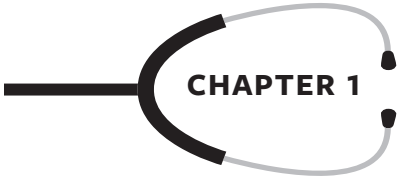

Ethical Dilemmas in Medicine

OPENING GAMBIT

The Transposition of the Great Arteries

Death is never easy, but the death of an infant is particularly traumatic for everyone involved. Infants born with transposition of the great arteries die lethargic, blue-tinged, and gasping for breath because the artery that sends blood to the lungs to receive oxygen bypasses the lungs altogether, sending oxygen-poor blood back into the body. For a long time there was only one way to save the infants: a complex surgery called the Senning procedure. The Senning procedure wasn't all that risky (infants died in only about 5 to 10 per cent of the cases), but survivors of the procedure were at a much greater risk for heart defects later in life; because their hearts were compromised, most never made it to old age.

The surgeons of the Great Ormond Street Hospital in London wanted to switch from the Senning procedure to something called the Jatene procedure. In the Jatene procedure, the arteries are surgically removed and reattached. The new procedure increases quality of life, and those who get the surgery can live full and active lives. There was a cost, however: Surgeons had to gain experience with the new procedure because surgeons learn on the job.

A study done twenty years after the fact showed that, in the beginning, infant deaths rose sharply for a few years but then declined rapidly so that almost no infant dies of transposition of the great arteries today. If the hospital had stuck with the traditional procedure, there would have been less risk to

infants during surgery, but those infants would have had a poor quality of life. Since the hospital offered patients a new procedure, there was a greater risk in the short term, until the surgeons learned the new procedure. In the long run, however, the quality of life for the patients was much better. The choice to switch from an older, reliable procedure to a new one was a choice "between expertise and progress," according to author and surgeon Atul Gawande.*

Imagine that now you are in a similar position, as either a surgeon or someone else who weighs in on a similar change in procedure. In a hypothetical hospital, surgeons are faced with learning a new procedure for treating infants. If surgeons do not perform the procedure enough, they will never get good at it, but if they do develop the expertise, the overall good for patients will be significant.

However, if we allow surgeons to practice, there is a greater risk of complications or death. Assume, for the sake of the exercise, that there is no way to learn the procedure without operating on actual humans (often the case in real life). Would you vote for allowing the new procedure, knowing that it will almost certainly be better in the long run but at the price of increased risk of infants dying in the short term? In addition, just how much should surgeons tell the parents about their inexperience with the new procedure? Should they mention just the increased risk of dying or their inexperience with the procedure as well?

WHAT'S AT STAKE?

The medical providers at the London hospital faced an ethical dilemma. There are two choices, and neither choice is ideal. Technically, if there were three choices, our case would represent a trilemma. However, the term "dilemma" has come to mean a situation where there are at least two choices. Both choices seem unethical somehow. In addition, doing nothing isn't really an option, as a dilemma requires that one of the two possible outcomes occur.

When it comes to the choice of implementing a new surgical procedure, the staff at the hospital might feel like they are damned if they do and damned if they don't. Such dilemmas force us to weigh the costs and benefits of a particular action, but not just in terms of number of lives saved, or protecting patient rights, but also in terms of what we think is right and good for interactions between patients, medical providers (doctors/nurses/administrators), and the public.

These sorts of ethical clashes are what make bioethics interesting, vitally important, and uniquely relevant. The fact is that if you have any dealings with

* Atul Gawande, *Complications: A Surgeon's Notes on an Imperfect Science* (New York: Picador, 2002). Elements of this case study were taken from Gawande's description.

medicine or biotechnology as either provider or patient, you will probably face a dilemma where you are damned if you do and damned if you don't.

We begin our study of bioethics with dilemmas because this is where the study of ethics becomes practical. Most moral decisions are not moral dilemmas. Everyday we are faced with situations where it would be better for us to lie, cheat, or steal, but common-sense morality says we should not. There is no damned if you don't. You are wrong and morally blameworthy if you lie, cheat, or steal. However, most ethical concerns occur when there are reasons to do something that otherwise would be unethical. That's a moral dilemma.

It is possible to face dilemmas head on and come out with a resolution that meets three criteria: clear, coherent, and justified. Note that we say "resolution" rather than "answer" because an ethical dilemma might allow for more than one permissible option. If we are lucky, there will be several good resolutions to a dilemma. However, when it comes to bioethics, it is more likely we will face a decision that may not be ideal but one we can live with. Let's look at each of these claims:

- *Clear*: everyone involved—patients, family members, and providers—can understand not only what decision was made but also why it was made.

