Minding the gap between logic and intuition: an interpretative approach to ethical analysis

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In an attempt to be rational and objective, and, possibly, to avoid the charge of moral relativism, ethicists seek to categorise and characterise ethical dilemmas. This approach is intended to minimise the effect of the confusing individuality of the context within which ethically challenging problems exist. Despite and I argue partly as a result of this attempt to be rational and objective, even when the logic of the argument is accepted—for example, by healthcare professionals—those same professionals might well respond by stating that the conclusions are unacceptable to them. In this paper, I argue that an interpretative approach to ethical analysis, involving an examination of the ways in which ethical arguments are constructed and shared, can help ethicists to understand the origins of this gap between logic and intuition. I suggest that an argument will be persuasive either if the values underpinning the proposed argument accord with the reader's values and worldview, or if the argument succeeds in persuading the reader to alter these. A failure either to appreciate or to acknowledge those things that give meaning to the lives of all the interested parties will make this objective far harder, if not impossible, to achieve. If, as a consequence, the narratives ethicists use to make their arguments seem to be about people living in different circumstances, and faced with different choices and challenges, from those the readers or listeners consider important or have to face in their own lives, then the argument is unlikely to seem either relevant or applicable to those people. The conclusion offered by the ethicist will be, for that individual, counterintuitive. Abortion, euthanasia and cadaveric organ donation are used as examples to support my argument.

One answer might refer to universal values, including respect for human life, dignity, autonomy and justice. If, for the sake of argument, we accept the idea that universal values exist, it is still possible to identify situations in which these values will come into conflict or will be given different priorities by different people in different circumstances. In healthcare, for example, it could be that one person values life above all else and is willing to suffer any manner of treatments that offer the prospect of prolonging life. Another person, with a similar health status, might value above all else the ability to remain independent and self-caring. This person may prefer to decline further medical intervention at the stage at which it prolongs life but at the price of physical dependence on others, or might even wish to exercise autonomy by ending his or her life. In these circumstances, insider information will be required to determine what matters to each of these individuals. When ethicists construct arguments that try to take into account the effect of the alternative possible outcomes on the interested parties, they are acknowledging the importance of the values and priorities of the individuals concerned.

An argument will be persuasive if the values underpinning it accord with the reader's values and worldview or if it succeeds in persuading the reader to alter these. Although the second outcome might well be a reasonable one for an ethicist to pursue, a failure either to appreciate or to acknowledge those things that give meaning to the lives of all the interested parties will make this objective far harder, if not impossible, to achieve. In other words, if the narratives ethicists use to make their arguments seem to be about people living in different circumstances, and faced with different choices and challenges, from those the readers or listeners consider important or have to face in their own lives, then the argument is unlikely to seem relevant or applicable to those people. The conclusions of the argument, however well made, will be, for that individual, counterintuitive.

It could perhaps be argued that although it would be rewarding for ethicists to be able to persuade others of the validity of their arguments, a failure to do so does not in any way imply that normative importance should be accorded to intuitive feelings about what is morally acceptable or desirable. This is a point I am happy to concede. What I am, however, interested in examining is whether this gap between logic and intuition might, at least sometimes, indicate that the reasoned analysis undertaken by the ethicist might have inadvertently paid insufficient attention to one or more morally important factors.

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Listening to or reading another person's argument involves an act of interpretation, a search for meaning. By constructing and communicating an argument, the proponent hopes to signify to the listeners or readers what he or she considers of value. The listeners or readers must then undertake a cognitive process whereby they in turn construct meaningful realities for themselves. This intersubjective act of interpretation helps the listener or reader to understand the values underpinning the proposed argument. The intersubjective nature of the sharing of an ethical argument raises an immediate question in regard to the objectivity of ethical analysis: when ethicists talk about what objectively matters we need to ask, matters to whom?

