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I am submitting herewith a dissertation written by Bonnie Dreps Voigtlander entitled "An Ethical Theory for Medical Decision Making with Special Reference to Neonatal Intensive Care." I recommend that it be accepted in partial fulfillment of the requirements for the degree of Doctor of Philosophy, with a major in Philosophy.

Rem B. Edwards

Rem B. Edwards, Major Professor

We have read this dissertation and recommend its acceptance:

John W. Davis

Glenn C. Graham

Charles H. Reynolds

[illegible]

Accepted for the Council:

L. Evans Roth

Vice Chancellor
Graduate Studies and Research

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AN ETHICAL THEORY FOR MEDICAL DECISION MAKING WITH SPECIAL REFERENCE TO NEONATAL INTENSIVE CARE

A Dissertation

Presented for the

Doctor of Philosophy

Degree

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Bonnie Dreps Voigtlander

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ABSTRACT

It is claimed that what the interdisciplinary field of medical ethics needs to go forward is an ethical theory for decision making which is well grounded in philosophical tradition and readily applicable to the medical model. This dissertation presents and defends such an ethical theory. The act utilitarian theory of right acts combined with a qualitative hedonistic theory of intrinsic good is a clear, readily understandable ethical theory which presupposes commonly held values, is well grounded in philosophical theory and has an excellent chance for acceptability in and applicability to medicine.

Qualitative hedonism is a philosophical statement of the good for man. It claims (1) that pleasure is the only good which is worth having for its own sake, all other goods being valued for the pleasure inherent in them or the pleasure to which they lead and (2) that pleasure is an inwardly experienced feeling which differs in kind as well as in degree. Pleasure cannot be abstracted from the non-hedonic properties of the purely pleasurable experience in order to be measured or compared to another purely pleasurable experience. It is bound up in the experience of which it is a part. When qualitative hedonism is added to the act utilitarian theory of obligation, the following normative statement results: An act is right if and only if, of the alternatives open to the agent and on the available evidence, it produces, for all those affected by the act, at least as much good and/or avoids at least as much evil as any other alternative, where good and evil are understood in terms of the qualitative hedonistic theory of intrinsic good.

Qualitative hedonism is found to be a theory of the good superior both to pluralism and to quantitative hedonism. It satisfies psychological realism in that pleasure is indeed a sought-after goal. It accounts for the nature of pleasure and pain and allows one to make distinctions between pleasures so that a pleasure of a higher quality cannot be replaced by a greater quantity of a pleasure of a lower kind. Act utilitarianism is found to be superior as an ethical theory to both formalism and rule utilitarianism. It accounts for duty in a clearer fashion than does formalism and thereby facilitates decision making. Rule utilitarianism is shown to be a derivation of act utilitarianism which adds little of a positive nature while presenting the confusing element of determining a class of actions and necessitating the addition of a generalization argument.

Neonatal intensive care is a field of medicine especially fertile with ethical dilemmas. Many of the problems encountered in this area of medicine, as in many others, are created by the growth of technology in the last thirty years. Technology has made it possible to save the lives of many severely defective newborns. Unfortunately, it cannot always provide intact survival. Where physical and mental handicaps are so severe that a life of greatly diminished quality is anticipated, ethical decisions must be made whether or not the right course for all involved is to allow the severely defective newborn to die.

The applicability of the act utilitarian/qualitative hedonistic ethical theory is justified by (1) a demonstration that this value theory is found acceptable to many physicians as shown by reference to medical literature and (2) an actual application of this theory to four

selected case studies: (a) prematurity with respiratory distress syndrome, (b) multiple anomalies, (c) genetic skin disease (dystropic epidermolysis bullosa), (d) Down's Syndrome with duodenal atresia.

It is concluded that the act utilitarian theory of right acts combined with a qualitative hedonistic theory of intrinsic good when applied to medical ethical decision making results in a way of life which rational persons would want to see effected.

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INTRODUCTION

Medicine has always involved making value decisions. This truth is more widely recognized today than ever before. With the ever increasing impact that medicine has on our lives and our deaths has come a public demand to know more about the inner workings of the field of medicine and to have a voice in the delivery of medical care. The public is no longer willing to treat medicine as a mystical body of knowledge which can only be known by the physician. People have become knowledgeable about the causes, courses, and available treatments of diseases. They have especially come to realize that their personal values concerning how to live well and how to die with dignity need not be surrendered to the paternalism of a physician or the routine of a hospital. The public demands a voice in the decision making about medical treatment.

Yet public knowledge is not that of the physician. Once illness has been diagnosed, the patient cannot make wise decisions about his medical care without depending on accurate medical information that only a health care professional can provide. There seems to be a need, then, for some kind of guidelines with regard to medical decision making which will allow for the acknowledged expertise of the physician and also for the values of the individual patients. A doctor may be best qualified to decide which type of drug will be effective in which disease but the individual patient may be best qualified to decide if the prolongation of life by respirator maintenance is more desirable than imminent death. The best possible decision will take into account the qualifications of both doctor and patient.

The absence of a shared value system in our society complicates the task of humane medical decision making. The heated controversy surrounding the abortion issue illustrates this difficulty. We seem to agree that legislating morality is not very effective nor desirable. Yet decisions of an ethical nature must be made daily in the field of medicine. These decisions are many. They vary from who should get the last bed in the coronary care unit to whether or not a pediatrician should prescribe an antibiotic to ease a parent's mind although the antibiotic is not medically indicated. No set of laws could be detailed enough to cover all possible situations. Nor would physicians or the public accept such widespread policing of decision making. Rather than a set of laws governing medicine, what is needed are practicable ethical guidelines. At a minimum this would bring forethought and consistency to medical decision making concerning values.

Philosophers are the traditional experts in proposing and defending systems of ethics. It is to be expected that philosophers are consulted in the search for guidelines in medical ethical decision making. Yet those philosophers who have expressed an interest and a desire to help in the field of medical ethics are often eager to claim that philosophy can give no answers. They are willing to raise questions and clarify issues. I believe that more is needed and more can be done. Daniel Callahan, a medical ethicist, sees the need for the additional step from questions and clarification to the development of an ethical system appropriate to medicine. He writes:

> . . . it has become absolutely urgent that the search for a philosophically viable normative ethic, which can presuppose some commonly shared principles, go forward with all haste.

> Short of finding that, I do not see how ethical methodologies can be developed which will include methods for reaching quick and viable solutions in specific cases. Instead, we are likely to get only what we now have, a lot of very broad and general thinking, full of vagrant insights, but on the whole of limited use to the practicing physician and scientist.[1]

It will be the project of this dissertation to develop and defend just this sort of ethical system--a philosophically viable normative ethics appropriate for medical decision making.

Working through and defending one ethical system which is particularly helpful in the clinical setting ought to be a significant advance over the "vagrant insights" now being offered in much of the medical ethics literature. Yet this sort of ethical theory should not be expected to give a definitive answer to each value question that arises in medicine. An ethical theory provides an explanation of the right and the good and develops a means of reasoning which will allow the individual faced with a moral choice to determine the stated right and good. Every ethical system is hampered at places by a conflict in stated moral rules or an inability to predict consequences accurately. Nevertheless, the benefit to medical decision making will still be significant if an ethical system which is well grounded in philosophical theory and appropriate to the medical situation can be offered. Pat answers for every conceivable case cannot be given but a direction and a method of thinking through ethical decisions in medicine can be outlined. Hopefully, given an ethical theory truly tailored for medicine, satisfactory answers can be reasoned to in the majority of cases.

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[1]Daniel Callahan, "Bioethics as a Discipline," Hastings Center Studies 1, No. 1 (1973), 72.

A "philosophically viable" ethical theory means, here, one which stems from a well argued and defensible philosophical position. Ethics has been a major branch of philosophy from Greek times to the present. There exists a great body of writing about it. In the history of philosophy much work has been done in judging which theories of ethics are internally inconsistent and even, to some extent, which are impracticable. The ethical system that will be defended here is a consequentialist theory. An act is judged right on the basis of the consequences that will follow from that act. This is opposed to a deontological ethical theory in which an act is judged right by the intrinsic nature of the act itself. Further, the theory presented here is a utilitarian system following the greatest happiness principle argued by John Stuart Mill. Happiness is considered to be the only good in itself and a right action is then one which maximizes this good for everyone affected. The greatest happiness utilitarian theory is contrasted to ideal utilitarian theories where other things than happiness are considered good in themselves, e.g., beauty, truth, wisdom. Utilitarians have in recent times divided into two groups--act utilitarians and rule utilitarians. The theory presented here will be an act utilitarianism in which each act is judged individually for maximizing happiness, as opposed to a rule utilitarianism which judges acts as they fall under certain rules, these rules, then, being judged as right or not by means of the greatest happiness criterion. One other aspect of the theory to be defended sets it apart from other common ethical theories. The highest good is considered to be happiness, which is thought to differ in quality as well as quantity. Happiness is

defined in terms of pleasure and the absence of pain. This makes the theory a form of hedonism. Following John Stuart Mill, the hedonism advocated here is known as qualitative hedonism. The opposing, and more widespread theory, is quantitative hedonism. The latter argues that pleasures differ only in terms of intensity, duration and certain other quantifiable distinctions. Qualitative hedonism argues that pleasures differ in kind so that certain pleasures are of such greater quality that they would be preferred over a greater quantity of a lower sort of pleasure.

The marks that distinguish the ethical theory to be presented here--consequentialist, act-utilitarian, qualitative hedonistic in its view of the highest good--are all aspects of ethics about which there is a great body of literature in philosophy. These theories have been a part of philosophy long enough to be thoroughly criticized and defended. Part of the significance of a philosophically viable theory is whether or not philosophical tradition can and does accept the theory. In philosophy few theories are ever accepted universally. The argumentation that surrounds a theory is what becomes of interest. If the proponents of a theory can defend themselves well against their opponents, then the theory can be considered philosophically viable. The act utilitarian theory of ethics where good is thought of in terms of qualitative hedonism can and will be defended in this dissertation against its numerous and worthy opponents.

The reasons why this ethical theory was chosen as particularly applicable to medical decision making are several. The good which is aimed at in this system is the same good which is avowedly the aim of

medicine--well-being. The World Health Organization's definition of health is "a state of complete physical, mental, and social well-being and not merely the absence of disease or infirmity."[2] Rene Dubos in Mirage of Health speaks in several places as if health and happiness are equatable terms. In one place he cautions that the aim of medicine is not simply curing disease: "But solving problems of disease is not the same thing as creating health and happiness."[3] Medicine is to promote health and happiness. A system of ethics, then, which uses as a guide for decision making the maximization of happiness for the patient and those immediately concerned with him or her, presumes values which are inherent in health care.

The value of general happiness or well-being is also one that a wide segment of society shares. Even those individuals who see a value in suffering for religious or character building purposes can share this value. They quite possibly would agree that their highest goal is happiness. They simply put a higher value on suffering as a means to future happiness than do many people. An ethical theory based on qualitative hedonism can accommodate this belief. That which any individual sees as furthering the chance for ultimate happiness is to be valued, be this physical pleasure or a higher mental pleasure. For example, if a patient is quite willing to put up with a certain amount

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[2]World Health Organization, "Preamble to the Constitution of the World Health Organization," World Health Organization: Basic Documents, 26th Edition (Geneva: World Health Organization, 1976), p. 1.

[3]René Dubos, Mirage of Health (New York: Harper and Row, 1959), p. 26.

of pain in order to avoid the greater pains of addiction or weakening of character or loss of identification with the suffering Christ figure, the qualitative hedonist could agree that happiness is best served for this patient by suffering that pain.

The ethical system proposed here is also readily understandable by health professionals and public alike. Years of training in philosophical subtleties are not required in order to comprehend it. Any theory of ethics is of course understandable when explained in a clear fashion. However, it would have to be acknowledged that few people would have the patience to follow through the subtle reasoning of the Kantian ethical system. If the Kantian principle is judged far superior on normative grounds to a utilitarian system, then the ready clarity of the utilitarian system would not be a sufficient recommendation for it. The normative superiority of the Kantian principle, however, is not proven. Given this, plus the desirability of an ethical system that medicine will be able and willing to use gives some advantage to a clearly stated utilitarian system.

An ethical system which concentrates on consequences which can in part be determined by empirical methods also has more of a chance to be accepted by health care professionals. The scientific method is well accepted by physicians and public alike. If the philosopher can convince the public that he or she is willing to deal with the cold facts of the real world, the philosopher is more likely to be given an audience. There is little patience in our society for the metaphysician who apparently carries out reasoning on the basis of intuition and abstract, esoteric premises.

An act utilitarian ethical theory is preferable not only for considerations of philosophical clarity but also because it considers the nature of medical decision making. The cases which a physician faces in daily practice are of such individual complexity that rules are difficult to formulate. What is clearly a good decision in one case is not so clearly productive of good in another case which differs from the first by many medical, personal, or social complexities. It is reasonable and often necessary in medicine to use rules as only a handy guideline while actual decisions are worked out on case by case considerations.

An act utilitarian theory of right acts combined with a qualitative hedonistic theory of intrinsic good is then a clear, readily understandable ethical system which presupposes commonly held values, which is well grounded in philosophical theory and which has an excellent chance for acceptability in and applicability to medicine.

In the following chapters of this dissertation the various components of the ethical system sketched above will be presented, clarified and defended against philosophical criticisms and vying philosophical theories. That this ethical system is appropriate and helpful to medicine will be demonstrated throughout the work by numerous examples and especially by applying it to the complex ethical decisions that are faced in the intensive care nursery. The clinical reality of neonatal intensive care is chosen as a test case for the act utilitarian system since it provides an especially fertile ground for ethical dilemmas. Many of the problems encountered in this area of medicine, as in many others, are created by the growth of technology in the last

thirty years. With monitoring equipment and laboratory testing techniques, infants who earlier would not have survived the first few weeks of life are now helped to live. Unfortunately, intact survival is not yet assured. Decisions must then be faced whether the kinder course for all involved would be to allow the severely defective newborn to die. Where technology cannot cure, perhaps it ought not prolong suffering.

In addition to the basic ethical question of whether or not withholding of treatment is ever justified, is the question of proxy consent. The neonate cannot speak for himself. He cannot tell us what degree of impairment he is willing to live with. Parents, loved ones, and the nursery staff must assume the responsibility for decision making. Often the decision process is undertaken in adverse circumstances. Parents have just sustained the emotional blow of having given birth to a less than perfect baby. Even the nursery itself is often an emotionally charged place. It is difficult to watch infants suffer and die. Decision making is often further hampered in the Intensive Care Nursery by the confusing lines of authority that may exist in a teaching hospital--often the site for an intensive care nursery. Clear, well thought out ethical decision making is, then, often difficult in neonatal intensive care.

For all these reasons, and others, neonatal intensive care is an especially appropriate test case for the ethical system to be developed in this dissertation. Although the intensive care nursery will be used as the basic source of case studies to test the applicability of the utilitarian system, it is maintained that the ethic developed here is

applicable to the broader spectrum of medical decision making.

The first chapter of this dissertation will be directed to an explanation and defense of qualitative hedonism as a theory of the good. I will explore hedonism as a psychological statement about what is desired. It will be shown that pleasure and the absence of pain is something which persons do seek. Advocating pleasure as the only intrinsic good, then, satisfies psychological realism. The nature of pleasure will also be discussed. It will be argued that pleasures and pains differ in kind as well as in quantity measures. Pleasure and pain cannot be abstracted from the activity of which they are a part and then measured, one pleasure against another. Certain pleasures and pains simply differ in kind. Pleasures of a higher quality can be preferred over, and cannot be replaced by, a larger quantity of an inferior kind of pleasure. Finally, I will defend the normative claim that pleasure is the only intrinsic good worth having. This is the ultimate principle of qualitative hedonism. John Stuart Mill's presentation of this principle will be defended against G. E. Moore's attacks. Since an ultimate principle cannot be justified by reference to other more basic principles, the method of justification taken here will be that acceptance and implementation of this principle results in a way of life acceptable to rational persons.

The second chapter will present act utilitarianism as an ethical theory for decision making. The act utilitarian principle of right acts will first be stated. I will then explain and discuss all the basic insights of this principle. The act utilitarian principle advocates judging the moral rightness of an act by consequences, on the

available evidence, for a universal distribution by considering all alternatives and choosing that one which produces at least as much good as or as little evil as any other alternative open to the agent. It excludes a consideration of the intrinsic nature of the act, motivation, and appeal to set rules. Rule utilitarianism is a recent development within the utilitarian system. It advocates judging particular acts as they fall under general rules. I will argue that, contrary to rule utilitarianism, decisions are best made case by case, judging the consequences of that particular case, rather than referring to a general rule. Rule utilitarianism introduces difficulties for the decision maker without offering any compensatory benefits. Finally, in this chapter, I will discuss formalism as an ethical theory opposed to utilitarianism. The formalist ethical theory, among other things, argues that acts are right by their intrinsic nature. W. D. Ross is a noted formalist whose theories I will discuss and critique. I will also argue that the utilitarian principle can account for the common sense moral insights involved in the just treatment of individuals without the addition of a fairness principle.

A third chapter will introduce the complexities of the intensive care nursery and of diseases and malformations that afflict the newborn infant. I will describe and discuss the clinical setting and organization of the typical intensive care nursery. Certain difficulties for clear and calm decision making in this setting will be pointed out. Although the entire range of neonatal disease cannot be presented here, I will present in some detail three serious neonatal complications. Hyaline membrane disease (usually affecting the premature infant),

spina bifida with meningomyelocele, and Down's Syndrome are chosen for discussion since they involve serious ethical dilemmas for the decision maker.

The fourth chapter is the actual justification and application of the act utilitarian theory of right acts combined with a qualitative hedonistic theory of the good to the clinical reality of newborn intensive care. In order to show that this ethical theory is acceptable among many physicians, articles from medical journals will be analyzed. Physicians often do advocate this method of decision making in solving difficult medical ethical questions. I will then present four case studies. Each will be followed by a discussion and application of the ethical system developed in this dissertation.

In the concluding chapter I will review the nature of ethical decision making. The success of act utilitarianism in providing guidelines for medicine will be reassessed. I will argue that the act utilitarian system with a qualitative hedonistic explanation of the good is readily applicable to not only neonatal intensive care but also to the wider spectrum of medical ethical decision making.

CHAPTER I

QUALITATIVE HEDONISM AS A THEORY OF THE GOOD

Qualitative hedonism is a philosophical statement of the good for man. It claims (1) that pleasure is the only good which is worth having for its own sake, all other goods being valued for the pleasure inherent in them or the pleasure to which they lead, and (2) that pleasure is an inwardly experienced feeling which differs in kind as well as in degree. Pleasure cannot be abstracted from the non-hedonic properties of the pleasurable experience in order to be measured or compared to another purely pleasurable experience. It is bound up in the experience of which it is a part. When qualitative hedonism is added to the utilitarian theory of obligation, there results the normative statement that one ought to act to maximize pleasure both in quality and quantity.

The above is a very concise statement of the qualitative hedonist's position. There are at least three aspects of this statement which need to be discussed. First, I will clarify hedonism as a psychological statement about what is desired as an end in itself. Is it true that humanity seeks after pleasure as its only intrinsic good? Are there things other than pleasure that are desired for their own sake? Secondly, I will discuss the nature of pleasure. Is pleasure a term that always refers to one and the same feeling or do pleasures differ to the extent that the term "pleasure" like "color" or "game" is a family term covering widely differing states of feeling? Can one

validly claim that some pleasures are "better" than others? Thirdly, the types of arguments that can be given for the normative claims that pleasure is the only intrinsic good worth having, and that man ought to act to maximize pleasure and to minimize pain, will be explored. Whether or not qualitative hedonism provides a theory of the good that we would want to see accepted will also be discussed. Additionally, one may inquire if qualitative hedonism is an appropriate and helpful theory of the good for medicine. Throughout the discussion of the three points just outlined I will refer to the medical model.

Before discussing hedonism as a psychological fact it might be well to discuss the prevalent but mistaken negative connotation of hedonism. To claim that pleasure is the only intrinsic good for man appears on first glance to be a less than admirable theory of the good. Calling someone a hedonist is often meant and taken as an insult. "Hedonist" has come to connote a self indulgent individual with little concern for other's happiness or for his own long-range happiness. A summary statement of hedonism is thought to be "Eat, drink, and be merry, for tomorrow we die."

This popular view of hedonism is not in accord with the philosophical theory of hedonism. However, from Epicurus to Mill philosophers who have espoused hedonism have faced critics who consider it an ethical system worthy only of pigs. This misunderstanding of hedonism seems to rest on a narrow and mistaken definition of pleasure as immediate, physical gratification. It might be more acceptable to label the only intrinsic good for man as well being or some other less controversial term than pleasure. Yet, pleasure and the absence of

pain is the way hedonistic philosophers have spoken of intrinsic good. Rather than change the terminology, it appears more appropriate to endeavor to understand the nature of pleasure as hedonism discusses it and advocates its pursuit. Once we understand the nature of what is being called intrinsic good, the specific term we wish to use for it, be that "pleasure" or "well being," will not matter.

Even before John Stuart Mill argued that pleasures differ in kind, hedonists advocated the pursuit of more than temporary, bodily pleasures. The Greek philosopher, Epicurus, tells us:

> For it is not continuous drinkings and revellings, nor the satisfaction of lusts, nor the enjoyment of fish and other luxuries of the wealthy table, which produce a pleasant life, but sober reasoning, searching out the motives for all choice and avoidance, and banishing mere opinions, to which are due the greatest disturbance of the spirit.[4]

Epicurus and other philosophers before Mill advocated these "higher" pleasures on a quantitative basis--they lead to more pleasure, contain no necessary concomitant pains, produce a more varied and thus greater amount of pleasure. Mill, as will be seen, introduces the idea of qualitative differences in pleasures and thus more easily defends the pursuit of higher, mental pleasures over lower, purely physical pleasures.

It can be seen, then, that philosophical hedonism is not saying that humanity finds its only intrinsic good in self indulgent sensual gratification. Given this broader definition of pleasure, as including the longer lasting, higher pleasures of reasoning, freedom, friendship

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[4]Epicurus, "Epicurus to Menoceus," in Ethical Theories, ed. A. I. Melden (Englewood Cliffs, New Jersey: Prentice-Hall, Inc., 1967), p. 145.

and the like, it now needs to be discussed whether or not mankind seeks only after pleasure as a matter of psychological necessity.

I. HEDONISM AS A PSYCHOLOGICAL THEORY

Some philosophers have based their arguments for ethical hedonism on an appeal to what they consider to be a fact of human behavior and motivation. They argue that it is the very nature of humanity to desire only what is thought to bring pleasure. Thus, John Stuart Mill states "to desire anything except in proportion as the idea of it is pleasant is a physical and metaphysical impossibility."[5]

This can be interpreted to mean that a person is only motivated to desire one thing over another if that thing holds out a greater amount or higher quality of pleasure for him personally. This would be a psychological and motivational theory of hedonistic egoism. Such a theory seems to conflict with the experience of many sincere individuals. Thoughtful, introspective individuals claim to act from other motives than personal pleasure. People do sacrifice their own short term and long term interests for those of their children or their friends. To claim that their real motivation is personal pleasure is either to insist on unwarranted insights into other's motivations or to reduce the claim to a tautology where one's choice is defined as in one's own interest by the very fact of being chosen. Hedonistic egoism appears disproved by empirical fact.

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[5]John Stuart Mill, "Utilitarianism," in Utilitarianism: John Stuart Mill, ed. Samuel Gorovitz (New York: Bobbs-Merrill, 1971), p. 40.

Egoism is not the only form of psychological hedonism. It can be claimed that although we do not only desire our own pleasure, yet we only desire that course of action which we believe will result in the greatest happiness of all concerned. Parents who sacrifice their interests for their children's do so because they desire the greatest net happiness--their children's in this case. The soldier who sacrifices himself for the safety of his company would not do this except that he feels that others will benefit (will gain happiness) from his action. This seems to be a more promising theory than psychological egoism. It is this universal sense of desiring happiness that Mill advocated. Even G. E. Moore, an avowed critic of all forms of hedonism, has less objection to this form of psychological hedonism. He states: "Of course, a Naturalist might hold that what we aimed at was simple "pleasure" not our own pleasure; and that, always assuming the naturalistic fallacy, would give an unobjectionable ground for Utilitarianism."[6] Yet, the only way to defend any psychological statement is by appeal to empirical fact and it appears that there are facts that contradict this form of psychological hedonism also. Certain people claim that they are motivated to desire one course of action over another by a sense of duty alone, apart from any consequences of happiness. It is also true that sometimes choices are made with no clear desire for one outcome over another. A choice simply has to be made. Others claim that there are certain things other than pleasure which are considered as intrinsically good and capable of motivating desire.

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[6]G. E. Moore, Principia Ethica (Cambridge: University Press, 1968), p. 105.

We might pause here and consider this claim that things other than pleasure are desired for their own sake. This does have some empirical support. Although most of us take aspirin for headache, there seem to be some who prefer to suffer. There are terminal cancer patients who refuse pain medication. There are individuals who wait too long before they present themselves to a physician with a serious and painful disease. It would appear that these persons are valuing something above happiness and freedom from pain. In other cases there are individuals who pursue an academic or medical degree while enduring great hardships for many years. People go to war risking death and enduring suffering for the sake of abstract ideals. Some philosophers claim that people value such things as beauty, friendship, wisdom, freedom, and virtue for their own sakes apart from any pleasure that is gained from their enjoyment.

At this point in our discussion, we must make the most honest determination of whether or not these things other than happiness <u>are in fact capable</u> of being desired for their own sakes. In the last section of this chapter the further question will be taken up of whether or not things other than pleasure or happiness[7] <u>ought</u> to be desired for their own sakes. Psychological hedonists claim that only happiness is capable of being desired for its own sake. Thus, they would explain away the above examples by calling for a closer look at those cases in which it appears that something other than happiness is sought. It will

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[7]Happiness and pleasure can be used interchangeably here if it is understood that the hedonist means by happiness a significant dominance of pleasurable experiences over painful experiences over time.

be seen, they claim, that happiness or pleasurable experience takes such a varied guise that it can look like an individual is sacrificing happiness for something else whereas he is only foregoing a lower pleasure in order to attain a higher pleasure, or willingly suffering a lower pain in fear of a greater pain. In any case an individual does not choose something other than happiness because he intrinsically values that other thing. The individual who chooses suffering over relief through medication does not believe that suffering is intrinsically valuable. Perhaps, he thinks the value of suffering lies in its bringing about a stronger character. It may be the case that this stronger character is in turn valued as a means to happiness or, more likely the case, a strong character has come to be valued as an inseparable part of the individual's happiness.[8] Happiness is still the only thing desired for its own sake by those individuals who willingly suffer physical pain in order to attain the higher pleasure of happiness, a part of which is considered to be a strong, free, integrated character.

The other examples cited above can be analyzed in a similar manner. Those who suffer painful diseases rather than present themselves to a physician do so, not because they value the suffering itself, but often because they fear the diagnosis of a terminal disease, or the expense of medical treatment. Physical suffering is chosen over mental anguish. Those who put off happiness and endure hardships while

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[8]John Stuart Mill in "Utilitarianism" suggests this analysis in his discussion of virtue coming to be desired for its own sake but only as a part of happiness. See Mill, pp. 37-41.

pursuing a chosen career do not choose the poverty conditions and time pressures for their own sake but only as a means to the happiness they anticipate in their careers. Nations and individuals who endure the hardships of war see no value in war itself but only in the greater happiness it will bring to their nation or to nations which have known the effects of an aggressor. It also seems apparent to the psychological hedonist that beauty and friendship are only considered valuable in that they afford pleasurable experiences to identifiable individuals. Wisdom, freedom, and virtue seem to fall into the same class of goods as the strong character of the drug-refusing patient. To some they come to be an inseparable part of happiness.

Psychological hedonism can in the above manner defend its claim that only pleasure or happiness is desired for its own sake. However, as was stated earlier, as a psychological theory it can only appeal to empirical fact. If an individual insists against the psychological hedonist that that individual is motivated by a sense of duty alone or indeed desires wisdom apart from any happiness that may be associated with it, the philosopher would do well to listen and be willing to abandon his theory in the face of new evidence. Even John Stuart Mill allowed for the possibility that there would not be universal agreement about psychological hedonism. He ends his discussion on this topic by acknowledging that whether or not this statement is true "must now be left to the consideration of the thoughtful reader."[9]

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[9]Mill, p. 41.

Fortunately, ethical hedonism is not dependent upon psychological hedonism to justify its claim. In the final section of this chapter the kinds of arguments that can be given to rationally justify normative hedonism will be examined. Before turning to this, however, I will discuss just what is meant by "happiness" or "pleasure."

