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Moral Intuition in Clinical Decision-Making

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Abstract

The United Kingdom's General Medical Council investigation of Dr. Michael Munro raises concerns about the ability of normative ethics to satisfactorily 'solve' ethical dilemmas in isolation within the real world. In this particular case it seems vague utilitarian principles were used to justify actions by a doctor that many people find morally unacceptable. This raises questions of what we might do when we find our normative ethical theories conflicting with our moral intuitions. Is there more to our ethical deliberations than merely implementing specific normative theories? Is there in fact a role for considering other elements in the decision-making process, such as one's moral intuition? I suggest that despite being criticised as overly subjective or unreliable, there may still be a persuasive social and moral justification for paying attention to the unease of moral intuition when we find it conflicting with our normative judgments, especially in complex real-life clinical situations.

Authorship: Dr. Liam Scott is the sole author of this paper, and consents to its publication. It has not been nor will be published elsewhere.

The author is a doctor currently working in Birmingham (United Kingdom). His interest in medical ethics developed during medical school, where he undertook an additional research degree in this area. Upon completion of his post-graduate training he intends to specialise in Intensive Care Medicine.

Moral Intuition in Clinical Decision-Making

In July 2007, Dr. Michael Munro was brought before a fitness-to-practice committee of the United Kingdom's General Medical Council (the GMC). The consultant neonatologist was under investigation following his management of two babies, Baby Y and Baby X, in July and December 2005. Both had been born prematurely, and both had respiratory or neurological disability severe enough to be considered incompatible with life (Dyer, 2007). In each case, the medical team (along with the parents) made the difficult decision to withdraw medical care and allow the babies to die. Soon after the ventilation was removed from both children, they began 'agonal gasping'—an intense and laboured respiratory pattern seen immediately prior to terminal apnoea. Dr. Munro, therefore, made a decision to administer the muscle relaxant pancuronium to the infants, and both subsequently died. The GMC committee was clear about the ramifications of Dr. Munro's actions:

> The administration by [Dr. Munro] of pancuronium in each case did not treat the cause of agonal gasping, prevented the manifestation of the sign of agonal gasping, stopped the baby breathing and hastened death (General Medical Council, 2007).

However, the committee went on to state they did not believe Dr. Munro had acted inappropriately. The panel based their reasoning on the 'undisputed' fact that his intention was to relieve the suffering he believed the babies were experiencing, not to hasten their deaths.

The controversial issue of using muscle relaxants to prevent or stop agonal respiration was addressed in the *Journal of Medical Ethics* in 2002 (Perkin & Resnik, 2002). Much of the subsequent debate focussed on the defensibility of employing the principle of double effect in such cases, and specifically on the problem of distinguishing outcomes which are *intended* from those which are merely *foreseen*. Critics commented it often proves impossible to draw such distinctions, therefore clouding the boundary between palliative care and euthanasia when muscle relaxants are used (Hawryluck, 2002; Kuhse, 2002). A key premise

underlying Perkin and Resnik's argument in favour of using muscle relaxants was that a patient who is exhibiting signs of agonal respiration *may* be suffering. Given the uncertainty, they argued, the most morally responsible thing to do is to "err on the side of relieving possible pain and suffering instead of erring on the side of not relieving pain and suffering"(Perkin & Resnik, 2002). Such a suggestion underlines the distinctly utilitarian character of their reasoning. This is further emphasised when they later go on to suggest that "When death is inevitable and compassionate terminal care is required, not only the patient's comfort but also the minimisation of the loved ones' distress becomes a priority".

