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The Emotions in Bioethical Decision-making

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In an era of evidence-based medicine and an increasing use of technology the question is raised again as to what extent emotions should play in medical and ethical decision-making. While clearly the correct facts in each case are a *sine qua non* for ethical decision-making, and one should evaluate each situation rationally in accord with accepted ethical principles, the appropriate role of the emotions in decision-making is gaining increased attention in part as a result of newer research in neuroethics. In end-of-life care there often exists a disconnect between the "rational" analysis by many philosophers and ethicists and the emotional reactions of many physicians and nurses with respect to the comparison between withholding and withdrawal of life-sustaining therapy. It is suggested that these attitudes of many health care workers should not be ignored because they represent a critical, almost universal, and laudable value of reluctance to take human life, a value so strongly ingrained in the ethos of the medical profession.

In an era when the phrases "decision analysis" and "evidence-based medicine" are heard regularly at our academic institutions it may be useful to examine whether the rational process *alone* should drive decision-making in medical ethics. On what basis do, or should, physicians reach ethical decisions? Should they always use some well-constructed algorithms based on pure rationality? Is that indeed a goal towards which to strive?

To what extent do, or should, the emotions or "intuitions"[1] play a role in ethical decision-making? Do they have a legitimate role at all, or must ones always act strictly on the basis of rationally derived principles? Studies in the neurosciences [1] have opened new vistas in "neuroethics". While the famous trolley problem (in which most people hesitate to directly push an individual to his death to save five others, but have no such hesitation to act indirectly to cause the death of one to save five others) has been a famous ethical theoretical exercise for several decades [2]. Research about ethical decision-making is still in its infancy. The divergent localization in the brain of the emotional decisions versus the rational has led to an explosion of research examining the neuroanatomic and neurophysiologic correlates of moral decision-making. The locale for the "emotional" decisions seems to be distinctly separate from that for the "rational" bioethical decisions [3].

Major controversy exists about the normative significance of moral intuition. This controversy may simply be a reiteration of the classic disagreement between Hume and Kant, but the discussion has been enriched and deepened by a great deal of research in psychology, neuroscience, and evolution, among other disciplines. Some philosophers deprecate such ethical intuitions as merely prejudice or bias [3]. But others [1,4,5], contend that these intuitions may actually lead to improved ethical decision-making and thus dare not be ignored. There is as yet no consensus in this dispute, and much more research is being carried out in a variety of relevant disciplines. A

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recent review [6] found that in medical practice emotional factors do indeed commonly affect clinical decision-making, including ethical decisions.

Leon Kass [7] has emphasized the pertinence of negative emotions as a potential factor in rejecting certain actions which on a purely utilitarian basis might be acceptable. He rejects activities such as cannibalism on the basis of a "yuck" factor. Of course, many actions now considered perfectly acceptable have been unjustifiably rejected in the past because of prejudicial "yuck" factors. Should the repugnance reaction to the active taking of human life also be discarded?

I should like to focus on the relevance of this controversy to a particular aspect of end-of-life decision-making. I would like to suggest that, at least from pragmatic considerations, we ignore the implications of health care workers' emotions at our peril. In particular I am referring to one specific area which Western philosophers and ethicists seem to have settled, while ignoring the feelings of many physicians and nurses. This is the area of the ethical comparison of *withdrawal* versus *withholding* of life-sustaining therapy. But my reasoning may be applied to other areas as well, such as the long running controversy as to whether active and passive euthanasia are ethically similar or different [3,8,9]. Studies of the attitudes of physicians in several Western countries consistently seem to show that support for physician-assisted suicide is considerably greater than for active euthanasia performed by the physician [10].

I remember an exchange in an internet discussion groups on bioethics in which a participant described a problem he was having with nurses in his intensive care unit who could not bring themselves to turn off a respirator in those situations in which this act resulted in the immediate death of the patient. The nurses felt that they would be killing the patient. Almost all the responding professional ethicists gave advice on how to persuade these nurses to go along with the approach of the ethicists and overcome their hesitation. Finally, as a "lurker" in the internet discussion group, and bothered by the virtual unanimity of the responders, I cautiously raised the possibility that perhaps instead of everyone trying to pressure the nurses to come around to the view of the initiators of the query, they might do well to listen to the nurses, to give some weight to the "gut reaction", the hesitation of the nurses, and try to deal with their emotional distress.

