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Editorial

Negotiating ethics in anaesthesia

There are many situations where the anaesthetist is involved in negotiations about ethically delicate matters. The anaesthetist must negotiate with the operating surgeon in cases where their opinions differ and the anaesthetist must negotiate with the patient when the patient asks for services that the anaesthetist finds problematic. In the present context, negotiations of the latter kind (between doctor and patient) will be the focus.

The moral aspect of these kinds of negotiations, not the legal ones will be examined in this editorial. The legal situation is a factor that must be taken into account, however, when a moral assessment is made. In certain circumstances, the law can prescribe a morally correct action and also prescribe a morally wrong action. This fact must then be taken into account when we discuss how a morally responsible physician ought to act.

In some cases, moral philosophy makes a clinical difference. We notice this, when, in order to solve practical questions, we apply moral theories to the case. However, there are also cases where moral philosophy does not make any difference. It is remarkable that what may seem to be rather mundane and easy practical problems may sometimes be philosophically loaded, while seemingly very complicated and controversial practical problems are not. This is brought out in this paper where it transpires that a seemingly mundane choice between two sorts of anaesthesia raises difficult philosophical problems while a serious kind of end-of-life decision does not.

How do we solve practical problems?

The proper way, in principle, to solve a practical problem can be characterized along the following lines:

Moral principle + True account of all facts
→ Practical conclusion

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Where do we find the proper moral principle from which to proceed in our pathway to a practical conclusion? This is bound to be controversial. Consider three proposals:

1. utilitarianism,
2. moral rights theories,
3. deontology.

According to utilitarianism, an action is wrong if, and only if, there is an alternative with better consequences. This is a pragmatic view of morality, then. In a hedonistic version of utilitarianism (the version I find most plausible), we ought always to act so as to maximize the sum-total of well-being in the universe. Jeremy Bentham (1748–1832) is the most famous historical advocate of this kind of moral view. I have defended this kind of moral approach myself [1].

According to a (negative) moral rights approach, each individual owns, in a moral sense, himself or herself. This means that each individual is free to do as he or she sees fit with himself or herself (and also with his or her property, but, to simplify my argument, I will not go into that aspect of the theory in the present context). We own our body, our talents, and so forth. And we have an absolute right to physical integrity. John Locke (1632–1704) is the most famous historical advocate of this kind of moral view. Note that we are here focusing exclusively on negative rights. According to this version of a moral rights theory there exist no positive rights. We have an absolute negative right not to be harmed, but we have no positive right whatever to receive help when we are in distress. The most well-known contemporary advocate of this kind of moral outlook was the late Harvard philosopher Robert Nozick [2].

According to deontology there are some kinds of actions that are prohibited. As rational creatures we can realize that these absolute obligations (not to perform the prohibited actions) are binding. Immanuel Kant (1724–1804) is the most famous advocate of this kind of moral view.

These are radically different approaches, then. They are mutually inconsistent. They all have competent

contemporary advocates. If we are lucky we find that, in the situation, they point in the same direction. If they do not, then we are in big trouble. There is no saying in advance, whether they will conflict or whether they will point in the same direction. So let us see what they have to say about two possible dilemmas that could face an anaesthetist.

The patient who insists on dangerous anaesthesia

Suppose a patient is making a request for general anaesthesia where the anaesthetist thinks that local anaesthesia is sufficient. Suppose furthermore that there are medical reasons against general anaesthesia. There is even a slight risk that the patient may die from it. The doctor points out this hazard but yet, for all that, the patient knowingly insists on having general anaesthesia. How should the problem be solved?

According to utilitarianism, the doctor must act in a way that maximizes well-being. This is a rather abstract answer, however. What if the doctor refuses to provide any anaesthesia at all, unless the patient accepts local anaesthesia, arguing that it goes against his or her medical ethics unnecessarily to risk the life of the patient? Well, if this threat works, it is all right. The patient receives local anaesthesia, undergoes the operation and is, hopefully, cured. But suppose the threat does not work and suppose the patient then refuses to undergo the operation in question. And suppose no operation means a greater risk to the patient than undergoing the operation under general anaesthesia. In that case, the doctor may have to abide by the wish of the patient. This seems to be the message sent to the doctor from utilitarianism.

