon educating habitually good or virtuous members of society, aiming thus to bring about a greater moral fabric in contemporary society. In moral decision-making we can then de-focus from the moral minimum of obligation, and re-focus towards moral excellence, and be ennobled as sentient beings. As Mill said, 'the contented man, or the contented family, who have no ambition to make anyone else happier, to promote the good of their country or their neighbourhood, or to improve themselves in moral excellence, excite in us neither admiration nor approval'.[460]

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. Put another way, virtue is a 'disposition cultivated by proper training, experience and critical reflection'.[461]

---

[458] Balousek (2014). Professional baseball and performance-enhancing drugs. Philosophy Now May-June(102): 14.
[459] Copp (2006). Introduction *The Oxford Handbook of Ethical Theory* p.29.
[460] Mill (1859, 1952). Representative Government *American State Papers, The Federalist, On Liberty, Representative Government, Utilitarianism* p.348.
[461] Kerridge, Lowe and Stewart (2013). Ethical theories and concepts *Ethics and Law for the Health Professions* p.19.

As alluded to from an historian's perspective, George Weisz is particularly critical of the undue emphasis in modern bioethical descriptors based upon deontology and teleology on 'the individual and his rights (as opposed to the web of human relationships that engender mutual obligations and interdependence)'.[462] Social scientists agree when they write that the restricted definition of 'persons as individuals' which dominates bioethics has been reductionist to 'values like decency, kindness, empathy, caring, devotion, service, generosity, altruism, sacrifice, and love'.[463] The theory that results reflects a 'truncated understanding of what morality is'.[464] Thus '[e]thics has shifted from a search for the good, to rights, values, and social convention. Morality, itself, is increasingly seen as the creation of our choices and the mores of a liberal society'.[465]

To avoid the circular argument that virtues are those character traits which virtuous people possess, and virtuous people are those who possess the character traits of virtue, it is possible to offer, as the final purpose of medical virtue ethics, the Hippocratic Good of the Patient. Pellegrino restates the Aristotelian definition of Virtue - 'the state of character which makes a man good and which makes him do his own work well',[466] in the setting of the physician *qua* physician, as 'a character trait which disposes the physician habitually to act well and wisely with respect to medicine, to its ends and purposes'.[467] The end, fulfilment or final purpose (*telos*) in medicine is the Good of the Patient - a right and good healing action or decision. The virtues required are both intellectual and moral, and under this framework they are not optional, or even merely desirable; they are required.

More specifically, the Good of the patient is health in all its dimensions – physical, psychological, social, spiritual, *inter alia*. The health of the patient is related to the health of the family, and to society as a whole. The moral dimension of health care by clinicians properly incorporates these considerations and it is appropriate therefore to consider costs of treatment options, opportunity costs, and the like; and also to recognise that appropriate referral for, for example, spiritual counselling may be apposite. Pellegrino argues that the good of the patient has been the foundation

---

[462] Weisz (1990). Introduction *Social Science perspectives on Medical Ethics* p.3.
[463] Fox and Swazey (1984). Medical morality is not bioethics - medical ethics in China and in the United States. Perspectives in Biology and Medicine 27: 355.
[464] Hoffmaster (1990). Morality and the social sciences *Social science perspectives on medical ethics* pp.241-260.
[465] Pellegrino (2001). The internal morality of clinical medicine: A paradigm for the ethics of the helping and healing professions. Journal of Medicine and Philosophy 26(6): 567-568.
[466] Aristotle (c340 BC, 1952). Nicomachean Ethics *The Works of Aristotle Volume II* p.351.
[467] Pellegrino (2007). Professing medicine, virtue based ethics, and the retrieval of professionalism *Working Virtue : Virtue Ethics and Contemporary Moral Problems* p.64.

of morality in clinical medicine since antiquity.[468] It is the ultimate arbiter in clinical decisions from a moral perspective. He proposes a hierarchy of Goods of the patient. He recognises four such Goods. His exposition is predicated upon the particular existential circumstances of the patient who is ill and needing help. Each participant in the decision-making process in a moral 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 – according with what action is to be taken as 'being in the patient's best interests'.

The highest Good, in Pellegrino's terms, is the Ultimate Good of the patient, his 'good of last resort' or *summum bonum.* He acknowledges the long and difficult history of the search for epistemological and ontological nature of *The Good* in the conversations of western philosophers and offers the undefined but generally understood notion of Good as morally-aware people conceive of it. The Ultimate Good serves to put the lesser goods below into context, 'to be examined in mapping the content of the good of the patient',[469] since it is these other goods which can be most appropriately brought into moral decision-making by clinicians. The Ultimate Good may be expressed as striving to attain congruence with the will of God, or with the secular frameworks offered by deontology, teleology, or virtue ethics, in one of their expressions.

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, which results in the best possible technical recovery of form and function which is possible under the natural history of the disease. Though the least in the hierarchy, it is the minimum Good that patients expect and is the necessary first step in actively caring for the patient, as a physician. Pellegrino prefers to limit its scope to the narrow technical aspects only – and not to enlarge this good so as to make judgements about the quality of life to be attained after maximising techno-medical good, since judgements about quality of life for the patient should be made by the patient not the clinician, and reflect higher order Goods of the patient.

Next in the hierarchy is the perceptual Good of the patient, how s/he understands the clinical situation and treatment options, and how s/he wants to proceed. While competent, only the patient can judge what is most perceptually good amongst treatment options, or indeed the no-treatment option. Once the technical aspects are explained appropriately, a dialogue can commence between clinician and the patient (and others, especially their family), about which choice maximise the

[468] Pellegrino (1985). Moral choice, the good of the patient, and the patient's good *Ethics and Critical Care Medicine* pp.117-138.
[469] Ibid. 120

perceptual good. This good is necessarily subjective and relative to the patient. 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';[470] as will the significance of the risks also be unique to him.

Next is the Good of the patient as a human person, reasoning and rational. By this, Pellegrino means that it is founded upon autonomy - 'the operation of the capacity to use reason to make choices' [471] and then articulate them. If not competent to choose, then another acts as a surrogate. The surrogate, however, is responsible to deduce the moral choice the patient would make (substituted judgement), not to make the choice the surrogate would make for him or herself; or is responsible to judge wherein lies the best interest of the patient. The clinician does not need to agree with the choice, but must not manipulate that choice or deceive. This is necessary in order to respect the concept of patient autonomy.

Perhaps modern medical equivalents of *Virtue* also include *wisdom*, and *empathy*. Wisdom involves the domains of 'rational decision making based on general knowledge of life; pro-social behaviours involving empathy, compassion, and altruism; emotional stability; insight or self-reflection; decisiveness in the face of uncertainty; and tolerance of divergent value systems'.[472] This thesis explores how two and a half centuries of philosophical thought should influence the moral decision-making of clinicians, as a prelude to how we should re-evaluate medical education.

The empathically caring attitude of a medical practitioner to patients and their families has long been recognised as an important component of the treatment paradigm of the patient. The literature supports quicker recovery with shorter post-operative stays, stronger placebo responses, and enhanced immune function following upon empathic medical relationships.[473] Pellegrino has argued that good clinicians require a certain 'inner background' to approach moral decision-making adequately.[474] In postulating a more specific model for 'the right moral attitude' in clinicians, Petra

[470] Cowley (2012). *Reconceiving Medcial Ethics* p.9.
[471] Pellegrino (1985). Moral choice, the good of the patient, and the patient's good *Ethics and Critical Care Medicine* p.125.
[472] Meeks and Jeste (2009). Neurobiology of wisdom: a literature overview. Arch Gen Psychiatry 66(4): 355-365.
[473] Riess (2010). Empathy in medicine--a neurobiological perspective. JAMA 304(14): 1604-1605.
[474] Pellegrino (2005). Toward a virtue-based normative ethics for the health professions. Kennedy Institute of Ethics Journal 5 (3): 266.

Gelhaus has looked at empathy,[475] compassion,[476] and care[477]; and proposed that these are 'necessary instrumental skill[s]' for that 'right moral attitude'. In her discussion of these concepts, rather than explore their empirical anthropology or moral emotivism in a general way, she limits her exploration to 'the *normative* image of a good physician', and the moral motivational aspects as physician *qua* physician of (the capacity for) empathy, compassion (the adequate professional inner attitude), and care (the active side of this attitude).[478] While sympathy implies a sharing of a common emotion or experience, empathy involves trying to understand the other without merging identities. Specifically, this means without feeling the breadth and depth of the emotion at the time. Sympathy implies a certain positivity toward the other. Empathy in the sense of understanding does not imply approval, or even liking the other. Clinicians should usefully distinguish the aim to be empathic towards a patient, rather than sympathetic, for two reasons. First, it is possible, and may well be preferable, to understand the emotional feelings of a patient without having the same feelings oneself. Both so to avoid the temptation to paternalism, but also because if the clinician actually reaches the same emotional state as the patient the ability to take an accurate history, perform an adequate examination and make clinical judgements will become impaired. Second, empathy will tend to help maintain the clinician's usual moral attitude whether or not the clinician 'likes' or approves of the patient (especially when the patient's own actions may have brought about the illness being treated).

Gelhaus defines empathy in the clinical setting as 'the adequate understanding by the physician of what happens inside the patient in relation to his complaints'.[479] She allows that this predominantly cognitive interpretation ('the adequate understanding') tends towards an epistemic analysis but, nonetheless, in clinical contexts it properly allows for moral analysis as well. Interestingly both philosophy and medicine sharply distinguish emotions and feelings from cognition and rationality. Empathy alone, defined as cognitively understanding what is happening inside the patient, does not of itself imply motivation to act in a morally good way, but does seem a necessary condition for moral motivation to develop. Understanding someone different yet similar to me may be the precondition for having respect for the other, the anthropological foundation for a moral

[475] Gelhaus (2011). The desired moral attitude of the physician: (I) empathy. Medicine, Health Care and Philosophy 15(2): 1-11.
[476] Gelhaus (2011). The desired moral attitude of the physician: (II) compassion. Medicine, Health Care and Philosophy: 1-14.
[477] Gelhaus (2012). The desired moral attitude of the physician: (III) care. Med Health Care Philos.
[478] Gelhaus (2011). The desired moral attitude of the physician: (I) empathy. Medicine, Health Care and Philosophy 15(2): 2-3.
[479] Gelhaus (2011). The desired moral attitude of the physician: (I) empathy. Medicine, Health Care and Philosophy 15(2): 3.

philosophy. Philosophically, empathy implies awareness that the individual clinician is being addressed by this individual patient. Although conceptualised as morally neutral, in situations of unsalvageable burns or incurable malignancy, providing empathy alone may be very worthwhile and valuable in terms of doing good. Perversely, in order for a sadist to derive pleasure from the suffering of another, they too must have the empathy to understand what is happening to another, albeit without compassion for the other's suffering.

In characterising the 'right moral attitude' of a clinician, Gelhaus requires empathy to be combined with compassion and with caring. Compassion may be characterised as 'the emotional and virtuous core'[480] of the right moral attitude. Gelhaus differentiates character (an agent-centred attribute) from attitude (the relationship of the agent to an 'other'). Compassion is often understood to mean sympathy, and in that sense has what may be an overly emotional component. Gelhaus' concept of compassion in the clinical sense is 'calmer and influenced by goals and duties of medical practice and relating to man as a vulnerable and solidary being'.[481] Compassion in the clinical setting has four attributes. First, although it implies recognition of suffering, this recognition may be incorrect – it is not empathy since misunderstood empathy makes no sense. Second, it implies a benevolent attitude aimed at helping another, although it may not be successful (empathy is morally neutral). Third, it appeals to the agent directly. Fourth, it does not imply any reciprocation by the other. Compassion is a moral motivator, prompting in the clinical context the inclination to help patients who are suffering. To make compassion prompt more than merely an attitude of help, however, the 'right moral attitude' also requires active caring. Feeling equally compassionate towards all patients in all contexts would very likely accelerate professional burn-out and ultimately be counter-productive. To make morally good decisions does not require major self-sacrificial altruism, and nor does it require supererogatory efforts. For Gelhaus, the clinician's 'right moral attitude' can be summarised as empathic compassionate care. Care is an activity, which if directed to another sentient being, is intrinsically morally valuable.[482] It is both predicated upon empathic recognition of a patient in a situation of need and the compassionate insight that the Agent should act, and it is what brings about activity directed towards helping a patient in that situation. It encompasses an adequate awareness of the health situation of another and acceptance of being addressed (empathy), a core of virtuous benevolent willingness to act (compassion), and then acting to realise this inclination (care). Empathy is morally neutral, compassion is morally motivating, but care is intrinsically morally

[480] Gelhaus (2011). The desired moral attitude of the physician: (II) compassion. Medicine, Health Care and Philosophy: 1-14.
[481] Ibid. 3
[482] Gelhaus (2012). The desired moral attitude of the physician: (III) care. Med Health Care Philos.

valuable. This thesis views the separation of empathy from compassion and also from care as very useful in terms of understanding and teaching the right moral attitude to clinicians. It is aware however that other conceptions of empathy include cognitive understanding of a patient's 'experiences, concerns and perspective' necessarily combined with a capacity to communicate this, and with an intention to help.[483]

One of the disadvantages attributed to the virtue ethics framework is that an explicit theory of right action is not articulated. There is however 'no agreement as to how specific, if at all, ethical directions should be'.[484] An ethical theory could be useless if it is so general that it lacks any practical specificity, but equally useless if too specific to be applied any realistic way. Rather than narrowly-framed deontological rules or contextually-varying majority rules, what may be needed is Aristotle's virtuous mean. It is this which provides directivity or usefulness for moral decision-making. An action is right if and only if it is what a virtuous person (acting in character) would do. Put another way, there is no independent right-making property of a moral decision. If there were then we could just open the "Technical Manual of Ethics" to the correct page. 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.[485] 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 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. Annas has said that 'right' unqualified and standing alone is a thin ethical concept compared with the thick ethical concept of the virtues.[486] Arthur W Frank writes that '[i]nstead of ethics-as-substance, we need ethics-as-process'.[487] That is, first, an explicit theory of right action is not required; and second, a process for moral decision-making is more apposite.

[483] Hojat, Vergare, Maxwell, Brainard, Herrine, Isenberg, Veloski and Gonnella (2009). The devil is in the third year: A longitudinal study of erosion of empathy in medical school. Academic Medicine 84(9): 1183.
[484] Annas (2011). *Intelligent Virtue* p.35.
[485] Balousek (2014). Professional baseball and performance-enhancing drugs. Philosophy Now May-June(102): 14.
[486] Annas (2011). *Intelligent Virtue* p.42.
[487] Frank (2004). Ethics as process and practice. Internal Medicine Journal 34: 355.

From the perspective of the deontologist or teleologist, 'the understanding of right action is prior to the concept of the virtuous person';[488] whereas, for a neo-Aristotelian, the virtuous person is prior to right action.

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 according 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.[489] 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. This approach clearly acknowledges parental role as more than a proxy decision-maker for their child. However parents are able to exercise their parental autonomy only up to a point, the point of significant harm. Potentially troublesome, however, is that the location of that point of significant harm is decided by an outside person (a clinician or a law court) rather than the parent.

In a similar vein, Rosalind McDougall looks to a virtue ethical framework to guide moral decision-making in the area of having children. She argues that, 1) 'an action is right if and only if it is what a virtuous parent would do', 2) 'a virtuous parent is one who has and exercises the parental virtues', and 3) 'parental virtues are character traits conducive to the flourishing of the child'.[490] Thus, moral decision-making as applied to reproduction moves from rules or consequences, to evaluation of the action in terms of whether it is what a virtuous parent would do. The parental virtues begin prior to

[488] McDougall (2007). Parental virtue: A new way of thinking about the morality of reproductive actions. Bioethics 21(4): 183.
[489] Gillam 2014) When parents and doctors disagree about medical treatment for a child: the ethics of decision making, The New Zealand Bioethics Conference,
[490] McDougall (2007). Parental virtue: A new way of thinking about the morality of reproductive actions. Bioethics 21(4): 184.

conception. The parental virtues she identifies to effect the flourishing of the child are termed, (somewhat awkwardly in order to emphasise that they are not acts, but are character traits): 'acceptingness' (recognising the unpredictable phenotype of their child, perhaps in that sense synonymous with "unconditional love"); and, 'committedness' (to nurture, to be active, to be present in the rearing of the child); and future-agent-focus (preparation of the child as a future moral agent).[491] As Aristotle emphasised, these virtues 'involve the notion of the correct amount'[492] of the virtue that is required to effect flourishing. Examples she cites include passively accepting a child's destructive behaviour or acting-out, or martyring oneself for a trivial increase in their child's subjective well-being. A more nuanced understanding may gesture less towards the flourishing of the (individual) child, and more towards the flourishing of the *family*.

Since the framework of virtue ethics requires moral growth and development through education and reflection, thus mere mimicry is not what is understood. All rational humans will likely see an actual or potential morally dilemmatic situation with some similarity, but not all will perceive it with the same insight. Much in the way that visitors to a football game will all see the same plays, an experienced sports analyst will perceive the plays in much greater depth. Aristotle's *phronesis* is 'a kind of excellence in moral perceptiveness, an ability to discriminate moral phenomena with greater than average perspicuity'.[493] As well, discarding the notion of a theory of right action, and recognising that a virtue ethicist aspires through self-reflection towards an ideal, imparts significant dynamism to the process-in-evolution. It also avoids the temptation to pedantic legal positivism – that there are no rights without legislation.

An important feature from the point of view of moral analysis is that two or more moral philosophers who are approaching an issue from a virtue ethical perspective should be able to discuss both in detail and with mutual respect, how each came to their moral decision. Thus, each can learn from the other and alter or reinforce their moral decision-making as it was taken in the situation. Dialogue is seen as fundamental to moral decision-making in clinical settings. Similarly, under a virtue ethical framework, senior clinicians should be able to dialogue with junior clinicians about what their thinking and their feeling was at the time. The phrases "my thinking was ..." and "my feeling was ..." are very commonly heard in explaining a clinical decision to junior clinicians when the clinical decision is not black and white, or there were uncertainties or incomplete information which required a value judgement or best guess. Indeed senior clinicians have a unique

[491] Ibid. 185-186
[492] Ibid. 187
[493] Paola, Walker and Nixon (2010). Theory in bioethics *Medical Ethics and Humanities* p.17.

opportunity to bring discussions about some decisions out of the clinical arena and relocate them into the arena of moral philosophy. While this discussion may not be about virtue and Aristotle, it would appositely be about empathy, compassion, caring, and wisdom as paths into Goodness as clinicians. Another possible avenue is that in discussing Best Practice Guidelines, discussion could be directed into the question of exceptions. For example, a recent Australian Best Practice Guideline included indications for tonsillectomy as 'more than four-five episodes per year for two years'.[494] Discussion could consider that the 'rules', based upon Evidence Based Medicine, should be followed; unless a particular situation suggests that not-following them may be reasonable in an individual case. Thus consideration might be given to time off work for the parents, time off school for the child, cost, side-effects, or allergies to antibiotics, a history of rheumatic fever. Thus could follow a discussion about absolutism, contextualism, and the virtue of seeking a balance between the two, based upon the Good of the patient. Although academic moral philosophy is often still taught in echoing lecture halls,[495] Socrates 'just talked with his friends in a plain way'.[496] Raimond Gaita may be speaking of just such a discussion between a senior and a junior clinician when he writes that this 'thinking about morality should clarify how ... it can deepen our thinking ... [and exposit] to the reflective but non-philosophical person ... an ever-deepening understanding of the nature of moral significance'.[497]

i) Pragmatism

Several similar frameworks termed variously *pragmatic Aristotelian virtue theory*,[498] or *prudent pragmatism*[499] can be identified. They are based upon the critical appraisal of the facts in a particular moral dilemma (and hence appeal to *situationism;* but not to consequentialism), comparing this conflict to other similar conflicts (*casuistry*, or 'case-based analysis'), emphasizing the intrinsic value in each, and seeking both similarities and differences, whilst allowing for practical exigencies. For example in examining a surrogate mother who chooses to keep the baby, an initial analogy is made with adoption for some guiding principles, but the particular facts of surrogacy, and

[494] Paediatrics and Child Health Division of The Royal Australasian College of Physicians and The Australian Society of Otolaryngology,(2008) A Joint Position paper of the Paediatrics and Child Health Division of The Royal Australasian College of Physicians and The Australian Society of Otolaryngology, Head and Neck Surgery, Sydney

[495] Schopenhauer (1841, 1965). *On the Basis of Morality* p.120.

[496] Williams (1985, 2006). Socrates' question *Ethics and the Limits of Philosophy* p.2.

[497] Gaita (2004). Mortal men and rational beings *Good and Evil: An Absolute Conception* p.41.

[498] Casebeer (2003). Opinion: Moral cognition and its neural constituents. Nature Reviews Neuroscience 4(10): 1002-1013.

[499] Bluhm and Heineman (2011). What is Prudent Pragmatism. Philosophy Now 87(Nov/Dec).

this individual surrogacy, are brought into focus to make a moral decision.[500] It allows for later facts to alter the initial decision, and for a balance to be found between the majority and the minority. Some argue for the identification of paradigm good moral decision cases and paradigm bad moral decision cases, and then comparing them to the case at hand.

ii) Ethic of care

The Ethic of Care is in some ways a reaction against the emphasis upon rationality and justice, autonomy, and individual rights which may said to characterise deontology and teleology. In their place, it emphasises care, interpersonal relationships, and communitarianism, respectively.[501] It traces its origins to a female-led re-interpretation of traditional male-dominated, perhaps overly dichotomous Western philosophical approaches. It applies to caring foremost for particular persons – for example one's own family and friends - as the morally highest motivation. Actions are judged morally good or not according as they care in this particular way. It may have an important place in decision-making in clinical settings, because 'the priority given to autonomy has obscured the significance of the special commitment health professionals have to care for their patients'.[502] Communitarians may be viewed as ordering their moral sensibilities according to social and cultural relationships – for example, close family, local community, and country.

iii) Narrative ethics

Narrative ethics, as understood in this thesis, recognises that we are each a 'particular person with a particular body with a particular history of development with a particular social and cultural community'.[503] Clinically, the history elicited from the patient is considered the cornerstone of medical diagnosis. The history, except for the emergency assessment of the unconscious patient, is the beginning of every clinical encounter. From the perspective of moral philosophy, the narrative quality of experience contributes to the question 'how should I act?' as well as contributing to the 'the inner sources of our outward actions' alluded to as being properly in the purview of ethical enquiry in 1.1 The purview of moral philosophy. In real life, ethical conflicts and dilemmas present themselves in specific, perhaps unique, contexts, on backgrounds of personal experience, insight, and socio-cultural heritage for all the participants in the moral situation. This necessarily distorts an

[500] Ibid.
[501] Kerridge, Lowe and Stewart (2013). Ethical theories and concepts *Ethics and Law for the Health Professions* p.24.
[502] Ibid. 25
[503] Olthius (1990). An ethics of compassion: ethics in a post-modernist age *What Right Does Ethics Have?: Public Philosophy in a Pluralistic Culture* p.133.

academic theory of right action, and points to the inadequacy of rationality alone. Akin to other neo-Aristotelian virtue ethical frameworks, moral *being* precedes moral *doing*. The epistemology of the narrative mode searches for connections and inter-connections amongst oneself and other participants, rather than what Jerome Bruner terms the paradigmatic or logico-scientific mode which seeks generality and universal truth conditions, and is predominantly set in a tradition of rationality and categorisation, wherein sympathy, compassion, and concern are not dominant.[504] James Olthius summarises this mode as 'a narrative ethical approach of care and responsibility – an ethics of compassion – which emphasises interconnectedness, multidimensionality and particularity',[505] and which is grounded in responsibility. This thesis argues that as a basis for moral decision-making, a narrative ethics approach must be aware of the potential subjectivity of interpretation of the narrative. Medical experimenters during the Holocaust may believe their own narrative is morally correct, but an objective assessment must argue that it is not. Similarly, the narrative context of Australia Day for white Australians, is different to that of Invasion Day for Indigenous Australians. As a reminder that moral decision-making is set in a particular context, narrative ethics is significant.

iv) Metaphysical empathy and phenomenology

Empathy and compassion were identified by Gelhaus in 3.5.2 Contemporary virtue ethics as the hallmarks of a virtue ethical approach to clinical care. The active praxis of clinical medicine – caring, is predicated upon empathy and compassion. This thesis 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 leads into further consideration of phenomenology as important in moral decision-making in clinical situations. While it may be said that the approach of metaphysical empathy emphasises sentiment over reason, that of phenomenology firmly places the patient in their actual reality, as the starting point for their care.

Schopenhauer underscored what he saw as the natural empathy amongst human beings, when he wrote that '[a]ll genuine virtue proceeds from the immediate and *intuitive* knowledge of the metaphysical identity of all beings'.[506] A monist account of metaphysical unity,[507,508] may or may not

[504] Brunner (1986). Two modes of thought *Actual Minds, Possible Worlds* pp.12-13.
[505] Olthius (1990). An ethics of compassion: ethics in a post-modernist age *What Right Does Ethics Have?: Public Philosophy in a Pluralistic Culture* p.138.
[506] Schopenhauer (1818, 1844, 1969). *The World as Will and Representation* pp.600-601.
[507] Plotinus (1952). Fourth Ennead *Plotinus: The Six Enneads* p.205.
[508] Plotinus (1952). Sixth Ennead *Plotinus: The Six Enneads* p.304.

be necessary, but metaphysical empathy is a necessary adjunct to intersubjectivity. In clinical interactions, as Schopenhauer went on to write, 'the moral significance of an action can lie only in its reference to others'.[509] His basis for a moral philosophy was compassion, 'the participation ... in the suffering of another',[510] which sees through the illusion of our separateness and thus destroys the distinction between I and not-I. '[I]n this fellow feeling … lies the very foundation of morality'.[511]

As noted in 2.2 Epistemology, truth, and language, Habermas grounds morality in the inherent vulnerability of socialized people, which thus requires a system which underlines mutual consideration in defending the integrity of the individual as well as the collective, thus simultaneously protecting the individual and the necessary intersubjective web amongst us all as members of a community. Thus the other is recognised, phenomenologically, as "like me" but "over there". Habermas derives from the vulnerability of humans his twin principles of morality – justice, and what he terms solidarity – empathic compassion and care for our neighbours. This compassion, philanthropy, or 'loving kindness' and the 'will to justice', both grounded in empathy, are intimately associated with human nature itself. Indeed, those found wanting in these characteristics are described as inhumane. Thus, the two-fold injunction of Schopenhauer 'Injure no one [the principle of justice]; on the contrary, help everyone as much as you can [the rule of compassion]', which for him is the 'true and genuine substance of all morality'.[512,513] Slote, when expounding an Ethic of Care, argues that 'our benevolent feelings towards distant others be conceptualised as caring'[514] which 'can take the well-being of all humanity into consideration'.[515] He argues that 'empathy is the primary mechanism of caring, benevolence, compassion'.[516] Gaita notes where someone helps another, and when asked why, responds that they saw no other choice, no other option, that they *had* to help. Rather than think that this person may have been motivated by something other than compassion, or by something additional to compassion, it may be that the person's compassion is especially pure, 'perfected by a proper understanding of its object - the reality of a suffering human being'.[517] Per Nortvedt, in considering the foundations of ethical sensitivity, reiterates[518] the question posed by Christine Korsgaard - when the pain of another person causes some kind of

[509] Schopenhauer (1841, 1965). *On the Basis of Morality* p.142.
[510] Ibid. 144
[511] Madigan (2013). Wad some power the giftie gie us. Philosophy Now January/February(94): 34.
[512] Schopenhauer (1841, 1965). *On the Basis of Morality* p.92 footnote 95.
[513] Schopenhauer (1841, 1965). *On the Basis of Morality* p.147 footnote 120.
[514] Held (2006). The Ethics of Care *The Oxford Handbook of Ethical Theory* p.545.
[515] Slote (2001). *Morals from Motives* p.ix.
[516] Slote (2007). *The Ethics of Care and Empathy* p.4.
[517] Gaita (2004). Naturalism *Good and Evil: An Absolute Conception* p.76.
[518] Nortvedt (2003). Subjectivity and vulnerability: reflections on the foundation of ethical sensivitiy. Nursing Philosophy 4: 223.

empathic distress, why help? Why not just take a tranquilizer?[519,520] He quotes the answer in terms of the pain of another being perceived as 'a reason for *you* to change the person's condition [original emphasis]',[521] '*as something to be relieved* [original emphasis]',[522] 'a reason to change *his* condition [original emphasis]'.[523] As Norvedt paraphrases Levinas, thus develops an 'ethical metaphysics that elucidates the awakening of moral consciousness by the vulnerability of the other person, as suffering for his suffering'.[524]

In the clinical encounter, this understanding of metaphysical empathy segues into the understanding offered by phenomenology. Phenomenology encompasses Heidegger's Being situated-in-the-world with others. For him, there can be no conception of a human being 'except as being in the midst of a world, an existent thing … in the middle of other things'.[525] Heidegger's word for human being is *Dasein*, literally, *Being there* (later, *Da-sein* to emphasise that this 'entity, has its place, *there*, in the world [original emphasis]').[526] Heidegger, concomitant with an awareness of others, recognised the need to care for others (which he terms *fursorge* or solicitude – care associated with Being-with-toward-others).[527] *Dasein* is not a thinking thing (*res cogitans*), but is a caring-about thing (*res curans*).[528]

Phenomenology is grounded in the perspective of the first person looking outward. Levinas used the term *alterity* (from the Latin, *alter*) meaning "otherness; in the sense of the other of two", it connotes the ability to distinguish between self and not-self, and consequently to assume that an alternative viewpoint exists.[529] When he wrote that '[r]esponsibility for the other, this way of answering without a prior commitment, is human fraternity itself, and it is prior to freedom',[530] he signalled that he also thought of it in terms of the significance (the value) of the Other as 'the unique

[519] Korsgaard (1996). The origin of value and the scope of obligation *The Sources of Normativity* p.148.
[520] Nagel (1970). Altruism: The intuitive issue *The Possibility of Altruism* p.83.
[521] Nortvedt (2003). Subjectivity and vulnerability: reflections on the foundation of ethical sensivitiy. Nursing Philosophy 4: 223.
[522] Nagel (1970). Altruism: The intuitive issue *The Possibility of Altruism* p.80 (footnote).
[523] Korsgaard (1996). The origin of value and the scope of obligation *The Sources of Normativity* p.149.
[524] Nortvedt (2003). Subjectivity and vulnerability: reflections on the foundation of ethical sensivitiy. Nursing Philosophy 4: 224.
[525] Warnock (1970). Martin Heidegger *Existentialism* p.50.
[526] Ibid.
[527] Ramplin and Hughes (2012). Mental illness and medical ethics: Insights from Heidegger and values-based medicine *Reconceiving Medical Ethics* p.90.
[528] Kenny (2010). Freud to Derrida *A New History of Western Philosophy* p.819.
[529] Levinas (1999). The proximity of the Other *Alterity and Transcendence* pp.97-103.
[530] Levinas (1968, 1989). Substitution *The Levinas Reader* p.106.

relation of ethical responsibility'.[531,532] Rather than existing in isolation, we are connected with others - 'a mode of being … where I am endlessly obligated to the Other, a multiplicity in being which … takes form … as fraternity and discourse'.[533]

The writings of Paul Ricoeur have been applied to the doctor-patient relationship. First, is recognition by the Clinician their self, as also being a fragile person. '[W]e receive something in particular from the fragile other which is the recognition of our own vulnerability and condition of mortality'.[534] Second, is learning that to speak the 'language of the other can be interpreted as a proper mode of being with others'.[535] He argues that, fundamental to an ethical framework, wherein "how should I live", is prior to "what should I do", our orientation as clinicians should be towards the dimension of being 'with and for' another – reflecting a relationship of mutuality, wherein each is unique and irreplaceable.[536] This underlies Habermas' intersubjectivity. As a clinician, this relationship 'with and for another' recognises the patient as a unique, suffering, human being. Recognition of suffering is what motivates the clinician to meet the patient with solicitude, compassion and caring, rather than scientific or laboratory curiosity.[537] Recall from 2.2 Epistemology, truth, and language that Bishop sees modern medicine's metaphysics as one of efficient causality focused upon the physiology of matter in motion, and which grounds its normativity in the dead body. [538] He argues that in order to combat this, physicians should recognise 'being-there-with-suffering-others', and that this should 'call one into becoming one who cares',[539] and, heeding that call, be changed.

**3.6 Islamic-Judaeo-Christian influences**

The question posed in this sub-chapter is whether the monotheistic Faiths of the Islamic, Judaic 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

[531] Lechte (2008). Emile Benveniste *Fifty Key Contemporary Thinkers: From Structuralism To Post-Humanism* p.62.
[532] Fleming (2013). Ethics is an optics: The Levinasian perspective on value as primary *The Routledge international handbook of education, religion and values* pp.362-372.
[533] Hand (1989). *The Levinas Reader* p.1.
[534] Fiasse (2012). Ricoeur's medical ethics: the encounter between the physician and the patient *Reconceiving Medical Ethics* p.41.
[535] Ibid. 30
[536] Ibid. 31-32
[537] Ibid. 32-33
[538] Bishop (2011). Transition one *The Anticipatory Corpse: Medicine, Power, and the Care of the Dying* p.90.
[539] Bishop (2011). Anticipating life *The Anticipatory Corpse: Medicine, Power, and the Care of the Dying* pp.310-311.

substantive moral code, which reached its zenith in the medieval era, arguably the Islamic-Judaeo-Christian tradition is no longer a moral framework with normative force. In the post-modern period, obedience to the word of God as a framework for morality has been comprehensively replaced by an ethic of science, but also of ego, and my success, social media credibility, physical attributes, ethnicity, and/or lifestyle; often mediated by way of the web. A further question might then arise – whether the monotheistic Faiths which are extant today, are only an attenuated and impoverished version of the moral insights of the authentic Islamic-Judaeo-Christian tradition.[540]

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. Historically, throughout the three epochs which follow the classical period, the monotheistic Islamic-Judaeo-Christian influence is recognised as informing the evolution of Western philosophical thought. This has been either as supportive of it, or as a reaction against it. Although classical Greek philosophers are traditionally viewed as not discussing kindness, compassion, moral guilt, self-denial or selflessness; it may cogently be argued that the epic poems and plays of the classical period did consider those ideals. Islam, Judaism and Christianity however brought these notions into the forefront of the thinking of Western philosophers. 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'.[541] The *Encyclopedia of Bioethics* argues that the clearest example of the influence of the life and times of philosophers upon Philosophy 'lies in the influence of Christianity on the history of theoretical ethics'.[542] Anthony Kenny wrote that '[f]or the long-term development of philosophy the most important event in the first century of the Roman Empire was the career of Jesus of Nazareth'.[543]

One of the issues with vesting authority for a moral code in God is that the source of that moral authority becomes discrete from, conventionally "above", both autonomous human beings and Society as a whole. Jonathan Berg addresses this question.[544] Apart from the simplification that "everything depends upon God", clearly religious teachings share much commonality with secular ethical norms. Divine Command Theory, wherein God wills all moral values into existence and on this basis gives them normative force, argues that *God's will* and *the Good* are one-and-the-same.

[540] McCoy (2004). Christian morality *An Intelligent Person's Guide to Christian Ethics* p.137.
[541] Warnock (2004). *An Intelligent Person's Guide to Ethics* p.9.
[542] Slote (1995). Task of ethics *Encycolpedia of Bioethics, Revised edition* p.720.
[543] Kenny (2010). Schools of thought: From Aristotle to Augustine *A New History of Western Philosophy* p.86.
[544] Berg (1993). How Could Ethics Depend on Religion *A Companion to Ethics* pp.525-433.

Proponents emerging during the transition from the medieval epoch to the modern epoch include William of Ockham, Martin Luther, and John Calvin. Luther indeed argued that we are to be saved, not by good works, since these stem from our naturally sinful nature. Rather, we are saved by our Faith alone. There was little relevance for a morality around right actions. A problem however arises with the large numbers of morally Good people who have no knowledge of, or belief in, God's will. Thus a variation is to suggest that the Good and God's will are not the same, but they do amount to the same thing. God's divine reward or punishment may also be a strong motivator for individuals to follow a morally good path. Again, it is in their own historical contexts that despite different moral vocabularies, the moral philosophy of 'Aquinas' Christian Aristotelianism and Luther's Christian fideism'[545] are derived, listened to, and understood by the society of their times.

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*. To the Hebraic *Tanakh*, is added the Qur'an by Muslims, and the New Testament by Christians.[546] Each tradition then allows, indeed fosters, interpretation of the divine scriptures in the practical moral decision-making of humans, by the community of the faithful. Each tradition is characterised 'with an ethical impact and practical action as constituting the keystone of faith in their traditions, be it the practice of the Ten Commandments, Jesus' Great Commandment to love God and neighbour, or the Five Pillars of Islam'.[547]

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'.[548] 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).[549] The negative ethic

[545] MacIntyre (1998). *A Short History of Ethics* p.121.
[546] Reid (2013). Books - "The Bible". Philosophy Now 99(Nov/Dec): 46-48.
[547] Lovat and Semetsky (2009). Practical mysticism and Deleuze's ontology of the virtual. Cosmos and History: The Journal of Natural and Social Philosophy 5(2): 2.
[548] Preston (1993). Christian Ethics *A Companion to Ethics* p.93.
[549] Valentinus (2007). The Gospel of Truth *The Secret Gospels of Jesus* p.106.

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'.[550] Words attributed to Jesus Christ himself which help to clarify right motive and right action are recorded in the three Synoptic Gospels of Mathew, Mark and Luke (probably recorded from 40 CE) and the more re-worked, more sophisticated Hellenistic Gospel of John (probably completed early in the second century AD).[551] The genuine teachings of Jesus recorded in the Synoptic Gospels however 'contains nothing abstract, theoretical and speculative … he rather tried to convey to his audience … how to draw near to God, and respond to his appeal through concrete religious behaviour and action'.[552]

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.[553] For example, in Confucianism 'what you do not wish for yourself, do not do to others' (Analects/Lunyu 12.2 and 6.30), in Buddhism 'Hurt not others in ways that you yourself would find hurtful' (Udana-Varga 5,1), in Hinduism 'This is the sum of duty; do naught onto others what you would not have them do unto you' (Mahabharata 5,1517), in Islam 'No one of you is a believer until he desires for his brother that which he desires for himself' (40 Hadith of an-Nawawi 13), in Judaism 'What is hateful to you, do not do to your fellowman. This is the entire Law; all the rest is commentary' (Talmud, Shabbat 3id), amongst others.

It is aligned with universalizability, which is proposed by many as a necessary condition for moral judgements and as a formal principle of moral justice[554]; and implies reciprocity. Because I would want others to feed me if I was hungry, then I should feed others if they are hungry. Since I would not want someone to kill me, then I should not kill anyone. In most people this rule typically evokes agreement and emotional resonance with the implied mutual respect of one's person and one's rights, and equally, few would deny the reciprocity implied. William James writes, when discussing moral principles, seeking a 'phenomenon of supernumerary order', that '"nothing can be right for me which would not be right for another similarly placed" … or … "what it is reasonable that another should do for me, it is also reasonable that I should do for him"'.[555] It is included in *The Fellowship*

[550] Hallie (1981). From Cruelty to Goodness. The Hastings Center Report 11(3): 23-28.
[551] Vermes (2003, 2009). *The Authentic Gospel of Jesus* p.xii.
[552] Vermes (2003, 2009). *The Authentic Gospel of Jesus* pp.413-414.
[553] http://www.virtuescience.com/golden-rule.html 2.9.2012
[554] Childress (1989). The normative principles of medical ethics *Medical Ethics* p.32.
[555] James (1890, 1952). The Principles of Psychology *The Principles of Psychology* p.887.

*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'.[556]

Indeed, the Golden Rule is proposed by George Hunsinger as the basis for a common morality.[557] Hunsinger argues that a common morality need not be a morally correct solution for all morally dilemmatic situations – 'it could well be a modest morality without being insignificant. It need not do everything in order to do something worthwhile'.[558] One may have a relatively unsophisticated understanding about justice, fairness, dignity, benevolence, and similar notions. One may intuitively apply these understandings to oneself, as a sufficient starting point, or a valid working set of definitions, for a morality one applies to others impartially. Hence, there is no necessity to philosophise deeply upon what those words actually mean. We are speaking of a common morality which involves empathically walking in the shoes of the other. If there is a concept of an ethical epistemic primitive or an irreducible normative truth, by which is meant an ethical construct that is so fundamental it cannot be the subject of doubt, or subjected to testing, without throwing moral philosophy as a gestalt into the inchoate void, and so may be a metaphysical construct, from which all ethical systems devolve; then the Golden Rule may be a candidate.

Kant argued that the Golden Rule is inferior to his categorical imperative since it does not contain 'the principle of duties to oneself, nor of duties of benevolence to others, … nor finally that of strict obligation to one another'.[559] He suggests that many might willingly forego help from others, if that means they will not need to, themselves, help others. This however is not what the Golden Rule says. Rather, it is what Kant's Categorical imperative might render universalised. He also suggests that a criminal might argue that the judge should not punish him by incarceration, because the judge himself would not wish himself punished similarly. The response of the judge would be along the lines of agreeing that s/he would not want to be incarcerated; unless s/he had committed the same crime. A similar analogy might be that of a white hotel owner who argues that he is willing to accept the reciprocity which follows from a rule excluding non-whites from certain hotels. The white hotel owner though misunderstands the Golden Rule. He ought to treat black people 'only as he would be willing to be treated *if he were going to be in their position* [original emphasis]'.[560] Thus either he himself is to be black, or all hotels are to be owned by blacks, who exclude whites. Thus, Derek Parfit

[556] http://www.facs.org/fellows_info/statements/stonprin.html#fp
[557] Hunsinger (2006). Torture, common morality, and the Golden Rule. Theology Today 63: 375-379.
[558] Hunsinger (2006). Torture, common morality, and the Golden Rule. Theology Today 63: 376.
[559] Kant (1785, 1952). The Fundamental Principles of the Metaphysic of Morals *The Critique of Pure Reason, The Critique of Practical Reason and other ethical treatises, The Critique of Judgement* p.272 footnote.
[560] Parfit (2011). *On What Matters* pp.323-324.

restates the Golden Rule as '[w]e ought to treat others only in ways in which we would rationally be willing to be treated, if we were going to be in these other people's positions, and would be relevantly like them'.[561] Michael Sandel offers another example to distinguish the Golden Rule from Kant's categorical imperative.[562] Consider the situation where your brother has died in a motor vehicle accident, and your elderly mother asks for news of him. The moral dilemma is whether to spare her the truth (and the shock of it), or to tell her the truth. The Golden Rule exhorts us ask how we ourselves would want to be treated. This answer is highly contingent – some want to be told the truth, while others don't. For Kant, the categorical imperative means that your mother's human dignity requires that she be told the truth. Otherwise, arguably, you are using her 'as a means to her own contentment'.[563]

While the Golden Rule of reciprocity *implies* a choice to do Good things, it could equally be interpreted to condone doing reciprocated hurtful, harmful, or sinful things. A person who likes to be aloof could be justified in being unfriendly to others; one who likes to be provoked into an argument could go about provoking others into an argument. And, of more significance, an individual would have 'only to consult his own tastes and needs to discover how he ought to behave toward other people'.[564] As a counter-argument, however, the Golden Rule stated in the form 'do unto others *as* you would have them do unto you' has more generalizability as a principle of moral behaviour, which in different circumstances may impel different action; than the Golden Rule stated with the much more particular 'do unto others *what* you would have them do to you''. It has been suggested that the Golden Rule implies that moral decisions should be made assuming that they will be judged by Rawls' 'impartial sympathetic spectator' or Hare's all-knowing archangel. Although this does underpin the notion of Justice in the Golden Rule, this understanding demeans the intensely personal appeal to look directly to one's own moral compass as unambiguous judge in deciding how to treat others.

Re-visiting reciprocity, as noted, the circumstances of each could be quite different resulting in reciprocation being inappropriate. Thus Edvard Westermarck clarifies, as his 'maxim of benevolence', that 'each ... is morally bound to regard the good of any other individual as much as his own, except in so far as he judges it to be less, ... or less ... knowable or attainable by him'.[565] However the reciprocity of the Golden Rule may be appealed-to in moral decision-making in clinical

[561] Ibid. 324
[562] Sandel (2009). What matters is the motive *Justice: What is the Right Thing to Do?* pp.127-128.
[563] Ibid. '127
[564] Russell (1942). Ideals and Practice. Philosophy XVII: 109-110.
[565] Sidgwick (The Methods of Ethics, MacMIllan London, 1907, 1994). The Methods of Ethics *Ethics* pp.136-137.

situations. It is especially useful when viewed, not as a sufficient principle, but rather, as a necessary principle, as a test of a reason to act – for example, to check whether one is making an unjustified exception of oneself.[566] However, in clinical situations reciprocity may also be especially inappropriate. For example, while the clinician may be happy to be told the gravity of the prognosis for himself because he has the strength and family support to prepare for his own death, a patient may have neither.