II. THE NATURE OF PLEASURE

If one were to explain the use of the word "pleasure" to a child, the only way to do it would be to describe situations in which pleasure is ordinarily felt. This is because pleasure is not the sort of thing that can be isolated from its context. One never experiences "pure" pleasure. It is always the pleasure of eating, of friendship, of music, of rest, or massage, or of some other context. Even introspectively it is difficult to imagine someone isolating the inward experience of pleasure from the circumstances in which the pleasure is experienced. It is the nature of pleasure, and also of pain, that it intends outward and requires an object.

Another and related aspect of the nature of pleasure is that pleasures differ in kind or quality. The pleasure of sexual orgasm is very different from the pleasure a good symphony brings. The nature of pain is parallel. The pain of an unhappy love affair is very different from the pain of toothache. Some pains and pleasures differ so much from certain other pains and pleasures that the only thing they appear to have in common is sharing the class name "pain" or "pleasure."

Concentrating on the notion of a class concept, "pleasure" can be taken as a term doing the same sort of job that "color" or "game" does. "Pleasure," "pain," "game," and "color" are all class concepts.[10] War maneuvers are not at all like Monopoly but they are both termed "games." Orgasm is not at all like the joy found in solving a logic problem but they are both pleasures. The term pleasure is applied to widely differing inner qualities of feeling

One might argue that pleasures are in a sense all alike in that they "feel good" or are that sort of experience which we desire to prolong or repeat. Describing pleasures as "feeling good" is more a definition of what is meant by pleasure than a listing of the common qualities of all pleasures. It could still be argued whether the "feeling good" common to all pleasures is really one uniform sensation, identical in each pleasurable experience. It seems not. We "feel good" in a very different sense when we experience orgasm and when we experience the joy of reading. It is true that both these pleasures are experiences which we normally wish to prolong and repeat. But this in itself does not tell us much about the nature of pleasure and whether or not "pleasure" always refers to an identical inner feeling.

Most philosophers who claim to be hedonists also claim that pleasures differ only in measures of quantity. Jeremy Bentham, a quantitative hedonist, suggests that pleasures and pains can be measured according to seven circumstances: intensity, duration,

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[10]Plato treats "pleasure" as a class concept similar to "color" in his dialogue Philebus. See The Dialogues of Plato, trans. B. Jowett (New York: Random House, 1937), II, pp. 344-345.

certainty or uncertainty, propinquity or remoteness, fecundity, purity, and extent.[11] Thus a pleasure which was more intense, lasted longer, and lead to future pleasures would be considered a better or higher pleasure. Pleasures, for Bentham, only differed in this quantitative way. He claimed: "Prejudice apart, the game of push-pin is of equal value with the arts and sciences of music and poetry. If the game of push-pin furnish more pleasure, it is more valuable than either."[12]

John Stuart Mill was the first hedonist to systematically develop the idea that pleasures also differed in kind or quality. He recognized the fact that quantitative hedonists before him had noted that pleasures differ. They even made a case for higher pleasures over lower pleasures. Higher pleasures were thought to be mental or distinctively human in character, while the lower pleasures were of a bodily, animalistic sort. The quantitative hedonists judged these pleasures to be higher because they offered greater quantities of pleasure in the sense of Bentham's seven measurements. Mill, recognizing all this, argued that another course could have been taken. He states:

> It must be admitted, however, that utilitarian writers in general have placed the superiority of mental over bodily pleasures chiefly in the greater permanency, safety, uncostliness, etc., of the former--that is, in their circumstantial advantages rather than in their intrinsic nature. And on all these points utilitarians have fully proved their case; but they might have taken the other and,

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[11]"An Introduction to the Principles of Morals and Legislation," in Melden, pp. 385-386.

[12]The Works of Jeremy Bentham, ed. John Bowering (New York: Russell and Russell, 1962), II, p. 253.

> as it may be called, higher ground with entire consistency. It is quite compatible with the principle of utility to recognize the fact that some kinds of pleasure are more desirable and more valuable than others. It would be absurd that, while in estimating all other things quality is considered as well as quantity, the estimation of pleasure should be supposed to depend on quantity alone.[13]

Mill argues that pleasures are truly different in kind. So much so, that one can prefer a pleasure of higher quality over a greater amount of pleasure of a lower quality.

Mill has been much criticized for his view of pleasures differing in kind. Henry Sidgwick is a quantitative hedonist who rejected Mill's theory. He rejected it on the grounds that all pleasures have a common property and can be compared in terms of that property.[14] Quantities of that common property are the only needed measurements. G. E. Moore argues against Mill on the same ground. He states:

> "Pleasant" must, if words are to have any meaning at all, denote some one quality common to all the things that are pleasant; and, if so, then one thing can only be more pleasant than another, according as it has more or less of this one quality.[15]
>
> For it brings out the fact that if you say "pleasure," you must mean "pleasure": you must mean some one thing common to all different "pleasures," some one thing, which may exist in different degrees, but which cannot differ in <u>kind</u>.[16]

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[13]Mill, pp. 18-19.

[14]Henry Sidgwick, <u>The Methods of Ethics</u> (London: Macmillan and Company, 1941), p. 94.

[15]Moore, p. 78.

[16]Moore, p. 80.

By claiming that pleasure is pleasure, or that all pleasures have a common property, or that pleasures cannot differ in kind, neither Sidgwick nor G. E. Moore present an argument against Mill. They simply assert that he is mistaken. There are no subtle philosophical arguments involved here. The nature of pleasure is open for anyone to examine. It should be a matter of empirical and psychological evidence then to decide whether pleasures differ in kind or if pleasure is one, uniform entity which can be isolated and measured.

Before we further explore the notion of quality differences between pleasures, it is worthwhile to note that Mill is not the only philosopher in history to take this position. Aristotle seems to agree with Mill. He writes:

> Perhaps pleasures differ in kind; for those derived from noble sources are different from those derived from base sources, and one cannot get the pleasure of the just man without being just, nor that of the musical man without being musical, and so on.[17]

Spinoza also argues that pleasures differ in kind:

> The pleasure, which arises from, say, the object A, involves the nature of that object A, and the pleasure, which arises from the object B, involves the nature of the object B; wherefore these two pleasurable emotions are by nature different, inasmuch as the causes whence they arise are by nature different. So again the emotion of pain, which arises from one object, is by nature different from the pain arising from another object, and, similarly, in the case of love, hatred, hope, fear, vacillation, etc.
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> Thus, there are necessarily as many kinds of pleasure, pain, love, hatred, etc., as there are kinds of objects whereby we are affected.[18]

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[17]The Basic Works of Aristotle, ed. Richard McKeon (New York: Random House, 1941), p. 1097.

[18]The Chief Works of Benedict de Spinoza, trans. R.H.M. Elwes (New York: Dover Publications, 1951), II, p. 168.

An important clue to the nature of pleasure is brought out in these two quotations. Pleasure cannot be isolated and considered apart from its source. This was stated earlier in the claim that one never experiences "pure" pleasure but always the pleasure of something. Quantitative hedonists speak as if the pleasure derived from hearing a symphony could be isolated, held in consideration, and compared to the pleasure derived from back massage. They argue that pleasure is pleasure, thus, these two pleasures are identical, only their sources differ. However, it does not seem as simple as these men think to separate the pleasure from the source of pleasure.

An appeal to experience is the only final deciding criterion there can be between Sidgwick and Moore on one side and Spinoza, Plato and Mill on the other. It does seem, at least from my experience, that the intrinsic nature of the pleasure felt from orgasm is so very different from the pleasure felt upon solving a logic problem that there is no common property which can be abstracted from the two, termed "pleasure," and then measured one against the other. They are simply different.

G. E. Moore, as quoted above, is arguing in part a linguistic thesis rather than an appeal to introspection on the nature of pleasure. He argues that if we have one term to cover all pleasures, then we must mean some one thing, some one common property, that all pleasures possess. This is a naive linguistic theory, especially since Wittgenstein pointed out the idea of family terms. Wittgenstein argued that it was an inappropriate "craving for generality" which led us "to

look for something in common to all the entities which we commonly subsume under a general term."[19] He uses the example of games to show that this is not true. Moore is, then, overly hasty in assuming that there must be a common property since there is one general term. Linguistically, then, qualitative differences in pleasures are possible. This possibility again leads to the conclusion that experience must provide the evidence for or against qualitative hedonism.

Another way to defend Mill and argue further that pleasures do differ in kind is to attempt a psychological distinction between higher mental pleasures and the lower bodily pleasures. Dr. Rem Edwards in his manuscript on qualitative hedonism suggests that this distinction can be drawn along the lines of localized and non-localized pleasures and pains.[20] Drawing out the implications of a distinction made by John Hospers, Edwards claims that there are both localized pleasures and non-localized pleasures. Examples of the former are having one's back rubbed, soaking one's feet in water, tasting a good wine or gourmet food, stimulation of the body's erogenous zones. Examples of the latter are the joys of friendship, of love, of learning, of parenting, of a symphony performance. Pains can also be separated into localized and non-localized. Here the former would consist of headache, pinprick, stabbing, muscle spasm, toothache, indigestion, and many others.

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[19]Ludwig Wittgenstein, The Blue and Brown Books (New York: Harper and Row, 1958), p. 17.

[20]Rem Edwards, Chapter II, "Do Pleasures and Pains Differ Qualitatively?" Qualitative Hedonism (Ithaca, New York: Cornell University Press, In Press). I have developed many of the ideas in this section from Dr. Edwards' fine manuscript.

Some of the latter would be grief, despair, anguish, worry, loneliness, jealousy. With localized pleasures and pains there is a part of the body that can be said to feel good or to hurt. With non-localized pleasures and pains it does not even make sense to ask where it feels good or where it hurts. It cannot even be said that it feels good all over or hurts all over. Bodily locus is simply not relevant to the pain of jealousy or the pleasure of learning.

This distinction between higher, mental pleasures and pains, on the one hand, and lower, physical pleasures and pains, on the other, supports the notion that pleasure is not simply pleasure--one, common, identifiable quality. Pleasures differ significantly from one another in kind. Pleasure cannot be abstracted from the activity or experience which ties it to its intentional object. The pleasure associated with one type of activity is simply of a kind different from the pleasure associated with a second type of activity. Pleasures differ not only in quantity terms, not merely in localizability, but also in quality.

Certain things follow from establishing the above picture of the nature of pleasure. For one thing, Bentham's argument about push pin and poetry[21] no longer holds true. For the quantitative hedonists, one pleasure would always be replaceable without loss of intrinsic worth by another pleasure as long as the quantity is the same. Thus, poetry can be replaced by push pin with no loss. Love can be replaced by sex with no loss as long as the quantity measurements are the same. Freedom can be replaced by three meals a day as long as quantity of pleasure is

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[21]Bowering, p. 253.

the same. Most quantitative hedonists do seem to prefer "higher" pleasures of love and freedom, but it is inconsistent for them to prefer these pleasures unless they mean that, for example, love is longer lasting or more intense. But even then love could be replaced by a greater quantity of sex which would balance out the length and intensity of love. Arguing that pleasure is pleasure, the quantitative hedonist would have to admit this.

A qualitative hedonist need not accept this kind of replacement or substitutability thesis. If pleasures truly differ in quality, it may be the case that some pleasures are of such superior intrinsic quality that an equal quantity of another pleasure could never replace the intrinsic worth of or substitute for the superior pleasure. This, in fact, seems to be the case. Many a poor person values independence and self respect over the pleasures of enough to eat when that food is attained through "charity." People often consider fidelity in marriage a higher pleasure than the admitted pleasures of promiscuity. Love and the security of being loved is chosen over mere excitement. One might even say that the quality of sexual intercourse with an individual whom one loves is of such greater worth that it is preferred over the greater quantity and possible intenseness of pleasure that intercourse with casual partners could bring.

With qualitative hedonism, then, it is meaningful to claim that one pleasure is better than another, and not simply that some sources of pleasure yield more pleasure than other sources. Some pleasures are simply qualitatively superior by their very nature. John Stuart Mill gives us a simple test with which to distinguish these superior pleasures.

He appeals to those qualified by knowledge of both pleasures, as judges to decide upon which is actually preferred. Mill states:

> Of two pleasures, if there be one to which all or almost all who have experience of both give a decided preference, irrespective of any feeling of moral obligation to prefer it, that is the more desirable pleasure. If one of the two is, by those who are competently acquainted with both, placed so far above the other that they prefer it, even though knowing it to be attended with a greater amount of discontent, and would not resign it for any quantity of the other pleasure which their nature is capable of, we are justified in ascribing to the preferred enjoyment a superiority in quality so far outweighing quantity as to render it, in comparison, of small account.[22]

This is another instance in which we must appeal to experience. In judging one pleasure superior to another we must have experience of both. It is true that some experience is necessary before a person can even know what is pleasurable for him at all. This is because people differ in what pleases them. Some individuals find all mathematical activity pure agony, others find it pure joy. Some find soaking in a warm tub full of bath water a great pleasure, others a necessary evil. Not only do pleasures differ but people differ in what they consider pleasures. Nevertheless, people are similar enough that there are standard sources of pleasure. There is also enough similarity in preference that Mill can state with confidence that it is the higher, distinctively human pleasures that qualified judges will give a marked preference.

As pointed out above there is evidence for Mill's confidence. Individuals do often choose the higher pleasures of freedom, dignity,

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[22]Mill, p. 18.

love, and education over mere convenience or bodily ease. Certainly there are also numerous examples of individuals who choose immediate bodily pleasures. This fact, however, does not contradict the claim that the human, non-localized pleasures are of far greater quality. Those who occasionally or habitually choose the lower pleasures may recognize this themselves but, for many reasons, consider themselves incapable of attaining the higher pleasure. The proud patient who finally submits to a pain pill would often prefer that he could overcome or bear the pain without aid. The teenager who habitually drops acid would probably prefer that his life were more exciting, his parents kinder, his friends more loving so that he did not need this stimulant. The alcoholic would not find his pleasure in a bottle if he had the joys of love and a feeling of self worth.

The same distinction can be drawn about bodily and mental pain. Very often those who have known both kinds of suffering would and do prefer bodily pain over the higher pains of grief, loss of loved ones, or loss of self respect. Some people will literally die rather than be admitted to the hospital and endure all the horrors which the very idea of a hospital invokes.

It is the nature of pleasure, then, to be an inwardly experienced feeling which takes a unique nature from each activity of which it is a part. Pleasure is no one, unique, easily identifiable entity. Pleasures differ in quality, some being of such superior quality that they are preferred over and could not be replaced by a larger quantity of an inferior pleasure. Pleasures and pains can be intelligibly grouped into lower, bodily, localized ones and higher, mental,

non-localized ones. Those people who have experience of both of these types of pleasures often recognize the mental pleasures to be of a superior quality and prefer them over lower pleasures.

Having established the above as the nature of pleasure it now remains to be seen if this largely psychological description can serve as a basis for a normative ethical theory. In the following section I will explore the types of arguments that can be given for the normative claims that pleasure is the only intrinsic good worth having, and that man ought to act to maximize pleasure and to minimize pain.

III. NORMATIVE HEDONISM

Thus far hedonism has been discussed in a largely psychological context. It has been established that the desire for happiness is a strong motivation for action, although not necessarily the only such motivation. The nature of pleasure has been discussed. It has been shown that pleasures differ significantly from one another, both in kind and in quantity measures.

These discussions are necessary background material to the statement and support of the main thesis of this chapter. The project of this dissertation is to develop a normative ethical theory for medical decision making. This chapter is to contribute a statement of what ought to be the good for man. In the next chapter a theory of action or obligation will be developed. Act utilitarianism, this theory of obligation, states that a right act is one which maximizes the good. It is claimed, here, that the good is happiness or pleasure as understood by reference to qualitative hedonism.

To state it once more, the qualitative hedonist's position on the good for man is: Pleasure, in terms of both quantity and quality, is the only good worth having for its own sake, all other goods being valued for the pleasure inherent in them or the pleasure to which they lead. Furthermore, one ought to act to maximize pleasure and minimize pain both in quality and quantity. The terms used in this statement have been explored above. Most importantly, it has been claimed that pleasure is not the sort of thing which can be abstracted from the non-hedonic properties of the total pleasurable experience. It was also claimed that certain pleasures are experienced as so far superior in quality that they cannot be replaced without loss of intrinsic worth by an equal amount of a lower quality pleasure.

Having stated and explained the qualitative hedonist's theory of the good, it remains to defend that statement. Difficulties are immediately encountered in trying to prove the basic principles of any system of thought. Proofs are deduced or constructed within a system by appeal to the system's basic principles. But to require a proof of the basic principle is to ask for the impossible. For example, within the qualitative hedonist's theory of the good, it can be shown that good health is often desired even at the expense of the inconvenience and monetary outlays of periodic visits to the physician, exercise, diet, and occasional hospitalizations. Good health brings more pleasure in the long run than other things the time and money invested in its reasonable pursuit could possibly bring. Empirical facts drawn from the experience of numerous people can be cited in support of this conclusion. These observations plus the principle that pleasure is the

only intrinsic good and ought to be maximized allows the conclusion that good health ought to be sought, even at the expense of inconvenience and monetary outlays. Thus, the basic principle is appealed to in each proof within the system, but itself necessarily remains incapable of deductive proof. There are no principles more basic from which to deduce it.

John Stuart Mill clearly saw that his basic normative principle of qualitative hedonism could not be deductively proved. "Questions of ultimate ends are not amenable to direct proof."[23] However, he was not content simply to leave the matter there and ask that his basic principle be accepted on the basis of direct intuition or simply accepted without argument as a first principle. Mill proceeded to give arguments for his principle which he felt would persuade the thoughtful, honest, and rational person to give assent to the principle. This is not offering proof but rather presenting considerations "capable of determining the intellect either to give or withhold its assent to the doctrine."[24]

Until recent times the evidence which Mill presented in defense of his basic principle has been treated rather harshly. G. E. Moore is principally responsible for supposedly refuting Mill's arguments. However, Moore's objections to Mill are really based on a misunderstanding of Mill's purpose. Moore treats Mill's arguments as if they were meant to be proofs of the greatest happiness principle, although

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[23]Mill, p. 15.

[24]Mill, p. 15.

Mill acknowledges and repeats throughout his discussion that such proof is impossible.

I will argue in the following that Mill was anticipating the contemporary trend in metaethics to develop theories of justification for ultimate principles. Mill was not offering a deductive proof for his first principle. The case will be made that he was not deriving normative principles from non-normative premises. G. E. Moore will be refuted in his criticisms of Mill. Finally, Paul Taylor's theory of vindicating an ultimate norm in terms of a way of life and justifying this way of life by showing it to be the result of rational choice will be presented both to defend Mill and to indicate a method of defending qualitative hedonism as an appropriate theory of the good for medicine.

After repeating in the opening sentence of Chapter IV of "Utilitarianism" that "ultimate ends do not admit of proof"[25] Mill states his first argument offered to gain assent to his greatest happiness or utilitarian principle which we have here called the basic normative principle of qualitative hedonism. His first argument is:

> The only proof capable of being given that an object is visible is that people actually see it. The only proof that a sound is audible is that people hear it; and so of the other sources of our experience. In like manner, I apprehend, the sole evidence it is possible to produce that anything is desirable is that people do actually desire it.[26]

G. E. Moore quotes this same passage and then proceeds to show that

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[25]Mill, p. 37.

[26]Mill, p. 37.

it is an inadequate and misguided proof of the good. Moore states:

> Mill has made as naive and artless a use of the naturalistic fallacy as anybody could desire. "Good," he tells us, means "desirable," and you can only find out what is desirable by seeking to find out what is actually desired. . . .
>
> Well, the fallacy in this step is so obvious, that it is quite wonderful how Mill failed to see it. The fact is that "desirable" does not mean "able to be desired" as "visible" means "able to be seen." The desirable means simply what ought to be desired or deserves to be desired; just as the detestable means not what can be but what ought to be detested and the damnable what deserves to be damned. Mill has, then, smuggled in, under cover of the word "desirable," the very notion about which he ought to be quite clear.[27]

A thoughtful, unbiased reading of Mill's entire theory shows that G. E. Moore is hasty in his criticisms. Mill recognizes that "desirable" does not mean only "able to be desired" but is generally used to mean "worthy of being desired." He is simply trying to say in this passage that it would be foolish to hold hedonism as a basic ethical premise if in fact no one ever desired pleasure. He is showing that his first principle satisfies the requirement of what E. W. Hall calls "psychological realism."[28] Acknowledging the impossibility of proving that pleasure is the only intrinsic good, Mill is claiming that this principle is at least a reasonable one in that people do desire pleasure. The sentence following the above quoted passage from Mill gives credence to this interpretation of Mill. He continues: "If the end which the utilitarian doctrine proposes to itself were not, in

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[27]Moore, pp. 66-67.

[28]Everett W. Hall, "The 'Proof' of Utility in Bentham and Mill," Ethics, 60 (1949), 1-18; rpt. in Gorovitz, p. 107.

theory and in practice, acknowledged to be an end, nothing could ever convince any person that it was so."[29]

While Mill is simply offering a reason to accept the greatest happiness principle, Moore is criticizing it as if it were a deductive proof. Moore accuses Mill of committing the fallacy of ambiguous middle in using the term "desirable" in two different senses. This implies that Mill has presented the following syllogism: The good is identical with the desirable. The desirable is identical with the desired. Therefore, the good is identical with the desired.[30] In the first premise "desirable" means "worthy of being desired." In the second premise the same term means "capable of being desired." Thus, a logical fallacy is committed. The problem is that there is no evidence that Mill meant to present such a syllogism. He is simply stating that the fact that people do actually desire pleasure is one fact capable of giving credence to the greatest happiness principle. It would be unreasonable to accept a theory of the good if no one ever desired that which one is proposing as good.

In the above passage quoted from Moore, he has also claimed against Mill that Mill has committed the naturalistic fallacy. Moore repeats this accusation a few pages later:

> This fallacy, I explained, consists in the contention that good <u>means</u> nothing but some simple or complex notion, that can be defined in terms of natural qualities. In Mill's case, good is thus supposed to <u>mean</u> simply what is desired;

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[29]Mill, p. 37.

[30]See Hall, p. 103.

> and what is desired is something which can thus be defined in natural terms.[31]

It is not at all clear that Mill is defining "good" as "desired" or as "pleasure." In fact, his theory as a whole gives every indication that he is not. Mill is not giving us a definition at all. He is simply pointing out which things are considered good. He concludes that we do not find anything good except that we also find it pleasurable. This is Mill's psychological hedonism which was discussed above. Mill does claim, perhaps mistakenly, that all things valued for their own sakes are found to be pleasure producing experiences. But this is not the same thing as claiming that good is by definition pleasure. The two terms are simply coextensional for Mill. In a similar fashion one can note that snow is also white without making the further claim that snow means white.

Having established that the happiness principle is reasonable in the sense that happiness is one of the things men actually desire, Mill goes on to claim that this principle is necessarily more reasonable than any other first principle since it appears to be a psychological fact that pleasure is the only thing man is capable of desiring. In establishing this argument Mill first argues for psychological hedonism in the manner that was indicated at the beginning of this chapter. He then concludes:

> We have now, then, an answer to the question, of what sort of proof the principle of utility is susceptible. If the opinion which I have now stated is psychologically true--if human nature is so constituted as to desire nothing which is not either a part of happiness or a means to

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[31]Moore, p. 73.

> happiness--we can have no other proof, and we require no other, that these are the only things desirable.[32]

This justification for the greatest happiness principle has also been mistakenly taken for a deductive proof in which it is concluded that happiness is the only good worth desiring for its own sake because it is the only good, in fact, desired for its own sake. This type of proof is objected to on the grounds that a normative statement cannot be deduced from non-normative statements. David Hume, G. E. Moore,[33] and the majority of contemporary philosophers argue that an "ought" statement cannot follow from "is" statements. There are at least two ways to defend this argument of Mill's from such a claim. Rem Edwards in the final chapter, "Methodology in Ethics and the Proof of Utilitarianism," of his manuscript on qualitative hedonism fleshes out Mill's argument in the following manner:

1 Happiness is desired for its own sake.
2 We cannot desire anything for its own sake other than happiness.
3 If we are obligated to do anything, then we can do it.
Deductions:
4 If we cannot do anything, then we are not obligated to do it. 3, Transposition.
5 If we cannot desire anything for its own sake other than happiness, then we are not obligated to do it. 4, Universal Instantiation.
6 We are not obligated to desire anything other than

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[32]Mill, pp. 39-40.

[33]G. E. Moore also objects to this argument of Mill's by rejecting psychological hedonism. Moore's arguments are largely based on a misunderstanding of the nature of pleasure. It was argued above that pleasure is an inward feeling, varying in kind, and incapable of being isolated from the experience of which it is a part. These arguments are sufficient to refute Moore's contentions against psychological hedonism, although, as acknowledged above, this type of hedonism might be refuted on other grounds.

happiness for its own sake. 5, 2 Modus Ponens.[34]

By claiming that the third premise is a normative claim--"it is wrong to hold a person obligated to do something when he cannot do it"[35]--Edwards argues that Mill is not deriving normative claims from non-normative premises, but simply deriving norms from more basic norms. This makes the "ought implies can" principle a more basic norm than "pleasure is the only intrinsic good." There would still be the problem, then, of justifying, although not proving, this more basic norm.

Another way to defend Mill's argument from psychological hedonism to normative hedonism is more in line with Mill's stated intent in Chapter IV of "Utilitarianism." Mill specifically repeats throughout his discussion that he does not intend to give a proof of his happiness principle. Thus, rather than assuming that Mill was implying an "ought implies can" principle and thus giving us a proof, Mill's discussion can be regarded as offering a further and conclusive reasonable justification for accepting the greatest happiness principle. It alone satisfies the criteria of psychological realism. Mill is not saying that the psychological necessity of intrinsically desiring only happiness <u>proves</u> that happiness is the only thing worth desiring for its own sake. Rather he makes the lesser claim that this psychological fact is a very good reason for rational, thoughtful people to accept the

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[34]Edwards, Chapter VI, "Methodology in Ethics and the Proof of Utilitarianism."

[35]Edwards, Chapter VI, "Methodology in Ethics and the Proof of Utilitarianism."

greatest happiness principle. It cannot be proved but it can be shown to be eminently reasonable, and this is the only "proof" we can have or need to have. E. W. Hall interprets Mill's intent in the above manner. He sums up Mill's argument in the following statement:

> It says that, if there is only one sort of thing that is ever desired, then psychological realism requires one's ethical theory to square with this. This sort of plausibility is all that can be required of any ethical theory.[36]

G. E. Moore's and others' criticisms and some defenses of Mill's "proofs"[37] in "Utilitarianism" are, then, wrong-headed in that Mill did not intend to offer a proof of the greatest happiness principle. Ultimate principles cannot be proved in any deductive sense. Acknowledging the impossibility of deductive proof, Mill does offer some considerations that defend his choice of the greatest happiness principle and which can, hopefully, rationally persuade others to also accept it.

The concept of offering justification for ultimate principles while denying any possible proof has lately been elucidated by Paul W. Taylor. Taylor does not defend any one system of ethics or definition of the good. He does give an explanation of the only rationally acceptable way one can defend the choice of an ultimate principle.

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[36]Hall, p. 109.

[37]Mill gives one more argument in the chapter of "Utilitarianism" under discussion. This argument regards the proper distribution of what is considered to be the only intrinsic good. This argument is more properly treated in the following chapter on act utilitarianism. See below pp. 54-59.

If one is asked to defend the norm "Good health is worth the necessary inconvenience and monetary outlays," one can appeal to other norms and finally to the ultimate norm "One ought to act to maximize pleasure and minimize pain." Formulating and following this ultimate principle is what Taylor calls adopting a way of life. One can now be asked to defend this way of life, this priority of values which results in validating the pursuit of health on the grounds of a duty to maximize pleasure. This would be vindicating one's choice of a way of life to another who is asking for a good reason that he should also adopt the way of life one has chosen. The only way another individual can come to accept a way of life is by freely choosing to commit himself to it and then judging whether or not this prioritization of values is indeed what he considers to be the good life. Taylor states:

> All we can do to justify anyone's adopting a value system as a whole is to ask (invite) him to adopt it. We then ask him, first, whether the consequences of his doing so do not further certain ideals which, on reflection, he really wants to see realized in the world, and second, whether living in accordance with that system is not part of a whole way of life which, on reflection, he really wants to live.[38]

Thus, the adoption and commitment to an ultimate principle can be vindicated by the resulting way of life. If judging one's decisions by whether or not they maximize pleasure results in a way of life that one can comfortably endorse, then this ultimate principle is vindicated.