- *Coherent*: a decision that is consistent with other, similar ethical decisions.

- *Justified*: all those involved will be able to point to reasons that the decision makers used to make the decision, and whether they agree with the decision or not, any reasonable person would agree it was a reasonable decision.

Why is "justified" the highest we can hope for? Why not aim for the "the right decision"? There is a fact that becomes very evident whenever one is faced with an ethical problem and multiple parties have a stake in the outcome: We live in a pluralistic society. *Ethical pluralism* holds that it is just a fact that people don't always agree on what is the right action to take in a given situation, or even on how to arrive at the right answer. Of course, a right answer may or may not actually exist. If the question is a matter of taste, such as "Which indie rock band is the best?" or "Who makes the best barbecue?" or "Which theory of nursing is best for teaching nurses?," there may not be a single right answer. However, the mere fact that just about everyone disagrees about the best course of action does not mean there is not a right answer. A jury in a trial may not ever agree at all whether the defendant is guilty or not guilty, and no one may ever really know except the defendant, the plaintiff, and (if the defendant is not guilty) the

actual guilty party. Regardless, there is a fact of the matter. The defendant is either guilty or not even though no one can agree.

It would be foolish to think that, in our politically charged society, there would be a consensus about how to ensure a fair distribution of wealth. However, that does not mean there is not a fair way to divide wealth in a given economy. The most we can hope for is that the laws passed are not arbitrary or self-serving. Likewise, medical staff may never agree on whether to honor a patient's request to turn off a pacemaker, but that does not mean there is no right answer about honoring that request. The most we can hope for is that whatever decision is made is one that can be explained to the patient and the family such that anyone would say, "I may not agree, but I understand why the decision was made."

This kind of pluralism should be contrasted with *ethical relativism* and *ethical monism*. In ethical relativism, all moral values are viewed as relative to something; nothing is good or bad, right or wrong, in itself. For instance, cultural relativists argue that moral values (right/wrong/good/bad) are dependent on the culture one is operating in. This means that nothing can be said to be right or wrong outside the culture in question. If you want to do right, then follow the old maxim "When in Rome, do as the Romans do," because literally that is what is right. Protagoras, an ancient Greek philosopher, is said to have argued that "whatever things seem to each city to be fine and just are so for that city, so long as it maintains them." In other words, what is ethically just is relative to a particular city. I guess you could call that municipal relativism. But instead of "city" substitute "region," "state," or "country" and you get the bigger picture.

Ethical monists say that some actions are right or wrong, good or bad, independently of a culture or a person. More importantly, they say that all morality is reducible to one single value. For instance, if you believed that all morality was a question of acting on what produced the least amount of pain for everyone, then you would be an ethical monist. Ethical monists believe that all moral dilemmas can be resolved by asking which action produces the one value the most. That choice then becomes the best resolution morally. For instance, philosopher Jeremy Bentham (1748–1832) was an ethical monist. He thought that you could figure out every ethical dilemma based on which action would produce the most amount of good, where good was measured in terms of pleasure, and bad in terms of pain, for the greatest number. He called this value *utility* and his theory *utilitarianism*. Later utilitarians like J.S. Mill (1806–73) would modify Bentham's proposal, but the core idea remained. The right thing to do was always whatever action would create the most amount of pleasure and the least amount of pain for everyone.

Ethical pluralists sit in between ethical monists and ethical relativists. Ethical pluralists say that there is not just one value that matters, like pleasure. An ethical pluralist might say there are several equally important ethical values, such as reducing pain and honoring patient requests, and there is no reason these values will not conflict. In the opening gambit, the choice about switching surgical procedures is a dilemma precisely because there may be more than one value at stake. On the one hand, we value medical progress, not the least because it results in less pain overall for everyone. The development of the smallpox vaccine involved some unpleasant suffering, but it resulted in a lot fewer people dead in the long run.

We also value our obligation to protect individuals from risk of harm or death. The question we asked about how much we should tell the patient about our lack of expertise in doing this procedure pits our value of what is best for everyone in the long run (surgeons getting good at the procedure through practice) against the value of patients' ability to decide what's best for them with adequate information. In Chapter 2 we will give names to those values, but for now it is important for us to see that an ethical dilemma is so difficult because we tend to think that values are plural, not monistic or relative.

If moral values were singular (ethical monism), resolving the "damned if you do, damned if you don't" moment might be simple. Figure out the single value and choose which option produces that single value the best. If the absence of pain for everyone is the single value, then we should most likely choose to implement the new procedure as much as possible, since surgeons who are good at the procedure will produce a better quality of life for everyone they operate on once they become experts.