The inversion of the Golden Rule is 'do unto others as *they* would have you do unto them'.[567] Taken at face value the inversion implies that we should acquiesce to a request to hand over property, become someone's slave, and similar untenable requirements. It implies perfect altruism. Kant writes 'that one should sacrifice his own happiness, his true wants, in order to promote that of others, would be a self-contradictory maxim if made a universal law', and that '[t]his duty, therefore is only indeterminate; it has a certain latitude within which one may be able to do more or less without our being able to assign its limits definitely'.[568] The inversion may, however, be a more apposite formula for clinical situations – in that it requires 'an understanding of other people as a basis of our behaviour toward them'.[569] Respecting the patient's autonomy in decisions around for example end-of-life withdrawal of support or heroic surgical intervention, revolves around adducing what it is that *they* would wish for you to do unto them, when in this situation.

Aquinas moved the *telos* of Man and the goal of virtue from the *eudaimonia* or 'flourishing' of the Greeks, to the *beatitudo* or 'blessedness' of eternal union with God.[570] Amongst the three cardinal virtues (1 Corinthians 13:13) *compassion* is most intimate to the Christian Ethic. Compared with the metaphysical notion of empathy and compassion explored in 3.5.2.iv Metaphysical empathy and compassion, compassion in the Christian ethic begins with the words Jesus articulated as the basis for His moral framework - '"You shall love the Lord your God with all your heart, and with all your soul, and with all your mind". This is the greatest and first commandment. And the second is like it: "You shall love your neighbour as yourself"' (Mathew 22:37-40). 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

[566] Childress (1989). The normative principles of medical ethics *Medical Ethics* p.32.
[567] Singer (1963). The Golden Rule. Philosophy 38(146): 294.
[568] Kant (1796, 1952). Metaphysical Elements of Ethics *The Critique of Pure Reason, The Critique of Practical Reason and other ethical treatises, The Critique of Judgement* p.373.
[569] Russell (1942). Ideals and Practice. Philosophy XVII: 109-110.
[570] Haldane (1993). Medieval and Renaissance Ethics *A Companion to Ethics* p.142.

to ethical decision-making.[571] Rulings were not given by Jesus in a wide variety of different situations which were morally dilemmatic. The ultimate test for concordance with a Christian Ethic is whether it accords with love of God and love of neighbour.

It may be that those who are educated into knowing what is good and evil will be required to be good to a higher standard – '[t]he greater and more complete thy knowledge, the more severely shalt thou be judged'.[572] King reasonably expected greater Goodness from his fellow white clergymen when he wrote to them that '[s]hallow understanding from people of good will is more frustrating than absolute misunderstanding from people of ill will'.[573] And later in the same letter he admonished them with '[w]e will have to repent in this generation not merely for the hateful words and actions of the bad people but for the appalling silence of the good people'.[574] In this he echoes "the darkest places in hell are reserved for those who maintain their neutrality in times of moral crisis"; a derivation from Dante's description of those souls he and Virgil meet on the way into Hell, who chose neither side in battles of good versus evil, and so are disdained by both God and Satan and must whirl eternally in Hell's vestibule.[575] It echoes too, the words attributed to Edmund Burke – "all that is necessary for the triumph of evil is that good men do nothing"; similar to Mill's 'bad men need nothing more to compass their ends, than that good men should look on and do nothing'.[576] According to this understanding, clinicians, as a consequence of their privileged education and their role in society, may be held to account if they do not reflect upon the moral nature of their interactions with patients and families.

What then is the practical mechanism by which a modern-day Christian might seek to make morally correct decisions? Charles Curran, after distinguishing absolute natural law from relative natural law, which exists because of the sinfulness of man, argues that Catholic theology has focused too much upon the absolute and metaphysical aspects of morality, and paid insufficient attention to the necessities brought about by the reality of the sinfulness of mankind.[577] Thus he argues for a balanced or proportional response to potentially sinful situations, aware of the abstract notions of absolute moral law, but equally cognisant of the reality of sin in the world. Ronald Preston argues in acting rightly from the right motives, 'spiritual formation' which he describes as 'a growth in

[571] Preston (idem Christian Ethics p.98.
[572] aKempis The Imitation of Christ, Book I, Chapter II, Section 3
[573] King (1963, 2010). Letter from a Birmingham Jail *Ethics: the Essential Writings* p.366.
[574] Ibid. 368
[575] Alighieri (2005). *Inferno* p.25.
[576] Mill (1st Feb 1867). Inaugural Address Delivered to the University of St Andrews,
[577] Curran (1979). Moral theology, psychiatry and homosexuality *Transition and Tradition in Moral Theology* p.75.

character through private prayers and public worship ... and discussion with fellow Christians (and others where appropriate) so that one's insight or powers of discernment deepen', is crucial.[578] 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'.[579] Rowan Williams writes that being faithful to the truth within me is a large part of deciding what I ought to do.[580] Williams echoes Habermas when he explains that Christians do not inherently have more information about moral truth in the abstract, but that the fact Christians are part of a Church influences their internal truth – knowledge of the covenant between God and Man. "Church" (Williams' Body of Christ) implies both the institution as well as the community of believers, but could be broadened to include influences from the historical traditions of one's denomination, the sum of our religious experience, and Biblical exegesis.[581] Importantly, the ethical authority of the Bible lies within the Community which interprets it rather than solely within the texts themselves.[582,583] The Bible 'does not present abstract reflection of a philosophical kind on the nature and grounds of moral action ... [nor] ... a systematic reflection on the good'.[584] This spares us an even more troublesome exegesis. Rather, the New Testament focuses on a new way of life revealed in and by Jesus Christ. As suggested earlier, considering the historical context of the New Testament and its focus upon the coming of the Kingdom in the near future, guiding ethical principles are not specifically offered in the same way that they are by Kant or Bentham and Mill. 'The gospels display the good in the form of narratives of the life of Christ seen in the light of the resurrection; the epistles display the good in the form of strenuous argument about the fulfilment of the scriptures in Christ'.[585] It is therefore appropriate to first have historians put the texts into their historical context, and only then should an ethicist be involved. This allows recognition of the 'particularity and even peculiarity'[586] of the texts in the contexts in which they were originally recorded, and would likely save considerable argument.

In certain specific 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

[578] Preston (1993). Christian Ethics *A Companion to Ethics* p.94.
[579] Lovat (2012). Bonhoeffer: Interfaith theologian and practical mystic. Pacifica 25: 178.
[580] Williams (2001). Making Moral Decisions *The Cambridge Companion to Christian Ethics* pp.3-15.
[581] Jones (idem The Authority of Scripture and Christian Ethics p.16.
[582] Jones (2001). The Authority of Scripture and Christian Ethics *The Cambridge Companion to Christian Ethics* p.19.
[583] Barton (idem The Epistles and Christian Ethics p.68.
[584] Ibid. 64
[585] Ibid.
[586] Ibid. 66-67

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.

Under this monotheistic framework (be it Islamic, Judaic or Christian), it may be that the Baby 'W' would not be treated here on earth, and so would be allowed to go to Heaven.

**3.6 Summary**

Three secular normative frameworks in the Western tradition have been the basis for secular claims to moral authority. The deontological framework focuses on the nature of the Act or decision to determine the morality of an Action, independent of situation or context. The teleological framework focuses on the actual or potential consequences of the Act, independent of the Act itself. Virtue ethics focuses on the character of the Agent performing the Action.

The Good of the patient is the ultimate *telos* of moral philosophical decision-making in clinical situations. Based upon Pellegrino's hierarchy of four interpretations of the good of the patient, in clinical practice, the virtue ethics framework favours empathy, compassion and care as constituting the essential underlying characteristics of the agent. In our current era, these approaches have limitations as substantive frameworks. The next stage of the argument proposes that moral decision-making in clinical contexts should look beyond the established frameworks towards a different approach, identified as Proportionism. The Proportionist approach seeks the highest good based upon a balance 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.

## CHAPTER 4 PRINCIPLISM AND THE DYNAMICS OF THE DOCTOR-PATIENT RELATIONSHIP

### 4.1 Introduction

As has been alluded to in Chapter 3, appeal to substantive normative moral frameworks to guide moral decision-making has been complicated by uncertainty about which normative framework to apply; and if more than one, with what weighting each should each be applied. Thus persistent attempts by medical ethicists to simplify the decision-making process in clinical situations followed. This they attempted by determining a smaller number of principles, and rules derived from them, which should guide moral decision-making by clinicians. Principles are viewed as being more general but may result in the concrete rules which specify actions in more detail. Thus develops an appellate approach wherein justification for specific moral decisions is via appeals to these rules or to their parent principles.[587] Various principles have been proposed, including obligations to respect the wishes of competent persons, to avoid harming persons, to benefit others, to produce a nett balance of benefit over harm, to distribute utility equally, to keep promises, to remain truthful, and to respect privacy. Derivative obligations may then follow, for example, veracity, fidelity, privacy, and confidentiality. Based upon these principles, various models of the doctor-patient relationship may be conceptualised.

### 4.2 Four principles relevant to medical ethics

Several lists of principles have been provided to guide clinicians. Frankena lists only two principles – beneficence and justice.[588] Recognising the limits of secular reasoning, Engelhardt seeks a content-less secular ethics of health care and also (initially) identified only two principles – permission and beneficence.[589,590] Later, however, he added two more principles – ownership (relevant in public versus private health care issues),[591] and political authority (applicable to the intensely regulated practice of medicine in our times).[592] Robert Veatch lists his primary principles as beneficence, justice, autonomy, veracity, fidelity, and avoidance of killing.[593] Fried offers lucidity (candour and full disclosure), autonomy (professional accountability and medical truthfulness), fidelity (loyalty to the

[587] Childress (1989). The normative principles of medical ethics *Medical Ethics* p.30.
[588] Frankena (1973). Utilitarianism and justice *Ethics* pp.43-46.
[589] Engelhardt (1996). The intellectual bases of bioethics *The Foundations of Bioethics* p.83.
[590] Engelhardt (1996). The principles of bioethics *The Foundations of Bioethics* pp.122-124.
[591] Engelhardt (1996). The foundations of bioethics *The Foundations of Bioethics* pp.164-166.
[592] Ibid. 177-179
[593] Robert M Veatch, Amy M Haddad and English (2010). Four questions of ethics *Case Studies in Biomedical Ethics* p.15.

interests of the patient), and humanity (compassion, respect for a patient's unique humanity).[594,595] Pellegrino offered six virtues of clinicians – fidelity to trust, suppression of self-interest, intellectual honesty, compassion, courage to pursue the good, and prudence.[596]

Beauchamp and Childress, in their foundational *Principles of Biomedical Ethics*, now in its sixth edition, propose a set of four *prima facie* principles as an analytical framework to express the norms of common morality as they see them applying to medical ethics.[597] The four principles they propose are *respect for autonomy*, *non-maleficence*, *beneficence*, and *justice*. Very influential in medical ethics they have an epistemic origin from within the normative ethical frameworks. Although they may be positioned as a group of intermediate or mid-level practical moral philosophical principles or norms which adherents of any one of the three normative frameworks may be able to agree with, 'located just below theories and just above rules';[598] at a minimum, regardless of philosophical, cultural, or religious background, they allow for a common moral language amongst clinicians. Because of their influence, they are considered now in greater detail.

### 4.2.1 Autonomy

Although the four principles of autonomy, non-maleficence, beneficence, and justice are conceived as having equal weighting, *de facto*, the principle of respect for autonomy is '*primus inter pares* - first among equals',[599] 'the "default" principle of applied principlism'.[600] This originated largely as a reaction against clinical and research "experiments" during the 20th century (those of the Nazis in World War II,[601] the Tuskegee syphilis experiment,[602] amongst others); but also the rise of awareness of individual and human rights in wider society. Three traditional concepts of *autonomy*, as they might apply to moral decision-making in clinical situations, must be considered – derived from the understandings of Kant, Mill, and Pellegrino. These traditional concepts of autonomy however, are

[594] Fried (1974). Personal care: interests or rights *Medical Experimentation: Personal integrity and Social policy* pp.101-103.
[595] Fried (1974). The practice of experimentation *Medical Experimentation: Personal integrity and Social policy* pp.152-156.
[596] Pellegrino (2001). The internal morality of clinical medicine: A paradigm for the ethics of the helping and healing professions. Journal of Medicine and Philosophy 26(6): 576.
[597] Beauchamp and Childress (2009). *Principles of Biomedical Ethics* pp.xiii, 417 p.
[598] Clouser and Gert (1990). A Critique of Principlism. Journal of Medicine and Philosophy 15(2): 220.
[599] Gillon (2003). Ethics needs principles - four can encompass the rest - and respect for autonomy should be "first among equals". Journal of Medical Ethics 29(5): 307-312.
[600] Wolpe (1998). The triumph of autonomy in American medical ethics: A sociological view *Bioethics and Society: Constructing the Ethical Enterprise* p.43.
[601] Weindling (2001). The origins of informed consent: the International Scientific Commission on medical war crimes, and the Nurenberg code. Bulletin of the History of Medicine 75(1): 37-71.
[602] Jones James H and the Tuskegee Institute (1981, 1993). *Bad Blood: the Tuskegee Syphilis Experiment* pp.xii, 272 p., 278 leaves of plates.

problematic in practical application. A more nuanced understanding, derived in part from insights proffered by phenomenology, may be more applicable to clinical moral decision-making.

The moral philosophical sense of *autonomy* has its grounding in the writings of Kant, outlined in 3.3.1 Deontological frameworks. It leans towards his categorical imperative of conforming one's will to the self-legislated rational dictates of the moral law.[603,604] This sense of autonomy is summarised by JB Schneewind:

> At the center of Kant's ethical theory is the claim that normal adults are capable of being self-governing in moral matters. In Kant's terminology, we are "autonomous". Autonomy involves two components. The first is that no authority external to ourselves is needed to constitute or inform us of the demands of morality. We can each know without being told what we ought to do because moral requirements are requirements we impose on ourselves. The second is that in self-government we can effectively control ourselves. The obligations we impose on ourselves override all other calls for action and frequently run counter to our desires. We nonetheless always have sufficient motive to act as we ought.[605]

Personal autonomy, however, leans away from conforming one's will to the self-imposed rational dictates of the moral law, and, instead, leans towards the sense inherent within Kant's practical imperative – that all persons have intrinsic moral worth, and that it is impermissible to treat another human as a mere means to an end. As applied to patients, it thus encompasses the concept that the individual makes decisions, free from the controlling influence of others, in the vision of their own values, and with adequate understanding of the decision, its necessity and consequences. Personal autonomy thus has a relationship to authenticity, and, especially in the sense of giving permission (moral agency), to personhood – to be further discussed in 7.4.1 Philosophical aspects of personhood.

Mill argued that society should allow individuals the liberty to express their freedom, even to harm themselves, provided they do not harm others.[606] Specifically, to forcibly intervene for 'his own good, either physical or moral, is not a sufficient warrant ... [nor] because it will be better for him ...

---

[603] Larmore (2008). The problem with morality *The Autonomy of Morality* p.88.
[604] Deligiorgi (2012). The many faces of Kantian autonomy *The Scope of Autonomy: Kant and the Morality of Freedom* p.18.
[604] Clouser and Gert (1990). A Critique of Principlism. Journal of Medicine and Philosophy 15(2): 220.
[605] Schneewind (1992). Autonomy, obligation, and virtue: An overview of Kant's moral philosophy *The Cambridge Companion to Kant* pp.309-310.
[606] Mill (1859, 1952). On Liberty *American State Papers, The Federalist, On Liberty, Representative Government, Utilitarianism* p.271.

because it will make him happier, because in the opinion of others to do so would be wise, or even right' and 'over himself, over his own body and mind, the individual is sovereign'.[607] A neo-liberal account of autonomy, founded upon individualism, 'whether from the egalitarian left or the market orientated right',[608] thus posits individuals as discrete social units, with self-interested desires, reached by rational calculation; and hence driven by means-ends thinking.[609,610] Perhaps mirroring trends in wider society, this understanding embodies the rights of the consumers to request, even to demand, treatments, and to have an entitlement to receive these treatments.[611] Habermas would likely agree that 'the modern ethics of autonomy cleave to an individualistic understanding of the self at odds with a substantive notion of community',[612] and that rather than consumerism or means-ends rationality, a communicative rationality linked to the public use of reason, thus reaching a consensus through discourse, is more apposite.[613]

Pellegrino, in basing his notion of the Good of the patient as a human person, upon patient autonomy, writes that '[w]e cannot override those choices even if they run counter to what we think is good for the patient … even to do what we think is good is to violate his good as a human being'.[614] Failure of a clinician to recognise and assist patient autonomy is *paternalism* – considered a highly pejorative appellation. This model for the doctor-patient relationship is further exposited below.

Practical concepts in clinical medicine which follow from the principle of autonomy include, amongst others, informed consent, medical confidentiality, and promise-keeping.

In the context of informed consent, the clinician is required to be both non-coercive and non-deceptive. Respect for autonomy generally takes priority over beneficence. It is not permissible to coerce or deceive patients, even in their own interests. Acting *in conformity with* duty connotes obtaining the signature on the bottom of the consent form. Acting *from* duty implies actively ensuring that the consent is informed consent. Coercive means of obtaining 'consent' include so dramatizing the risks of alternative treatment options that the patient recoils from them and

---

[607] Ibid.
[608] Callahan (2003). Principilism and communitarianism. Journal of Medical Ethics 29(5): 287-291.
[609] Gillett and Amos 2014) Words are not just things, The New Zealand Bioethics Conference,
[610] Bowyer (2014). Autonomy and why you can "Never let me go". Journal of Bioethical Inquiry 11(2): 139.
[611] Kekewich idem Market liberalism in health care: A dysfunctional view of respecting "consumer"autonomy. (1): 21.
[612] Cronin (1993). Translator's Introduction *Justification and Application: Remarks on Discourse Ethics* p.xix.
[613] Thomassen (2010). Introduction *Habermas: A Guide for the Perplexed* p.10.
[614] Pellegrino (1985). Moral choice, the good of the patient, and the patient's good *Ethics and Critical Care Medicine* pp.125-126.

chooses the treatment which the clinician prefers. In seeking consent, coercion and deception both rule out a patient's dissent; and so preclude their consent. Put another way, for patients to rationally give consent, they must know the true facts. Medical confidentiality encompasses decisions about whether it is morally permissible to breach patient confidentiality about, for example, a fatal infectious disease (HIV) in order to protect another who is innocent, or whether to advise genetically-related family-members about a serious genetic diagnosis in the patient; and whether it is permissible to lie in order to engender a better psychological attitude, to avoid depression, and so achieve a better outcome. Veracity is considered a 'medical ethical rule' by Beauchamp and Childress, but Terence Perlin argues that it should be added as a fifth principle because without it autonomy and, specifically, informed consent has no meaning and compromises 'the premise of an open health care professional-patient relationship'.[615] In his first edition of *The Foundations of Bioethics*, Engelhardt also named autonomy as one of his two principles.[616] In his second edition, he renamed this principle as 'permission' in order to acknowledge that, when recourse cannot be made to a theistic framework or to reason, moral authority derives from the freely given permission of those involved in a common undertaking.[617] Permission, however, is in tension with beneficence. Consider the commitment of clinicians to the best outcome for patients, who knowingly live a noxious non-compliant lifestyle, and the conflict in ranking these two conflicting principles in the emphysematous adult who wants to continue to smoke a little. Englehardt argues that the principles both of permission and of beneficence are justified deontologically rather than in terms of their consequences. However, the concrete rules of beneficence are likely to appeal to consequences and so be justified teleologically, while the concrete rules of permission are binding independent of consequence, and so are justified deontologically.[618] Hence, they are principles in tension with each other.

Models of informed consent have been conceptualised in various ways. These include consideration of validity (consent being given voluntarily, and by someone mentally competent) and information (disclosure and understanding).[619] 'Voluntariness and competence are *protective* of autonomy … disclosure and understanding are *productive* of autonomy [original emphasis]'.[620] Completely informed consent is likely not possible. Rather, information transfer, with variable success, occurs.

[615] Perlin (1992). Getting down to cases: An introduction to clinical medical ethics *Clinical Medical Ethics: Cases in Practice* p.10.
[616] Engelhardt (1986). The principles of bioethics *The Foundations of Bioethics* p.66ff.
[617] Engelhardt (1996). The intellectual bases of bioethics *The Foundations of Bioethics* p.83.
[618] Engelhardt (1996). The principles of bioethics *The Foundations of Bioethics* p.119.
[619] Jordens, Montgomery and Forsyth (2013). Trouble in the gap: A bioethical and sociological analysis of informed consent for high-risk medical procedures. Journal of Bioethical Inquiry 10(1): 68.
[620] Jordens, Montgomery and Forsyth idem: 69.

Preferable to the illusionary language of "informed consent", there should be a migration towards "adequately accurate information" following upon intelligent, relevant, successful and bi-directional dialogue. Perhaps "participatory agreement" is a more apposite terminology – implying that as much as clinicians 'recognise and act on their responsibility to inform and educate patients' there is an associated expectation that requires 'patients to reciprocate these efforts by demonstrably engaging in the education process'.[621] This requires a clear articulation that informed consent is a dialogue not a monologue.

Recent biomedical advances render more problematic questions around respect for autonomy in several areas.

Consider once again the elderly patient in 3.3.2.iV Natural law theories who has a fully implanted permanent cardiac pacemaker (PPM).[622] Recall that the PPM senses whether there is a cardiac rhythm and, if not, it is programmed to generate an electrical stimulus. Compare this with a patient with an implanted mechanical cardiac valve. Despite being implanted, it may be argued that the patient with the cardiac valve retains autonomy about whether to continue with this life-maintaining treatment. The patient can effectively withdraw consent for this treatment by discontinuing the prescribed warfarin dose; aware that without warfarin, the valve will likely thrombose and fail. The patient with a PPM has no autonomy to withdraw consent for this life-sustaining treatment. Even if 'tired of life', and seeking death, it is not possible for the patient to switch off or re-programme the PPM herself. The patient cannot withdraw consent for this treatment. In fact, the issue of re-programming will likely only be addressed as permissible or impermissible, if the patient has some other life-threatening illness.

As a way forward, it is important that issues, and constraints, around device reprogramming, be discussed with the patient before device implantation,[623] as an inherent part of respecting their autonomy. It is reported that a majority of adult patients with congenital heart disease want to have this conversation.[624] However, a recent study of 420 patients implanted with a defibrillator, found

[621] Ibid. 67
[622] Walker, Lovat, Leitch and Saul (2014). The moral philsophical challenges posed by fully implantable permanent pacemakers. Ethics and Medicine 30(3): 157-165.
[623] Matlock and Stevenson (2012). Life-saving devices reach the end of life with heart failure. Prog Cardiovasc Dis 55(3): 274.
[624] Kirkpatrick, Kim and Kaufman idem Ethics priorities in adult congenital heart disease. 269.

only 30% had prepared an advanced care directive; and only two of these mentioned the device or its deactivation at the end-of-life.[625]

A further example, wherein traditional understandings of autonomy and informed consent are problematic, is seen in the human genome project. In sequencing the child's genome from blood drawn from the mother, the mother's genome must also be sequenced, so that it is clear which is that of the mother and which is that of the child. Thus non-invasive prenatal screening has become a reality. Mother, and child, may find out that they have the genetic code for a serious, but currently asymptomatic disease, for which there is no available intervention. There will also be insurance issues. Does "reproductive autonomy" over-ride the child's and the mother's right *not* to know?[626] Similarly, tissue-banking may allow familial diseases to be diagnosed well after the donor has no use for the information. The donor's descendants gave no consent for the information to be looked-for. Future information which may be available is unknown, and arguably, unknowable.

This thesis argues that we need to move towards a more nuanced understanding of autonomy.[627]

In order to further consider autonomy in practical clinical application, consider the critically-ill patient in ICU, potentially with their end-of-life in view. This patient, or their relatives, may claim the right to unlimited technological support, without consideration of feasibility, or costs and limitations to resource availability, on the basis of autonomy. We suggest, however, that this simplified concept of autonomy is impoverished. Because derived from rational self-legislation (Kant), and giving the individual primacy (Mill), even to the exclusion of staff experienced in critically-ill situations (Pellegrino), it is ultimately egoistic,[628] individualistic, and does not require positioning the individual in the world of alterity, the world of others, the world as it actually *is*. That is, echoing the notion of personhood to which we subscribe, rather than existing in isolation, we are 'interdependent, interconnected, and intermingling' with others.[629] As well, within the technologically-enhanced *milieu* of the ICU, the self is recognised as being a fragile person whereby silver-hued, hard-edged metallic bio-technologies can be seen as intrusive. An authentic autonomy recognises the other, those in relationship with the agent (in this case, the patient), and ethical decisions should therefore

[625] Tanya, Abigale and David (2012). The use of advance directives among patients with implantable cardioverter defibrillators. Pacing Clin Electrophysiol(35): 567.
[626] Newson 2013) Genomic advances and testing and screening before birth: What's at stake?, Australian Association of Bioethics and Health Law Conference,
[627] Walker and Lovat (2014). Concepts of personhood and autonomy as they apply to end-of-life decisions in intensive care. Medicine, Health Care and Philosophy In Press.
[628] Deligiorgi (2012). Preface *The Scope of Autonomy: Kant and the Morality of Freedom* p.v.
[629] Jonathan Herring and Chau (2007). My body, your body, our bodies. Medical Law Review 15(1): 45.

be predicated upon this reality. A richer account of autonomy in this context implies that the patient not simply act upon desire, but, rather, connect with their actual situation-in-the-world, a world shared with others.[630] It is clear that, in the nuanced understanding we are in favour of here, we lean towards the optic which phenomenology provides – as has been outlined in 1.4 Medical morality and 2.4 The perspective of phenomenology. Thus, in trying to make morally-good decisions in this situation, the quality of the person's future life should become part of the context of the patient in an ICU setting – that is, as noted above, 'seeing patients' ethical dilemmas as grounded in concrete existential situations'.[631] Put another way, the lived body 'is not a thing, it is a situation'.[632]

An important part of the patient-in-ICU's situation concerns the staff members who care for them. The traditionally accepted role of staff in ICU privileges the provision of unbiased information about treatment options, free of any suggestion that paternalism is at work – to 'make the relevant information available, then to adopt a stance of non-interference in the patient's decision-making',[633] since to go beyond that and seek to influence the patient is ethically problematic for autonomy in its traditional sense. Under a nuanced understanding argued-for here, wherein the patient is critically-ill in ICU, the staff caring for them should, permissibly, actively engage with the patient and others interconnected in the relationship, and use their skills to facilitate the decision-making process.[634] Philosophically, the aim is, first of all, to clarify where the Good lies for this patient, and, second, to seek to maximise that Good by grounding a full and frank discussion about the quality of life the patient is likely to have, rather than merely its quantity, upon this understanding.

As if to summarise this argument, Alastair Campbell writes:

> … we cannot separate this bodily based emotionally rich self from the centrality of relationships with others in our moral lives. The lone rational decider, emerging from a stark rationalistic individualism rooted in Cartesian Dualism, is a parody of the moral agent in real life. It is in our *interdependency* that we find our moral compass and our moral worth, not in some isolated mental space in which 'right' choices are made [original emphasis][635]

---

[630] Gillett and Amos 2014) Words are not just things, The New Zealand Bioethics Conference,
[631] Carel (2011). Phenomenology and its application in medicine. Theoretical Medical Bioethics 32(1): 33-46.
[632] Beauvoir (2011). Biological data *The Second Sex* p.46.
[633] Stoljar (2011). Informed consent and relational conceptions of autonomy. Journal of Medicine and Philosophy 36(4): 375-376.
[634] Jennifer K Walter and Ross (2014). Relational autonomy: Moving beyond the limits of isolated individualism. Pediatrics 133: S16.
[635] Campbell (2012). The body: property, commodity, or gift *Reconceiving Medical Ethics* pp.19-20.

This approach is similar to that which has been labelled *relational autonomy*.[636,637]

This thesis views this nuanced approach to autonomy as arguing that the mainstream moral-, political- and sociological- philosophical perspective on autonomy is individualistic, and that recognition of what Catriona Mackenzie terms a 'socially embedded conception of agency'[638] is more appropriate in clinical moral decision-making. Ultimately too, relating to others contributes to our understanding of ourselves, and clarifies what it is that we want in terms of our Good. Thinking once again of a virtue ethical framework, it is 'an important part of leading a good, valuable, and flourishing human life.'[639]

Pellegrino, having based the Good of the Human Person in autonomy, goes on to say that '[o]nly the patient can free us of the obligation to abide by his choices by giving us a mandate to make decisions for him if he feels emotionally or intellectually overwhelmed'.[640] This thesis argues that this approach perpetuates the individualistic notion of autonomy, and that recognition of the reality of a critically-ill patient in ICU, set in relationship with those around him or her, mandates an open negotiated dialogue, in which the individual patient must play whatever role they are able to.

### 4.2.2 Non-maleficence, Beneficence, Justice

*Non-maleficence* imposes a negative duty or obligation not to inflict harm. This duty is usually regarded as taking precedence over the duty of beneficence. For example it is not morally acceptable to sacrifice one person in order to harvest sufficient organs to save five others despite the obvious utilitarian attraction. A needle however is a necessary pre-requisite to the avoidance of measles. 'Harm' for a deontologist involves that which contravenes the imperatives or opposes our rationality; for a teleologist is a negative in the calculation of utility; and for a virtue ethicist is what may be an impediment to achieving *eudaimonia*. Practical concerns which follow from this principle include the provision of sufficient training to perform the planned procedure in this individual patient, the consideration of side-effects of medication in this individual patient, and the consideration of possible negative effects of participation in research trials.

---

[636] Mackenzie and Stoljar (2000). Introduction: Autonomy refigured *Relational Autonomy: Feminist Prespectives in Autonomy, Agency, and the Social Self* pp.3-31.
[637] Mackenzie (2008). Relational autonomy, normative authority and perfectionism. Journal of Social Philosophy 39(4): 512.
[638] Ibid. 519
[639] Ibid. 529
[640] Pellegrino (1985). Moral choice, the good of the patient, and the patient's good *Ethics and Critical Care Medicine* pp.125-126.

*Beneficence* requires that we help patients. While it is typically thought to be of a lesser order duty than non-maleficence, beneficence may in fact be more difficult because it requires an active positive intervention, with a necessary but often difficult and time-consuming balancing of risks and benefits. This is especially true when the beneficent clinical intervention is prophylactic. Consider a patient who is asymptomatic, but has an ear drum which appears structurally vulnerable to the development of a tumour in the ear. It is possible to offer an operation to try to make the vulnerable ear safe from developing a tumour, but that operation has potential risks to hearing and balance. At present the patient is asymptomatic because a tumour has not developed. If it does develop, then the same operation will be offered semi-urgently. The risks however become more acceptable because the alternative, now a tumour is present, include definite loss of hearing and balance. If the operation is done now, it may successfully avoid the development of a tumour. If not successful however, and a tumour does develops in the operated ear, then a bigger operation, with greater risks, will then be required. Clinical situations, such as seen in this instance, entail a difficult trade-off between beneficence and non-maleficence, both for the clinician and the patient.

Teleological frameworks are specifically formulated on the basis of maximising beneficence and minimising maleficence. For a teleologist, beneficence is a re-statement of utilitarianism; for a deontologist, beneficence is a reflection of motivation towards a good will; and for a virtue ethicist, beneficence is a major component of *eudaimonia*. Beneficence includes aiming for the medical or technical restoration of structure and function, identifying and assisting with the Good as the patient sees it, striving towards the Good of human-kind in that patient, and considering spiritual Good for humans in general, and for this human in particular. Engelhardt makes two further points.[641] First, rejecting beneficence as a principle 'leads to an essential impoverishment of moral life'. Most, however, will not likely completely reject the principle. Rather they will substitute the principle of their own beneficence for that of others. Second, in contexts which he might agree would include sexually inappropriate behaviour from a treating clinician towards a vulnerable patient, when one wills to do evil to another, then, even if acting with the permission of the patient, such maleficence denies them a proper place within the moral community. Practical concepts which follow from the principle of beneficence, of relevance to this thesis, include adequate balancing of the clinical likelihood of risks versus benefits for therapeutic options, constant researching of the newest options available, life-long continuing medical education, and active empowerment of patients.

[641] Engelhardt (1996). The principles of bioethics *The Foundations of Bioethics* p.110.

*Justice* includes obligations related to fairness – in terms of the distribution of limited health resources, respect for patient's rights and respect for the Law. Aristotle points out though that to be treated justly does not mean all should be treated equally – justice involves treating equal persons equally, and treating unequal persons unequally.[642] Practical concepts which follow from this principle include equal access for all, to limited health care resources. Potential conflicts between patient autonomy to choose a treatment which is likely to be futile, and limited health care resources which are likely to be more beneficial if directed elsewhere, have been alluded to above. As Sandel writes, however, '[j]ustice is not only about the right way to distribute things. It is also about the right way to value things.'[643] It is necessary to have a conversation about the meaning of the good of the patient in his or her particular context, what values we agree, as a society, are to be ascribed to this concept and how to resolve disagreements about it. Also falling under this principle are questions about taking responsibility for the consequences of poor personal health choices, for example, continuing to smoke, or to abuse drugs, where there may be an argument about forfeiture of the right to health care.

### 4.2.3 The four principles in practice

Recognising the methods clinicians use in their assessment of patients, a similar approach has been applied to moral decision-making in clinical situations. In patient assessments, clinicians do not begin with a consideration of patho-physiological principles and move down towards a diagnosis (a "top-down" approach). Instead, clinicians follow a pattern of determining the presenting complaint, the history of the presenting complaint, past medical history, family history, social history, system review, physical examination, and investigations (a "bottom-up" approach). While the universal top-down approach to diagnosis is necessarily informed by a detailed patho-physiological understanding of health and disease, and although the practical decision-making process does not begin with that, in difficult cases principles of patho-physiology will be re-visited to elucidate the final diagnosis. A similar 'four topics' or 'four boxes' method has been proposed to help in the resolution of medical ethical situations, drawing upon the four principles.[644] This approach considers: 1) medical indications (the relevant diagnostic and therapeutic interventions, exploring beneficence and maleficence); 2) patient preferences (the articulated choices of the patient or surrogate, exploring respect for autonomy); 3) quality of life (pertinent features of the patient's pre-treatment and post-treatment life, exploring beneficence and maleficence, and respect for autonomy) and 4) contextual

[642] Aristotle (c340 BC, 1952). Politics *The Works of Aristotle Volume II* p.477.
[643] Sandel (2009). Justice and the common good *Justice: What is the Right Thing to Do?* p.269.
[644] Jonsen, Siegler and Winslade (2010). Introduction *Clinical Ethics: A Practical Approach to Ethical Decisions in Clinical Medicine* p.8.

features (relevant familial, social, institutional, financial and legal settings, exploring loyalty and fairness). Information is collected and distributed into the four areas (quadrants) and this forms the basis for a moral decision-making analysis.[645] A detailed, four-topics, analysis has been published for the Terri Schiavo case.[646]

The four principles of Beauchamp and Childress are seen as *prima facie* and if they conflict, a moral dilemma exists. Critics argue that the four principles (and other similar lists collectively grouped together as the pejorative *principlism*) act as prompts for 'values worth remembering, but lack deep moral substance and capacity to guide action'.[647] However, to simply describe them as 'an unwitting effort to cling to four main types of ethical theory: beneficence incorporates Mill; autonomy, Kant; justice Rawls; and non-maleficence, Gert',[648] is an over-simplification. This thesis sees their value as somewhere between being no more than a mere checklist, of use primarily to those with limited ethical knowledge;[649] and, viewing them as 'the four moral nucleotides that constitute moral DNA – capable, alone or in combination, of explaining and justifying all the substantive and universalizable moral norms of health care ethics'.[650] Lack of a systematic relationship amongst the principles and lack of an explicit priority ranking are also seen as deficiencies. The four principles have been described as useful in 'consciousness-raising' but not as a means of clarifying the moral issues nor providing guidance towards a solution in a moral decision-making dilemma.[651] For example, the principle of non-maleficence simply combines four or five general moral rules into one more general principle – don't kill, don't cause pain, don't disable, don't deprive of pleasure, don't deprive of freedom, become 'don't harm', which critics feel is unhelpful and overly simplistic because the sub-parts can be ranked, an ability which is lost when they are aggregated as a single principle. Lack of ranking encourages paternalism, and this aspect of autonomy is further discussed in 4.3 The dynamics of the doctor-patient relationship. The principle of justice is proposed without an endorsement of any particular account of justice or fairness. Justice and the principles of beneficence and autonomy blur the distinction between what is morally required and that which is merely encouraged.[652] As critics correctly identify and as noted above, patient autonomy has been

[645] Ibid.
[646] Paola, Walker and Nixon (2010). Case-based decision making in ethics *Medical Ethics and Humanities* pp.112-116.
[647] Beauchamp and Childress (2009). *Principles of Biomedical Ethics* p.372.
[648] Clouser and Gert (1990). A Critique of Principlism. Journal of Medicine and Philosophy 15(2): 223.
[649] Harris (2003). In praise of unprincipled ethics. Journal of Medical Ethics 29(5): 303-306.
[650] Gillon (2003) Ethics needs principles - four can encompass the rest - and respect for autonomy should be "first among equals". Journal of Medical Ethics 29(5): 307-312.
[651] Clouser and Gert (1994). Morality vs principlism *Principles of Health Care Ethics* p.252.
[652] Ibid. 253

the most paradigm-influencing principle and, contemporarily, is seen as taking priority over the other three, but under this principle the lines are blurred between rational decisions and autonomous decisions. Can rational people not under the influence of drugs or delirium, make irrational choices (for example to refuse treatment) and claim justification and moral authority, on the basis of the principle of autonomy? Can patients, whose reasons are based upon false beliefs, claim moral authority to refuse treatments? The principle of autonomy involves consideration of the patient's knowledge, as well as their understanding, and even their wisdom. Patient autonomy cannot be evaluated to the exclusion of the clinician's autonomy, the clinician who will have his or her own human value set. The autonomy of the patient in requesting assisted killing cannot trump the value system of the clinician who finds assisted killing impermissible. Can a Jehovah's Witness allow themselves to die, while a caring and compassionate clinician watches on, with any moral validity? Is there a moral dilemma when a patient claims autonomy in requiring medical treatments known to the clinician to lack scientific rigour, to be unproven, and/or to be very expensive, thus reducing resources available to other patients? A dialogue within the community affected, as articulated in this thesis, which then confers normative force upon the decision, is posited to be the most appropriate way to make the morally good decision in this context. Because both patient and clinician are moral agents there must be allowance, in order to avoid violating the autonomy of one or the other, for the doctor-patient relationship to be terminated, on the basis of mutual respect for each other's autonomy. Justice should, reasonably, take priority over autonomy when an illness puts others at risk and the patient is not willing to advise those or to avoid risk-taking behaviour – for example, Human Immunodeficiency Virus (HIV) infectivity and a sexual partner, substance abuse in an airline pilot. In this context Habermas argues that morality 'cannot protect the rights of the individual without also protecting the well-being of the community to which he belongs'.[653]

A number of commentators view the four principles as foundational to a modern medical ethic. At the very least, they have proven pivotal in re-invigorating medical ethics and providing a language with which to speak about moral dilemmas. The four principles have been reviewed in terms of each of the normative moral frameworks, the differing religions of the Western and Eastern worlds, Marxism, humanism, assessments from different geographic, gender, and sociological perspectives, as well as considerable debate about their roles and contributions in a wide variety of general and specific medical ethical dilemmas.[654] Pellegrino goes further and argues that if the *telos* of Medicine is helping patients, seeking to maximise the various hierarchies of the Good of the patient, then

[653] Habermas (1988). *On the Logic of the Social Sciences* p.200.
[654] Gillon (1994). Principles of Health Care Ethics pp.1-1118.

beneficence must be the over-riding prima facie principle or duty. Perhaps therefore he speaks of a basis in teleology as it was originally formulated by Aristotle, but implies that because the end is to help, the means to help follow naturally – implying implicit respect for autonomy, justice, and non-maleficence.[655] Being physician *qua* physician implies these duties, with beneficence being most important. This thesis supports a virtue ethical framework, as one having both the depth and the flexibility to guide moral decision-making in clinical situations. Pellegrino argues that, in fact, these principles can be applied to all professions. He argues that '[t]he good of the person is linked ontologically to the end of [all] professional activity'.[656] Thus autonomy is mandatory in order to avoid violating the dignity and humanity of the person; justice is linked to the good of humans *qua* humans, in all professional acts; and beneficence 'becomes the *primum principium* of all ethics since its aim is to do good and avoid harm'.[657] The well-formed conscience of the moral agent is conspicuously absent from the four principles approach.

William Muirhead is a critic of principlism on the twin grounds that it is not action-guiding, and that it is liable to individual interpretation. Nonetheless, he proposes two principles – 'it is the ethical duty of the clinician to maximise the patient's best interests, subject to the constraints of professional integrity'.[658] "Best interests" may be often used by clinicians, but this thesis argues that this term is vague and simplistic. It should be more rigorously restated in terms of the *Good* of the patient, allowing recourse to the four Goods proposed by Pellegrino. It seems that the pursuit of the patient's best interests is a consequentialist approach, but that 'subject to the constraints of professional integrity' allows absolute deontological constraints against, for example, active euthanasia. Thus, Muirhead argues that his two principles are both action-guiding and allow for rapid and consistent decision-making. However he offers the observation that 'defining a ceiling of care for a patient in a persistent vegetative state moves us into territory where our grasp of best interests becomes much less intuitive' and thus presents a 'genuine dilemma'. This thesis argues that the resolution of 'genuine dilemmas' in clinical medicine is possible – and necessary - utilising the insights of Habermas, Lovat, and Laura, with respect to a Proportionist approach, and utilising Habermasian paradigms of discourse theory of morality and communicative action as the practical

[655] Pellegrino (1994). The four-principles and the Doctor-Patient relationship: The need for a better linkage *Principles of Health Care Ethics* pp.632-364.
[656] Pellegrino (2001). The internal morality of clinical medicine: A paradigm for the ethics of the helping and healing professions. Journal of Medicine and Philosophy 26(6): 576.
[657] Ibid.
[658] Muirhead (2011). When four principles are too many: bloodgate, integrity and an action-guiding model of ethical decision making in clinical practice. J Med Ethics 38: 196.

methodology to put the Proportionist approach into practice, and investing decisions made by dialogue within the particular community with normative force.

### 4.3 The dynamics of the doctor-patient relationship

Each doctor-patient contact involves dealing with another human being. It is this which underlines the belief in this thesis that clinical decisions are set against a backdrop of a necessary philosophy about moral decision-making. Individual medical clinicians can relate to individual patients and their families in various ways. The role of clinicians has been intimately associated with moral responsibilities since antiquity. The Hippocratic Oath (and similar Commitments) has been professed at graduation ceremonies of young doctors over centuries. It is grounded in a classical-epoch virtue ethic framework. While in moral philosophy overall, virtue ethics has declined from late medieval times, as duties, rights, and consequences began their ascendancy, the decline was much slower in the morality of medical practice. Nonetheless a foundation of medical decision-making predicated upon a virtue ethical framework has declined in significance over the past several decades as a more legalistic type of practice has been forced upon clinical medicine, together with a general reduction in altruism, spirituality, egalitarianism, a morally fragmented culture of modernity which proved a segue into post-modernity, the rise of patient autonomy, contractual obligations over trust-based covenants, self-interest, and principle-based ethics.

#### 4.3.1 Traditional models

In broad terms, three models for the doctor-patient relationship may be articulated.

The *Paternalistic* model is traditional, and in this understanding, implies caring based upon long training and expert, specialised, and often technical knowledge. The model may be summarised as “the doctor knows best”. Paternalistic models are based predominantly upon beneficence, with patients receiving the intervention best suited, in the assessment of the clinician, to help them be restored to health or to relieve their suffering. It requires the clinician place the benefit of the patient above their own, and that they seek assistance from other clinicians when it is in their patient’s best interests. This model is most readily accepted in emergency settings where immediate life-saving intervention, often protocol-driven, is required. As a model in non-emergent situations, it brings into conflict the principles of beneficence and that of autonomy. As already alluded to, this paradigm shift from paternalistic clinician-centred decision-making to autonomous ‘client’-centred market-consumeristic decision-making is arguably the most significant change in the last quarter century of health care delivery, especially amongst Western cultures.

Habermas recognises the changing relationship of power between experts and lay persons, in which citizens are disillusioned at the way that "expert opinion" is increasingly used cynically by politicians and others to reinforce their agendas; but there is also the reasonable recognition that medical certainty is not possible. Pellegrino suggests that this shift may reflect the essential elements of contemporary society - participatory democracy, an increasing moral pluralism and moral heterogeneity, increasing forays into heath education by the media directly and through medical docu-dramas, as well as the internet, the weakening of all forms of authority – be it religious or family, or authority *per se*, as well as the greater technical success of medical technology in restoring function and prolonging life.[659] Pellegrino also credits the entry of the professional philosopher into medical ethics as a significant impetus towards patient autonomy as the dominant paradigm. He may agree that it is presumptuous of clinicians to aim to maximise the Good of the patient, before knowing from the patient what that particular Good is.[660] Equally however, it may be true that the concepts and language of rights:

> came to prevail over those of responsibility, obligation, and duty in bioethical discourse ... the socio-moral importance of the interdependence of persons, and of reciprocity, solidarity, and community between them, have been overshadowed by the insistence on the autonomy of self as the highest moral good.[661]

Wide-reaching changes in the medico-legal system follow principles of autonomy and the impermissibility of paternalism.