As well as being able to reason for themselves, current and future doctors also need to be able to evaluate these third-party arguments. In addition, doctors are required to accept moral codes of conduct from society and from medical culture,^{1,2} as well as rules and obligations from their employers. In responding to and evaluating these various codes and rules, medical students and doctors must draw both on their powers of reason and on the values, experiences and influences that are specific to them and to their lives. Many or most of these values, experiences and influences predate entry to medical school. It is these values and ideas that inform the intuitive feelings individuals often have about ethically problematic issues. The challenge for ethicists is to engage the listener or reader in moral reasoning in a way that recognises and responds to their “intuitive” feelings about what is acceptable or desirable. This is not an inconsiderable task. For every well-argued analysis of an ethical dilemma, there will be at least one contradictory analysis offered by fellow ethicists and other interested parties. Even when the logic of the argument put forward by an ethicist is accepted, for example by healthcare professionals, those same professionals might well respond by stating that the conclusions are, despite the admittedly clever argument presented, unacceptable to them.

It is not only healthcare professionals who can find the conclusions of carefully reasoned ethical arguments counter-intuitive. Patients can also find that the explanations offered to them, whether by ethicists or clinicians, sit uncomfortably with their view of the world and they too sometimes fail to be convinced of the logic or wisdom of the course of action being suggested. According to Foucault,³ “[the] patient is only an external fact; the medical reading must take him into account only to place him in parentheses.” Foucault’s metaphor, in which patients are placed in parentheses, expresses his analysis of one of the ways in which doctors try to recognise and characterise patterns of illness and behaviour despite the confusing individuality of how people respond to and express ill health. In an attempt to be objective, doctors risk removing from the equation the individual factors that underlie the different ways in which people respond to ill health.

In an attempt to be rational and objective, and, possibly, in order to avoid the charge of moral relativism, ethicists also seek to categorise and characterise ethical dilemmas. This approach is intended to minimise the effect of the confusing individuality of the context within which ethically challenging problems exist: the backdrop for the real and practical problems faced by actual human individuals living rich and complicated lives. Foucault’s metaphor can be extended, by analogy, to argue that the patient, doctor and other interested parties can all too often be placed in parentheses by ethicists whose arguments place little value on the individual context within which patients exist, doctors practise and society makes decisions about advances in biotechnology and healthcare delivery.

I have qualified this penultimate sentence with the word “attempt”, mindful of Derrida’s claim that it is impossible for the reader, or the author, of a text to be outside of the text.⁴ If Derrida is correct then it must be equally impossible for ethicists to be outside of the arguments they make despite the efforts so rigorously and consciously made by many ethicists to be so. Even when ethicists actively attempt to place themselves and all their values, influences and prejudices in brackets, they will, as Derrida claims, fail.

Derrida described reading as the attempt to construct an intelligible reality from the variety of signs we receive about ourselves, others and the world around us. He argued that we do this to try to make sense of the world we live in, and of our place within that world. Reading involves an interpretation of these signs, and the way in which we interpret these signs will

depend on where we, as readers, stand within the text. As no two readers can occupy exactly the same place in the text, no two readings will be exactly the same. It is on the basis of these unique readings that individuals construct equally unique versions of themselves and the world that they inhabit.

As in medicine, this bracketing by the ethicist might of course serve a valuable role in allowing general arguments to be developed, and patterns to be recognised. But if these general arguments cannot be generally applied, because they fail to take account of matters of great importance to the individuals they are meant to guide, then an impasse might be swiftly reached. Useful as the device of bracketing can be, as Foucault makes clear, something important is lost in the process. In the case of doctors, this something is the person whose trust they must gain if advice is to be heeded and treatment adhered to. For the ethicists, this something is the person whom they wish to convince of the validity of their arguments.

What I have called the gap between logic and intuition is perhaps most easily exemplified by the debate between those who consider abortion morally permissible (often characterised and labelled as pro-choice) and those who consider abortion morally impermissible (often characterised and labelled as pro-life). Both these terms—pro-choice and pro-life—are implicitly positive labels declaring what the proponents are in favour of rather than what they might wish to prohibit. Indeed, it is difficult to imagine that those on either side of this debate would wish to declare themselves against, respectively, either choice or life. The use of these labels reinforces the already polarised stances of each side and invites opponents to condemn themselves by challenging either the concept of choice (equivalent in this case to the right to self-determination) or the idea that life is something of value. Rather than pursuing the argument either for or against these two opposing viewpoints, what I am interested in here is the consequences of reframing these two terms.