What if the situation is viewed from a deontological point of view? In that case the doctor can be adamant in the negotiations. Certainly, once again the doctor feels obliged to help the patient, but this obligation is not a strict one. The doctor can say once again, that unnecessarily risking the life of the patient goes against the doctor's ethic. If the patient then refuses the operation, the doctor can blame what happens on the patient! The hands of the doctor are clean. He or she has not killed or risked the life of the patient. He or she has offered to help, on their own conditions, and the patient is all alone to blame for not having taken the opportunity offered.

Finally, what are we to say if we view the situation from the point of view of an ethics of (negative) rights? Here it is really up to the doctor and the patient to negotiate. Whatever solution they reach, if it is reached freely and without manipulation on any part, we, a third party (society) must accept it. It would be to violate their autonomy if we were to stop them from proceeding with their agreement, irrespective of the content of it. The ethical problem now transforms into a mere problem of negotiation.

Which moral theory provides the most plausible answer to the anaesthetist's query? I cannot help feeling that, if in this short space I have got the facts right, utilitarianism does. Both the deontological and the moral rights theory seem to be too liberal in their view of the responsibility of the doctor. However, this is not my main point. My main point is that, in this seemingly mundane clinical case, philosophy makes a difference.

The patient who makes a request for terminal sedation

Let us now turn to a difficult end-of-life decision. Let us imagine that a patient is suffering from a terminal disease. The patient is terminally ill and dependent for her breathing upon a ventilator. She is very ill, then, but death is not imminent. For all the doctor knows, the patient may go on living on the ventilator for several weeks. Now the patient informs the anaesthetist that she wants to be disconnected from the ventilator in order to be spared further suffering. However, before having the ventilator removed the patient wants to be sedated into oblivion [1]. The doctor hesitates. We imagine that this takes place in a country where euthanasia is illegal and the doctor feels that, even if he is not certain about this, sedating the patient and then disconnecting her from the ventilator may be to perform an act of illegal euthanasia. To complicate matters even more, suppose the doctor cannot guarantee that the patient will die once taken off the ventilator, even if this is a very likely outcome. Suppose the doctor informs the patient about this. And suppose that the patient repeats her request but also adds that, if she does not suffocate immediately, she wants to stay sedated until she is dead, without any provision of treatment, nourishment or fluids.

Depending on what basic moral outlook we take, as our point of departure when we view it, the shape of the moral problem facing the doctor is seemingly very different. The utilitarian may feel that by doing as the patient asks, the doctor is doing her a service. But what if the action can be correctly described as an illegal act of euthanasia? This does not settle the moral case, of course. It might sometimes be morally correct to break the law. In particular it might be correct to do so if the law is unjust. But is a legal ban on euthanasia unjust? This is a difficult question for the utilitarian to settle, since it has to do with how all sorts of empirical evidence should be assessed. Personally I believe that, if utilitarianism is correct, then there are good reasons to legalize euthanasia. However, this is not the place to try to substantiate this claim.

Killing	Death intended	Death merely foreseen
Active	**Forbidden**	**Tolerated**
Passive	**Tolerated**	**Tolerated**

Figure 1.
Sanctity-of-Life Doctrine.

And many utilitarians are likely to disagree with me about this putative conclusion.

Deontologists typically adhere to some version of the Sanctity-of-Life Doctrine. This doctrine is inconsistent with euthanasia. From the point of view of deontology it is crucial to know then, whether sedating the patient in the example would be a case of euthanasia in disguise. But we must be clearer about what it means to perform a morally illegitimate action of killing. From the point of view of deontology, not all kinds of hastening death are forbidden. According to this view, it is only the active and intentional killing of a patient, which is forbidden in principle. This is how the situation is viewed (Fig. 1). We see that the Sanctity-of-Life is well in accordance with the legal situation in most countries. Where does this leave terminal sedation of the patient? Does it fall within the forbidden corner of the figure?