Having vindicated an ultimate norm by appeal to a way of life there is one more step of justification. The final question to be

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[38]Paul W. Taylor, Normative Discourse (Englewood Cliffs, New Jersey: Prentice-Hall, Inc., 1961), p. 132.

answered is: "What sort of commitment to a way of life would anyone on reflection be willing to call a justified one?"[39] Here again no proof can be offered. But this does not mean that one chooses an ultimate principle and a way of life arbitrarily. One way of life can be shown to be more rational than another.

Taylor proceeds to justify the commitment to a way of life by defining what a rational choice is. A choice is rational if it is free, enlightened, and impartial. That is, the choice is not decisively determined by unconscious motives; not at all determined by internal or external constraints; the nature, probable effects and means necessary to bring about alternative ways of life are fully known; and the choice is disinterested, detached and unbiased.[40] This is, of course, an ideal. However, the only way to justify a particular way of life will be to determine if people would choose this way of life under the ideal conditions of a rational choice.

Both Mill and Taylor then admit there can be no proof of an ultimate principle. Mill goes on to indicate justifications for his ultimate principle. Taylor outlines methods of justification. Neither is willing to accept that ultimate norms must be simply accepted, intuited, or arbitrarily chosen.

It is impossible and presumptuous here to apply the test of ideal rational choice to qualitative hedonism as the ultimate norm of the good. No one individual could ever even closely approximate the

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[39]Taylor, p. 160.

[40]Taylor, pp. 165-174.

conditions of rational choice. However, some considerations can be presented that, hopefully, will rationally persuade the reader that the priority of values which qualitative hedonism vindicates is a way of life especially appropriate for medicine.

Advocating qualitative hedonism as a theory of the good for medicine does not specify just who is to be committed to promoting this good. "Medicine" does not adopt principles or commit itself to norms. Individual people, not abstract entities, adopt ethical systems. The question of who ought to make value decisions and the proper decision making method will be discussed in subsequent chapters. It can be stated here that it is surely not simply physicians and health care professionals who must decide on a priority of values. Patients must also do this. For simplicity's sake, however, in the following brief scenario qualitative hedonism will be tested as an ultimate norm by noting what way of life would result if health care professionals adopted this norm.

Health care professionals are supposedly dedicated to the care of patients. If they were interested only in disease control, they presumably would have gone into the research end of medicine or into public health. This is not, of course, a strict either/or. One need only observe a university medical center to become confused between what is research and what is caring for patients. But it can safely be said that one of the goals of medicine is to care for sick people. The health care professional, in caring for sick people, would be following the qualitative hedonist theory of the good if he or she always acted in such a way that the patient would be in the least

amount of pain possible while enjoying the greatest amount of pleasure both in terms of quality and quantity. The health care professional's own pleasure and pain would also be considered since our theory of the good allows us to consider the happiness of all persons involved.

Concretely, this would mean pain medication would be given freely unless patient and/or doctor felt it would lead to more or higher level pain in the future. If limited visiting hours in a critical care unit caused more anguish to a family than interruption of care for patients, the hours would not be limited. A dying patient would be allowed to go home if the joys of being with her family outweighed any loss of days of continued life that hospital care could give. Examples could easily be multiplied.

Having, in imagination, freely committed ourselves to the ultimate norm of qualitative hedonism and painted the above picture of the resulting way of life, we need only ask if this is a way of life we could comfortably endorse for the health care professional. Each person will have to judge this for him or herself. Adopting this theory of the good, however, does not seem to have any consequences in the medical world that could be considered inappropriate or undesirable. It furthers the ideal of care of patients. It creates a world of respect and consideration for all.

This justification of the qualitative hedonistic theory of intrinsic good is perhaps hasty at such an early point in our discussion. Justification of the ethical system developed here will again be considered in the concluding chapter. After a discussion of

the act utilitarian method of decision making and an application of this method to selected case studies in neonatal medicine, we will be in a better position to judge the merit and the applicability to medicine of the act utilitarian theory of right acts combined with a qualitative hedonistic theory of intrinsic good.

CHAPTER II

ACT UTILITARIANISM AS A THEORY OF OBLIGATION FOR DECISION MAKING

In the previous chapter a basic principle of intrinsic good was stated and defended. The task of this chapter is to state and defend a basic principle of obligation. Claiming that happiness is the only good worth having for its own sake does not automatically result in a principle of what one ought to do. Knowing what is intrinsically good does not necessarily result in a complete theory of duty. It may be that maximizing the good is not a duty or only one duty among others. The justification of a decision as a right decision requires a basic principle or principles of obligation. As was found in the previous chapter, these basic principles of obligation will not be open to direct, deductive proof. A basic, ultimate principle in any system has no more basic principles from which it can be derived. Ultimate principles of obligation can, however, be justified. They can be shown to result in a way of life, or a method of decision making, that is rationally preferable to alternatives.

In this chapter, then, the one basic principle of obligation of act utilitarianism will first be stated and explained. Some important philosophical criticisms of act utilitarianism will be explored. The purpose of this dissertation is to develop an ethical theory for decision making in the medical context. Therefore, I will treat criticisms of act utilitarianism, in the main, insofar as they count

for or against the applicability of the utilitarian ethical system to moral decision making. Although much recent literature in this area deals with metaethical topics, questions of the analysis of ethical terms will not be dealt with except where it seems necessary to clear up an issue in normative ethics. After an explanation of the act utilitarian principle the task for the remainder of the chapter will be to defend utilitarianism against formalism in ethics and to reconcile act utilitarianism with rule utilitarianism. I will discuss the formalist theories of obligation in an attempt to answer the question, is it true that an act is right if and only if it is productive of the most good? Rule utilitarianism is a recent philosophical theory which attempts to build a bridge between the formalist systems of ethics and consequentialist ethical systems by judging individual actions as they fall under certain rules. I will treat this alternative to act utilitarianism by answering the question, are there certain acts which individually are not productive of the most good but which ought to be performed because they fall into a class of actions, which, if performed by everyone, will be productive of the most good? It will be concluded that act utilitarianism with qualitative hedonism as a theory of the good adequately covers the notions of obligation, duty and the rightness of actions resulting in a philosophically viable normative ethical theory appropriate for decision making in the medical ethical context.

I. THE ACT UTILITARIAN PRINCIPLE

The basic principle of act utilitarianism can be formulated in a number of different ways. The following formulation is offered as a simple, straight-forward statement which covers all the basic insights necessary for decision making. The basic principle of obligation which I will defend here is the following:

> An act is right if and only if, of the alternatives open to the agent and on the available evidence, it produces, for all those affected by the act, at least as much good and/or avoids at least as much evil as any other alternative, where good and evil are understood in terms of the qualitative hedonistic theory of intrinsic good.

In order to fully explain this principle it is necessary to indicate just that type of actions and considerations the principle advocates and also those considerations which it excludes. The act utilitarian principle advocates judging the moral rightness of an act by appeal only to the consequences of the act. This principle further recommends basing judgments on available evidence. It advocates a universalistic distribution of good where each person's happiness is considered equally desirable to every other person's happiness affected by the decision. This principle of ethical right also covers those decisions, frequently met with in medicine, where one has to choose the lesser of two evils. Even if choices are so limited that no significant pleasure can be attained, the principle recommends the choice of that course of action which will minimize pain to all concerned. All alternative actions must be explored, including the choice to do nothing. If two actions produce an equal amount of good or avoid an equal amount of pain, both are considered equally ethically right.

One or the other is a duty when there is no superior alternative.

On the other hand, act utilitarianism excludes the intrinsic nature of the act from consideration in judging its ethical rightness. No act will be wrong by its very nature. A judgment of probable consequences alone determines ethical duty. This principle also excludes a consideration of motive. An act with avoidably evil consequences done from good motives will not be considered a morally right act. Act utilitarianism also excludes judging the rightness of a particular act by reference to a standard rule covering acts of that type.

Therefore, the act utilitarian principle advocates judging the moral rightness of an act by consequences, on the available evidence, for a universal distribution by considering all alternatives and choosing that one which produces at least as much good or as little evil as any other alternative. It excludes a consideration of the intrinsic nature of the act, motivation, and appeal to set rules. A closer look at each of these factors is needed.

Consequences

Act utilitarianism as a consequentialist ethical system claims that in addition to the principle itself, all that is needed to determine whether or not an act is morally right is a weighing of all the consequences of any particular act and a comparison of those to the consequences of any alternatives to the act. Thus, for example, an act of killing, often thought to be wrong by its very nature, can be morally right if the consequences of the act are better than the consequences of any alternative would be. Most acts of killing would still

be judged wrong by use of this consequentialist theory. This is because the happiness that results from a killing is almost always outweighed by the pain produced. When weighing consequences the agent must be very careful to include all the consequences, even those consequences which are long range and affect those individuals only secondarily involved in the act. The agent must also be careful that he weighs consequences disinterestedly. He must not, without good reason, give greater weight to his own interests since the act utilitarian principle advocates maximizing happiness on a universal distribution model. In considering whether or not an act of killing is wrong, the agent may consider that his own happiness would be increased but he must also weigh the loss of happiness by the victim, the unhappiness of the victim's friends and family, and his own friends and family if he were to be caught. There are also important long range consequences such as a weakening of respect for the law, a pattern being set in the killer whereby it becomes easier to kill again, and the fear generated in society upon news of the killing. However, since consequences will vary radically from case to case, it still may turn out in some cases, when weighing both immediate and far ranging consequences, that an act of killing is morally right. Some utilitarian authors note that killing Hitler in 1943[41] would certainly have had better consequences for humanity than his continued life turned out to have. An example, more practical and closer to the

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[41]See, for example, John Hospers, Human Conduct (New York: Harcourt, Brace and World, Inc., 1961), pp. 204-205.

purpose of this dissertation, is the act of killing a terminal patient in intractable pain. It may turn out, in a particular case, when all alternatives and consequences have been determined, on available evidence, that the killing of this individual will serve to maximize happiness. One would have to determine the wishes of the patient if he is able to indicate them. The wishes and probable effects on family and friends should be noted. The effect on health care professionals and other patients who know of the case must be determined. The consequences to this same group of people of any alternative acts must then be considered. An alternative here would be to "allow nature to take its course." Another would be radical nerve cutting surgery to reduce or eliminate pain. Once all alternatives and consequences are determined a choice can be made which maximizes pleasure and/or minimizes pain to all involved. It may, indeed, turn out that the right action is to kill the patient.

It can be seen just from the above example that determining consequences is no easy task. However, according to the act utilitarian principle, it is only by such a thorough examination of all consequences that an ethically right act can be determined. It is also emphasized that a course of action cannot be judged ethically right without weighing it against all alternative courses of action.

Available Evidence

The act utilitarian qualifies his principle of right action with the phrase "on the available evidence." This is because it must be acknowledged that even the most thorough and painstaking investigation of consequences will seldom result in a definitive prediction.

Given the empirical fact of the unpredictability of nature, one cannot base the determination of the ethically right act on an impossibly complete determination of consequences. In measuring consequences in certain circumstances one may have to settle for very limited knowledge. When a decision is needed quickly in a medical or other emergency, available evidence will be limited by time and situation factors. The act utilitarian does not claim that an ethically right decision cannot be made since there is no opportunity to determine all the consequences. One does the best one can. The decision is still based on available knowledge of consequences although circumstances do not allow as complete an investigation as one might desire. Thus, when a comatose patient is brought to the emergency room bleeding badly from self inflicted wounds, there is not time to determine completely if happiness would be maximized by letting the patient die as was apparently intended by the patient. The patient cannot be consulted. Family and friends may be unknown. Here the medical staff must make a quick calculation of probable consequences without much information to go on. Past experience with these types of cases may have convinced the physician that the majority of attempted suicides are grateful when their lives are saved. On this basis, then, the physician will be ethically right by the act utilitarian principle to attempt to save the patient. On the limited available evidence it appears that happiness is maximized by saving the patient. It may turn out in this particular case that the patient had attempted suicide with good reason and the consultation and acceptance of family and friends. The physician's interference and life saving techniques may be resented by

the patient and simply necessitate another attempt at suicide. The act utilitarian would then judge that it was unfortunate that the patient was saved. More suffering was probably caused by saving the patient than would have been caused if the patient had died from the first suicide attempt. Yet, by the act utilitarian principle, the physician was ethically right in his action. He simply could not get the necessary information but acted on available evidence. Available evidence did indicate life saving measures. Although maximum knowledge of alternatives and consequences is desirable, it is not always possible, and the rightness of an action does not depend on complete knowledge.

Universal Distribution

To argue that happiness is the only intrinsic good and that a right action is one which maximizes happiness does not in itself indicate whose happiness is to be maximized. Egoism would maximize only the agent's happiness. Altruism would maximize everyone's but the agent's happiness. Universalism is the distribution theory favored by John Stuart Mill and defended here. Happiness is to be maximized for all those persons affected by the act in question. Each of these persons' happiness is to be considered equally desirable to each other person's. Mill claims that this universal distribution is inherent in the utilitarian principles of intrinsic good and maximizing happiness. He states: "That principle is a mere form of words without rational signification unless one person's happiness, supposed equal in degree (with the proper allowance made for kind), is counted for

exactly as much as another's."[42]

There are a number of ways that this kind of universal distribution can be interpreted. It appears on the surface that there will be many situations where either happiness can be maximized for all or it can be equalized but not both. This supposed contradiction between utility and justice will be thoroughly discussed in the third section of this chapter. Until that discussion we must settle for an explanation of, rather than a defense of, the utilitarian theory of maximizing the general happiness as this is traditionally interpreted.

Each person's happiness is considered equally desirable. This means that every creature capable of feeling pleasure and suffering pain must count as one, no more and no less, in any decision that involves his or her interests. Children or the poor or the foreign born cannot count less than the adult or the rich or the societally elite. In medical situations the utilitarian would caution that the happiness of the sick poor be considered as equally important to the happiness of the well respected research physician at a university hospital. The research physician is acting wrongly if he or she weights the satisfaction of his or her own interests over the happiness and suffering of the patient. Happiness is to be maximized for all concerned. After all alternatives are considered, it may, however, turn out that the benefits of research do outweigh a certain amount of suffering on the part of the patient.

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[42]Mill, p. 55.

Some authors on this subject explain decision making in order to maximize happiness by speaking of positive and negative units of pleasure or pain. Thus a decision could be schematized in the following manner. Three people A, B and C are affected by a decision. Only two alternatives are possible. Alternative I results in the following distribution of happiness A, 10; B, 8; C, -3. Alternative II produces A, 4; B, 4; C, 4. The act utilitarian will consider Alternative I to be the right act since it results in fifteen units of happiness whereas Alternative II results in only twelve units. The act utilitarian principle does not in itself advocate an equal distribution of good. It advocates producing the greatest amount of good for the people affected by the decision while considering each person's interests equally desirable to each other person's. Alternative A, above, produces more good even though person C has to suffer. It is assumed that one unit of good for A is the same as one unit for B or C.

In order to substitute a real life example into the schematization above, any problem would need simplification. Real life ethical problems are not textbook simple. There are seldom only two alternatives or only three people affected by a decision. However, we can give an example for clarity's sake once we admit it is oversimplified. Let A be Mr. Jones, B his adult son and C the wife of B. Alternative I is that Mr. Jones live at home with his son and daughter-in-law. Alternative II is that Mr. Jones be placed in an old age community. Alternative II is satisfactory to the Jones family and results in moderate happiness for all of them. Alternative I causes a great deal of happiness for the older Mr. Jones and also considerable happiness

for his son. However, this alternative causes a certain amount of inconvenience and unhappiness for Mrs. Jones. The act utilitarian principle claims that Alternative I is the right act. Even though it causes a certain amount of pain to Mrs. Jones, this pain is significantly outweighed by the happiness it gives the elder Mr. Jones and his son.

This type of decision making by assigning numerical values to relative happinesses will not be used in this dissertation when applying the act utilitarian principle to medical ethical decision making. In real life situations, especially in medicine it is impossible to quantify and thus compare pleasures or pains. It is possible to determine that a decision will probably result in happiness for two people and that one of those people will be even happier than the other. For example, giving a job to John or to Jim will make either of them happy but it may make John even happier than Jim if John needs the job much more desperately than does Jim. Although pains and pleasures can be compared in this way we can never compare them so accurately as to assign numerical values. Another reason why pains and pleasures cannot be compared with complete accuracy is that pleasures and pains differ in kind as has been explained in the previous chapter. We can state that grief is a pain more to be avoided than a bee sting, and security is a pleasure more to be sought than a full stomach. But to compare them on a quantitative basis is to assume that pain or pleasure can be abstracted from the activity of which it is a part and that one unit can be identified and used as a base no matter what the kind of pleasure or pain. This is not possible for

reasons explored in the previous chapter. In real life situations weighing alternatives and consequences and maximizing happiness for all concerned will always remain something less than an exact science.

It must be emphasized that an act is not considered the right act according to the act utilitarian principle simply because it results in more pleasure than pain. There must be no alternative open to the agent which produces more pleasure and/or avoids more pain. In the example above concerning Mr. Jones going to a community for the aged, it was decided that some inconvenience for the daughter-in-law could be justified if happiness was maximized when considering all three people affected by the decision. Alternative I in that example would no longer be the right action if a third alternative was possible which avoided the inconvenience to the daughter-in-law while preserving the happiness of the other two involved. Perhaps Mr. Jones has a daughter, living with whom would make him equally happy. His son would be able to visit him there, causing his son equal happiness to that produced in Alternative I. Mr. Jones' daughter and son-in-law would be glad to have him. This alternative would provide as much or more pleasure than Alternative I and would avoid pain to Mr. Jones' daughter-in-law. The third alternative, and not Alternative I, would then be the right act according to act utilitarianism. The bare fact that Alternative I produces more pleasure than pain does not make it a right act.

Two additional positive aspects of the act utilitarian principle can be briefly mentioned. The principle states in part that a right act is one which "produces at least as much good and/or avoids at least

as much evil." In those situations where no good can be realized by any alternative action the act utilitarian principle advocates avoiding as much evil as possible. It also notes that there may be situations where there is no clear advantage between two alternatives. Either action is then considered right. Weighing alternatives and consequences may not always result in one clear choice. This need not block decision making. Since both maximize happiness, both are equally right. An arbitrary choice between them can be made. Our example of Mr. Jones can be revised once more to demonstrate both of these points. Perhaps Mr. Jones would be very unhappy to leave his family and retire to a senior citizens community. His only son and daughter-in-law may also be unhappy to have him live with them which is the only other alternative. This is a no win situation. The act utilitarian will first try to determine in which case the suffering is more. Perhaps Mr. Jones would be distraught to the point of total withdrawal from life, while the son and his wife will only be slightly inconvenienced. If this is the case, more evil will be avoided by allowing Mr. Jones to stay with his family and this, then, is the right act. On the other hand, it is possible that the suffering caused to the younger Mr. Jones and his wife is equal to that which the older Mr. Jones suffers. An arbitrary choice can be made between the two alternatives since one avoids at least as much evil as the other.

Intrinsic Nature of Acts

We now turn to a discussion of those elements which the act utilitarian principle excludes. The utilitarian does not consider

the very nature of the proposed act to have any effect on deciding if the act is an ethically right one. As will be discussed below, formalist or deontological ethical theorists do make this claim. Certain acts like murder, breaking promises, and lying are wrong by their intrinsic nature in a formalist system of ethics. These theorists appeal to a certain intuition or to a rational deduction to support their claim. While the act utilitarian judges the consequences of a particular act of lying, the formalist claims to know immediately that lying is by its nature at least prima facie wrong. For some formalists, lying can become a right act if the duty to tell the truth conflicts with another more binding duty. The difference here between the act utilitarian and the formalist is the method by which an act is judged right. The formalist judges the intrinsic nature of alternative acts and determines which one involves the most binding duty. The act utilitarian judges only consequences of alternative acts open to the agent and determines which one maximizes good and/or minimizes evil. For the act utilitarian no act is intuitively, immediately or prima facie wrong. Only a complete investigation of alternatives and consequences can determine right and wrong. A further discussion of this conflict between the utilitarian system and formalist ethical systems will be given under the last major heading in this chapter.

Motivation

The act utilitarian method of judging right acts also excludes from consideration the question of the motive behind the act. Again, the utilitarian theory only judges consequences. The motive behind the

act does not matter in judging the act to be right. Thus, if a person does that action which maximizes happiness, it will be considered a right action even if the agent had an evil intent. The action would be right although we may not admire the agent. Evil intentions do not ordinarily result in right actions. On the other hand, a person may have a good motivation but perform a wrong act. A parent who takes a child from hospital to hospital hoping for an impossible cure may cause unnecessary pain to that child and financial and emotional suffering to the rest of the family. The parent's motives are to save the sick child but, all things considered, the action does not maximize happiness or minimize pain. The action is wrong and the parent is misguided although with the best of motives. The parent desires to save his sick child but he is not considering known facts and consequences. If doctor after doctor declares the case hopeless but the parent will not listen, then he is reprehensibly not choosing the ethically right alternative. He is not considering all alternatives and all consequences. It can be emphasized that a person need not be motivated by the act utilitarian principle in order to be in accord with it. A person may not consciously desire to maximize happiness but yet choose that very alternative for other reasons. This person's choice is still a right act. A doctor may save an individual's life only because he or she hopes to be paid handsomely for the act. If the saving of that life is a right act by the act utilitarian principle, the doctor's less-than-admirable intentions do not matter to its being judged right. As in the case of the right action with the evil intent, the reason we consider the doctor's

motives to be less-than-admirable is because working only on a money motive does not lead to right actions in every case. One motivated thus will be inclined to maximize one's own happiness rather than impartially to consider the happiness of all involved.

A further question seems to be involved in the foregoing discussion: What kinds of acts then, are morally blameworthy or praiseworthy? The most plausible utilitarian answer to this is that we ought to blame or praise an action if there is some good accomplished by doing so.[43] In other words, the act of blaming or praising, just like any other act with ethical consequences, must be tested by the act utilitarian principle. If, all things considered, it would be productive of more good to blame the parent of the hopelessly ill child in the example above, then he ought to be blamed. If this would only add to his misery and would do no good for the child or family, then blaming would not be called for.

Although this question of motive is often spoken of in the literature, it is not actually as significant a point as it may first appear. This is especially true for an ethical system concentrating on decision making. Consequences rather than motives are the final appeal in judging an act to be right. But, in promoting a method of decision making the act utilitarian principle must advise that the agent also be motivated by the act utilitarian principle since in this way he will be best able to arrive at a proper decision. The agent with

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[43]For a more complete discussion of this topic and some alternative interpretations of the concept of blame, see Hospers, pp. 470-478.

the evil intent or the money motivated doctor fall upon the right act by chance. We cannot deny that their acts are right. However, we are giving a method for choosing the right course of action and a test of right action. The first is more important for this dissertation.

Appeal to Set Rules

Judging particular acts by reference to a rule is also excluded by the act utilitarian principle. This topic will be thoroughly discussed in the following major section of this chapter: Act vs. Rule Utilitarianism. Here it will be sufficient to note that for the act utilitarian each individual act must be referred back to the ultimate principle and judged upon its own merits. This does not mean that we cannot use handy rules of thumb which summarize our past experience with cases of one type. Many of us have learned, for example, that lying ordinarily causes unhappiness. We act on this rule of thumb and try not to tell lies. But in the hard cases in which it seems possible that it might be best on the whole to tell a lie, the act utilitarian advocates laying aside the rule of thumb and appealing directly to the act utilitarian principle, weighing alternatives and judging consequences of this particular act of lying. An act utilitarian will not always tell the truth just because on the whole this rule tends to maximize happiness. Each case must be judged individually and happiness maximized in each particular decision.

Judging, on its own merits, each situation calling for a decision with ethical implications seems especially appropriate for the medical model. Cases vary so much, one to another, that rules

cannot take into account the peculiarities of any one particular case. Some of this variance is due to the myriad courses that disease can take. Each case of spina bifida, for example, is almost unique. The degree of injury can vary from minor to catastrophic. One cannot, then, make a rule about how to treat every infant born with spina bifida. Decisions are, and must be, made case by case. Variation among cases is also due to the differing psychology and values of each individual human being. A rule such as "Always tell the patient the whole truth about his or her diagnosis" seems to be a rule which would on the whole maximize happiness.[44] Under this rule patients are treated with the respect and dignity they need to maintain control of their lives in a difficult situation. However, to follow this rule, never allowing for exceptions, would mean that in some cases because of an individual's psychological make-up or value system happiness would not be maximized nor pain minimized. There may be a case where a physician, knowing a patient's history of hypochondria, decides that it would be better if he does not mention a finding which shows up on a complete diagnostic physical examination. Perhaps the patient has a very insignificant and completely harmless heart murmur. The doctor knows that if he tells the patient, that particular patient will disregard the physician's explanation and will needlessly worry about the heart murmur. It seems best here to refrain from telling "the whole truth."

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[44]In support of this statement see Elisabeth Kübler-Ross's discussion of truth telling in On Death and Dying (New York: Macmillan Company, 1969), pp. 28-37.

Another rule that might seem to maximize happiness, on the whole, would be "Never disconnect a patient from life sustaining machinery unless a diagnosis of brain death has been made." The reasoning here might include the fear that even if passive euthanasia is allowed only in the very hard cases of hopeless suffering, these exceptions to the general rule will still generate a lack of respect for life. Eventually patients will be killed for less than noble reasons. It may seem better under this reasoning to make a rule and allow no exceptions. The act utilitarian cannot agree with such a rule because it will involve some cases where happiness is not maximized--namely, those hard cases of hopeless suffering. Yet, the act utilitarian cannot ignore the possible long range consequences of eventual lack of respect for life. This consequence must be weighed when judging the particular case. However, in accord with the act utilitarian principle cases must still be judged case by case without appeal to a rule which does not allow of exception.

In the foregoing explanation of our act utilitarian principle two major issues have stood out in need of further discussion. One issue concerns whether or not the act utilitarian principle adequately covers a common sense notion of duty. Formalist traditions in ethics argue that there are certain principles of ethics that men acknowledge as binding which are not based on a calculation of consequences. This was spoken of above as some acts being wrong by the intrinsic nature of the act, regardless of the consequences. Another important principle of ethics that some authors claim the utilitarians are unable to account for is justice. They claim that the ethically

right lies in the just distribution of good. A maximization principle does not necessarily result in a just distribution. These objections to the very basis of the utilitarian ethic will be taken up in the third section of this chapter. The following section will be devoted to a question internal to utilitarianism. As has been pointed out, one branch of utilitarianism argues that happiness is maximized by the formulation of and reference to general rules. The rule utilitarians argue that happiness ought to be sacrificed in some cases in favor of a rule which maximizes happiness only when obeyed in every case. One of the motivating forces behind the development of rule utilitarianism was to provide an answer to some of the objections raised against utilitarianism by formalism. It will be argued in the following section that rule utilitarianism is an unnecessary and inconsistent compromise between utilitarianism and formalism, a compromise which introduces more difficulties than it solves.

I. ACT VS. RULE UTILITARIANISM

Act utilitarianism, sometimes called extreme or unrestricted utilitarianism, is the original utilitarian position. Rule utilitarianism is a later modification. There are a number of different interpretations of this modification of the original utilitarian position. One interpretation is that the rule utilitarian claims that if a high percentage of acts of a certain kind are such that they are productive of the most good, then a rule stating "Do acts of this kind" should be made and all such acts should be considered right and always to be done. Examples might be "keep

promises" or "preserve lives." On this interpretation of rule utilitarianism, it is difficult to understand why a utilitarian would condone doing 100 percent of acts of a certain kind when possibly only 95 percent of these actually maximize good consequences. It appears most consistent with utilitarianism to claim that acts of a certain kind are ordinarily productive of the most good and ought to be done unless under certain special circumstances more good can be produced by not doing an act of that kind. In other words, follow the rule in that percentage of the cases where it is clearly best to follow it but carefully weigh circumstances in the remaining percent and judge if it is indeed best to follow the rule or not in these special cases. Thus, one would keep promises except in such cases where keeping a promise will, on the whole, be productive of less good than failing to keep the promise.