In an article in the Journal of the American Medical Association [11], the authors stated categorically "the law and medical ethics treat the withholding and the cessation of life-sustaining treatment the same," and that the view that they were different was classified as a "myth", which had already been so recognized a decade earlier. But just a few pages earlier *in that very same issue* [12], a survey of neonatologists from 10 European countries revealed that over two-thirds of them did not equate withholding and withdrawing.

In another study [13], the overwhelming majority of American and British physicians and nurses *attending ethics courses on death and dying* felt that there was an ethical difference between withholding and withdrawing life support measures.

Many philosophers reason logically that when comparing the intent and outcome of withdrawing and withholding therapy, both actions are identical, but to the individual who has to carry out the procedure there seems to be an important difference between the two. Shutting off a respirator leading to immediate death of the non-brain-dead patient may in the eyes of the performer be morally equivalent to active euthanasia [14], a procedure about which many health care workers still have serious reservations. Perhaps the deep, almost instinctive, aversion to killing, that has for so long been a part of the medical heritage, is healthy and appropriate. It has been referred to as the medical profession's "gyrocompass" [15].

I have always found it quite relevant that support for active euthanasia within the medical profession is greatest among those physicians who do not have to directly perform such acts and is least among oncologists and those dealing with dying patients [16]. Philosophers, as a group, are much more favorably inclined to euthanasia than are physicians.

In this light, I found amusing, but quite telling, the tongue-in-cheek short article [17], which recommended, instead of physician-assisted suicide, rather philosopher-assisted suicide. Since many philosophers see no logical distinction between active and passive euthanasia, since they do not fear the so-called "slippery slope", and many deny its existence or significance, and since they apparently do not have the same deep moral inhibitions against killing that most physicians do, perhaps the particular task of assisting suicide might better be turned over to philosophers; after all, these are unusual individuals who, unlike ordinary mortals, operate only by logical and rational methods.

It is interesting that in another context entirely, that of capital punishment in those societies in which it was acceptable, firing squads consisting of multiple individuals were usually used, and one of the participants would frequently be given a blank to fire. This procedure was used in order to prevent any single one of the firers from feeling that he had actually done the killing.

There are many studies about the effect of killing on soldiers, with deleterious long-term consequences [18], even where the act was seemingly justified. Thus, in the equation comparing withdrawing and withholding life-sustaining treatment, it behooves us to take into consideration the psychological impact on the medical and nursing staff. If, in their opinion, they have directly

caused the death of an individual this psychological impact dare not be ignored, whatever the persuasiveness of the logic justifying the action.

In describing an episode involving end-of-life care, Grant Gillett [19], describes movingly what he calls "the pause". He begins his article by quoting from Thurston Brewin, a physician involved in the care of terminal patients, who writes about euthanasia: "… it is very illogical of us to make this distinction between active and passive. Well so it is. Logically there is little or no difference. But our gut instinct tells us that there is. And like it or not, we are not going to be browbeaten into changing our minds by mere logic; nor even by the remarkable fact that, whereas in the case of human beings passive euthanasia is widely regarded as a civilized and human compromise, in the case of animals the same thing is considered an inexcusable cruelty." After some negative comments about such a seemingly illogical and primeval approach to ethical decision-making, Gillett elaborates his own thesis. He posits that medical intuitions, as he calls them, are and should indeed be a "central part of our moral reasoning even though they cannot be captured in formalisable ethical principles." He then describes the case of a one-day-old child born with severe irremediable congenital defects. The senior neurosurgical resident on duty felt unequivocally that non-intervention was indicated. During the examination, the child uttered a cry. This cry gave the examining doctor pause in delivering his opinion. As a result of this hesitation the resident called his consultant to discuss the case with him. The consultant endorsed the resident's decision. Gillett's contention is that the momentary pause was morally significant, rather than being the result of an irrational and distracting emotional reaction which should have been ignored. Gillett goes on at great length to defend this moral intuition, this "pause". I quote from his elegant writing, "Unlike many problems with which modern medicine has come to deal, moral conflict is not a disease awaiting a cure, indeed it should be seen as a symptom of moral health". At the end of his paper he goes back to defend Dr. Brewin saying that the latter does *himself* a disservice by calling his own position "irrational", merely because it does not have an easily describable underpinning in ethical formulations. Gillett contends that these feelings are "as rational as, although different in quality, from many other judgments we value with personal content or where knowledge cannot be formalized. They engage that moral sensitivity which informs, but is not completely formulated, in terms of moral principles, and thus may indicate that in medical ethics philosophy has its limits." One might call this a more holistic, rather than reductionist, approach.