One, linguistically logical, counterpart to the term pro-choice is anti-choice, and that to pro-life is anti-life. Both these alternative framings are implicit in the more accepted framing of pro-choice and pro-life. The consequence of the premises and values that lead to the current framing—pro-choice versus pro-life—is an inevitable gap between logic and intuition. Those who argue against abortion (pro-life) usually begin from the premise that all human life, from conception, is intrinsically valuable and ought not to be destroyed. For them a life begins with conception, and the value they place on this human life is greater than the value they place on autonomy, in this case that of the pregnant woman. They are not anti-choice so much as “anti” the choice to end human life. Those who are pro-choice value personhood rather than humanness in itself. For them a person is a self-conscious being, aware of itself as existing over time and place. They therefore value life but consider the life of an embryo, for them devoid of personhood, to be of less value than the autonomy of a pregnant woman. So although those who are pro-choice and those who are pro-life seem to begin from the same premises—that the lives of people are of value and that it is good to respect the autonomy of people—this apparent agreement over the starting premises is illusory because the two sides mean something very different by the word person.

As I have discussed elsewhere,⁵ one way to understand the impasse that these opposing parties find themselves in is to examine the linguistic consequences of using biological discourse to make normative arguments. The use of language in biological discourse has been described as operational rather than substantive.⁶ Yet in the debate about abortion and stem cell research, an operational use of language, which could change as knowledge of embryonic development advances, is all too often used to make a normative point. At one end of the

spectrum the term “human individual” is a normative one, reflecting the belief that such an entity is morally valuable, whereas at the other end the term is merely a biological marker that does not confer moral recognition. The words used are the same but the values they carry with them are different. Put simply, as the two sides are talking different languages it should be no surprise if they do not understand each other.

End of life care, as currently practised, can also, sometimes, lead to a disquieting gap between professional attempts to care for patients and the unheeded call of some patients to die. Implicit in the ideological basis on which palliative care is currently provided are two assumptions that can contribute to this gap between logic and intuition: the first is the assumption that human beings value life above all else and the second is the assumption that there are no symptoms—physical, emotional or psychological—that, given enough skill and care from the palliative care team, cannot be ameliorated sufficiently to render ongoing life desirable. Consistent with this ethos is the assumption that a request by a patient to end his or her life, or an attempt to do so, should be interpreted not as an autonomous desire to die but instead as an indication that the healthcare provided has been inadequate to the patient’s needs. The patient’s request for death is deemed counter-intuitive by the medical system caring for him or her. In addition to the tension that exists when patients would rather die than carry on living, there can also exist tension between the personal values and beliefs of healthcare professionals and the system within which they work. In such a circumstance it is possible for the patient’s request to accord with the personal beliefs of the professional carers while being counterintuitive to the paradigm within which they have been trained and work.

In many ways this is a taboo subject in palliative medicine, and Cicely Saunders’⁷ opinion that a call for euthanasia is an indictment of the care being given is oft quoted in response. Undoubtedly, there will be cases in which more can be done to ease the suffering of distressed individuals and, as a consequence, people might well change their minds and want to live out what remains of their natural life span. However, there will remain cases where despite optimal symptom control and psychosocial support the patients remain steadfast in their wish to control the manner and time of their death. A recent legal case in the UK, brought by a woman in the terminal phase of motor neurone disease who wanted access to assisted suicide to be recognised as a human right, is an example of this.¹

Although death is clearly not viewed as a sign of failure in palliative care, it would seem that a call from the patient for help in dying often is. It is not my intention to discuss the case either for or against euthanasia. It is, however, important to consider the potential consequences of the over-simplistic equation of calls for euthanasia with failure of palliative care—a danger that the wishes of the person concerned would then be de-emphasised in the efforts of the team to “get it right” and “sort things out”. Some things cannot be sorted out, and no matter how disturbing and distressing and contrary to the values of the attending doctor, the wishes of the patient at this time deserve to be listened to and acknowledged. I am not of course suggesting that palliative care staff in some way wilfully mis-read or ignore the wishes of their patients. Instead I am suggesting that even though it might seem logical, from the perspective of the palliative care team, to equate a call for euthanasia with a failure of palliative care, this is an assumption that they should be prepared to have challenged.