The advocate of rule utilitarianism might claim in response to the objection that certain qualifiers could be built into the rule such as "Keep promises unless a life can be saved by breaking the promise." Besides the difficulty that would be encountered in clearly stating all legitimate exceptions to the rule, resorting to qualifying phrases also seems to make those rules rules-of-thumb, which, then, makes this type of rule utilitarianism no different than act utilitarianism. Decisions made on the principle: "An act is right if and only if, of the alternatives open to the agent and on the available evidence, it produces, for all those affected by the act, at least as much good and/or avoids at least as much evil as any other alternative where good and evil are in accord with qualitative

hedonism" would turn out to be the same as those made on the principle: "An act is right if and only if, of the alternatives open to the agent and on the available evidence, it conforms to a rule which is productive of the most good and/or avoids the most evil, except in those cases where non-conformity to the rule will produce more good or avoid more evil, in which case an act is right if it produces, for all those affected by the act, at least as much good and/or avoids at least as much evil as any other alternative act, where good and evil, in any case, are in accord with qualitative hedonism." The only difference here is that second order rules are introduced which can always be overridden in complex cases by a direct appeal to the first order principle--our act-utilitarian principle. The act utilitarian has no objections to these second order rules as long as they are used as rules-of-thumb.

To dismiss rule utilitarianism so easily on this "95 percent of the time" argument, however, does not do justice to all the insights of the rule utilitarians. On a line of reasoning much like the above, act utilitarians have accused rule utilitarians of rule worship,[45] and thus handily dismissed rule utilitarianism. A more careful view of how rule utilitarianism was developed and the problems it is meant to solve can be taken without any harm done, in the end, to the act utilitarian position.

Rule utilitarianism is meant by many of its advocates to combine the simple common sense appeal of utilitarianism with some of the

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[45]See for example J.J.C. Smart, "Extreme and Restricted Utilitarianism," The Philosophical Quarterly, 6 (1956), pp. 344-345.

valid moral insights of formalism which, it is supposed, utilitarianism cannot account for in its act form. These insights can be dealt with here by means of a number of examples. It appears to formalists and to rule utilitarians that keeping promises is a kind of right action that is made right not only by a consideration of consequences. It is argued that keeping a promise has a special binding force even when, in a special case, breaking the promise will have better consequences on the whole. Another example, somewhat different in its implications, is the obligation one feels to refrain from doing a certain action when this action, if performed by everyone, would have bad consequences. A frequent example used here is that of crossing a lawn. If I cut across the lawn rather than use the footpath, it will not appreciably harm the lawn. However, if everyone did this, the lawn would eventually turn to an unsightly dirt patch and the pleasure found in contemplating a well kept lawn would be lost to everyone. Thus, it appears to the rule utilitarian that, except in a dire emergency, no one ought to cut across the lawn since everyone's cutting across the lawn would have harmful consequences. Other examples of actions that would be harmful if performed by everyone can be imagined. Some are prescribing unnecessary medication, failing to tell a patient that he has a terminal disease, charging a patient with adequate insurance coverage more for a standard procedure than other patients are charged, failing to vote in an election, failing to pay one's income taxes.

The first claim to be considered is whether there is a right making characteristic in certain actions that stems from something

other than the consequences of that action, and if so, whether the rule utilitarian theory can better account for this than the act utilitarian theory can. The rule utilitarian assumes that there is a stated right-making characteristic and attempts to incorporate it into his theory. This is necessarily a difficult thing for the rule utilitarian to do since he is already committed to a consequence theory, but now tries to account for a non-consequential aspect of right actions. One way to do this is by claiming that rules such as "keep promises" are to be justified on the basis of whether or not the rules maximize good consequences, but particular actions are to be judged only by whether or not they comply with the rule. It becomes no longer proper in this rule utilitarian theory to judge the consequences of a particular action and decide the rightness of the act on those particular consequences. John Rawls indicates an analysis of rules which clarifies the distinction between act and rule utilitarianism in this respect. Although Rawls himself does not claim to be a rule utilitarian, his analysis has carried much weight with those who do favor rule utilitarianism. Rawls discusses one type of rule--summary rules--which he describes much as rules-of-thumb have been described above. These, he claims, are the rules which an act utilitarian is able to accept.

> Rules are pictured as summaries of past decisions arrived at by the direct application of the utilitarian principle to particular cases. . . .
>
> It will still make sense, however, to speak of applying the utilitarian principle case by case, for it was by trying to

> foresee the results of doing this that one got the initial estimates upon which acceptance of the rule depends.[46]

Opposed to these rules are what Rawls terms "practice" rules:

> On this conception, then, rules are not generalizations from the decision of individuals applying the utilitarian principle directly and independently to recurrent particular cases. On the contrary, rules define a practice and are themselves the subject of the utilitarian principle.[47]

Conformity to these rules must be appealed to when judging an action. Actions cannot be judged case by case.

> . . . a practice necessarily involves the abdication of full liberty to act on utilitarian and prudential grounds. . . . Therefore, it doesn't make sense for a person to raise the question whether or not a rule of a practice correctly applies to his case where the action he contemplates is a form of action defined by a practice. . . .
>
> But when the challenge is to the particular action defined by the practice, there is nothing one can do but refer to the rules.[48]

The distinction here may be easier to see when applied to the example of promise keeping. Rawls argues that a rule utilitarian, using the concept of practice rules, can account for the special obligation thought to exist in promise keeping better than an act utilitarian can. He claims it is inappropriate for a promiser, when it comes time to fulfill his promise, to ask if keeping this promise will maximize good consequences. It is inappropriate simply because it involves not understanding what it means to make a promise.

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[46]John Rawls, "Two Concepts of Rules," The Philosophical Review, 64 (1955), 3-32; rpt. in Gorovitz, p. 188.

[47]Rawls, p. 189.

[48]Rawls, pp. 189-191.

> What would one say of someone who, when asked why he broke a promise, replied simply that breaking it was best on the whole? Assuming that his reply is sincere, and that his belief was reasonable (i.e., one need not consider the possibility that he was mistaken), I think that one would question whether or not he knows what it means to say "I promise" (in the appropriate circumstances). It would be said of someone who used this excuse without further explanation that he didn't understand what defenses the practice, which defines a promise, allows to him.[49]

This is to claim that promise keeping is a practice. One cannot promise without understanding the practice of promising. Rawls seems to imply further that it is part of the practice of promising that promises are kept, except under the most dire of unexpected circumstances. Furthermore, when one is faced with the dilemma of keeping a promise which does not appear to be the right (productive of the most good) action, one is not free to judge his individual case but can only refer to the practice and judge whether or not the practice of promise keeping is not a valuable (on a utilitarian basis) practice. Only if he can claim that the practice is unjustified, can he fail to keep his promise.

An example might be helpful here. Suppose a dying patient had made his doctor promise him that he would not allow an autopsy done on his body after his death. The patient had never mentioned this preference to any of his family and the promise was known only to the doctor and his patient. After the death it turns out that the family is very much interested in knowing the exact cause of death and requests an autopsy be done. There were unexpected developments in the last

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[49]Rawls, p. 184.

few days of the patient's life, and it would ease the minds of the family as well as possibly advance medical knowledge if an autopsy be done. Rawls wants to claim that the doctor is not free to judge whether or not it would be best in this case to ignore the promise he made and do what appears to be best on the whole. The doctor must only judge whether or not promise keeping as a practice in society tends to maximize happiness. In the words of Rawls, the doctor can only conclude "he will not want to change the practice, and so as a promiser he has no option but to keep his promise."[50]

In Rawlsian terms, then, the special obligatoriness of promises and certain other acts is inherent in their status as practices. The act utilitarian fails to note this because he is committed to judging every act on its own merits. The rule utilitarian understands that certain practices are deemed necessary "in order that the future may be tied down and plans coordinated in advance."[51] It is an advantage to know that when a promise is made it will be kept. Insecurity results if we realize that a promiser always has the option to reconsider and then fail to keep his promise if he considers that course of action is best on the whole. Since the practice is justified, it is proper that one should "abdicate one's title to act in accordance with utilitarian and prudential considerations"[52] in individual cases for the sake of the practice.

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[50]Rawls, p. 191.

[51]Rawls, p. 183.

[52]Rawls, p. 183.

It is not at all clear that Rawls' theory of practice rules is correct.[53] Over and above this it does not appear that rule utilitarianism is needed to account for the sense of obligation felt in promise keeping. Act utilitarianism can adequately and more consistently account for such obligation.

Rawls claims that someone who breaks a promise because it is "best on the whole" does not understand the practice of promising. He implies that this reason for breaking a promise is totally unacceptable. When one deals in concrete examples, Rawls' conclusions do not appear at all obvious. There are two points to be made here. One is that there are occasions when a promiser might explain the breaking of a promise on the grounds that it was not "best on the whole" and this would be perfectly understood by the one to whom the promise was made. Imagine a man who promises to pay back a five dollar debt on a certain date. When that date arrives the man discovers that he could make better use of the five dollars by buying gasoline to visit an ailing relative. He approaches the one promised and explains that he really cannot fulfill the promise as he intended because now he feels that it would be best if he postponed the repayment to a future date. It seems quite possible that this explanation would be accepted. There need not be any accusation that the man did not understand the words "I promise." Rawls also claims that this excuse would mean that the man "didn't understand what defense the practice, which defines a

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[53]In addition to the discussion here, see David Lyons, Forms and Limits of Utilitarianism (Oxford: Clarendon Press, 1965), pp. 182-197.

promise, allows to him." But there is no codified system of proper and improper defenses for promise breaking. If promising is a practice at all, it certainly isn't a practice with the clearly stated rules of say, baseball.

> We cannot appeal to rules that indicate the necessary and sufficient (or just sufficient) conditions for justifiably breaking promises; we cannot appeal to rules that indicate exception-making criteria or that list exempting-conditions; we cannot appeal to an arbitrator (judge) or administrator or lawyer for advice or a ruling. We cannot decide whether one is justified in not keeping his promise in such a way, we do not do so, and we need not.[54]

Promising can take various forms and the strictness which a promiser is held to his promise depends upon the situation in which the promise is made. This brings us to the second point.

Rule utilitarians often speak as if promising is a very uniform thing and their examples are always of the most serious type of promises. This need not be the case as has been pointed out. However, even if we take the rule utilitarians' examples of very serious promises, it appears that the act utilitarian can better account for the obligation incurred. The rule utilitarian has argued as the basis of obligation that there is a rule which allows of no (or only very limited) exceptions. He claims that this is why case-by-case evaluation of what is "Best on the whole" is not allowed. An evaluation of how the act utilitarian will judge what is best on the whole will show that the act utilitarian is able to incorporate the special

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[54]Lyons, p. 192.

obligation felt in promise keeping while still maximizing utility in each case.

Evidently the rule utilitarian supposes that the act utilitarian promiser will, when the time comes to fulfill his promise, judge among all the acts open to him, which act will maximize the general good, as if he had never made a promise.[55] There is no reason why an act utilitarian must argue this way. The person to whom the promise was made clearly does have a special claim on the promiser--a claim that supersedes the claim of the general good. This claim is simply that the promiser has voluntarily raised the expectation in the one promised that a certain action will be done.

> If we ask, now, "Why do we have a prima facie obligation to keep promises?" the answer is evident. When I promise you to do something, I do so because you are interested in the performance of it, and by promising you that I'll do it, I have led you to expect that I will do it in a way that you would not have expected me to do it if I hadn't promised. Consequently, if I default, it is more serious than if I hadn't promised, because this expectation is then disappointed.[56]

Rawls seems to feel that the only way an act utilitarian can explain the obligation to fulfill promises in a hard case is by an argument that damaging the general faith in promise keeping is a consequence of that act itself. However, the act utilitarian cannot always claim this because breaking a certain number of promises would

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[55]John Rawls speaks this way in the article cited above and W. D. Ross also speaks this way in The Right and The Good (London: Oxford University Press, 1930), pp. 34-39.

[56]Jan Narveson, Morality and Utility (Baltimore, Maryland: Johns Hopkins Press, 1967), pp. 192-193.

probably not have this consequence. Also a death bed promise known only to the two persons involved (as in the autopsy example given above) could be broken without damage done to the general faith. Jan Narveson in the above quotation suggests that the act utilitarian need not argue that the obligation of promise keeping comes only from safe guarding promise keeping as a general practice. An act utilitarian is committed to maximizing the general happiness in each case. In the case of promises one person's happiness is more at stake than others. It is the person promised whose happiness must be given special weight, because it is he who will be most hurt by the breaking of the promise. There is no reason why the act utilitarian must overlook his special case and reduce his legitimate expectations to the level of the general public. This still leaves room, however, for the possibility that greater good will be accomplished by breaking a promise in some circumstances. It still can be argued, as above, that it might be "best on the whole" to break a promise. Once special weight has been given to the promisee's interests in computing "best" it can still be decided that the promise ought to be broken.

> Thus, the excuse "because it was best on the whole for me to break it" is a perfectly proper one, though one which cannot be offered if I do not take into account the disappointment which you will feel if I default, and the extent of your interests which will be unsatisfied by this failure. And this is all there is to it.[57]

This seems to be consistent with the common moral consciousness.[58]

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[57]Narveson, p. 193.

[58]See Narveson's excellent examples on page 194.

One accepts the breaking of a promise if the good that was done in breaking it outweighs the harm that is done to the one promised. Thus, a trivial reason (e.g., watching a favorite television program) for breaking a promise, say, to help another with his income tax will not do, whereas a more serious reason (e.g., driving a child to the doctor) will be understood.

One of the faults of philosophers who discuss the issue of promise keeping is the level of abstraction at which they work. W. D. Ross for example states:

> Suppose, to simplify the case by abstraction, that the fulfillment of a promise to A would produce 1000 units of good for him, but that by doing some other act I could produce 1,001 units of good for B, to whom I have made no promise, the other consequences of the two acts being of equal value; should we really think it self-evident that it was our duty to do the second act and not the first? I think not. We should, I fancy, hold that only a much greater disparity of value between the total consequences would justify us in failing to discharge our prima facie duty to A.[59]

In place of this abstraction, a concrete example can show that, if the legitimate special expectation voluntarily raised in the promisee is considered, then a small difference in good produced will indeed be acceptable. For example, a doctor may promise to visit that afternoon one of his hospitalized patients. As the doctor's afternoon develops he makes a judgment that it would be best on the whole if he broke his promise and stayed at the clinic, spending the last available hour of that afternoon counseling a distraught parent. If we are forced to assign numerical values to satisfy

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[59]Ross, pp. 34-35.

Ross's objection, this could be done in the following manner. Alternative A: keeping the promise to the hospitalized patient: 1800 units of good for the patient minus 800 units of evil for the parent who goes uncounseled equals 1000 units of good. Alternative B: breaking the promise to the hospitalized patient: 2000 units of good to the distraught parent minus 800 units of evil for the patient not being reassured minus 100 units of evil for the break down of confidence in promise keeping in general and in that physician in particular minus 99 units of evil for the raised expectations of the hospitalized patient being disappointed equals 1001 units of good. The act utilitarian principle would then advocate that the doctor stay at the clinic and counsel the distraught parent--given that these two alternatives are the only two open to the physician. The good done in comforting the distraught parent must be of a significantly greater quantity to outweigh the evil involved in breaking a promise and in disappointing the raised expectations of the hospitalized patient. If it is, then we can see that breaking the promise could be a right act even though there is not a great disparity of value in the final assessment of the two alternatives.

Rule utilitarianism was designed in part to answer the challenge put to utilitarianism by formalism. Formalism argues that certain acts, such as promising, by their very nature carry an obligation that cannot be completely explained in terms of consequences. Rule utilitarianism accepts this special obligation and explains it in terms of practices defined by rules. It has been argued that it is inconsistent with utilitarianism to accept that obligations can arise from anything but

consequences. Further, the act utilitarian is quite capable of explaining the obligation incurred in making a promise. It is not the case that a rule or a practice needs to be applied to promise keeping in order to account for its special binding force. Each case of promising is best analyzed by itself, and its binding force will depend upon the circumstances of that promise. Some promises are made where the interest of the promisee is very grave and the expectation incurred by the promise is high. In these cases it takes a very serious reason to fail those interests and disappoint that expectation. However, even here if a greater good can be accomplished by breaking the promise--if it is "best on the whole"--then the act utilitarian will favor breaking the promise. This will never be done lightly and never without considering the special obligation owed to the interests of the promisee. If in such a case the rule utilitarian advocates that the promise be kept anyway, it is difficult to see how he can still call himself a utilitarian. If breaking the promise is truly "best on the whole," where the special obligation to the promisee is considered, it is inconsistent with any form of utilitarianism to claim that the promise be kept anyway.

Thus, it is concluded that the rule utilitarian does not better account for the right-making characteristic of promise keeping and that there need not be any considerations introduced to explain the special obligation of promise keeping other than the consequences of the particular act of promising.

The second problem which rule utilitarianism was formulated to answer is the special obligation one feels to refrain from doing a

certain action when this action, if performed by everyone, would have bad consequences. The act-utilitarian, judging case by case, supposedly favors an individual doing a certain act, if in that case good is maximized without looking to the consequences of "if everyone did that." By forming rules, the rule utilitarian argues that there will be certain times when in an individual case good will not be maximized, but the rule must be followed in order that the good, which depends upon everyone doing the act, or the harm that can be avoided by everyone refraining from the action, can be brought about or avoided. It is argued that the act utilitarian cannot account for the role that everyone else's actions take in certain moral situations, while the rule utilitarian can.

There are a number of difficulties which rule utilitarianism creates by introducing a generalization principle claiming that no one should perform actions if everyone's performing them has damaging consequences. These difficulties will first be discussed. Besides pointing out the problems with the rule utilitarian theory, I will take a positive approach showing how the act utilitarian can account for the consequences that follow from everyone's doing a certain class of actions, while still judging actions case by case.

Marcus Singer, in his book Generalization in Ethics, presents a clear argument for the generalization principle. Part of Singer's intention is to discuss and defend logic in ethics. This is a metaethical question and not our concern here. However, his formulation of the generalization argument can stand as the rule utilitarian's argument for obligations of this nature.

> It may be useful to display in one place . . . this deduction of the generalization argument from the generalization principle and the principle of consequences. The principle of consequences (C) states that: If the consequences of A's doing x would be undesirable, then A does not have the right to do x. The following principle (GC) is what I have called a generalization from C: If the consequences of everyone's doing x would be undesirable, then not everyone has a right to do x. Now the generalization principle (GP) may be stated as follows: If not everyone has the right to do x, then not anyone (no one) has the right to do x. The generalization argument (if the consequences of everyone's doing x would be undesirable, then no one has the right to do x) clearly follows from GP and GC.[60]

On a purely logical basis Roger Hancock argues that this argument is in need of some hidden premises before it becomes clearly valid. However, on a simple common sense basis it does not seem at all clear why if it is true that not everyone has a right to do x, that it follows that no one can do x. If we refer to our lawn crossing example, it would seem evident that if everyone cut across the lawn, bad consequences would follow. But this does not necessarily mean that no one ought to cross the lawn. The more immediate conclusion would be that only those number of people consistent with the lawn's not being harmed should be allowed to cut across the lawn.

David Lyons in his discussion of the generalization argument points to a way that the act utilitarian can account for the consequences of an "if everyone did that" type of situation. (The main thesis of Lyons' book is that when a class of actions is relevantly

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[60]Marcus Singer, Generalization in Ethics (New York: Random House, 1961), p. 66. For criticisms of Singer's position see Lyons; Narveson, pp. 129-140; and Roger N. Hancock, Twentieth Century Ethics (New York: Columbia University Press, 1974), pp. 165-181.

described, a decision based on most rule utilitarian principles will be equivalent to one based on the act-utilitarian principle. Where there is non-equivalence, Lyons argues, it is due to the failure of the rule-utilitarian to follow a utilitarian ethic.) He does this by means of introducing the concept of "threshold effects." Jan Narveson's argument in Morality and Utility is similar to this, although it is not as fully developed as that of Lyons. It would be impossible to fully present and develop Lyons' argument here but the impact of it for the act utilitarian theory can be indicated.

Using the example of lawn crossing, it can be seen that over a certain number and frequency of lawn crossing actions, the lawn will be damaged. This number and frequency (or density in the case of examples like voting) can be thought of as a threshold beyond which damage will be done. Beneath this threshold an act of crossing the lawn will not have an adverse effect. There will be another threshold of interest to the act utilitarian. This will be an upper threshold. If many people have already cut across the lawn, thereby causing significant damage to the lawn, it will make no difference if I too cut across the lawn. Instead of the generalization argument (if everyone ought not do x, no one ought do x) then, a more careful look at the circumstances, indicates that only acts of x that fall beneath the minimum threshold may be done. Judging case by case with a threshold effect consideration appears to maximize the good rather than the generalization argument since these individual judgments allow for exceptions where the bad consequences of everyone's doing an action are not involved.

An example drawn from medicine which is similar to the lawn crossing example is that of prescribing unnecessary medication. Although one instance of prescribing, for example, an antibiotic for a child's cold because the parents insist on this would not do any great damage, it is possible that if all doctors freely dispensed medications where none was needed this would lead to undesirable effects in society. We would have a society (if, indeed, we do not already) which could not cope with everyday ailments. Doctors would be looked to to cure every little inconvenience even when there were no miracle drugs to effect a cure. Here a rule utilitarian would claim that since it would have evil consequences if all doctors prescribed medicine that was not indicated, therefore no doctor should prescribe unneeded medication. The act utilitarian could speak of threshold effects and claim that since society is already at this point it would not hurt to prescribe an antibiotic if after carefully explaining that an antibiotic has no effect on viral infections and that there is always a chance of side effects or allergies to antibiotics, the patient still insists that he would feel much better if the antibiotic be prescribed.

One more point about the threshold effect argument needs to be made clear. Thus far the discussion shows that the generalization argument does not hold. It remains to be pointed out how the act utilitarian can account for threshold effects while making case by case decisions. This further point involves the much discussed topic of relevantly describing a class of actions when applying the generalization argument. Jonathan Harrison, a major proponent of

rule utilitarianism, points out this difficulty:

> An action it [the rule utilitarian principle] says, is right if it is of a sort which would produce good consequences, if generally practiced, and wrong if it is of a sort which would produce harmful consequences, if generally practiced. But no action is an instance of just one sort of class of actions; every action is an instance of many such sorts. . . . Which of these classes should be considered, when we are wondering whether such an action is a right and proper one for us to do?[61]

Examples can be thought of which clearly counter the intent of the generalization argument. Thus, we could argue that since it would have bad consequences if everyone became a university lecturer no one should become a university lecturer, or if everyone signed up for Introduction to Philosophy at 7:50 it would have bad consequences, so no one should sign up for the 7:50 class. Harrison's solution to this problem is a claim that classes of acts must be "relevantly specified." In the university lecturer example he would specify the class of actions in this way:

> But entering into the profession of university lecturer is a class of actions which contains species such as that of becoming a university lecturer by men who have no aptitude for medicine, no liking for the civil service, and who have a capacity for acquiring and disseminating information which would be unsuitable for school-children, but of not much use or interest to ordinary adults. Becoming a university lecturer is a class of actions which can be relevantly specified, and, since this is so, it is the consequences of the general practice of the species which we should consider, not the consequences of the genus.[62]

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[61]Jonathan Harrison, "Utilitarianism, Universalization, and Our Duty to Be Just," Proceedings of the Aristotelian Society, 53 (1952-1953), pp. 105-134; rpt. in Gorovitz, p. 156.

[62]Harrison, p. 158.

Singer also has methods for dealing with these counter-examples. He calls the first example "invertible."[63] Such an example is invalid according to Singer because if it is inverted--if no one became a university lecturer--bad consequences will also follow. The second example Singer calls "reiterable."[64] This is invalid according to Singer because it relies for its force upon something being done at a particular time or place or by a particular person. If everyone signs up for this Philosophy class at 8:55 or 10:00 or 11:05, it will also have bad consequences. Thus it would seem that no one should sign up for Introduction to Philosophy.

These explanations, however, do not prove satisfactory.[65] Harrison's criteria do not really explain or argue for what type of properties are to be considered relevant in specifying a species from its genus. Singer's dismissal of counter-examples suffers from some logical difficulties and it does not account for properly describing such valid (in Singer's own view) examples such as voting. David Lyons, after a lengthy and careful analysis of relevantly describing an action, concludes:

> There is, therefore, no simple formula for determining relevance for the application of a form of utilitarian generalization. Reference must be made to our scientific knowledge and view of the world. Moreover, the class of general utilitarian properties will be determined, not only by the content of this body of knowledge and theory, but also by

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[63]Singer, pp. 72 ff.

[64]Singer, pp. 81 ff.

[65]See Lyons, Chapter II, "Describing An Action," pp. 30-62 for a criticism of both Singer and Harrison.

> value-criteria, that is, the criteria which can be applied in determining the value of states of affairs. The determination of relevance is, therefore, in principle a highly complex matter.[66]

This problem of relevantly describing a class of actions was raised here in connection with showing how the act utilitarian can account for threshold effects while making case by case decisions. The act utilitarian can avoid the difficulties of relevantly describing a class of actions and concentrate on the less difficult task of completely describing the case at hand. A complete description of any act will involve specifying where that act stands in relationship to the threshold of similar acts. Thus, when the act utilitarian attempts a decision on whether or not he is justified in cutting across the lawn, a relevant aspect of his act will be how many others and with what frequency have been crossing the lawn. If his act of crossing the lawn is near the threshold where it will cause damage, then it will be a consequence of his act that the lawn will be damaged.

It has been shown that there are serious difficulties with the generalization argument for the rule utilitarian. Not only does the argument itself not seem to hold, but there are nearly insurmountable difficulties involved in trying properly to apply it to a class of actions. The positive approach--showing how the act utilitarian can account for the consequences that follow from everyone's doing a certain class of actions--has already been partly accomplished in the above discussion of threshold effects.

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[66]Lyons, p. 60.

There is another type of generalization case which does not lend itself to a threshold effect argument. The example of this type which is generally used is paying one's taxes. The rule utilitarian assumes that an act utilitarian will justify the non-payment of taxes in hard cases since it may maximize happiness in an individual case. However, if no one paid taxes, it is clear that all would be hurt. Therefore, the rule utilitarian concludes that a rule must be made whereby everyone must pay taxes. An example drawn from medicine exemplifies this type of case equally well. It may seem that in a particular case of a patient covered by federal aid such as medicare it would be justified to charge a larger than ordinary fee. The patient is not hurt and the doctor may truly need the extra fee. If all doctors, however, charged medicare patients higher fees, this would hurt everyone since taxes would be increased.

In these examples of paying taxes or of increased fees for medicare patients, the rule utilitarian judges too quickly if he claims that the act utilitarian will argue for exemptions in hard cases. The lawn crossing example is one wherein it takes a certain number of acts before damage is done. These new examples are ones where each act causes some harm. It is not really true that a few people not paying their taxes will not hurt the government--it will merely not hurt the government <u>as much</u> as if many people refused payment. Therefore, the act utilitarian must say that not paying taxes will always be wrong (unless they are not justly levied, which is a different problem). Jan Narveson argues this point very well:

> The question is, do I have any reason to pay? Unlike the "grass" case, the answer here is Yes. How much reason? As much as I owe. If I argue that it's just a pittance and the public won't miss it, the government, of course, can point out equally well that it's just a pittance and I won't miss it. . . . To say that my $25 is very trivial set aside the public's $100 billion is a red herring. For each of those hundred billion dollars is worth precisely $1 (i.e., the price of a lunch, a movie, a sack of flour for some needy person on welfare or of a titanium bolt that keeps some rocket from exploding, and so on). The same amount of money is worth exactly as much to the public as it is to me, neither more nor less.[67]

In these generalization examples, then, which are not of the threshold effect type, rule utilitarianism still does not have an advantage over act utilitarianism. Both types of utilitarianism will advocate not performing an act where each act contributes a small amount to a general evil. The general public suffers from <u>each act</u> of non-payment of taxes and from <u>each act</u> of increased fees to medicare patients.

Act utilitarianism then can account for the obligation felt to refrain from doing actions when these actions, if performed by everyone, will have bad consequences. Avoiding the difficulties of specifying the relevant aspects to include in judging a class of actions and without resorting to the generalization argument, the act utilitarian judges actions case by case while still accounting for the actions of others. The suspect generalizations of the rule utilitarian are not needed, and good is maximized in a way not allowed to the rule utilitarian. In those cases where the threshold effects hold, and they are many,[68] the act utilitarian allows good to be maximized in

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[67]Narveson, pp. 138-139.

[68]Lyons, p. 73.

each case, whereas the rule utilitarian will require the rule to be followed even when acts can do no harm by virtue of falling below the relative threshold or above the upper threshold. Thus, the act utilitarian theory simplifies decision making while maximizing good consequences in a way superior to the rule utilitarian theory.

A major question asked in the introduction to this chapter is then answered. There are not acts that must be done because they fall into a certain class of acts, which if performed by everyone, will be productive of the most good, even when those individual acts are not productive of the most good. The internal conflict in utilitarianism is settled in favor of act utilitarianism. Decisions are best made case by case, judging the consequences of that particular case on the available evidence, and choosing that alternative among those open to the agent which produces, for all those affected by the act, at least as much good and/or avoids at least as much evil as any other alternative.