If values were relative, ethical dilemmas would not be as problematic. If our prevailing culture thinks the right of the individual is more important than the good of the community, as is often the case in the United States for example, then the hospital has an obligation to warn patients about how inexperienced surgeons are even if this means surgeons never really get good at the new procedure. On the other hand, if the culture values the collective good of the community over the individual, then it may be permissible to inform but not warn. The point is that dilemmas are not as difficult or as vital if we are either ethical monists or ethical relativists.

Let's review: An ethical dilemma is one where there are at least two options about what is the right thing to do. Choosing any option will cause us to sacrifice some value. We are damned if we do this and we are damned if we don't. The reason we feel this clash of values is that ethical values seem inescapably plural. There seems to be more than one value and no good way to say that one value

is more important than any other. We should respect patients, but we should also make their lives better. What happens when respecting patients' decisions actually leads to things being worse off for them (and everyone else)? Which value wins so we can have a resolution that is clear, coherent, and justified?

Answering that question is the heart of what we call *ethical decision making* or *moral reasoning*. Throughout this text, we will be referring to cases where an ethical decision has to be made. These are usually real-life stories of patients and providers who faced a dilemma. The goal of looking at these cases is to figure out how to resolve the dilemma in a way that is clear, coherent, and justifiable.

This sort of analysis goes on all the time in health care. A patient's family asks the doctor to shut off a defibrillator that keeps the patient's heart beating at the correct rhythm. This is not some machine to unplug; it is a device implanted in the patient's chest. A code must be transmitted to stop the tiny electric shocks that keep the patient's heart beating properly. The family wants this device deactivated because the patient is in the end stages of the dying process. The family feels that the device is prolonging the patient's life unnecessarily. However, we also find out that the patient is awake, eats with some help, and can communicate, though they aren't capable of making their own decisions. Some nursing staff worry that shutting off the defibrillator will hasten the patient's death.

Since the patient is not capable of making their own decisions, standard policy is to defer to the patient's designated surrogate as if their wishes were the patient's themselves. We value a patient's right to make their own decisions, what we often refer to as their *autonomy*. Families request that staff remove breathing tubes every day, and all things considered, we should treat their request as if it came from the patient. This is referred to as *substituted judgment*. However, we also value *non-maleficence*, the duty not to harm someone without a compelling reason.

We know this is an ethical dilemma because if we agree to the family's request we may violate the principle of non-maleficence, but if we don't agree then we violate the family's autonomy. Now, we value autonomy in bioethics, but not at the expense of causing harm. Medical staff have to make the call that a patient could harm themself or others every time they restrain a patient.

So now that we can recognize a dilemma, what do we do with it?

There are several ways to analyze an ethical dilemma. The most frequently used method in bioethics and medicine today is usually called *principlism* because it focuses on principles like autonomy and non-maleficence and tries to balance them in a way that is clear, coherent, and justified.

We can think of ethical dilemmas as being like a diagnosis and treatment, whereby we break our process down into problem, data (including facts, medical goals, patient goals, and context), ethical assessment, dialogue, and best course

of action.* It turns out that more or less every professional, ethical-decision–making model has the same sorts of elements even if they are not labeled the same. For instance, The American Accounting Association categorizes its ethical decision making as follows:

1. Determine the facts
2. Define the ethical issue
3. Identify the major principles, rules, and values
4. List the courses of action
5. Compare values and alternatives (see if a clear decision is evident)
6. Assess the consequences
7. Make a decision.†

The one thing missing, however, is the place of identifying the ethical dilemma. Can you find the dilemma in the accounting model? It is in step 5. But we've seen that what makes ethical reasoning difficult is when major principles, rules, and values clash in a "damned if we do, damned if we don't" moment. It certainly is true that lots of ethical issues have clear and evident decisions. If you have a choice between lying to a client and not lying to a client, all things being equal, you shouldn't lie to clients mainly because, all things being equal, we shouldn't lie. Accountants, nurses, and administrators should do likewise. But what everyone needs is a way to resolve those thorny ethical issues that represent a dilemma. Let's combine these similar models into one that emphasizes the dilemmas in bioethics.

The first step to any treatment is to examine the patient and sort out what things are relevant and what things are not. Let's call this step the "describe" phase. Here we want to pay close attention to the facts of the case and the stakeholders—all the people who have an interest in the outcome of the dilemma. Stakeholders typically include the medical staff, the hospital administration, the patient, and the family members. Scientific researchers might also be involved. In a public health department, the public at large would be included.