¹Mrs Pretty had the degenerative disorder motor neurone disease. She sought a judicial review as to her husband’s legal position were he to help her commit suicide. The final judicial review, delivered by the House of Lords, ruled that such an intervention by Mr Pretty would be illegal and that he would be liable for criminal prosecution.⁸

One can only assume that the public support given by her general practitioner to the woman with motor neurone disease mentioned earlier was very important to her. I do not know what the personal views of that general practitioner on euthanasia are, but his support of Mrs Pretty’s right to have her views listened to is an example to us all.

Another type of gap between logic and intuition, which I have considered elsewhere, can occur when doctors or other healthcare professionals are expected to request permission for the use of the organs of a patient who is brainstem dead for transplantation into other patients unknown, either personally or professionally, to that doctor. Logically, the doctor in question might well see organ transplantation as something of value and wish to enable those in need of organs to receive them. In practice, some doctors find themselves emotionally ill equipped to make these requests. Under such circumstances it is perhaps unsurprising that asking grieving relatives for permission to use organs for transplantation can be both disturbing and counterintuitive. Failure to acknowledge this gap between logic and intuition will lead some people to avoid asking even if, logically, they know why they should. Importantly, the failure to ask will be a consequence of the emotional and psychological difficulties the healthcare professional encounters when faced with this particular duty and not, at least in most cases, because the argument in favour of asking has failed to convince the doctor that there is an ethical duty to do so. I have argued elsewhere that acknowledging this altruistic act, and thereby acknowledging the personal cost that asking can entail, might help more healthcare professionals to feel able to fulfil their duty to ask.⁸ The types of gap between logic and intuition that I am suggesting ethicists should be mindful of therefore include not only the gaps between what two opposing sides argue in a given case, such as abortion, but also the gaps that are exposed by the differences between what people are logically persuaded that they ought to do and what they in fact choose to do or express a desire to do.

So who, or what, must the ethicist understand to try to bridge the gap between logic and intuition? One answer to this question is offered by, among others, Alasdair MacIntyre. MacIntyre¹⁰ argues that people seek narrative order in their lives. He defines this as a human need for people to feel that the events in their lives, and the role they have, are consistent with the values they hold, the emotional commitments they have to others and the wider historical context or order of things. MacIntyre argues that this need for narrative coherence is an essential component of the search for meaning in life so characteristic of human beings. If MacIntyre is right then, in theory at least, a logical argument that makes sense within the narrative construct for the individual patient or doctor is more likely to make sense to that individual, to convince not just on an intellectual level but also on an intuitive one.

This line of argument is not of course unique to MacIntyre, or indeed to those philosophers traditionally associated with narrative approaches to medical ethics. Williams,¹¹ for example, argued that success in creating and delivering a system of morality that is truly impartial would come at a high price, with many factors people consider most important in their lives excluded from consideration. Williams argued that these excluded factors are the very things that often inspire individuals to take moral goals seriously. Although an impartial analysis of ethical concerns might require the removal or placing in parentheses of these individual factors, convincing people on an intuitive level of the validity of the conclusions so carefully reached would appear to require these individual factors to be added back in.

As I acknowledged at the beginning of this paper, just because someone has strong feelings about something does not mean that

normative importance should be accorded to their intuitive feelings about what is morally acceptable or desirable. Nevertheless, given that the gap between logic and intuition can considerably affect clinical behaviour and patient care, I believe it merits further attention from ethicists and clinicians alike.

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