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COMMENTS ON A MEDICAL ETHICS FOR THE FUTURE: A COMMENTARY ON ANDRE DE VRIES*

De Vries' warning about both the urgency and at the same time, the difficulty of shaping an ethics for the future, is both accurate and timely. Biomedical developments clearly will not allow us to opt out of making ethical decisions. For in effect, not to decide at all, by ignoring the problem, is to implement a particular course of events. However, as de Vries points out, there is no universally accepted definition of ethics, no set of principles algorithmically decidable in particular cases. How then are we to proceed? Such decisions are, as de Vries argues, partly emotional, and are therefore non-mechanistic. But at the same time they must be logical, or at least not unreasonable in our arguments and deliberations. Can we be logical without being purely mechanistic?

An elderly man, dying of chronic obstructive lung disease, is in an intensive care unit. He is unconscious and has left no directions for his care. His wife wants him to be taken off the ventilator. The attending physician has decided that it is too soon to cease aggressive therapy, and that he should be kept on the ventilator. No doubt they both have their reasons. But they conflict. What is the correct ethical decision?

One impressive and rather forbidding fact about the development of ethics is the disagreement and divergencies of principles when one attempts to rule on a particular case. In the hard choices characteristic of biomedical ethics, two or more moral principles characteristically conflict. Which principle has priority often appears to be determined by the religious, professional, or perhaps even political or philosophical presumptions or tenets of a particular individual. It seems that we can look at the pros and cons of a particular case, and, by dialogue and argument, map out justifications for the various conflicting proposals for resolution. But when it comes down to the hard choice of deciding one way or the other, characteristically we are prevented from a definitive resolution by the conflict of principles.

For example, when a Jehovah's Witness parent's refusal of a blood transfusion for his child threatens the child's life, there is the conflict between honouring freedom of religion and protecting a child from life-threatening harm. But in a particular case, it is very difficult to see how one of these principles clearly outweighs the other. Other issues like that of proxy consent also are involved. Do the parents have the right to make this decision for the child? Even if the child agrees not to have the transfusion, can this be regarded as a meaningful exercise of autonomy? Does the state have a right to decide to treat, on the basis of its interest in the well-being of this child? Certainly one can find out what

Metamedicine 3 (1982) 121–124. 0166–2031/82/0031–0121 $00.40.

the general principles are, but how to priorize them to definitively resolve the problem? We appear to have no method.

One's observation is that in actual fact such decisions are ultimately arrived at by a kind of open-ended dialogue among the concerned participants. While principles will certainly play a role in a superior dialogue, they are seldom decisive in directing a particular outcome.

De Vries subscribes to the ethical principle of negotiating between individuals on the basis of responsibility, truthfulness and respect for opinions. As I see it, this principle is the correct approach for ethical reasoning about a particular biomedical-ethical problem or decision. In any pluralistic society, or in a pluralistic world, one cannot dogmatically adhere to religious or moral imperatives that others may not agree with, or may priorize differently. However, the reaction to this pluralism should not be a moral relativism – 'whatever feels good is the right decision'. Relativism need not even bother to isolate ethical principles, let alone engage in meaningful dialogue on how to apply them. On the other hand, taking the hard stance of dogmatic authoritarianism – 'My principles are the right ones' – is not a reasonable or practical solution either. Rather, the reflective and honest person must attempt to sincerely negotiate a solution based on truthful and clear-minded dialogue. True, this process is very hard for stubborn or angry people to engage in; but the fact is that it is successfully accomplished in hospital wards every day all over the world. Of course it often fails too, but that doesn't mean it can't be done.

The method is as old as Socrates. You have a group of interested people willing to engage in a sincere attempt at dialogue with each other. Often the dialogue falters, sometimes it is very difficult to go on, and the participants are sometimes very uncomfortable with, not to say unwilling to accept, arguments urged on them by the others. But in the end, if the dialogue is a good one, the participants will at least better understand why their opponents take the views they persist in.

As a Canadian who lives in a highly pluralistic society composed of people of different ethnic and religious backgrounds, I may be even more constantly aware of pluralistic ethical dialogues than some who live in a more monolithic culture. Most Canadians were immigrants not too long ago. By necessity, Canadians have made something of a virtue out of diplomatic tact and negotiation with more powerful other countries. Our bilingual and multi-cultural society makes life for us, as an individual, a constant negotiation and interaction with others who may not cleave so closely to the particular principles we place a high priority on.

But no democratic country can tolerate the enforcement of one philosophical or religious viewpoint upon citizens who might wish to direct their personal affairs by individual philosophical principles. And even internal, national or

religious unanimities must deal with other cultures and viewpoints, if they are to survive. The autonomy of other rational agents, along with their divergent ethical principles and beliefs, may be argued against but must not be set aside in thoughtless quarrels, or crushed by aggressive persuasion or needless warfare.

Where does this leave our unconscious patient in intensive care management? The physician must try to make it clear to the patient's wife why he thinks aggressive therapy (the ventilator) should be withdrawn. Perhaps his justification of that course of action is based on his prognosis. If so, he must make a sincere effort to try to explain to this layperson why he as a doctor has arrived at that conclusion. That may be hard; for she may have no special knowledge of medicine or of the patient's real condition.

On the other side of the dialogue, the wife must make it clear why she feels therapy should be discontinued. Perhaps her husband has fear of hospital, finds the ventilator an intolerable burden, and his wife understands how he feels better than anyone else could. Then she must put up her arguments for her husband, and try to get the physician to see it her way. Both parties being of good will, and trusting one another, at least to some extent, perhaps a decision will be arrived at that both can accept. In ethical reasoning about a particular case there is never any guarantee, but there is always some hope, given that each will try to understand the other's arguments.

What we are saying then is that the logic of ethical disagreement is not a mathematical algorithm that always gives a uniquely determined result once the proper inputs are made. It is a free dialogue – what Aristotle called dialectic – that may swing the argument one way or the other, or may simply result in a stalemate. And the outcome is always highly influenced by the particular circumstances of an individual case. For all its shortcomings, ethical reasoning works well in many difficult decision-making situations every day, without the necessity for adversary legal procedures and enforced judgements. It could work better in many instances if physicians took more time to explain their recommendations to concerned patients, and if patients tried harder to understand their own medical needs, and the medical services available to meet those needs.

Thus de Vries is right to emphasize the need for truthful communication between patient and physician if ethical reasoning is to be possible in making hard ethical choices in a pluralistic and democratic society. Not that both parties must always tell the whole truth, however that is to be defined; but both must attempt to truthfully and sincerely communicate in reasonable dialogue, to try to understand each other's arguments and enunciate their own arguments and justifications.

As de Vries points out, the same requirements also apply to successful political decision-making in the larger group setting of nations and societies. The

greatest heroes, I would say, are those disagreed with unfair authoritarian political directives, basing their individual decisions on their own arguably superior personal ethics. The greatest atrocities occurred where dogmatic political philosophies have overruled personal ethics, as de Vries comments.

My conclusion is that if ethics has a logic, it is not the logic of mathematical proof and demonstration, but the logic of dialogue. So construed, an argument is a two (or many) person interchange, a sequence of moves and countermoves according to a set of rules agreed upon by the participants. This view of the foundations of ethical reasoning is one I believe that can yield enough of a common denominator among the pluralisms to form a basis for a new ethics.

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NOTE

* Cf. Andre de Vries, 'Reflections on a medical ethics for the future', *Metamedicine* 3, (1982) 115–120 (this issue).