I tend to think that the answer to this question is 'no'. The sedation may as such kill the patient, but, if it does, this is not an intended consequence of the sedation. The intended consequence of the sedation is to keep the patient comatose when the ventilator is removed and hence to spare the patient a painful experience. The intention behind disconnecting the patient from the ventilator is certainly to hasten death (in accordance with the wish of the patient). However, this is merely a case of allowing nature (the disease) to take its course, that is, a case of allowing death to come, rather than a case of active killing. Once we separate the two medical measures, the sedation and the disconnecting of the patient from the ventilator, we see that each of them is in accordance with standard medical practice.

But is this not too simplistic? Is it not even sophistry? What about the combination of these two actions? Well, I concede that the combination is both active and passive, and hence we should perhaps say that it is active. However, there is not any one intention behind the compound action. So we cannot reasonably claim that the compound action constitutes both active and intentional killing of the patient [3].

If this is so, there seem to be no reasons stemming from the Sanctity-of-Life Doctrine (deontology) stopping the doctor from doing as the patient asks.

What would a moral rights theorist say about the case? From a moral rights perspective it is clear that if the doctor freely accepts to do as the patient asks him to do, and sedates the patient before disconnecting her from the ventilator, and keeps her sedated until she is dead, then this is not problematic from a moral point of view. It does not matter whether the actions should be considered a case of 'euthanasia in disguise' or not, since euthanasia is as such not morally problematic. If the doctor freely accepts to act as the patient wants him to do, no third party should meddle with their agreement.

Finally, once the utilitarian is convinced that what we are here considering is not a case of euthanasia (in disguise), even the utilitarian can accept the action, without having to go into a discussion about whether euthanasia should be legalized or not.

Moreover, sedating the patient is, according to my strong moral intuition, the right thing to do in the circumstances.

One could of course argue that if the patient really wants to die, she should be prepared consciously to suffocate. If she is not prepared consciously to suffocate, she should stay on her ventilator. But this strikes me as cruel. It takes a lot of courage to get off the ventilator in a situation such as this one. Why should we require such bravery of our patients? We do not require that they undergo surgery awake. But this case is in moral respects no different from an operation.

Be that at it may, it has transpired that somewhat unexpectedly, in the more controversial of the two cases I have discussed, all three basic moral outlooks here presented, point in the same direction. There is no saying then, which one of them gives the most plausible verdict in this case. We do not need to bring in the philosopher in the discussion about them. But we may need the philosopher to reach the conclusion that the problem is, philosophically speaking, innocuous.

Conclusion

The main thrust of the argument in this paper has been as follows. When we want in a serious manner to assess the moral status of simple medical procedures, we sometimes have to take as our point of departure very general and abstract moral principles. Such principles are essentially contested. There is reasonable disagreement about them. And yet for all that, they sometimes make a difference to the outcome of our moral (practical) reasoning. This means that there are no simple solutions to these clinical problems. This is, in a way, good news for the philosopher. Philosophy makes a clinical difference! The philosopher will sometimes

have something to contribute to the ongoing discussion about good clinical practice. At the same time, of course, this is bad news for the clinician. No matter how much attention the clinician gives to a hard medical question, no matter how thorough he or she thinks it through, there may exist no way to satisfy all possible criticisms that can be levelled against their clinical decision.

On the other hand, there are also cases that appear morally very complicated, cases we tend to describe as true moral 'dilemmas' which, upon closer inspection, can be 'dissolved'. Moral reasoning from very different points of departure tend to lead us to the same practical conclusion. Simple pragmatic reasons could settle the case. This may be good news for the doctor. Once again, however, it may take some philosophical reflection to see that the example really is of this innocuous kind.

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