The *radical individualism* model is based upon the recognition that patients have absolute autonomy and absolute rights over their own bodies. The 'positive-rights approach to the consent process assumes that, even as a lay person, each patient is capable of identifying medically reasonable alternatives and that physicians are obligated to carry out patients' requests simply because they are patients' requests'.[662] While they may choose to take advice from professionals they are required to make the decisions themselves, as best they can, and whether they actually want to or not. Emanuel and Emanuel describe a similar model as the *consumer* or *informative* model.[663] Health care is a commodity to be obtained by the consumer (patient) with due diligence, seeking information but

[659] Pellegrino (1994). The four-principles and the Doctor-Patient relationship: The need for a better linkage *Principles of Health Care Ethics* p.354.
[660] Capron (1984, 2002). Forward *The Silent World of Doctor and Patient* p.x.
[661] Fox (1990). The evolution of American bioethics *Social Science perspectives on Medical Ethics* p.207.
[662] Minkoff (2006). The ethics of caesarian section by choice. Seminars in Perinatology 30(5): 309-312.
[663] Ezekiel J Emanuel and Emanuel (1992). Four models of the Physician-patient relationship. Journal of the American Medical Association 267(16): 2221.

not value judgement, from the potential supplier (doctor). The moral responsibilities of clinicians are to inform patients of their diagnoses and the range of treatment options available, provide the requested service, not necessarily the doctor's recommended treatment, with competence, so as to enhance the consumer's autonomy or what some term 'sovereignty'. This underlines patient choice and patient control, emphasised by re-labelling clinicians in commercial terms as 'health care providers' and patients as 'consumers'[664] and in the several charters of patient's rights, and perhaps most tangibly, legalistically enforcing informed consent duties aimed specifically at empowering consumers to make their own decision.

As a model, it appears to lack an ethos of caring. It is incomplete in that a consumer's grasp of the vast amount of technical information they must absorb, and then themselves, while ill, re-evaluate as treatment proceeds, smoothly or less-well than they envisaged, is a daunting prospect, coloured more so by the highly personal relevance for that consumer. It is also impoverished in that it does not recognise the reality of the patient being-in-the-world and necessarily in relationship with other individuals – family, the community, other patients who may be competing for limited resources, or clinicians aware of the limits of medical technology in terms of what is feasible and what may not be. 'While there are countless illustrations of bad paternalism and the rightful exercise of autonomy, the point remains that the right to exercise one's autonomy does not exist in a vacuum and should not be unconstrained'.[665] This thesis argues, founded both upon moral philosophical principles already articulated, and cognisant of practical reality in an increasingly complex clinical medical *milieu*, respecting patient autonomy does not, should not, and cannot equate to delivering all requested services.[666] Seeking medical help is not the same as going to a supermarket for groceries. Medicine is not neutral; it is aimed at helping the patient.[667] Rather than focus upon 'moments of decision as the loci of ethical importance',[668] and thus emphasise autonomy, we should re-focus upon the desired outcome of maximising the several Goods of the patient.

The *reciprocal* model involves a team approach wherein health professionals are allied with patients and their families, all aiming to help, thus recognising the humanity of clinicians, recognising the importance of ownership by the patient of their own body, and perhaps offering a more holistic

[664] Emanuel and Emanuel idem: 2223.
[665] Kekewich (2014). Market liberalism in health care: A dysfunctional view of respecting "consumer"autonomy. Journal of Bioethical Inquiry 11(1): 22.
[666] Ibid. 24
[667] Agledahl, Forde and Wifstad (2011). Choice is not the issue: The misrepresentation of healthcare in bioethical discourse. Journal of Medical Ethics 37(4): 214.
[668] Kukla (2005). Conscientious autonomy: Displacing decision sin health care. The Hastings Center Report 35(2): 34-44.

approach, recognising that not all medical decisions are limited to clinical signs and symptoms. Information is offered freely by patients (no symptoms or signs are withheld), and advice about likely diagnoses, and treatment options are provided by medical clinicians, communicated appropriately, so a joint decision can be made about what the patient might do. Conceptually, the model is that of a bilateral covenant, implying mutual respect, truthfulness, dignity, justice. For example, the clinician offers a technically knowledgeable percentage for prolongation of five year survival following radical mastectomy versus lumpectomy plus adjuvant radiotherapy. The patient decides whether, for her, sacrificing her breast is worth that prolonged survival percentage. In this model, the values of the patient and of the doctor, with regard to both health care and morality, are discussed by the two autonomous parties. It recognises that the values of the patient may not be clearly recognised by the patient and the clinician should guide the patient to understand and make coherent their value structure and so assist them to make their own decisions.

In order for this approach to be within the skill-set of the clinician, education about how to engage in a moral discourse, and how to avoid prioritising health-care values over other values, is necessary. Emanuel and Emanuel speak of the *deliberative* model, which aims to help the patient identify 'the best health-related values which can be realised in the clinical situation'.[669] Conceiving of a dialogue as if explaining the situations and options to a close friend, may underpin this model. Empathy and wisdom are important. Patient re-evaluation after reflection is important. The caring clinician should properly attempt to show the patient which path is likely to maximise their well-being, without coercing them. In other words, while patients are (generally) best at knowing what maximises their Good, clinicians are (generally) best-placed to know what options are available, from which patients can choose, so as to maximise their Good.[670] Perhaps this is providing a "normative frame" within which the patient chooses.[671] Put another way, clinicians need to 'acknowledge the authoritative role they properly play in *inculcating* patients into normatively contoured health practices, and … need to claim and examine this role [original emphasis]'.[672] Hamish Wilson conceptualises the "doctor-patient" relationship to be distinct from the "doctor-disease" relationship.[673] In other words, he places the patient in his or her context. Habermas writes that '[n]either interrogations nor

[669] Emanuel and Emanuel (1992). Four models of the Physician-patient relationship. Journal of the American Medical Association 267(16): 2222.
[670] Kekewich (2014). Market liberalism in health care: A dysfunctional view of respecting "consumer"autonomy. Journal of Bioethical Inquiry 11(1): 25.
[671] Ibid.
[672] Kukla (2005). Conscientous autonomy: Displacing decisions in health care. The Hastings Center Report 35(2): 43.
[673] Wilson 2014) The challenge of whole person care, The New Zealand Bioethics Conference,

analytic conversations between doctor and patient may be considered to be discourses'[674] in the sense of a cooperative search for truth. A dialogical hermeneutic approach to moral decision-making in clinical situations supports this model.[675]

This model of the doctor-patient relationship has come to be known as the *shared decision-making* model.[676] It is predicated upon exploring and respecting "what matters most" to the individual patient, Pellegrino's perceptual good; and so it develops informed preferences. In that it is articulated to be based upon 'respecting both individual competence and interdependence upon others … the key tenets of both self-determination and relational autonomy',[677] it is in sympathy with the central tenent of this thesis discussed in 4.2.1 Autonomy. Practical utilisation has three steps – 1) introducing choice, 2) describing options, and 3) facilitating patients to explore their preferences, and so make decisions.[678] As noted in 7.3 Practical difficulties with the Habermasian paradigm in clinical practice, it recognises that poor health literacy, cultural disinclinations to make autonomous decisions, and time-constraints during a consultation may be confounding constraints. It is for this reason that shared decision-making 'has to be built upon the core skills of good clinical communication'[679]- which are properly fundamental to medical undergraduate curricula.

### 4.3.2 The shared decision-making continuum

To re-cap the current state of the doctor-patient relationship, this thesis draws upon the insights of Alexander Kon, who speaks of the shared decision-making continuum.[680] He identifies five points along this continuum. At one extreme is strictly (and narrowly) autonomous decision-making by the patient wherein the clinician presents the options with no recommendation, and the autonomous agent makes the decision. Next along the continuum is when the clinician presents the options and makes a recommendation, based upon the patient's values (which discussion has elucidated) not their own, avoiding any coercion. Next along the continuum is where both doctor and patient strive to be equal partners, working together to make a mutual decision, based upon each party

[674] Habermas (2001). Truth and society: the discursive redemption of factual validity claims *On the Pragmatics of Social interaction: Preliminary Studies in the Theory of Communicative Action* p.93.
[675] Widdershoven and Abma (2007). Hermeneutic ethics between practice and theory *Principles of Health Care Ethics* p.218.
[676] Hoffmann, Legare, Simmons, McNamara, McCaffery, Trevena, Hudson, Glasziou and Mar (2014). Shared decision making: what do clinicians need to know and why should they bother? Medical Journal of Australia 201 (1): 35-39.
[677] Elwyn, Frosch, Thomson, Joseph-Williams, Lloyd and Kinnersley (2012). Shared decision-making: A model for clinical practice. Journal of General Internal Medicine 27(10): 1361.
[678] Ibid.
[679] Ibid. 1362
[680] Kon (2010). The shared decision-making continuum. Journal of the American Medical Association 304(8): 903-904.

understanding and mutually-respecting the values of the other. The penultimate stop is when the clinician informs the patient of the recommended best course of action, the reasons for which, the patient understands, and the patient vetos that recommendation, or, by non-dissent, signifies acceptance of that recommendation. At the other extreme of the continuum from the patient-driven decision, is the clinician-driven decision. While this ideally is restricted to value-neutral decisions, such as the size of endotracheal tube to be placed in a child of a given age and weight, as noted above, it is necessarily invoked in emergency, often protocol-driven, resuscitations. However, the decision to resuscitate or not, is itself extremely value-laden. Many decisions are in fact not value-neutral - in deciding which hand to cannulate, the clinician should aid the patient's journey by being aware of whether the patient is right or left handed, for example. Different points along the continuum may be called-upon in different moral decision-making clinical settings. It may be that, for example, at the end-of-life, the clinician wants very much to be at the patient/relative-making–the-decision end of the spectrum, while the patient/relative wants very much to be at the clinician-making-the-decision end of the spectrum. Or vice-versa can be the situation when a potential intervention appears clinically futile.

**4.4 Summary**

Moral decision-making considerations specific to the clinical dyad have been considered – the four principles approach, and the dynamic of the doctor-patient relationship.

The four discrete *prima facie* principles proposed by Beauchamp and Childress, which can be distilled from the normative frameworks, are recognised to have a persisting influence, at least as a vocabulary, upon moral decision-making in clinical contexts. The rise of patient autonomy as the guiding paradigm, reflecting similar changes in our wider society, may constitute the most significant change in medical morality over the past twenty-five years. However, several understandings of autonomy are possible, and significantly impact upon moral decision-making in clinical situations. This thesis concludes that deficiencies in the four principles approach may be explicable because '[t]he bioethical principled approach to ethical decision-making has not fully recognised that these moral imperatives are grounded in a relational context, which all clinical settings invariably are.'[681] This thesis favours the doctor-patient relationship being seen as a shared decision-making continuum.

[681] Lutzen and Ewalds-Kvist (2013). Moral distress and its interconnection with moral sensitivity and moral resilience: Viewed from the philosophy of Victor E. Frankl. Journal of Bioethical Inquiry 10(3): 318.

## CHAPTER 5 THE PROPORTIONIST APPROACH

### 5.1 Introduction

In Chapter 3, how clinicians might make ethically good decisions was explored from the perspective of the three substantive frameworks in the secular Western tradition, as well as the Islamic-Judaeo-Christian tradition. The deontological framework predicates moral permissibility upon the intrinsic nature of the Act. The teleological framework predicates moral permissibility upon the consequences of the Act. The virtue ethics framework focuses on the character of the Agent performing the Action, with maximising the Good of the Patient, being the *telos* of medicine. In Chapter 4, principles derived from the normative frameworks were discussed. The four principles approach of Beauchamp and Childress is an attempt, without benefit of the Habermasian paradigm, to produce action-guiding principles to which appeal could be made in moral decision-making situations.

This chapter, and the next, address two critical parts of the argument advanced in this thesis. In so doing, they draw upon the Habermasian paradigm of "ways" of knowing, his discourse theory of morality and his principles of communicative action.

First, in this chapter, a Proportionist approach is favoured as the most apposite means for moral decision-making in clinical settings. Aware of the ontological imperative of context, the Proportionist approach seeks the highest good based upon a balance between *a priori* rules and empirical "greatest good for the greatest number" utilitarian calculations, with, as its starting point, the actual reality of the patient and their situation. Second, in the next chapter, how to put the Proportionist approach into practice in our contemporary era will be explored, by utilizing Habermas' discourse theory of morality and communicative action.

The importance of the four epochs of philosophical thought has been outlined in 2.3 Historical contexts. In the classical period were laid the foundations of philosophical thought. In the medieval period, allegiance of the people and their rulers to the classical epoch polis, or city-state, was comprehensively replaced by allegiance to God. In the Modern period, an ethic emphasising duty and obligation, law and justice, came to replace the external motivations originating in the classical period (polis) and medieval period (God). In the modern epoch normative ethical frameworks were placed 'prior to and the ultimate source of legitimacy for particular ethical judgements'.[682] The contemporary era is here termed 'post-modern'. Widespread increase in the extent of technology

[682] Paola, Walker and Nixon (2010). Theory in bioethics *Medical Ethics and Humanities* p.11.

available in the world, especially to do with communication, imparts a substantially more disseminated knowledge of different cultures and ways of living. Equally widespread immigration results in a pronounced pluralism and fragmentation, with increased tension amongst society's members following upon different life-views and value-constructs.[683]

As has been noted in 2.2 Epistemology, truth, and language, society is viewable as 'a network of meanings that are constructed by human beings through language, and so may only be understood through language'.[684] In contemporary society, it is language which impels knowledge and understanding. At a more simple level, being told by a clinician that "you have AIDS" profoundly reorientates the patient's lifeworld and (generally) impels significant change, based upon the perceived sequelae associated with those words. On a broader level, since society and societal norms are constantly shifting, this results in language and meaning constantly shifting. In the same way that the prognosis which follows upon the word "AIDS" is improving, this shifting within language results in the meanings attributed to Right and Good, being recognisable at a multiplicity of depths, to different members of pluralist society.

This thesis holds that, in our current era, it is not possible to seek a single universal truth accepted by all. Rather, there is an awareness of a multiplicity of truths, each of which is viewed from the individual's perspective. Thus the post-modern era (as understood here) is characterised by the need for dialectic in order to achieve a consensual understanding. The introductory 1.1 The purview of moral philosophy, proposed that moral philosophy be informed by the question "how should I act?", or better, the question of Socrates, "how should we live?" Understanding that each clinical doctor-patient contact, since it inherently involves interacting with another human being, has a basis in moral philosophy, impels clinicians to move their perspective from *ego*, to *alterity*. Thus, the question of Socrates should now be re-conceptualised as "how should we live, together?"[685] Moral decision-making, and congruent normative force, are properly derived from a *process*, rather than from a substantive framework. Put simply, this process entails an inclusive, non-coercive and self-reflective dialogue within the community affected, underpinned by principles articulated by Habermas and others.

---

[683] Loewy (1989). Physicians and patients in a pluralist world *Textbook of medical ethics* pp.85-87.
[684] Hugman (2005). Contemporary professional ethics *New Approaches in Ethics for the Caring Professions* p.8.
[685] Hayden 2012) Cosmopolitan Education and Moral Education: Forging Beings Under Conditions of Global Uncertainty, School of Arts and Sciences, Columbia University, 116, 130

**5.2 Development of the Proportionist approach**

Pellegrino speaks of the mid nineteen sixties as a time of 'inchoate stirrings of social change'.[686] Zygmunt Bauman speaks of 'the modern age reaching its self-critical, often self-denigrating and in many ways self-dismantling stage'.[687] Habermas speaks of an uncoupling of system and lifeworld as a feature of the post-modern era.[688] Lovat encapsulates an assessment of contemporary society, which he describes as a 'moderately post-scientific age',[689] defined as an age 'that still relies on science yet is more conscious of its limitations and sceptical about its potential to adequately address all of life's demands and provide all of its answers'. Medicine clearly has a significant basis in science and technology, and an identical definition could usefully be applied. Modern medicine is characterised by significant scientific technology, and has an explicit concern with a mechanistic evidence-based approach based upon empirical facts and objective outcomes. It may be however, that modern medicine should be looking more towards the measurement of *values*. It is also likely true that modern medicine is increasingly moving towards being made fiscally responsible for its expenditures in general, and perhaps towards a business model in particular – 'forced to understand itself as at once care, business, and applied science'.[690]

As has been posited above, in moral decision-making in our contemporary epoch, two principles should be reiterated. First, moral principles exist but their application in specific contexts will vary. No moral precept contains within itself the criteria for applicability to all situations (R Laura, 28 March 2013, Research Higher Degree Seminar, University of Newcastle). Second, a hierarchy of *prima facie* duties (3.3.2.iii WD Ross' deontology), as well as a hierarchy of consequences - present and future (3.4.2 Contemporary Teleology), exist. Hierarchical moral decision-making is here proposed as a dynamic response to context.

Historically, the development of a balanced, contextual, or *Proportionist* approach to moral decision-making, owes much to the four epochs of philosophical enquiry. In the classical period, allusion has been made to the Aristotelian synthesis of the absolutists with the situationists. In the medieval epoch, Aquinas, informed by Aristotle and the scholars of Islam, developed a transcendent moral framework. This in turn was visited by writers sharing a commonality within the framework of virtue ethics.

---

[686] Pellegrino and Thomasma (1993). The ends of medicine and its virtues *The Virtues in Medical Practice* p.55.
[687] Bauman (1993). *Postmodern Ethics* p.2.
[688] Habermas (1987). Marx and the thesis of internal colonization *Theory of Communicative Action* pp.361-363.
[689] Lovat (2004). Aristotelian Ethics and Habermasian Critical theory: A conjoined force for proportionism in ethical discourse and Roman Catholic moral theology. Australian eJournal of Theology 3(1): 1.
[690] Williams (1985, 2006). Socrates' question *Ethics and the Limits of Philosophy* p.3.

As noted in 3.4 Contemporary teleology, Godwin proposed a synthesis of rules and consequences. He allowed that in moral decision-making 'duty is the mode of action which constitutes the best application of the capacity of the individual to the general advantage'.[691] He added nonetheless that the consequences of our actions need to be considered, and the happiness of a number of people is of more value than that of one. Additionally, making exceptions based on partiality is impermissible and, given that reason is the discerning force amongst conflicting emotions, it is to the improvement of reason that 'we are to look for the improvement of our social situation'.[692] He further argued that the strength of reason is dependent upon its cultivation.

In his book of the same name, Fletcher describes as *Situational Ethics* a method of situational or contextual-based moral decision-making. He did not agree that a framework of ethics was possible, only a method to approach moral decision-making. He proposed that 'in actual problems of conscience the situational variables are to be weighed as heavily as the normative ... constants'.[693] Adherence merely to rules about permissibility and impermissibility effectively removes conscience and indeed the moral agents themselves from the decision-making process. In Situational ethics, the moral agent is the decision-maker, judging what is best in the particular circumstances and allowing for the foreseeable consequences. Fletcher describes his method as case-based (casuistry) in the non-pejorative sense, pragmatic, and sensitive to complexity and variety. His method is based upon a sophisticated *agape* or 'love' in the Christian sense of unconditional love from God to Man, and therefore amongst men, love of neighbour *as* oneself. Preston argues that a*gape* alone 'as motivation does not give detailed content to ethical decisions'.[694] For Fletcher however the emphasis was upon the aim of an unemotional rational *agape* directed unwaveringly towards people as an active goodwill towards one's neighbour – to the extent that when 'the impersonal universal conflicts with the personal particular, the latter prevails'.[695] This is appositely described by Fletcher as an 'agapeic calculus'.[696] Other moral principles, maxims, rules, and guidelines serve simply as 'illuminators ... not directors'[697]

As alluded to in 3.3.2.iv Natural law theories, Richard McCormick accepts a somewhat Proportionist approach in making decisions in clinical situations – more than 'a simple utilitarian calculus' but

[691] Godwin (1793, 1985). *Enquiry Concerning Political Justice and its influence on modern morals and happiness* p.77.
[692] Ibid.
[693] Fletcher (1966). *Situation Ethics: the new morality* p.29.
[694] Preston (1993). Christian Ethics *A Companion to Ethics* p.98.
[695] Fletcher (1966). *Situation Ethics: the new morality* p.31.
[696] Fletcher (1966). *Situation Ethics: the new morality* p.95.
[697] Fletcher (1966). *Situation Ethics: the new morality* p.31.

'more fruitful and Christian than deontology would allow us'.[698] His approach might entail choosing the proportionately lesser of two (or more) evils, or choosing an action which is proportionately more likely to be achievable over an action which is less likely achievable. As alluded to in 3.6 Islamic-Judaeo-Christian influences, Curran argues for what he describes as a theory of Compromise. From a theological point of view, he apportions natural law to primary and secondary natural law. Primary natural law is the state of human existence before the fall of the world into sin. Secondary natural law is the state of human existence after the fall into sin. He also distinguishes absolute natural law from relative natural law. Absolute natural law is based on the 'ontological, abstract human nature'.[699] Relative natural law is based on the actual reality of the human situation. In individual morally dilemmatic situations, the nature of absolute natural law is unchanged. However the abstraction of absolute natural law is applied differently in different situations - 'the formal demands of the absolute natural law remain the same, but they are abstractions which are then applied differently in different situations'.[700] Examples of situations which fall under relative natural law rather than absolute natural law include killing in self-defence, just war, and capital punishment, amongst others.[701] McCormick notes that clearly there is something wrong in killing to protect innocent victims of mass hatred, or when a woman is forced to have an abortion in order to save her own life. Curran might agree that the wrongness is not exclusively (perhaps even dominantly) in the act itself so much as in the situation within which the act is forced to be done. 'From one point of view the action is good, because it is the best that one can do. From another viewpoint the action is wrong; that is, it manifests the sinfulness of the situation.'[702] McCormick goes on to argue, however, that he has concerns with this approach in that it does not say which compromises it is reasonable to make. Others, such as Timothy O'Connell, advocate a moderate proportionism in making bioethical decisions in which they try to balance good and evil – via aiming to 'maximize the premoral good and mimimize the premoral evil'.[703] Compared with situationists, proportionists do recognise that certain rules should be guiding principles in moral decision-making, and then they balance those principles with their consequences.

Foucault's norms have been characterised as contextually-grounded without being relativistic – in that they are 'based on historical and personal context, and they … cannot be given a universal

[698] McCormick (1973). *Ambiguity in Moral Choice* p.97.
[699] Curran (1979). Moral theology, psychiatry and homosexuality *Transition and Tradition in Moral Theology* p.74.
[700] Ibid.
[701] Ibid. 75
[702] McCormick (1967). Notes on moral theology: January-June, 1967. Theological Studies 28(4): 759.
[703] O'Connell (1990). Morality: values and norms *Principles for a Catholic Morality: Revised Edition* p.177.

grounding independent of those people and that context'.[704] Jacques Derrida agreed when he wrote unequivocally that 'no meaning can be determined out of context'.[705] Clouser and Gert describe a moral theory which underpins their moral system of how, in practice, to make moral judgements. In practical application, they would approach a situation of moral conflict by applying the moral rules, and the moral ideals, and then decide whether it is justified to violate the rule in this particular situation.[706] This in turn is predicated upon whether violation would be publically allowed. Clouser and Gert may allow that theirs is a balanced or Proportionist approach to moral decision-making, in that they argue it allows for Kant's deontological impartiality as well as allowing for Bentham and Mill's teleological consequences, without what Gert describes as the 'absurdities' of either alone.

Of equal import for this thesis, and as discussed further in Chapter 6, Habermas' Discourse Theory of Morality and Communicative Action, is Clouser and Gert's articulation of the importance of the *process* to be used for making moral decisions. They write 'we do not concur … that there has to be agreement about the answer to all moral questions, but … everyone must agree on the procedure to be used in deciding moral questions'.[707]

It is contended in this thesis that the most apposite approach to moral decision-making in clinical practice is predicated upon a balance between rule-based frameworks and frameworks emphasising the consequences of action, interpreted in the vision of a virtue ethics framework.

Habermas agrees when he writes that, in clinical contexts and considering the doctor-patient relationship, there must be a 'contextual sensitivity and prudence on the one hand and autonomy and self-governance on the other'.[708] Habermas also informs the discussion from an epistemological perspective. Founded upon the incorporation of empirical-analytic and historical-hermeneutic knowing into self-reflective critical knowing, thus is impelled 'the kind of reasoned and compassionate reflection and self-reflectivity that issues in benevolent action'.[709] As will be discussed below, Habermas' discourse theory of morality generalises the Kantian categorical imperative as determined by ethical monologue, to a wider consensus-seeking dialogue, and also, via practical discourse amongst the participants, inter-subjective contextual interpretation is incorporated via a process of reflective discourse. Thus consensual agreement is reached about what

[704] Flyvbjerg 2000) Ideal theory, real rationality: Habermas versus Foucault and Nietzsche, Political Studies Association's 50th Annual Conference, 9
[705] Derrida (1979). Living on *Deconstruction and Criticism* p.81.
[706] Clouser and Gert (1990). A Critique of Principlism. Journal of Medicine and Philosophy 15(2): 234.
[707] Ibid. 236
[708] Habermas (1981, 1990). *Moral Consciousness and Communicative Action* p.181.
[709] Lovat (2013). Jurgen Habermas: education's reluctant hero *Social Theory and Educational Research: Understanding Foucault, Habermas, Bourdieu and Derrida* p.70.

constitutes morally-correct action through an integrative balance between deontology and teleology. However, it is to Lovat that we owe further articulation of the Proportionist approach. As he allows, deontologists may be unhappy with the Proportionist approach for 'purporting to posit universal determinants that are in fact malleable to the situation at hand' and teleologists may be dismayed that 'however rigorous the process and clear the result, [it] is liable to modification by insertion of the apparently mystical'.[710] Lovat and Gray also point to the underpinning of an epistemic approach to moral decision-making when they say:

> [c]oming to know in an unbiased, just way is essential to good judgement, which is always a process of weighing up possibilities and finding the golden mean—that "all-things-considered" point we inevitably reach. We strive not for perfectionism but for proportionism, for a balancing of universals ... with the culturally contingent exigencies of the particular situations of which we are an intrinsic part.[711]

In this understanding, clinical decision-making is appositely set in the context of this particular patient. A purely empirical, greatest Good, utilitarian option needs to be balanced by a proportional awareness of fundamental *a priori* rules; and a rules-based decision needs to be balanced by an appropriate proportion of empirical utility situation awareness.

In the complex world of moral decision-making, within a society reflective of increasingly sociological, cultural, and religious diversity, and while humans in twenty-first century society seem no longer as willing to be constrained by rules as once was the case, there is equally a recognition that utilitarian greatest good calculations have practical disadvantages. A Proportionist approach allows for tolerance of anomalous positions in an ethical dilemma where interpretations offered by both the deontological and the teleological frameworks are valid, but both need to be moderated and made complete by an empathic compassionate caring, self-insightful and wise clinician in communicative discourse with the participants in the dilemma. Thus, together, they achieve *synderesis* (practical wisdom) in order to impel *praxis* (practical action) which results in the *eudaimonia* (flourishing) of all in the discourse.

Lovat and Gray also recognise that a moral decision in a clinical situation which runs counter to generally accepted norms in either the common morality, wider society, the particular morality, or in the individual culture or family, is a significant source of emotional tension both at the time and

[710] Lovat (2004). Aristotelian Ethics and Habermasian Critical theory: A conjoined force for proportionism in ethical discourse and Roman Catholic moral theology. Australian eJournal of Theology 3(1): 10.
[711] Lovat and Gray (2008). Towards a proportionist social work ethics: A Habermasian perspective. British Journal of Social Work 38: 1110.

perhaps later with recriminations and guilt supervening; this can occur even when the decision is for the Good of the patient.[712] This approach implies on-going follow-up and help for patients and their families after the moral decision has been made. If a moral decision is made amongst conflicting claims, then there remains a residual obligation, a residual duty, to remain involved; as already noted in 3.3.2.iii WD Ross' deontology.

In the case of Baby 'W', notwithstanding Baby 'W''s human dignity, knowing that baby 'W' will return to China, will mean that titrating CPAP and obtaining a regular supply of anticonvulsants may be unreliable. As well, allowing for the cost of transferring resources from some other purpose, and China's one-child policy, a Proportionist approach reasons and reflects that to commence CPAP, enteral feeding, and anticonvulsants is not an appropriate action for Baby 'W'. Thus we provide compassionate support for the parents and their child, as he dies.

**5.3 Summary**

This chapter argues that an evolution from Situational Ethics, and particularly apposite to our current epoch, a Proportionist approach to moral decision-making has much to offer clinical decision-making. It is positioned as a balance point between rules and context and as a synthesis of both.

[712] Ibid. 1107-1108

## CHAPTER 6 HABERMAS' DISCOURSE THEORY OF MORALITY AND COMMUNICATIVE ACTION

### 6.1 Introduction

Recall that in 1.2 *Ethics* or *morals*?, important differences between these two words were explored. This thesis argues that ethics is a more individual subjective assessment of values as relatively good or bad, while morals is a more collective and intersubjective assessment of what is Right or Just for all those affected. Hence, decision-making in the clinical encounter should be approached from the perspective of moral dialogue, rather than ethical monologue.

This differentiation also 'provides a leverage point for methodological developments. We can rationally *argue* about moral questions, whereas we can only *recognize* the diversity of people's ethical assumptions, that is, their individual notions of improvement and forms of life [original emphasis]'.[713] Lasse Thomassen notes that '[i]n this sense, the moral perspective is deontological, whereas the ethical perspective has a teleological character'.[714] He argues that in a situation where both perspectives may be applicable, the moral perspective takes precedence.[715] Habermas might agree that he distinguishes ethical *values* from moral *norms*, in terms of both their derivation and their applicability.[716] This is more than a pragmatic (or strategic) "we agree to disagree", and means that this morality must encompass 'a degree of generality and a binding character that *transcends* the competing value conceptions [original emphasis]'.[717]

It also reassures those who may become hesitant about their own ethical truths when they become aware of the multiplicity of values that others hold. The distinction argued-for here does not mean that ethical questions are any less important than moral questions. Self-reflective critical knowing necessarily evaluates answers to complex questions about how I might live the good life, in the context of my lived experiences, motivations, and final purpose. Decisions made with patients and their families, are seen from the perspective of this thesis, as predominately moral questions. In this sense, ethical values and moral norms are procedurally distinct[718] in that ethical values are *a priori* (prior to argumentative discourse), while moral norms are *a posteriori* (after argumentative discourse).

---

[713] Ormerod and Ulrich (2013). Operational research and ethics: A literature review. European Journal of Operational Research 228(2): 294.
[714] Thomassen (2010). Discourse ethics *Habermas: A Guide for the Perplexed* p.85.
[715] Ibid. 96
[716] Fultner (1999, 2003). Translators introduction *Truth and justification* p.ix.
[717] Forst (2007, 2014). Ethics and morals *The right to justification: Elements of a constructive theory of justice* pp.63-64.
[718] Ibid. 64

In our present era, in making a moral decision, appeals to gods (in the classical epoch), to God (in the medieval epoch), or to rationalism (in the modern epoch) are no longer apposite. The basis for moral decision-making in our post-modern epoch must look to a *process*, rather than to a substantive normative framework. Having developed his theory of language and communication, derived from communicative rationality, as outlined in 2.2 Epistemology, truth, and language, Habermas then developed his discourse theory of morality and his principles of communicative action. These are grounded in intersubjectivity - 'characterized by an intermeshing of the perspective of each with the perspectives of all'.[719] Rather than appeal to a substantive ethical framework, Habermas argues in favour of appeal to a process of dialogue and argumentation in order to answer the practical questions of moral philosophical decision-making. Consideration of the public sphere (system and lifeworld) 'expresses the idea of the force of the public use of reason in the area of ethics'.[720] Thus, also, normative force (*oughtness* or *shouldness* as it applies to morality) can be achieved.

**6.2 Discourse theory of morality**

In the understanding championed by Habermas, in addressing the rational basis behind the answer to the question "what should I do?", there is an important difference between decision-making about a pragmatic problem, about an ethical problem, and about a moral problem. A practical problem (for example, what to do if my car battery is flat) has no dimension of goodness attached to it (although I should not steal someone else's car). Ethical questions, for Habermas, do not need to be answered universally, since they resonate around the values I monologically ascribe to good, right and just as I apply them to the problem. Additionally, ethical questions remain egotistical, since they tend to 'take their orientation from the telos of one's own life',[721] rather than inherently being aware of alterity. Since alterity is implicit to them, moral questions can and must be answered universally, and dialogically, since they deal with Good, Right, and Justice for all.

As a simple example, consider the decision of which career I choose. First, I collect the facts (for example, the pre-requisites which I need in order to enrol in the course). Collecting the facts precedes any ethical or moral decision-making. The ethical dimension of the decision leads me to think about myself and recognise, for example, that I have certain talents, or that I would like to maximise my work-life balance. The moral dimension is added when I recognise that my decision affects others - my family, the community in which I live - in terms of being able to serve others,

[719] Habermas (1993). On the pragmatic, the ethical, and the moral employments of practical reason *Justification and Application: Remarks on Discourse Ethics* p12.
[720] Thomassen (2010). Discourse ethics *Habermas: A Guide for the Perplexed* p.84.
[721] Habermas (1993). On the pragmatic, the ethical, and the moral employments of practical reason *Justification and Application: Remarks on Discourse Ethics* p.6.

rather than simply earn an income. Thus, I widen my own perspective and discuss with those around me, how we should decide.

> [B]ecause we live in an epoch of ethical pluralism, moral reflection and argumentation are relevant so as to give everyone a fair chance to articulate and (with due respect for the different views and values of others) to live their own notions of the good. It is precisely where ethical conflicts arise that rigorous moral questioning becomes important.[722]

As has been noted in 3.3.2 Contemporary deontology, Habermas captured Kant's principle of the universalizability of his categorical imperative and widened its social applicability by reformulating it in his discourse theory of morality as requiring that *all* affected people must be able to agree that it is universalizable. While individuals can of course have moral thoughts, an isolated individual cannot, monologically, determine a moral norm which is applicable to others. Moral thoughts have no normative force upon others unless all in a community, after public communal discourse, agree. Habermas goes on to add that, as well, '*all* affected can accept the consequences and the side effects its *general* observance can be anticipated to have for the satisfaction of *everyone's* interests (and these consequences are preferred to those of known alternative possibilities for regulation [original emphasis]',[723] thus introducing the perspective of teleological values to deontological rules. As an example, consider a neighbour who gives you a valuable family heirloom to look after while she goes on holidays. She tells no one of this. She dies while on holidays. None of your neighbour's family ask about the heirloom. You might well be able to argue that a maxim "if no one knows about an item freely given into the care of another, then since everyone is ignorant of the situation, no one feels they are missing out" and argue this maxim is universalizable. Habermas would argue that in fact your neighbour's niece is a person affected by this situation, whether she knows it or not; and her interests are not satisfied under your maxim. Thus, under a Habermasian- widened socialisation, your maxim is impermissible. Recognising that dialogue between patient and clinician is fundamental to moral decision-making in medicine, and that this in part determines the intention and the result of the doctor-patient relationship itself, allows further recourse to the expositions of Habermas. He wrote that 'our only hope for the rationalization of the power structure lies in conditions that favour political power for thought developing through dialogue'.[724,725]

---

[722] Ormerod and Ulrich (2013). Operational research and ethics: A literature review. European Journal of Operational Research 228(2): 291-307.
[723] Habermas (1981, 1990). *Moral Consciousness and Communicative Action* p.65.
[724] Outhwaite (1994). The colonization of the lifeworld *Habermas: A Critical Introduction* pp.84-85.
[725] Habermas (1971). *Toward a Rational Society* p.61.

Historically, as noted in 2.1 Epistemology, truth, and the significance of language, Charles Sanders Peirce was seminal to both communicative action and the discourse theory of morality. He recognised that normative validity resided in the adjudication of the community. George Herbert Mead's theory of social consciousness was also based upon inter-subjective relationships, as an extension of Kant's universalizability premise as the basis for moral decision-making, via considering all interested parties impartially. [726,727,728] As noted in 3.3.2.vii Derek Parfit's triple theory, Parfit also widens Kant's categorical imperative, to become 'everyone ought to follow the principles whose universal acceptance everyone could rationally will'.[729] Klaus Günther distinguishes two kinds of discourse[730] – that of justification, and that of application. The former may be understood to seek a generalizable moral truth, independent to context. The second asks the question whether its application is appropriate in this particular case. The latter is concrete and action-guiding in this particular context. As Habermas quotes Günther, '[w]hat must be decided [in application discourse] is not the validity of the norm for each individual and his interests but its appropriateness in relation to all of the features of a particular situation'.[731,732] In a similar vein, Carol Gilligan distinguishes 'the generalised other' from 'the concrete other'. By the latter she means 'responding to the particularities of the other person and of the concrete circumstances of their situation'.[733] In this sense, importantly, these nuances underline the appropriateness of the Proportionist approach to moral decision-making in clinical situations, consistent with the central proposition of this thesis. In fact, it is possible to argue that both the justification discourse and the generalised other, though important in that they are underscored by Kantian deontology, are ultimately (and practically, given the plethora of ethical situational variations) less relevant than the application discourse and the concrete other. Consider the birth of a severely handicapped baby, for example one with anencephaly (no brain). The discourse of justification and the generalised other will argue that all human life is of value, and is incommensurable with other lives. That is, no measure of the functional ability of a human baby is a criterion for deciding whether a baby should live or die. However, the discourse of application and the concrete other will argue that this anencephalic baby has no capacity to function in a way considered to be human, with no potential to be aware of his or herself

[726] Rasmussen (1990). The stategy of the theory of communicative action *Reading Habermas* p.34.
[727] Thomassen (2010). Discourse ethics *Habermas: A Guide for the Perplexed* pp.96-99.
[728] Habermas (1987). Intermediate reflection: system and lifeworld *Theory of Communicative Action* p.94.
[729] Parfit (2011). *On What Matters* p.342.
[730] Thomassen (2010). Discourse ethics *Habermas: A Guide for the Perplexed* p.103.
[731] Günther (1988). *Der Sinn fur Angemessenheit* p.55ff.
[732] Habermas (1993). Remarks on discourse ethics *Justification and Applicatiion: Remarks on Discourse Ethics* p.37.
[733] Thomassen (2010). Discourse ethics *Habermas: A Guide for the Perplexed* p.105.

or his or her family or environment in any way. Therefore, this could constitute criteria for discontinuing life.

Conceptions of *personhood* are very important in clinical decision-making, and will be explored further in 7.4.1 Philosophical aspects of personhood. It should be noted however, that the wisdom in the Proportionist approach as a framework for making moral decisions in clinical situations is that it allows a balanced weighing-up of absolute rules and relative contexts. The process-centred Habermasian paradigm is argued-for in this thesis as the practical method to empower the Proportionist approach, that is, to put the Proportionist approach into practice in clinical situations.

Perhaps moral decision-making relocates ethical decision-making away from a monological reflection upon imperatives, utility, or an agapeic calculus, into a social space cognizant of the other, wherein we need to have a dialogue. Hence, principles of Habermas' discourse theory of morality are necessarily invoked in that all participants need to agree that the decision can be universalised to all who are affected. Kant's generalizability criterion gestures towards incorporating others, but Habermas' discourse theory of morality embodies it. The dialogue which follows is predicated upon principles of communicative action.

In non-clinical situations, it is highly contentious whether a dilemma is seen predominantly (or exclusively) as an ethical dilemma, or as a moral dilemma. For example, consider euthanasia, homosexuality, suicide, or the Israeli-Palestinian conflict. Each may be seen by different observers, as a dilemma either for the individual to make a decision about (an ethical dilemma), or for a society to make a decision about (a moral dilemma). How we see the dilemma in large part determines the approach we will take to the decision to be made. That is, whether I think about it via a monologue, or whether we, all together, enter into a dialogue about it.

**6.3 Communicative action**

In communicative action, speech acts are orientated to understanding. As noted in 2.2 Epistemology, truth, and language, consensus via mutual understanding is Habermas' *telos* of language, and it lays the foundation for a normative relationship. Habermas terms the alternative to communicative action to be 'strategic action'.[734] In strategic action, speech acts are orientated to success, aiming to influence, and are associated with power. In the clinical context, the former is a feature of the reciprocal model of the doctor-patient relationship. The latter is a feature of the paternalistic model.

[734] Habermas (1987). Intermediate Reflections: social action, purposive activity, and communication *Theory of Communicative Action* pp.273-337.

Open strategic action occurs when the intention to influence is declared. Concealed strategic action involves conscious or unconscious deception. It may be possible for a doctor or (less commonly) a patient to act with an unconscious orientation towards success rather than understanding; a systematically distorted communication ensues.[735] Habermas may agree that strategic action characterises oratory, while communicative action characterises discussion or dialogue – wherein 'we must be present in what we say and to those to whom we speak ... the Socratic concept of conversation, of what it is to be present to an "other" in conversation, involves a certain conception of intersubjectivity'.[736]

Specific to the language of clinical decision-making, it is very common to refer to "clinical judgements" versus "patient or parent wishes".[737] This language of the "judgement" of clinicians implies expertise, rationality, and validity. It privileges the clinician's views as being reasoned, whereas, the "wishes" of the patient or parent imply mere preference and so lack validity. Making a moral judgement requires collecting the facts, and then reasoning about them based upon a set of ethical values. Both clinicians and patients/parents are able to make moral "judgements", from the value set they have, respectively, as "good clinicians" and as "good parents".[738] It is incorrect to portray the views of the clinicians and the parents, when they conflict, as 'different in structure, not just content'.[739]

Historically, Durkheim argued that, in the pre-modern epochs, people followed norms and were bound by them, independent of external sanctions because they were sacred. Habermas extends this understanding and proposes that communicative reason substitutes for sacredness. Thus, norms are binding because 'they have been mediated by communicative reason'.[740] The socio-biological context for this is what Habermas terms the *lifeworld* - the actual space in which people live and interact. 'Moral Strangers' are those who do not share a common set of moral values, hold the same moral opinions, or recognise a common authority. In our contemporary, secular, fragmented and pluralistic society, bringing our own disparate beliefs to a decision-making place, and having an argument based solely upon reason without being willing to try to understand the beliefs of the

[735] Scambler and Britten (2001). System, lifeworld and doctor-patient interaction *Habermas, Critical theory, and Health* pp.52-54.
[736] Gaita (2004). Moral understanding *Good and Evil: An Absolute Conception* p.278.
[737] Gillam and McDougall 2013) Clinicians' 'decisions' versus parents' 'wishes': Ethical implications in conflict situations, Australian Association of Bioethics and Health Law Conference,
[738] McHaffie (2004). Commentary. J Med Ethics 30.
[739] McDougall and Gillam (2014). Doctors' "judgements" and "parents' "wishes": clinical implications in conflict situations. Medical Journal of Australia 200(7).
[740] Thomassen (2010). Discourse ethics *Habermas: A Guide for the Perplexed* p.97.

other participants, is unlikely to achieve any concordance. Rather, there needs to be a willingness to reach a shared moral viewpoint.[741]

Thus, in his theory of communicative action, Habermas aims towards truth-seeking via participatory democracy and argues that the use of language, in the sense of either linguistic, or non-verbal, communication, aims 'to attain consensus in a context in which all participants are free to contribute and have equal opportunities to do so'.[742] It has been characterised as a form of linguistic interaction 'where all speech acts contain validity claims concerning comprehensibility, sincerity, truth and justification, which are openly criticizable and discursively redeemable'.[743] This means that 'we can ask a speaker "What do you mean?", "Is what you say true?", "Are you entitled to say that?' or "Do you really mean that?"'.[744] Habermas argues that more than being pre-cursors to partake in the dialogue, they '*make possible* the practice that participants understand as argumentation [original emphasis]'.[745] Habermas identifies the four most important presuppositions of the discourse as: inclusiveness, so that anyone who can make a relevant contribution is included; equal rights of all participants to engage in communication and contribute; exclusion of absence of deception; and absence of coercion.[746]

Assumptions underlying the discourse dictate that each participant mutually considers each other to be accountable; and they mutually consider each other ready and willing to reach mutual understanding – by which he means that each acts so as to aim to reach consensus.[747] In practice, participants use linguistic expressions in the same way, all relevant arguments are brought to the dialogue, each is allowed to participate and express their attitudes, wishes and needs, each can introduce or question any proposal, and there should be no internal or external compulsion applied by or toward to any speaker.[748] In ideal speech situations of undistorted communication, concern is only for the most valid argument – 'the unforced force of the better argument'.[749] Discourse is rational and impartial, and further presupposes that participants share the perspective of others in

[741] Engelhardt (1996). The principles of bioethics *The Foundations of Bioethics* p.103.
[742] Scambler (2001). Introduction: Unfolding themes of an incomplete project *Habermas, Critical theory, and Health* p.10.
[743] Jones (idem Health care decision making and the politics of health p.70.
[744] Outhwaite (1994). Communication and discourse ethics *Habermas: A Critical Introduction* p.40.
[745] Habermas (1994). Remarks on discourse ethics *Justification and Application: Remarks on Discourse Ethics* p.31.
[746] Habermas (2005, 2008) Between naturalism and religion: Philosophical essays, 50: 50
[747] Habermas (1984, 2001). Reflections on communicative pathology (1974) *On the Pragmatics of Social Interaction: Preliminary Studies in the Theory of Communicative Action* pp.147-148.
[748] Jones (2001). Health care decision making and the politics of health *Habermas, Critical theory, and Health* p.69.
[749] Habermas (1992, 1996). Democratic procedure and the problem of its neutrality *Between Facts and Norms* p.306.

the discourse. This presupposition is informed by Habermas' universalizability criterion above – wherein all accept that the precept is able to be universalised as being in the best interests of everyone in the discourse. Bent Flyvbjerg enumerates requirements for 'validity and truth' in a discourse, and hence normative force, in greater detail. These requirements are: 1) generality – by which he means that no affected party should be excluded from the discourse; 2) autonomy - participants have equal possibility to present and criticize validity claims; 3) ideal role taking - participants are willing and able to empathize with each other's validity claims; 4) power neutrality - existing power differences between participants, especially that power vested in clinicians, are to be neutralized so they have no detrimental impact upon consensus; 5) transparency - participants must openly explain their goals and intentions and avoid strategic action; and 6) 'given the implications of the first five requirements', sufficient time.[750] To this list might also be added the requirement that no treatment option should uncritically be disallowed before the dialogue commences. As well, there needs to be an awareness that in medical consultations there is usually a considerable emotional flux present during the dialogue.

