
A case conference revisited: Commentary 1

Comments on an obstructed death

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Author's abstract

The paper comments on Scott Dunbar's An obstructed death and medical ethics, arguing contra Dunbar that we should not view truth-telling to the terminally ill as primarily governed by principles of veracity and respect for autonomy. All such rules are of limited value in medical ethics. We should instead turn to an ethics deriving from the centrality of moral relationships and virtues. A brief analysis of the connections between moral relationships and moral rules is offered. Such an ethics would lower the value that philosophical fashion places on truth-telling and autonomy and leave decisions about truth-telling and the terminally ill more dependent on the circumstances of particular cases.

Scott Dunbar's *An obstructed death and medical ethics* (1) makes appropriate noises of disgust and indignation over a case of deceit practised by a surgeon on a dying patient. I am not sure, however, that the details of his response are quite right.

We are in the familiar territory of exactly what and how much should be told to a terminally ill patient about his condition. Dunbar presents the argument against deliberate deceit over the awful truth of impending death by appealing both to consequences and to principles. The consequences give the title of his piece: instead of dying in repose (the ideal we would all share) the patient dies disturbed and confused. As well as deceit leading to bad results it also violates the principles of veracity and respect for autonomy and so is inherently wrong.

Granted that we need considerations that get to grips with the nature of the surgeon's actions, rather than merely their consequences, are we sure that Dunbar's appeal to autonomy and truth-telling brings out these considerations properly? Surely we can all imagine circumstances in which the possibility of a reposeful death was positively destroyed by a doctor bearing down (with the latest textbook on 'philosophical medical ethics' in his hand) upon a vulnerable, dependent patient, demanding that he react to his

predicament as an autonomous moral individual who must be ready to face all the awful facts about his illness. What happens, as Dunbar himself notes, if someone does not want to be autonomous and does not want all the medical truth?

This is not a plea to forget principle if deceit is expedient. What makes deceit wrong is that it is a violation of trust and thus of the moral relationship which ought to be established between doctor and patient. A moral relationship is one whose very possibility is constituted by the mutual recognition by the parties to it of conventions and norms concerned with kinds of trust between people (2). Recognition of norms entails in this context a willingness to allow the pursuit of personal goals brought to the relationship from outside (such as the doctor's desire to avoid messy and time-consuming communication with patients) to be modified by the demands arising out of the relationship itself. Friendship is a paradigm of such a relationship. We all recognise that an individual cannot be true to a friendship unless he is prepared to accept that the friendship itself and the needs of the other in the friendship provide aims that claim attention and limit how private ends can be attained. Friendship is thus governed by principle, but the principles are non-specific. Rules such as 'Don't use, cheat, or deceive a friend' do not tell us with any precision how to treat individuals to whom we are related as friends. They enjoin fidelity to the interests of friends and the interests that grow out of friendship. But friends and friendships are irreducibly different: what is patronising, overbearing behaviour in one friendship may be properly supportive help and guidance in another. 'Deceit' is useful as a name for failure of fidelity in communication between friends, or between those in moral relationships of other sorts. So used, its opposite is not 'truth-telling' (understood as 'leave no information or facts unsaid') but 'truthfulness'. To be faithful in communication is to be alert to the other's perceived need and desire to know and to respond to these honestly and with a true awareness of his interests. I do not deceive my eight-year-old if I respond to his desperate requests to know if Father Christmas is real by giving him the reassurance on this score he so obviously wants and needs at this point in his childhood. I give him such of the truth as he is ready

Key words

Terminal care; truth-telling; autonomy; moral relationship.

and capable of accepting, but this may be very little.

I think all of the above applies to the doctor-patient relationship and to good doctoring that grows out of it. Friendship is not merely a model moral relationship; the doctor-patient relationship ideally partakes of some of the character of a friendship.

Fidelity to a patient diagnosed as terminally ill may require acceptance of his need to sustain the thought that recovery is possible, or recognition that this individual cannot be treated according to the ideals of autonomy that post-Kantian moral philosophers laud. Communication should above all be patient-led and adjusted to the needs and desires of the particular patient. Communication according to general formula is what in general violates the requirements of moral relationship and fidelity. It would be as bad to substitute a formula demanding that all patients must be treated as potential moral heroes who can cope with truth in large doses for a formula which positively ruled out truth-telling.

Dunbar is aware of the need to balance 'the principle of beneficence' against the principles of 'veracity' and 'autonomy' (pages 86 and 87). But I wonder if we need to go much further than he does in questioning the nature of 'medical ethics *qua* principle or rules' (page 86). The fact is that emphasis on rules or principles as the *basis* of medical ethics may be wholly misleading. It may be better to start with an ethics of virtues and relationships.

The surgeon in the case discussed has treated the patient with neither justice nor benevolence and has

not been prepared to enter into a morally structured relationship with the patient. We can come up with rules which describe the conduct of the just and benevolent man, capable of respecting others in moral relationships. For instance: 'Give each his due; further the interests of others; be faithful to the demands of trust created by moral relationships'. These still leave us, however, with all the work to do.

I am at a loss to see why anything other than philosophical fashion (from which phenomenon heaven preserve us) should make us conclude after Dunbar that justice, benevolence, fidelity etc bid us to treat each person as 'the author of his/her own mode of existence' (page 86). The ideal of autonomy seems singularly inappropriate as a guide to how the just, benevolent and faithful doctor should approach the sick and the vulnerable.

I think Dunbar should think further about his question on (page 87): 'But what about people who don't want to be treated autonomously?'

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References

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