III. ACT UTILITARIANISM VS. FORMALISM

This chapter has aimed at an explanation and defense of act utilitarianism. One final set of considerations needs discussion. A defense needs to be developed against the criticisms of formalist traditions in ethics. A major criticism credited to formalism has already been covered in the foregoing section of this chapter. This criticism is that certain acts by their very nature carry an obligation that cannot completely be stated in terms of consequences.

Promising is thought to be such an act. I have argued above[69] that the act utilitarian can explain the special obligation felt to fulfill promises while still judging the rightness of acts solely by their consequences. In the act of promising, special expectations are raised in the person to whom the promise is made. Thus it becomes a consequence of that act of promising that, if the promise is broken, disappointment of a kind not experienced where there is no promise is involved. Hence we feel a special duty to keep promises. W. D. Ross was referred to above in connection with this argument. Ross is one of the more noted and clear formalists in modern philosophy. His treatment of full description of acts and the role of intuition in judging right acts will be discussed further in this section.

Another well known formalist is Immanuel Kant. His theories will not be discussed here as many of his insights, insofar as they bear on normative ethics, have been treated above. Kant advocated judging acts as they fall under one general rule. This involves serious problems of relevantly describing a class of actions.[70] Kant's other insights (on freedom, motive, good will, for example) have either been discussed above or involve metaethical problems which are not of immediate concern to a decision making theory of ethics.

In addition to covering W. D. Ross's criticisms of utilitarianism, the topic of justice will be treated in this section. Philosophers have claimed that utilitarianism cannot account for the common sense

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[69]See above, pp. 70-81.

[70]See above, pp. 84-87.

moral insights involved in the just treatment of individuals. The formalist tradition in ethics claims that utilitarianism, in advocating maximization of happiness, does not consider a just distribution. In some cases the utilitarian unjustly sacrifices the happiness of some for the greater happiness of others. In less serious cases, the utilitarian still prefers the greatest net happiness over an alternative that spreads the good more equally over a larger part of the population. On the basis of examples, such as the satisfaction of malicious desires or sacrificing an innocent man for the good of the community, the critics of utilitarianism claim that judging on the basis of consequences alone does not always result in right acts. Justice must also be considered.

I will argue that act utilitarianism can account for justice when this is a relevant moral consideration. It will also be argued against Ross, that judging alternatives solely by their consequences is a clearer and equally valid, if not better, method of decision making, resulting in right actions.

Intrinsic Nature of An Act

W. D. Ross, in The Right and The Good, claims that we do not and ought not judge which actions are right on the grounds of which will result in the most good. Rather, we note that certain duties are incumbent upon us. Faced with a choice of acts we must study the situation fully and form a considered opinion as to which duty is primary in this situation. An act is right, then, "by its own nature

and not because of its consequences."[71] We apprehend its nature by fully describing the act and by an intuition as to the general principles of duty which "come to be self-evident to us just as mathematical axioms do."[72] These emphases on intrinsic nature of acts, duty, and intuition are common to most formalist ethicists. Often, as is the case with Ross, formalists do not claim to have developed a complete system of ethics with first, second and third order rules that can cover all possible areas of ethical decision making. Rather, they are content to show that utilitarianism is wrong in its explanation of the origin of right-making characteristics. Often this is done by giving detailed examples in which, it is believed, the utilitarian clashes with common sense morality. It is then argued that any ethical system which cannot account for the sense of duty we feel to perform this stated action must surely fail. One such example is the case of promising and the 1001 units of good produced. This example was discussed above. Another example is that of the innocent man hanged to maximize the good of the community. This example will be treated below.

Rather than deal with examples at this point it would be well to look more closely at the formalist system of ethics and see if it offers any special insights or advantages to decision making in ethics.

There is some difficulty with the notion of the intrinsic nature of an act and with what will count as a complete and morally

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[71]Ross, p. 44.

[72]Ross, p. 32.

relevant description of an act. Formalists claim that utilitarians judge acts right and wrong only by their consequences, whereas in many cases an act is quite simply right or wrong by its very nature which can be readily seen once it is relevantly described. It seems quite possible that this is a false distinction between the formalist and the utilitarian. For example, the formalist claims that promise keeping is right by its intrinsic nature, irrespective of its consequences. There is a sense in which the utilitarian could readily agree with this. If a complete and relevant description of an act of promise keeping is "fulfilling voluntarily raised expectations in the individual to whom a promise has been made," then the utilitarian will agree that promise keeping is by its nature a right act. Its nature is pleasure producing and this is exactly what the utilitarian has claimed to be the good and the ground of the right. If a complete and relevant description of an act of stealing is "forcing someone to relinquish a good which he has been led to expect will remain his," then the utilitarian will agree that stealing is by its nature a wrong act. Its nature is pain producing and this is exactly what the utilitarian has claimed to be evil and the ground of wrong.

It is not an easy task to relevantly describe an act, nor to consistently distinguish between an act and its consequences. One could describe the act of an assassin as squeezing a trigger or as killing a man. Squeezing a trigger appears to be a neutral act. Killing a man is a description that involves consequences. The very description does not necessarily involve the probable consequences of pain, grief for family, punishment. But it does necessarily involve at

least the consequence of depriving a man of his freedom to rule his own life--such freedom being a high quality of pleasure. Killing a man is then equally prima facie wrong under a formalist or a utilitarian system of ethics. Upon careful investigation it will turn out that what the formalist considers prima facie intrinsically wrong, the utilitarian will also condemn as intrinsically morally wrong since its full description will involve a consequence that is pain producing.[73]

The distinction between judging an act by its intrinsic nature or by its consequences is not, then, a crucial distinction. Noting that certain acts are intrinsically right or wrong, however, is not the most important task in normative ethics. The vast majority of ethical decisions involve greater complexity than simply identifying an act as one of, say, promising or stealing. While the utilitarian, in complex cases, weighs alternatives and measures consequences, the formalist attempts to balance duties. Ross admits that, although duties arise in at least six specifiable ways, they are compounded together in highly complex ways. These six duties are, therefore, only prima facie duties. Actual duty must be figured out in each case by balancing the relevant prima facie duties. Ross admits that, for this balancing "no general rule can, so far as I can see, be laid down."[74] The only guide we have is a "sense of our particular duty in particular circumstances, preceded and informed by the fullest reflection we can

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[73]See Narveson's discussion on this topic, pp. 95-101.

[74]Ross, p. 41.

bestow on the act in all its bearings."[75] Ross readily admits that this guide is "highly fallible" but believes it is all we have to rely on.

Ethical decision making by intuition seems very unsatisfactory. It is especially unsatisfactory in the field of medical ethics where cases are particularly complex and rapidly changing. It is obvious that doctors and others are having a very hard time coming to decisions about late abortion, active euthanasia, infanticide of severely defective neonates and many other complex issues. Clear intuitions are exactly what is lacking. To suggest that we reflect further, balancing Ross's six prima facie duties as a guide, does not offer significant aid. Utilitarianism, advocating the judgment of consequences, is a clearer, more fruitful ethical guideline for decision making.

However, lack of clarity in ethical guidelines might be the reality as Ross suggests. If so, it would behoove us to develop guidelines that, with time, can become clearer. Intuition fails here too. Ross admits that developing a sense of duty in particular cases as a guide is fallible. However, it is difficult to see how we could even come to know that it was fallible. This implies an independent test of ethical right whereby we could then judge, after the fact, that a particular decision had been ethically wrong and thus an intuition fallible. In utilitarianism there is a clear sense in which we learn by our mistakes. I judge all alternatives and choose

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[75]Ross, p. 42.

that one which, on the available evidence, appears to be productive of the most good. I have made an ethically right choice. I then discover that, because of a circumstance I could not have known about, happiness is not maximized by the chosen alternative. In the future, given the additional empirical information, I can make more clearly informed and better ethical decisions. The formalist, however, judges that in a particular case the duty of, say, fidelity outweighs that of beneficence. He then keeps his promise and sacrifices happiness. He has no way of knowing after the fact if this was the best decision or not. There is no clear way in which he develops his intuition about duty in particular cases since he gets no feedback. Each decision is necessarily made equally in the dark.

Formalism, then, is not a superior alternative to utilitarianism. The notions of intrinsic nature of acts, duty and intuition are either adequately covered by utilitarianism or introduce unneeded confusion into the ethical decision making process. We must still, however, judge whether the examples formalism brings against utilitarianism are indeed damaging to the utilitarian case. The major type of examples that need to be discussed here are those involving justice.

Justice

Considerations of justice have been, historically, the most difficult for utilitarianism to incorporate into their theory. This problem has prevented many philosophers from accepting utilitarianism as a completely adequate ethical system. The basic objection can be simply stated: utilitarianism advocates the maximization of happiness

even when such a maximization is achieved at the cost of an unjust distribution. It appears to many thinkers that given a choice between a number of alternatives it is morally preferable to choose that alternative which spreads the good more equally over a larger part of the population than simply to choose that alternative which results in the greatest sum of good, regardless of distribution.

Justice is treated by some authors in two very distinct aspects, that branch concerned with distribution and the branch concerned with criminal law or punishment. In reference to the latter it is debated whether our moral instincts justify a retributive application of punishment or a utilitarian one. Retribution requires punishment simply because a crime was committed and justifies an extent of punishment to a degree parallel with the seriousness of the crime. Utilitarianism sees punishment in terms of rehabilitation for the criminal and deterrence for other would-be criminals. This debate will not be of concern here since it has no direct effect on decision making within medicine.[76]

The basic objection to utilitarianism which formalists and others offer under the heading of justice or fairness is, then, that the distribution of good which the utilitarian principle advocates does not coincide with the distribution a rational person would

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[76]Another topic not to be discussed here is John Rawls' work, A Theory of Justice, which has received much attention in recent literature. It is not directly relevant to our discussion here since its main thrust is a defense and a basis for choosing which guiding principles will enable an ethically right choice of institutions. We are concerned here with acts being right rather than social institutions.

consider as morally preferable. This topic was briefly introduced in the first section of this chapter.[77] There an example was given of an elderly man being placed in an old age community. It was shown that the utilitarian principle would consider as right the alternative of allowing the elderly Mr. Jones to stay at home with his son and daughter-in-law. This was justified as right because significant happiness followed from this choice for Mr. Jones and his son, albeit at the sacrifice of some happiness for the son's wife. It seems that the formalists would argue that a more equal distribution of happiness be attempted so that Mr. Jones and his son do not gain their pleasure at the expense of pain to Mrs. Jones. Mr. Jones and his son gaining pleasure at Mrs. Jones's expense, they claim, is not fair. Where there is an alternative, one should not be made to suffer in order to maximize happiness for others. Utilitarianism fails because it cannot account for the sense of duty we feel to distribute happiness in a just manner. The formalist case rests on gaining agreement that ordinary moral convictions lie in their favor. They, therefore, use much more drastic examples than the one we used above. One often used example is that of the innocent man being framed and hanged in order to insure the safety and happiness of the community. Here it is even clearer that one is made to suffer for the happiness of others. Critics of utilitarianism have even complained that utilitarianism would have to advocate a malicious beating of one person by several others as long as the pleasure of the beaters outweighed the pain of the beaten.

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[77]See above, pp. 54-60.

One time honored defense of the utilitarian principle against this sort of attack by the formalists is the claim that in the long run utility and justice do not conflict. What serves happiness also serves justice. This defense will be argued below. Another defense of utilitarianism against the need for additional considerations of justice is an appeal to the basic insights and spirit of the utilitarian principle. I will first discuss the drastic examples of the satisfaction of malicious desires and the innocent man problem. These are slightly different considerations about justice than the distribution problem in the Mr. Jones example. After a discussion of these two examples, I will return to our elderly Mr. Jones and consider once more if the greatest net happiness is ethically preferable to a more equal distribution of happiness.

John Stuart Mill argued in his essay "Utilitarianism" that justice is grounded in and takes its authority from the principle of utility. For this reason there is no conflict between justice and utility. Mill claims, along with contemporary defenders of utilitarianism, that if one carefully analyzes real life situations it quickly becomes apparent that satisfying the demands of justice will also, in the long run, maximize happiness. A utilitarian will not, without very grave reason, approve of any alternative that causes harm to one individual for the greater happiness of others. A utilitarian does not approve of one man being beaten as long as his pain is overbalanced by the happiness of others. One reason he does not is because this is a textbook example that does not occur in real life. In a real life situation there will always be alternatives to beating

an innocent man. These alternatives, once all consequences are considered, can be shown to truly maximize happiness and minimize pain without resorting to the choice of malicious pleasures taken at others' expense. One of the consequences to be considered is the fear generated in society when it is known that it has been considered ethically right, on occasion, to beat innocent men. Another evil consequence is that the men who justified their malicious beating will have their hearts hardened and their appetites whetted for more evil, thereby increasing the likelihood for more unhappiness from their hands in the future. Given these and other evil consequences, surely an alternative can be found that will give happiness to others without causing pain to the innocent. In a real life situation, then, it will seldom turn out that a right act--that alternative productive of at least as much good and/or avoiding at least as much evil as any other alternative--will be one which gives pleasure to others at the expense of unmerited pain to some.

Another reason why utilitarianism objects to pleasure gained from malicious desires is that avoiding this sort of harm is the very basis of the utilitarian insight. Looking carefully at the grounding principle and basic interest of utilitarianism one soon realizes that happiness which is bought at the expense of others' unwilling and unjustified suffering cannot be condoned within a utilitarian ethical system. By adopting any ethical principle an individual is saying that he will allow his acts to be guided and thus restrained according to some idea of the right and/or the good. In adopting the utilitarian principle the idea of good which guides the individual is that

happiness is desirable and pain is to be avoided. With this as a guiding principle, it would seem strange indeed for a utilitarian to easily condone decreasing anyone's happiness or causing anyone pain. It is true that the utilitarian wishes to fulfill desires for happiness. But certainly by his principle some desires become illegitimate and even punishable. These illegitimate desires will be malicious desires, that is, those desires which are for pleasure gained by causing pain to others.

It can easily be seen that if an individual guided by the utilitarian principle is not allowed to harm another for his own benefit that it will follow from consistency that even if a group will benefit from another's suffering this type of action cannot be condoned. It is a serious misinterpretation of utilitarianism to claim that the utilitarian blindly sets out to maximize happiness at whatever the cost. Certain desires for happiness are illegitimate and are to have negative value within utilitarianism--namely, those desires that involve malicious harm to others.

But perhaps the malicious beating is an easy example for the utilitarian to counter. The more difficult example would be the innocent man framed to save the community. Whereas the malicious beating example is one where other alternatives can easily be found, it is often argued that there will be cases where all alternatives are honestly considered to cause pain and in these cases the utilitarian will find himself bound by his utilitarian principle to maximize happiness at the cost of justice. Here again the traditional utilitarian defense is that if a real life example is fleshed out it will be seen

that justice and utility need not conflict. To give such a plausible example: In an American southern town in the 1950's, let us say, a white woman is found raped and killed. The crime was presumably committed by a black man. The town becomes enraged and it appears that a widespread riot and indiscriminate killings of blacks is imminent. The utilitarian mayor decides that it will quiet the town if he claims to have found the rapist and gives him to the crowd to be hung. There not being enough time to find the true criminal, an innocent man is convincingly framed. In this way the riot is avoided and only one man dies instead of many. The formalists use just this sort of example, confident that a utilitarian will have to advocate this unjust sacrifice of an innocent man since it maximizes happiness. Utilitarians have cautioned that one must consider the long range consequences such as its becoming known the hanged man was truly innocent. This would cause guilt and insecurity in the community. A more thoughtful utilitarian might caution even further and note that there is a third alternative not mentioned in the formalist version of the example. The course that would truly maximize happiness would be a cool headed, equally utilitarian mayor, who would employ talk and, if necessary, troops, to calm the crowd, prevent the lynchings and take the time to find and try the truly guilty individual. This alternative satisfies both the utilitarian principle and justice. This course could result in a minimum of physical pain and in a maximum of the higher pleasure of respect for individuals, black and white. This would be treating an angry crowd as if they were a group of rational individuals rather than a blind force of nature. The long range happiness and

safety of the innocent black community would be enhanced. Education of the white community would be, at least, attempted. Even if in this case it turns out that the crowd will not listen to the voice of reason and a number of lynchings take place before order is restored, it will still be a desirable consequence of the mayor's choice not to sacrifice an innocent man that the ground is laid for more unprejudiced thinking in the future. If an innocent man is framed and hung, the community becomes more entrenched in its decadent ways. With this refusal to sacrifice an innocent man the first step is taken to guarantee future happiness for the community, free of fear and blind prejudice.

Although in most difficult cases an alternative can be found that satisfies both justice and happiness, there are some very hard cases where innocent lives have to be sacrificed for the sake of others. It seems that there are certain social conflicts that occur where even the formalists among us may be willing to modify their concept of justice in favor of a utilitarian standard. In some very hard cases the deaths of innocent people, although not their direct murders, are condoned for the greater happiness of others. A modern day example of this is the hard line Israel has taken toward negotiating with terrorists' demands. This country will not negotiate with terrorists even if it means loss of innocent hostage lives. They attempt to rescue hostages but they do not give in to terrorist demands. Their largely utilitarian argument is that once terrorists have their demands considered, with any kind of possibility to surrender, their entire country and people are no longer safe from the constant threat that

does and will surround them. Many countries admire Israel for their firm stand and attempt to do likewise. When the future happiness and safety of large populations is at stake, there may be times at which the right alternative is to allow the sacrifice of innocent lives.

But perhaps we are mistaken in only answering the drastic examples which some formalists raise against utilitarianism. It may be admitted that the satisfaction of malicious desires is contrary to the very spirit of utilitarianism. It may be equally clear that the utilitarian will not easily sacrifice an innocent man without seeking long and hard for an alternative action. But what about the example of the elderly Mr. Jones and his placement in a senior citizens' community? Alternative I is that Mr. Jones live at home with his son and daughter-in-law. This causes great happiness for the two men and some inconvenience to the woman. Alternative II is that Mr. Jones be placed in the old age community. This alternative is satisfactory to all concerned but the net happiness is not as great as in Alternative I even when subtracting the unhappiness of Mrs. Jones. The formalist, advocating a fairness principle, claims that even if the net happiness is less in Alternative II, this is the right alternative. Alternative II is a more just distribution of happiness.

This example is different from the malicious beating example. The happiness which results for Mr. Jones and his son is not caused by making Mrs. Jones suffer. Nor is this example really like the innocent man problem. There is no deceit here. Nor is Mrs. Jones snatched from the street and made to suffer so that others need not. Supposedly, Mrs. Jones is consulted in the decision making process

about her father-in-law. Her happiness could not have been weighed unless she communicated just what degree of inconvenience the elder Mr. Jones's presence in her home would cause her.

We can pause here and take special note of two very important considerations when applying the act utilitarian principle. The first consideration was mentioned above in discussing malicious desires. Persons will always have a very serious right within utilitarianism to not be harmed. It is the goal of the utilitarian to insure happiness and avoid suffering. The other consideration is a related idea to this one. When attempting to maximize happiness it will always be important to ask the persons involved what will secure their happiness. We must never project our concept of happiness onto other persons. Even physical pain may have some value in an individual's concept of his long range happiness. When in doubt as to what action will best insure another's happiness, the best course for the utilitarian is to ask the person who is most likely to know--that person whose happiness is at stake.

In the case of Mr. Jones, then, the three parties involved would have to gather to make a decision. Each would explain his or her position and what each sees as happiness or pain. It is not unreasonable, given this method of decision making, that the parties judge Alternative I to be the right action. It maximizes happiness, yet does not maintain an equal distribution. If it makes Mr. Jones and his son that much happier for the elder Mr. Jones to remain in his home, Mrs. Jones ought to sacrifice some happiness for the sake of the whole. This is not in open conflict with ordinary moral insights. As long as

Mrs. Jones is consulted in the decision making process and herself estimates her conception of inconvenience caused by the elder Mr. Jones, the choice of Alternative I does not appear unfair or unethical.

Another example drawn from medicine will be helpful in emphasizing the manner of decision making which the act utilitarian principle recommends. Jan Narveson reports the following case as one which the formalist in defending justice over a maximization of happiness brings against the utilitarian.

> This is the case of "involuntary euthanasia." For example, here is a man with a mortal case of cancer; his whole future life, which won't be very long anyway, will be filled with pain and unrelieved by any possibility of productive participation in the community life, or by amusements or spiritually enriching activities. Why not put an end to him and save a lot of trouble on the part of physicians, as well as taxpayer's [sic.] good money which could be used for more worthy projects than maintaining him in being for a few miserable months? And what difference does it make if he doesn't go along with the project?[78]

It should be clear from the above discussion that this is an incorrect portrayal of utilitarian reasoning. The idea of judging what will be for the patient's happiness without consulting him on the matter is ignoring the richest source of information for making a utilitarian judgment. But let us go about this carefully.

First we will restate our act utilitarian principle and then consider alternatives and consequences without the arrogance of assuming we know what is in another's best interests even when he is there to tell us. The act utilitarian principle states:

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[78]Narveson, p. 157.

> An act is right if and only if, of the alternatives open to the agent and on the available evidence, it produces, for all those affected by the act, at least as much good and/or avoids at least as much evil as any other alternative, where good and evil are understood in terms of the qualitative hedonistic theory of intrinsic good.

Those affected in the case in question will include first and foremost, the patient himself. Next are those who are near and dear to him, i.e., those who will most share in his happiness or pain, be these relatives, friends or the nursing staff. Finally are the physicians and hospital staff, and, last, and only marginally, the taxpaying public. These groups are ranked by the degree to which they will be affected by the choice being made.

The alternative of killing the patient will not be one the utilitarian could easily condone. It contradicts the very basic insights of his ethical system. He is to refrain from harming others, to always consider the happiness of all involved and never to allow avoidable pain. But, say in the case above the patient is not sure of what he ought to do and he himself is the one who is trying to apply the utilitarian principle and decide the right course of action. It would be relevant information then to know his exact medical prognosis, to what extent pain medication is available and effective, the extent of pain that is being felt by family and friends who watch him linger, the expense of his care, and if others could better benefit from medical resources he is using. If after careful consideration the patient decides more good would be realized by his death, then the utilitarian will have to support him in this decision. If the patient concludes that the extra months of life are very valuable to him and worth the

expense, inconvenience and physical pain, then the utilitarian supports this decision. Since the patient is most affected and has best access to knowledge, it is up to him to make this decision about his own life.

It may be, as is often the case, that our terminal patient is not capable of making the decision nor of giving input to a decision. He may be brain damaged, comatose or a severely defective newborn infant. In that case the utilitarian will still advocate decision making with the patient's interests always foremost. This is true because, ordinarily, the patient's happiness is most at stake. If a doctor is to make the decision of continuing support or removing the patient from life support systems, he will surely rely heavily on the advice of a close relative or friend of the patient. This relative or friend will be responsible for informing the doctor about what, to the best of his knowledge, the patient would have wanted. In the case of an infant even this information will not be available. The infant never had a chance to develop or express a personality of its own. In that case those who have the most reason to unselfishly care for the infant will have to judge what they think will be best for the infant and also for all others affected by any decision about the infant.

In actual application, then, it must be emphasized that the utilitarian principle strongly advocates considering all alternatives, never gaining happiness by the satisfaction of malicious desires, and always consulting those most involved about their concept of what constitutes happiness and/or pain for them.

The formalist is wrong in thinking the utilitarian will advocate gaining happiness from malicious desires. Neither will the utilitarian

easily advocate sacrificing one person's life that others may live more happily. In real life situations that which serves justice will also serve happiness in the long run. In difficult cases an alternative can ordinarily be found which is both just and serves to maximize happiness. As for the formalist's claim that a right act ought to distribute the good as equally as possible to as large a population as possible, this is not as clear and obvious as the formalist would want us to believe. This formalist insight might be more critical if one were considering decision making on the level of political or social policy. Here equal distribution of goods and services would very probably best serve justice and quite possibly also long range happiness. However, on the level of decision making about individual cases, with identifiable persons who can often participate in the decision making process, choosing that alternative which produces the greatest net happiness is the ethically right course. At least, it is not clear that a more equal distribution at the loss of net happiness is an ethically superior course.

It has been argued that the act utilitarian theory of obligation with qualitative hedonism as an explanation of the good is a consistent, philosophically defensible normative ethical system which is readily applicable to medical ethical decision making. Guidelines for the application of the act utilitarian principle have been discussed. Major objections to this ethical system have been dealt with. It now remains to further argue for the applicability of the act utilitarian principle to medical problems by developing a detailed application of this method of decision making to a specific area of medical concern.

The area of medicine that has been chosen for discussion is that of intensive care for severely ill newborns. The next chapter will be devoted to a presentation of a range of neonatal problems that are encountered in the critical care nursery. It is important to have a clear picture of the medical area we are dealing with before attempting an application of ethical theory to medical decision making.

CHAPTER III

THE CLINICAL SETTING OF NEONATAL INTENSIVE CARE

Some of the most difficult ethical problems which medicine faces are those that have risen with the growth of technology in the last thirty years. Neonatal intensive care presents many such problems. The term "neonatology" was coined in 1960. It was at that time that medical care for the fetus and the newborn infant became specialized enough to require special care nurseries and health care professionals to staff them. Prior to that time full term healthy babies, premature infants and babies with special problems were mostly handled together in one nursery. By 1970 medical technology had advanced to the point where it was possible to continuously monitor the newborn's blood pressure, heart rate and rhythm, and breathing rate and pattern. Blood gases and chemistries of the neonate could also be monitored. With this technology came aggressive treatment of all forms of infant disease, infection, and malformation. Mortality figures for the newborn dropped. "Between 1964 and 1974, the neonatal mortality rate (deaths under 28 days of age) in the United States declined from 17.9 deaths per 1,000 live births to 12.1 per 1,000 live births."[79]

However, actual survival is only one way to measure the success

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[79]William H. Tooley and Roderic H. Phibbs, "Neonatal Intensive Care: The State of the Art," in Ethics of Newborn Intensive Care, eds. Albert R. Jonsen and Michael J. Garland (Berkeley: Institute of Governmental Studies, 1976), p. 13.

of neonatal intensive care. Perhaps a more significant measure is intact survival. Some infants whose lives are saved by advanced medical knowledge are unfortunately not completely cured nor enabled to live normal, healthy lives. While there is growing evidence that, in time, intact survival of defective newborns can be achieved for many,[80] there are still instances where neonatal intensive care simply delays, for a number of days or weeks, an inevitable death or leaves survivors with severe neurological and other damage.[81] Some of the failure to provide intact survival is due to still limited medical knowledge. On occasion damage results to the infant from the very care that is provided. One group of workers in an intensive care nursery reports that "intensive care techniques increase the risk of infection and iatrogenic [medically or surgically induced] complications."[82] It is now known that the high oxygen concentrations that were used to aid breathing in premature and other high risk infants in the 1930's and 1940's is related to subsequent blindness in these infants.

With medicine's increased, but never total, knowledge comes questions of how best to use this knowledge. When technology can provide for an infant a longer life which is however still one of pain and suffering, it becomes a question of value theory as to whether

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[80]See, for example, Harry S. Dweck, et al., "Early Development of the Tiny Premature Infant," American Journal of Diseases of Children, 126 (1973), 28-34.

[81]L. D. Prod'hom, et al., "Care of the Seriously Ill Neonate with Hyaline Membrane Disease and with Sepsis (Sclerema Neonatorum)," Pediatrics, 53 (1974), 176-181.

[82]Prod'hom, p. 177.

intervention is justified. It is no longer purely a medical decision. Ethical problems, thus, arise with medicine's increased capacity to affect the course of disease. Physicians and other concerned individuals are beginning to question if aggressive treatment of all defective newborns is the ethically right course of action. Concern about the consequences in quality of life for the newborn has even found expression in a textbook on neonatology. This textbook[83] considers passive and active euthanasia as possible courses of action in treatment of myelomeningocele. The traditional role of medicine has largely been to preserve life at all costs. With the increasing power of technology, however, "do no harm" of the medical code is beginning to be applied to assaultive treatment of neonatal problems when no compensatory improvement in overall prognosis can be expected. An infant can be harmed by keeping it alive to suffer physical pain and permanent loss of function.