In case-conferences, clinicians have a vital role to play in facilitating the practical realisation of discourse requirements. McCarthy argues that 'Habermas's [*sic*] discourse model, by requiring that perspective-taking be general and reciprocal, builds the moment of empathy *into* the procedure of coming to a reasoned agreement'.[751] Habermas appears to favour cognitive rationality as the role-model the participants assume. This thesis suggests that in a medical setting, reciprocal empathy is more likely to be an effective model for participants to adopt. Apel argues that, when considering the academic possibility of a universally valid foundation for ethics, the argumentative discourse presupposes not merely that the participants have a particular historical tradition, but that the presuppositions necessarily brought to the argumentative discourse

> … pertain to this enterprise of argumentative discourse itself ... [a]nd everybody who participates ... must acknowledge certain normative principles. Not concrete norms, but very formal procedural norms which are *a priori* universal … [and which] hold for all members of the community of argumentation.[752]

[750] Flyvbjerg 2000) Ideal theory, real rationality: Habermas versus Foucault and Nietzsche, Political Studies Association's 50th Annual Conference, 3-4

[751] McCarthy (1981, 1990). *Moral Consciousness and Communicative Action* p.viii.

[752] Griffioen and Woudenberg (1990). We must not forget those who are absent: Interview with Karl-Otto Apel on the universality of ethics *What Right Does Ethics Have?: Public Philosophy in a Pluralistic Culture* pp.14-15.

He then generalises by arguing that the first step in grounding an argumentative discourse is self-reflection by the participants. Thereafter, the presupposition follows that the participants, in principle, have an equal right to solve problems, equal duties, and equal co-responsibilities. He argues that this is the 'ideal situation which we *must* anticipate when entering into the discourse',[753] and this is to be understood at a transcendental rather than psychological level, naturally following for someone who seriously enters into the discourse. This is the foundation for a universally valid ethic. Apel goes on to describe what he holds to be the epistemic primitives for members of a communication community who have entered into an argumentative discourse - 'presuppositions which cannot themselves be called into question without performing a performative self-contradiction',[754] synonymous with what he terms elsewhere, 'the transcendental core'.[755] These are the just-mentioned equal rights, equal duties, and equal responsibilities, to which he adds that the community, in principle, is infinite. In other words no-one can be excluded without a reason; but many must be excluded to avoid an utterly unwieldy discourse. Some restrictive conditions are a practical necessity. The point has already been made in 3.4.2 Contemporary teleology, that in calculating the nett value equation for Care of the Land, the interests of future citizens need to be calculated as part of the denominator. Future citizens cannot come to the ethical ecological discourse but are potential members of the infinite community. The question of the weighting they (and others in the discourse) should be given is for discussion. As has been alluded to in 2.2 Epistemology, truth, and language, despite the epistemology of power deriving from a clinician's position within the dialogue, Laura speaks of 'empathic connectivity' as the necessary aim of the dialogue.

It has already been noted that the deontological and the teleological normative frameworks developed during the modern era of moral philosophical thought, with their emphasis upon the specifics of *doing* Good, thus incorporate a prescriptive theory of right action explicitly concerned with what should be done in given dilemmas. This may be contrasted with virtue ethics, which has more of an emphasis upon *being* morally Good; an abstract theory of right action is not implicit. As has also been noted, what characterises the modern epoch is typified by the substantive, rational, frameworks of deontology and teleology based upon right action. What characterises the post-modern epoch, cognisant of the plurality and fragmentation of our society, is looking to a *process* of dialogue for moral decision-making. Agreement is reached or the reasons for disagreement are understood. In the discourse of a medical case conference, each mature participant brings some

[753] Ibid. 15
[754] Ibid. 16
[755] Ibid. 18

moral sensibilities, inchoate and uninterrogated though they may be. The clinicians will often be able to use Beauchamp and Childress' vocabulary of autonomy, beneficence, non-maleficence, and justice (discussed in detail in 4.2 Four principles relevant to medical ethics), as starting points from which the dialogue can proceed. Borrowing from Susan Wolf's deliberations on the Kantian Contractionalist Formula of Parfit, it may well be that in the dialogue, an individual may not be able to follow their preferred moral principle, but will recognise that another principle, agreed to by all, may not be rationally unreasonable in the context at hand. In Wolf's words, during the dialogue, 'the recognition that everyone rationally *could* accept a principle may count as a reason for someone *to* accept the principle'.[756] Practical ways of reconsidering dissensus will be further exposited. It is the contention of this thesis that moral truth is attained through consensus, obtained on the basis of conditions set out above, and this is the basis for normative force.

As noted, truth is analysed by Habermas as a validity-claim, defined in terms of inter-subjective consensus. Thus truth and falseness can be applied to moral decisions. 'When I state that one norm should be preferred to another, I aim precisely to exclude the aspect of arbitrariness: rightness and truth come together in that both claims can only be vindicated discursively, by way of argumentation and a rational consensus'.[757] And elsewhere, '[a]rgumentation insures that all concerned in principle take part, freely and equally, in a cooperative search for truth, where nothing coerces anyone except the force of the better argument'.[758] Thus, he argues there is no need to begin the discourse under John Rawls' 'veil of ignorance'. In fact, decisions made under the veil are not likely to be as motivating once the veil is lifted, and the real world is observed, as are decisions made by real persons after communicative dialogue in their actual situations.

Habermas nonetheless 'stresses that communicative action is not identical with communication; though it takes place by means of communication',[759] describing it as a type of interaction coordinated through speech acts but not coincident with speech acts. What then of non-verbal communication – for example aiming to reach consensus about whether to offer a cochlear implant to the child whose parents are both deaf? The process of communicative action is more difficult, both because the educational achievement of profoundly deaf adults is usually less than hearing adults, which, conceivably, may limit their capacity to discuss relevant concepts, and also because of limitations around the need to write down questions and answers or use a deaf interpreter to relay

[756] Wolf (2011). Hiking the range *On What Matters* p.45.
[757] Habermas (1976, 1979). *Communication and The Evolution of Society* p.109.
[758] Habermas (1981, 1990). Morality and ethical life: does Hegel's critique of Kant apply to discourse ethics? *Moral Consciousness and Communicative Action* p.198.
[759] Outhwaite (1994). Rational action and social rationalization *Habermas: A Critical Introduction* p.72.

via signing. Therefore, it may be that the dialogue exists at a lesser level of sophistication and so has less normative force. Habermas might agree that communicative action in this setting simply requires more time and effort from the participants, and that deaf parents are uniquely able to completely understand the experience of deafness, in a way hearing parents (and hearing clinicians) are not able to. In practice, having experienced deafness themselves they do not have the initial great fear hearing parents often have, and so can more realistically weigh up the pros and cons of interventions such as cochlear implants. Non-verbal communication is often enhanced in the hearing impaired, which may indeed avoid misunderstandings related to the limitations of language. Consider trying to put the feelings inspired by a work of art, into words.

Flyvbjerg posits that, in offering a process rather than a substantive ethical framework, Habermas is a 'universalistic "top-down"' moralist with regard to the *process* – giving the procedures for normatively correct process (that is, the requirements for an ideal speech situation) in advance. However, as regards *content*, Habermas is a '"bottom-up" situationalist' – what has normative force is determined solely by the participants in that process.[760] He contrasts this with the 'bottom-up' approach of Foucault to both the process and to the content of a moral decision.[761] It is the contention of this thesis that there is a system of morals, a morality, in the process that Habermas and others envision, despite certain practical difficulties considered further below. Perhaps it is possible to describe this process of discourse and argumentation aiming to reach consensus as "wide reflective equilibrium".

Although unacceptable to some, given the plurality of modern society, Habermas distinguishes norms from values.[762] Norms, or rules we must follow, require moral justification in terms of deontological validity. Values or value-configurations do not require moral justification deontologically, although they may be evaluated subjectively from an individual's perspective. In addition, the values or value-configuration which individuals hold are historically and culturally embodied. It is neither necessary, nor possible, for participants in the dialogue to separate themselves from their core values in order to participate. Despite living in a pluralistic fragmented society, '[g]iven the communicative presuppositions of an inclusive and non-coercive discourse ... the principle of universalisation requires each participant to project himself into the perspective of

[760] Flyvbjerg 2000) Ideal theory, real rationality: Habermas versus Foucault and Nietzsche, Political Studies Association's 50th Annual Conference, 3-4
[761] Ibid. 11
[762] Habermas (1981, 1990). Moral consciousness and communicative action *Moral Consciousness and Communicative Action* pp.177-178.

all others ... [which] makes explicit what it means for a norm to be able to claim validity'.[763] All affected persons seek to reach consensus. In clinical situations this includes, at least, the patient and any affected family, Habermas posits that in his understanding moral philosophy 'does not have privileged access to particular moral truths',[764] rather, it offers a procedure to follow in order to make moral decisions, to seek moral truths.

Let us recall that, for Apel, the first step in grounding an argumentative discourse is self-reflection. After a discourse, those engaged in ethical reflection should necessarily evaluate whether all alternative resolutions and conceptions have been explored, whether participants have determined the ways in which the consequences of the alternatives may affect every participant, whether everyone potentially able to participate has participated, and whether the discourse itself occurred in a free and open way. In practical terms common sense determines how many need to be actively involved in a particular case, and also what relative contribution might be judged as appropriate. Consider a case conference after a serious head injury. Weighting of the prognostic guide offered by the neurosurgeon would intuitively be relatively more important because s/he would seem most likely to have the entitlement to prognosticate about the likely outcome from this particular head injury. For the same reason, listening closely to the relative who is offering their knowledge of what the patient might want is also relatively more important. Input from the discharge planner as to what facilities for rehabilitation are available near-by or distant is relatively important. The business manager might be listened to in terms of costs but ideally would not try to predict likely neurological outcome from this particular injury.

Communicative action, while occurring in a particular cultural context, also has an ahistorical factor of communicative symmetry - compulsion-free consensus. Habermas allows that 'only in an emancipated society, whose members' autonomy and power have been realised, would communication have developed into the non-authoritarian and universally practised dialogue' such that 'the truth of statements is based on anticipating the realization of the good life'.[765] Perhaps he would agree that participants in the discourse benefit from a somewhat heightened moral sophistication; itself aided by education of the participants. This thesis contends that in medical encounters too, his theory of communicative action has normative force. This paradigm offers insights into the distortion of communication by individuals or groups with power. This is recognised when any of the presuppositions are broken. As Apel and Habermas have both emphasised,

[763] Habermas (1993). Remarks on discourse ethics *Justification and Application: Remarks on Discourse Ethics* p.52.
[764] Habermas (1981, 1990). Morality and ethical life *Moral Consciousness and Communicative Action* p.211.
[765] Habermas (1972). *Knowledge and Human Interests* p.314.

participation presupposes the validity of the discourse; necessarily, participation together with universability, is the basis for a normatively-valid discourse ethic. Thus it is an ethic grounded in cognition, allowing rationalisation of potentially conflicting opinions expressed during the discourse. Practical impediments and possible solutions are explored in 7.3 Practical difficulties with the Habermasian paradigm in clinical practice.

As iterated, for Habermas, determining normative validity within and as, a system of morality (behaviours or customs with normative force), requires more than a single individual thinking deeply. It requires inter-subjective consensus after dialogue; or discourse theory of morality predicated upon communicative action. Put another way, '[h]ighlighting moral speech-agency and practice brings consensus and kindred concepts to the fore, as consensus is something moral agents construct, it is not something they contemplatively discover'.[766] Engelhardt too recognises that 'authority can only be derived from the concurrence of individuals'.[767] Given his view of the moral pluralism of contemporary society, he meant that single individuals cannot decide moral maxims. Moral authority can only be created through, and be limited to, 'the actual agreements of actual persons'.[768] Since actual people are in a moral dilemma, actual people need to dialogue in order to make what is intended to be a morally good decision. To achieve this requires a willingness to be open to the other, to listen without seeking to dominate; to understand, to explore the other.[769] As alluded to in 2.2 Epistemology, truth, and language, Gadamer argues that hermeneutic understanding requires extending one's perspective from that specific to oneself, and by extending one's perspective, one's understanding can also be extended.[770] The basis for hermeneutic understanding is dialogue, and this must be reciprocal dialogue – '[d]ialogic hermeneutics requires that all parties are open to one another and prepared to listen and change'.[771]

**6.4 Summary**

This chapter, and the previous chapter, have argued that, given the plurality and fragmented nature of contemporary society, there can be no absolute universal moral truths. Therefore, in deciding

[766] Jennings (1991). Possibilities of consensus: towards democratic moral discourse. The Journal of Medicine and Philosophy 16: 448.
[767] Engelhardt (1996). *The Foundations of Bioethics* p.x.
[768] Cherry and Iltis (2010). *At The Roots of Christian Bioethics: Critical Essays on the Thought of H. Tristam Engelhardt Jr* p.1.
[769] Mead (1967). The social foundations and functions of thought and communication *Mind, Self, and Society: From the Standpoint of a Social Behaviourist* p.254.
[770] Widdershoven and Abma (2007). Hermeneutic ethics between practice and theory *Principles of Health Care Ethics* p.217.
[771] Ibid.

how we should live together, we need to move away from a relativistic and essentially subjective *ethical* construct and move towards a universally-applicable process-driven *moral* construct. Compared with the subjective orientation of ethical questions, moral decision-making is implicitly cognisant of the other. Moral questions need to be answered with universal applicability. All persons affected should be considered. The Habermasian paradigms built around the notions of discourse theory of morality, universalizable to all, and communicative action as a cooperative search for truth, constitute an approach which seeks consensus. This approach to the practical enactment of moral decision-making thus relocates ethical decision-making away from a monological reflection upon imperatives, utility, or an agapeic calculus, into a social space cognizant of the other, wherein we need to have an inclusive and non-coercive reflective dialogue. It is especially apposite in the clinical encounter.

In the next chapter, an example of the process in a clinical setting is offered. The difficulties with the paradigm in clinical practice are then explored.

## CHAPTER 7 APPLICATION OF THE HABERMASIAN PARADIGM IN CLINICAL PRACTICE

### 7.1 Introduction

The argument of this thesis has been predicated on Habermas' three "ways" of knowing and on conceptions of intersubjectivity favoured by Habermas and also articulated in the understanding of phenomenology. The thesis is aware of the classical era lines of philosophical thought originating in the writings of Plato and of the nexus between the writings of Aristotle and the medieval Aquinas. These result in the substantive ethical frameworks of deontology, teleology, and virtue ethics. Additionally, the thesis shows considerable alertness to the value pluralism, and even fragmentation, which are proffered as characteristic of our current era.

Building upon this, in searching out an approach to moral decision-making in clinical situations, this thesis favours the Proportionist approach, as constituting an integrative balance between *a priori* rules and empirical, "greatest good for the greatest number" consequentialism. The Proportionist approach has as its starting point the concrete reality of the patient in the situation of their illness.

The Proportionist approach is put into clinical practice via Habermas' paradigm of his discourse theory of morality and his principles of communicative action. Together these underlie a non-coercive consensus-seeking dialogue within the community affected. Thus, amongst models for the doctor-patient relationship, that of shared decision-making is prioritised. As will be shown, the paradigm also underlines the way that, from the virtue ethic perspective, this approach seeks to maximize the good of the family – actualizing the concept of actively caring.

Practical difficulties and limitations of the discourse theory of morality and of communicative action are then explored in detail. It will be argued that, practical difficulties in achieving the ideal dialogue notwithstanding, the process described here has both applicability and merit for moral decision-making in clinical contexts. Nonetheless, confounding factors remain that are more or less specific to clinical moral decision-making. Conceptions of personhood, the 'Rule of Rescue', and insights from neurobiological studies will be explored.

### 7.2 A clinical example employing the Proportionist approach, discourse theory of morality and communicative action

The decision-making model proposed in this thesis invokes deliberate consideration of the moral issues at hand, cognisant of the normative ethical frameworks, and founded upon dialogic

consensus. A mature understanding of the moral decision-making process in clinical settings, at which this thesis has arrived, benefits from consideration of a further case-study – Baby 'H'.

Consider an in-utero MRI diagnosis of Congenital High Airway Obstruction Syndrome due to tracheal atresia (absent windpipe) at 22 weeks gestation. The decision is whether to offer an EX-utero InTra-partum (EXIT) procedure,[772] wherein an airway is established while on placental support, while the baby has only the head, neck and one or both shoulders delivered from within the uterus. Tracheostomy must follow, and then multi-staged tracheal reconstructions. Mum has gone through four years of in-vitro fertilisation (IVF) and, at 42 years old, this is arguably her last chance to conceive. The family have an older child, aged six, who is perfectly well. Without successfully establishing an airway at birth, Baby 'H' will not survive.

The first step in approaching a moral conflict is to collect the relevant facts. This thesis is aware that non-philosophers, when making the most of their moral decisions, do not specifically articulate the moral framework they are using to make their moral decision. It is analogous however to recognise that in considering the language of every-day communication, non-grammarians do not explicitly refer to the system or rules of grammar when speaking, or when listening to the speech of others. In making decisions about serious medical conflicts, it behoves us to adequately reflect the gravitas of the situation, by deliberately articulating the moral issues under consideration, lest an irreversible decision is made erroneously. Rather than discretely choosing amongst the normative ethical frameworks recognised in the secular Western tradition, allowing for the influence of the monotheistic belief systems, specific consideration should, in each case, be given to both deontological precepts and teleological precepts. The Proportionist approach seeks a balance between the two.

Returning to the importance of language once again, during the case conference, attention must be given to the participants aim to foster Habermas' ideal speech conditions for a dialogue. As noted in 2.2 Epistemology and language, the use of illocutionary language, wherein each speaker speaks truthfully and non-coercively, rather than perlocutionary speech which is aimed at influencing or coercing other participants in the dialogue, is crucial. The aim of the case conference is to reach consensus in the decision, via mutual understanding. Habermas would thus understand that language during the case conference is deployed in two ways. The first is the communicative dimension of language via illocution. The second is the cognitive dimension of language, that is, the

[772] Walker P, Cassey J and S (2005). Management of antenatally detected lesions liable to obstruct the airway at birth – an evolving paradigm. International Journal of Pediatric Otolaryngology 69(6): 805-809.

facts and the situation which are the subject of the discourse, and about which a consensual decision must be reached. Fostering an ideal speech situation would seem to be one of the responsibilities of the clinicians in the dialogue; which presupposes education in how to accomplish it.

Seeking truth in the outcome requires each participant to speak their own truth. For the clinicians especially, this in turn requires that Habermas' "ways" of knowing are understood. Empirical-analytic knowing is most straightforward, although that is not to be taken to mean that this thesis views all medical outcomes as quantifiable with certainty. There will always be a level of uncertainty, often significant uncertainty, about what outcome an individual patient will have following treatment. Historical-hermeneutic knowing follows upon understanding the importance of meanings and values. In other words, there must be an attempt by all participants to understand the actual reality of the patient's situation, and how this affects the goods of the patient and their family; for example, what is actually important to them? Thus, the patient's embodiment both in their situation, and in-relationship with those others around them, is recognised. Self-reflective critical knowing is driven by our interest in being emancipated in our knowing, being freed from unhelpful preconceptions, and outdated or incomplete beliefs. Achieving dialogue at this level is necessary for the practical outcome of a meaningful discourse.

For Baby 'H', deontological precepts might be introduced and acknowledged via articulating the special joy of a baby within, being aware of the essential personhood and inherent dignity of a human baby, independent of function or contribution to society, who cannot permissibly be deliberately killed by the doctor (but who can permissibly be allowed to be born, and die at birth).

Teleological consequences include articulating in a way which encourages all in the dialogue to contribute, difficulties in terms of risks to the mother during EXIT procedure, care of a tracheostomy in a new-born, difficult multi-staged reconstruction of the trachea, which may cause suffering to the baby, and may be unsuccessful, together with the risk of unacceptable badness considered in 3.4.2 Contemporary Teleology. Normal speech and swallowing cannot be assumed. There will be significant time off work for both parents, with corresponding financial consequences, consequences to the family dynamics in terms of the older child, and the potential for parental divorce. A study of 'severely unhealthy infants' reviewed 12-18 months after birth reported a ten per cent rate for the

parents no longer cohabiting.[773] There will also be direct financial and missed opportunity costs to society in general.

The vision of a virtue ethical framework, maintaining empathy, compassion, and caring, striving indeed for wisdom, overlies the dialogue. Description of the facts is followed by elucidation of their meaning for this patient and their family. In so doing, the goods of the patient are able to be determined. For example, in an anencephalic baby questions can be explored about the perceptual and the human goods of this patient, and the goods of the family into which the baby is born.

Clearly, each of these normative framework perspectives is likely to have validity to someone in the discourse. The identified ethical aspects need to be related to the particular context at hand. This balancing of ethical concepts constitutes part of the wisdom inherent in the Proportionist approach. It also aims to reach a balanced conclusion seeking both rational and emotional coherence amongst all the parts - the information (empirical facts and their meaning to this community) and the participants (each as parts of the community involved in the dialogue). The Habermasian paradigm of discourse theory of morality and communicative action offer a practical way to actualise the Proportionist approach during this case conference.

Despite the likely disparate social and moral backgrounds of the participants, during the medical case conference for Baby 'H', good clinicians and good parents dialogue about the morally conflicted situation they are in. The discourse theory of morality widens Kant's principle such that all those affected by the discourse agree that it can be universalized, and adds acceptance of the consequences for all, by all. Principles of communicative action govern the argumentation. Thus, a truth validity claim is made, and the process gives the moral decision normative force without mandating privileged access to absolute moral truth. In our post-modern epoch, characterised medically by an ever-increasing armamentarium of life-sustaining technology, an active process of moral decision-making in clinical situations, rather than mere contemplation, is required in order to reflect the gravitas of clinical decisions.

As hinted at in 7.1 Introduction, an additional advantage of this process accrues in terms of the psychological well-being of the parents. It is common for parents to ask, during a case conference or consultation, the anguished question "how can I make this decision?" The rise of patient autonomy as a dominant principle of medical decision-making, discussed in 4.2 Four principles relevant to medical ethics, means the response is traditionally along the lines of "you must" or "only you can

[773] Reichman, Corman and Noonan (2004). Effects of Child Health in Parents' Relationship Status. Demography 41(2): 569-584.

make this decision". Understanding the process of the discourse theory of morality and of communicative action, offers the singular advantage to the parents that they can be reassured that they don't have to make the decision alone - that "we", those in the community having the dialogue, make the decision jointly and that that decision thus has normative force. From a virtue ethical compassionate and caring perspective, the family is then less likely to have lingering unresolvable doubts about whether the normatively right decision was made, at a later stage, if this concept of normative force by way of the *process* undertaken, is understood and reflected upon. This outcome, that of compassionate reassurance for the parents that the "right" or "best" decision was made, contributes greatly to their good as parents and members of a family.

There is also a practical advantage for clinicians – in that they can come to know that even previously unmet morally-challenging situations can be approached successfully by following this paradigm.

Educating clinicians about this process of moral decision-making is of profound importance.

**7.3 Practical difficulties with the Habermasian paradigm in clinical practice**

Criticisms of the Habermasian paradigm point, first, to its epistemological basis, and second to problems with discourse theory of morality and (more so) communicative action. Critics hint that Habermas comes too close to contextualism, and find this potentially dilemmatic for him.[774] This thesis, however, views context as fundamental to moral decision-making in clinical situations. As well, it is upon Habermas that Lovat elucidates his Proportionist approach for moral decision-making.[775,776] This thesis views applying the paradigm described here to moral decision-making in clinical medicine as potentially useful to further its refinement.

The epistemological basis of the Habermasian paradigm is questioned as too abstract. This is an argument which this thesis rejects. Proposing instead that his three ways of knowledge build upon the earlier writings of Peirce, Apel, Dreyfus, Gadamer, and others in a way which is logically sound, yet emphasises emancipation as deriving from our cognitive interests, and via critical thinking, impels practical action (*praxis*) in a way which is very appropriate for moral philosophy, especially in so far as it informs moral decision-making. This epistemological base segues well into a

[774] Rasmussen (1990). Reading Habermas: modernity vs posmodernity *Reading Habermas* pp.96-98.
[775] Lovat (2004). Aristotelian Ethics and Habermasian Critical theory: A conjoined force for proportionism in ethical discourse and Roman Catholic moral theology. Australian eJournal of Theology 3(1): 1-14.
[776] Lovat and Gray (2008). Towards a proportionist social work ethics: A Habermasian perspective. British Journal of Social Work 38: 1100-1114.

contemporaneous understanding of the development of virtue ethics by way of deontology and teleology, and for this thesis, does allow apposite consideration of the Good.

Communicative action is aimed at mutually-respectful consensus, and the process which achieves the decision reached, imbues normative force to that decision. Critics of Habermas point to problems with consensus and especially with unanimity, and argue that in a plural world, achieving either is impossible. Habermas himself allows that he (and presumably those who preceded him in this area) may be viewed as idealists. This thesis contends however, that the process of discourse theory of morality and communicative action can be very usefully applied to moral decision-making in clinical situations. As was exposited in 4.3 The dynamics of the doctor-patient relationship, what has become known as "shared decision-making", wherein clinicians and patients make decisions about treatment in partnership, is not only soundly based upon ethical principles, but has been shown to reduce mortality, reduce readmission rates, reduce healthcare acquired infections, reduce length of stay, enhance compliance, and improve functional status.[777] It is important that we recognise that moral dilemmas in clinical settings (but not limited to those settings) may be very complex. Not the least reason for this is the rapidly advancing pace of medical technologies, which are able to save or preserve life in ways not previously considered (for example, fully implanted pacemakers, discussed in 4.2.1 Autonomy). As already noted, a simple solution is rarely possible; and rarely should it be expected. The fact that the process of moral decision-making may be difficult, simply underlines the seriousness of the decision being made, and is not fatal to the process.

There is a difference between unanimity, acquiescence, and consensus. Unanimity is agreement by all participants, both publically and privately. Acquiescence is agreement out of a sense of benevolence, of altruism, of coercion, or another reason which denies true argumentation. Consensus is general agreement, following argumentation, in reaching a decision about what is best for the group or the community which is making the decision. Hence some individual members can legitimately disagree with the decision itself, but still agree that it is the best decision for the group. As already noted, it may be possible for participants to accept a position which it is not reasonable for them to reject, and so reach consensus. In clinical settings, individual dissensus is not fatal to moral decision-making. Ultimately, if one clinician simply cannot agree with a modality of treatment, then transfer of care to another clinician is an option.

[777] Australian Commission on Safety and Quality in Health Care September 2011) National Safety and Quality Health Services Standards, Standard 2 - partnering with consumers: 23

Consensus is tolerant of value pluralism. There exists a multiplicity of human goods. Since they are each genuinely valuable, and necessarily share a moral parity with each other,[778] they are incommensurable with each other.[779] They might not align neatly, and indeed they could be incompatible. Put another way by George Agich, value pluralism:

> is the view that there are many viable concepts of the good life, many viable concepts of how one's life should be constructed. These concepts are neither different versions of a single homogenous good nor related in any discernible hierarchical pattern.[780]

The inevitable differences which follow, result in conflict, hence tolerance is an essential corollary to pluralism. Given this, only genuine, mutually respectful and transparent discussion is likely to resolve moral conflicts.[781] In the context of discourse, values may need to be ranked, - affirming that all perceived goods have value, but must be chosen amongst in actual concrete situations, including those values to which we ourselves do not subscribe.[782] A clinical example is that of an adult Jehovah's Witness who refuses blood transfusion, even to avoid death, because it will result in the loss of his or her eternal soul. The import of incommensurability means there should pragmatism and, ideally, flexibility in choosing amongst different goods by the participants in the dialogue, remaining attentive to the specifics of the situation while 'including the claims and circumstances of those people affected'.[783]

The pre-condition of non-coercive mutually-respectful dialogue is required in order for consensus to have any claim to normative force. '[W]hen the preconditions for that dialogic democratic practice are met, consensus has a justificatory role in ethics; when they are not, consensus … can have no moral authority'.[784] One of Habermas' necessary presuppositions for communicative action (as distinguished from strategic action) is that participants 'mutually consider one another *ready and*

---

[778] Crowder 2003) Pluralism, relativism and liberalism in Isaiah Berlin, Australasian Political Studies Association Conference, 15
[779] Ibid. 3
[780] Agich (2003). *Dependence and Autonomy in Old Age: An Ethical Framework for Long-term Care* p.15.
[781] Kerridge, Lowe and Stewart (2013). Ethical theories and concepts *Ethics and Law for the Health Professions* p.34.
[782] Crowder 2003) Pluralism, relativism and liberalism in Isaiah Berlin, Australasian Political Studies Association Conference, 15
[783] Ibid. 15-16
[784] Jennings (1991). Possibilities of consensus: towards democratic moral discourse. The Journal of Medicine and Philosophy 16: 447.

*willing to reach mutual understanding* … [i]n other words, they must attribute to each other dispositions to *reach agreement* [original emphasis]'.[785] He goes on to specify that the:

> validity of the *sentence* used depends upon whether it is *well formed* in accordance with grammatical rules. The validity of the *proposition* (or the existential presupposition of the propositional content) depends upon whether it (or they) *correspond(s)* to reality. The validity of the *intention* expressed depends on whether it *coincides* with what the speaker means. And, finally, the validity of the speech act depends on whether it *fulfills* [sic] acknowledged background norms [original emphasis].[786]

Nor is consensus simply a vote, where the majority decision is chosen. By itself, agreement by vote does not imply moral truth. William Wilberforce presented anti-slavery bills to the British House of Commons, for parliamentary debate, for over 20 years before slavery was abolished.

Consensus links its moral authority to the consent of the participants in the dialogue.[787] Consensus and consent have the same etymological root[788] - deriving from the Latin *consentio*, for 'to feel together, to agree'. However, as noted, consent to an outcome reached by vote, is not consensus. Nor is agreement by trading-off some other agreement in exchange. And nor is pragmatic agreement, in order to reach a decision, especially by a certain time. These may be recognised as compromise, as a way of reaching a conclusion, rather than consensus.[789]

Critics might point out that, in the real world, strategic action in pursuit of rational self-interest is much more likely to be the dominant approach to actual decision-making situations after dialogue. In making clinical decisions however, in considering an individual decision, the clinician does not *need* the patient to agree to the course of action the clinician is proposing in the same way that a salesman needs to make a sale, that a venture capitalist needs the investor to invest, that a lawyer or politician argue their case. If the patient declines surgery it is the patient who remains in pain. There is not the same degree of self-interest as a motivator, as there may be in the commercial, legal, or political worlds. That being said, for the clinician who is taking Habermas' third "way" of self-reflective knowing seriously, there remains a strong empathic compassion for the other as a suffering vulnerable patient. If a patient has a kidney stone and is in pain the clinician might offer an

---

[785] Habermas (1984, 2001). Reflections on communicative pathology (1974) *On the Pragmatics of Social Interaction: Preliminary Studies in the Theory of Communicative Action* p.148.
[786] Ibid.
[787] Jennings (1991). Possibilities of consensus: towards democratic moral discourse. The Journal of Medicine and Philosophy 16: 454.
[788] Caws idem Committees and consensus. (4): 377.
[789] Ibid. 378-379

operation to remove that kidney stone and, aware pragmatically that next week someone will be placed on his operating list, has a motivation to understand what fears or concerns the patient might have in order to help this particular patient agree to be on that next list.

If the dialogue is to be relevant, then those who partake in the dialogue – the community that is affected - deserve serious consideration. *Constituency* is the term applied to those who are selected from the community affected, to take part in the discourse. It is necessary to clearly articulate who are the participants; and to consider their weighting. Increasing the number of participants may or may not increase the likelihood of consensus. Allowing as many members of the community as is reasonable, to participate in the process reflects our shared humanity and underlines its importance to the participants and to others who may not be participating directly, but observing it. When considering decisions for child members of a family, the age and maturity of siblings, for example, will help determine whether they should be included, formally or informally, or not. *Stakeholder analysis* is a tool which has as its primary objective 'to map the power, interest and influence of relevant stakeholders around a decision'.[790] Stakeholders are those who have an interest in the outcome of a problem. Beyond questions about constituency, the analysis estimates the salience, relevance, or significance of each stakeholder by characterising their dynamic of power, legitimacy, and urgency.[791] The greater the stakeholder's power, legitimacy and urgency, the greater is their salience. Consider the provision of blood post-operatively. Stakeholders include the patient, the surgeon, the blood donors, other community members who may need blood one day, the blood bank technicians who preserve the blood and keep it free from contamination, and the administrators who keep the supply available and distributed to where it is needed. When blood is needed by a particular patient, the recipient patient has great legitimacy and urgency, but only power if the surgeon requests the blood be provided. The surgeon has legitimacy, but only urgency when the patient needs blood. Technicians and administrators have power and legitimacy, but urgency only when there is a shortage of blood.[792] An awareness of stakeholder analysis as it applies to participants in the dialogue seeking to achieve consensus, is an important aspect of trying to achieve the best result we can, and could usefully be more widely applied to the Habermasian paradigm.

Information sources available are protean – the internet, community support groups, magazine and television stories, medically trained friends and relatives, other specialists, even neighbours. Too

[790] Kerridge, Lowe and Stewart (2013). Problem solving in clinical ethics and law *Ethics and Law for the Health Professions* p.147.
[791] Montgomery and Little (2001). Ethical thinking and stakeholders. MJA 174(8): 405.
[792] Ibid. 406

much information may be conflicting and thus confusing to patients. However, in complex medical dilemmas, the truth may be complex. What information is emphasised and how that information is presented may sway the argumentative process intentionally or unintentionally. Clinicians will often begin the dialogue, usually by summarising the medical facts. Those clinicians favouring the medical model as dominant will likely present the information from that point of view. Amongst ways of "framing" information presented to patients, several factors have been shown to incline the patient towards one or other course of action. These include a percentage chance of not developing a particular complication versus developing it, describing negatively-framed information numerically rather than merely describing it, highlighting perceived losses from inaction rather than perceived gains.[793]

As exposited in 2.2 Epistemology, truth, and language, Laura and Bishop (among many others) recognise, as characteristic of modern medicine, the tendency towards empiricism, predictability and power, resulting in reductionist model of efficient causality, in turn impelling an interventionist paradigm. They argue that the drive of modern medicine to categorise medical events, then exhausts further re-categorisation. This is clearly problematic when medical-model clinicians me*et al*ternative-model families, unless empathic connectivity is actively practised in the dialogue. This implies that the clinician is aware of the temptation to the epistemology of power, by for example, simply ignoring or significantly discounting the wishes of the patient or their family. Successful participation in the dialogue, aiming at communicative rather than strategic action, requires skill and training to minimise the influence of power-differentials. Through self-insight and self-reflection, one recognises that each member brings to the dialogue their own historical and socio-cultural background, and each needs to be aware of this in themselves and in others. Habermas' critical, self-reflective knowing represents the emancipatory drive to discern truth, and this, itself, impels *praxis*. In the context of a clinical consultation, the aim is to establish a situation of non-coercive dialogue, so that a consensus can be reached. The participants each seek to understand the truths being expressed by each other as the only way to know the good of the patient, in order that it can be maximised. To bring about the best outcome for the patient and the community, substituting recognition of values, goodness, and wisdom, in the place of empirical facts and strategic action aimed to coerce or manipulate, is necessary. Medical education at undergraduate and postgraduate levels needs to be tailored to this recognition. As well, power-differentials, which may impede the ideal speech situation, exist both amongst clinicians and within families. For example, a junior nurse

[793] Aggarwal, Davies and Sullivan (2014). "Nudge" in the clinical consultation - an acceptable form of medical paternalism? BMC Medical Ethics 15(31): 3.

who provides day-to-day practical care may not be willing to speak up in the presence of the senior specialist who directs overall treatment for the ward. Some family members may have a history of decision-making for younger or newer members of the family, such as the example of the matriarch of an extended family who makes decisions on behalf of a new spouse.

Hallmarks of the use of strategic action in the clinical consultation are protean. They would include beginning the consultation with the clinician outlining his or her significant expertise in this particular operation, without comparing surgical outcomes with non-surgical outcomes, or perhaps even mentioning non-surgical options. Language may be chosen to manipulate the patient's emotions, by, for example: underlining the fact that the patient is fortunate to be under the care of a clinician with such a wealth of operative experience; making it clear that the patient's best interests are, undoubtedly and obviously, served by the clinician operating; and, perhaps engaging the family to empathise with the clearly very knowledgeable clinician. In practice, this may be via using medical terminology which the patient does not understand, which sounds both impressive, and fearful, or which appeals to a patient's historical or cultural vulnerability. Conversely, communicative action would acknowledge both operative options and non-operative options, before exploring the benefits and the risks of both operative and non-operative options. Thus, the discourse seeks to balance the options and their potential consequences, for this patient, as this patient is helped to reach understanding. In the ideal speech situation, language is chosen which does not aim at manipulating the patient's emotions or responses. Medical terminology will be used, but its use will be open to challenge – primarily as to what the language actually means. Reference has already been made to decisions about radical prostatectomy for prostatic cancer in terms of incontinence and erectile dysfunction in 3.5.2 Contemporary virtue ethics, and will be re-visited with respect to radical mastectomy for breast cancer in 4.3.1 Traditional models for the doctor-patient relationship.

At this point, it should be acknowledged that a clinician who understands Habermas' three "ways" of knowing could conceivably mis-employ them in order to foster strategic action to achieve a desired end-result, rather than communicative action to seek truth.

Leaving this aside however, it is likely to be frustrating for the clinician who aims for communicative action that patients from some cultures may believe camomile tea has beneficial effects well beyond those proven by published studies. As noted in the preceding chapter, however, disallowing any treatment option (or any religious ideology), before the dialogue commences, is impermissible to the process. The paternalistic doctor-patient model may be acting unfettered when a surgeon disallows non-surgical options entirely, by failing to mention them as an option to be considered by

the community assembled. Beyond factual disputes there is also, increasingly, the likelihood the clinician's moral beliefs are not shared by the community participants. An irreligious clinician may not allow for parents of a multiply-handicapped child, who have a belief in an afterlife as a good place, deciding that going into that afterlife may be a better choice that suffering here on earth.

Although medical education is the chosen focus of this thesis, the most appropriate facilitator of the dialogue may be a senior member of the nursing staff or an allied health worker, or a psychologist, social worker, or chaplain. From a pragmatic perspective, these professionals may have more skills in facilitating discourse than the clinician. Equally, a facilitator who is not the patient's usual doctor may be less-threatening to the values of the participants, perhaps because they may not themselves be categorised as the interventionist, the one who will be operating if that is the consensus decision, and who thus may be perceived as having something of a vested interest in an operative outcome. The self-reflective clinician, who has no temptation towards the epistemology of power, will willingly take a facilitatory role, without needing the label of "the facilitator". This is why, as alluded to in 1.4 Medical morality, this thesis may have application to educating these other professional groups, as well as medical clinicians.

Impartiality in the discourse is an important criterion. Speaking in the context of politics and political power, Thomas Nagel uses the term *epistemological restraint* – 'the distinction between what is needed to justify belief and what is needed to justify the employment of political power depends upon a higher standard of objectivity, which is ethically based'.[794] In the context of this thesis, the fact the speaker holds a belief cannot, of itself, justify its applicability to or acceptance by others. The basis for such restraint is the epistemic understanding that some things cannot be proven infallibly (while allowing that some things, after investigation and assessment, are a reasonable best belief). The clinician (or anyone else) has no inherent right to force their own beliefs upon others in the discourse. Acting under Rawls' veil of ignorance is not thought by this thesis to be apposite, because participant-held beliefs about the Goods of the patient should, properly, be articulated and subject to discourse. The deliberations themselves have a moral dimension; and appeal to the process (properly enacted) may itself be the final arbiter of morality. The articulated over-arching aim to maximise the Goods of the patient may be the impetus to a positive consensus to an action, or to allow participants to fail to reject an action. Re-visiting autonomy, as will be argued in 4.2.1 Autonomy, moral decisions should be predicated upon the actual reality of our situation. In clinical situations, the patient's desires or preferences are often a surreal montage assembled from medical

[794] Nagel (1987). Moral conflict and political legitimacy. Philosophy and Public Affairs 16(3): 229.

myths, images,[795] and personal desires (as well as those of their relatives). These preferences are but a part of their existence as an ill patient. The patient is entitled to a reasonable medical opinion, and that opinion is subject to critique – so implying legitimacy. Interestingly, clinical consultations using a professional interpreter have been found to be less often associated with reaching the preconditions for communicative action than when a family member is used to interpret.[796] Use of a family member as interpreter is traditionally avoided because of perceived privacy concerns, as well as potential bias or undue influence. Yet there is evidence that the lack of trust, time constraints, and exacerbation of power imbalance identified as being associated with a professional interpreter, are outweighed by the fact that family members are generally trusted by the patient, likely share the lifeworld experience of the patient, and tend to lessen the power differential between clinician and patient.

This thesis recognises that even with theoretical difficulties displaced to one side, there are complex processes at work in the dialogue consequent upon the human nature of the participants. These are further liable to engender an amount of tension within the process itself. The potential tension is greater, and the potential therefore to slip into strategic action, the more diverse are the personal beliefs of the participants. Mead, Habermas, and others, understand that 'taking the role of the other'[797] allows the process of mutual cooperation in the dialogue, to progress. Aside from relying upon a consensus rather than unanimity, another response is to make it explicitly clear that the clinician is not in an authority figure role - which is a central trigger for passive-aggressive types for example. The clinicians in the dialogue may usefully be made aware of quantitative research which shows that in multidisciplinary groups in Danish Hospitals, compared with nursing staff, physicians use more of the discussion time, use a more assertive style of argumentation, and the solutions chosen are usually first proposed by physicians.[798]

In clinical moral decision-making, time has already been mentioned in 3.5.2 Contemporary virtue ethics, as a necessary constraint. It can take time for the patient or his or her relatives to come to a full understanding of the medical condition and what its prognosis might be. Several dialogues may need to be scheduled in order to explain and re-explain the facts of the medical situation, initially focusing upon understanding rather than decision-making. Eventually however, a decision needs to

[795] Gillett and Amos 2014) Words are not just things, The New Zealand Bioethics Conference,
[796] Greenhalgh, Robb and Scambler (2006). Communicative and strategic action in interpreted consultations in primary health care: A Habermasian perspective. Social Science & Medicine 63(5): 1170-1187.
[797] Mead (1967). The social foundations and functions of thought and communication *Mind, Self, and Society: From the Standpoint of a Social Behaviourist* p.254.
[798] Holm, Gjersoe, Grode, Hartling, Ibsen and Marcussen (1996). Ethical reasoning in mixed nurse-physician groups. Journal of Medical Ethics 22(3): 168-173.

be made amongst possible treatment options. There may be changes in the clinical situation over time, requiring re-evaluation and prompting a further dialogue within the community. Consider a newborn with changes in the brain evident on imaging, whose prognosis takes time to become clear. In clinical scenarios there may well be a time-constraint upon the decision-making process itself, if not of hours, then conceivably of days.

From an epistemological perspective, Habermasian insights have application to decision-making in clinical situations by care-givers. This also has an important dimension of time - in the sense initiating a process of ethical reflection over time, rather than making a discrete and self-contained moral decision at a single point in time. Two illustrative case studies may explicate this. Consider an adult child who is with his father during the rehabilitation weeks and months after a cerebro-vascular accident (stroke).[799] The decision about whether to actively treat, for example, a pneumonic complication, depends upon the prior initiation of a process of data collection (empirical-analytic knowing), understanding the meaning of the facts collected (historical-hermeneutic knowing) and self-reflective critical reflection upon the progress the father is making in rehabilitation over time. The decision to be made about whether to initiate antibiotic treatment depends upon the insights the son has developed about his father's condition, his progress in rehabilitation, and how the father views his own situation. Attention to the *process* of moral decision-making, rather than looking to or expecting a substantive stand-alone moral framework, encourages the moral decision to be made that is best in the situation.