What does each of the stakeholders want? It may not be readily apparent that during the describe phase we need to isolate those facts that are ethically important. A patient's temperature is medically relevant, but is it ethically relevant? Only if it contributes to what makes our case a dilemma. Some facts should not even be considered in case analysis. Suppose we are part of an organ

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* For a discussion of this method, see Lauris C. Kaldjian, Robert F. Weir, and Thomas P. Duffy, "A Clinician's Approach to Clinical Ethical Reasoning," *Journal of General Internal Medicine* 20, no. 3 (2005): 306–11.

† See https://www.accaglobal.com/gb/en/student/exam-support-resources/professional-exams-study-resources/strategic-business-leader/technical-articles/ethical-decision-making.html.

transplant network and have two equally sick people in need of a kidney: Does it matter that one is a woman and one is a man? How about if one is single and the other is married with three children? These factors should be considered only if they contribute to a better chance of long-term survival because we already want the organ to go to the person who will benefit the most from it.

Now let's examine another case study concerning the use of a ventilator. After going through the *describe* phase, we will move on to the other elements of our bioethics dilemma model: *dilemma*, *discern*, *decide*, and *defend*.

> A 48-year-old man with no immediate family suffers from a rare paralysis of the diaphragm. He has been on a ventilator (breathing machine) for the last ten years. He is dependent on the ventilator and cannot breathe unaided. He arrives at the ER because his home ventilator was malfunctioning and not giving him enough air. After the staff hook him up to a hospital ventilator, his breathing returns to normal. Nonetheless, he is admitted for observation. After he regains consciousness, he requests that his ventilator be removed and that he be allowed to die. He says he is tired of having this machine breathing for him. In another age he would have died a long time ago. When the medical staff express to him that other than the ventilator he is fairly healthy and can expect to live into his 70s, he remarks that this is precisely the problem. The staff is reluctant to remove the ventilator because the patient is not terminally ill. The patient insists that the right to refuse treatment is one of the strongest rights he has.

Describe

In the describe phase, we are interested only in which details of the story are relevant ethically:

1. The patient can't breathe unaided.
2. He's been on a vent for 10 years.
3. He is otherwise healthy.
4. His vent was blocked, and he almost died.
5. Now he wants the vent permanently removed.
6. The medical staff are reluctant to comply.
7. He has no immediate family.

Now let's get philosophical. Why is the fact that the patient can't breathe unaided *ethically* relevant? If we comply with his request, he will die fairly soon. What about the fact that he's been on a ventilator for ten years? Does it matter that he is otherwise healthy? Should we include that in our ethical analysis? Of course: The fact that he is otherwise healthy is what is giving the staff ethical fits.* Does it matter that he has no immediate family? Well, yes and no. Even if he did have immediate family, that wouldn't mean we could ignore his autonomy, but it would mean that there would be people he should ethically consider in his decision.

See how this works? Every fact that we allow into our analysis has to be ethically relevant. Does it matter that he is 48 as opposed to 70? If so, why?

> Notice that this scenario is relevant not only if you are interested in medicine. The person asking for the breathing tube to be removed is making an ethical decision as well. This person is choosing to refuse treatment, and that refusal is likely to end up killing him. Patients and their family members will often face ethical dilemmas. People with a family history of genetic abnormalities face a dilemma involving testing for that disease. If they test for the genetic marker and find they have it, the symptoms could take years to materialize and be very mild. On the other hand, if they do not test, they could risk passing on the trait to others. Consider that the patient in this case is requesting that medical staff do something many of them find unethical.

Dilemma

If we look at the case above, there is a very clear dilemma, which we can articulate as follows: If the staff comply with the request, they may harm someone unnecessarily. But if the staff refuse to honor the request, they violate the patient's freedom to refuse treatment. Of course, if there were more than two options, we could articulate the trilemma using all three options, etc. If it helps, think of dilemmas in terms of the following formula:

> *If we do* (*action*)*, we violate* (*value*)*, but if we don't do* (*action*)*, we violate* (*other value*)*.*

* I deal with this in more detail in the chapter on end-of-life issues (Chapter 5), but we have strong intuitions about how people should die, and it usually means they are terminal.

Once we isolate the dilemma, we can check to see if it is a true dilemma. Is there any way to compromise? Is there a way to honor the patient's desires even if we don't obey his request? Is there a way to minimize harm to the patient while allowing him the freedom to do wrong?

Discern

So now we've gone below the average intuitions about harm and freedom to discern two very real principles of bioethics: non-maleficence and autonomy. I say more about principles in the next chapter, but for now let's assume that no laws will be broken regardless of whether we remove the ventilator. We make this assumption because we want to zero in on the ethical issues of the case. We have to decide, as medical providers (in this scenario), whether we will remove the breathing tube as the patient requests.