Informed and consistent ethical decision making is often more difficult in intensive care nurseries than it is in other fields of medicine. There are a number of reasons why this is true. As was indicated above, neonatology is a new field with limited knowledge. Causes of many neonatal problems are not clearly known. The course of diseases that have only recently been identified and treated are not known. Possible side effects of treatment cannot always be accurately predicted. In addition to these medical problems are value factors that cause ethical decision making in the intensive care nursery to be especially difficult. Treatment of infants and children is often done

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[83]Richard E. Behrman, ed., Neonatology, Diseases of the Fetus and Infant (St. Louis: The C. V. Mosby Company, 1973), pp. 557-558.

in an emotionally charged atmosphere for both medical professionals and the family of the child. An infant is normally conceived, carried and born with the highest of hopes. Our society places great value on infants and children. It is difficult to see them suffer and die. It is also problematic to determine who ought to decide on treatment or non-treatment of severely defective newborns. The infant cannot tell us what degree of impairment it is willing to live with. Since the infant cannot decide, someone else must. Both parents and doctors seem to have some prima facie right to be the decision makers for the infant. For the above reasons, and others, the ethical concerns of neonatal intensive care is the area of medicine chosen to be the test case for the applicability of the ethical system developed in the preceding two chapters. Neonatal intensive care seems to be an especially fertile ground for ethical dilemmas, while at the same time affording many difficulties for clear and consistent decision making. If the ethical system of act utilitarianism can be justified in this context, it has a good chance of being the "philosophically viable ethic"[84] that medical ethicists like Daniel Callahan are calling for.

A direct application of our ethical system of decision making to specific problems and cases of neonatal medicine will be made in the next chapter. This chapter will attempt to familiarize the reader with the clinical setting in which these critical decisions are made. The actual organization of an intensive care nursery will be described and discussed. A number of the more serious courses of neonatal disease

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[84]Callahan, p. 72.

will then be described. A careful consideration of the real life atmosphere of medical decision making is necessary so that an ethical system, developed in theory, is not applied simply to textbook cases while at no point touching the true situation that medical professionals must face.

I. THE INTENSIVE CARE NURSERY

Treatment in an intensive care nursery necessarily involves expensive and complicated medical machinery along with medical professionals competent to apply the technology and familiar with the ever increasing body of knowledge. For this reason intensive care nurseries tend to be established in large metropolises serving a wide surrounding area. They are often associated with a teaching hospital and a medical school. This, in itself, is significant to decision making in the nursery. In teaching hospitals lines of authority, although clear in theory, often become confused in practice. An intensive care nursery, similar to other services in a teaching hospital, is staffed by nurses, interns, residents, fellows, and attending physicians in an ascending order of authority. Attending physicians are most often appointed by the hospital and the medical school. Their salaries come from these two sources and also (and often significantly) from their own research grants. In one intensive care nursery, associated with a large Eastern University, three attending physicians took final responsibility for the nursery on a rotating schedule. Each spent one month on active duty in the nursery alternating with two months largely devoted to research. Neonatal research is most

frequently laboratory work, often involving animal studies. With this kind of setup, which is standard, the attending physician is, in a sense, paid to stay out of the nursery and in the research laboratory. Understandably, physicians' main interest is frequently in research. The day to day care of newborn patients is handled by interns and residents consulting with the fellows and the attending physician. A fellow is a graduate physician who is taking extra training in a specialty field. Fellows also pursue independent research interests. When a baby is admitted to the ICN, an intern is assigned to its day to day continuing care. He or she, along with the family pediatrician, if there is one, becomes known as the baby's doctor. Family pediatricians take a variable role in the newborn's care. Policy usually demands that the pediatrician be a full partner in the baby's care and be kept informed of all aspects of treatment. In practice, the family pediatrician, by choice or circumstance, takes a back seat to the nursery physicians. Some pediatricians stay in close contact with both the nursery and the family. Others gradually disappear from the scene. In reality, then, the intern assigned to the case has most contact and familiarity with the newborn. Interns are in training to be pediatricians of all kinds and not necessarily neonatologists. They rotate through the ICN staying from a period of three to eight weeks. In the large Eastern University with which I am most familiar, interns did two rotations through the ICN, each for a period of three weeks. At one time the rotation was a one time, standard six week period. It was broken into two since the stress of neonatal care was felt to be very burdensome and better handled in two separate rotations.

It can easily be seen from the above description that this kind of setup has a good potential for confusing lines of authority. When communication between the various levels of physicians and with the rest of the nursery staff breaks down, decision making becomes difficult. This type of setup is also frequently confusing to the parents of the neonate patient. When they become familiar with and confident in the intern assigned to their baby, he or she may be rotated to another service, and trust in a new physician must be built up all over. It can happen that the attending physicians fill this lack and take personal and professional continuing interest in especially the more troublesome cases. Nurses also serve to provide a more constant source of comfort and information to the parents. When it is known from the time of admission that an infant will have a long and troublesome course of treatment, one nurse can be assigned to the baby to provide continuing care for the infant and its family.

The fact that an ICN often serves a wide geographical area also causes difficulties for communication and decision making. A newborn can be transferred into the ICN as soon as possible after birth leaving the mother in a hospital many miles away and the father commuting between wife and baby as well as caring for any siblings. These difficulties can also be overcome by a dedicated staff and a liberal visiting policy in the nursery. I observed a case in which after initial presentation of the case to the father and maternal grandfather of a one-day-old infant with multiple anomalies, the physician traveled some fifty miles that evening to the hospital where the mother was. The case was again presented to both parents and maternal grandparents

together. When the mother was released from the community hospital, parents, grandparents, siblings, aunts and uncles were given every opportunity to visit the newborn during the five days the infant survived.

The significance of the role of nurses in a ICN can hardly be overemphasized. Unlike older patients, a newborn's condition can change from minute to minute as well as from day to day. Nurses, then, who have the most physical contact with the infants are often the first to observe changes in a baby's appearance. It is often they who alert the physicians to apnea (temporary stopping of breathing) episodes. It is their alertness and responsiveness that can mean life or death for an infant. Nurses are also the ones who have most chance to become emotionally attached to their charges. Although this is mostly advantageous to the infant who needs loving attention in order to thrive, it can also occasionally work to the detriment of the infant. I was told of one case in which this was apparently so. A premature infant with severe respiratory distress underwent a long and ultimately unsuccessful course of treatment in the ICN. The nursing staff over a period of time became very attached to this infant and mourned its death. The same day this infant died, another premature infant with an identical presenting diagnosis was admitted to the ICN. This second infant even had the same last name as the first infant. Still hurting from their experience with the first infant, the nurses were not as quick as they might have been in calling for resuscitation of the newly admitted infant. This delay could have been responsible for brain damage in the infant. Emotional stress and the need for quick

action can, then, work against well-thought-out, fully-informed decision making.

Nurses also carry a large burden when a decision is made to not treat or to discontinue treatment on an infant with poor prognosis. An infant who cannot be fed because of intestinal blockage may be not treated if there are also other significant complications. The nurses then hold this baby and cradle it throughout the day as time permits. They can be asked to stop suctioning the build up of fluids in the respiratory system. It is difficult for a nurse to watch a baby struggling for breath when a simple suctioning procedure will give it temporary relief. Nurses and physicians, in these cases, can disagree as to whether or not an infant is experiencing pain. Physicians often believe that because of sedation or extensive neurological damage a particular infant is incapable of feeling pain. Nurses can argue that the infant does give signs of distress.

The parents and family of the newborn patient also play an important role in decision making in the intensive care nursery. Although the neonate is always the primary patient, good intensive care nurseries are also set up to handle the information, emotional and financial needs of the parents. The ICN has one or more social workers. Their role can be a limited one or a very expanded one. The social worker on one nursery in which I observed was an important factor in aiding parents and families of the newborn. She kept fully informed on each neonate's medical prognosis and served as a counselor and informant to parents. It was her primary duty to identify potential family problems. Such problems include attaining financial assistance

from various helping agencies, identifying potential child abuse situations, noting parents who are having more than ordinary problems in handling the crisis of a defective newborn, aiding in travel problems of visiting families from long distances, and keeping the physicians informed of changes in family situations. One social worker conducted a weekly family management conference. This time was spent in sharing information and impressions of family needs. If it was noted that a family had stopped visiting an infant, the social worker or intern would follow up and contact the family. Occasionally in these conferences it would be noted that the course of treatment on a particular infant needed reevaluation. A further conference would be scheduled and, often with the parents present, options of treatment, including discontinuing treatment, would be discussed. In this way the social worker can be a catalyst for coordination of effort and a reminder of value considerations involving families.

The physical setup of an intensive care nursery need not be discussed here, except, perhaps to point out that the amount and complexity of medical machinery can be overwhelming to those not familiar with hospitals. Parents are first confronted with the necessity of washing their hands at an imposing sink with foot and knee controls for water pressure. They are then given a surgical type, sterile gown. Next they see their infant, often in an incubator with a confusing array of machines, tubes, and buzzers. There are side rooms for nursing mothers, visiting or conferences, but always one passes by machinery. I have known parents, chaplains, secretaries, and students whose initial impression of an intensive care nursery is

as a place best avoided. The sensitive physician will be aware of these problems of first exposure. Once machinery is simply explained, it no longer appears so threatening. Even offering a cup of coffee can give one familiar point of reference in an alien world.

The intensive care nursery, then, can be an imposing and confusing backdrop for ethical decision making. There are myriad levels of authority in a teaching hospital. Fatigue and stress are constant companions of interns and residents. Research interests compete with patient care among fellows and attending physicians. Ethical decision making becomes difficult in these situations since parents are not always fully or honestly informed about their infant's condition. A physician interested in research may color the diagnosis to make the infant's prognosis appear more hopeful than it actually is. Patient care decisions may be made to enhance research goals. Beyond a point, this makes research subjects of patients who may benefit, not be helped, or may be harmed. Yet review of these consequences may be minimal or biased. The parents, not able to make a decision on the best available evidence, will have their hopes falsely buoyed by the specialist's views and allow experimentation which they wrongly see as established treatment. Interns and residents may also be blocked from giving the parents an honest prognosis since they must act to please research oriented faculty in order to protect their own chances for a favorable recommendation for their next post.

Adding to these problems is the emotional stress faced by the parents. Calm, thoughtful decision making can be difficult for parents so recently faced with the disappointment of a less than

perfect infant. All of these problems can be overcome by a sensitive nursery staff dedicated to patient care.

II. NEONATAL DISEASE

In this dissertation it is clearly impossible and also not necessary to cover all the possible diseases and malformations that can occur in the newborn. In order to give the reader some idea of the medical complexity of neonatal disease, several disorders will be described. The majority of infants admitted to the ICN are there because of prematurity, malformations, or both. One of the more serious complications of prematurity will first be described. I will then discuss a number of serious malformations. I will concentrate here on very serious, life-threatening diseases, since these raise the most serious ethical problems of possible non-treatment. It must be emphasized, however, that many admissions to the ICN are not of such a serious nature. Premature infants can be admitted simply as a precautionary measure and are soon released when their breathing ability and weight gain are stabilized. Some infants are simply small for gestational age and are checked for possible complications, then released. A baby can be admitted to the ICN if a mother has had an unusually long labor. There can be a problem with infection in these cases. Often these babies can be sent back to the well baby nursery or to their mothers' rooms after a twenty-four hour period of observation in the ICN.

Before discussing three of the more serious neonatal afflictions, a partial list of high-risk neonates can be given to indicate the

variety of problems that are encountered in the intensive care nursery. The following list is taken from Ethics of Newborn Intensive Care. High-risk neonates include:

> Those born of diabetic or drug-addicted mothers; infants whose mothers suffered severe blood poisoning associated with pregnancy; those born of Rh-negative mothers with rising quantities of Rh antibodies in their blood; infants born by Caesarean section because of a variety of complications; infants born after a prolonged labor, especially if the fetus has been in distress; certain low birth-weight infants, whether born preterm or at term; postterm infants (more than 42 weeks gestation); infants distressed at delivery (e.g., respiratory distress); multiple birth infants with potential problems; infants with generalized infections (sepsis) or exhibiting post delivery distress (e.g., cardiac, respiratory, gastro-intestinal); jaundiced infants; and those with congenital defects requiring immediate treatment, such as heart malformation or gastro-intestinal blockage.[85]

Hyaline Membrane Disease

One of the most serious complications of prematurity is idiopathic respiratory distress syndrome, also called hyaline membrane disease (HMD). The more premature the infant, the greater the likelihood of a complicated course of this disease. The etiology of the disease is not completely known. Several competing theories are offered.[86] There is no specific treatment for the disease. Treatment of symptoms, however, is established. The lungs of a premature infant with HMD are not sufficiently developed to keep them from collapsing. The infant also has a poorly stabilized chest wall and relatively weak

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[85]Albert R. Jonsen, "Introduction: Ethics and Neonatal Intensive Care," Jonsen, p. 2.

[86]Behrman, p. 364.

chest-wall muscles. Oxygen therapy is thus needed since the infant is unable to take in sufficient oxygen and rid itself of carbon dioxide. Blood gases must be closely monitored in order to keep the proper oxygen level.

> Nursing care of the infant with respiratory disorders requires great skill and technical expertise. . . . This includes enhancing good lung ventilation by proper positioning of the infant and by mechanical ventilation, thinning of secretions, and proper removal of secretions from the infant's respiratory tract by postdural drainage and gentle suction.[87]

Oral feeding is avoided since it tires the infant. Calories and fluids are provided intravenously. Complications of therapy frequently arise.[88] High oxygen concentrations can damage the lungs. Indwelling tubes for feeding or drawing blood samples for tests can become infected. Since the premature infant has little resistance, infection can quickly become generalized (e.g., septicemia or meningitis). Infants with HMD also show a higher incidence of intraventricular hemorrhages in the brain causing brain damage. Several other lung and heart complications have been known to occur.

Infants usually show symptoms of HMD at birth or within the first six hours of life. The following is a description of a typical course of HMD, but there is wide variation.

> The clinical course is characterized by a progressive worsening of these symptoms, with a peak severity from 48 to 72 hours, although occasionally maximum severity occurs in less than 12 hours. . . .

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[87]Sophie H. Pierog and Angelo Ferrara, Medical Care of the Sick Newborn (St. Louis: The C. V. Mosby Company, 1976), p. 147.

[88]Behrman, pp. 367-368.

> If the infant survives and there are no complications, there is a gradual decrease of clinical signs, associated with a reduced oxygen requirement, and lessening tachypnea and retractions. Clinical recovery is complete in 10 days to 2 weeks.[89]

Many infants do not survive hyaline membrane disease; 25,000 infants in the United States die each year from this disease.[90] A Toronto hospital reports a mortality of 33 percent for infants with HMD.[91] Although infants who survive can have a normal course of development, medical follow-up is advisable.

> The survivors of this disease will certainly need a careful medical follow-up, since neurologic sequelae of hypoxia and sequelae of oxygen toxicity such as retrolental fibroplasia and chronic lung disorders may not be manifested until much later in life.[92]

The most difficult cases of HMD are those in which the infant initially responds to treatment but then begins to develop complications. It may become impossible to wean the baby off of oxygen. Brain damage may occur. When permanent impairments have been suffered and the infant is not progressing well, termination of treatment may be considered. We will speak of a case of this nature in the following chapter.

Spina Bifida with Meningomyelocele

Some of the most serious malformations in the newborn are those which involve the central nervous system. Of the possible developmental

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[89]Behrman, p. 361.

[90]Behrman, p. 361.

[91]Behrman, p. 361.

[92]Pierog, p. 148.

failures in the nervous system, one which is much discussed in relation to medical ethics is spina bifida with a meningomyelocele. A spina bifida is a failure of formation of the bony arch surrounding the spinal column. It is estimated that as many as 25 percent of children may have such a defect.[93] Most such defects are of little or no consequence. The most serious type of spina bifida, however, is where the failure of closure is high on the spinal column and associated with a herniation of a saclike mass, called a meningomyelocele. Spina bifida with this added complication occurs in about two in every one thousand live births.[94] Neurological deficit resulting in motor disfunction is always involved in varying degrees. Treatment of the infant with meningomyelocele is controversial as reported in both medical and nursing texts:

> A newborn infant with a meningomyelocele presents the pediatrician with difficult decisions of what to tell parents and whether or not to recommend surgical closure of the defect on the back.[95]

> Parents' rights in the decision-making process regarding surgery for a neonate born with a major defect such as meningomyelocele are a highly controversial issue.[96]

Treatment involves immediate (ideally within the first 24 hours) closure of the spina bifida to prevent infection and further rapid

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[93]Eugenia H. Waechter and Florence G. Blake, Nursing Care of Children (Philadelphia: J. B. Lippincott, 1976), p. 246.

[94]As reported in Moral Problems in Medicine, ed. Samuel Gorovitz (New Jersey: Prentice-Hall, Inc., 1976), p. 341.

[95]Behrman, p. 557.

[96]Gladys M. Scipien, et al., Comprehensive Pediatric Nursing (New York: McGraw-Hill Book Company, 1975), p. 479.

neurological loss. Repair of the spina bifida often involves subsequent hydrocephalus--abnormal fluid collection in the ventricles of the brain resulting in an enlargement of the head. A shunt must then be installed in the brain to drain the excess fluid. Shunts must be replaced as the infant grows. They are always a site of possible infection. Orthopedic problems must also be treated. Treatment of the ever-present bowel and bladder control problems is usually unsatisfactory. Repeated entries to the hospital after a lengthy initial stay can be expected. "One pediatric surgeon estimates that years of spina bifida treatment will cost $250,000 to $300,000 per patient."[97]

The decision to initially close the back, then, is only the first step of many.

> Closure of the back, while usually not technically difficult, carries significant implications. It greatly increases the chances of the infant's survival but in doing so obligates the profession to total care of the child and places a considerable burden on the family for the numerous operations and the rehabilitation that will be required. It also involves appreciable suffering for the infant.[98]

It is reported that if, on the other hand, no treatment whatsoever is given to the infant with meningomyelocele "40% are stillborn or die within the first weeks of life. Forty percent of the survivors die by 2 months of age, another 30% survive."[99] The 30 percent who live

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[97]Gorovitz, p. 341.

[98]Behrman, p. 557.

[99]Behrman, p. 558. It is quite possible that the 40 percent stillborn figure includes those infants reported as stillborn, but who are actually killed in the delivery room.

will, of course, have significantly greater impairment because of non-treatment.

Some effort has been made to determine by clinical manifestations which infants will either die or suffer maximum impairment. John Lorber, a British physician, published, in 1971, criteria for determining which newborns with spina bifida would most benefit by treatment.[100] It is known, for example, that if the meningomyelocele is at the first or second lumbar vertebrae of the spinal column or above that the maximum motor deficit is complete paraplegia, prognosis for ambulation is no functional ambulation and the risk of hydrocephalus is 96 percent.[101] Thus, by such indications as site of lesion, circumference of head, and sensory and motor testing of the infant, the physician can make a fairly accurate determination of prognosis.

Down's Syndrome

There are many malformations other than spina bifida. Some are single malformations such as cleft palate or club foot. Other malformations are multiple and can fit into definable syndromes. Occasionally a baby is admitted to the intensive care nursery with a presenting diagnosis of "funny looking kid." This is a non-labeling, initial diagnosis until the particular syndrome from which the infant suffers can be identified. Multiple malformations or anomalies do not always

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[100]John Lorber, "Results of Treatment of Myelomeningocele," Developmental Medicine and Child Neurology, 13 (1971), 279-303.

[101]Behrman, p. 557.

fit into such syndromes, but there are hundreds of identified syndromes.

One of the most common (one in every 650 births)[102] congenital malformations is Trisomy 21 or Down's Syndrome, once called Mongolism because of the characteristic Oriental slant of the eyes. Down's Syndrome is a chromosomal defect in which there is an extra number 21 chromosome or extra chromosomal material of number 21 attached to another chromosome.. This can be due to a defective sperm or egg or an error in the first cell division of the developing zygote. Since each body cell contains the extra chromosome, the malformations are multiple:

> Some of the principal abnormalities that can be identified at birth are hypotonia; protruding tongue; small nose with a low nasal bridge; upward-slanted eyes; inner epicanthal folds; speckling of the iris (Brushfield's spots); small ears with overfolding of the helix; small ear lobes; short neck with loose folds; short fifth finger with clinodactyly (inturning); wide gap between first and second toes; fine, soft hair; and cutis marmorata.[103]

The intellectual development of the Down's Syndrome child is impaired. An I.Q. of between 25 and 50 is usual. The Down's Syndrome child also undergoes a premature aging process with pathological changes similar to presenile dementia. About 40 percent of these children also have a heart defect. A certain percentage suffer from duodenal atresia, an obstruction of the small intestine.

In general, none of the defects of Down's Syndrome are incompatible with life except the heart disease and the intestinal blockage.

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[102]Waechter, p. 233.

[103]Waechter, p. 233.

The operation for duodenal atresia is relatively simple and has a high success rate. The Down's Syndrome child also well tolerates cardiac surgery.[104] There is, however, some controversy about treating the child with Down's Syndrome. There was a case at Johns Hopkins in which the parents refused permission for the duodenal atresia operation since they did not want a retarded Down's Syndrome child. The hospital did not operate and the infant starved to death in eleven days.[105]

Certainly the defects of the Down's Syndrome child are less severe than occurs with the diseases discussed above. This means, at the very least, that we must go much more slowly in deciding for non-treatment of the infant with Down's Syndrome.

With this discussion of the actual setting of the intensive care nursery, difficulties for decision making, and several diseases and malformations that afflict the newborn, we are ready to move into applying our method of ethical decision making to actual newborn cases. This will be done in the following chapter with the overall purpose of justifying the use of act utilitarianism as a decision making method for ethical decisions within medicine.

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[104]Behrman, p. 242.

[105]For a thorough discussion of the ethical aspects of this case see James M. Gustafson, "Mongolism, Parental Desires, and the Right to Life," Perspectives in Biology and Medicine, 16 (1973), 529-557.

CHAPTER IV

ACT UTILITARIANISM/QUALITATIVE HEDONISM APPLIED TO MEDICAL ETHICAL DECISION MAKING IN THE INTENSIVE CARE NURSERY

At the end of Chapter I in this dissertation is found a discussion[106] of what it means to justify an ultimate principle. It was argued that although an ultimate principle in any system cannot be deductively proved since it has no more basic principles from which it can be derived, such a principle can be justified. One method of justification is to show that reasonable persons can accept the way of life that follows upon implementation of the principle. This is the method which will be used here to justify the applicability to medicine of an act utilitarian theory of right acts combined with a qualitative hedonistic theory of intrinsic good.

As stated in the Introduction,[107] it is the purpose of this dissertation to develop and defend a philosophically viable normative ethical system for medical decision making. It was shown in Chapters I and II that act utilitarianism with qualitative hedonism as a theory of the good is, indeed, philosophically viable. It now remains to be shown in this chapter that such an ethical system is, in addition, appropriate to medicine. This will be done by first arguing that doctors, to some extent, already agree with the underlying principles

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[106]See above, pp. 41-46.

[107]See above, p. 3.

of act utilitarianism. A careful reading of texts and journal articles written by physicians about medical ethical questions shows this to be true. There is certainly not universal agreement. If there were, the argument here would not be needed. The strongest voices against utilitarianism and for a sanctity of life ethic, however, come from outside of the medical profession and outside of the everyday harsh reality of the clinical setting. It can be shown, then, by reference to medical literature that act utilitarianism is acceptable to reasonable persons directly involved in the relevant decision making process.

The second and major approach to justifying the applicability of the ethical system developed here will be an actual application of this ethical system to several case studies encountered in the Intensive Care Nursery. It will be seen that in this ethical system decisions can be quickly and consistently arrived at, room is made for continued improvement and refinement in the decision making process, and consequences of decisions are such that rational persons will be able to live with them. Reference to medical literature can only show that medical personnel find utilitarian decision making acceptable. However, it is neither true nor desirable that medical professionals are the only decision makers in medical ethical problems. For this reason, if our ethical system is to be justified, direct application of it to newborn problems must result in a way of life acceptable to all rational persons, not only to physicians. Of course, it is not possible to directly prove that all rational persons will accept the results of utilitarian decision making. All that can be done is to carefully and

consistently apply the ethical system to the clinical reality. In the end, each reader must decide for himself or herself if the result is acceptable.

In the process of working through several case studies, it will be seen, more clearly, just what can be expected from a consistent application of act utilitarianism with qualitative hedonism as a theory of the good. Significant areas of ethical concern will be identified and the utilitarian answer clarified. The sorts of information needed and valuable to a utilitarian decision maker will be indicated. The necessity of judging case by case on relevant information will be emphasized. Certain difficulties for completely accurate decision making will also be identified. It will be concluded that the ethical system developed here fares well in its applicability as a decision making theory for medical ethical problems.

I. MEDICAL ACCEPTANCE OF UTILITARIAN PRINCIPLE

In defending qualitative hedonism in Chapter I above it was pointed out that psychological realism demands that what we claim to be good is, at least, something that is actually found to be good by rational persons, something that is desired. In a similar sense, realism demands that the outcome of decision making which is proposed for medicine is something that reasonable medical professionals find to be desirable. It is advocated that medical decision making ought to seek to maximize pleasure and/or minimize pain for those involved. This is found to be one goal of many physicians and often the basis of decision making in difficult cases. Confusing and conflicting interests

in medicine and in society can obscure this goal. It will be argued below that these interests ought not and need not interfere with ethical decision making. First, evidence from medical literature will be cited to show that maximizing happiness both in terms of quality and quantity is a goal that satisfies psychological realism in that physicians professedly do seek this end.

John Lorber at Children's Hospital, Sheffield, England, is one physician who apparently uses the utilitarian principle as a guideline in his medical practice. His criteria for selection for treatment in spina bifida cases were mentioned in the previous chapter.[108] The motive behind selection for treatment parallels the goals of a utilitarian ethical system. Lorber hopes to develop criteria to select at birth those individuals whose life will be filled with physical and psychic pain in spite of all medical treatment. Where aggressive treatment cannot result in a reasonably healthy life, he argues that treatment should be withheld and the individual allowed to die. He gives the following justification for developing criteria for selection for treatment:

> . . . there are large numbers who are so severely handicapped at birth that those who survive are bound to suffer from a combination of major physical defects. In addition, many will be retarded in spite of everything that can be done for them. It is not necessary to enumerate all that this means to the patient, the family and the community in terms of suffering, deprivation, anxiety, frustration, family stress and financial cost. The large majority surviving at present have yet to reach the most difficult period of adolescence and young adult life and the problems of love, marriage and employment.

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[108]See above, p. 129.

> It would be of considerable value if one could foretell from simply physical signs present on the first day of life the likely future of a baby if he were untreated, and compare this with his chances if he were given the total care as is known today. This paper attempts to give such data, which may serve as a guide to those called upon to advise and deal with infants born with myelomeningocele.[109]

With this justification Lorber goes on to develop clinical criteria which can forecast severe paralysis and/or mental retardation. He advocates a decision making method similar to the one developed in this dissertation. Alternatives are weighed, and that alternative is sought which results in the least suffering for the patient. Lorber concentrates on the consequences for the patient. He acknowledges the secondary suffering to "family life and finances" but states, "All these are important and will be dealt with elsewhere, but their consideration should not cloud the main issue: the interest of the patient."[110]

Lorber concludes that a life of great physical suffering is an alternative to be rejected. Even if mental development is not greatly impaired; Lorber would have the severely handicapped infant not treated at birth. He points out that "It must be remembered that, after early childhood, the suffering of a person with such severe physical defects and so few opportunities in life is likely to be greater in those with normal intelligence."[111] Some of the physical defects that can be anticipated in a spina bifida patient are life in a

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[109]Lorber, pp. 279-280.

[110]Lorber, p. 299.

[111]Lorber, p. 300.

wheel chair, fecal incontinence, urinary diversion, and impotence accompanied by normal libido. Not only does Lorber weigh physical pain but also he is here warning about the higher quality suffering of rejection and lack of freedom.

Here then, is one physician working with severely defective newborns who uses the goal of minimizing physical pain and psychological suffering as a rational goal for medicine.