Recall that Habermas' principle of discourse theory of morality requires that participants accept the consequences which can be anticipated.[800] This may mean that the morally good decision may change over time, during the process of on-going dialogue. In a clinical setting, consider Jacques Lacan's concept of the 'quilting point' (from the French *point de capiton*, upholstery button). For Lacan, language is seen as an artefact for the communication and construction of the imaginary, collectively and individually. The imaginary is a shifting relationship to the actual or situational experience of a human being.[801] Based upon psychotic conversations, which move in and out of lucidity, at some stage the clinician and the patient understand the words - in language, there is room for slippage, momentarily secured at times and recognised as quilting points. The quilting point is explained by Grant Gillett as:

---

[799] Frank (2004). Ethics as process and practice. Internal Medicine Journal 34: 355.
[800] Habermas (1981, 1990). *Moral Consciousness and Communicative Action* p.65.
[801] Gillett 2013) The quilting point: Post-structuralist ethics, engaging with others, and vertical connections, Australian Association of Bioethics and Health Law Conference,

> a point at which a network of signifiers reflects and is in contact with the world in which we have our physical being … each person's speech is open to a number of interpretations unless a word/signifier uttered in a situation fixes the meaning of an utterance so that what is being signified becomes clear … [a]t this point a potentially amorphous or inherently ambiguous mass of thoughts is crystallized into a meaningful structure in which every element has a place given by its articulation within the whole.[802]

Now consider a teenager with large vestibular aqueduct syndrome - an ear condition characterised by progressive decrements in hearing in response to trivial head injuries. Additionally, he has Asperger syndrome, and speech and language delay. He has little useful hearing on one side, and fluctuations on the other side, but overall trending downwards in terms of hearing thresholds. He is a candidate for a cochlear implant into the poorer hearing ear. The young patient is concerned about the cosmetic appearance of the implant. He is slowly coming to accept that his deteriorating language skills are impacting negatively upon his school performance and upon his social interactions. His parents worry about the surgical risks. They worry as well about the effect of the hearing loss, which is becoming steadily, although only slowly, worse as he becomes older. The clinical team is aware of the risks and the cosmetic aspects for the child, but sees the hearing steadily deteriorating, with measurable speech and language parameters gradually falling behind age-appropriate response levels.

Eventually, there comes a point where there is an 'ah-ha' moment, which unambiguously, and strikingly, connects us with one another in context. At this moment, the patient realises that the cosmetic risks are of less concern than the hearing loss, the parents recognise that the surgical risks are of less concern than the hearing loss, and the clinical team reaches and understanding that the delay in speech and language, is significant enough to now justify cochlear implantation, aware of the concerns of the patient and the parents. Each member of the community striving to make the correct decision comes to the same realisation, from their unique perspectives but at the same time. Lacan's quilting point. The discourse which follows is then based upon these mutually-shared insights.

Beauchamp suggests six options for dealing constructively with moral disagreement, which may be usefully applied to the discourse.[803] 1) Specification is the process of narrowing a general norm, to the specific context at hand. General norms may be too indeterminate or too broad to be useful.

---

[802] Ibid.
[803] Beauchamp (2009). Moral foundations *Ethics and Epidemiology* pp.39-41.

Consider the general norm "Do not kill", which one party may hold steadfastly. This is usefully narrowed to the context of killing an attacking enemy in war, so that it can be allowed in this specific context. Or, in decisions about how much information to provide to potential operative candidates, the general norm might be either "provide all information, explicitly, regardless of how terrified the patient may become", or the equally unhelpful "provide no explanation so as not to worry the patient". Narrowing the general risks to those applicable to this patient, with these co-morbidities, at this stage of the disease, in the hands of this surgeon, at this hospital may resolve the dilemma. 2) Adopting a gate type of policy may be helpful when, for example, resources are very limited. This may be a set of medical criteria requiring that hearing loss must be bilateral (in both ears) and greater than 80%, before cochlear implantation may be considered as an option, by either the patient or the clinician. 3) Obtaining factual information about the disagreement may show that it is not a moral dilemma at all. 4) Providing definitional clarity means exploring just what each party means by terms which each feels have a common understanding. 5) Using examples and counter-examples to contextualise this particular dilemmatic situation, or to explain complex terms, may be useful or may hint at a fallacious argument. 6) Analysing arguments involves identifying thought processes and logical arguments which are culturally-based, based upon ignorance, or which are in fact illogical. Showing the incoherence of an argument may result in its resolution.

Another option is mediation. Referral to what might be termed a clinical ethics committee (to distinguish it from a research ethics committee) is another option.

> Discourse theory of morality sees ethical disputes as a "disruption of consensus" … [and] the task of ethics consultation is one of rebuilding consensus, by taking as many different perspectives into account as possible and, through an iterative process of consultation, ensuring that all parties agree … Discourse theory of morality rests on a belief in the moral power of communication and the validity of discourse and experience. In practice it provides an effective means of mediating between widely divergent perspectives to generate agreement.[804]

Pre-case conference dialogic discussion has been mentioned above as a means for providing factual information about the clinical condition. This may also be useful when opinions seem to vary widely – as a way of encouraging participants to consider the perspective of the other, and perhaps have

[804] Kerridge, Lowe and Stewart (2013). Problem solving in clinical ethics and law *Ethics and Law for the Health Professions* p.153.

the opportunity, after self-reflection and consideration of the patient's actual situation in the world, to moderate an extreme stance.

It remains to be said however, that there are at least four situations in which participants may exclude themselves from the dialogue.

The first situation is when disagreements are "deeply intractable moral disagreements", not in the sense that they adduce complex multi-factorial arguments, but in the sense that, what may be termed "the world view" (the entire approach to life) of one or more of the participants in the dialogue, are so far apart, that it will require a significant amount of rational argument to find a common ground to resolve the issue. Indeed, this may not be possible. For example, the argument by anti-vaccinators who feel that it is wrong to interfere with the natural history of disease and death, by preventing it. This belief is not possible to oppose by recourse to logic, or to any possible design of medical trial. In this situation, 'because one's concept of health is entwined with one's fundamental assumptions about reality, an attack upon a person's belief in unorthodox healing becomes a threat to his or her entire metaphysical outlook. Understandably, this will be resisted fervently'.[805] To generalise further, communicative action is only conceivable on a background of broad agreement concerning at least the basic features to be submitted to argumentation – 'it is impossible to problematize all factual or normative claims simultaneously'.[806]

The second situation is when there exists an abnormal psychology or unconscious pattern of faulty thinking, in either the clinician, or the patient or a relative, in the dialogue. An example would be an illness with no or little empathic awareness for the perspective of others; which may include, for example, sociopaths. This will likely de-rail the process. In this situation, it is not unreasonable to set limits to the obligation to respond to arguments. Members of the dialogue with cognitive impairment are a similar challenge. If affected by the outcome of the dialogue, then their contribution needs to be imputed wherever possible.

The third situation is when patients or their surrogates adopt either of the extreme stances of "only the patient or their surrogate can make the decision" or "only the doctor can decide". If they cannot be educated that they are entering into a mutually-consensual dialogue, then they have chosen to exclude themselves from the process of a meaningful dialogue. This situation is able to be recognized in certain cultural groups. In these groups the voice of a dominant single person, for example a matriarch-figure, is deferred-to by other members who have been invited to be part of a

[805] Beyerstein (2001). Alternative medicine and common errors of reasoning. Academic Medicine 76(3): 231.
[806] Cronin (1993). Translator's introduction *Justification and Application: Remarks on Discourse Ethics* p.xiv.

mutual dialogue, but who are reticent to oppose the dominant person. While it may be possible to educate the participants that each member of the dialogue has an equal co-responsibility to contribute the consensual decision, there is unlikely to be sufficient time, and nor might there be any willingness on the part of the participants. Indeed, attempting to break down a tradition which has served the members well for thousands of years is fraught with other risks.

The fourth situation is when members of the community entering into dialogue, "already know the answer" and are unwilling to listen to the other.

As a paradigm for moral decision-making in medicine, Habermas' Discourse theory of morality and communicative action theories have a great deal to offer. It may be that, in the clinical setting, a tendency towards strategic rather than communicative action based upon altruism, occurs by way of misunderstanding or ignorance rather than deliberate intent. It would seem an important pre-amble to a case-conference utilising these principles, to educate the patient and their relatives about the process to be followed. How much information the clinician should give depends upon how much information the patient wants, and their level of education and ability to understand. Questions should be determined by empathic connectivity amongst the participants in the dialogue. Thus educating clinicians about Discourse theory of morality and Communicative Action becomes even more important, both for clinicians themselves and for their patients. Habermas generalises this further, perhaps seeking a moral framework, when he writes:

> I never say that people *want* to act communicatively, but that they *have to*. When parents bring up their children, when the living appropriate the transmitted wisdom of preceding generations, when individuals and groups cooperate ... they all have to act communicatively. There are elementary social functions that can only be satisfied by means of communicative action.[807]

Argumentation, Habermas reportedly sees as 'islands in the sea of praxis', and posits that genuine communicative action 'however elusive ... is what we *should* be doing'.[808]Thus participants in the discourse achieve what Ian Kerridge, Michael Lowe, and Cameron Stewart describe as 'conclusions that are rigorous, valid, inclusive and morally defensible'.[809] They go on to posit that:

---

[807] Habermas (1991, 1994) The past as future; Interviewed by Michael Haller, Modern German Culture and Literature, xxvi, 185

[808] Outhwaite (1994). The theory of communicative action *Habermas: A Critical Introduction* p.112.

[809] Kerridge, Lowe and Stewart (2013). Problem solving in clinical ethics and law *Ethics and Law for the Health Professions* p.153.

> Regardless of the moral framework adopted, it would seem that many ethical "conflicts" will be able to be worked through by listening to the patient and to others involved in the case, by attention to basic and widely held values, by common sense and by adopting a position somewhat outside the hospital hierarchy.[810]

By 'outside the hospital hierarchy' they presumably mean striving towards power-neutrality in the discourse. In the view of this thesis, this represents the Habermasian paradigm in action.

Further, this thesis understands that the decisions reached, following a dialogue within the community affected, which is founded upon the principles of Discourse theory of morality and communicative action, will have normative force when consensually agreed-to by the participants. The "community affected" may be a single clinician and a single patient, or among a group of clinicians and a patient and their family, in outpatients, on a general ward, or in a specialised unit such as an ICU.

This thesis does not side-step recognition of the practical difficulties associated with a process which aims to achieve the best possible decision, amongst human beings discoursing under anxiety-inducing circumstances. It is, however, argued that practical difficulties notwithstanding, the process of dialogue and consensual decision-making, imparts normative force to the decision. By this it is meant that this process impels a motivation to act upon the decision. Closely allied to this, it also gives participants *permission* to act upon the decision. Consider the situation where, in order to save a life, a potentially heroic intervention is required. The decision reached by the community of those affected is to, on balance, not proceed with the potentially heroic intervention. Aware of the normative moral *oughtness* or *shouldness* inherent in the decision made this way, all the members of the community involved can, together, look towards palliation and allow life to end. As noted in discussion about baby 'H' above, this is very reassuring to family members who have been involved in the decision.

If not absolute truth, then this process seeks the best possible outcome in the circumstances. Aware of the divergent strands of contemporary society, where time allows, this thesis argues that it is the most apposite choice for moral decision-making in clinical situations,.

---

[810] Ibid.

### 7.4 Confounding factors in moral decision-making in medicine

Two further issues, which may confound, but certainly complicate, moral decision-making in clinical situations albeit when aware of the Habermasian paradigm, will now be discussed.

First, issues around *life, moral agency,* and *personhood* are fundamental moral philosophical predicates to decision-making in clinical situations. Second, moral decision-making can be confounded by psychological imperatives active in clinical situations. Awareness of these issues is therefore important to the education of clinicians.

#### 7.4.1 Philosophical aspects of personhood

Consideration of prenatal genetic screening, abortion, and test-tube embryos (amongst many others) has been termed 'biosocial ethics'.[811] These issues are generally addressed definitively by society as a whole, almost always with legislative sanctions. In practice, there is a certain ambiguity in consideration of these wider 'public' issues compared with individual 'private' doctor-patient clinical interactions.[812] For moral justification, the former generally encourages, and indeed requires, an explicit basis in rationality, and outside objective comment. While in the latter, decisions are seen as more personal, and generally not subject to outside analysis. Intuitively, however, the rigour of moral justification should not vary between the two contexts.

Life can be understood functioning at two levels. The first is biological or physiological life. This is 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.[813] 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. This may be conceptualised as loss of the essence of .life. Although the *quantity* of life one can enjoy is a factor amongst the multitude of factors to be heard, it is not the only one; and nor is it necessarily the most important one. Notions of the soul are left aside in discussing moral decision-making at the end-of-life.

James Walter asserts that:

---

[811] Muirhead (2011). When four principles are too many: bloodgate, integrity and an action-guiding model of ethical decision making in clinical practice. J Med Ethics 38: 195.
[812] Paola, Walker and Nixon (2010). *Medical Ethics and Humanities* p.4.
[813] McMahan (2003). Endings *The Ethics of Killing* p.423.

> [t]he moral obligation to treat or not treat patients is derived from the objective presence or absence of a valued property that gives worth and moral standing to the patient's life. When the properties that define humanhood are absent, the patient is not considered a moral subject who possesses any rights to healthcare.[814]

LK Radha Krishna notes as follows:

> [f]or many authors, it is consciousness that is seen to be the seat of personhood, thus its loss is seen to rob a patient of their moral and ethical worth, leaving them in a state that cannot ethically be differentiated from death.[815]

From the perspective of relatives and loved ones, assigning or denying *personhood* to a patient who is critically ill in the ICU would very likely be more emotionally distressing to them than considering and discussing the potential of their loved one for a meaningful future life. Nonetheless, from a philosophical perspective, the conception of personhood remains a fundamental predicate for consideration, and offers a potential way forward to guide end-of-life decision-making in the ICU.[816]

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',[817,818] 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 "human being" as ontologically discrete from "personhood". Rene Descartes' '*Cogito, ergo sum,* I think, therefore I am'[819] implies that "rationality" is the basis for personhood (especially in the Kantian sense of autonomy), a separable notion from that denoting a biological human being. This notion is also independent of being in-relationship with others. Under these criteria, certain members of the species, *homo sapiens*, can be denied personhood. These include anencephalics, infants, young children, the intellectually handicapped, those psychotic,

---

[814] Walter (2004). Life, Quality of *Encyclopedia of Bioethics* p.1391.
[815] Radha Krishna (2013). Accounting for personhood in palliative sedation: the Ring Theory of Personhood. Medical Humanities 40(1): 17-21.
[816] Walker and Lovat (2014). Concepts of personhood and autonomy as they apply to end-of-life decisions in intensive care. Medicine, Health Care and Philosophy In Press.
[817] Scanlon (1998). Wrongness and reasons *What We Owe To Each Other* p.185.
[818] Radha Krishna (2013). Accounting for personhood in palliative sedation: the Ring Theory of Personhood. Medical Humanities 40(1): 17-21.
[819] Descartes (2011). Of the principles of human knowledge *The Principles of Philosophy* p.18.

demented and those in a persistent coma.[820,821,822,823,824,825,826,827] In support of this view, Engelhardt argues that if the significantly neurologically or physically damaged human being no longer has the attributes listed above, centred on "rationality", then that human no longer enjoys a claim to personhood. They can no longer be regarded as possessing a meaningful life and so, in that sense, death will be merely about the termination of physiological life, the meaningful life connoted by personhood having already terminated. There is no longer any autonomy to affront.[828] In these circumstances and according to this understanding of life and death, there should no longer be the need for a philosophical dilemma about physiological death. A proper and full understanding of personhood, and the notion of autonomy that follows, renders the situation of end-of-life more complex than the above position appreciates.

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'.[829] In appreciating the flawed nature of Descartes' approach to rationality, two corollaries follow. The first is that, in this sense, we as persons are embodied. By this, we mean 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. As an embodied cultural creature, we rely on intersubjective bonds which follow from the phenomenological understanding of 'being in the world'.[830] We are embodied and 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.[831] 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',[832] and thus our identities exist within the context of relationships. Second, a mature understanding of self-awareness recognises an

[820] Gert (2004). Features of the moral system *Common Morality: Deciding What To Do* pp.26-27.
[821] Engelhardt (1996). The foundations of bioethics *The Foundations of Bioethics* pp.138-139.
[822] Fletcher (1998). Four indicators of humanhood - The enquiry matures *On Moral Medicine: Theological Perspectives in Medical Ethics* p.377.
[823] O'Donovan (idem Again: Who is a person p.381.
[824] DeGrazia (2006). On the question of personhood beyond *homo sapiens In Defence of Animals: The Second Wave* p.42.
[825] Warren (1973). On the moral and legal status of abortion. The Monist 57(1): 43-61.
[826] Ibid.
[827] Hellsten (2000). Towards an alternative approach to personhood in the end of life questions. Theoretical Medical Bioethics 21(6): 517.
[828] H. Tristram Engelhardt (1996). The context of health care: persons, possessions and states *The Foundations of Bioethics* p.139.
[829] Mathews (2012). Old age and dependency *Reconceiving Medical Ethics* pp.68-71.
[830] Svenaeus 2014) Phenomenology as a method within the realm of bioethics, The New Zealand Bioethics Conference,
[831] Gillett and Amos idem Words are not just things,
[832] Mathews (2012). Old age and dependency *Reconceiving Medical Ethics* p.70.

empathic relationship with both our self and with others. '[T]he Cartesian (and Kantian)[833] conception of a person, as a kind of disembodied … thinker and decision-maker'[834] 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'.[835] Merleau-Ponty (amongst other phenomenologists) points to an understanding of ourselves as embodied human beings – in order to perceive, we require our body and its senses, not only in an empirical sense, but in the sense of transcendence – which 'posits the body as the condition of possibility for perception'.[836] 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.[837] Douglas Hofstadter understands it as:

> …an epiphenomenon that results from a series of loops that links various parts of the person's brain; one person's brain with those of their significant others; the brain with the body; and the brain and body with the environment which includes all aspects of culture, beliefs and religion.[838]

This is a similar view to the 'situated embodied agent', embedded in a history and culture, described by Hughes.[839] These understandings allow us to re-visit our embodiment as human beings and necessarily recognise our place within a community of others.

There is also a temporal element to personhood. Ramachandran writes that self-consciousness itself has a sense of unity or coherence (despite a multiplicity of sensory impressions and beliefs) and of continuity over time - a linking of past, present, and future.[840] In this, he echoes Ricoeur who 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

---

[833] Kant (1788, 1952). The Critique of Pure Reason *The Critique of Pure Reason, The Critique of Practical Reason and other ethical treatises, The Critique of Judgement* pp.122-123.
[834] Mathews (2012). Old age and dependency *Reconceiving Medical Ethics* pp.68-71.
[835] Ibid.
[836] Carel (2011). Phenomenology and its application in medicine. Theoretical Medical Bioethics 32(1): 33-46.
[837] Kitwood (1997, 2001). On being a person *Dementia Reconsidered* p.8.
[838] Ward (2013, October 14). What happens to the 'self' in dementia: implications for the health care system, Clinical Unit in Ethics and Health Law seminar, University of Newcastle
[839] Hughes (2001). Views of the person with dementia. Journal of Medical Ethics 27(2): 86-91.
[840] http://www.edge.org/3rd_culture/ramachandran07/ramachandran07_index.html

between past, present, and future'.[841] Don Marquis has entered the debate by positing that what makes the taking of a life by a murderer wrong, is the effect on the victim in terms of their loss of future 'experiences, activities, projects, and enjoyments'[842] which are of value to them. This future-value loss is more morally reprehensible than the loss of biological life *per se*. At the same time it affirms a future-of-value as a *telos* of human life.

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 as to 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. While this thesis recognises that a fine line must be trodden in the process of interpreting dynamics within the relationship, especially family dynamics, we do agree that so long as those in relationship with the patient are committed to 'a collaborative arrangement that balances power relationships equitably, apparently diverging interests do not necessarily imply irresolvable conflicts or undue pressure.'[843]

Thus, we contend, based upon these relational conceptions of personhood and autonomy, as well as the Habermasian paradigm, 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. Ordinary Care and Extra-Ordinary Care distinctions, exposited in 3.3.2.iv Natural law theories, are viewed as having the most appeal as an aid to moral decision-making in the ICU because they allow for the wider considerations of personhood and autonomy for which we have argued. In this respect, Ordinary versus Extra-Ordinary Care distinctions are set in the context of the

[841] Mackenzie (2001). On bodily autonomy *Handbook of Phenomenology and Medicine* p.423.
[842] Marquis (1989). Why abortion is immoral. The Journal of Philosophy 86(4): 189.
[843] Ho (2008). Relational autonomy or undue pressure? Family's role in medical decision-making. Scandanavian Journal of Caring Sciences 22(1): 132.

individual, and, properly, also the context of relationships with family and community; as such, they aim to maximise the (several) Goods of the patient who is critically-ill in ICU. The dialogue which follows, which is aimed at elucidating the particular context of the particular patient in question at the stage of this patient's end-of-life, is, properly, characterized by being inclusive, non-coercive and reflective. The Habermasian paradigm of discourse theory of morality and communicative action authenticates the patient's personhood and, in the view of this thesis, strengthens the patient's autonomy. It strengthens the patient's autonomy in that the discourse clarifies for the patient (and family), who the patient is, in terms of life experiences, family relationships, and the concrete reality of her present situation. Thus the patient (and the family) is better able to decide what to do.

This approach is also reflected in what has been termed a "process-centred logic", to be distinguished from an "outcome-centred logic".[844] This thesis sees advantages in making it clear to all participating that such a dialogue should be an essential part of the care that the patient receives at the end-of-life stage. Because of time-factors inimical to ICU, identifying those in relationship, and articulating the process of dialogue, is an important consideration soon after admission into ICU.

Another factor potentially impacting upon moral decision-making in ICU is evidence of *consciousness.* With its connotation of awareness, consciousness traditionally leans clinicians towards preservation of life. Yet, suffering is more likely in the conscious patient than in the unconscious patient. In a provocative review, Guy Kahane and Julian Savulescu question whether, in fact, the presence of consciousness should lean decision-makers *away* from the preservation of life.[845] The 'Vegetative State' (VS) characterises brainstem recovery from neurological insult wherein ventilatory and sleep-cycle functions are maintained, but higher level cognition and consciousness, in the generally-accepted sense, are not maintained. When following a coma, this condition is also termed Post-Coma Unresponsiveness (PCU). A less-severe state, wherein variable levels of consciousness are maintained, is termed the 'Minimally Conscious State' (MCS) (also termed Minimally Responsive State, MRS). Loss of brainstem function, via loss of the reticular activating system, is generally held to preclude consciousness/awareness. Hence, brain death is a criterion for organ harvest and other end of life decisions rather than cessation of cardiac or respiratory function.

[844] Stonington (2013). The debt of life - Thai lessons on a process-oriented ethical logic. New England Journal of Medicine 369(17): 345-349.
[845] Guy Kahane and Savulescu (2009). Brain damage and the moral significance of consciousness. Journal of Medicine and Philosophy 34.

The question that Kahane and Savulescu ask was hinted at in comparing the VS and the MCS state in children.[846] Both are unable to perform any of the activities of daily living and are completely dependent upon others. They are distinguishable however in that MCS children have some degree of consciousness. Thus, they have the potential to suffer physically and psychologically from their situation. Hence, 'one can make a stronger argument for withdrawing treatment in patients who are in a permanent MCS compared with those in a permanent VS'.[847] Another example is the patient who is 'locked-in' following neurological insult. This might be because of a significant cerebral event (cerebromedullospinal disconnection or ventral pontine syndrome), or might be seen in a fracture of the base of skull injury resulting in quadriplegia with bilateral facial nerve paralysis and foramen jugulare syndrome (of paralysis to cranial nerves X, XI and XII). Both will be fully conscious and aware and cognisant of their situation but unable to communicate with the world in any way beyond, except perhaps by blinking. It may be argued that 'such a life is even less worth living than in the MCS'.[848]

Existential distress or existential pain refers to persistent non-physical distress, or suffering, following upon the patient's conscious awareness that they have lost their normal life, and their normal relationships, *inter alia*. It may be just as real for the patient as physical pain, but harder to relieve pharmacologically. It is only possible if there is a level of consciousness sufficient to feel angst. The moral significance of being conscious but with significant physical or neurological impairment, because of the potential to experience suffering, should perhaps lead care-givers away from acting to preserve biological life. At best, the moral significance of consciousness is unclear.

### 7.4.2 The 'rule of rescue' and insights from neurobiological studies

A recently published vignette[849] sets the scenario that the respondent is the admitting clinician for ICU. There is only one available bed remaining when the Emergency Department rings requesting admission for two patients, both of whom require full cardio-respiratory support. One is a severely ill patient with disseminated malignancy, with only a small chance of meaningful recovery (5% chance of ICU discharge), and a prognosis for survival from his oncologist of one more year. The other is a similar-aged patient declared brain dead from anoxic brain injury willing to donate his otherwise

[846] Stephen Ashwal and Cranford (2002). The minimally conscious state in children. Seminars in Paediatric Neurology 9(1).
[847] Ibid. 28
[848] Guy Kahane and Savulescu (2009). Brain damage and the moral significance of consciousness. Journal of Medicine and Philosophy 34: 20.
[849] Kohn, Rubenfeld, Levy, Ubel and Halpern (2011). Rule of rescue or the good of the many? An analysis of physicians' and nurses' preferences for allocating ICU beds. Intensive Care Med 37(7): 1210-1217.

healthy organs, with these organs providing an extra 15 years of life to their recipients. Poor weather prevented transfer to another Unit, there was no possibility of an extra bed becoming available in ICU, and ventilation was not possible anywhere outside of ICU. The choice of 46% of clinicians was to allocate the last bed in ICU to the severely ill patient with disseminated malignancy and poor meaningful survival chances, over the brain-dead patient willing to donate organs to others. This is illustrative of 'Rule of Rescue' behaviour which confounds moral decision-making.

The Rule of Rescue may be paraphrased as 'the imperative to rescue identifiable individuals facing avoidable death, without giving too much thought to the opportunity cost of doing so'.[850] The Rule is disinterested in whether the condition threatening the identifiable individual is self-inflicted, whether intervention will result in a life worth living, or whether intervention is cost-effective. It seems to have two components – the immediacy of the imperilled life in front of us, and the faceless, nameless, others who may be the opportunity cost of saving that life.

As originally described in 1986, it follows on from the insight that while those who allocate scarce health resources may not have read the writings of Bentham or Mill, when they try to balance cost with benefit in the assessment of new and often expensive technology, they are being Utilitarians in practice.[851] In the context however of the Rule of Rescue, on face value they are being unsuccessful Utilitarians. It would be far cheaper and hence of far greater benefit to the majority to allow patients who develop cardiomyopathy to die rather than to develop an artificial heart with which to implant them. But proponents come up against the imperative of the Rule of Rescue wherein with a tangible identifiable life in front of us in imminent danger of potentially avoidable death, there is an overwhelmingly strong compulsion (whether it be psychological, or deontological duty for the sake of duty, is considered shortly) to save that life, regardless of the consequences in terms of cost; or risk to the rescuers. Thus we dispatch Navy personnel to risk their lives to rescue round-the-world sailors in heavy seas, we dig for miners trapped in a collapsed mineshaft, and we rush into burning buildings to save a life. The life immediately in front of us is more important than any other considerations, including cost, but also the risk to large numbers of rescuers.

In a non-clinical context, Peter Singer quotes the example of a small child who falls into a pond I am walking past, and to be rescued needs me to wade in, wet and dirty my shoes and trousers, and so miss my lecture[852] or be late for work.[853] This decision could also be put in terms of cost. My shoes

[850] McKie and Richardson (2003). The Rule of Rescue. Social Science & Medicine 56(12): 2407.
[851] Jonsen (1986). Bentham in a box: technology assessment and health care allocation. Law Med Health Care 14(3-4): 172-174.
[852] Singer (2010). Rich and Poor *Ethics: the Essential Writings* p.517.

cost several hundred dollars. Are my shoes worth the life of a small child? Obviously they are not. The morally good choice is to wade into the pond and save the child despite the damage to the shoes. Hauser proposes a similar example where an injured bleeding child would stain my car's leather upholstery if I stop for the child.[854] Singer writes 'if it is in our power to prevent something very bad happening, without thereby sacrificing anything of comparable moral significance, we ought to do it'.[855] The same several hundred dollars could be used to immunise dozens of unknown children in a far-away country. The moral choice should be similar (shoes/leather or save life), but is not seen to be so by many. The unknown faceless children in an unknown country far away are not seen in the same moral headlights as the child right in front of us. In a clinical context, as an example, consider whooping cough immunisations. In this case, a small amount of pain for an older child or adult can help a large number of vulnerable children avoid a serious disease. For babies, whooping cough is potentially fatal. However they are too young to be immunized against whooping cough. For adults and older children it is a relatively benign condition. So, if older children undergo a relatively small discomfort (ie. experience the pain of an injection) and are immunised, then other babies, who have no choice in the matter, albeit unknown to the older children, will be protected.

John McKie and Jeff Richardson argue that there is also a legal precedent to, for example, a special duty of care by mining companies to launch rescue missions to save trapped workers.[856] They point out too that it is difficult to imagine a mining company successfully explaining to the public that the cost of a life-saving attempt (to the corporation) was much greater than the potential benefits of life-saving (to the worker or their families), so the rescue was not attempted.

Rather than being a moral imperative, the Rule of Rescue is more likely to be a psychological proclivity, perhaps more accurately termed the 'Identifiable Victim Effect'.[857] A psychological imperative is not something we *ought* or *should* do in order to be morally good, but is an emotional tendency which can be hard for individuals to resist. The moral imperative is prescriptive, the psychological imperative is descriptive.

Following the Rule of Rescue as a moral imperative will have significant felicific utility attached, associated with actually caring for an individual in danger but also knowing that society supports the

---

[853] Singer (2009). *The Life You Can Save: Acting Now to End World Poverty* p.3.
[854] Hauser (2006). What's wrong *Moral Minds: How Nature Designed Our Universal Sense of Right and Wrong* p.9.
[855] Singer (2010). Rich and Poor *Ethics: the Essential Writings* p.517.
[856] McKie and Richardson (2003). The Rule of Rescue. Social Science & Medicine 56(12): 2408.
[857] Jenni and Loewenstein (1997). Explaining the Identifiable Victim Effect. Journal of Risk and Uncertainty 14(3): 235-257.

choice that helps contribute to a better, more caring, society. However, as an appeal to Utilitarian impartial egalitarian distribution of resources, it fails because it violates the assumption of 'distributive neutrality' – added value is apportioned to rescuing *this* identifiable person[858]; which under a rationally egalitarian approach to distributive justice, is unjust when compared to anonymous persons who may well be worse off. While it is conceivable that there may be morally-relevant reasons for discrimination (paraplegics being able to use a lift to ascend to the cafeteria rather than use the stairs), simply being 'identified' is not a morally relevant criterion for discrimination. Rawls' 'veil of ignorance' underlining 'justice as fairness' decries identifying individuals.[859]

Mark Sheehan evaluates the Rule of Rescue by re-visiting obligations as either Agent-neutral or Agent-relative.[860] Agent-relative obligations are relative to the relationship the agent has with the person (for example, a patient already known), or are dependent upon the position the agent is in and the skill-set extant in the context or circumstances at the time (for example, being trained to resuscitate). In a hierarchy of duties, agent-relative obligations *may* take priority over agent-neutral obligations, and in the context of the Rule of Rescue *may* mean that the agent-neutral obligation to do the most good for the greatest number with limited resources is over-ridden by the agent-relative obligation to save an identifiable individual. Nonetheless, even if the Rule of Rescue is itself a moral principle, in the clinical context the duties in question are very likely to include a mix of both agent-relative and agent-neutral obligations.

There is a significant weight of evidence that the Rule of Rescue is a strong psychological imperative. 'There is a fact about the human psyche that will inevitably trump the utilitarian rationality that is implicit in cost-effectiveness analysis: people cannot stand idly by when an identified person's life is visibly threatened if rescue measures are available'.[861] McKie and Richardson explain that often Rule of Rescue situations are associated with shock and horror, with high emotions rapidly unfolding in the beholder as the desperate plight of doomed miners or lone yachtspersons are revealed.[862] As a psychological imperative, it confounds attempts by the Proportionist approach to balance rules with consequences.

---

[858] McKie and Richardson (2003). The Rule of Rescue. Social Science & Medicine 56(12): 2409.
[859] Rawls (1971, 1971). *A Theory of Justice (Original Edition)* p.12.
[860] Sheehan (2007). Resources and the Rule of Rescue. Journal of Applied Philosophy 24(4): 352-366.
[861] Hadorn (1991). Setting health care priorities in Oregon. Journal of the American Medical Association 265(17): 2219.
[862] McKie and Richardson (2003). The Rule of Rescue. Social Science & Medicine 56(12): 2409.

Also of relevance is information about moral decision-making at a neurobiological level using neuro-imaging studies (for example, functional Magnetic Resonance Imaging, fMRI). Results show that for internally guided decision-making (that is, moral decision-making) the pathway or network of ventro-medial pre-frontal cortex – pregenual anterior cingulate cortex – posterior cingulate cortex – superior temporal gyrus, was activated consistently, and is postulated to be the default network.[863,864] As noted in 3.4.2 Contemporary Teleology, Greene and colleagues distinguished between 'personal' and 'impersonal' moral decisions.[865] A moral decision is personal if it is likely to cause serious bodily harm to a particular person. It can be simplified to Me-Hurt-You – an identifiable person, in a potentially physically harmful situation, addresses me personally. Greene reported his group's fMRI studies and found that evaluating personal moral dilemmas produced increased activity in areas associated with emotional processing, compared with evaluating impersonal moral dilemmas; and that emotional processing overwhelms cognitive decision-making. Situations which act to trigger specific emotions, for example compassion or sympathy or a long-term relationship with a patient, may act even more strongly to overwhelm cognitive decision-making.

These studies lend support to the 'dual process theory' or the 'process dissociation approach' to the moral psychology of decision-making. They posit that both 'top–down reasoning processes of a more cognitive nature and bottom–up emotionally triggered processes interact in moral judgment formation',[866] either cooperatively or competitively. A conscious cognitive and rational system evaluates facts and adduces a teleological response (favouring the many over the few), and is activated when there is reduced personal or emotional involvement with the moral decision-making process. An autonomic affective emotion processing system adduces a deontological response (acting according to perceived rules and duties), and is activated when there is greater emotional involvement in the moral decision-making process.[867] Stress also contributes - a study of 65 volunteers randomised into a stressed group (confirmed by salivary cortisol levels) and a non-stressed group, and then offered a series of dilemmas (non-moral, impersonal moral, and personal

[863] Moll, Krueger, Zahl, Pardini, Oliveira-Souza and Grafman (2006). Human fronto-mesolimbic networks guide decisions about charitable donation. Proceedings of the National Academy of Science 103(42).
[864] Nakao, Ohira and Northoff (2012). Distinction between externally vs. internally guided decision-making: operational differejnces, meta-analytical comparisions and their theoretical implications. Frontiers in Neuroscience 6(31).
[865] Greene, Sommerville, Nystrom, Darley and Cohen (2001). An fMRI investigation of emotional engagement in moral judgement. Science 293(5537): 2105-2108.
[866] Christensen Julia F and Antoni (2012). Moral dilemmas in cognitive neuroscience of moral decision-making: A principled review. Neuroscience and Biobehavioral Reviews 36: 1262.
[867] Koven (2011). Specificity of meta-emotion effects on moral decision-making. Emotion 11(5): 1255-1261.

moral) demonstrated a negative correlation between stress and utilitarian responses to personal moral dilemmas, and also between female gender and utilitarian responses.[868]

In summary, a moral dilemma initially adduces a quick, intuitive, emotional response. This is subsequently re-evaluated cognitively, more slowly and deliberately. The initial intuitive response favours a deontological judgement. The subsequent cognitive re-evaluation favours a teleological judgement. This re-evaluation is undermined by conditions of time-shortage, operant stress conditions, and sleep-deprivation. Very often decisions in clinical settings are made with a background of stress for the clinician, perhaps exacerbated by the considerable stress of the patient or family, and very often with a critical time constraint and relative sleep-deprivation. Additionally, clinical situations may be seen as personal rather than impersonal moral situations, thus further tending towards deontological decision-making, and away from teleological decision-making. In making moral decisions in clinical situations, the influence of emotion, stress and time likely vary in a systematic way.

This knowledge is important in educating clinicians about what factors may be confounding their decisions-making processes.

**7.5 Summary**

After offering an example of how the Habermasian paradigm may be applied in practice, criticisms of this approach have been considered from a practical perspective. Consideration needs to be given to the underlying epistemological basis, concepts of unanimity, acquiescence and consensus, and approaches to resolve disagreements - while also recognising the plurality of ethical opinions. Practical difficulties in achieving the ideal dialogue notwithstanding, this thesis argues that the process described here has both applicability and great merit for moral decision-making in clinical contexts. Nonetheless, certain confounding factors remain.

[868] Youssef, Dookeeram, Basdeo, Francis, Doman, Mamed, Maloo, Degannes, Dobo, Ditshotlo and Legall (2012). Stress alters personal moral decision making. Psychoneuroendocrinology 37(4): 491-498.

## CHAPTER 8 PRAXIS

### 8.1 Introduction

It is clear that clinical medicine is at least a technical science, aimed at a technically good outcome for the patient, using what technology is currently available to achieve that outcome. Two important points need to be made at this point. First, to limit clinical medicine to technical excellence alone is to miss the ineluctable intertwining of the technical aspects of being a physician with the moral motivation to be a *good* physician. As discussed in 3.5.2 Contemporary virtue ethics, the *telos* of medicine should be towards the Good of the patient. This is driven by empathic compassionate caring. Second, Habermas' three "ways" of knowing implies that science should be a method of open enquiry able to be critically reflective about its own assumptions and hidden values.[869] This is seen by this thesis as being fundamental to the epistemology of medicine and medical education.

Exploration of the ways in which clinicians may make moral decisions, suggests that current approaches have shortcomings in clinical settings in our current era. This is partly because of biomedical advances in our current era, and partly because of the value pluralism which is a characteristic of our current era. This realisation of shortcomings prompts consideration of other approaches. The approach favoured in this thesis is that of the Proportionist approach. This is put into practical application using Habermas' principles of Discourse theory of morality and communicative action. Before a change to the undergraduate medical curricula will be considered, there needs to be an awareness that the clinical paradigm for making moral decisions in clinical encounters needs to be re-evaluated. Only then will there be an impetus for educational re-alignment. As well, Habermas' third "way" of knowing, critical reflective self-knowing, is necessary. This allows *praxis* to occur. It also fosters life-long self-reflective practice, as well as continuing education. One of the identifying characteristics of medicine and its allied areas is an acknowledged implicit desire to teach, in a non-adversarial, collegiate way. This is also codified in the Hippocratic Oath, this, the origin of 'doctor' from *docere* (from the Latin, *to teach*).

### 8.2 Rationale for practical action

The monograph of the United Nations Educational, Scientific and Cultural Organisation (UNESCO) *Intersectoral Strategy on Philosophy* recommends that philosophy be a component of all educational curricula. This is partly because it develops 'capacities for independent thought and judgement, by enhancing critical skills to understand and question the world and its challenges, and by fostering

[869] Laura and Chapman (2009). *The Paradigm Shift in Health* p.xii.

reflection on values and principles'.[870] UNESCO's monograph *Philosophy: A School of Freedom* posits that philosophy teaches critical reasoning 'through reflection … a matter not just of knowing, but of understanding … of developing a critical mind'.[871]

For Aristotle, 'all forms of education are explicitly or implicitly directed towards a human ideal … education is essential for the complete self-realization of man … Ethics and education merge into the one'.[872] He also prescribed that education should be a life-long process – 'they must, even when they are grown up, practise and be habituated to them … to cover the whole of life'.[873]

As has been iterated, the *telos* of medicine is directed towards the good of the patient. *Good* in terms of the four Goods of the patient articulated by Pellegrino, as exposited in 3.5.2 Contemporary virtue ethics, and expressed as empathic compassionate caring. Thus clinical decision-making cannot be separated from moral decision-making. Put another way, good clinical judgements are moral judgements.

Two thoughts follow. First, good judgement in clinical settings is likely to be at least a partial manifestation of 'good judgement' in a more general, broader, sense.[874] Decisions in the sense here of judgements (as distinct from pragmatic decisions whether to have tea with milk or lemon) are normative. That is, they have a relationship with *should* and *ought*. They can be evaluated as good or bad, in this context or situation. Second, while the foundations are laid in undergraduate courses, good clinical judgement (as also 'good judgement' in the broader sense) continues to mature with experience, with time being-in-the-world, with practice. The key to experiential gain is necessarily seated in critical thinking and self-reflection.

Critical thinking has been defined as helping to decompose a situation 'into its most simple expression, in order to reflect upon their multiple meanings, underlying intentions and primary stakes',[875] based upon rigorous logic and methodology. Hence, skills in both critical thinking and self-reflection must be a vital and integral part of medical undergraduate curricula. Aristotle maintained that youth and the inexperienced cannot have moral insight.[876] In his assessment, moral judgement comes from considering moral issues and entering into a dialogue with morally-competent

[870] UNESCO,(2005) Intersectoral Strategy on Philosophy, Sector Paris
[871] Matsuura 2007) Philosophy: A School of Freedom (Teaching Philosophy and Learning to Philosophize. Status and prospects). Preface: viii
[872] Hummel (1993). Aristotole. Prospects: The Quarterly Review of Comparative Education 23(1/2): 40.
[873] Aristotle (c340 BC, 1952). Nicomachean Ethics *The Works of Aristotle Volume II* p.434.
[874] Hughes and Ramplin (2012). Clinical and ethical judgement *Reconceiving Medical Ethics* pp.220, 223.
[875] UNESCO,(2007) Philosophy: A School of Freedom (Teaching Philosophy and Learning to Philosophize. Status and prospects). Paris, France Annex 3, 247
[876] Aristotle (c340 BC, 1952). Nicomachean Ethics *The Works of Aristotle Volume II* p.348.

educators, and then reflecting upon the discussion to confirm or deny the calibration of the moral compass with which the medical student arrives on campus. The intimate coincidence of clinical decision-making with moral philosophical decision-making should be articulated to commencing students on day one of their course.

Once these two understandings, namely that clinical encounters are moral encounters, and that self-reflection is critical, are reached by senior medical educators, then curriculum change which fosters moral philosophical development paralleling the acquisition of factual knowledge and physical skills, will necessarily follow. Both clinical decision-making and moral decision-making will be acquired simultaneously, at increasing levels of sophistication, as the undergraduate course progresses. This should continue throughout the clinician's career. Perhaps also, questions aimed at assessing the 'good judgement' of medical school applicants could become more commonplace in selecting candidates entering medical school, in order that they might be better educated as clinicians.

Karl Marx wrote that philosophers need to go beyond merely interpreting the world, and actually change it.[877] As Onora O'Neill writes, philosophy helps to explain the realities of our world when it encourages clear thinking about mutually incompatible aims or goals or standards, which governments or institutions may aspire towards.[878] Philosophers, if they are to change the world, need to engage with others in order to foster greater understanding of moral issues and normative reasoning. In 1.1 The purview of moral philosophy, reference was made to Wittgenstein's (amongst others) understanding that philosophy aims at the logical clarification of thoughts, and as such is an activity rather than a body of doctrine.[879] Mark Addis agrees that most aspects of the human condition benefit from the 'persistent questioning, assumption-testing and rational analysis which characterise philosophy as an activity'.[880] Although speaking of mass education, Gordon Tait's insights could equally well be applied to medical education. He writes:

> '[i]f the intention is to look … with a fresh pair of eyes, then philosophy can provide the necessary critical skills to do precisely that. As a discipline based upon clear thinking and cogent argument philosophy is useful not only for the production of thoughtful future citizens, it is also a valuable skill set for anyone interested in studying our education system.[881]

[877] Marx (1845, 1998). *The German Ideology* p.571.
[878] O'Neill (2013). Interpreting the world, changing the world. Philosophy Now March-April(95): 9.
[879] Wittgenstein (1918, 2011). *Tractatus Logico-Philosophicus* p.34.
[880] Addis (2013). Philosophy in the workplace. Philosophy Now March-April(95): 10.
[881] Tait (2013). Philosophy and mass education *Making Sense of Mass Education* p.205.

He may agree that in the morally complex domain wherein are positioned both Medicine and Education, philosophical study can help address the issues and assist in seeking after truth. This approach of moral understanding, education, and normative reasoning, is viewed by this thesis as profoundly useful to modern medicine.