The discern phase of the ethical analysis does not easily admit of hard and fast rules. If it did, there would be no need for case analyses. We would just subject our dilemma to a foolproof test and get a resolution. Unfortunately, ethics is not that precise. Remember, we want a decision that is clear, coherent, and justified. There is no clear consensus in ethics about which principle should take precedence: autonomy or non-maleficence. There are some rules of thumb, however, some of which are provided by Beauchamp and Childress:

1. There are good reasons for choosing one principle over the other
2. There's a realistic chance that choosing the option can be achieved
3. No morally preferable options are available
4. The best option is one that violates a principle the least
5. All negative effects of the violated principle are minimized
6. All stakeholders have been treated impartially.*

Decide

It would be a lot easier if we could just do all this analysis in the discern phase and then say something like "There are good arguments on all sides and I'm not sure which I prefer." Unfortunately, the nature of dilemmas is that if we refuse to take a side, it is like opting for the status quo, resulting in one of the options happening

* Tom L. Beauchamp and James F. Childress, *Principles of Biomedical Ethics*, 8th ed. (Oxford University Press, 2019), p. 23.

regardless. So we have to make a decision. We can't stay on the fence. (In real life, hospital ethics committees almost never "decide"; however, they recommend a resolution, but ultimately it is up to the provider to take the advice or not.)

Defend

The last step is to defend the conclusion. This involves justifying the choice that was made by the individual or the committee. In this stage, various objections to the decision that is reached are considered. Suppose your conclusion is that the medical providers should honor the man's request and remove the breathing tube. In that case, they would be honoring his autonomy at the expense of beneficence. What sort of objections might you hear from those who disagree, and what would you say in reply? Throughout this book, you will be asked to settle in your mind your position on a controversial issue. Part of that settling process is considering objections to your position. Are there any long-range implications of your decision? If everyone were to adopt your decision, would it lead to consequences with which you are uncomfortable? The key idea in this step is having a clear, consistent, and justified position.

WHAT'S THE DEBATE?

Now that we have some idea about how moral dilemmas work, let's look at how some other authors wrestle with ethical dilemmas. The first reading is from Sir David Ross (1877–1971). Ross was an ethical pluralist, and he writes about how to handle conflicts of duties in "What Makes Right Actions Right?" The second reading is from another Englishman, John Stuart Mill. Mill was an ethical monist who thought that all ethical dilemmas can be resolved by appeal to one value: utility. The last reading is from British philosopher Stephen Toulmin (1922–2009) about the ways in which we look at cases.

along with the apprehension of the self-evident *prima facie* rightness of the same act in virtue of its having another characteristic as well, and perhaps in spite of the apprehension of its *prima facie* wrongness in virtue of its having some third characteristic, we come to believe something not self-evident at all, but an object of probable opinion, viz. that this particular act is (not *prima facie* but) actually right....

Notes

1. I take the theory which, as I have tried to show, seems to be put forward in *Ethics* rather than the earlier and less plausible theory put forward in *Principia Ethica*....
2. These are not strictly speaking duties, but things that tend to be our duty, or *prima facie* duties....
3. Some will think it, apart from other considerations, a sufficient refutation of this view to point out that I also stand in that relation to myself, so that for this view the distinction of oneself from others is morally insignificant.
4. I should make it plain at this stage that I am *assuming* the correctness of some of our main convictions as to *prima facie* duties, or, more strictly, am claiming that we know them to be true. To me it seems as self-evident as anything could be, that to make a promise, for instance, is to create a moral claim on us in someone else. Many readers will perhaps say that they do not know this to be true. If so, I certainly cannot prove it to them; I can only ask them to reflect again, in the hope that they will ultimately agree that they also know it to be true. The main moral conviction of the plain man seem [*sic*] to me to be, not opinions which it is for philosophy to prove or disprove, but knowledge from the start; and in my own case I seem to find little difficulty in distinguishing these essential convictions from other moral convictions which I also have, which are merely fallible opinions based on an imperfect study of the working for good or evil of certain institutions or types of action.
5. For a needed correction of this statement, cf. pp. 22–23 [of *The Right and the Good*, the 1930 book by Ross from which this extract is taken].

Reading 1.2: John Stuart Mill, from *Utilitarianism*

One of the biggest criticisms of Ross's prima facie duties is that they do not give us any way to decide when duties conflict. Ross does say that some of these duties will trump others, but he does not actually give us a system for deciding when one prima facie duty trumps another. Does Ross's pluralistic ethics really help us resolve dilemmas? We turn now to a monist response to this problem. Monists like J.S. Mill argue that their way is better because all dilemmas are resolvable in terms of one value. If all goodness is reducible to one value, then all dilemmas are resolvable.

