Analysis: An introduction to ethical concepts

Definitions and ethical decisions

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The resolution of a number of important questions in medical ethics is often thought to depend on agreement in definitions. For example, the morality of abortion is said to depend on whether or not a given fetus is a person (or is human), and this in turn presupposes agreement on the definition of the concept 'person' (or 'human'). Likewise, the morality of decisions to cease medical treatment of certain patients—for example, a patient who satisfies the Harvard criteria of brain death—is said to depend on whether or not such patients are dead. Again, such decisions presuppose some definition of human death. This type of reasoning implies that one of the first questions to answer, by way of resolving many ethical dilemmas, is a definitional question such as, What is a human person? Or, What is death? Despite the initial plausibility of this reasoning, the definitional strategy often involves two related mistakes: a) confusing the source of moral disagreements with disagreements about word usage, and b) the fallacy of begging the question at issue in a given moral dilemma.

Inexact concepts

One reason for the demand for definitions is the fact that many of our ordinary language concepts are inexact, in the sense that the list of things to which they properly apply is not precisely determined in advance. We are evidently familiar with paradigm cases of what a person is, and what a person is not, and with paradigm examples of being alive or dead. In other words, we understand the concepts 'person' and 'death' without ambiguity. As a result of this, we assume that our clear understanding of the concepts implies that we can definitely decide, for any new or unusual case, whether it falls within the proper range of application of such (inexact) concepts or not. This assumption might be expressed by saying, for example, since we understand clearly what is meant by the word 'person', this fetus either is or is not a person. Therefore, all we need to do is to decide if the fetus is a person or not, and the moral issues of abortion will be clear—at least for those who reject the killing of innocent persons. And to decide this issue, we must first agree on a definition of the concept 'person'.

But this is a mistake because it fails to distinguish between our clear understanding of such concepts as 'person' and the evident inexactness of the same concepts. The criteria which define a person as such are not exact and where exact criteria are proposed, they are not agreed on by competent speakers of English. Once we recognize this, it follows that we have no guarantee in advance that we will always be able to decide whether something is, or is not, a person. And if we consider a borderline case which does not fit neatly into our categories it should be evident that the indecision we experience in applying ordinary language concepts is a direct result of the inexactness of many such concepts. Therefore, where moral dilemmas coincide with disagreements about the correct use of inexact concepts the apparent ease with which these dilemmas might be resolved by definition, is an illusion.

Stipulative definitions

Once the source of the problem is identified, it seems we might make progress by making the relevant concepts more exact. The temptation to stipulate more precise boundaries for the application of inexact concepts is especially attractive when we are already agreed on a general moral norm, such as one ought not intentionally kill an innocent person. Since the main obstacle to applying this principle to the discussion of abortion is the relative inexactness of the concept 'person', it might seem reasonable to make this concept more exact and thereby resolve the ethical problem also. This is where the mistake is made, for that move is equivalent to attempting to resolve ethical disagreement by securing agreements in word usage.

This does not mean that all definitional work in ethics is mistaken; the problem only occurs when ethical disagreement is either camouflaged, or apparently resolved, by the stipulative definition of a central concept in the original moral disagreement. Consider the following example. A comatose patient breathes spontaneously but shows no signs of any neocortical activity and, given the presentation...
state of our medical knowledge, has no hope of a recovery of consciousness. The ethical problem for the physician and those responsible for the patient is, What treatment, if any, ought one prescribe for this patient? If the physicians disagree about the answer to this question then they cannot hope to resolve their disagreement by recourse to a definition, or redefinition, of the word 'death'. If they are not already in agreement about describing the patient as alive or dead (and in one obvious sense, the patient is not dead because we would not bury him in his present condition), then any proposed definition which is introduced at this stage of the debate is not simply a report of the normal use of the word 'death'. To that extent, the proposed definition is stipulative or persuasive (though not necessarily unreasonable). The definitional strategy merely shifts the focus of the original ethical disagreement (How should we treat this patient?) to a discussion of definitions (Is this patient dead?). Where there is no agreed answer to the second question, a new definition of 'death' may easily involve the fallacy of begging the question at issue in the first (ethical) question.