As the exposition of philosophy, though of undoubted intellectual and moral benefit, struggles to find a place in the education curriculum, so it struggles to find a place in the medical curriculum. From a purely practical perspective, educating medical students in the benefits of self-reflection might help to reduce burnout rates in clinicians, especially in high-stress areas like ICU. It makes sense that the need to replace burnt out clinicians incurs significant costs, not the least of which are financial.[882] It has been argued that senior clinicians need to become 'effective teachers and mentors in our training programmes, both at the undergraduate and postgraduate levels.'[883] This should properly encompass moral competence as well as therapeutic competence.[884]

**8.3 Theoretical implications for medical education**

Despite significant pressures towards a more secular, industrialised, mechanistically reductivist and outcome-driven methodology of clinical practice, modern medical education should rightly aim to embody a holistic approach to health. It is difficult to conceive of the practice of empathic medicine on a background of a paradigm of scientific mechano-reductivism. Hence, an understanding of epistemology is an important pre-requisite. Another important pre-requisite is that clinicians allow themselves to attend to the suffering of the patient (as 'the other') through being curious about the meaning of their suffering and, in turn, practising in a way which is fundamentally reflective.

As has been reiterated, morality (in the understanding of the word exposited in 1.2 *Ethics* or *morals*?), is integral to clinical practice – not something to be 'applied' intermittently, but fundamental to each doctor-patient clinical contact. Knowledge of, and hence teaching of, moral decision-making is fundamental to good clinical practice. Although algorithms, clinical pathways, best practice guidelines, and the like, can be applied to many clinical scenarios, they should not limit the clinical judgement clinicians make about how best to maximise the good in a specific clinical situation. Best Practice Guidelines offer guidance. Good judgement goes beyond mere rules, and

[882] Waldman, Kelly and Smith (2004). The shocking cost of turnover in health care. Health Care Management Review 29(1): 2-7.
[883] Papadimos, Manos and Murray (2013). An extrapolation of Foucault's *Technologies of the Self* to effect positive transformation in the intensivist as teacher and mentor. Philosophy, Ethics, and Humanities in Medicine 8: 1.
[884] Ibid. 7

balances those rules with the consequences which will follow, given the unique context of the individual patient. As noted in 3.5.2 Contemporary virtue ethics, although rules to justify tonsillectomy, on empirical grounds, on the basis of a certain number of episodes per year, other considerations should be considered in the final judgement. For example, time off school for the child or time off work for the parents, allergies to antibiotics, amongst other situational factors which necessarily, and perhaps uniquely, impact upon the consequences of on-going episodes of tonsillitis in this individual child in this family. Medical students need to be made aware that, properly, clinical history-taking needs to actively explore the consequences for the child and family. A balanced 'totality of judgements is required'.[885]

From an historical perspective, classical epoch theorists influenced educational pedagogies in an enduring way. Plato argued that knowledge is a 'fixed unchanging commodity' and thus under this pedagogy, teaching is a 'process of prescribing and imposing the set knowledge', with 'teacher-set, specific objectives, a concentration on content and an emphasis on standardised testing and measurement of performance'.[886] Protagoras argued that knowledge is a 'dynamic, ever-changing commodity' and thus under this pedagogy, teaching is a 'process of facilitating, assisting pupils to explore, enquire and experience', where 'objectives are flexibly set … leading to independent learning'.[887] Mark Holochak identifies the educative model of the stoics as featuring 'self-knowing, the need for logic and critical thinking for informed decision-making, [and] learning as preparation for life'.[888] He draws upon Martha Nussbaum[889] to describe this pedagogy (which he labels *stoic cosmopolitanism)* as embodying the examined life (critical reflection), inter-subjective connectedness, being able to put oneself in the shoes of the other, and he combines this with respect for scientific understanding and the seeking of practical wisdom.[890] Aristotle argued that virtue is like any skill, in that it can be learned, and it requires regular practice in order to perfect it. '[A]cting ethically and/or becoming virtuous is the result of experience, time, effort and habituation'.[891] Rote copying of any skill (for example, electrical wiring) is insufficient without understanding. An experienced teacher is required to explain the rationale for wiring this building

[885] Wittgenstein (1969. 1975). *On Certainty (Parallel Text)* pp.145,210.
[886] Lovat and Smith (2003). Curriculum and philosophy *Curriculum: Action on Reflection* p.78.
[887] Ibid. 78-79
[888] Holowchak (2009). Education as training for life: Stoic teachers as physicians of the soul. Educational Philosophy and Theory 41(2): 167.
[889] Nussbaum (1997). Socratic self-examination *Cultivating Humanity: A Classical Defence of Reform in Liberal Education* pp.15-49.
[890] Holowchak (2009). Education as training for life: Stoic teachers as physicians of the soul. Educational Philosophy and Theory 41(2): 168.
[891] Zeiler (2012). Bringing the lived body to medical ethics education: Learning to see the suffering other *Reconceiving Medical Ethics* p.46.

this way. The student understands and reflects upon the rationale for this wiring pattern in this building, and can apply it to similar but different situations. During the apprenticeship period, the student and teacher dialogue about why this or that pattern of wiring was chosen. Some 'degree of articulacy'[892] of both teacher and student is required in order to teach and learn any skill, including the skill of virtue. 'The learner in virtue, like the learner in a practical skill, needs to understand what she is doing, to achieve the ability to do it for herself, and to do it in a way that improves as she meets challenges, rather than coming out with predictable repetition'.[893] Thus, a clearly-articulated understanding of the substantive normative and theistic frameworks and the process for moral decision-making is fundamental for teachers of medical morality in order to educate their students in how to be *good* doctors. This requires time. The required time is ideally spread over the whole undergraduate curriculum, and then reflected upon throughout medical practice. Thus, clinicians develop in a way which makes them 'flexibly responsive to a range of different challenges and situations'.[894]

Habermas also informs deliberations in education pedagogies. Regardless of the subject being studied, we need, by virtue of our human cognitive nature, to collect the data or facts about the matter (empirical-analytic knowing). We need to come to understand the connections amongst the facts, including any prior beliefs and heritage impacting on meaning (historical-hermeneutic knowing). Then, impelled by our drive to be autonomous and emancipated, we need to critically reflect upon the facts and their meanings in the context of our own self, the one who is aiming to know (self-reflective, critical knowing). It is this self-knowledge which brings about *praxis* - practical action for change.

As an example, a conference or published paper gives the clinician the opportunity to hear a factual presentation (empirical-analytic knowing), to relate that new information or evidence to our existing knowledge and practice, aware of our own outcomes from our current practice (historical-hermeneutic knowing), and then impelled by our drive to emancipation, to reflect upon the evidence and decide whether to incorporate it into our future practice (self-reflective, critical knowing). Then, if so, the clinician should act as an agent of change by teaching junior clinicians that the new technique is more appropriate in their clinical practice as well.

---

[892] Annas (2011). *Intelligent Virtue* p.19.
[893] Ibid. 20
[894] Ibid. 27

Habermas' third way of knowing is most appropriate for developing life-long learning habits. This in turn leads to 'engagement in metacognitive processes (ie thinking about one's own thinking)',[895] and to self-interrogation, itself leading to active learning, and with particular reference to philosophy or critical reasoning, is a means of improving a thinker's internal consistency of beliefs, opinions, and attitudes.[896] Being aware of unexamined or uncritically accepted beliefs and biases is a necessary adjunct to moral decision-making in clinical situations.

The virtues-as-skills approach argues that virtue can be learned in the same way that any other practical skill can be learned.[897] Echoing Aristotle, this is based upon habituation, via repetition, together with education, time and effort. Exposure to potentially morally dilemmatic clinical situations allows the teacher to point out the salient issues and suggest responses which, with practice, are recognised and incorporated by the student into the self. Thus, the skill of moral discernment is acquired by the student. Just as an aesthetic plastic surgeon may, after years of active learning, "see" the potential reconstruction of cosmetic deformities, so will a virtuous clinician "see" the moral situation and potential actions available.

Hubert and Stuart Dreyfus propose an ethics-as-skill model in five stages.[898] The novice is taught to note specific meaningful aspects of a dilemmatic situation. With experience, the advanced beginner learns to recognise these aspects herself. With further experience, a competent learner recognises and examines a subset of features, of particular relevance to this particular dilemmatic situation, seeking principles which can be acted-upon. A proficient and then expert student has reflected upon previous experience, and thus their response arises intuitively, based upon similarities with previously encountered situations. In this understanding, an appropriately calibrated moral compass in clinical medicine depends initially upon explanation and clarification of the relevant moral issues by teachers, then practice, and then experiential reflection upon the outcomes of their deliberations.

Inherently, medical education about morality 'is about making explicit that which is implicit'.[899] Medical education is considered here in a broad sense – including undergraduate curricula, post-

---

[895] Joyce Hendricks, Deborah Mooney and Berry (1996). A practical strategy approach to use of reflective practice in critical care nursing. Intensive and Critical Care Nursing 12: 97.
[896] Stokes (2012). Philosophy has consequences! Developing metacognition and active learning in the ethics classroom. Teaching Philosophy 35(2): 146.
[897] Zeiler (2012). Bringing the lived body to medical ethics education: Learning to see the suffering other *Reconceiving Medical Ethics* pp.46-53.
[898] Dreyfus and Dreyfus (2004). The ethical implications of the five-stage skill acquistion model. Bulletin of Science, Technology & Society 24: 251-264.
[899] Hugman (2005). Key debates about ethics *New Approaches in Ethics for the Caring Professions* p.29.

graduate ward and operating theatre experience, and post-Fellowship practice at a mature level. Laura points to the loss of inter-connectedness amongst humanity from the perspectives of health and health education,[900] but also from the perspectives of education in the wider sphere, our technological, and our natural environments.[901] Both clinical doctor-patient interactions and doctor-student educative interactions involve asymmetries of knowledge between the doctor and the patient or student. As already alluded to, Laura articulates that knowledge on the part of doctor and medical educator should lead to empathy. However, in his assessment of contemporary educative paradigms, via prioritising predictability, knowledge asymmetries lead to an epistemology of power and control. In turn, this leads to dominance of clinician over patient, of teacher over student, and hence subjugation of one to the other.[902] Aiming, instead, to empower the patient and student, leads to an empathic epistemology 'reconceptualizing knowledge as connectivity expressed empathetically'.[903] This, in turn, fosters participatory consciousness, and in both teachers and learners, fosters self-reflection.

In 1.1 The purview of moral philosophy, reference was made to an holistic understanding which locates morality as concerning *all* that which matters, with no distinctions between ethical or moral, and other practical considerations. Laura may agree that his expositions encompass what may be understood as a holistic moral ontology. Medical education, as part of its own epistemology, prioritises empirical facts over non-empirical values. While facts are clearly important, this thesis argues that more balance needs to be found, so increasing the import of medical morality both in undergraduate curricula and in post-graduate clinical experience. Insights drawn from the paradigms of Laura, of Habermas, and of Lovat inform this re-balancing.

At the medical undergraduate level, the goals of education in ethics have been said to 'include the development of professional virtues and skills so that students emerge as thoughtful and reflective ethical practitioners'.[904] Because this aspect of medical education has been deemed 'integral to all clinical encounters and public health interventions, and ... is essential for students to become virtuous doctors', both the United Kingdom General Medical Council and the British Medical Association have declared that medical ethics is a core content of medical learning, to be integrated

[900] Laura and Chapman (2009). *The Paradigm Shift in Health* pp.vii-xxiii.
[901] Laura, Tim Marchant and Smith (2008). Technological connections: are you too plugged in? *The New Social Disease: from high tech depersonalisation to survival of the soul* pp.15-22.
[902] Laura and Chapman (2009). The theory of transformative subjugation and understanding its ramifications for integrated well-being *The Paradigm Shift in Health* pp.75-81.
[903] Laura, Tim Marchant and Smith (2008). Reconceptualizing knowledge as connectivity expressed empathetically *The New Social Disease: from High Tech Depersonalisation to Survival of the Soul* pp.149-154.
[904] Parker, Watts and Scicluna (2012). Clinical ethics ward rounds: building on the core curriculum. J Med Ethics 38(8): 501.

both vertically and horizontally throughout the undergraduate medical curriculum.[905] Similar statements have been made around the world, including in Australia.[906] Included in these statements are aims pointing towards equipping students for a lifetime of learning, critical or reflective thinking, academic rigour and shared obligations for teaching about ethics amongst all clinicians. Steven Miles and his colleagues posit that terms including 'medical ethics education' and 'clinical ethics' focus upon 'the clinical practice of ethically informed medicine' in the relationships of clinicians with patients, as well as with colleagues, other providers, and society.[907] This is derived from education about human values in general, grounded in the humanities and liberal arts.

The authors of the various position statements above might agree that medical ethics education aims to confirm in clinicians the human and ethical aspects of their vocation, to enable clinicians to reflect and re-reflect upon their own moral compass, to inform clinicians about their philosophical, social and legal responsibilities, and to enable and indeed empower clinicians to deploy their knowledge of moral reasoning in clinical encounters, thus to enhance patient care. They might also agree that medical ethics education cannot create a sound moral character in students where there is not at least an inchoate one. In our pluralistic, diverse, and indeed fragmented society, this should not lead to the prescription of a single moral viewpoint.

As has been iterated, the epistemic approach of Habermas directed towards ways of knowing is based upon patterns of human cognition: an 'empirical-analytic' way of knowing; an 'historical-hermeneutic' way of knowing; and a 'critical' or 'self-reflective' way of knowing. Lovat posits that all three ways of knowing are active both across and within different educative disciplines.[908] Yuri Koszarycz paraphrases these ways of knowing in the educational setting as technical, interpretive, and critical, respectively, and quotes Habermas, echoing Laura, as saying 'most education leads to submission and acceptance, whereas critical evaluation leads to liberation and change'.[909] In the view of Rhett Gayle, 'transfer of knowledge, conceived of as collections of facts and their relationships, as the central task of education inclines against teaching wisdom'.[910] Wisdom is not

[905] Stirrat (2010). Teaching and learning medical ethics and law in UK medical schools. Clinical Ethics 5: 156.
[906] Australian Commission on Safety and Quality in Health Care (2001). An ethics core curriculum for Australasian Medical schools. A position satement of the Association of teachers of Ethics and Law in Autralia and New Zealand Medical Schools. Medical Journal of Australia 175.
[907] Miles, Lane, Bickel, Waker and Cassel (1989). Medical ethics education: Coming of age. Academic Medicine 64(12): 705.
[908] Lovat (2013). Jurgen Habermas: education's reluctant hero *Social Theory and Educational Research: Understanding Foucault, Habermas, Bourdieu and Derrida* p.72.
[909] Koszarycz 1994) Constructive nurse education for critical reflectivity in ethical decision-making, Australian Association for Research in Education,
[910] Gayle (2011). Befriending Wisdom. Analytic Teaching and Philosophical Praxis 31(1): 70.

the same as knowledge. It cannot be taught, then tested, and then correct answers be rewarded, in the same pedagogy that knowledge in other fields can be taught, tested, and correct answers be rewarded.

Catherine Caldicott and Marion Danis argue that a 'more nuanced teaching about the ethics of the doctor-patient relationship might improve the way that medical students learn to engage with patients and manage their health issues'.[911] Undergraduate modelling of simple dichotomous choices without considering the context of the patient 'do not necessarily attend to the real needs, circumstances and human relationships manifested in these medical encounters',[912] because it fails to place the patient in their wider frame of family, work, and their fellow citizens. Essential to placing patients in their wider context is mutual discourse, and communicative rather than strategic action, as in the Habermasian paradigm. Importantly, this approach is likely to impel praxis in the patient to act in their own self-interest, given the situation of illness in which they find themselves. Although Kant is quoted as the basis for such an approach, Habermas offers a more complete and satisfying underpinning. Caldicott and Danis suggest that a taxonomy of cases is useful for role playing by medical students, grouped under issues of deception, patient-professional interactions, patient attitudes, patient behaviour, and preventative medicine, and suggest some specific lines of questioning to adopt. Again, however, the Habermasian paradigm seems more satisfying. The shared decision making model for the doctor-patient relationship focuses, pragmatically, via favouring specific phraseology, upon:

> *choice talk*, *option talk* and *decision talk*, where the clinician supports deliberation throughout the process ... *Choice talk* refers to the step of making sure that patients know that reasonable options are available. *Option talk* refers to providing more detailed information about options and *decision talk* refers to supporting the work of considering options and deciding what is best [original emphasis].[913]

Additionally, in order to be at the most appropriate place on the shared decision-making continuum, active listening skills are essential,[914] and are properly fundamental in medical undergraduate curricula. Some authors use the phrase *deliberation space* in this model, to

---

[911] Caldicott and Danis (2009). Medical ethics contributes to clinical management: teaching medical students to engage patients a moral agents. Medical Education 43(3): 284.
[912] Ibid.
[913] Elwyn, Frosch, Thomson, Joseph-Williams, Lloyd and Kinnersley (2012). Shared decision-making: A model for clinical practice. Journal of General Internal Medicine 27(10): 1363.
[914] Kon (2010). The shared decision-making continuum. Journal of the American Medical Association 304(8): 904.

encompass the process of considering information about options, potential outcomes, and their impact upon the patient in their existential context, in an iterative and recursive way.[915] This approach is very much in sympathy with the Proportionist approach and the Habermasian paradigm.

Aware of these insights, it is possible to borrow further from Lovat and from Laura to look anew at medical education.[916,917] A model of empirical-analytic teaching implies that knowledge is power, such that the teaching clinician is expert and the student significantly less so. The expert is custodian of the repository of knowledge to which the student aspires. It fosters a primarily didactic way of lecturing to the student. Examination determines the reproducibility of the knowledge the student has gained. This model can be completely appropriate when teaching a particular skill (for example venepuncture) where there is little to no need for understanding nuances of meaning, for students to offer their own interpretations of how to do it and where each unsuccessful attempt is increasingly painful for the patient.

A model of historical-hermeneutic teaching implies that the balance of knowledge is still with the teacher, but that some knowledge already resides within the student (from, for example, pre-reading). Knowledge needs to be explored in the contexts of meaning and understanding. There is some negotiation about understandings, extended and so to be made complete, by dialogue within a partnership of teacher and learner. Although a partnership, the teacher has more experience in understanding in the field at hand. Examination requires interaction between teacher and student in order to explore the extent of the student's understanding. It is apposite when there is no single correct answer, but a set of possible courses open. This is not uncommonly the case in clinical decision-making.

A model of self-reflective knowing impelling practical action is a development or synthesis from both of these models. In medical education, serious errors need to be corrected in a didactic way. Misunderstandings of meaning or culture can be explored with the teacher progressively divesting power to the student as learning progress is made. Thus, praxis is empowered within the student. Under this model, the student is self-motivated to learn. Examination requires that the teacher listen to what the student knows. The continuous process of learning through reflection, in an

[915] Elwyn, Frosch, Thomson, Joseph-Williams, Lloyd and Kinnersley (2012). Shared decision-making: A model for clinical practice. Journal of General Internal Medicine 27(10): 1365.
[916] Lovat (2013). Jurgen Habermas: education's reluctant hero *Social Theory and Educational Research: Understanding Foucault, Habermas, Bourdieu and Derrida* pp.74-75.
[917] Lovat (2004). 'Ways of knowing' in doctoral examination: how examiners position themselves in relation to the doctoral candidate. Australian Journal of Educational and Developmental Psychology 4: 148.

environment characterised by dialogue amongst experienced clinicians and students, wherein the senior clinician acts as a Socratic midwife,[918] encourages the student to deliver the answer. Annas may agree that this model 'enables the learner to come to be able to assess and criticize what he has been taught, and to be able to correct the teacher and the context and culture in which he has been taught'.[919] This is most likely to bring the medical student to the point of being an agent of change, pursing medical education (in its broadest sense) as a life-long occupation, and is fundamental to the paradigm of Habermas.

Reflection means reviewing events, both on their intellectual dimension and in their emotional dimension, in order to evaluate the event, and so learn from it. This process has been variously termed: 'retrospective thinking';[920] 'action learning';[921] 'critical reflection' - 'a total learning process that highlights a search for meaning, enlightenment … and emancipation,'[922] an 'active, persistent and careful consideration of any belief or supposed form of knowledge in the light of the grounds that support it and the further conclusions to which it tends';[923] and 'critical thinking' - 'reasonable reflective thinking that is focused on deciding what to believe or do' and is based upon an analysis of the important elements, aimed at 'deciding whether the conception is balanced, sufficiently specific, comprehensive, and relevant'[924] as a basis for making judgements. Jennifer Allen suggests that this brings us to:

> 1) become conscious, critique ourselves and others; 2) recognise how our interests and the interests of others influence how we perceive, act or think; and finally 3) to seek to and question the things "taken for granted" …[925]

UNESCO admonishes that '[i]t is up to individuals to search inside themselves for the capacities proper to exercising reflection'.[926] In order to better understand reflective thinking in medicine, Silvia Mamede and Henk Schmidt devised a five factor model of reflective practice. These factors were deliberate induction, deliberate deduction, testing and synthesising, openness for reflection, and meta-reasoning. These were tested via an 87 item structured questionnaire in a cohort of 202

---

[918] Plato (c390 BC, 1952). Theaetetus *The Dialogues of Plato, The Seventh Letter* p.516.
[919] Annas (2011). *Intelligent Virtue* p.25.
[920] Coz and Tassy (200'7). The philosophical moment of the medical decision: revisiting emotions felt, to improve ethics of future decisions. J Med Ethics 33(8): 470-472.
[921] Beaty and McGill (1992, 2013). What is action learning *Action Learning: A Practitioner's Guide* pp.11-28.
[922] Allen (1992). Reflection as critical to the teacher *Sociology for Teachers* p.261.
[923] Dewey (1933). What is thought *How We Think* p.8.
[924] Ennis (1991). Critical thinking: A streamlined conception. Teaching Philosophy 14(1): 5-6.
[925] Allen (1992). Reflection as critical to the teacher *Sociology for Teachers* p.263.
[926] Goucha,(2007) Philosophy: A School of Freedom (Teaching Philosophy and Learning to Philosophize. Status and prosepcts., Paris, France xvii

experienced primary care doctors.[927] They reported that their model allowed quantification of the tendency to reflective thinking by doctors in their cohort, and that the multidimensional structure of their model is important. They argued that better understanding of the thinking process is critical to its teachability.

Donald Schon argues for 'a new epistemology of practice'[928] – one which takes as its point of departure the competence already embedded in skilful professional practice. He especially points to 'reflection-in-action', which he characterises as 'thinking what they are doing as they are doing it'. 'Reflection-in-action' is understood by this thesis as that which experienced clinicians bring to clinical situations of uncertainty or conflicting information or values. Schon contrasts this approach with the privileged status given by universities to scientific knowledge, whereby they treat 'professional competence as the application of privileged knowledge to instrumental problems of practice'. Laura points out the proliferation of the appendage 'science' within university faculties and schools to, among others, engineering science, animal science, political science, behavioural science.[929] Schon defines *technical rationalism*, which he sees as a development from positivism, as characterised by practitioners who 'solve well-formed instrumental problems by applying theory and technique derived from systematic, preferably scientific knowledge'.[930] Incomplete information, conflicting information, and unique information, all elude capture by technical rationality. Yet these information-situations are not uncommon in clinical practice.

Schon articulates as the aim of his 'reflective practicum', first, to help students become more proficient in reflection-in-action, and second, to invoke dialogue between student and teacher (whom he terms a coach, helping students to see for themselves) which 'takes the form of reciprocal reflection-in-action'.[931] Reminiscent of Habermas' three ways of knowing as they apply to education, he lists the three models of coaching as 'follow me!', 'joint experimentation', and 'hall of mirrors'. Reflective practice for Schon involves 'knowing-in-action, reflection-in-action, and reflection on reflection-in-action'.[932] In his practicum, his setting for learning is either a simulation which closely resembles real world practice, or participating in a real world problem under close supervision.[933] In

[927] Mamede and Schmidt (2004). The structure of reflective practice in medicine. Medical Education 38(12): 1302-1308.
[928] Schon (1987). *Educating The Reflective Practitioner* p.xi.
[929] Laura and Chapman (2009). The philosophical principles of unfolding consciousness *The Paradigm Shift in Health* pp.160-161.
[930] Schon (1987). Preparing professionals for the demands of practice *Educating The Reflective Practitioner* pp.3-4.
[931] Schon (1987). *Educating The Reflective Practitioner* p.xii.
[932] Schon (1987). Preparing professionals for the demands of practice *Educating The Reflective Practitioner* p.1.
[933] Schon (1987). Teaching artistry through reflection in action *Educating The Reflective Practitioner* p.37.

teaching registrars how to operate, one apposite structure borrowed from reflective teaching[934] is to ask the registrar, after completing the operation, what s/he did well, did poorly, and might do differently next time. This prompts the student to reflect upon what s/he did, and encourages a life-long pattern of critical reflection upon operative steps in order to produce a better, albeit techno-medical, outcome. Schon points out that the student will do better in this practicum when fully able to partake in the dialogue. Koszarycz translates Plato's *Apology* (38a) as 'the unreflected life is not worth living' and then paraphrases this as 'the unreflected practice is not worth practising'.[935]

Foucault echoes Habermas when he writes that 'a certain structure of spirituality tries to link knowledge, the activity of knowing, and the conditions and the effects of this activity, to a transformation in the subject's being'.[936] This "self-transformation" however is not limited to the mature years of a clinician's practice. The importance of self-reflection should be taught early in medical school:

> These trainees are not just our moral responsibility; they are the future of the medical profession … [to] know ourselves better … and improve ourselves … help us carry on our important work in regard to the guidance, care, tutelage, and instillation of a moral conscience in our students in order to make them effective healers and purveyors of truth.[937]

The processes of Habermas' discourse theory of morality and of communicative action allow self-reflection upon the *meanings* we value for ourselves and for our patients. Reflective practice includes an awareness of values, and virtues. It is important to teach by modelling the technique to be used in clinical practice. Thus, medical educators, in all clinical teaching areas, should teach via dialogue and encouragement of reflection. Useful advice to establish boundaries for the reflective process in Critical Care Nursing are set out by Hendricks *et al*.[938]

In response to the suggestion that medical moral philosophy is either too hard or too theoretical for medical students, this thesis contends that it is absolutely necessary that clinicians-in-training are

---

[934] Lake and Ryan (2006). Planning a teaching session *Teaching on the Run* p.9.

[935] Koszarycz 1994) Constructive nurse education for critical reflectivity in ethical decision-making, Australian Association for Research in Education,

[936] Foucault (6 January 1982, 2005). 6 January 1982: Second hour *The Hermeneutics of the Subject: Lectures at the Collège de France, 1981–1982* p.28.

[937] Papadimos, Manos and Murray (2013). An extrapolation of Foucault's *Technologies of the Self* to effect positive transformation in the intensivist as teacher and mentor. Philosophy, Ethics, and Humanities in Medicine 8: 7.

[938] Hendricks, Mooney and Berry (1996). A practical strategy approach to use of reflective practice in critical care nursing. Intensive and critical care nursing 12: 99-101.

taught the value of a moral philosophy. *That the best Physician is also a Philosopher* is the title of a treatise attributed to Galen. As Paul Carrick wrote, 'given the gravity of the topics it involves, medical ethics is truly everybody's business'.[939] Carrick also wrote that, in Graeco-Roman times, there seems little doubt that, in the mind of the populous, philosophers held greater prestige than physicians - 'the philosopher was by far more generally esteemed ... the philosopher seeks to define what a life worth living is, and may prescribe rules of conduct for achieving it'.[940] In the same way that detailed understanding of pathophysiology makes decision-making in a complex clinical situation more likely to be correct, a sound understanding of the principles of moral decision-making 'provides a framework in which choices can be organised and evaluated logically, avoiding conclusions not justified by the evidence and decisions made on irrelevant grounds'.[941]

**8.4 Practical implications for medical education**

The New York School of Medicine includes a formal component of study termed "Medical Humanities". This is distinct from teaching interpersonal skills using behavioural methodology. Their Mission Statement includes the rationale that:

> The humanities and arts provide insight into the human condition, suffering, personhood, our responsibility to each other, and offer a historical perspective on medical practice. Attention to literature and the arts helps to develop and nurture skills of observation, analysis, empathy, and self-reflection -- skills that are essential for humane medical care. As a component of narrative medicine, it may also be used to help medical students 'reflect on suffering, death, disease, and healing'.[942] The social sciences help us to understand how bioscience and medicine take place within cultural and social contexts and how culture interacts with the individual experience of illness and the way medicine is practiced.[943]

AC Grayling defines philosophy as 'the continuous "preparation for life" that helps make life rich and good, or – when otherwise – courageous and noble'.[944] There are at least as many times in a clinician's professional practice when s/he meets patients and their families 'when otherwise'. The humanities contribute to both empathy, and resilience, in student clinicians.

---

[939] Carrick (1985). *Medical Ethics in Antiquity* p.xvii.
[940] Carrick (1985). *Medical Ethics in Antiquity* pp.11-12.
[941] Toon (1993). After bioethics and towards virtue? Journal of Medical Ethics 19(1): 17-18.
[942] Fiasse (2012). Ricoeur's medical ethics: the encounter between the physician and the patient *Reconceiving Medical Ethics* p.31.
[943] http://medhum.med.nyu.edu/ 6 October 2012
[944] Grayling (2006). *The Form of Things: Essays on Life, Ideas and Liberty in the Twenty-first Century* p.ix.

Not including a formal component of medical ethics or moral philosophy in undergraduate medical education teaches students that it is unimportant. David Seedhouse though has a serious issue with the subject called 'medical ethics' in medical education. In this, he may be echoing Gert's thought in 1.4 Medical morality that bioethics is not aimed at inventing a new ethical framework, or the holistic understanding that morality concerns *all* which matters. More strongly, however, Seedhouse, in a provocative paper,[945] argues that overcrowded medical undergraduate courses should not be further populated by yet another subject which, as it exists, is viewed as 'non-clinical' by students. His complaint echoes the proposition intrinsic to this thesis that every doctor-patient encounter, in that it involves one human being in contact with another human being, is a moral encounter. Thus, it should not be separated-out from general medical training. There may also be some possibility that claiming ownership of specific issues – stem-cell storage, abortion, euthanasia – limits its *prima facie* applicability to these specific issues only, rather than in fact being integral to every clinical encounter. He argues that lawyer educators and engineer educators have no purview to include their client's non-technical emotional, psychological, or spiritual issues. For medical educators, however, these concerns are both essential and universally applicable for their students. Other curriculum additions of, for example, bio-statistics or critical appraisal of the literature, are able to be called upon in specific clearly-defined situations. Moral interactions between clinician and patient are always present. A more apt title for such necessary teaching about moral interactions in the broadest sense may be to re-label those classes 'Critical Thinking' or indeed 'Medical Morality' in order to underscore their applicability to all clinical interactions; and to inspire students to understand that decision-making in medicine is both complex and rewarding. Adapting Habermas' tri-partite approach to medical education enhances the flexibility of future clinicians to adapt to different moral scenarios.

Debbie Plath differentiates four ways of teaching critical thinking: 'general' where critical thinking principles are taught in a separate instruction unit; 'infusion' where theories and values are explicitly taught prior to a case study problem; 'immersion' where theories and values are implicit in the case study problem to be solved by the group; and 'mixed' where the general approach is combined with either the infusion or immersion method.[946] The mixed approach seems generally to be favoured. Plath's group found that the scores of their students on tests designed to measure critical thinking improved after their final year course 'of explicit and concentrated instruction on critical thinking'.[947]

[945] Seedhouse (1991). Against medical ethics: A philosopher's view. Medical Education 25(4): 280-282.
[946] Plath, English, Connors and Beveridge (1999). Evaluating the outcomes of intensive critical thinking instruction for social work students. Social Work Education: The International Journal 18(2): 209-210.
[947] Ibid. 216

In order to encourage senior clinicians to become actively involved in self-reflection, and mentoring, it may be possible to tie academic promotions to participation in programmes fostering self-reflection, and mentoring of junior colleagues and medical students.

Beyond the educational aids available in any undergraduate curricula - large group lectures, small group tutorials, web-based interactive and non-interactive programmes, audio-visual aids, role-plays, essays, other media presentations, *et al*, additional medical ethical options include ward rounds, ethics rounds, grand rounds, volunteer patients, real patients, case-studies, Journal Clubs, or a re-design of a professional code of ethics,[948] narrative writing, and mentoring,[949] amongst others.

Lisa Parker *et al* established clinical ethics ward rounds, where students brought clinical dilemmas to a facilitated peer group review, in their Rural Clinical School based at the University of NSW.[950] Part of their aim was to counter what has been described as 'the hidden curriculum' - the 'tacit ways in which knowledge and behavior get constructed, outside the usual course materials and formally scheduled lessons', and which 'posits a network of assumptions that, when internalised by students, establishes the boundaries of legitimacy',[951] or 'the unintended outcomes of the schooling process … the messages that get transmitted to the students by the total physical and instructional environment, governance structures, teacher expectations, and grading procedures'.[952] This is one explanation proffered for the observation that medical student empathy progressively declines during a medical undergraduate's studies.[953,954] As a counterpoint, Susan Rosenthal *et al* have shown that exposure to their 'Humanism and Professional' course of reflecting upon their clerkship experiences, allowed maintenance of empathy as they measured it longitudinally,[955] and self-reported agreement with the statement "viewing things from a patient's perspective is not difficult" increased. Parker *et al*, also found that the students valued the learning experience, and showed statistically significant ($p<0.05$) improvement in the students' ability to contribute to ethics

[948] Hugman (2005). Discursive professional ethics *New Approaches in Ethics for the Caring Professions* p.162.
[949] Papadimos, Manos and Murray (2013). An extrapolation of Foucault's *Technologies of the Self* to effect positive transformation in the intensivist as teacher and mentor. Philosophy, Ethics, and Humanities in Medicine 8: 4.
[950] Parker, Watts and Scicluna (2012). Clinical ethics ward rounds: building on the core curriculum. J Med Ethics 38(8): 501-505.
[951] Apple (1975). The hidden curriculum and the nature of conflict *Curriculum Theorizing: The Reconceptualists* pp.95-119.
[952] McLaren (1994). Critical pedagogy: A look at the major concepts *Life in Schools* p.191.
[953] Hojat, Vergare, Maxwell, Brainard, Herrine, Isenberg, Veloski and Gonnella (2009). The devil is in the third year: A longitudinal study of erosion of empathy in medical school. Academic Medicine 84(9): 1182-1191.
[954] Newton, Barber, Clardy, Cleveland and O'Sullivan (2008). Is there a hardening of the heart during medical school? Idem 83(3): 244-249.
[955] Rosenthal, Howard, Schlussel, Herrigel, Smolarz, Gable, Vasquez, Grigo and Kaufman (2011). Humanism at heart: preserving empathy in third-year medical students. Idem 86: 350-358.

discussions; at the same time, there was no significant improvement in terms of helping patients make decisions, determining what action to take, or assisting them in feeling less powerless in clinical ethical situations.[956] Of concern to medical educators, however, it also found that undergraduates were generally not confident to raise moral issues with their clinical supervisors.

Fern Brunger and Pauline Duke, from the Montreal Medical School in Canada, have described a novel approach to integrating moral decision-making into their clinical skills curriculum in first year,[957] which this thesis sees as very attractive. They also foster the development of self-reflective thinking in their student cohort, cognisant of the "hidden curriculum". First, they changed their timetable so that moral philosophical aspects of medical decision-making were more closely tied to clinical skills teaching. The different modules of clinical skills teaching were followed the next day by discussion of moral decision-making as they applied to that module. This allowed seamless integration and underscored the fact this thesis is predicated upon, that each doctor-patient contact is a moral decision-making situation. Attendance at both streams was compulsory. Clinical skills modules examined during the first year include communication skills, patient centred care, continuity of care, head and neck examination, cardiovascular and respiratory system examination, writing medical histories, domestic violence, prescription drug abuse, prenatal diagnosis, substance abuse, poverty and health, and adolescent sexuality. Ethics modules covered include foundations of ethics, principles of ethics, consent, confidentiality, truth-telling, resource allocation, patient advocacy, and poverty and professionalism. Illustrative cases are offered around poverty and refugees - reflecting the author's concern to set medical decision-making in the context of their local community, itself characterised by increasing poverty and refugees as patients. As an example, the clinical module of Head and Neck examination may involve teaching the students how to examine the ear using an otoscope, the nose using a speculum or telescope, and the throat using tongue depressors, a mirror, and a telescope, and the neck by palpation. The use of investigations helpful in this region would be discussed. The next day the corresponding Head and Neck ethics module could consider a non-English speaking father with laryngeal cancer who continues to smoke, perhaps thus contributing to his own malignancy. His adult children do not wish the treating doctor to frighten the father by telling the father the truth about his diagnosis, and wish to choose the treatment options themselves. Prognosis for two year survival is very poor but total laryngectomy (leaving no voice and no swallowing) with gastrostomy (for feeding via the abdomen) and six weeks of radiotherapy, in a

[956] Parker, Watts and Scicluna (2012). Clinical ethics ward rounds: building on the core curriculum. J Med Ethics 38(8): 503.
[957] Fern Brunger and Duke (2012). The evolution of integration: Innovations in clinical skills and ethics in first year medicine. Medical Teacher 34: e452-458.

distant regional city, is the option the oldest child is leaning towards. The medical morality discussion is ideally facilitated by clinicians familiar both with the clinical aspects and investigations and potential morbidities, as well as the moral philosophical issues which are inherent in this scenario. Thus, each reinforces the other, as they must in practice if the *telos* of clinicians is to be the Good of the patient. Timetabling the discussions a day apart underlines their integration in the minds of the students.

Equally importantly in the view of this thesis, the Montreal undergraduate course also requires that the students journal their own reflections through their first year. This may be in the form of a narrative, a diary, an essay, a poem, a video, or other media. These reflections would be insights into themselves and their reactions to the different scenarios, as well as insights into their local community, which they may not have been aware of. The ethics component of the clinical skills course contributes twenty percent of the total score. This is insufficient to bring about an outright fail, but is sufficient to prompt serious consideration by students. The authors underline the need for a willingness to change scheduling to allow this degree of integration, and for clinicians to recognise its importance in the formation of young clinicians.

A tool used for teaching senior general practice registrars in the United Kingdom has been devised employing an 'ethical tree' with three branches labelled duty, consequence, and virtue. Each reflects one of the three major secular frameworks.[958] To this is added the 'ethical cycle' of identifying the dilemma, the facts, the values, and then proposing a sound argument. This approach has been seen by registrars as 'positive' in terms of exposure to various ethical approaches, to the language of moral philosophy, and to identify strategies to manage ethical dilemmas. In an evaluation of medical students' attitudes to medical ethics courses, it was found that student satisfaction with medical ethics teaching is proportional to how much teaching they receive, that input from both ethicists and clinicians is preferred, and that pre-clinical input should be continued into clinical settings.[959]

In hospitals, rather than "ethics committees" centred-upon approving research projects, a move towards "medical morality committees" could be initiated. As part of this, a moral philosopher could sit in the case conference to identify the moral issues and facilitate their resolution. At the same time this could be a useful forum to encourage and enhance self-reflection on the moral decision-making process amongst the participants.

---

[958] Knight (2007). Tools for teaching medical ethics to specialty registrars. Education for Primary Care 18(6): 749-753.

[959] Howe (1987). Medical students' evaluation of different levels of medical ethics teaching: implications for curricula. Medical Education 4(July).

Also at the post-graduate and post-Fellowship levels the formal contribution of medical organisations, for example the specialist medical and surgical societies, should supplement the self-reflection of individual clinicians. To paraphrase Lovat, thinking about senior advanced trainees being taught by experienced clinicians on the ward, it would likely be intolerable in an empirical-analytic model for the trainee to know more than the teacher, likely tolerable but unexpected in the historical-hermeneutic model, but a cause for celebration under the critical self-reflective model. At the post-Fellowship level, the Royal Australasian College of Surgeons audit of an aspect of surgical practice is an illustrative example to consider. This audit involves empirical-analytic data collection, historical-hermeneutic interrogation, and then self-reflection about what might have been learnt or what needs to change. This audit must be presented amongst a group of surgical peers in order that discourse ensues, thus impelling change. The discourse itself is protected by statutory privilege in order that meaningful and unencumbered dialogue can proceed.

**8.5 Summary**

If the shared decision-making model is the basis for the doctor-patient relationship, then clinicians in-training will need to be educated about moral and health values and how to explain and encourage patient's in their own understanding of these, without pejorative paternalism. The Habermasian paradigm provides a strong epistemological underpinning for this. Practical innovations for undergraduates include ethical ward rounds, integrating the teaching of clinical skills in regional modules, with discussion about moral decision-making in the same modules, and journaling as an aid to self-reflection. Post-graduate audits further encourage life-long self-reflective practice.

**CHAPTER 9 CONCLUSIONS**

This thesis began by postulating that the purview of moral philosophy encompassed two aims. The first was to address the question "how should I act?" This may now be more comprehensively articulated as, "how should we live, together?" The second was to emphasise critical thinking. This may now be more comprehensively articulated as, to emphasise reflective thinking.

In considering why society and individuals should privilege the importance of morality, of a systematic moral code, of clear notions of right and wrong, of prescriptions as to what should and should-not be done, and of reflective thinking upon our moral values, we can approach the question from the perspective of society as a whole (understood herein to reflect moral decisions), as well as from the perspective of the individual within society (understood herein to reflect ethical decisions). Cognisance of, and acquiescence with, a code of moral behaviour is necessary at a societal level for successful living together as groups of people. This is seen as a better alternative than living in Hobbes' state of nature, wherein life is 'solitary, poor, nasty, brutish, and short'.[960] It is also a better alternative to a totalitarian civil state wherein laws forcibly enforce all behaviour. At an individual level, it is necessary to so live in order to satisfy one's duty, to maximise our utility, to achieve *eudaimonia*, or to attain salvation.

Moral philosophy, unlike other more analytical branches of philosophy, is a very personal but very serious enquiry into how we should behave, how we should treat other humans, and what inner motivations best enhance our human dignity, as well as of those others with whom we co-exist and are necessarily in intersubjective relationship. In clinical contexts, this especially applies to our patients and their inter-relationship with us. In their daily clinical interactions with patients, clinicians deal with intensely personal and often serious situations. This thesis holds that it is perfectly reasonable to expect that clinicians approach moral decision-making situations with appropriate gravitas. It is founded upon the premise that, with rare exceptions, every clinical interaction has a moral philosophical dimension. This holistic approach suggests that part of the task of clinicians is, as a corollary, to support the wider moral community in its development.

As Wittgenstein asserted, 'philosophy unties knots in our thinking. Hence its results should be simple. But philosophising has to be as complicated as the knot it unties'.[961] As medical educators,

[960] Hobbes (1651, 1952). Leviathan *The Prince, Leviathan* p.85.
[961] Wittgenstein (1984, *A Wittgenstein primer* p.2.

our responsibilities are even greater. Intellectual knowledge alone is insufficient - 'the teacher has to be able to stand behind his words, to be present in his words'.[962]

This thesis has sought to interweave the threads of clinical medicine with those of moral philosophy. In making moral decisions, clinicians may draw upon the substantive normative frameworks, or a theistic framework, as the situation requires. Then, clinicians should look to a process for moral decision-making, a process based upon the Habermasian paradigm of his three "ways" of knowing, discourse theory of morality and communicative action. Pellegrino, having delineated the four Goods of the patient, has articulated that:

> Medicine is at heart a moral enterprise and those who practice it are de facto members of a moral community. We can accept or repudiate that fact, but we cannot ignore it or absolve ourselves of the moral consequences of our choice.[963]

Later, he wrote that 'Medicine qualifies as a de facto moral community not simply because its members are dedicated to a common purpose and a common set of ethical ideals but because those ideals are morally grounded'.[964] Fried writes that 'The doctor's interventions are placed in a special category just because he intervenes at a special point in the system which is the person. In illness, the patient himself, not just some extraneous interest, is threatened'.[965]

As has been argued in this thesis, discourse is predicated upon language. It is language which makes the moral concept transferable. The seeking of wisdom, as characteristic of moral philosophy (1.1 The purview of moral philosophy), and re-visited in the virtue ethics framework (3.5 Virtue ethics), is a necessary part of being a good doctor. It is wisdom not in the sense merely of a wise person saying clever things, or even being an expert in making moral judgements about the actions of others. Rather, it is wisdom in the more meaningful sense that 'in his presence and under his compassionate attention one is oneself more inclined to say wise things' – pointing to the importance of wisdom in achieving meaningful dialogue.[966] Wisdom, in the view of Gayle, may be characterised by four qualities: 1) an ability to discern appearance from reality; 2) an awareness of the limits of our own knowledge and understanding; 3) a desire for a good outcome; and 4) self-knowledge, with 'ongoing

---

[962] Cowley (2011). Moral philosophy and the 'real world'. Analytic Teaching and Philosophical Praxis 31(1): 24.; paraphrasing Gaita (2004). Moral understanding *Good and Evil: An Absolute Conception* p.272.
[963] Pellegrino (1990). The medical profession as a moral community. Bulletin of the New York Academy of Medicine 66(3): 222.
[964] Ibid. 226
[965] Fried (1974). Personal care: interests or rights *Medical Experimentation: Personal integrity and Social policy* p.96, ibid.
[966] Cowley (2011). Moral philosophy and the 'real world'. Analytic Teaching and Philosophical Praxis 31(1): 27.

transformative impact on the knower', described by him as the core of 'choosing well'.[967] This wisdom, this understanding, rather than merely knowing, segues into values, and hence morality, and is integral to decision-making in clinical contexts. Perhaps Laura's empathic epistemology summarises it best.