In the Jewish tradition, from which I draw my ethical underpinnings, withdrawing of therapy is regarded as much more problematic than withholding. In deference to this position the Israeli law on treatment of the terminal patient [2] differentiates between the two. This issue proved to be the major point of disagreement among members of the committee that proposed the law. The law, as it is constituted, poses difficulties in withdrawing respirator therapy on patients with amyotrophic lateral sclerosis (ALS). But a technical solution was proposed [21]: use of a timer on the respirator which can convert "withdrawing" to "withholding". While this may seem to be a legal fiction, which in fact it is, this solution essentially acknowledges and respects the psychological and emotional elements of the health care staff, and perhaps also of some of the families.

The hesitation of families to bear the responsibility of giving the physicians authority even for DNR orders is likened beautifully to the behavior of the Karamazov brothers in Dostoevsky's classic novel [22].

I believe that bioethics has progressed significantly from so-called principlism, which to many observers presents too limited a view of the wide range of ethical approaches. Feminist ethics, narrative ethics, casuistic ethics, and other systems have been proposed, and all have enriched the discipline. The kind of rigorous thinking and analytic processes that are being applied to clinical medicine by decision analysis can be very helpful in sorting out the various considerations that need to be analyzed, and rational thinking is a real desideratum. But intuitions and psychological impact of decisions should, I believe, also be considered. They enrich decision-making, particularly when intuitions against taking human life seem so universal and so important in our violent world.

I would like to close with several quotations – the first from Joanne Lynn's summary chapter [23] on insights gained from the SUPPORT study. This study has contributed more first-rate hard scientific data on which to base end-of-life decision-making than any previous or contemporary study. So, she may be allowed a little subjectivity as well.

In the summary she includes a section entitled Insights on Decision Making:

> In medical ethics and law, virtually all actions are spoken of as "decisions", and statements of optimum care systems focus heavily on optimum decision making. In a trivial sense, of course, such language is not inaccurate. For almost any action, another action was possible, and could have been "chosen". It is not at all clear, however, that the putative decision-maker sees the options in this way. An artist puts a daub of orange paint on a canvas in a certain way. We would not usually say he had "chosen" to paint that way. We would probably focus upon his overall vision and intent. He created that sunset with certain methods and paints. It is satisfying or not, in various ways, and we can critique his method, his vision, or his result. However, we are not likely to do so in terms of his "decisions". In much the same way,

creating a life may seem more like painting, and less like a decision tree, than we usually acknowledge. We follow some pathways because they are well-trod, or because they appeal to our sense of who we are, or for emotional reasons, rather than their being justified by having the highest expected yield of benefit compared with other possibilities. We may never actually have held the other possibilities on mind. Furthermore, what often really shapes the patient's experience might well not have been a real decision at all.

And finally, a quotation by Kathryn Hunter [24], a spokeswoman for the new discipline of narrative ethics, who draws a parallel with medicine's relationship with science, "While principles remain essential to bioethics and biological science must always inform good clinical practice, the tendency to collapse morality into principles and medicine into science impoverishes the two practices. In both instances such a reduction takes science as a model for what cannot be purely scientific. It is an attempt to know generally and abstractly what cannot be known except through the particular case – and to be best understood the case must be richly understood."

So, I find myself with a personal dilemma since by nature and scientific training I am a devotee of rationality in decision-making. Instinctively I favor evidence-based medicine. Yet I remain unconvinced that in the field of bioethics we can do full justice to our actions purely by use of classic decision analysis methodology. Joanne Lynn's analogy of a painting [23] or Thomas Murray's [25] of a tapestry seem more appropriate than the algorithm experts' stick-like decision trees.

[1]For the sake of this paper I use "emotions" and "intuitions" interchangeably, although they are clearly different.

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