The Utilitarian position

Utilitarianism belongs to the class of moral theories which state that the consequences of our actions are the most important factors to evaluate when making a decision. The overriding principle of utilitarianism is the so-called "Greatest Happiness Principle" established and refined by Jeremy Bentham and John Stuart Mill. Broadly stated, it says that one should aim to promote the maximum net welfare (described in terms of happiness) for the greatest number of people. Preference is given to the action that promotes the most welfare compared to the other options available (Steinbock et al, 2003). Importantly, utility is judged from an impartial perspective, the right action being the one that produces the most happiness overall and not just for the agent involved (Mackie, 1990). A broadly utilitarian justification for the use of muscle relaxants was repeated by Dr. Munro at his hearing, and is apparently condoned by the GMC within their ruling of his case (General Medical Council, 2007). What is noticeable about such reasoning is that, by giving the benefit of the doubt to the uncertainty of the infants' experiences, the utilitarian position gives itself freedom to justify actions which could otherwise be argued to be intuitively unacceptable – in this case, hastening the deaths of these two babies. It might seem somewhat bizarre that the GMC was satisfied Dr. Munro had not acted inappropriately, despite finding he had indeed prescribed

twenty-three times the normal dose of pancuronium [a muscle relaxant with no analgesic or sedative properties], and that his actions clearly hastened the deaths of the two children. An English court of law would necessarily find him guilty of murder, given that the link between his actions and the deaths of the infants can clearly be established (Brazier, 2003). (Sure enough, in the case against Dr. Nigel Cox in 1992, the prosecution made it clear any doctor who deliberately ends the life of a patient—however compassionate the motive—is liable for murder (R. v Cox, 1992)). In dismissing the claim against Dr. Munro, the GMC circumvented the impossible task of exploring his *intention* at the moment he administered the pancuronium, and instead opted to sanction his conduct with an apparently general utilitarian justification that he had acted to maximise the welfare of each child (by minimising their suffering), and arguably also of the relatives and carers involved. The counterargument that the committee's decision was based on a different, 'middle-level' ethical principle such as beneficence is not convincing, given that it is by no means clear that the infants were in fact suffering. The appearance of a calculation by Dr. Munro and the GMC regarding the course of action that would maximise overall welfare and utility underlines the overtly utilitarian approach employed in this case, either consciously or not. As previously suggested, this calculation bypasses a crucial issue - his intention - and will therefore remain unsatisfactory to those who believe there is something intuitively wrong about Dr. Munro's actions.

Has something gone amiss? The application of normative theory in moral dilemmas such as this is thought to help us decide (or justify) what we ought to do. But how should we view our familiar normative theories when they seem to lead us to conclusions or justifications which conflict with our moral intuitions? It can be argued in the case of Dr. Munro that the application of broad utilitarian principles has been used to justify an action which is contrary to widely-held moral convictions about the acceptable limits of medical intervention at the end of life. It is interesting to note Dr. Munro himself specifically warned

the babies' parents that administering the pancuronium was on "the verge of what society finds acceptable." (BBC News, 2007). What does this suggest about the presence of a significant discrepancy between our generalised moral theories and our day-to-day, specific moral judgments? Can we ever reconcile supposedly 'objective' normative reasoning with our subjective, intuitive beliefs?

Moral intuition: origins, uses and problems

From personal experiences, we are all aware human beings often have immediate and instinctive emotional reactions to various situations; behaviours or actions can simply 'feel' right or wrong. Sometimes the reasoning underlying these feelings is not scrutinised or justified, but the intractably personal nature of a moral conviction is taken by many to be a sure sign of its validity. Without receiving any formal preparatory ethical teaching in infancy, we are generally able to navigate our way through myriad social situations, relationships, conflicts and dilemmas with remarkable success as we grow up, and all the time we continually refine our day-to-day ethical concepts. Miranda Fricker has argued along similar lines, and further suggests moral intuitions are the result of previous ethical interactions and events, the "internalisation of lessons learned from past experiences that are brought about by an appropriate moral 'upbringing'"(Fricker, 1995). But even basic attempts such as these to rationalise intuitions are fraught with difficulties. For instance, Fricker's simple explanation leads us to question further what an "appropriate" moral upbringing involves, or how our current moral convictions would be constructed if the lessons learned from past experiences were contradictory or incoherent.