There must be some standard by which to determine the goodness or badness, absolute and comparative, of ends, or objects of desire. And whatever that standard is, there can be but one; for if there were several ultimate principles of conduct, the same conduct might be approved by one of those principles and condemned by another; and there would be needed some more general principle, as umpire between them.

Accordingly, writers on Moral Philosophy have mostly felt the necessity not only of referring all rules of conduct, and all judgments of praise and blame, to principles, but of referring them to some one principle; some rule, or standard, with which all other rules of conduct were required to be consistent, and from which by ultimate consequence they could all be deduced. Those who have dispensed with the assumption of such a universal standard, have only been enabled to do so by supposing that a moral sense, or instinct, inherent in our constitution, informs us, both what principles of conduct we are bound to observe, and also in what order these should be subordinated to one another.

> In the next section, notice that Mill doesn't argue for what he calls the greatest happiness principle (we should do whatever action produces the most amount of happiness for the most number of people, embraced by utilitarians). He does that elsewhere. Rather, he argues that this principle is the one value to which all other values can be reduced. He admits that virtue is a worthy goal, but what makes it worthy is that it produces utility.

Without attempting in this place to justify my opinion, or even to define the kind of justification which it admits of, I merely declare my conviction, that the general principle to which all rules of practice ought to conform, and the test by which they should be tried, is that of conduciveness to the happiness of mankind, or rather, of all sentient beings; in other words, that the promotion of happiness is the ultimate principle of Teleology.

I do not mean to assert that the promotion of happiness should be itself the end of all actions, or even of all rules of action. It is the justification, and ought to be the controller, of all ends, but it is not itself the sole end. There are many virtuous actions, and even virtuous modes of action (though the cases are, I think, less frequent than is often supposed), by which happiness in the particular instance is sacrificed, more pain being produced than pleasure. But conduct of which this can be truly asserted, admits of justification only because it can be shown that, on the whole, more happiness will exist in the world, if feelings are cultivated which will make people, in certain cases, regardless of happiness. I fully admit that this is true; that the cultivation of an ideal nobleness of will and conduct should be to individual human beings an end, to which the specific pursuit either of their own happiness or of that of others (except so far as included in that idea) should, in any case of conflict, give way. But I hold that the very question, what constitutes this elevation

of character, is itself to be decided by a reference to happiness as the standard. The character itself should be, to the individual, a paramount end, simply because the existence of this ideal nobleness of character, or of a near approach to it, in any abundance, would go farther than all things else toward making human life happy, both in the comparatively humble sense of pleasure and freedom from pain, and in the higher meaning, of rendering life, not what it now is almost universally, puerile and insignificant, but such as human beings with highly developed faculties can care to have.

> In the next section, Mill addresses the sort of moral laws Ross mentioned in the previous reading. Why does Mill think his one moral law (utility) is better than relying on several moral laws "all claiming independent authority"?

There exists no moral system under which there do not arise unequivocal cases of conflicting obligation. These are the real difficulties, the knotty points both in the theory of ethics, and in the conscientious guidance of personal conduct. They are overcome practically, with greater or with less success, according to the intellect and virtue of the individual; but it can hardly be pretended that any one will be the less qualified for dealing with them, from possessing an ultimate standard to which conflicting rights and duties can be referred. If utility is the ultimate source of moral obligations, utility may be invoked to decide between them when their demands are incompatible. Though the application of the standard may be difficult, it is better than none at all: while in other systems, the moral laws all claiming independent authority, there is no common umpire entitled to interfere between them; their claims to precedence one over another rest on little better than sophistry, and unless determined, as they generally are, by the unacknowledged influence of considerations of utility, afford a free scope for the action of personal desires and partialities. We must remember that only in these cases of conflict between secondary principles is it requisite that first principles should be appealed to. There is no case of moral obligation in which some secondary principle is not involved; and if only one, there can seldom be any real doubt which one it is, in the mind of any person by whom the principle itself is recognised.

If the preceding analysis, or something resembling it, be not the correct account of the notion of justice; if justice be totally independent of utility, and be a standard per se, which the mind can recognise by simple introspection of itself; it is hard to understand why that internal oracle is so ambiguous, and why

so many things appear either just or unjust, according to the light in which they are regarded.