John Freeman is a pediatrician at Johns Hopkins in Baltimore. He comes to an opposite conclusion from John Lorber. Freeman argues for and practices aggressive treatment on infants with meningomyelocele. However, his justification for this conclusion is the same as Lorber's--minimizing suffering. Freeman's major concern is for the infant who is selected for non-treatment but does not die as expected and desired. In his article "Is There a Right to Die Quickly?" he argues that physicians like John Lorber ought to recognize that they are deciding for death when they opt to withhold treatment from a severely defective newborn. If they recognized and openly admitted this, logic and loving concern would demand that they follow through on their decision and mercifully kill the infant since this is the desirable end of withholding treatment. Freeman states:

> A discussion of killing is an anathema to most of us who are trained and dedicated to saving lives. However, physicians should admit that in deciding that some children with meningomyeloceles should not be operated upon, as Lorber has done, they are making a decision between life and death. The unoperated infant is being condemned to death, sooner or later, by less than optimal care--what might be termed passive euthanasia. The physician does not take into account the increased pain and suffering to both child and parent attendant to "letting nature take its course." . . . Having seen children

> with unoperated meningomyeloceles lie around the ward for weeks or months untreated, waiting to die, one cannot help but feel that the highest form of medical ethic would have been to end the pain and suffering, rather than wishing that the patient would go away. . . .
>
> In short, when one decides not to treat, or to treat only partially, patients survive. It is not the patient or the problem that goes away--it is the physician who goes away from the problem, leaving the family and the patient to suffer.[112]

Freeman is clearly arguing here for active euthanasia in those cases where non-treatment is selected. However, active euthanasia is illegal and thus Freeman contends that the only alternative available which minimizes pain is aggressive treatment for all meningomyelocele patients. With aggressive treatment there are no survivors of non-treatment with severe complications that could have been avoided.

The disagreement between Lorber and Freeman is not so much one of choosing an appropriate ethical system but rather one of empirical data. Freeman argues that there are a significant number of survivors of non-treatment. Lorber denies this claim. Freeman cites a case study[113] of an infant with a large meningomyelocele who was not treated at birth. With ever increasing complications this infant was still alive at the age of eight years. If he had been treated, Freeman argues, his physical and emotional impairment would be significantly less. Lorber, writing on this same case study presented by Freeman, claims that such survival is rare and is often the result of partial treatment

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[112]John Freeman, "Is There a Right to Die Quickly?" Journal of Pediatrics, 80 (1972), 905 and 904.

[113]See John Freeman, "The Short-sighted Treatment of Myelomeningocele: A Long-Term Case Report," Pediatrics, 53 (1974), 311-313.

rather than non-treatment. Lorber presents his data:

> With the management I proposed so far none of 34 untreated infants lived to 9 months of age and half were dead before 1 month. Of 55 untreated infants in Liverpool none survived for 6 months; of 99 referred to Oxford 4% lived for two years; and of 79 referred to Melbourne 2% lived for two years.[114]

It is very possible that "the management" actually effected by Lorber and his associates comes very close to the active euthanasia which Freeman reluctantly rejects. Lorber concludes his article concerning the survivors of non-treatment selection with this statement: "Occasional hard cases should not sway the discerning physician to do what he considers the best for his patient and his patient's family."[115]

It can be seen in this debate that lack of sufficient empirical data often complicates utilitarian decision making. In judging an individual case Lorber argues that long term survival without treatment has a low probability. He therefore chooses non-treatment when his criteria indicate this course. Freeman, on the other hand, places a higher probability on survival without treatment. He, therefore, chooses to treat in even the very difficult cases. Both physicians, however, use the utilitarian standard of choosing that alternative which, on the available evidence, minimizes suffering. Stronger data or legal freedom for active euthanasia could settle the debate between Lorber and Freeman.

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[114]John Lorber, "Selective Treatment of Myelomeningocele: To Treat or Not to Treat," Pediatrics 52 (1974), 308.

[115]Lorber, "Selective Treatment," p. 308.

Eliot Slater is another physician, the past director of a British Psychiatric Genetics Unit, whose experience with treatment and non-treatment of infants with severe malformations such as meningomyelocele has led him to an ethical system of minimizing pain. He argues in the following passages that an infant with a severe malformation is a mistake of nature that is best left untreated. The important thing for our purposes, here, is that Dr. Slater bases his argument on an attempt to choose that alternative which results in the least suffering for all parties involved, from the afflicted infant to society at large.

> The spina bifida baby is a mistake of nature not equipped to survive. Who suffers if he dies at birth? Certainly not the child, though if he is forced to survive he faces years of suffering. Do the parents suffer if he dies? Yes, in the disappointment of not having a baby when they had hoped for a normal little boy or girl; but in a few months they can try again. If the child survives, however, they have years of servitude, of tortured love, trying to make up to him for all his disadvantages. And society, the community? The death costs nothing; the life costs not only money but the pre-emption of precious medical, nursing, social, and educational resources. . . . The true ethic is, I believe, that normal parents have a right to a normal child. It is their first duty to preserve the normality of their home, the welfare of their marriage, their mutual relationship, and their family life. They should think it wrong to inflict an abnormal sib on their other normal children, who cannot defend themselves against this trauma.[116]

In the same article quoted above, Slater goes on to argue that physicians must recognize that they are "servants of our patients and not their masters."[117] In this he is agreeing with the utilitarian

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[116]Eliot Slater, "Health Service or Sickness Service?" British Medical Journal, 18 Dec. 1971, p. 735.

[117]Slater, p. 735.

principle that those who have the most to gain or lose by a decision should have considerable input to the decision making process. Slater admits that "the preservation of life often means the prolongation of suffering."[118] For this reason the patient should be allowed to have control over his own destiny. Slater criticizes those physicians who would maintain life at all costs:

> We must put him [the patient] in the position to be master of his destiny and provide him with the information he needs to know what is available and to decide what he wants. Part of the trouble is that for the sake of a simplistic ethical rule, such as the sanctity of life, we assume that all patients are the same, that they all want to live for an indefinite term longer, and if they don't it is because their minds are disordered. Patients differ as much as their circumstances differ. In making a single rule valid in all conditions we deny the patient's individuality, even his humanity.
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> Let me submit for consideration a different ethic. The doctor's first duty, subject to the patient's consent, is to do all he can to maintain health and vigour; to restore health when it has been impaired; to repair incapacities when they are sustained. Second to this comes the duty to relieve or if not relieve then alleviate suffering. If we bear these principles in mind the preservation of life will look after itself in all cases in which it is desirable and desired. Per se it is no part of the doctor's ordinary duties.[119]

Slater argues, then, that alternatives should be weighed, patients should be consulted, and happiness be maximized and/or suffering minimized, where happiness and suffering are defined by the patient whose welfare is at stake.

Two articles appeared in the October 25, 1973 issue of the New England Journal of Medicine which raised some consternation in medical and public forums. The first article was written by Dr. Anthony Shaw,

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[118]Slater, p. 735.

[119]Slater, pp. 735-736.

a pediatric surgeon at the Virginia Medical Center in Charlottesville. This article raised serious questions about the ethics of treating every defective newborn and about the parents' right to decide their infant's welfare. The second article, written by Drs. Raymond Duff and A. G. Campbell of the Yale-New Haven Intensive Care Nursery, was perhaps even more controversial. This article, for the first time, gave hard data on how many consecutive deaths in a two and one-half year period were due to withholding or withdrawing treatment. Although such withdrawal of treatment is common in many ICN's, no one before had openly published this in a medical journal. Both articles advocate a decision making policy similar to the one argued for in this dissertation.

Anthony Shaw's article is a series of case study presentations with each one followed by a discussion. In the discussions Dr. Shaw raises pointed questions to show the complexity of ethical concerns encountered in an intensive care nursery. Although he provides few answers, it is clear that Shaw would like to see an open policy of decision making in which the infant's condition and the parents' wishes can be dealt with on a case by case basis. He concludes in his final discussion that "If an underlying philosophy can be gleaned from the vignettes presented above, I hope it is one that tries to find a solution, humane and loving, based on the circumstances of each case rather than by means of a dogmatic formula approach."[120] This statement is clearly

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[120]Anthony Shaw, "Dilemmas of 'Informed Consent' in Children," The New England Journal of Medicine, 289 (1973), 889.

in line with the act utilitarian principle developed in this dissertation.

The Duff and Campbell article, which immediately follows Shaw's article, goes further in answering some of the difficult questions which Shaw raises. This article is largely a presentation of Duff and Campbell's experiences with complex ethical decision making. They report that of 299 consecutive deaths occurring in their nursery, 43 or 14 percent were related to withholding treatment. The following passage shows both the rationale and the difficulty of opting for a cessation of treatment.

> Another child had chronic pulmonary disease after positive-pressure ventilation with high oxygen concentrations for treatment of severe idiopathic respiratory-distress syndrome. By five months of age, he still required 40 percent oxygen to survive, and even then, he was chronically dyspneic and cyanotic. He also suffered from cor pulmonale, which was difficult to control with digoxin and diuretics. The nurses, parents and physicians considered it cruel to continue, and yet difficult to stop. All were attached to this child, whose life they had tried so hard to make worthwhile. The family had endured high expenses (the hospital bill exceeding $15,000), and the strains of the illness were believed to be threatening the marriage bonds and to be causing sibling behavioral disturbances. Oxygen supplementation was stopped, and the child died in about three hours. The family settled down and 18 months later had another baby, who was healthy.[121]

The authors, like John Freeman above, consider active euthanasia to occasionally be a desirable and merciful course. They note:

> When maximum treatment was viewed as unacceptable by families and physicians in our unit, there was a growing tendency to

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[121]Raymond S. Duff and A.G.M. Campbell, "Moral and Ethical Dilemmas in the Special-Care Nursery," The New England Journal of Medicine, 289 (1973), 891-892.

> seek early death as a management option, to avoid that cruel choice of gradual, often slow, but progressive deterioration of the child who was required under these circumstances in effect to kill himself. Parents and the staff then asked if his dying needed to be prolonged. If not, what were the most appropriate medical responses?[122]

As to the present illegality of active euthanasia, Duff and Campbell state "If working out these dilemmas in ways such as those we suggest is in violation of the law, we believe the law should be changed."[123]

Their experiences have also led the authors to a belief in active participation in decision making by the parents and families of the newborn.

> In our opinion, if families regardless of background are heard sympathetically and at length and are given information and answers to their questions in words they understand, the problems of their children as well as the expected benefits and limits of any proposed care can be understood clearly in practically all instances. Parents are able to understand the implications of such things as chronic dyspnea, oxygen dependency, incontinence, paralysis, contractures, sexual handicaps and mental retardation. . . . We believe the burdens of decision making must be borne by families and their professional advisers because they are most familiar with the respective situations. Since families primarily must live with and are most affected by the decisions, it therefore appears that society and the health professions should provide only general guidelines for decision making.[124]

Similar argumentation is used by the same authors in an article appearing in Pediatrics. Here the authors contrast a "disease-oriented" philosophy with one that is "person-oriented." They see the second philosophy as affording a wider range of considerations for decision

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[122]Duff, p. 893.

[123]Duff, p. 894.

[124]Duff, pp. 893-894.

making. Persons differ and decisions must be made according to the values of the persons involved. It is again argued in this later article that patients, parents and families have primary responsibility for decision making. Physicians must aid them with their expertise and their continuing concern. Society should not hinder them by restrictive legislation. The authors see sufficient safeguards in physician involvement and the bonds of familial affection that society need not fear a widespread slaughter of innocents. Drs. Duff and Campbell end this article with a recommendation for a policy very much in agreement with act utilitarianism as it has been defended in this dissertation. They state:

> It seems evident that suffering patients (when able), sorrowing families, and concerned physicians have always sought the least detrimental alternative while deciding care in the face of tragedy. Sometimes, despite the law, they have chosen early death by passive or active means as was required in the varied situations. There is a need in our society for a policy of deciding care according to individual situations as the parties most involved feel is correct. In view of the complexities of human experience and human tragedy and the difficulties and conflicts in deciding the proper use of medical technology, this approach to the problem of life and death control seems to make sense.[125]

One last article will be considered, as much for its excellent treatment of the topics under consideration as for its agreement with the ethical system advocated here. This article appeared in a 1975 issue of The Lancet. It was written by a working-party set up under the auspices of the Newcastle Regional Hospital Board in England. The party

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[125]Raymond S. Duff and A.G.M. Campbell, "On Deciding the Care of Severely Handicapped or Dying Persons: With Particular Reference to Infants," Pediatrics, 57 (1976), 492.

consisted of ten persons, four of them physicians. Their task was to develop ethical guidelines for selection for treatment of spina bifida. The authors try to strike a balance between two ethical systems: "The first is that any decision requires an estimate of the balance of suffering and happiness for those concerned in any action, and the other is the assertion that human life is sacred."[126] While cautioning that each human life must be considered intrinsically valuable, the authors make some strong statements in favor of the first ethic. The following passages speak for themselves in their clarity and their agreement with the greatest happiness principle.

> . . . of the two traditional aims of medicine--the prevention of suffering and the preservation of life--the former carries the greater weight. It is the balance of pain and happiness--in other words, the utilitarian principle--which holds sway.[127]

> To assert respect for human personality, and so to preserve life at any cost without considering what in general makes human beings happy, may lead, and often has led, to unnecessary suffering for the sake of blind adherence to beliefs.[128]

> It seems natural to try to draw up a balance sheet of happiness for a family with a deformed baby and, in the case of the baby itself, to try to make some estimate of its potentiality for enjoying itself or finding even some minimum of fulfillment. On a wider social scale, questions concerning the use of medical skills, the allocation of resources, and the provision of institutions and other forms of care and support, likewise in the end involve estimates of what is best for the happiness and well-being of society as a whole. On the level of social legislation there seems to be no other fair and reasonable way of making decisions.[129]

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[126]Working Party of the Newcastle Regional Hospital Board, "Ethics of Selective Treatment of Spina Bifida," The Lancet, 11 Jan. 1975, p. 85.

[127]Working Party, p. 85.

[128]Working Party, p. 86.

[129]Working Party, p. 86.

An investigation of the above nine articles appearing in medical journals and written by physicians involved in the care of defective newborns clearly shows that maximizing happiness and minimizing pain are goals that medical professionals do seek. Examples could be multiplied, especially since only the area of neonatology has been considered here. The above sampling is sufficient to satisfy the requirement of psychological realism for the act utilitarian theory of right acts combined with a qualitative hedonistic theory of intrinsic good. We can now turn to an application of this decision making theory to the clinical reality found in the intensive care nursery.

II. APPLICATION TO CASE STUDIES

Four case studies will be presented here. Each will be followed by a discussion and application of the act utilitarian/qualitative hedonistic ethical system developed in the early chapters of this dissertation. The first case study concerns a premature infant who develops respiratory and other multiple complications. This case exemplifies the type of infant who upon initial presentation appears to be a candidate for aggressive treatment since the outlook for complete recovery is at least probable. In time this outlook dims and cessation of treatment is considered. The second case presentation is one of an infant born with multiple anomalies. Here initial withholding of treatment is considered. A third infant is born with a rare genetic skin disease. This condition is not incompatible with life but involves great pain for the infant, a foreshortened life, and ever increasing disability. The final case study is that of an infant with

Down's Syndrome complicated by duodenal atresia. This type of case is very controversial in medical ethical literature. It will be presented here as a seemingly difficult case for the utilitarian ethical system.

These four cases are presented in order of medical complexity, with the most seriously afflicted infant presented first. The order of ethical complexity is necessarily reversed. An infant with very little hope for a near normal life presents an easier task for ethical decision making. It is clearer in such a case that suffering must be ended and life no longer prolonged. Decision making is more agonized in those cases in which a child's handicaps are not incompatible with life. Yet the child will not have a completely normal life. Here values must be weighed very carefully.

Every case study is unfortunately far from complete. In the actual clinical situation such factors as family involvement, nursing attitudes, finances, and resources for institutional care can be ascertained. In our discussion here some assumptions about such matters will have to be made when the appropriate data are not contained in the case study. In particular, family involvement will be stressed.

Prematurity with Respiratory Distress Syndrome

This first case study is found in an article in Ethics of Newborn Intensive Care, a study which originated from a conference held in 1974 by the University of California School of Medicine. The article is a transcript of a Pediatric Grand Rounds. A moderator, along with residents, interns and nurses, discuss decision making on

three difficult cases in the Intensive Care Nursery. In the case that follows discussion centered on when the nursery staff would be willing to give up on this baby. The case will be presented here in some length to demonstrate the ever increasing complexity of many cases of this type.

> This boy weighed 1000 grams (2 lbs. 3 oz.), was the second of twins, and was born after a 30-week gestation to a 35-year-old woman who had excess amniotic fluid. The other twin was live-born but died during the first week of life. Onset of labor followed spontaneous rupture of membranes, and delivery was by Caesarean section. At 1 minute of age the baby had an Apgar score of 1 and was resuscitated vigorously. A tube was inserted into his airway, his lungs were inflated, and catheters were placed in his aorta. At 23 minutes of age he was given a blood transfusion.
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> He had a very rocky course in the first few hours of life. By 90 minutes of age he was breathing spontaneously for the first time. He was eventually moved to the Intensive Care Nursery from the delivery room, where he continued to have a difficult course. At the end of 1-1/2 hours it was judged that he had been successfully resuscitated (by blood gas criteria) although he had extensive bruising over his scalp and had poor muscle tone. Throughout the therapy of this baby there were communication difficulties with the parents, who spoke very little English. In general, they simply went along with the decisions of the doctors regarding the intensity of therapeutic efforts that needed to be expended upon this child.
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> At 5-1/2 hours of age, the baby suddenly became blue, stopped breathing, and required vigorous ventilation through the tracheal tube before he began to breathe on his own. During this episode his blood pressure fell and he received sodium bicarbonate. At 8 hours of age he was again breathing spontaneously, but it was noted that his red cell concentration had fallen to nearly half of what it had been, and the soft spot on the top of his head was bulging. His spinal fluid was grossly bloody. It was assumed that he had suffered a massive cerebral hemorrhage and he was given a blood transfusion.
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> At 22 hours of age, the red blood cell concentration had risen. At 42 hours of age, he began to twitch, his color became blue, he had full-blown seizures, and his blood pressure fell to almost half of normal. He was again

resuscitated. Somewhat later it was noted that his blood cell concentration had fallen to nearly one-third the normal level. It was again assumed that he had a large cerebral hemorrhage, and he was again given a blood transfusion. Mechanical ventilation was continued. . . .

This baby developed severe respiratory distress. Each time they tried to take him off the respirator, his carbon dioxide rose to dangerous levels, and he had to be put back on the ventilator. By 10 days of age it became clear that he had a large open ductus arteriosus (a blood vessel required in prenatal life which normally closes off during the first day after birth). He was in congestive heart failure and could not be removed from the ventilator unless he were operated on to close the ductus arteriosus. . . .

At 13 days of age, the ductus was closed and he tolerated the procedure well; feeding was resumed on the 14th day of age. He was removed from the ventilator at 15 days of age; however, because of a rise in the carbon dioxide level he was put back on the mechanical ventilator on the 16th day. By this time, X-rays of the lungs showed severe chronic lung disease. His eyes were examined at weekly intervals and retinal vascular disease was noted at 2 months. The retina detached at 3 months of age, and fibrous tissue replaced the retrolental area by 4 months of age. He eventually became totally blind.

At 3-1/2 months of age, he was still on a ventilator. An attempt was made to wean him from the respirator but within 24 hours he became dangerously asphyxiated and severely acidotic, with a pH of 6.80. He was lethargic, the soft spot on the top of his head was bulging; his head was rapidly enlarging; his abdomen was distended; and he was twitching, cold, and clammy. . . .

It was felt that he had acute cerebral edema because of the high carbon dioxide and he was once more placed on the respirator. When he was again spontaneously breathing 60 percent oxygen against a pressure of 10 mm Hg and maintaining satisfactory arterial carbon dioxide concentration, another attempt was made to wean him from the respirator. Five days later, he began to have irregularities of the heart, his breathing was labored, his carbon dioxide concentration began rising and in several days it was quite high. A few days later he had signs of congestive heart failure, premature ventricular contractions became more common, and he had a respiratory and cardiac arrest.[130]

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[130]Alex Stalcup, Moderator, "Critical Decisions in the Intensive Care Nursery," in Ethics of Newborn Intensive Care, eds. Albert R.

The baby at this point is five and one-half months old. He is blind, has brain damage, chronic lung disease, heart trouble, and cannot be weaned from the respirator. The medical ethical question for the parents of the infant and the nursery staff is whether or not treatment should be terminated. If the infant is not resuscitated from his respiratory and cardiac arrest, he will die.

This case study well demonstrates the rapidly changing conditions of a premature infant. At the same time, various opportunities for reflection can be identified. When the infant was ten days of age, he required heart surgery. At this point careful thought could have been given to the alternative of withholding surgery. The infant, by that time, had apparently sustained serious brain damage and was showing signs of an inability to be weaned from the respirator. After the heart surgery failed and chronic lung disease and blindness was confirmed, another opportunity is given for careful reflection about possible termination of treatment.

Before any fully informed decision making can proceed, however, it is important that communication be established with the parents. The act utilitarian principle advocates decision making on the basis of all available evidence. The parents have the best access to some of this evidence. They must consider the environment to which the infant will come home. They must weigh how their new child will affect their welfare and the welfare of any siblings. Since there are language difficulties with the parents, an interpreter could be found

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Jonsen and Michael J. Garland (Berkeley: Institute of Governmental Studies, 1976), pp. 25-28.

among the hospital staff or a bilingual relative or friend of the family could be encouraged to accompany the parents to the nursery. It is irresponsible on the part of the nursery staff and the parents to simply have the parents agreeing with what the physicians feel necessary. The parents need to understand the extent of damage which their son has sustained. In the first few hours or even days of the infant's life, in this case, it is necessary and thus understandable for the physicians to do all they feel is necessary without excessive consultation with the parents. Once the infant is stabilized, and surely by the time heart surgery was contemplated, the parents should be fully informed and give their views on further treatment. If the baby survives, it is they who will be responsible for his continued care.

The act utilitarian principle cautions that all available evidence and the consequences of all alternatives must be known. At the birth of this infant available evidence would indicate that aggressive treatment is the best alternative. This is true because many premature infants in distress at birth can make a complete recovery with proper care. An Apgar score of one is recorded at birth in the above case. An Apgar score is a rating from one to ten based on the newly born infant's "physical condition by evaluating his heart rate, respiratory effort, reflex irritability and skin color."[131] A score of one is the poorest score given. Nevertheless, aggressive treatment is indicated on the premature infant. There is still a significant chance that

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[131]Sister Agnes Clare Frenay, Understanding Medical Terminology (St. Louis: Catholic Hospital Association, 1973), p. 210.

this child can have a happy future.

By ten days of age, in this particular case, the initial decision for treatment needs to be reevaluated. More evidence has been gathered, the situation has changed and a further decision is called for. In accord with the utilitarian principle, alternatives and consequences should again be weighed. It is now time for the parents, with the advice of their chosen support system of clergy, relatives and friends, and the nursery staff to sit down, discuss, and carefully consider the alternatives. The physicians must determine to the best of their ability if the cerebral hemorrhages already sustained have caused brain damage, and if so, to what extent. The parents need to be advised of the probability of damage. They also need to know the probabilities of continued hydrocephalus and of respirator dependence along with the complications this entails. At this point the parents may feel that they cannot cope with such a severely defective infant in their home. On the other hand, mental retardation and some lung impairment may not deter these parents from a desire for aggressive treatment for their infant.

In order to guarantee that parents do freely offer their insights, physicians presenting an infant's diagnosis to its parents, must be very careful to not unduly influence the parents to decide in accord with the physicians' wishes. It is almost impossible not to bias the presentation toward the course of treatment or non-treatment that the physicians see as favored. Because this is true, it may be better for the physicians to abandon the attempt for a completely neutral presentation, identify their bias, and honestly assure the

parents that if they desire an opposing course of treatment, the physicians will abide by their choice. This means that if the parents want continued treatment when the physicians think it is time to give up, the physicians should be willing to continue treatment. One exception to this would be if the case is truly hopeless (e.g., a brain dead child on a respirator) and the parents refuse to face reality. In such a case the parents can be given some time, under the care and consultation of the infant's physicians, to come to understand the hopelessness of the situation. If they cannot, the physician may have to go ahead and discontinue care for the sake of the infant and the medical facilities it is using without benefit. If, on the other hand, the parents are too eager to refuse treatment on an infant, who with treatment could make a satisfactory recovery (e.g., the infant with cleft palate), the physicians may have to override the parents' wishes and treat the infant.

It may seem that the above discussion is advocating parental control with one hand and taking it away with the other. In a sense this is true, but only for the reason that the primary concern must always be the infant. The infant's future happiness or suffering will be the most direct and significant consequence of any decision. When parents and physicians share responsibility in decision making, there is a check and balance system set up whereby the interests of the infant are protected. In general, parents should have the last say on their infant's treatment. They have the best reason of natural love and concern to look out for its welfare. But physicians provide a check for completely unreasonable parents. The physician must not abuse

this power, but use it only in extreme cases. The infant has the most at stake, therefore, his likelihood of present and future happiness or suffering must carry the most weight. Second to the infant, the parents' happiness is most affected. Therefore, their input to the decision making process should not be easily superceded by the physician. When it must be, the physician should make every effort to bring the parents around to a reasonable point of view. Their happiness is protected by the physician who makes a concerted effort to have them fully understand their infant's prognosis.

At ten days of age, then, the premature infant with respiratory distress syndrome and probable brain damage has a dim outlook for future happiness. At this point, however, there may be some hope that the brain damage is minimal. There is also some chance that this infant will be able to recover lung capacity and breathe on his own. Depending on a careful medical diagnosis and the parents' reaction, treatment might be continued and the heart surgery performed.

At four months of age continued treatment could again be re-evaluated. By this time it is known that the hydrocephalus is continuing to worsen. This indicates certain brain damage. The infant is blind. The heart surgery has failed to facilitate his being weaned from the respirator. Severe chronic lung disease has been confirmed. Although the case study does not give this information, it can be assumed that the financial and emotional toll on the parents has been great. Marital difficulties and sibling problems may have arisen. After four months, the nursery staff is also undoubtedly very attached to this child and upset by his suffering. One need only spend some

time in an Intensive Care Nursery to note with what high hopes an infant is weaned off of a mechanical ventilator and the great sorrow and disappointment the staff feel when he must be placed back on the respirator. The case study again does not indicate but it can be assumed that the infant himself is in some pain and discomfort.

It seems quite clear at this point that suffering will be minimized for all concerned if the infant is allowed to die. This could be done by the act of removing the infant from the respirator and letting nature take its course or the staff could fail to resuscitate the infant at its next respiratory and cardiac arrest. If the infant is removed from the respirator and other mechanical monitors, the parents may want to be present to hold the infant and say their final goodbyes. Some parents find this a very rewarding experience. Contact with the infant in his four months of life may have been minimal and hampered by tubes and connections. It may also be important to the parents to witness the child's death in order to grieve his passing. The nurse or nurses charged with his primary care may also want to be present.

Ethical decision making in this case, then, centers around continued reappraisal of alternatives as the situation changes and more data are gathered. Parents are kept informed by physicians and in turn inform the physicians about their assessment of their welfare and their child's future welfare. When the infant's hope for any significant happiness is outweighed by a great probability for much suffering, it is time to seriously consider withdrawal of treatment.

Multiple Anomalies

The next case is one that I observed while spending a six week clinical practicum at an Intensive Care Nursery associated with a large Eastern University.[132] In contrast to the above case, the infant did not need extensive medical attention at birth. Consequently, time was taken to discuss fully the case with the family before any course of treatment was instituted.

> Baby J was born the third infant of young, middle class parents. It had multiple anomalies. These included a large sack on the lower back, a paralyzed, withered arm and leg, a lopsided tongue, intestinal problems, no anus, no urinary outlet, and no discernible genitalia. In addition there were probable heart, lung, and brain complications, not yet diagnosed. The baby was transferred soon after birth to the Intensive Care Nursery in another city. The baby was intubated and was frequently suctioned for respiratory congestion. The day after the baby's birth, the pediatric surgeon along with several of the nursery staff presented the infant's case to its father and maternal grandfather. It was recommended that nothing be done since treatment would involve a series of assaultive surgeries with no hope for a near normal child. It was learned that the mother of this infant felt certain from the second month of pregnancy that the fetus was defective in some way. The case was again presented that evening to both parents and to both maternal grandparents. The parents were encouraged to speak at length about their concerns and their wishes. The physician again recommended that nothing be done but assured the parents that aggressive treatment would be instituted if that was their desire. The decision was made to withhold treatment from the infant. The intubation was withdrawn and suctioning was ceased. The baby was kept comfortable on pain medication and was frequently held and rocked by the nursing staff. The parents, siblings and relatives visited each day. On the fifth day of life the infant died in its mother's arms, with the father and primary nurse present.

One often hears that medical decision making is done under crisis

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[132]As is customary in reporting case studies of this nature, the case studies used in this dissertation are altered in unessential aspects so as to respect the confidentiality of persons involved.

circumstances with little time for careful reflection. In this case, as in many others, the infant was stabilized while decisions were carefully thought out. Time was made available. In other cases, like the first considered here, this cannot be done. Over-generalizations that all medical decision making must be made very rapidly should be avoided.