In discerning what is a morally Good choice for an individual, the substantive (in the sense of stand-alone) frameworks of deontology and teleology focus upon motivations to act. Although much has been argued about theories of right action, it is more fundamental and more important to a moral framework, to first *be Good*. At an individual level, being sensitive to the presence of a moral issue and then being able to follow the well-formed conscience of a virtue ethicist seeking preferentially after intrinsic goodness, seems intuitively richer and more appealing than either teleological or deontological frameworks. In addition, a virtue ethics framework 'assumes, in a way oddly absent from many modern theories, that ethical thought essentially includes an *aspiration* to be better than we are',[968] - 'in an ethic of virtue it matters what kind of person you are'.[969] In medicine, this is able to be characterised as empathic compassionate caring.

As iterated above, moral principles exist but their application in specific contexts will vary, and recognising a hierarchy of duties and consequences is a dynamic response to context. Hare argues for an awareness of moral decision making at two levels – the intuitive where lies one's personal historical-culturally influenced moral compass, and the critical from whence comes critical thought derived from reflection upon prior moral decisions. This means that moral decision-making refinement should be a fundamental tenet of medical education, as an active process.

As a framework for clinicians to make moral decisions, Lovat champions an interpretation of the writings of Habermas, leading to a moral philosophical paradigm formed as the Proportionist approach. It is derived as a synthesis of the classical Hellenistic lines originating in the writings of Plato and Protagoras, combining elements of deontology and teleology, and sharing much of the foundations of virtue ethics by way of Aristotle and Aquinas. It attempts to maintain the *eudaimonism* of both Aristotle and Thomist natural law but without the conjoined authoritarianism and legalism favoured by natural law moralists.[970] It is in favour of positive moral norms and ideals but without exceptionless prohibitions. Human flourishing is seen as the highest good and moral decisions are made on this basis, thus allowing for situational contexts to be considered. Both the

[967] Gayle idem Befriending Wisdom. 72.
[968] Annas (2006). Virtue Ethics *The Oxford Handbook of Ethical Theory* p.523.
[969] Ibid. 517
[970] Pope (2001). Natural law and Christian ethics *The Cambridge Companion to Christian Ethics* p.89.

scientific facts and pre-moral principles are conjoined in the moral decision-making process. 'It is in finding the balance between these two extremes [of fixed standards and empirical judgement] that "good, just and right" care will be exercised'.[971]

Tying together the threads of phenomenology and proportionism, Fried writes that a person:

> has a right when he is confronted by another in a concrete situation to demand that his particular situation be taken into account … the professional who undertakes to deal with a patient's serious illness by that undertaking is obliged not only to acknowledge but to respect, to make provisions for the peculiarities, the needs and values of that individual.[972]

Understanding that there is no independent right-making property of a moral decision, demands a balanced or Proportionist perspective.

As has been noted in Chapter 6, Habermas' Discourse Theory of Morality and Communicative Action, once we recognize that in making moral decisions, appeals relevant to earlier epochs – be that to gods, to God, or to rationalism - are no longer apposite, the basis for moral decision-making must look to a process, rather than to a substantive normative or theistic framework alone. To achieve normative force, a process of discourse communication must follow, wherein the participants in the dialogue are drawn from the community affected and follow principles of communicative action. That is, intersubjective consensus after dialogue. In the context of practical decision-making using the Habermasian paradigm of his discourse theory of morality and communicative action, participants in the discourse consider extant moral frameworks, and weigh them as appropriate to the situation and the community involved in the dialogue. 'Regardless of whether or not one accepts Habermas's [sic] theory, these claims appear intuitively correct, at least in the setting of the clinical dyad'.[973]

In a post-modern understanding of moral decision-making, the clinician appreciates the essential inter-relationship of persons, and that this is based upon language and meaning. A well-formed intuition considers contextual situations, evaluates them seeking reflective equilibrium, through communicative action with others in the moral situation, which then impels a decision. That decision has normative force because of the process by which it is made. The virtuous clinician takes

[971] Lovat and Gray (2008). Towards a proportionist social work ethics: A Habermasian perspective. British Journal of Social Work 38: 1103.
[972] Fried (1974). The practice of experimentation *Medical Experimentation: Personal integrity and Social policy* p.156.
[973] Kerridge, Lowe and Stewart (2013). Ethical theories and concepts *Ethics and Law for the Health Professions* p.34.

responsibility for the decision, in that they are able to articulate the basis for what is Good or Right or Just, in the situation. Additionally, recognising inter-subjective relationships, 'each clinician seeks moral responsibility in themselves and looks for it in others'.[974] Bauman agrees that in the post-modern era, it is only in the 'moral impulse'[975] of the clinician that morally good decisions will be made – and that this is best based in a virtue ethical framework, ideally a Proportionist ethic.

The foundations for an understanding of this moral decision-making process must be laid in medical school. In this setting, Laura's empathic connectivity is a necessary part of the student-teacher relationship. The Habermasian epistemology of knowing is directly applicable to the pedagogy of medical education. It is an appropriate entree into life-long self-reflective practice. As noted in 8.3 Theoretical implications for medical education, understanding oneself in this context necessarily impels *praxis*. Learning medical morality requires that the student clinician have the relevant moral issues explicated by teachers, then practiced, and finally, experiential reflection helps them to become intuitive. In the words of Kristin Zeiler, 'there is nothing mystical about this'.[976] Perhaps, indeed, the mystery is why it is not recognised more clearly in medical undergraduate courses.

In final summary, clinical encounters should be seen primarily as inter-relations between persons. Hence they are moral encounters and so should be firmly set upon the tapestry of two and a half thousand years of moral philosophical thought. Clinical encounters should be, implicitly, both cognisant of the other (intersubjectivity) and contextualised to the concrete realities of the patient's illness and total situation. The virtue ethical framework, itself derived epistemically, seeks to maximise the Good of the patient. For the clinician-as-Agent, this may be articulated as empathic compassionate caring. This active caring is put into practice in clinical settings via the Proportionist approach. This approach seeks to balance intrinsic *a priori* rules with empirical consequences. Especially in our current era, characterised by pronounced value pluralism, Habermas' discourse theory of morality (universalizable to all, all of whom accept the consequences) and the principles of communicative action (a cooperative search for truth) seek an inclusive, non-coercive and self-reflective consensual decision. Consensus after dialogue, the discourse theory of morality predicated upon communicative action, is required in this shared decision-making model, which aims, above all, to maximise the patient's Good. *Praxis* impels an emancipatory change in medical education towards

[974] Hugman (2005). Postmodernity and ethics beyond liberation *New Approaches in Ethics for the Caring Professions* p.112.
[975] Bauman (1993). *Postmodern Ethics* p.62.
[976] Zeiler (2012). Bringing the lived body to medical ethics education: Learning to see the suffering other *Reconceiving Medical Ethics* p.47.

facilitating an awareness of Habermas' three "ways" of knowing, the importance (and limitations) of discourse, and of life-long self-reflective clinical practice.

**REFERENCES**


Addis, Mark. (2013) Philosophy in the workplace. *Philosophy Now,* March-April (95): 10.

Agich, George. (2003) *Dependence and Autonomy in Old Age: An Ethical Framework for Long-term Care* (Cambridge: Cambridge University Press).

Agledahl, Kari Milch, Reidun Forde, & Age Wifstad. (2011) Choice is not the issue: The misrepresentation of healthcare in bioethical discourse. *Journal of Medical Ethics, 37*(4): 212-215.

Ajay Aggarwal, Joanna Davies, & Richard Sullivan. (2014) "Nudge" in the clinical consultation - an acceptable form of medical paternalism? *BMC Medical Ethics, 15*(31): 1-6.

aKempis, Thomas. (Harvard Classics, Vol 7 Part 2, *The Imitation of Christ* (MobiPocket The Portable Library).

Alighieri, Dante. (2005) (A. Esolen, Trans.) *Inferno* (New York: The Modern Library).

Allen, Jennifer. (1992) Reflection as critical to the teacher. T. J. Lovat (Ed.), *Sociology for Teachers* (Wentworth Falls: Social Science Press), 56-65.

American College of Surgeons. (2008, March 2004) Fellowship Pledge. Retrieved 28 April, 2014, from http://www.facs.org/fellows_info/statements/stonprin.html#fp.

Annas, Julia. (2006) Virtue Ethics. D. Copp (Ed.), *The Oxford Handbook of Ethical Theory* (Oxford: Oxford University Press), 515-536.

--------. (2011) *Intelligent Virtue* (Oxford: Oxford University Press).

Anscombe, Gertrude Elizabeth Margaret (1958) Modern moral philosophy. *Philosophy, 33*(124): 1-19. doi: 10.2307/3749051, http://www.jstor.org/stable/3749051.

Apel, Karl-Otto. (1976) The transcendental conception of language communication and the idea of a first philosophy. H. Parret (Ed.), *The History of Linguistic Thought and Contemporary Linguistics* (Berlin: DGruyter), 32-62.

--------. (Der Denkweg von Charles S. Peirce, 1981) (J. M. Krois, Trans.) *Charles S Peirce: From Pragmatism to Pragmaticism* (Amherst, Mass: University of Massachusetts Press).

--------. (1984) (G. Warnke, Trans.) *Understanding and Explanation: A Transcendental-Pragmatic perspective* (Cambridge, Massachusetts: MIT Press ).

Apple, Michael. (1975) The hidden curriculum and the nature of conflict. W. Pinar (Ed.), *Curriculum Theorizing: The Reconceptualists* (Berkely Ca: Mccutchan), 95-119.

Aquinas, Thomas. (1265-1274, 1947) *Summa Theologica.* Christian Classics Ethereal Library, *Treatise on the Cardinal Virtues* (pp. Question 64, Article 67) (Benziger Bros).

--------. (1265–1274, 1952) (Fathers of the English Dominican Province & D. J. Sullivan, Trans.) Summa Theologica. *Thomas Aquinas II* (first ed.). (Chicago: William Benton, Encyclopedia Britannica Inc).

Aristotle. (c340 BCE, 1952) (W. Ross, Trans.) Nicomachean Ethics. *The Works of Aristotle Volume II* (first ed.). (Chicago: William Benton, Encyclopedia Britannica Inc), 339-444.

--------. (c340 BCE, 1952) (W. Ross, Trans.) Politics. *The Works of Aristotle Volume II* (first ed.). (Chicago: William Benton, Encyclopedia Britannica Inc), 445-552.

Ashton, Carmel O, & Ronald S Laura. (2012) *Dimensions of Health: Educating for A Quantum Perspective* (CreateSpace Independent Publishing Platform).

Augustine, Saint. (413-426, 1952) (M. Dods, Trans.) The City of God. *The Confessions, The City of God, On Christian Doctrine* (first ed.). (Chicago: William Benton, Encyclopedia Britannica Inc), 129-618.

Australian Commission on Safety and Quality in Health Care. (2001) An ethics core curriculum for Australasian medical schools. A position satement of the Association of Teachers of Ethics and Law in Autralia and New Zealand Medical Schools. *Medical Journal of Australia, 175*: 205-210.

--------. (September 2011) *National Safety and Quality Health Services Standards*. Sydney.
Ayer, Alfred Jules. (1946, 1952) *Language, Truth and Logic* (2nd ed.) (New York: Dover).
Babor, Eddie R. (2006) Ethics: The philosophical discipline of action, Rex Bookstore Inc, https://books.google.com.au/books?id=qzETCc5fhkkC&printsec=frontcover#v=onepage&q&f=false.
Balousek, Darrin. (2014) Professional baseball and performance-enhancing drugs. *Philosophy Now, May-June* (102):12-15.
Baron, Marcia W. (1997) Introduction. M. W. Baron, P. Pettit & M. Slote (Eds.), *Three methods of ethics* (Massachusetts, Oxford: Blackell Publishers), 3-5.
Barton, Stephen. (2001) The Epistles and Christian Ethics. R. Gill (Ed.), *The Cambridge Companion to Christian Ethics* (Cambridge: Cambridge University Press), 63-73.
Bauman, Zygmunt. (1993) *Postmodern Ethics* (Oxford: Blackwell).
Beaty, Liz, & Ian McGill. (1992, 2013) What is action learning. *Action Learning: A Practitioner's Guide* (revised 2nd ed.). (Oxon: Routledge).
Beauchamp, Tom. (1994) The 'four-principles' approach. R. Gillon (Ed.), *Principles of Health Care Ethics* (Chichester: John Wiley and Sons), 3-12.
Beauchamp, Tom L. (2003) A defense of the common morality. *Kennedy Institute of Ethics Journal, 13*(3): 259-274. doi: http://www.ncbi.nlm.nih.gov/pubmed/14577460.
--------. (2009) Moral foundations Steven S Coughlin, Tom L Beauchamp & D. L. Weed (Eds.), *Ethics and Epidemiology* (2nd ed.). (Oxford: Oxford University Press).
Beauchamp, Tom L., & James Childress. (2009) *Principles of Biomedical Ethics* (6th ed.). (New York: Oxford University Press).
Beauvoir, Simone de. (2011) (Constance Borde & S. M. Chevallier, Trans.) Biological data. *The Second Sex* (New York: Random House).
Beebe, Gilbert W, & Michael E DeBakey. (1952) *Battle Casualites: Incidence, Mortality, and Logistic Considerations*. (Springfield Illinois: Charles C Thomas).
Beecher, Henry K. (1969) Scarce resources and medical advancement. *Daedalus, 98*(2): 275-313. doi: http://www.ncbi.nlm.nih.gov/pubmed/11609507.
Bennett, Jonathan. (1995, 1998) Arguing for making/allowing asymmetry. *The Act Itself*. (Oxford, Clarendon Press).
Bentham, Jeremy. (1789, 1988) *The Principles of Morals and Legislation* (New York: Prometheus Books).
Benveniste, Emile. (1966, 1971) (M. E. Meek, Trans.) *Problems in General Linguistics* (Coral Gables, Fla: University of Miami).
Berg, Jonathan. (1993) How Could Ethics Depend on Religion. P. Singer (Ed.), *A Companion to Ethics* (Malden MA: Blackwell), 525-533.
Berkeley, George. (1710, 1952) A treatise concerning the principles of human knowledge. *John Locke, George Berkeley, David Hume* (first ed.). (Chicago: William Benton, Encyclopedia Britannica Inc), 403-448.
Berman, Marshall. (1988) *All That Is Solid Melts Into Air* (New York: Viking Penguin).
Bernstein, Richard J. (1981) (J. M. Krois, Trans.) *Charle S Peirce: From Pragmatism to Pragmaticism* (Amherst: University of Massachusetts Press).
Bertens, Hans. (1995) *The Idea of the Postmodern: A History* (London and New York: Routledge).
Besio, Christina, & Andrea Pronzini. (2014) Morality, ethics, and values outside and inside organisations: An example of the discourse on climate change. *Journal of Business Ethics, 119*: 287-300.
Beyerstein, Barry. (2001) Alternative medicine and common errors of reasoning. *Academic Medicine, 76*(3): 230-237. doi: http://www.ncbi.nlm.nih.gov/pubmed/11242572.
Bishop, Jeffrey P. (2011) *The Anticipatory Corpse: Medicine, Power, and the Care of the Dying* (Notre Dame, Indiana: University of Notre Dame ).

Bluhm, William, & Robert Heineman. (2011) What is Prudent Pragmatism. *Philosophy Now, 87* (Nov/Dec): 31-33.

Blum, Lawrence A. (1994) *Moral Perception and Particularity* (Cambridge: Cambridge University Press).

Bowyer, Lynne. (2014) Autonomy and why you can "Never let me go". *Journal of Bioethical Inquiry, 11*(2): 139-149.

Brunger, Fern & Pauline S Duke. (2012) The evolution of integration: Innovations in clinical skills and ethics in first year medicine. *Medical Teacher, 34: e453-458*.

Brunner, Jerome. (1986) Two modes of thought. *Actual Minds, Possible Worlds* (Cambridge, MA: Harvard University Press).

Caldicott, Catherine V, & Marion Danis. (2009) Medical ethics contributes to clinical management: Teaching medical students to engage patients a moral agents. *Medical Education, 43*(3): 283-289. doi: 10.1111/j.1365-2923.2008.03277.x

Callahan, Daniel. (2003) Principilism and communitarianism. *Journal of Medical Ethics, 29*(5): 289.

---------. (2000) Stripping death bare: The recovery of nature. *The Troubled Dream of Life: In Search of a Peaceful Death* (Washington DC: Georgetown University Press), 57-90.

Calman, Kenneth C. (1984) Quality of life in cancer patients - an hypothesis. *Journal of Medical Ethics, 10*(3): 124-127. doi: http://www.ncbi.nlm.nih.gov/pubmed/6334159.

Campbell, Alastair V. (2012) The body: property, commodity, or gift. C. Cowley (Ed.), *Reconceiving Medical Ethics* (1 ed.). (London: Bloomsbury Academic), 15-29.

Candlin, Christopher, Yon Maley, & Heather Sutch. (1999) Industrial instability and the discourse of enterprise bargaining. S Sarangi & C. Roberts (Eds.), *Talk, Work and Institutional Order: Discourse in Medical, Mediation and Management Settings* (Berlin: Mouton De Gruyter).

Capron, Alexander Morgan. (1984, 2002) Forward. *The Silent World of Doctor and Patient* (Johns Hopkins Edition ed.). (Baltimore: Johns Hopkins University Press).

Caputo, John D. (1992) A phenomenology of moral sensibility. George F McLean & F. Ellrod (Eds.), *Philosophical Foundations for Moral Education and Character Development: Act and Agent* (2nd ed.). (Washington DC: The Council for Research in Values adn Philosophy).

Carel, Havi. (2011) Phenomenology and its application in medicine. *Theoretical Medical Bioethics, 32*(1): 33-46. doi: 10.1007/s11017-010-9161-x.

Carrick, Paul. (1985) *Medical Ethics in Antiquity* (Dordrecht: D. Reidel).

Casebeer, William D. (2003) Opinion: Moral cognition and its neural constituents. *Nature Reviews Neuroscience, 4*(10): 840-847. doi: 10.1038/nrn1223.

Cassin, Barbara, Marc Crepon, et al. (2014) Morals/Ethics. Dictionary of untranslatables: A philosophical lexicon. B. Cassin. (Princeton, Princeton University Press**:** 691-700).

Catholic Health Australia. (2001) *Code of Ethical Standards for Catholic Health and Aged Care Services in Australia*. Red Hill, ACT, Australia: Catholic Health Australia Inc Retrieved from http://www.cha.org.au/images/resources/Code%20of%20ethics-full%20copy.pdf

Caws, Peter. (1991) Committees and consensus. *The Journal of Medicine and Philosophy, 16*(4): 375-391. doi: http://www.ncbi.nlm.nih.gov/pubmed/1895023.

Cherry, Mark J, & Ana Smith Iltis. (2010) *At The Roots of Christian Bioethics: Critical Essays on the Thought of H. Tristam Engelhardt Jr* (Salem MA: M & M Scrivener Press).

Childress, James F. (1989) The normative principles of medical ethics. R. M. Veatch (Ed.), *Medical Ethics* (Boston: Jones and Bartlett Publishers), 27-48.

Christensen Julia F, & Antoni Gomila. (2012) Moral dilemmas in cognitive neuroscience of moral decision-making: A principled review. *Neuroscience and Biobehavioral Reviews, 36*: 1249-1264.

Cicero. (54 BCE, 1841) (F. Barham, Trans.) Treatise on the Laws *The Political Works of Marcus Tullius Cicero* (London: Edmund Spettigue).

--------. (54 BCE, 1841) (F. Barham, Trans.) Treatise on the Republic (Cicero's Commonwealth) *The Political Works of Marcus Tullius Cicero* (London: Edmund Spettigue).

Cicero, M Tullius. (44 BCE, 1991) *De Fato*, *On Fate*. R. Sharples (Ed.), (Warminister, England: Aris and Phillips Ltd), 52-92.

Clouser, K Danner, & Bernard Gert. (1990) A critique of principlism. *Journal of Medicine and Philosophy, 15*(2): 219-236. doi: http://www.ncbi.nlm.nih.gov/pubmed/2351895.

--------. (1994) Morality vs principlism R. Gillon & A. Lloyd (Eds.), *Principles of Health Care Ethics* (Chichester: John Wiley and Sons).

Comte-Sponville, André. (2001) (C. Temerson, Trans.) *A Small Treatise on The Great Virtues* (1st American ed.). (New York: Metropolitan Books).

Copp, David. (2006) Introduction. D. Copp (Ed.), *The Oxford Handbook of Ethical Theory* (Oxford: Oxford University Press), 3-35.

Cowley, Christopher. (2011) *Analytic Teaching and Philosophical Praxis, 31*(1): 21-30.

--------. (2012) Introduction. C. Cowley (Ed.), *Reconceiving Medcial Ethics* (London: Continuum International Publishing). 1-12.

Coz, Pierr Le, & Sebastien Tassy. (2007) The philosophical moment of the medical decision: Revisiting emotions felt, to improve ethics of future decisions. *Journal of Medical Ethics, 33*(8):470-472.

Crigger, Nancy. (1994) Universal prescriptivism: traditional moral decision-making theory revisited. *Journal of Advanced Nursing, 20*(3): 538-543. doi: http://www.ncbi.nlm.nih.gov/pubmed/7963062.

Cronin, Ciaran. (1993) (C. Cronin, Trans.) Translator's introduction. *Justification and Application: Remarks on Discourse Ethics* (Cambridge: Polity Press), xi-xxxi.

Crowder, George. (2003) *Pluralism, relativism and liberalism in Isaiah Berlin*. Paper presented at the Australasian Political Studies Association Conference, University of Tasmania.

Curran, Charles E. (1979) Moral theology, psychiatry and homosexuality *Transition and Tradition in Moral Theology* (London: University of Notre Dame Press).

d'Entreves, Maurizio Passerin. (1997) *Habermas and the Unfinished Project of Modernity: Critical Essays on 'The Philosophical Discourse of Modernity* Maurizio Passerin d'Entreves & S. Benhabib (Eds.), (Cambridge Massachusets: MIT Press).

Dare, Tim. (2014) *Intractable moral disagreements: what may we do?* Paper presented at the The New Zealand Bioethics Conference, Dunedin, Otago.

Davis, Nancy (Ann). (1993) Contemporary Deontology. P. Singer (Ed.), *A Companion to Ethics* (Malden MA: Blackwell), 205-218.

Deer, Brian. (2011) How the case against MMR vaccine was fixed. *British Medical Journal* (Jan 6):342. doi: http://dx.doi.org/10.1136/bmj.c5347.

DeGrazia, David. (2006) On the question of personhood beyond *homo sapiens* P. Singer (Ed.), *In Defence of Animals: The Second Wave* (Malden, MA: Blackwell Publishing), 40-53.

Deligiorgi, Katerina. (2012) *The Scope of Autonomy: Kant and the Morality of Freedom* (Oxford: Oxford University Press).

Derrida, Jacques. (1979) Living on. *Deconstruction and Criticism* (New York: Continuum: The Seabury Press).

Descartes, Rene. (2011) (J. Veitch, Trans.) Of the principles of human knowledge *The Principles of Philosophy* (Whitefish, Montana USA: Kessinger Publishing LLC (www.kessinger.net).

Dewey, John. (1933) What is thought. *How We Think* (DC Heath and company).

Dostoevsky, Fyodor Mikhailovich. (1879-1880, 1952) (C. Garnett, Trans.) The Brothers Karamazov. *Dostoevsky* (first ed.). (Chicago: William Benton, Encyclopedia Britannica Inc).

Douglas, Charles. (2009) End-of-life decisions and moral psychology: Killing, letting die, intention and foresight. *Bioethical Enquiry, 6*: 337-347. doi: 10.1007/s1 1673-009-9173-2.

Dreyfus, Hubert L. (1980) Holism and hermeneutics. *The Review of Metaphysics, 34*(1): 3-23.

Dreyfus, Hubert L, & Stuart E Dreyfus. (2004) The ethical implications of the five-stage skill acquistion model. *Bulletin of Science, Technology & Society, 24: 251-264*.

Dworkin, Ronald. (2000) *Sovereign Virtue* (Cambridge MA: Harvard University Press).

Edwards, Jonathan. (1960) *The Nature of True Virtue* (Michigan: University of Michigan Press).

Elwyn, Glyn, Dominick Frosch, Rhicard Thomson, MNatalie Joseph-Williams, Amy Lloyd, & Paul Kinnersley, et al. (2012) Shared decision-making: A model for clinical practice. *Journal of General Internal Medicine, 27*(10): 1361-1367. doi: 10.1007/s11606-012-2077-6.

Emanuel, Ezekiel J, & Linda L Emanuel. (1992) Four models of the physician-patient relationship. *Journal of the American Medical Association, 267*(16): 2221-2226. doi: http://www.ncbi.nlm.nih.gov/pubmed/1556799.

Engelhardt, H Tristram. (1986) *The Foundations of Bioethics* (1st ed.). (New York: Oxford University Press).

--------. (1996) *The Foundations of Bioethics* (2nd ed.). (New York: Oxford University Press).

Engels Frederich, Karl Marx. (1845, 1998) Theses on Feurbach. *The German Ideology* (New York: Prometheus Books).

England, Ruth, Tim England, & John Coggon. (2007) The ethical and legal implications of deactivating an implantable cardioverter-defibrillator in a patient with terminal cancer. *Journal of Medical Ethics, 33*(9): 538-40. doi: 10.1136/jme.2006.017657

Ennis, Robert. (1991) Critical thinking: A streamlined conception. *Teaching Philosophy, 14*(1): 5-24.

Fiasse, Gaelle. (2012) Ricoeur's medical ethics: the encounter between the physician and the patient. C. Cowley (Ed.), *Reconceiving Medical Ethics* (1 ed.). (London: Bloomsbury Academic), 30-42.

Fine, Paul EM. (1993) Herd immunity: History, theory, practice. *Epidemiologic Reviews, 15*(2): 265-302. doi: http://www.ncbi.nlm.nih.gov/pubmed/8174658.

Finnis, John. (1980) *Natural Law and Natural Rights* (2001 ed.). (Oxford: Oxford University Press).

Fleming, Daniel. (2013) Ethics in an optics: The Levinasian perspective on value as primary James Arthur & T. Lovat (Eds.), *The Routledge International Handbook of Education, Religion and Values* (London: Routledge), 362-372.

Fletcher, Joseph F. (1966) *Situation Ethics: the new morality* (London: SCM Press).

--------. (1972) Indicators of humanhood: A tentative profile of man. *Hastings Center Report, 2*(3): 1-4.

--------. (1998) Four indicators of humanhood - The enquiry matures. Stephen E Lammers & A. Verhey (Eds.), *On Moral Medicine: Theological Perspectives in Medical Ethics* (2nd ed.). (Grand Rapids, Michigan: William B Eerdmans Publishing).

Flyvbjerg, Bent. (2000) *Ideal theory, real rationality: Habermas versus Foucault and Nietzsche*. Paper presented at the Political Studies Association's 50th Annual Conference, The Challenges for Democracy in the 21st Century.

Forst, Rainer. (2007, 2014). (J. Flynn, Trans.) Ethics and morals. *The right to justification: Elements of a constructive theory of justice* (New York: Columbia University Press), 62-78.

Foucault, Michel. (1997) On the genealogy of ethics. (R. H. e. al, Trans.) With P. Rabinow, *Ethics: Subjectivity and truth - the essential works of Foucault 1954-1984* (Harmondsworth: Penguin).

--------. (6 January 1982, 2005) 6 January 1982: Second hour. A. Davidson (Ed.), *The Hermeneutics of the Subject: Lectures at the Collège de France, 1981–1982* (New York: Palgrave Macmillan), 25-41.

Fox, Renee C. (1990) The evolution of American bioethics. G. Weisz (Ed.), *Social Science perspectives on Medical Ethics* (Dordrecht, Netherlands: Kluwer Academic Publishers), 201-219.

Fox, Renee C, & Judith P Swazey. (1984) Medical morality is not bioethics - medical ethics in China and in the United States. *Perspectives in Biology and Medicine, 27*: 336-360.

Frank, Arthur W. (2004) Ethics as process and practice. *Internal Medicine Journal, 34*: 355-357.

Frankena, William K. (1973) *Ethics* (Englewood Cliffs, NJ: Prentice-Hall).

--------. (1980) *Thinking About Morality* (Ann Arbor: University of Michigan Press).

Fried, Charles. (1974) *Medical Experimentation: Personal Integrity and Social Policy* (Amsterdam: North-Holland Publishing).

--------. (1978) *Right and Wrong* (Cambridge: Harvard University Press).

Friedman, Alexander W. (2002) *Minimizing Harm: Three Problems in Moral Theory*. Doctoral Thesis. Massachusetts Institute of Technology.

Fultner, Barbara, & Jürgen Habermas. (2001) (B. Fultner, Trans.) *On the Pragmatics of Social interaction: Preliminary Studies in the Theory of Communicative Action* (Cambridge, Mass: Massachusets Institute of Technology).

--------. (1999, 2003). (B. Fultner, Trans.) *Truth and justification* (Cambridge, Mass: Massachusets Institute of Technology).

Gadamer, Hans-Georg. (1979) (W. Glen-Doepel, Trans.) *Truth and Method* (London: Sheed and Ward).

Gaita, Raimond. (2004) *Good and Evil: An Absolute Conception* (2nd ed.). (London: Routledge).

Gayle, Rhett. (2011) Befriending Wisdom. *Analytic Teaching and Philosophical Praxis, 31*(1): 70-78.

Gelhaus, Petra. (2011a). The desired moral attitude of the physician: (I) empathy. *Medicine, Health Care and Philosophy, 15*(2): 1-11. doi: 10.1007/s11019-011-9366-4.

--------. (2011b). The desired moral attitude of the physician: (II) compassion. *Medicine, Health Care and Philosophy, 15*(4): 1-14. doi: 10.1007/s11019-011-9368-2.

Gelhaus, Petra. (2012) The desired moral attitude of the physician: (III) care. *Medicine, Health Care and Philosophy*. doi: 10.1007/s11019-012-9380-1.

Gert, Bernard. The Definition of Morality. from http://plato.stanford.edu/archives/fall2012/entries/morality-definition/

--------. (2002) The relevance of moral theroy to pediatric neurology. *Seminars in Pediatric Neurology, 9*(1): 2-9.

--------. (2004) *Common Morality: Deciding What To Do* (Oxford: Oxford University Press).

Gert, Bernard, CJ Culver, & KD Clouser. (2000) Common morality versus specific principlism: Reply to Richardson. *Journal of Medicine and Philosophy, 25*(3): 310.

Gillam, Lyn. (2014) *When parents and doctors disagree about medical treatment for a child: the ethics of decision making*. Paper presented at the The New Zealand Bioethics Conference, Dunedin, Otago.

Gillam, Lynn, & McDougall, Rosalind. (2013) *Clinicians' 'decisions' versus parents' 'wishes': Ethical implications in conflict situations*. Paper presented at the Australian Association of Bioethics and Health Law Conference, Sydney.

Gillett, Grant R. (2001) The RUB. The risk of unacceptable badness. *New Zealand Medical Journal, 114*(27): 188-189. doi: http://www.ncbi.nlm.nih.gov/pubmed/11396669.

Gillett, Grant. (2013) *The quilting point: Post-structuralist ethics, engaging with others, and vertical connections*. Paper presented at the Australian Association of Bioethics and Health Law Conference, Sydney.

Gillett, Grant, & Clair Amos. (2014) *Words are not just things*. Paper presented at the The New Zealand Bioethics Conference, Dunedin, Otago.

Gillon, Raanan. (1994) *Principles of Health Care Ethics*. (Chicester: John Wiley and Sons).

--------. (2003) Ethics needs principles - four can encompass the rest - and respect for autonomy should be "first among equals". *Journal of Medical Ethics, 29*(5): 310.

Godwin, William. (1793, 1985) *Enquiry Concerning Political Justice and its Influence on Modern Morals and Happiness* (2nd ed.). Middlesex, England: Penguin).

Goucha, Moufida. (2007) Philosophy: A School of Freedom (Teaching Philosophy and Learning to Philosophize. Status and prosepcts), Paris, France xvii.

Greene, Joshua, R Brian Sommerville, Leigh E Nystrom, John M Darley, & Jonathan Cohen. (2001) An fMRI investigation of emotional engagement in moral judgement. *Science, 293*(5537): 2105-2108. doi: 10.1126/science.1062872.

Griffioen, Sander, & Rene Van Woudenberg. (1990) We must not forget those who are absent: Interview with Karl-Otto Apel on the universality of ethics. S. Griffioen (Ed.), *What Right Does Ethics Have?: Public Philosophy in a Pluralistic Culture* (Amsterdam: VU University Press), 11-21.

Gunther, Klaus. (1988) *Der Sinn fur Angemessenheit* (Frankfurt).

Habermas, Jürgen. (1971) *Toward a Rational Society* (London: Heinemann).

--------. (1972) (J. J. Shapiro, Trans.) *Knowledge and Human Interests* (London: Heinemann Educational).

--------. (1976, 1979) *Communication and The Evolution of Society* (Heinemann Educational).

--------. (1987) (Thomas McCarthy. Trans) *Theory of Communicative Action* (Boston: Beacon Press)

--------. (1988) (Shierry Weber Nicholsen & J. A. Stark, Trans.) *On the Logic of the Social Sciences* (Cambridge: Polity Press).

--------. (1981, 1990) (C. L. S. Weber, Trans.) *Moral Consciousness and Communicative Action* (Cambridge: Polity Press).

--------. (1993) (C. Cronin, Trans.) *Justification and Application: Remarks on Discourse Ethics* (Cambridge: Polity Press).

--------. (1991, 1994) (M. Pensky, Trans.) *The Past as Future: Interviewed by Michael Haller* (Cambridge: Polity Press ).

--------. (1992, 1996) (W. Rehg, Trans.) Democratic procedure and the problem of its neutrality *Between Facts and Norms* (Cambridge: Polity Press).

--------. (1984, 2001) (B. Fultner, Trans.) *On the Pragmatics of Social Interaction: Preliminary Studies in the Theory of Communicative Action* (Cambridge: MIT).

Hadorn, David. (1991) Setting health care priorities in Oregon. *Journal of the American Medical Association, 265*(17): 2218-2225. doi: http://www.ncbi.nlm.nih.gov/pubmed/1901610

Haldane, John. (1993) Medieval and Renaissance Ethics. P. Singer (Ed.), *A Companion to Ethics* (Malden MA: Blackwell), 133-146.

Hallie, Philip. (1981) From Cruelty to Goodness. *The Hastings Center Report, 11*(3): 23-28. doi: http://www.ncbi.nlm.nih.gov/pubmed/7239893.

Hamilton, Clive. (2008) *The Freedom Paradox:Towards a Post-Secular Ethics* (Sydney: Allen & Unwin).

Hand, Sean. (1989) Introduction. S. Hand (Ed.), *The Levinas Reader* (Oxford: Basil Blackwell), 1-8.

Hare, Richard Mervyn. (1989) The Structure of Ethics and Morals. *Essays in Ethical Theory* (Oxford: Clarendon Press), 175-190.

--------. (1993) Universal Prescriptivism. P. Singer (Ed.), *A Companion to Ethics* (Malden MA: Blackwell), 451-463.

Harper, Sarah J. (2009) Ethics versus morality: A problematic divide. *Philosophy and Social Criticism, 35*(9): 1074-75 footnote 10.

Harris, John. (2003) In praise of unprincipled ethics. *Journal of Medical Ethics, 29*(5):303-306 doi: http://www.ncbi.nlm.nih.gov/pubmed/14519841.

Hauser, Marc. (2006) *Moral Minds: How Nature Designed Our Universal Sense of Right and Wrong* (New York: Harper Collins).

Hauser, Marc, Fiery Cushman, Liane Young, R Kang-Xing, & John Mikhail. (2007) A dissociation between moral judgements and justifications. *Mind and Language, 22*(1): 1-21.

Hayden, Mathew J. (2012) *Cosmopolitan Education and Moral Education: Forging Beings Under Conditions of Global Uncertainty.* (PhD thesis), Columbia University.

Heath, Joseph. (2014). Rebooting discourse ethics. *Philosophy and Social Criticism, 40*(9): 829-866. doi: 10.1177/0191453714545340.

Heelan, Patrick A. (2001) The lifeworld and scientific interpretation. S. K. Toombs (Ed.), *Handbook of Phenomenology and Medicine* (Dordrecht: Kluwer Academic Publishers), 47-66.

Hegel, Georg. (1821, 1952) (T. M. Knox, Trans.) The Philosophy of Right. *The Philosophy of Right, The Philosophy of History* (first ed.). (Chicago: William Benton, Encyclopedia Britannica Inc), 1-150.

Held, Virginia. (1990) Feminist Transformations of Moral Theory. *Philosophy and Phenomenological Research*, 50: 321-344.

--------. (2006) The Ethics of Care. D. Copp (Ed.), *The Oxford Handbook of Ethical Theory* (Oxford: Oxford University Press), 537-566.

Hellsten, Sirkku Kristiina. (2000) Towards an alternative approach to personhood in the end of life questions. *Theoretical Medical Bioethics, 21*(6): 515-536. doi: http://www.ncbi.nlm.nih.gov/pubmed/11196219.

Hendricks, Joyce, Deborah Mooney, & Catherine Berry. (1996) A practical strategy approach to use of reflective practice in critical care nursing. *Intensive and Critical Care Nursing, 12*: 97-101.

Herman, Barbara. (2011) A mismatch of methods *On What Matters* (Vol 2) (Oxford: Oxford University Press), 83-115.

Ho, Anita. (2008) Relational autonomy or undue pressure? Family's role in medical decision-making. *Scandanavian Journal of Caring Sciences, 22*(1): 128-135. doi: 10.1111/j.1471-6712.2007.00561.x.

Hobbes, Thomas. (1651, 1952) (N. Fuller, Trans.) Leviathan. *The Prince, Leviathan* (first ed.). Chicago: William Benton, Encyclopedia Britannica Inc), 39-283.

Hoffmann, Tammy C, France Legare, Magenta B Simmons, Kevin McNamara, Kirsten McCaffery, Lyndal J Trevena, Christopher B Del Mar. (2014) Shared decision making: what do clinicians need to know and why should they bother? *Medical Journal of Australia, 201* (1): 35-39.

Hoffmaster, Barry. (1990) Morality and the social sciences. G. Weisz (Ed.), *Social Science Perspectives on Medical Ethics* (Dordrecht, Netherlands: Kluwer Academic Publishers), 241-260.

Hojat, Mohammadreza, Michael J. Vergare, Kaye Maxwell, George Brainard, Steven K. Herrine, Gerald A. Isenberg, Joseph S. Gonnella. (2009) The devil is in the third year: A longitudinal study of erosion of empathy in medical school. *Academic Medicine, 84*(9): 1182-1191.

Holm, Soren, Gjersoe, Peter, Grode, Glenn, Hartling, Ole, Ibsen, Karen E, & Marcussen, Henrik. (1996) Ethical reasoning in mixed nurse-physician groups. *Journal of Medical Ethics, 22*(3): 168-173. doi: http://www.ncbi.nlm.nih.gov/pubmed/8798940.

Holowchak, Mark A. (2009) Education as training for life: Stoic teachers as physicians of the soul. *Educational Philosophy and Theory, 41*(2): 166-184. doi: 10.1111/j.1469-5812.2007.00384.x.

Honeybul, Stephen, Grant Gillett, K. M. Ho, & C. R. Lind. (2011) Neurotrauma and the rule of rescue. *Journal of Medical Ethics, 37*(12): 707-10. doi: medethics-2011-100081 [pii] 10.1136/medethics-2011-100081.

Honneth, Axel. (1995) The other justice: Habermas and the ethical challenge of postmodernism. S. K. White (Ed.), *Cambridge Companion to Habermas* (New York: Cambridge University Press), 289-324.

Hornsby, Roy. What does Levinas consider to be the relative strengths (and weaknesses) of Phenomenology?; And how does his own philosophical perspective differ from that of Husserl and Heidegger? Retrieved 7 April 2014, from http://royby.com/philosophy/pages/levinas.html.

Howe, Ken R. (1987) Medical students' evaluation of different levels of medical ethics teaching: implications for curricula. *Medical Education, 4*(July): 340-349.

Hughes, Julian C. (2001) Views of the person with dementia. *Journal of Medical Ethics, 27*(2): 86-91. doi: http://www.ncbi.nlm.nih.gov/pubmed/11314164.

Hughes, Julian C, & Steve Ramplin. (2012) Clinical and ethical judgement. C. Cowley (Ed.), *Reconceiving Medical Ethics* (1 ed.). (London: Bloomsbury Academic), 220-234.

Hugman, Richard. (2005) *New Approaches in Ethics for the Caring Professions* (Hampshire: Palgrave MacMilln).

Hume, David. (1748, 1952) (W. Ross, Trans.) An Enquiry Concerning Human Understanding. *A Letter Concerning Toleration Concerning Cicvil Governemnt, An Essay Concerning Human Understanding; The Principles of Human Knowledge; An Enquiry Concerning Human Understanding* (first ed.). (Chicago: William Benton, Encyclopedia Britannica Inc), 451-509.

--------. (1777, 1975) Concerning the principles of morals. With L. Selby-Bigge, *Enquiries Concerning Human Understanding and Concerning the Principles of Morals* (3rd ed.). (Oxford: Clarendon Press).

--------. (1739, 1994) A treatise on human nature. In P. Singer (Ed.), *Ethics* (Oxford: Oxford University Press), 118-123.

Hummel, Charles. (1993) Aristotole. *Prospects: The Quarterly Review of Comparative Education, 23*(1/2): 39-51.

Hunsinger, George. (2006) Torture, common morality, and the Golden Rule. *Theology Today, 63*: 375-379.

Hursthouse, Rosalind. (1999) *On Virtue Ethics* (Oxford: Oxford University Press).

Husserl, Edmund. (1931, 2012) Sciences of the dogmatic and sciences of the philosophical standpoint *Ideas: General Introduction to Pure Phenomenology* (New York: Routledge).

James, William. (1890, 1952) The Principles of psychology. *The Principles of Psychology* (first ed.). Chicago: William Benton, Encyclopedia Britannica Inc).

Janssens, Louis. (1979) Ontic and moral evil. Curran C & M. RA (Eds.), *Readings in moral theology: moral norms in the Catholic tradition* (New York: Paulist Press), 40-93.

Jefferson, Thomas. (1952) The Declaration of Independence. *American State Papers, The Federalist, On Liberty, Representative Government, Utilitarianism* (first ed.). (Chicago: William Benton, Encyclopedia Britannica Inc), 1-3.

Jenni, Karen, & George Loewenstein. (1997) Explaining the Identifiable Victim Effect. *Journal of Risk and Uncertainty, 14*(3) doi: 10.1023/a:1007740225484.

Jennings, Bruce. (1991) Possibilities of consensus: Towards democratic moral discourse. *The Journal of Medicine and Philosophy, 16*: 447-463.

John Paul II, Pope. (1995) *Evangelium Vitae*. Vatican City, Italy: Libreria Editrice Vaticana Retrieved from http://www.vatican.va/holy_father/john_paul_ii/encyclicals/documents/hf_jp-ii_enc_25031995_evangelium-vitae_en.html

Jonathan Herring, & P-L Chau. (2007) My body, your body, our bodies. *Medical Law Review, 15*(1): 34-61.

Jones, Gareth. (2001) The authority of Scripture and Christian Ethics. R. Gill (Ed.), *The Cambridge Companion to Christian Ethics* (Cambridge: Cambridge University Press), 16-28.

Jones, Ian Rees. (2001) Health care decision making and the politics of health. G. Scambler (Ed.), *Habermas, Critical theory, and Health* (London: Routledge), 68-85.

Jones James H, & the Tuskegee Institute. (1981, 1993) *Bad Blood: the Tuskegee Syphilis Experiment* (Revised ed.). (New York: Free Press).

Jonsen, Albert R. (1986) Bentham in a box: technology assessment and health care allocation. *Law Med Health Care, 14*(3-4): 172-4. doi: http://www.ncbi.nlm.nih.gov/pubmed/3645228.

Jonsen, Albert, Mark Siegler, & William Winslade. (2010) Introduction. *Clinical Ethics: A Practical Approach to Ethical Decisions in Clinical Medicine* (7th ed.). (New York: MacMillan), 1-8.

Jordens, Christipher FC, Kathleen Montgomery, & Rowena Forsyth. (2013) Trouble in the gap: A bioethical and sociological analysis of informed consent for high-risk medical procedures. *Journal of Bioethical Inquiry, 10*(1): 67-77. doi: 10.1007/s11673-012-9414-7.