Much of the debate over the defensibility of intuition, therefore, inevitably leads to the conclusion that our moral convictions are inescapable subjective ethical biases, and as such their reliability is severely questionable. But despite the possibility our intuitions can be irrational, confused, mistaken, or amenable to persuasion or modification, there remains a

great reluctance to disregard them entirely. Firstly, Shaw reminds us that "moral intuitions are so often right, or at least consistent with a widespread view of what is right."(Shaw, 2001). There is of course, something faintly question-begging about this claim, as it necessarily presupposes an objective standard of rightness. Secondly, it has been recognised by others that our ordinary moral convictions have been used widely throughout history as a test of the adequacy of our formal normative ethical theories; those theories which have appeared counter-intuitive have often found it difficult to be widely accepted (Frey, 1977). But even this fact by itself helps us very little when deciding what to do upon discovering an otherwise agreeable and defensible normative theory being employed to defend morally dubious, possibly illegal actions (such as those of Dr. Munro).

Of course, there are many who would simply find fault with the normative theory itself, or look towards different interpretations of the same theory for assistance. For example, whereas act utilitarians may yield to the conclusion Dr. Munro acted appropriately, rule utilitarians might well conclude he acted inappropriately by violating a utility-maximising rule against doctors 'killing' patients (assuming of course that such a rule would be utility-maximising). The debate over these issues is clearly long and complex, and will not be reiterated in depth here. For my purposes, it is enough to recognise that one can accept utilitarian principles as a suitable approach to ethical problems in broad and general terms, yet still be uncomfortable with some of its counter-intuitive conclusions. What should we do in such situations? My suggestion is that we can give more weight to our intuitive judgments, and thereby confront the largely unchallenged supremacy of the normative theories to tell us how we ought to act. Cowley (2005) has suggested there is a danger in always simplifying and standardising the competing components of ethical dilemmas to fit within normative frameworks:

> In a welter of conflicting ethical intuitions, it is undoubtedly tempting to reach for a scientific way to solve the problem: and it is at this point that the cumbersome machinery of ethical theories and principles are wheeled in.

The problem with these 'cumbersome' ethical theories and principles is that a reliance on applying them to moral dilemmas may lead to what Lawlor (2007) has dubbed a "particularly crude form of ethical relativism" in which the answer to an ethical problem simply depends on one's own preference for a particular ethical theory. But I believe to overlook the varying intuitive convictions surrounding a moral problem is to forget a crucial aspect of any particular ethical deliberation.

In defence of moral intuition for clinical dilemmas

With all the controversy surrounding the application of our ethical theories in isolation, we may find ourselves in certain clinical dilemmas returning to consider the defensibility of our moral intuitions or judgments. Possibly the most damning charge against such intuitive convictions is that they are wholly subjective, relative and unreliable. As Rachels (2003) claims, "We cannot rely on our feelings, for no matter how powerful they may be our feelings may be irrational: they may be nothing but the products of prejudice, selfishness, or cultural conditioning." But might we yet be able to defend a role for the consideration of moral intuitions in real-life dilemmas? I believe a persuasive argument can be made that, because of our complex social existence, all our social interactions (and the rules and customs we derive from them) are inextricably linked with our understanding of morality. Wilson claims "To most people, morality is imbedded in particular social relationships," and goes on to say that in the real world, morality consists of society reconciling a variety of normative theories and intuitive beliefs into a coherent whole (Wilson, 1996). In broad terms, one can argue that the dilemmas which have occupied ethicists and philosophers since antiquity essentially revolve around the intricacies of *Homo sapiens'* social existence. Killing, stealing, lying, giving, and so on might all be argued to be

intrinsically social concepts. They all noticeably require the assumption of social relationships or interactions in order to make them ethical issues in the first place. (For example, can stealing pose a moral dilemma if there is no 'agent of moral concern' to steal *from*? Similarly, can killing present an ethical dilemma if there is no-one or nothing *to kill*?) With a socially-based perspective such as this, it seems most (if not all) ethical dilemmas invariably require at least two moral subjects related to each other in some physical or circumstantial way by their actions, behaviours or intentions.

Furthermore, it is from within this socially-orientated moral sphere then that we develop and refine our day-to-day ethical concepts or judgments which form the basis of our moral experience and understanding. As suggested earlier, our developing intuitions and "common ethical concepts" appear to allow us to navigate the moral dilemmas of normal life successfully, enough at least to function well within our social relationships or environments. This process may appear subjective and culturally conditioned, but it is at least justifiable (and—arguably—acceptable) within our real world of ethical decision-making. One might take this argument a step further to suggest the social conditioning of our moral intuitions might be enough to give more credence to our intuitive unease when we find it arising in response to a presumptuous and 'cumbersome' normative theory.