Another widespread opinion is that parents are incapable of assimilating a physician's explanation so soon after suffering the grief of giving birth to a defective newborn. This was not my experience. Nor is it the experience of Drs. Duff and Campbell as quoted earlier in this chapter. Dr. Anthony Shaw, referred to above, is of the same opinion. Parents do grieve, but at the same time they can dry their tears and make well-thought-through decisions. Sympathetic physicians and staff can facilitate this process. Physicians must guard against assuming that parents cannot participate in decision making, or that they will simply go along with the physician's advice. Parents often do agree with the physicians but this can be because they honestly agree. I have seen parents reject a physician's advice. It is difficult for parents to overrule a physician (especially a dogmatic, paternalistic physician), but given good will on both sides, it is not impossible.

In this case the infant's prognosis for a happy life is very poor. Many months would initially be spent in the hospital with frequent readmissions for further surgery and therapy. The child would certainly have severe physical handicaps along with probable mental handicaps. Children who become constant candidates for surgery

have been known to grow to adolescence thinking of themselves as defects kept alive to insure patients for "specialists and trainees."[133]

Along with this poor prognosis for the infant goes a dim outlook for the infant's family. Family resources would have to be diverted from the care and education of this couple's first two children and given to multiple physicians and hospitals for probable life-long therapy for this third child. In addition the mother in this case has already suffered months of mental agony while carrying this child. It is not uncommon that a mother senses the ill condition of the fetus she carries. This mother's intuitions were strong. She knew the child would be defective. She suffered with this information and with the guilt she felt for rejecting the fetus she carried. This grief and guilt had caused family problems during the pregnancy. It is more than probable that bringing the infant into the home would aggravate these problems. Studies have shown that a defective child in the home frequently causes marital and family problems.[134]

The alternatives, then, are aggressive treatment, partial treatment, and no treatment. Aggressive treatment would result in a

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[133]Joel Herskowitz and Alan N. Marks, "The Spina Bifida Patient as a Person," Developmental Medicine and Child Neurology, 19 (1977), 413-417.

[134]Many nurses and physicians working in newborn centers are of this opinion. See also: S. Olshansky, "Chronic sorrow: A Response to Having a Mentally Defective Child," Social Casework, 43 (1962), 190-193; G. M. Hunt, "Implication of the Treatment of Myelomeningocele for the Child and His Family," The Lancet, 8 Dec. 1973, pp. 1308-1310. For an opposing viewpoint see Rosalyn Benjamin Darling, "Parents, Doctors, and Values in Conflict," The Hastings Center Report, 7, No. 4 (1977), 10-13.

suffering infant and a suffering family as described above. Partial treatment might involve a continuance of the suctioning for respiratory congestion and also some surgery so that the infant could assimilate and eliminate food. As was pointed out by physicians in the first section of this chapter, such partial treatment is cruel. It allows the infant to survive for a longer period of time while yet not giving it every chance for optimal functioning. The alternative of non-treatment appears to minimize suffering. The infant will be spared a life of pain. The parents and family will grieve, but with the infant's death, life can begin to return to normality.

One other option is not open to the family and physicians. This is active euthanasia, for example, by injection of a lethal substance into the infant. This is not, now, legal. Ethically, however, it would be the alternative with least pain in those cases when the child is likely to linger for a long time and suffer great pain. In the case above, any pain was easily sedated, the child could not live long, and the parents and family used the five days he lived to good advantage. They visited him, held him, discussed his case and their decision with the physicians, explained the situation fully to the young siblings, and generally came to terms with the tragedy they were suffering.

Genetic Skin Disease

The following case is another which I personally observed. I first saw this infant when he was five months of age. At one year of age there was little change in his condition.

> This baby boy was born with a rare genetic skin disease called dystropic epidermolysis bullosa of the recessive form. This is a very serious life-limiting disease. Such children rarely live past five years of age. "Repeated episodes of blistering, infection and scar formation lead to severe deformities, loss of hair, buccal mucosal scarring, dysphagia, and retarded physical and sexual development . . . toe and finger lesions heal with fusions of digits and loss of nails."[135] Little is known about successful treatment for this disease. The baby was put on high doses of steroids. Antibiotics were used against possible infection. Demaril was given for pain. The baby gave the appearance of a burn patient with open blisters over much of his body. Throughout the daily bath and dressing change and in spite of the demaril, the baby screamed with pain and/or anticipation of pain. He was alert and had normal mental development for his age. However, he was distrustful of humans, appearing to anticipate pain when held. By four months of age he was receiving only nursing care in the intensive care nursery. His parents took him home at this point where with the aid of visiting nurses, he can be adequately cared for. The parents wavered between wanting to do everything possible, hoping for a miracle, and feeling that death would be a welcome relief because of the baby's apparent severe pain. The stress of having the baby in the home was exhausting the mother and causing behavioral problems in siblings.

This case is a very sad one for all concerned. It would appear that the alternative which causes least pain would be the death of this child. However, withholding treatment would not cause this child's immediate death as it did in the first two cases considered here. In the first case simply removing the respirator or failing to resuscitate would cause the infant to die with little pain. In the second case the baby could not live long, since it could not adequately assimilate food without surgery. In this case, the infant could survive with ordinary means of feeding and care. Antibiotics could be withdrawn, eventually allowing death by a massive infection of the

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[135]Behrman, p. 591.

child's open sores. This might take time and would certainly involve more pain for the already suffering infant.

Active euthanasia, besides being illegal, would have been painful to the parents of the baby and against their strongly held beliefs. The parents are willing to experience a disruption of family life to care for the infant. They are acutely aware of their own and their other children's distress. Financial concerns also weigh heavily on the parents, especially the father. Insurance covered much of the expense but this still left considerable costs to the parents. Being fairly affluent, avenues of public financial aid were closed to these parents. Yet, there was a mortgage payment to be met and myriad ordinary living expenses of maintaining a home and supporting a wife and children.

It is in this sort of case that the ethicist must be careful of defining for another what ought to constitute their happiness. The parents must be the ones to decide what considerations have become an inseparable part of their happiness. These parents had a strong religious faith and freely chose to accept the burden of a defective child in their home. With the physicians and social worker, they explored the possibility of institutional care. It was decided that they would hold this as a future option if home care became impossible. In the meantime they considered the financial and emotional stresses caused by their youngest child to be outweighed by the satisfaction they found in giving the best possible care to a child sent to them by God. They interacted with their son and clearly loved him. The baby was faring better in the home environment than he had in the

hospital. He appeared more alert and content, although his physical suffering continued.

In another case of this sort a family might base its decision on a feeling of guilt caused by the thought of not doing everything possible for their child. Or, to phrase it another way, a family in this situation might feel it is their duty to keep the child alive if at all possible. Decision making on the basis of balancing duties is not according to the act utilitarian principle advocated here. The parents in this case can be seen to have many duties--to themselves, to each other and their marriage, to their older children, and to their newborn. If it is true that nurturing this newborn conflicts with their duties to each other and their older children, then a balancing of duties, hoping for a clear intuition, is needed to decide a right act in a formalist theory of ethics. Considering alternatives and measuring consequences seem to be a clearer basis for decision making in a case of this sort. There are still uncertainties. The infant's long range prognosis is not certain. The siblings and the parents' long range adjustment to any alternative cannot be known completely. Given the direction offered by the act utilitarian principle, however, an attempt to collect these sort of data can be made.

This type of case reinforces the act utilitarian insight that each case must be handled individually. No rules covering all cases of a certain type can be made. In another case the parents may have found the burden overwhelming. Then, active euthanasia would have been a clear ethical alternative. Here, the alternative of least pain and greatest happiness, in terms of quality and quantity, appears to

be nurturing the infant in the home. Pain medication for the infant is a necessity along with all possible effort to reduce the number and severity of blistering episodes.

Down's Syndrome

The final case study to be considered is an infant with Down's Syndrome complicated by duodenal atresia. The case study is taken from an article written by Dr. Anthony Shaw. Treatment of Down's Syndrome with duodenal atresia is a controversial issue in medical ethical literature, partly due to a celebrated case at Johns Hopkins Hospital in which an infant was denied surgery. The physicians wanted to perform the surgery but since the parents objected, they did not get a court order to force the issue. The baby died by starvation and dehydration after fifteen days. The lingering death severely demoralized the nursery staff. The case raised a national storm of controversy. A documentary film was made of this case and it was widely publicized. The following case study is brief but gives a picture of the typical case of this sort.

> Baby B was referred at the age of 36 hours with duodenal obstruction and signs of Down's syndrome. His young parents had a 10-year-old daughter, and he was the son they had been trying to have for 10 years; yet, when they were approached with operative consent, they hesitated. They wanted to know beyond any doubt whether the baby had Down's syndrome. If so, they wanted time to consider whether or not to permit the surgery to be done. Within 8 hours a geneticist was able to identify cells containing 47 chromosomes in a bone-marrow sample. Over the next 3 days the infant's gastro-intestinal tract was decompressed with a nasogastric tube, and he was supported with intravenous fluids while the parents consulted with their ministers, with family physicians in their home community and with our geneticists. At the end of that time the B's decided not to permit surgery.

> The infant died 3 days later after withdrawal of supportive therapy.[136]

The main reason why this sort of case appears especially difficult for the utilitarian is because a Down's Syndrome child seems to be quite capable of a happy life. Although their mental retardation is significant--an I.Q. of between 25 and 50 is usual--physical handicaps are minimal. The Down's Syndrome child who is surrounded by loving support is often an alert and unusually affectionate child. With training they can care for themselves and perform simple work tasks. They ordinarily do require custodial care, not being able to compete in the work market. Again, one must be careful of assuming that since the retarded child cannot experience the same degree of happiness as that of the normal child that no significant happiness is possible. Considering the happiness of the parents, however, it is true that many parents are unable to cope with such a retarded child in the home.

It would seem at first consideration that the parents' happiness and the child's happiness are opposed with one having to be sacrificed for the other. The utilitarian ethical system, however, advocates considering all alternatives. An alternative which deserves careful consideration in these cases is placement of the child in a private or state institution. Although a home environment is better for the child, this alternative is a compromise that maximizes happiness when the parents judge that they cannot cope with the child at home.

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[136]Shaw, p. 886.

The parents need not feel that their only choice is between a retarded child in their home or an early death for their child.[137] Since the child's interests should be primary in medical ethical decision making and the Down's Syndrome child is capable of a happy life, it is unfair for the parents to refuse surgery simply because they cannot assume the burden of his care. A primary consideration, however, must be the quality of institutional care that is available to the child. A private facility may be beyond the means of many parents. Public institutions may vary greatly in quality from state to state. If the only available institution provides poor quality of care, this greatly diminishes the probability of a happy life for the Down's Syndrome child.

The best alternative for the Down's Syndrome child with duodenal atresia would appear to be performing the surgery. If the parents cannot cope with the child, it can be institutionalized. In cases where the Down's child has additional serious handicaps, another decision may be appropriate. If the quality of institutional care is poor, this also changes the outlook. Once again no general rule can be made covering all cases of Down's Syndrome. In a particular case, the prospect of having a child in a public institution may be so distressing to parents that this parental agony would have to be weighed against the happiness the child is able to experience.

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[137]For a thorough discussion in favor of the alternative of parents giving up custody rather than refusing treatment see Norman Fost, "Proxy Consent for Seriously Ill Newborns," in No Rush to Judgment, ed. David H. Smith (Indiana: The Poynter Center, 1977), pp. 1-7.

Judging just what degree of happiness a retarded child is able to experience is a serious problem in itself. The Down's Syndrome child does indeed provide a difficult case for medical ethical decision making.

III. CONCLUDING REMARKS

It can be seen in the above application of the act utilitarian ethical system to four actual case studies that this theory of decision making does give direction for thought and can arrive at acceptable answers to difficult questions. As can be expected, this ethical system relies heavily on the collection of appropriate data. Adequate medical, family, and social information must be gathered. When medicine is at a loss to provide certain information, decision making can still proceed. Here decisions can be improved as time goes on and medical research provides more data. By concentrating on weighing alternatives and consequences, vague phrases like "doing one's duty" can be clarified. Parents are often concerned that they do "the right thing by their child" or fulfill their "parental duty." When it is explained that right and duty ought to be considered in terms of maximizing happiness and/or minimizing pain, decision making is facilitated.

In my experience with parents, nurses and the staff of an intensive care nursery, the ethic of maximizing happiness was accepted as a proper and natural method of decision making. When parents expressed a desire to do the right thing they almost always meant that course which would cause least pain to their newborn child and to their already established family. Families varied, however, in how

much pain they thought appropriate to bear. If one were to measure happiness and suffering in some sort of objective, quantifiable terms, it would appear that the infant with the rare genetic skin disease, for example, should be helped to a merciful death. However, the theory of the good espoused here allows for a more complex view of what constitutes happiness. When happiness, in an individual case, cannot be contemplated apart from fidelity to strong religious and personal beliefs, this higher quality of happiness outweighs freedom from physical, financial and emotional burdens. It is because happiness is not a uniform, objective entity that those whose happiness is most at stake must be directly involved in decision making. In the case of the defective newborn, the individual whose interest is primary cannot participate in decision making. This is why physicians and parents serve to safeguard the infant's interests.

Utilitarian decision making as seen in the above four cases results in a way of life that shows loving concern for all individuals. Time is taken for careful decision making. Decisions are reviewed as situations change and more data are gathered. A support system is fostered to aid parents during a stressful period of their lives. Infants are nurtured while there is hope for significant happiness and lovingly supported when death is considered the best alternative. This description appears to be a way of life that rational persons would want to see effected. The final court of appeal would be the reaction of thoughtful, informed persons after this ethical system of decision making became common in medicine.

CHAPTER V

CONCLUSION

The normative ethical theory of act utilitarianism combined with a qualitative hedonistic theory of intrinsic good has now been presented, defended, and applied to the test case of neonatal intensive care. In this chapter I will return to a discussion of some of the basic principles of ethical decision making in medicine. As stated in the Introduction, medicine today is in need of practicable ethical guidelines. The objective of this dissertation is to provide such guidelines through the development and defense of a philosophically viable normative ethics appropriate for medical decision making. We must now determine if this task has been adequately accomplished.

I will first discuss the nature of decision making, and, in particular, ethical decision making. The applicability of act utilitarian decision making to medicine will then be reassessed. This ethical system was applied here mainly to the difficulties encountered in an Intensive Care Nursery. The ethical dimensions of neonatal medicine are not significantly different from similar value questions in other areas of medicine. However some dissimilarities exist; one important difference is that in many other areas of medicine, the patient himself can have a voice in decision making about his care. I will discuss the similarities and differences between neonatal intensive care and other problem areas in medicine. I will argue that act utilitarianism is not limited in its applicability to

neonatal difficulties but can easily be applied to all areas of medical ethical decision making. Finally, the differences between decision making in individual cases, to which discussion here has been limited, and decision making on a broader social scale will be briefly discussed. I maintain that with some revision the argumentation given in this dissertation will support the applicability of the act utilitarian principle to social scale decision making as well as decision making concerning the individual patient.

I. ETHICAL DECISION MAKING

Decision making presupposes a number of elements. First among these is that the agent be faced with a number of alternatives, even if these are merely the choice between doing an act and doing nothing. Where there are no alternatives, there is no need for a decision. When there is only one means of transportation to a certain destination, one need not decide which way to travel. When an infant is born without kidneys, one need not decide if he should be kept alive. He cannot be kept alive; death is imminent and inevitable.

When true alternatives are available, a method of decision making must be adopted. Random choice might not be considered a <u>method</u> of decision making, but even here, where choices appear random, there is often some subconscious method employed such that the decision is not truly random. However, the best means of decision making is one which has a rational basis. A general description of rational decision making includes the following elements: (1) Clarifying the problem; (2) Clearly defining the objectives; (3) Identifying

the alternatives; (4) Gathering the relevant data; (5) Weighing and judging the alternatives; and (6) Choosing one of these alternatives. Step number five would include such considerations as cost effectiveness, side effects of alternatives, and the availability of resources. This general description of decision making would apply to myriad situations ranging in importance from the allocation of national revenue to the planning of a vacation. An American sight-seer who arrives at Heathrow Airport needs to decide how best to see the British Isles. One of his objectives may be to see the Scottish Highlands. Alternative means of transportation are the train system, car rental, or a guided tour. He stops at the travel information booth to gather the necessary data on these alternatives. He then determines which alternative he can best afford, which will allow him to see the most, which means of travel provides the most comfortable accommodations, and so forth. He then chooses that alternative which best meets his objective.

Ethical decision making differs from the above description in at least one important aspect. In a decision having ethical dimensions, after all data are weighed for each alternative, there remains the problem of determining the ethical value of each alternative. The agent must still determine which alternative he <u>ought</u> to choose, which is the <u>right</u> alternative. Collecting more empirical data cannot in itself answer this question. In deciding to take a train or a car to the Scottish Highlands, collecting enough data will likely decide the issue. At least this is not necessarily an ethical value question, although values are involved and it could have ethical implications.

But in deciding whether to steal the train fare or borrow money from a credit union, more than empirical data is needed. One must make a value judgment about these two alternatives. A principle of right action must be adopted to note that one ought not steal. Ethical decision making, then, involves value judgments which can be stated in the form "In situation A, person B ought to do C."

The treatment of a child born with a high lesion meningomyelocele necessitates ethical decision making. One might assume that the objective would be to do the best thing possible for all persons involved. Alternatives are aggressive treatment for all defects and complications, partial treatment, no treatment, and active euthanasia. Relevant data include the prognosis for the child under each alternative, the outcome of other cases of this sort, and the family situation. Having all these data, however, does not automatically lead to the choice of an alternative. One must know what value is placed on continued life and on a life of severely diminished capacities. How should we interpret "the best thing possible"? The decision cannot be made rationally outside of a framework of what is good and/or what is right.

The ethical framework advocated in this dissertation is that decisions ought to maximize happiness for all parties involved. The good is considered to be happiness and pleasure, considered in both quantity and quality. The right is that which maximizes the good. This ethical framework is claimed, here, to facilitate medical ethical decision making.

II. VALUE OF ACT UTILITARIAN SYSTEM FOR DECISION MAKING

The act utilitarian principle which is defended in this dissertation was given in Chapter II. It states:

> An act is right if and only if, of the alternatives open to the agent and on the available evidence, it produces, for all those affected by the act, at least as much good and/or avoids at least as much evil as any other alternative, where good and evil are understood in terms of the qualitative hedonistic theory of intrinsic good.

Within this principle is a method of decision making. Like decision making in general, it advocates gathering all available data and weighing alternatives. In addition to this, it contains a means of determining the right and the good. Thus, it contains everything necessary for ethical decision making. Once empirical data are gathered concerning each alternative, alternatives can be weighed according to their ethical value. In the case sketched above, we can now determine what is meant by the best thing possible for the child with a high lesion meningomyelocele. The best is that which leads to a life of happiness, or if this is not possible, one that minimizes pain for all parties. If a life without significant higher and lower quality pain is impossible, the best thing may be death for the child. The right alternative can now be chosen given this framework of what is good.

With the act utilitarian principle, medical ethical decision making is facilitated by a clear, well formulated framework of ethical value. It can still be asked if this is the proper or best means of justifying first principles. A discussion of this topic was given at the end of Chapter I, in which it was claimed that an ethical principle

is vindicated by judging the way of life which results when the principle is freely chosen and life is ordered according to it. The best means of justifying the act utilitarian principle for medicine would be to have physicians, health care professionals, patients, and other concerned parties actually accept this principle, make decisions according to it, and then have these same people judge whether or not the resulting way of life promotes what these individuals judge to be their highest good. Since we cannot easily effect this, the only means left is, in imagination, to project the acceptance of this principle and examine the results. This was done in Chapter IV by projecting act utilitarian decision making onto neonatal medicine.

The result of act utilitarian medical ethical decision making can be seen in the four case studies discussed in Chapter IV. Fully informed patients and/or guardians are advocated. Supportive measures for patients and loved ones during and after the decision making process are judged to be vital. The interests of the patient, whose happiness is most at stake, are considered of primary importance. Happiness, or total well being, is judged to be of more value than continued biological life when this life is one of suffering. The personal and religious values of individuals are to be carefully considered when weighing alternative means of medical treatment. Final decisions are allowed to vary widely from case to case depending on the circumstances of each case.

Given this resulting way of life, it must be left up to the reader to judge if this is a way of life that he would like to see effected within medicine. This does not mean that the final decision

about an ethical principle is left to personal preference, one principle being as good as another. By claiming that each person must justify the way of life which follows from decision making according to the act utilitarian principle, I simply mean that for an ultimate principle to be vindicated to an individual, he must freely accept it, live according to it, and then judge for himself. If a further question is asked concerning which way of life, upon reflection, can be called a justified one, then an appeal must be made to what constitutes a rational choice. Paul Taylor's description of a rational choice given at the end of Chapter I is a complete and workable definition. A choice is rational if it is free, enlightened and impartial. This is an ideal. It is not claimed that persons actually make choices in this manner, but, rather, that for a choice to be completely rational, these criteria would have to be met.

If we are to judge then whether or not the act utilitarian principle is justified as an ethical system for decision making in medicine, we would have to approximate the conditions of a rational choice and then judge if the resulting way of life is preferable to other ways of life resulting from contrasting ethical principles. About such a process, Taylor states:

> Although we can never be certain whether one way of life is rationally preferable to another, we can reach a probable knowledge of this in the following way. We can say that, to the extent that choices become more and more rational and to the extent that more and more people who make such choices tend to prefer a way of life A to a way of life B, then to that extent it is reasonable for anyone to accept A as preferable to B. Such acceptance must remain tentative only. It must be open to revision in the light of further choices under conditions which more closely approximate

> those of an ideal rational choice. But it provides the best available way of knowing whether A really is preferable to B.[138]

I believe that the evidence provided in this dissertation indicates that the way of life which follows from an application of the act utilitarian theory of right acts combined with a qualitative hedonistic theory of intrinsic good is one which free, enlightened and impartial persons would choose. A full justification of this ethical system would rest on a complete comparison of the "way of life" consequences of all competing ethical theories. Such a comparison is beyond the scope of this dissertation. What is given in this dissertation is a presentation and defense of act utilitarianism and qualitative hedonism as leading to a rational decision making system for medicine.

III. APPLICABILITY OF THE ACT UTILITARIAN SYSTEM BEYOND NEONATAL MEDICINE

Although case studies in Chapter IV were drawn from the area of neonatal medicine, it has been maintained throughout the dissertation that the act utilitarian system of ethical decision making can easily be applied to all fields of medicine. The medical ethical problems that arise in neonatal medicine are similar to many medical ethical dilemmas. Questions of withholding or withdrawing available medical treatment must be faced in both neonatal care and care of the terminally ill, adult patient. A terminally ill patient may be able to communicate his desires about treatment. When this is true,

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[138]Taylor, p. 174.

decision making is easier than in the defective newborn case. In the vast majority of cases the conscious, adult, terminal patient can decide for himself about the desired extent of medical treatment. When an adult terminal patient slips into a coma, decision making more closely resembles that in the newborn case. However, with an adult patient we have some idea of what the patient would have wanted if he could only tell us. Close family members and friends will know the patient's value system. In this way the patient's desires can be represented in the decision making process. Decisions can still be made in all of these cases, as in our sample four case studies, by weighing alternatives and maximizing happiness and/or minimizing pain.

Not all medical ethical problems are of this continued life vs. earlier death type of dilemma. Decision making can also be facilitated by acceptance of the act utilitarian principle in other types of medical ethical problems. A few examples can be given here. Frequently pediatricians are asked to prescribe antibiotics for viral infections. Antibiotics will do no good for the child but will relieve the mind of the insistent parent. The act utilitarian principle, in this situation, advocates that the physician fully inform the parent that an antibiotic does not help counteract a viral infection, that the child might be allergic to it, that he might build up antibodies to the drug, and any other relevant information. Then, if the parent still insists and the child is not allergic to the antibiotic, the physician could go ahead and give the prescription. It will do little harm, and the parent's mind is set at ease.

There are much discussed cases of refusal of blood transfusions

on the basis of religious belief. Here the act utilitarian would judge that if an individual truly believes that he will be damned to hell if he accepts the blood transfusion, understands that refusal means death, and chooses the latter, this is maximizing higher quality pleasure for that patient. There may, however, be extenuating circumstances. The happiness of all concerned needs to be considered. If the refusing adult is the only responsible parent for a number of small children, it might be that the right act is to keep the parent alive. There have been cases where this dilemma is solved by the physician taking responsibility for the decision to give a blood transfusion. This can be done when the religious patient confides that he wants to live but does not want the decision for the blood transfusion to be his own. Happiness is served since the patient observes the letter, if not the spirit, of his religious belief and also enjoys continued life.

Many ethical problems are not of this individual case type of decision making. Certain medical ethical decision making is done on a social scale without taking specified individuals into consideration. This area of concern includes permitting innovative experimentation like DNA or cloning research, allocating the national health dollar and thereby health resources, and instituting mass genetic screening procedures. Decision making on this level can still be done according to the act utilitarian principle. Consequences and alternatives can be assessed with the goal of maximizing the net general happiness. Relevant data here might be a public opinion poll of attitudes and perceived needs. Some work needs to be done in refining the act

utilitarian principle to allow an application to this type of decision making. There is some evidence,[139] however, that act utilitarianism, since it does not adhere to set rules, could, more easily than rule utilitarianism, be adapted to decision making on a wider, social scale. Resources could be allocated or DNA research permitted, while a critical eye was kept on consequences and public reaction. As situations change the act utilitarian principle would advocate reassessment and a new decision.

I have concentrated in this dissertation on the type of medical ethical decision making that is done concerning one, identifiable patient. Decision making techniques would be slightly different when considering societal problems. Consideration would have to be given to who could best make these types of decisions. Perhaps an elected or appointed board of informed citizens would be needed. Further consideration concerning justice would be appropriate. John Rawls' work on social institutions and distribution of good would be a helpful study for this purpose. Another important consideration would be how societal decisions would relate to freedom for decision making on the individual case level. Freedom from excessive interference in patient/doctor decisions would be consistent with the arguments presented in this dissertation. Additional work is needed, but the act utilitarian principle could be made applicable to medical ethical problems on a broader, social scale.

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[139]See Duncan MacRae, Jr., "Utilitarian Ethics and Social Change," Ethics, 78 (1968), 188-198.

A motivating force behind the development of this dissertation was the quotation from Daniel Callahan given in the Introduction. I repeat that quotation--

> . . . it has become absolutely urgent that the search for a philosophically viable normative ethic, which can presuppose some commonly shared principles, go forward with all haste. Short of finding that, I do not see how ethical methodologies can be developed which will include methods for reaching quick and viable solutions in specific cases. Instead, we are likely to get only what we now have, a lot of very broad and general thinking, full of vagrant insights, but on the whole of limited use to the practicing physician and scientist.[140]

I believe that the act utilitarian theory of right acts combined with a qualitative hedonistic theory of intrinsic good is the philosophically viable, normative ethical system which medical ethics needs. This dissertation goes far beyond offering vagrant insights. I have not been afraid to take a stand on specific cases and offer definitive answers. This ethical theory is applicable to medical ethical problems and acceptable to health care professionals and patients alike. It is based on commonly shared principles of respect for human dignity, desire for happiness, and promotion of the well being of all persons.

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[140]Callahan, p. 72.

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VITA

Bonnie Dreps Voigtlander was born in Sheboygan, Wisconsin, on July 5, 1945. She graduated from St. Mary's Academy, Milwaukee, Wisconsin in 1963. After attending Cardinal Stritch College in Milwaukee for three years, she transferred to the University of Wisconsin, Madison campus, where she was awarded a Bachelor of Arts degree in Philosophy on September 10, 1971, under her maiden name, Bonnie Mae Dreps.

She entered the Graduate School of The University of Tennessee, Knoxville, in September 1972 and received the Master of Arts degree with a major in Philosophy in June 1974.

In her Ph.D. studies, Ms. Voigtlander entered The University of Tennessee's medical ethics concentration within the Philosophy Department. She served a four-month clinical practicum at The University of Tennessee Center for the Health Sciences in Memphis from July 1976 through November 1976. In the fall of 1977 she served a second six-week clinical practicum under Dr. Raymond Duff at the Yale-New Haven Critical Care Nursery in New Haven, Connecticut.

Ms. Voigtlander was awarded the Ph.D. in December of 1978. She accepted a post-doctoral appointment at the University of Florida Medical Center in Gainesville, Florida.

Bonnie Dreps Voigtlander is married to Clyde William Voigtlander, an ecologist with the Tennessee Valley Authority in Norris, Tennessee.