We are continually informed that Utility is an uncertain standard, which every different person interprets differently, and that there is no safety but in the immutable, ineffaceable, and unmistakable dictates of justice, which carry their evidence in themselves, and are independent of the fluctuations of opinion. One would suppose from this that on questions of justice there could be no controversy; that if we take that for our rule, its application to any given case could leave us in as little doubt as a mathematical demonstration. So far is this from being the fact, that there is as much difference of opinion, and as much discussion, about what is just, as about what is useful to society. Not only have different nations and individuals different notions of justice, but in the mind of one and the same individual, justice is not some one rule, principle, or maxim, but many, which do not always coincide in their dictates, and in choosing between which, he is guided either by some extraneous standard, or by his own personal predilections....

Who shall decide between these appeals to conflicting principles of justice? Justice has in this case two sides to it, which it is impossible to bring into harmony, and the two disputants have chosen opposite sides; the one looks to what it is just that the individual should receive, the other to what it is just that the community should give. Each, from his own point of view, is unanswerable; and any choice between them, on grounds of justice, must be perfectly arbitrary. Social utility alone can decide the preference ...

> Mill now turns to one of the strongest "moral laws," that of justice (people should get what they deserve), and shows that even that principle needs an ultimate grounding in utility. Why does he say that justice as a moral requirement has a "more absolute obligation" than other moral rules? How does this square with Mill's utilitarianism?

While I dispute the pretensions of any theory which sets up an imaginary standard of justice not grounded on utility, I account the justice which is grounded on utility to be the chief part, and incomparably the most sacred and binding part, of all morality. Justice is a name for certain classes of moral rules, which concern the essentials of human well-being more nearly, and are therefore of more absolute obligation, than any other rules for the guidance of life; and the notion which we have found to be of the essence of the idea of justice, that of a right residing in an individual implies and testifies to this more binding obligation. The

moral rules which forbid mankind to hurt one another (in which we must never forget to include wrongful interference with each other's freedom) are more vital to human well-being than any maxims, however important, which only point out the best mode of managing some department of human affairs. They have also the peculiarity, that they are the main element in determining the whole of the social feelings of mankind. It is their observance which alone preserves peace among human beings: if obedience to them were not the rule, and disobedience the exception, every one would see in every one else an enemy, against whom he must be perpetually guarding himself. What is hardly less important, these are the precepts which mankind have the strongest and the most direct inducements for impressing upon one another. By merely giving to each other prudential instruction or exhortation, they may gain, or think they gain, nothing: in inculcating on each other the duty of positive beneficence they have an unmistakable interest, but far less in degree: a person may possibly not need the benefits of others; but he always needs that they should not do him hurt. Thus the moralities which protect every individual from being harmed by others, either directly or by being hindered in his freedom of pursuing his own good, are at once those which he himself has most at heart, and those which he has the strongest interest in publishing and enforcing by word and deed. It is by a person's observance of these that his fitness to exist as one of the fellowship of human beings is tested and decided; for on that depends his being a nuisance or not to those with whom he is in contact. Now it is these moralities primarily which compose the obligations of justice. The most marked cases of injustice, and those which give the tone to the feeling of repugnance which characterises the sentiment, are acts of wrongful aggression, or wrongful exercise of power over someone; the next are those which consist in wrongfully withholding from him something which is his due; in both cases, inflicting on him a positive hurt, either in the form of direct suffering, or of the privation of some good which he had reasonable ground, either of a physical or of a social kind, for counting upon....

It appears from what has been said, that justice is a name for certain moral requirements, which, regarded collectively, stand higher in the scale of social utility, and are therefore of more paramount obligation, than any others; though particular cases may occur in which some other social duty is so important, as to overrule any one of the general maxims of justice. Thus, to save a life, it may not only be allowable, but a duty, to steal, or take by force, the necessary food or medicine, or to kidnap, and compel to officiate, the only qualified medical practitioner. In such cases, as we do not call anything justice which is not a virtue, we usually say, not that justice must give way to some other moral principle, but that what is just in ordinary cases is, by reason of that other principle, not just in

the particular case. By this useful accommodation of language, the character of indefeasibility attributed to justice is kept up, and we are saved from the necessity of maintaining that there can be laudable injustice.

Justice remains the appropriate name for certain social utilities which are vastly more important, and therefore more absolute and imperative, than any others are as a class (though not more so than others may be in particular cases); and which, therefore, ought to be, as well as naturally are, guarded by a sentiment not only different in degree, but also in kind; distinguished from the milder feeling which attaches to the mere idea of promoting human pleasure or convenience, at once by the more definite nature of its commands, and by the sterner character of its sanctions.