Kamm, Francis, & Alex Voorhoeve. (2009) In search of the deep structure of morality. *Conversations on Ethics* (Oxford: Oxford University Press), 15-40.

Kant, Immanuel. (1903, 1906) (A. Churton, Trans.) *Kant on Education (Ueber Padagogik)* (Boston: DC Heath & Co).

--------. (1788, 1952) (T. K. Abbott, Trans.) The Critique of Practical Reason. *The Critique of Pure Reason, The Critique of Practical Reason and other ethical treatises, The Critique of Judgement* (first ed.). (Chicago: William Benton, Encyclopedia Britannica Inc), 291-361.

--------. (1788, 1952) (J. M. D. Meiklejohn, Trans.) The Critique of Pure Reason. *The Critique of Pure Reason, The Critique of Practical Reason and other ethical treatises, The Critique of Judgement* (first ed.). (Chicago: William Benton, Encyclopedia Britannica Inc), 1-250.

--------. (1785, 1952) (T. K. Abbott, Trans.) The Fundamental Principles of the Metaphysic of Morals. *The Critique of Pure Reason, The Critique of Practical Reason and other ethical treatises, The Critique of Judgement* (first ed.). (Chicago: William Benton, Encyclopedia Britannica Inc), 253-287.

--------. (1796, 1952) (T. K. Abbott, Trans.) Metaphysical Elements of Ethics. *The Critique of Pure Reason, The Critique of Practical Reason and other ethical treatises, The Critique of Judgement* (first ed.). (Chicago: William Benton, Encyclopedia Britannica Inc), 365-379.

--------. (1796, 1952) (W. Hastie, Trans.) The Science of Right. *The Critique of Pure Reason, The Critique of Practical Reason and other ethical treatises, The Critique of Judgement* (first ed.). (Chicago: William Benton, Encyclopedia Britannica Inc), 397-458.

--------. (1785, 1994) Foundations of The Metaphysics of Morals. In P. Singer (Ed.), *Ethics* (Oxford: Oxford University Press), 123-131.

--------. (1797, 1996) M. Gregor (Ed.), *The Metaphysics of Morals* (Cambridge: University of Cambridge).

--------. (1783, 2004) (G. Hatfield, Trans.) Preamble *Prolegomena to Any Future Metaphysic* (Revised ed.): (Cambridge University Press).

--------. (1784, 2010) (H. Nisbet, Trans.) *An Answer to The Question: What Is Enlightenment* (London: Penguin).

Kekewich, Michael A. (2014) Market liberalism in health care: A dysfunctional view of respecting "consumer"autonomy. *Journal of Bioethical Inquiry, 11*(1): 21-29. doi: 10.1007/s11673-013-9492-1.

Kenny, Anthony. (2010) Frued to Derrida *A New History of Western Philosophy* (Oxford: Ocford University Press).

Kerridge, Ian, Michael Lowe & Cameron Stewart. (2013) *Ethics and Law for the Health Professions* (4th ed.). (Sydney: The Federation Press).

King, Martin Luther. (1963, 2010) Letter from a Birmingham Jail. In G. Marino (Ed.), *Ethics: the Essential Writings* (New York: Modern Library Classics (Random House Group)), 356-377.

Kirkpatrick, James N., Yuli Y. Kim, & Beth D. Kaufman. (2012) Ethics priorities in adult congenital heart disease. *Progress in Cardiovascular Disease, 55*(3): 266-273 e3. doi: 10.1016/j.pcad.2012.10.004.

Kitcher, Philip. (2011) The shape of things to come. *The Ethical Project* (Harvard MA: Harvard University Press).

Kitwood, Tom. (1997, 2001) On being a person. *Dementia Reconsidered* (Buckingham, UK: Open University Press), 7-19.

Knight, Rhona. (2007) Tools for teaching medical ethics to specialty registrars. *Education for Primary Care, 18*(6): 749-753.

Koczanowicz, Leszek. (2010) Cosmpopolianism and its predicaments. *Studies in Philosophy and Education, 29*: 141-149.

Kohn, Rachel, Gordon D. Rubenfeld, Mitchell M. Levy, et al (2011) Rule of rescue or the good of the many? An analysis of physicians' and nurses' preferences for allocating ICU beds. *Intensive Care Medicine, 37*(7): 1210-1217. doi: 10.1007/s00134-011-2257-6.

Kon, Alexander. (2010) The shared decision-making continuum. *Journal of the American Medical Association, 304*(8): 903-904. doi: 10.1001/jama.2010.1208.

Korsgaard, Christine M. (1996) The normative question. O. O'Neill (Ed.), *The Sources of Normativity* (Cambridge: Cambridge University Press), 7-48.

Koszarycz, Yuri. (1994) *Constructive nurse education for critical reflectivity in ethical decision-making*. Paper presented at the Australian Association for Research in Education. http://www.aare.edu.au/publications-database.php/1140/Constructive-nurse-education-for-critical-reflectivity-in-ethical-decision-making.

Koven, Nancy S. (2011) Specificity of meta-emotion effects on moral decision-making. *Emotion, 11*(5): 1255-61. doi: 2011-21907-008 [pii] 10.1037/a0025616.

Kramer, Daniel B., Susan L. Mitchell, & Dan W. Brock. (2012) Deactivation of pacemakers and implantable cardioverter-defibrillators. *Progress in Cardiovascular Disease, 55*(3): 290-9. doi: 10.1016/j.pcad.2012.09.003.

Kukla, Rebecca. (2005) Conscientious autonomy: Displacing decisions in health care. *The Hastings Center Report, 35*(2): 43.

LaFollette, Hugh. (1991) The truth in ethical relativism. *Journal of Social Philosophy, 22*(1): 146-154. doi: 10.1111/j.1467-9833.1991.tb00027.x.

Lake, Fiona, & Gerard Ryan. 2006) Planning a teaching session *Teaching on the Run* (Sydney: Australian Medical Publishing Company).

Langton, Rae. (1992) Duty and Desolation. *Philosophy, 67*: 495.

Larmore, Charles. (2008) The problem with morality. *The Autonomy of Morality* (Cambridge: Cambridge University Press).

Laura, Ronald S. (1978) Philosophical foundations of religious education. *Religious Education, 28*(4): 310-317.

Laura, Ronald S, & Amy Chapman. (2009) *The Paradigm Shift in Health* (Lanham: University Press of America).

Laura, Ronald S, & Mathew C Cotton. (1999) *Empathic Education: An Ecological Perspective on Educational Knowledge* (London: Falmer Press).

Laura, Ronald S, & Heaney, Sandra. (1990) *Philosophical Foundations of Health Education*. (New York: Routledge).

Laura, Ronald S, Tim Marchant, & Susen R Smith. (2008) *The New Social Disease: from High Tech Depersonalisation to Survival of the Soul* (New York: University Press of America).

Lechte, John. (2008) *Fifty Key Contemporary Thinkers: From Structuralism To Post-Humanism* (second ed.). (New York: Routledge).

Lemmon, Edward John. (1962) Moral dilemmas. *Philosophical Review, 71*(2): 139-158.

Levinas, Emmanuel. (1999) (M. B. Smith, Trans.) The proximity of the Other. *Alterity and Transcendence* (New York: Columbia University Press), 97-110.

--------. (1968, 1989) (A. Lingi, Trans.) Substitution. S. Hand (Ed.), *The Levinas Reader* (Oxford: Blackwell Publishers Ltd), 88-126.

Locke, John. (1690, 1952) Concerning Civil Government, Second Essay. *John Locke, George Berkeley, David Hume* (first ed.). (Chicago: William Benton, Encyclopedia Britannica Inc), 25-81.

--------. (1690, 1952) Concerning Human Understanding. *John Locke, George Berkeley, David Hume* (first ed.). (Chicago: William Benton, Encyclopedia Britannica Inc), 85-400.

Lovat, Terence. (2004a). 'Ways of knowing' in doctoral examination: how examiners position themselves in relation to the doctoral candidate. *Australian Journal of Educational and Developmental Psychology, 4*: 146-152.

--------. (2004b). Aristotelian Ethics and Habermasian Critical theory: A conjoined force for proportionism in ethical discourse and Roman Catholic moral theology. *Australian eJournal of Theology, 3*(1): 1-14.

--------. (2006) Practical mysticism as authentic religiousness: A Bonhoeffer case study. *Australian eJournal of Theology, 6*: 1-11.

--------. (2012) Bonhoeffer: Interfaith theologian and practical mystic. *Pacifica, 25*: 177-189.

--------. (2013a) Practical mysticism, self-knowing and moral motivation. K. Heinrichs, F. Oser & T. Lovat (Eds.), *Handbook of Moral Motivation* (Rotterdam: Sense Publishers).

--------. (2013b) Jürgen Habermas: education's reluctant hero. M. Murphy (Ed.), *Social Theory and Educational Research: Understanding Foucault, Habermas, Derrida and Bourdieu* (London: Routledge), 69-83.

Lovat, Terence, & Mel Gray. (2008) Towards a proportionist social work ethics: A Habermasian perspective. *British Journal of Social Work, 38:* 1100-1114.

Lovat, Terence J, & Kenneth R Mitchell. (1991) The history of ethics: trends and directions. *Bioethics for Medical and Health Professionals* (Wentworth Falls, Sydney: Social Science Press).

Lovat, Terence J, & David L Smith. (2003) Curriculum and philosophy. *Curriculum: Action on Reflection* (4th ed.). (Tuggerah NSW: Social Science Press), 77-98.

Lovat, Terence, & Inna Semetsky. (2009) Practical mysticism and Deleuze's ontology of the virtual. *Cosmos and History: The Journal of Natural and Social Philosophy, 5*(2): 1-14.

Loewy, Erich H. (1989). *Textbook of Medical Ethics* (New York: Plenum Medical Book Company).

Lucretius. (1952) (A. Munro, Trans.) On the Nature of Things. *Lucretius, Epictetus, Marcus Aurelius* (first ed.). (Chicago: William Benton, Encyclopedia Britannica Inc), 1-97.

Lutzen, Lim, & Beatrice Ewalds-Kvist. (2013) Moral distress and its interconnection with moral sensitivity and moral resilience: Viewed from the philosophy of Victor E. Frankl. *Journal of Bioethical Inquiry, 10*(3): 317-324. doi: 10.1007/s11673-013-9469-0.

Lyotard, Jean-Francois. (1979). (Geoff Bennington & B. Massumi, Trans.) *The Postmodern Condition: A Report on Knowledge* (Manchester University Press).

MacIntyre, Alasdair. (1998) *A Short History of Ethics* (2nd ed.). (London: Routledge).

--------. (1981, 2007) *After Virtue* (3rd ed.). (New York: University of Notre Dame Press).

MacIntyre, Alasdair, & Alex Voorhoeve. (2009) The illusion of self-sufficiency. *Conversations on Ethics* (Oxford: Oxford University Press), 111-131.

Mackenzie, Catriona. (2001) On bodily autonomy. S. K. Toombs (Ed.), *Handbook of Phenomenology and Medicine* (Dordrecht: Kluwer Academic Publishers), 417-440.

--------. (2008) Relational autonomy, normative authority and perfectionism. *Journal of Social Philosophy, 39*(4): 512-522.

Mackenzie, Catriona, & Natalie Stoljar. (2000) Introduction: Autonomy refigured. C. Mackenzie & N. Stoljar (Eds.), *Relational Autonomy: Feminist Prespectives in Autonomy, Agency, and the Social Self* (New York: Oxford University Press).

Madigan, Tim. (2013) Wad some power the giftie gie us. *Philosophy Now, January/February* (94):32-34.

Mamede, Silvia, & Henk G Schmidt. (2004) The structure of reflective practice in medicine. *Medical Education, 38*(12) doi: 10.1111/j.1365-2929.2004.01917.x.

Marino, Gordon. (2010) Introduction. *Ethics: the Essential Writings* (New York: Modern Library Classics (Random House Group)), ix-xiv.

Maritain, Jacques. (1964) *Moral Philosophy: An Historical and Critical Survey of The Great Systems* (London: Geoffrey Bles).

Marquis, Don. (1989) Why abortion is immoral. *The Journal of Philosophy, 86*(4): 183-202.

Mathews, Eric. (2012) Old age and dependency. C. Cowley (Ed.), *Reconceiving Medical Ethics* (1 ed.). (London: Bloomsbury Academic), 59-71.

Matlock, Daniel D., & Lynne W. Stevenson. (2012) Life-saving devices reach the end of life with heart failure. *Prog Cardiovasc Dis, 55*(3): 274-81. doi: 10.1016/j.pcad.2012.10.007.

Matsuura, Koichiro. (2007) Philosophy: A School of Freedom (Teaching Philosophy and Learning to Philosophize. Status and prospects). (Paris, France) Preface viii.

McCabe, Herbert. (2005) *The Good Life: Ethics and the Pursuit of Happiness* (London: Continuum).

McCarthy, Thomas. (1978) *The Critical Theory of Jürgen Habermas* (London: Hutchison).

--------. (1981, 1990) (C. L. S. Weber, Trans.) *Moral Consciousness and Communicative Action* (Cambridge: Polity Press).

McCormick, Richard A. (1967) Notes on moral theology: January-June, 1967. *Theological Studies, 28*(4): 749-800.

--------. (1973) *Ambiguity in Moral Choice* (Milwaukee, Wis: Marquette University Press).

McCoy, Alban. 2004) *An Intelligent Person's Guide to Christian Ethics* (London: Continuum).

McDougall, Rosalind. (2007) Parental virtue: A new way of thinking about the morality of reproductive actions. *Bioethics, 21*(4): 181-190.

McDougall, Rosalind J, & Lynn Gillam. (2014) Doctors' "judgements" and "parents' "wishes": clinical implications in conflict situations. *Medical Journal of Australia, 200*(7): 372.

McHaffie, Hazel. (2004) Commentary. *Journal of Medical Ethics, 30*: 406-407.

McKie, John, & Jeff Richardson. (2003) The Rule of Rescue. *Social Science & Medicine, 56*(12): 2407-2419. doi: 10.1016/s0277-9536(02)00244-7.

McLaren, Peter. (1994) Critical pedagogy: A look at the major concepts. *Life in Schools* (2nd ed.). (White Plains, New York: Longman Group), 175-203.

McMahan, Jeff. (2003) Endings. *The Ethics of Killing* (Oxford: Oxford University Press), 423-503.

McNaughton, David, & Piers Rawling. 2006) Deontology. D. Copp (Ed.), *The Oxford Handbook of Ethical Theory* (Oxford: Oxford University Press), 424-458.

Mead, George Herbert. (1967) The social foundations and functions of thought and communication. *Mind, Self, and Society: From the Standpoint of a Social Behaviourist* (Chicago: University of Chicago Press).

Medical Board of Australia. (2010) Good medical practice: A code of conduct for doctors in Australia; Section 3.12. Retrieved 21 March 2013, 2013, from http://www.medicalboard.gov.au/Codes-Guidelines-Policies/Code-of-conduct.aspx.

Meeks, Thomas W, & Dilip V Jeste. (2009) Neurobiology of wisdom: a literature overview. *Archives of General Psychiatry, 66*(4): 355-365. doi: 10.1001/archgenpsychiatry.2009.8.

Midgely, Mary. (2010) Trying Out One's New Sword. G. Marino (Ed.), *Ethics: the Essential Writings* (New York: Modern Library Classics (Random House Group)), 321-327.

Miles, Steven H, Laura Weiss Lane, Janet Bickel, Robert Waker, & Christine Cassel. (1989) Medical ethics education: Coming of age. *Academic Medicine, 64*(12): 705-714. doi: http://www.ncbi.nlm.nih.gov/pubmed/2686674.

Mill, John Stuart. (1859, 1952) On Liberty. *American State Papers, The Federalist, On Liberty, Representative Government, Utilitarianism* (first ed.). (Chicago: William Benton, Encyclopedia Britannica Inc), 267-323.

--------. (1859, 1952) Representative Government. *American State Papers, The Federalist, On Liberty, Representative Government, Utilitarianism* (first ed.). (Chicago: William Benton, Encyclopedia Britannica Inc), 327-442.

--------. (1861, 1952) Utilitarianism. *American State Papers, The Federalist, On Liberty, Representative Government, Utilitarianism* (first ed.). (Chicago: William Benton, Encyclopedia Britannica Inc), 445-476.

Mill, John Stuart. (1st Feb 1867) *Inaugural Address Delivered to the University of St Andrews*. London. Retrieved from http://quoteinvestigator.com/

Minkoff, Howard. (2006) The ethics of caesarian section by choice. *Seminars in Perinatology, 30*(5): 309-312.

Moll, Jorge, Frank Krueger, Roland Zahl, Matteo Pardini, Richard de Oliveira-Souza, & Jordan Grafman. (2006) Human fronto-mesolimbic networks guide decisions about charitable donation. *Proceedings of the National Academy of Science, 103*(42): 15623-15628.

Moll, Jorge, Richard de Oliveira-Souza, & Roland Zahn. (2008) The neural basis of moral cognition. *Annals New York Academy of Science, 1124*: 161-180. doi: 10.1196/annals.1440.005.

Montgomery, Kathleen, & J Miles Little. (2001) Ethical thinking and stakeholders. *Medical Journal of Australia, 174*(8): 405-406. doi: http://www.ncbi.nlm.nih.gov/pubmed/11346086.

Moon, J Donald. (1995) Practical discourse and communicative ethics S. K. White (Ed.), *The Cambridge Companion to Habermas* (New York: University of Cambridge), 143-165.

Moore, George Edward. (1903) Great Books in Philosophy, *Principia Ethica* (pp. Chapter 5 Section 103) Prometheus Books. Retrieved from http://fair-use.org/g-e-moore/principia-ethica/ doi: http://fair-use.org/g-e-moore/principia-ethica/.

Moran, Dermot. (2000) *Introduction to Phenomenology* (London UK: Routledge).

Moser, Paul K. (1987) *A Priori Knowledge* (Oxford: Oxford University Press).

Muirhead, William. (2011) When four principles are too many: Bloodgate, integrity and an action-guiding model of ethical decision making in clinical practice. *Journal of Medical Ethics, 38*: 195-196.

Nagel, Thomas. (1970) Altruism: The intuitive issue *The Possibility of Altruism* (Princeton NJ: Princeton University Press).

--------. (1987) Moral conflict and political legitimacy. *Philosophy and Public Affairs, 16*(3): 215-240.

Nakao, Takashi, Hideki Ohira, & Georg Northoff. (2012) Distinction between externally vs. internally guided decision-making: operational differejnces, emta-analytical comparisions and their theoretical implications. *Frontiers in Neuroscience, 6*(31): 1-26.

Newson, Ainsley. (2013) *Genomic advances and testing and screening before birth: What's at stake?* Paper presented at the Australian Association of Bioethics and Health Law Conference, Sydney.

Newton, Bruce W., Laurie Barber, James Clardy, Elton Cleveland, & Patricia O'Sullivan. (2008) Is there a hardening of the heart during medical school? *Academic Medicine, 83*(3): 244-249.

Nortvedt, Per. (2003) Subjectivity and vulnerability: Reflections on the foundation of ethical sensivitiy. *Nursing Philosophy, 4*: 222-230.

Nussbaum, Martha C. (1997) Socratic self-examination. *Cultivating Humanity: A Defence of Reform in Liberal Education* (Camridge, Massachusetts: Harvard University Press), 15-49.

O'Connell, Timothy E. (1990) Morality: Values and norms. *Principles for a Catholic Morality: Revised Edition* (San Francisco: Harper), 174-186.

O'Donovan, Oliver. (1998) Again: Who is a person. Stephen E Lammers & A. Verhey (Eds.), *On Moral Medicine: Theological Perspectives in Medical Ethics* (2nd ed.). (Grand Rapids, Michigan: William B Eerdmans Publishing), 380-386.

O'Neill, Onara. (1996) Introduction. O. O'Neill (Ed.), *The Sources of Normativity* (Cambridge: Cambridge University Press), xi-xv.

O'Neill, Onora. (2013) Interpreting the world, changing the world. *Philosophy Now, March-April* (95):8-9.

O'Rourke IC, RJ McNeil, PJ Walker, & CA Bull. (1992) Objective evaluation of the quality of palliation in patients with oesophageal cancer comparing surgery, radiotherapy and intubation. *Australian and New Zealand Journal of Surgery, 62*(12): 922-930. doi: http://www.ncbi.nlm.nih.gov/pubmed/1280947.

Olthius, James H. (1990) An ethics of compassion: Ethics in a post-modernist age. S. Griffioen (Ed.), *What Right Does Ethics Have?: Public Philosophy in a Pluralistic Culture* (Amsterdam: VU University Press), 125-146.

Onions, Charles Talbut (Ed.) (1966) The Oxford Dictionary of English Etymology. (Oxford: Clarendon).

Ormerod, Richard, & Werner Ulrich. (2013) Operational research and ethics: A literature review. *European Journal of Operational Research*(228): 291-307.

Outhwaite, William. (1994) *Habermas: A Critical Introduction* (Cambridge: Polity Press).

Paediatrics and Child Health Division of The Royal Australasian College of Physicians and The Australian Society of Otolaryngology, Head and Neck Surgery. (2008) A Joint Position paper

of the Paediatrics and Child Health Division of The Royal Australasian College of Physicians and The Australian Society of Otolaryngology, Head and Neck Surgery, Sydney.

Paola, Frederick A., & Robert M. Walker. (2000) Deactivating the implantable cardioverter-defibrillator: a biofixture analysis. *South Med J, 93*(1): 20-23. http://www.ncbi.nlm.nih.gov/pubmed/10653059.

Paola, Frederick A., Robert Walker, & Lois LaCivita Nixon. (2010) Case-based decision making in ethics. *Medical Ethics and Humanities* (Sudbury, Mass.: Jones and Bartlett Publishers), 95-120.

Papadimos, Thomas J, Joanna E Manos, & Stuart J Murray. (2013) An extrapolation of Foucault's *Technologies of the Self* to effect positive transformation in the intensivist as teacher and mentor. *Philosophy, Ethics, and Humanities in Medicine, 8*: 1-7. http://www.peh-med.com/content/8/1/7.

Parfit, Derek. (2011) *On What Matters* (Oxford: Oxford University Press).

Parker, Lisa, Lisa Watts, & Helen Scicluna. (2012) Clinical ethics ward rounds: building on the core curriculum. *J Med Ethics, 38*(8): 501-505. doi: 10.1136/medethics-2011-100468.

Paton, Herbert James. (1947) *The Categorical Imperative* (London: University of Chicago Press, Hutchison).

Peirce, Charles S. (1960) *Collected Papers of CS Peirce* (Cambridge, Massachusetts: Belknap Press).

Pellegrino, Edmund. (1985) Moral choice, the good of the patient, and the patient's good. John C Moskop & L. Kopelman (Eds.), *Ethics and Critical Care Medicine* (Dordrecht: D Reidel Publishing), 117-138.

--------. (1990) The medical profession as a moral community. *Bulletin of the New York Academy of Medicine, 66*(3): 221-232.

--------. (1994) The four-principles and the Doctor-Patient relationship: The need for a better linkage. R. Gillon (Ed.), *Principles of Health Care Ethics* (Chichester: John Wiley and Sons), 353-365.

--------. (2005) Toward a virtue-based normative ethics for the health professions. *Kennedy Institute of Ethics Journal, 5* (3): 253-277 doi: http://site.ebrary.com/lib/newcastle/docDetail.action?docID=10271554.

--------. (2007) Professing medicine, virtue based ethics, and the retrieval of professionalism RL Walker & P. Ivanhoe (Eds.), *Working Virtue : Virtue Ethics and Contemporary Moral Problems* (Oxford: Oxford University Press).

Pellegrino, Edmund D. (2001) The internal morality of clinical medicine: A paradigm for the ethics of the helping and healing professions. *Journal of Medicine and Philosophy, 26*(6): 559-579. doi: 10.1076/jmep.26.6.559.2998.

Pellegrino, Edmund D, & David C Thomasma. (1993) The ends of medicine and its virtues *The Virtues in Medical Practice* (New York: Oxford University Press).

Pence, Greg. (1993) Virtue theory. P. Singer (Ed.), *A Companion to Ethics* (Malden MA: Blackwell), 249-258.

Perlin, Terry M. (1992) Getting down to cases: An introduction to clinical medical ethics *Clinical Medical Ethics: Cases in Practice* (Boston: Little, Brown).

Pigliucci, Massimo. (2012) Reflective Equilibrium. *Philosophy Now, January/February*(88): 27.

Plath, Debbie, Brian English, Louisa Connors, & Alex Beveridge. (1999) Evaluating the outcomes of intensive critical thinking instruction for social work students. *Social Work Education: The International Journal, 18*(2): 207-217.

Plato. (c390 BCE, 1952) (B. Jowett, Trans.) Apology. *The Dialogues of Plato, The Seventh Letter* (first ed.). (Chicago: William Benton, Encyclopedia Britannica Inc), 200-212.

--------. (c390 BCE, 1952) (B. Jowett, Trans.) Cratylus. *The Dialogues of Plato, The Seventh Letter* (first ed.). (Chicago: William Benton, Encyclopedia Britannica Inc), 85-114.

--------. (c390 BCE, 1952) (B. Jowett, Trans.) Crito. *The Dialogues of Plato, The Seventh Letter* (first ed.). (Chicago: William Benton, Encyclopedia Britannica Inc), 213-219.

--------. (c390 BCE, 1952) (B. Jowett, Trans.) The Dialogues of Plato. *The Dialogues of Plato, The Seventh Letter* (first ed.). (Chicago: William Benton, Encyclopedia Britannica Inc).

--------. (c390 BCE, 1952) (B. Jowett, Trans.) Laws.. *The Dialogues of Plato, The Seventh Letter* (first ed.). (Chicago: William Benton, Encyclopedia Britannica Inc), 640-799.

--------. (c390 BCE, 1952) (B. Jowett, Trans.) Phaedo. *The Dialogues of Plato, The Seventh Letter* (first ed.). (Chicago: William Benton, Encyclopedia Britannica Inc), 220-251.

--------. (c390 BCE, 1952) (B. Jowett, Trans.) The Republic. *The Dialogues of Plato, The Seventh Letter* (first ed.). (Chicago: William Benton, Encyclopedia Britannica Inc), 295-441.

--------. (c390 BCE, 1952) (B. Jowett, Trans.) Theaetetus. *The Dialogues of Plato, The Seventh Letter* (first ed.). (Chicago: William Benton, Encyclopedia Britannica Inc), 512-550.

--------. (c390 BCE, 1997) (G. Grube, Trans.) Republic. J. M. Cooper (Ed.), *Plato: Complete Works* (Indianapolis, Cambridge: Hackett Publishing Company), 971-1223.

Plotinus. (1952) (Stephen MacKenna & B. Page, Trans.) *Plotinus: The Six Enneads* (first ed.). (Chicago: William Benton, Encyclopedia Britannica Inc).

Pogge, Thomas W. (1997) The Categorical Imperative. P. Guyer (Ed.), *Kant's Groundwork of the Metaphysics of Morals: Critical Essays* (Maryland: Rowman & Littlefield), 189-214.

Pope, Stephen J. (2001) Natural law and Christian ethics. R. Gill (Ed.), *The Cambridge Companion to Christian Ethics* (Cambridge: Cambridge University Press), 77-95.

Preston, Ronald. (1993) Christian Ethics. P. Singer (Ed.), *A Companion to Ethics* (Malden MA: Blackwell), 91-105.

Price, Linnie. (1984) Art, science, faith and medicine: the implications of the placebo effect. *Sociology of Health & Illness, 6*(1): 61-73. doi: 10.1111/1467-9566.ep10777362.

Priestley, Joseph. *An Essay on the First Principles of Government, and on the Nature of Political, Civil, and Religious Liberty* (2nd ed.). (London: Mobi Books).

Quill, Timothy E., Rebecca Dresser, & Dan W. Brock. (1997) The rule of double effect--a critique of its role in end-of-life decision making. *New England Journal of Medicine, 337*(24): 1768-71. doi: 10.1056/NEJM199712113372413.

Quinn, Warren S. (1989) Actions, intentions, and consequences: The doctrine of doing and allowing. *Philosophical Review, XCVIII*(3): 287-312.

Rabinow, Paul. (1984) Space, knowledge, and power. *The Foucault Reader* (New York: Pantheon Books), 239-256.

Rachels, James. (1975) Active and Passive Euthanasia. *New England Journal of Medicine, 292*(2): 78-80. doi: 10.1056/NEJM197501092920206.

Radha Krishna, Lalit Kumar. (2013) Accounting for personhood in palliative sedation: the Ring Theory of Personhood. *Medical Humanities, 40*(1): 17-21. doi: 10.1136/medhum-2013-010368.

Railton, Peter. (1988) Alienation, Consequentialism, and the Demands of Morality. S. Scheffler (Ed.), *Consequentialism and Its Critics* (Oxford: Oxford University Press), 93-133.

Ramachandran, Vilayanur S. (1997) The neurology of self-awareness {The Edge 10th Anniversary Essay). Retrieved 21 October 2013, from http://www.edge.org/3rd_culture/ramachandran07/ramachandran07_index.html.

Ramplin, Steve, & Julian C Hughes. (2012) Mental illness and medical ethics: Insights from Heidegger and values-based medicine. C. Cowley (Ed.), *Reconceiving Medical Ethics* (1 ed.). (London: Bloomsbury Academic), 84-98.

Rasmussen, David M. (1990) *Reading Habermas* (Cambridge Ma: Basil Blackwell).

Rawls, John. (1971) *A Theory of Justice (Original Edition)* (Cambridge MA: Harvard University Press).

--------. (1985) Justice as Fairness: Political not Metaphysical. *Philosophy & Public Affairs, 14*(3): 223-251. doi: http://www.jstor.org/stable/2265349.

--------. (1971, 1999) *A Theory of Justice (Revised Edition)* (Cambridge MA: Harvard University Press).

Reichman, Nancy E, Hope Corman, & Kelly Noonan. (2004) Effects of Child Health in Parents' Relationship Status. *Demography, 41*(2): 569-584. doi: http://www.ncbi.nlm.nih.gov/pubmed/15461015

Reid, Les. (2013) Books - "The Bible". *Philosophy Now, 99*(Nov/Dec): 46.

Rescher, Nicholasd. (1989) *Moral Absolutes* (London: Peter Lang Publishing).

Riess, Helen. (2010) Empathy in medicine--a neurobiological perspective. *Journal of the American Medical Association, 304*(14): 1604-1605. doi: 304/14/1604 [pii] 10.1001/jama.2010.1455.

Rosenthal, Susan, Brian Howard, Yvette Schlussel, Dana Herrigel, Gabriel Smolarz, Brian Gable, et al. (2011) Humanism at heart: Preserving empathy in third-year medical students. *Academic Medicine, 86*(3): 350-358.

Ross, David. (2002) With Philip Stratton-Lake. *The Right and the Good* (Oxford: Oxford University Press).

Ross, WD. (1998) *Aristotle: Nicomachean Ethics* (Oxford: Oxford University Press).

Russell, Bertrand. (1946, 2004) *History of Western Philosophy* (London: Routledge Classics).

Russell, Leonard J. (1942) Ideals and Practice. *Philosophy*, XVII, 109-110.

Sachs, Joe. (2002) (J. Sachs, Trans.) *Aristotle: Nicomachean Ethics* (Newburyport MA: Focus Publishing, R Pullins Company).

Sandel, Michael J. (2009) *Justice: What is the Right Thing to Do?* (New York: Farrar, Straus and Giroux).

Satre, Jean-Paul. (1957, 2010) Existentialism and Human Emotion. In G. Marino (Ed.), *Ethics: the Essential Writings* (New York: Modern Library Classics (Random House Group)), 328-332.

Scambler, Graham. (2001) Introduction: Unfolding themes of an incomplete project. G. Scambler (Ed.), *Habermas, Critical theory, and Health* (London: Routledge) 1-24.

Scambler, Graham, & Nicky Britten. (2001) System, lifeworld and doctor-patient interaction. G. Scambler (Ed.), *Habermas, Critical theory, and Health* (London: Routledge), 45-67.

Scanlon, Thomas (Tim). (1982) Contractualism and Utilitarianism. *Utilitarianism and Beyond* (Cambridge: Cambridge University Press), 103-128.

--------. (1998) Wrongness and reasons. *What We Owe To Each Other* (Cambridge, Mass: Belknap Press of Harvard University Press), 147-188.

Scanlon, Thomas, & Alex Voorhoeve. 2009) The kingdom of ends on the cheap. *Conversations on Ethics* (Oxford: Oxford University Press), 179-192.

Schlick, Moritz. (1967, 1992) The future of philosophy. R. Rorty (Ed.), *The Linguistic Turn: Essays in Philosophical Method* (Chicago: University of Chicago Press), 43-54.

Schneewind, JB. (1992) Autonomy, obligation, and virtue: An overview of Kant's moral philosophy P. Guyer (Ed.), *The Cambridge Companion to Kant* (Cambridge: Cambridge University Press), 309-341.

Schon, Donald A. (1987) *Educating The Reflective Practitioner* (San Francisco: Jossey-Bass Publishers).

Schopenhauer, Arthur. (1841, 1965) (E. Payne, Trans.) *On the Basis of Morality* (Indianapolis: Bobbs-Merrill Company Inc).

--------. (1818, 1844, 1969) (E. Payne, Trans.) *The World as Will and Representation* (New York: Dover Publications).

Seedhouse, David. (1991) Against medical ethics: A philosopher's view. *Medical Education, 25*(4): 280-282. doi: http://www.ncbi.nlm.nih.gov/pubmed/1890955.

Sheehan, Mark. (2007) Resources and the Rule of Rescue. *Journal of Applied Philosophy, 24*(4): 352-366. doi: 10.1111/j.1468-5930.2007.00383.x.

Sidgwick, Henry. (1907, 1962) *The Methods of Ethics* (7th ed.). (London: MacMillan & Company Ltd).

Singer, Marcus. (1963) The Golden Rule. *Philosophy, 38*(146): 293-314.

Singer, Peter. (1994) Introduction. *Ethics* (Oxford: Oxford University Press), 3-13.

--------. (2005) Ethics and Intuitions. *The Journal of Ethics, 9*(9): 331-352. doi: 10.1007/s10892-005-3508-y.

--------. (2009) *The Life You Can Save: Acting Now to End World Poverty* (New York: Random House).

--------. (2010) Rich and Poor. G. Marino (Ed.), *Ethics: the Essential Writings* (New York: Modern Library Classics (Random House Group)), 506-529.

Skeat, Walter W (Ed.) (1999) An Etymological Dictionay of the English Language. (Oxford: Clarendon Press).

Slote, Michael. (1995) Task of ethics. W. T. Reich (Ed.), *Encyclopedia of Bioethics, Revised edition* (New York: Simon and Schuster, MacMillan Library Reference), 722-727.

--------. (2001) *Morals from Motives* (Oxford: Oxford University Press).

--------. (2007) *The Ethics of Care and Empathy* (New York: Routledge).

Smart, John Jamieson Carswell, & Bernard Williams. (1973) *Utilitarianism: For and Against* (Cambridge Cambridge University Press).

Sokolowski, Robert. (1999) *Introduction to Phenomenology* (Cambridge: Cambridge University Press).

Sophocles. (1952) (R. C. Jebb, Trans.) Antigone. *Aeschylus, Sophocles, Euripides, Aristophanes* (first ed.). (Chicago: William Benton, Encyclopedia Britannica Inc), 131-142.

Stirrat, Gordon M. (2010) Teaching and learning medical ethics and law in UK medical schools. *Clinical Ethics, 5*: 156-158.

Stokes, Patrick. (2012) Philosophy has consequences! Developing metacognition and active learning in the ethics classroom. *Teaching Philosophy, 35*(2): 143-169.

Solomon, W. David. (1995) Normative ethical theories. In S. G. Post (Ed.), *Encyclopedia of bioethics* (3rd ed., Vol. 3) (New York: Macmillan), 812-824.

Stoljar, Natalie. (2011) Informed consent and relational conceptions of autonomy. *Journal of Medicine and Philosophy, 36*(4): 375-384. doi: 10.1093/jmp/jhr029

Stonington, Scott D. (2013) The debt of life - Thai lessons on a process-oriented ethical logic. *New England Journal of Medicine, 369*(17) doi: 10.1056/NEJMp1308613.

Strawson, Peter Frederick. (1961) Social morality and individual ideal. *Philosophy, 36*(136): 1-17.

Streiffer, Robert. (2003) Defining moral relativism. *Moral relativism and reasons for action*. (New York: Routledge), 93-100.

Sulmasy, Daniel P, & Edmund Pellegrino. (1999) The rule of double effect: Clearing up the double talk. *Archives of Internal Medicine*, 159(6): 545-550. http://www.ncbi.nlm.nih.gov/pubmed/10090110.

Svenaeus, Frederik. (2014) *Phenomenology as a method within the realm of bioethics*. Paper presented at the The New Zealand Bioethics Conference, Dunedin, Otago.

Sykes, Nigel, & Andrew Thorns. (2003) The use of opioids and sedatives at the end of life. *Lancet Oncology, 4*(5): 312-318.

Tait, Gordon. (2013) *Making Sense of Mass Education* (Cambridge: Cambridge University Press).

Tajouri Tanya, Ottenberg Abigale, & Hayes David. (2012) The use of advance directives among patients with implantaable cardioverter defibrillators. *Pacing and Clinical Electrophysiology* (35): 567-573.

Tassy, Sebastien, Pierre Le Coz, & Bruno Wicker. (2007) Current knowledge in moral cognition can improve medical ethics. *Journal of Medical Ethics, 34*: 679-682.

Taylor, Charles. (1989) The conflicts of modernity. *Sources of the Self: The Making of the Modern Identity* (Cambridge: Cambridge University Press), 495-521.

Thiroux, Jacques, & Keith Krasemann. (2007) Consequentialist (teleological) theories of morality. *Ethics Theory and Practice* (9th ed.). (New Jersey: Pearson, Prentice Hall), 33-52.

Thomassen, Lasse. (2010) *Habermas: A Guide for the Perplexed* (London: Continuum International).

Thomson, Judith Jarvis. (1971) A Defense of Abortion. *Philosophy and Public Affairs, 1*(1): 47-66.

--------. (2008) Turning the Trolley. *Philosophy & Public Affairs, 36*(4): 359-374. doi: 10.1111/j.1088-4963.2008.00144.x.

Todd, Sharon. (2010) Living in a dissonant world: Towards an agnostic cosmopolitics for Education. *Studies in Philosophy and Education, 29*(2): 213-228.

Toon, Peter D. (1993) After bioethics and towards virtue? *Journal of Medical Ethics, 19*(1):17-18 doi: http://www.ncbi.nlm.nih.gov/pubmed/8459433.

UNESCO. (2005) Intersectoral Strategy on Philosophy, Social and Human Scoences Sector, Paris, France.

--------. (2007) Philosophy: A School of Freedom (Teaching Philosophy and Learning to Philosophize. Status and prospects). (Paris, France Annex 3).

Valentinus. (2007) The Gospel of Truth. M. Meyer (Ed.), *The Secret Gospels of Jesus* (London: Darton, Longman and Todd Ltd), 89-112.

Veatch, Robert M, Amy M Haddad, & Dan C English. (2010) *Case Studies in Biomedical Ethics* (New York: Oxford University Press).

Vermes, Geza. (2003, 2009) *The Authentic Gospel of Jesus* (London: Folio Society).

Vernon, Mark. What is the Good Life (2010), from http://www.markvernon.com/friendshiponline/dotclear/index.php?post/2007/01/07/484-what-is-the-good-life.

VirtueScience. The Golden Rule. 2.9.2012, from http://www.virtuescience.com/golden-rule.html.

Voorhoeve, Alex, & David Velleman. (2009) Really seeing another. *Conversations on Ethics* (Oxford: Oxford University Press), 233-255.

Waldman, J Deane, Frank Kelly, & Howard L Smith. (2004) The shocking cost of turnover in health care. *Health Care Management Review, 29*(1): 2-7. doi: http://www.ncbi.nlm.nih.gov/pubmed/14992479.

Waldmann, Michael R, & Jorn H Dieterich. (2007) Throwing a bomb on a person versus throwing a person on a bomb: Intervention myopia in moral intuitions. *Psychological Science, 18*(3): 247-243.

Walker, Paul, John Cassey, & Stephen O'Callaghan. (2005) Management of antenatally detected lesions liable to obstruct the airway at birth – an evolving paradigm. *International Journal of Pediatric Otolaryngology, 69*(6): 805-809.

Walker, Paul, & Terrence Lovat. (2015) Concepts of personhood and autonomy as they apply to end-of-life decisions in intensive care. *Medicine, Health Care and Philosophy, 18*(3): 309-315. doi: 10.1007/s11019-014-9604-7.

Walker, Paul, Terrence Lovat, James Leitch, & Peter Saul. (2014) The moral philsophical challenges posed by fully implantable permanent pacemakers. *Ethics and Medicine, 30*(3): 157-165.

Wallace, Kathleen A. (2009) Common morality and moral reform. *Theoretical and Medical Bioethics, 30*(1): 55-68. doi: 10.1007/s11017-009-9096-2.

Walter, James. (2004) Life, Quality of. *Encyclopedia of Bioethics* (3rd ed.). (New York: MacMillan), 1388-1394.

Walter, Jennifer K & Lainie Friedman Ross. (2014) Relational autonomy: Moving beyond the limits of isolated individualism. *Pediatrics, 133*: S16-S23.

Ward, John. (2013) *What happens to the 'self' in dementia: implications for the health care system*. paper presented at University of Newcastle, Clinical Unit in Ethics and Health Law seminar.

Warnock, Mary. (1970) *Existentialism* (Oxford: Oxford University Press).

--------. (2004) *An Intelligent Person's Guide to Ethics* (London: Duckworth Overlook).

Warren, Mary Anne. (1973) On the moral and legal status of abortion. *The Monist*, 57(1): 43-61. DOI: 10.5840/monist197357133.

Weindling, Paul. (2001) The origins of informed consent: The International Scientific Commission on medical war crimes, and the Nurenberg code. *Bulletin of the History of Medicine, 75*(1), 37-71.

Weisz, George. (1990) Introduction. G. Weisz (Ed.), *Social Science perspectives on Medical Ethics* (Dordrecht, Netherlands: Kluwer Academic Publishers), 3-17.

White, Stephen K. (1991) The postmodern problematic. *Political theory and Postmodernism* (Cambridge, England: Cambridge University Press), 1-12.

Widdershoven, Guy, & Tineke Abma. (2007) Hermeneutic ethics between practice and theory. Richard Ashcroft, Angus Dawson, Heather Draper & J. McMillan (Eds.), *Principles of Health Care Ethics* (Chichester, England: John Wiley & Sons)', 215-222.

Wildes, Kevin W. (1996) Ordinary and extraordinary means and the quality of life. *Theological Studies, 57*(3): 500-512. doi: http://www.ncbi.nlm.nih.gov/pubmed/11658197.

Williams, Bernard. (1985, 2006) *Ethics and the Limits of Philosophy* (London: Routledge Classics).

Williams, Rowan. (2001) Making Moral Decisions. R. Gill (Ed.), *The Cambridge Companion to Christian Ethics* (Cambridge: Cambridge University Press), 3-15.

Wilson, Hamish. (2014) *The challenge of whole person care*. Paper presented at the The New Zealand Bioethics Conference, Dunedin, Otago.

Wittgenstein, Ludwig. (1984, T. Lowes (Ed.), *A Wittgenstein Primer* (Reprinted electronically December 2011 HTML editor carolinelewis@eircom.net)

--------. (1969. 1975) (Denis Paul & G. Anscombe, Trans.) GEM Anscombe & GH von Wright (Eds.), *On Certainty (Parallel Text)* (Malden, MA: Blackwell Publishing).

--------. (published 1965 *Philosphical Review* 74/1, delivered Nov 1929, 1994) A Lecture on Ethics. In P. Singer (Ed.), *Ethics* (Oxford: Oxford University Press), 140-147.

--------. (1918, 2011) *Tractatus Logico-Philosophicus* (CreateSpace Independent Publishing Platform).

Wolf, Susan. (2011) Hiking the range. *On What Matters* (Vol 2) (Oxford: Oxford University Press), 33-57.

Wolpe, Paul Root. (1998) The triumph of autonomy in American medical ethics: A sociological view. Raymond DeVries & J. Subedi (Eds.), *Bioethics and Society: Constructing the Ethical Enterprise* (New Jersey: Prentice Hall), 38-59.

Wong, David. (1993) Relativism. P. Singer (Ed.), *A Companion to Ethics* (Malden MA: Blackwell). 442-450.

Wood, Allen. (2011) Humanity as end in itself. *On What Matters* (Vol 2) (Oxford: Oxford University Press), 58-82.

Youssef, Farid F., Karine Dookeeram, Vasant Basdeo, et al. (2012) Stress alters personal moral decision making. *Psychoneuroendocrinology, 37*(4): 491-498. doi: 10.1016/j.psyneuen.2011.07.017.

Zeiler, Kristin. (2012) Bringing the lived body to medical ethics education: Learning to see the suffering other. C. Cowley (Ed.), *Reconceiving Medical Ethics* (1 ed.). (London: Bloomsbury Academic), 43-55.