Intuition and normative theory—striking the balance

One way of explaining the apparent discrepancy between normative theories and moral intuitions may be by appreciating that our common morality, by definition, functions within the real world and not within an abstract or theoretical dimension. Within our real world it is an unfortunate reality that there is a large number of infants born into circumstances as dire as those encountered by Dr. Munro. In the flurry of resulting discussions and debates we must not lose sight of the fact we are seeking real answers to real-life questions about how these children ought to be treated during the course of their

tragically short lives. In such situations, rigid theoretical ethics might, therefore, present significant difficulties for those hoping to 'solve' practical problems (Elliot, 1992). The result of this approach is an apparent mismatch between what our normative theories can logically justify but what we find acceptable as fallible, idiosyncratic, and socially-orientated beings.

I do not at this point intend to propose all normative theories should therefore be completely abandoned in favour of our intuitive moral beliefs. I firmly believe the principle normative theories used in ethics—be they consequentialist, deontological or otherwise—can each provide commendable and valid approaches to help analyse or debate moral dilemmas. I simply mean to suggest that the satisfactory resolution of real ethical problems should not rest solely with these familiar normative giants. This seems particularly evident to me when, for example, a mere calculation of utility can be used to justify an action which makes many feel morally uneasy—as in the case of Dr. Munro. Equally, we can often find that with two related theories - such as act and rule utilitarianism - people can reasonably disagree over what conclusions they yield when applied to clinical cases. This demonstrates the general problem of bridging the gap between our theories and our real life clinical cases. In such situations, to use our moral intuitions to question, enhance or moderate a normative position clearly takes considerable courage, for as we have seen it would be easy to disregard such feelings as subjective or unreliable. But to ignore or fear our moral intuitions when used in this way would be to overlook the valuable social perspective they may provide to the ethical deliberations in progress. Such a suggestion is, therefore, only truly aimed at those theorists holding the strictest normative positions (be they consequentialists, deontologists or otherwise) who believe that all other concepts or considerations outside the remit of their particular theory is untenable.

My overall position can now be articulated. In those rare clinical circumstances in which our moral intuitions appear to conflict with our normative conclusions, it may be

unwise to disregard completely the anti-normative unease outright. Such feelings may be criticised as subjective, emotional, labile or unreliable, and yet it is this same subjectivity which brings a necessary measure of humanity and socially-orientated compassion to the otherwise mechanical ethical calculations. The incorporation of moral intuitions in these difficult deliberations helps us to acknowledge the light they shed on the social reality of the unfolding drama, to awaken our moral senses to the human crisis being engulfed by the impersonal and unyielding ethical 'machinery'. In the cases of Baby X and Baby Y, the crisis revolved around two helpless infants struggling to survive. The babies and their distraught families represented one of the social aspects of a tragic situation. But we must also reflect on our standards and beliefs at such times, and be prepared to question behaviours or actions which appear to challenge the boundaries of social and moral acceptability. It is this social aspect too that we must not overlook when making our decisions. Real-life ethical choices affect many people—vulnerable patients, their families, and the healthcare team. It is hard to imagine situations more deserving of some measure of intuitive moral reflection than these—especially when it appears a familiar normative theory is being exploited so as to find convenient justifications for morally questionable actions.

Conclusion

The GMC ruling on the case of Dr. Munro was notable for the way it appeared to sanction the controversial treatment of two terminally ill children using a vague and generalised utilitarian justification. This causes concern for those who believe the familiar normative theories may be inadequate when used in isolation to tackle complex ethical dilemmas in real clinical situations. In rare situations where our common moral intuitions and the normative position disagree or conflict, I suggest there are justifiable reasons for not completely disregarding our 'subjective' moral unease when it arises. Our moral intuitions can be argued to be both hallmarks and products of our complex social existence. The unease

we subsequently feel in certain clinical dilemmas might be an indication that the normative positions can potentially overlook essential social and humanitarian perspectives in their decision-making process.

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