**Begging the question**

The use of definitions to resolve ethical disagreements may involve the fallacy of begging the question, as in the following example. We might be agreed on the ethical principle:

**PRINCIPLE**
The physician has no moral obligation to attempt to revive the dead.

The physician can still disagree on its application to an individual case, such as:

**DECISION I**
One ought not to treat medically patient X.

Those who are not prepared to make the move from the moral principle to decision I might endorse their refusal by claiming that the patient in question is not dead. The introduction of a more exact definition of death, such as the following, will not help to resolve the problem.

**DEFINITION**
A patient who no longer shows any signs of brain activity on an EEG is dead.

**INTERACTION BETWEEN PRINCIPLE, DECISION I AND DEFINITION**
While the definition makes explicit what is involved in the inference from the principle to decision I, it is of no assistance to the other party in the discussion. The rejection of the decision is logically tied to the rejection of the definition. And to the extent that the definition is stipulative or at least open to discussion, it is no more certain than decision I. Consequently, the definitional strategy of focusing attention almost exclusively on the definition in an effort to resolve the ethical disagreement is doomed to failure because it begs the question at issue between the two parties. For those who agree on the principle and disagree on decision I, the precise definition of death merely covers over the real source of their disagreement, viz, the reasons they might offer for accepting or rejecting decision I. In a word, if reasonable people are at odds about the morality of treating, or not treating, a patient they cannot hope to resolve their disagreement by first adopting a new linguistic convention.

**Alternative strategy**

If the definitional strategy for smothing ethical disagreement is a mistake, the explanation of the mistake involved might point the way towards a more successful strategy for resolving ethical dilemmas. The dodging manoeuvre tends to be made in the ordinary language context of well accepted ethical norms. The inexactness of some of the key concepts on which we rely to express our ethical intuitions makes for a poor fit, in many cases, between our moral principles and developing medical practice. To cope with this, we are tempted to redefine the relevant inexact concepts and then apply our ethical norms as before. The main attraction in this seems to be the apparent certainty of definitions vis-à-vis the uncertainty of moral intuitions.

There is a tradition in philosophical thinking which regards definitions as unassailable, a tradition which finds expression in the theory of analytic propositions. That this tradition itself rests on a mistake has been ably demonstrated by W V O Quine. There are no convincing reasons why one cannot change one’s way of talking about the world if it is appropriate in the light of new evidence or changing theories. Apart from philosophical arguments for this thesis, the history of science is adequate testimony for the appropriateness of conceptual change.

Thus, given the empirical status of definitions as reports of common usage or the stipulative character of suggestions for new definitions, there is nothing sacrosanct or un revisable about definitions of such words as ‘death’, ‘person’, etc. But it is also the case, for the same reasons, that definitions of concepts are not more highly guaranteed than the ethical opinions which are expressed by the use of such concepts. Therefore, it is impossible to resolve ethical dilemmas by the redefinition of inexact concepts when the uncertainty about the former coincides with the lack of precision in the latter.

Rather than short circuit the discussion of ethical
dilemmas by redefining inexact concepts, we should reexamine the moral norms which provoke the problems in the first place and ask, for example, Ought one to abort this fetus? (rather than, Is this fetus a person?); Ought one to discontinue treatment of this patient? (rather than, Is this patient alive or dead?). Evidently this does not imply that we should reject proposed definitions of death, such as the Harvard criteria, as useless for medical practice. The point is rather that we cannot hope to win acceptance for this type of definition unless we can also win acceptance for the opinion that those who are 'dead' by the Harvard criteria ought not be sustained by further medical interventions. And it is futile to hope to win acceptance for this latter opinion by simply changing our way of talking about the patients whose treatment, or otherwise, is at issue.

References