Reading 1.3: Stephen Toulmin, "How Medicine Saved the Life of Ethics"

Philosopher Stephen Toulmin argues that bioethics changed the trends in moral philosophy for the better. As you read, ask yourself what the strengths and faults of bioethics are as moral reasoning, according to Toulmin. (*Numbers in brackets are keyed to the list of references at the end of the reading.*)

... The new attention to applied ethics (particularly medical ethics) has done much to dispel the miasma of subjectivity that was cast around ethics as a result of its association with anthropology and psychology. At least within broad limits, an ethics of "needs" and "interests" is objective and generalizable in a way that an ethics of "wishes" and "attitudes" cannot be. Stated crudely, the question of whether one person's actions put another person's health at risk is normally a question of ascertainable fact, to which there is a straightforward "yes" or "no" answer, not a question of fashion, custom, or taste, about which (as the saying goes) "there is no arguing." This being so, the objections to that person's actions can be presented and discussed in "objective" terms. So, proper attention to the example of medicine has helped to pave the way for a reintroduction of "objective" standards of good and harm and for a return to methods of practical reasoning about moral issues that are not available to either the dogmatists or the relativists.

> Before you move on to the next paragraph, can you summarize Toulmin's thesis?

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Notes

1. The work of the national commission generated a whole series of government publications—mainly reports and recommendations on the ethical aspects of research involving research subjects from specially "vulnerable" groups having diminished autonomy, such as young children and prisoners. I have written a fuller discussion of the commission's work for a forthcoming Hastings Center book on the "closure" of disputes about matters of technical policy. As a member of the commission, A.R. Jonsen was also struck by the casuistical character of its work, and this led to the research project of which this paper is one product.
2. The *Lettres provinciales* were published periodically, and anonymously, in 1656–57, but it did not take long for their authorship to be discovered, and they have remained perhaps the best-known documents on the subject of "case reasoning" in ethics. The intellectual relationship between the vigorous attack on the laxity of the Jesuits' case morality contained in the *Lettres* and the larger program of seventeenth-century philosophy deserves closer study than it has yet received.
3. For the word "casuistry," see the entry in the complete *Oxford English Dictionary*, which revealingly points out how many English nouns ending in "ry" (e.g., "sophistry," "wizardry," and "Popery") are dyslogistic. It seems to be no accident that the earliest use of the word "casuistry" cited in the *OED* dates only from 1725—i.e., after Pascal's attack on the Jesuit casuists. This helps to explain, and confirm, the current derogatory tone of the word.
4. See Bledstein's discussion [14, p. 107] of the nineteenth-century confusion between codes of ethics and codes of etiquette within such professional societies as the American Medical Association.
5. Once again, the *Oxford English Dictionary* has a point to make. It includes the word "ethicist" but leaves it without the dignity of a definition, beyond the bare etymology, "ethics + ist."

ETHICS COMMITTEE

A Minor in a Research Trial

Suppose that you sit on the ethics committee of a hospital or you are a family member. Your job is to recommend a course of action. Review the following case.

> Timmy is a bright 14-year-old boy with a rare lung cancer. He is currently ventilator dependent and has undergone both chemotherapy and a bone-marrow transplant but to no avail. He has less than six months to live. He has discussed end-of-life care with his doctor and

his parents. His parents want his ventilator removed so that Timmy can die with dignity. Timmy agrees. However, two days later, Timmy and his parents are approached to participate in a clinical trial for lung cancer. This would require Timmy to stay on the ventilator and receive IV infusions of an experimental drug researchers are hoping will help lung-cancer patients. Timmy wants to enroll in the trial. He is aware that there is little hope that the treatment will do anything for his condition. He tells his parents: "I want to help other kids before I die." Timmy even writes an essay for his school newspaper arguing that terminal patients have an obligation to help others in research.

The medications do have potential for some very nasty side-effects. Animal testing showed that vomiting, diarrhea, and night sweats are common. One rare side-effect found in 20% of animal subjects is a fatal heart condition. Timmy, however, tells his parents that "this is no worse than all that chemotherapy I did and so what if it quickens my death? I'm going to die anyway." His parents are very reluctant to give their consent. They worry about the suffering Timmy might experience and insist that Timmy previously agreed to palliative (comfort care) only. Timmy is adamant that he wants to help others. He has appealed to the hospital to let him make his own decisions. His doctor does not want him to participate because of the possibility of fatal side-effects. The legal department has expressed that Timmy could go to court against his parents in order to enter the clinical trial; however, it would likely take months to sort it out—months Timmy does not have. The hospital staff are willing to declare Timmy a mature minor and allow him to make his own decision, but they ask for a recommendation from the ethics committee.

As a group or individually, work through the steps of ethical reasoning and then vote on the best course of action. What is the "damned if you do and damned if you don't" aspect of this case? What facts do you wish you knew but do not? How could you honor the patient and the duty not to put him at risk? What ethical reasons can your committee agree on in order to make a recommendation?