



Procedural questions

Bioethics in a liberal society: the political framework of bioethics decision making

Thomas May

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Thomas May's *Bioethics in a Liberal Society* is not intended as an ethical argument about "the good" in health care practice (read: "content ethics"). Rather, the focus of this brief text is on "structure," specifically the structure to impose on our decision-making when we choose among diverse moral views concerning "the good" in health care practice (read: "procedural ethics"). The author's discussion is further limited to consideration of a structure appropriate in the political context of US-style liberal constitutionalism, with its attendant values of equality, democracy and freedom from undue interference from the state.

The book comprises four sections. Attention to the first ("The Liberal Framework") is essential to understanding what follows regarding "Patient Autonomy" and "Professional Rights of Conscience." The concluding chapter on "Health Care Ethics Committees and Consultants in a Liberal Framework" identifies agencies that the author perceives as implementing the structure he proposes.

According to May, society sets the limits of health care practice; as a result, many of the ethical questions that arise in medicine are political in nature. The philosophical basis for the current US variety of political liberalism dictates that no privileged moral perspective exists; that being said, so as to maintain the "no privileged moral perspective" in practice, individual autonomy and moral diversity are themselves highly valued. Consistent with this view, and in defence of it, the mechanism of legally enforceable rights has been devised. This mechanism is seen

to be neutral as among diverse moral viewpoints, even as it is satisfactory in terms of the current political context.

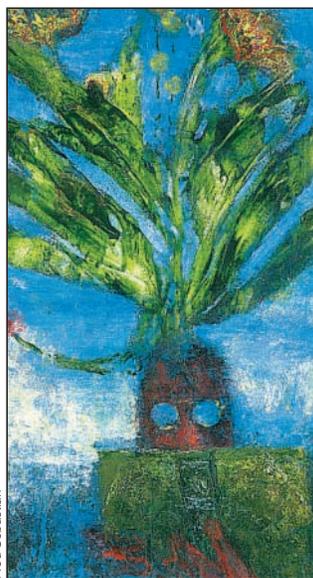
May's discussion of patient autonomy and informed consent holds no surprise for observers of current US health care practice. Canadians will note the use of a "subjective" standard regarding the provision of patient information. (In this understanding, the obligation of the health care practitioner is to meet the requirements for information-giving as set by the patient, not as set by the practitioner.) This contrasts with the

"reasonable person in similar circumstances" standard that is applied in Canada. (The former is consistent with the US emphasis on autonomy; the latter is dismissed as "too vague.") In the matter of patient responsibility and decision-making, May argues that consent for therapeutic intervention should be a cooperative process involving caregiver and patient. Such decisions need not be "good," as this requirement would restrict the patient's autonomous choice. At the same time, such decisions should be "sane." May does not identify the standard for assessing this core component of autonomy, even as he concedes that individuals differ in their perceptions of reality. Consistent with his strict definition of autonomy, May concludes that

advance directives do not embody this value, for the person involved no longer has the ability to "reconsider the commitment to this strategy at the time of application." Thus, advance directives function as second best and should be observed only within certain limits. Such documents can serve as "predictors of choice," however, and are more likely to be accurate than the choices made by (paternalistic) health care practitioners.

May then gives attention to a more personal concern of caregivers, which is the difficulty of "recogniz[ing] when a refusal to participate in a patient's treatment choice represents adherence to the professional's own right to frame her life, and when such refusal is an abandonment of the patient." In response, May identifies beneficence as a key social value in the physician-patient relationship. This requires promotion of the patient's welfare as the patient defines it, where this involves "insignificant or no cost to the provider."

On this basis, the physician has positive obligations: to not abandon the patient; to treat those in need. Does the physician thus lose all right of conscience? No, but the physician must take account of the patient's values when suggesting appropriate treatments: what is suitable from the patient's perspective must be considered along with what is medically indicated. (Debate continues regarding the scope of the "medically indicated"; space does not permit an exploration of this question, or of the fact/value dichotomy, in this review.) Making his point even more precisely, May distinguishes be-



tween the patient's right to refuse an offered intervention, and the patient's "non-right" to request that the physician perform or omit an action designed to further a patient's valued aim, when the action or omission is not consistent with the physician's values. Mutual tolerance remains key in all this discussion.

Concluding his commentary, May gives attention to the work of ethics consultants and ethics committees. Consistent with his stated intent, he argues that both groups are needed on the grounds that patients are a vulnerable population; any "neutrality" will allow providers' views to prevail. To avoid this, and to ensure legitimacy and fairness in the decision-making process, such consultants and committees have an important role to play. They should not function as moral experts (since society has no preferred moral stance) but, rather, should serve to enhance appropriate decision-making within the structure required by society.

May succeeds admirably in what he has set out to do. At the same time, his text fails on several counts, not least of which is a lack of criticism regarding contradictions within the system he describes. If, for example, there is no preferred ethical position, how can we justify insistence on the "good" of autonomy and of tolerance for it, as well as the "good" of beneficence in the physician-patient relationship? Further, in this description of procedural ethics, has content ethics not been eliminated, such that procedure alone remains? In the end, perhaps the real lesson is even more subtle. When the good is to be sought only individually, and practised only within a tolerant political context, does acceptance of that context not only inhibit the search for the good, but also preclude the existence of any real societal good? Are there no limits to tolerance?

Abbyann Lynch

Director

Ethics in Health Care Associates

Associate Professor, Faculty of Dentistry

University of Toronto

Room for a view

Daila's wings

Daila Dossett had wings she'd wear on some days. Those were usually her good days. I'd visit her in the summer and feel the doors wheeze shut behind me and the outside air yield to the ceaseless vinegar of the nursing home. Limp scraps of paper hung down from a corkboard in the hallway, announcing Meatloaf Tuesday, Square Dancin' Sunday. On the days Daila wore her wings she didn't seem to belong in that place at all.

The wings consisted of a wire frame with a thin, gossamer fabric stretched over it. Roundish pixie wings. I never found out where she got that fabric; perhaps she had cut it from an old dress. Whatever it was, it had the same mystifying colour that you see coming from the eyes of a fly. It shone and changed from vermilion to emerald when it tilted this way and that in the light.

On those days, the days when she waited for me with the wings on, Daila would greet me with a cordial kiss. I would lean down to the good side of her face to return the kiss, smelling powder and a memory of lilac. Her smile was lopsided and beautiful; she had an air of sharpness to her on those days.

Some of the others would look at her sitting up proudly in her wings, and they would shake their heads slightly or cast their eyes down. Daila was not affected by this; she told me she had made the wings for special occasions and some people just didn't understand. But if I asked her about the wings she would grow quiet and dense, lost in a memory or vision, and a nurse would wheel her back to her room.

She had loved chocolate milkshakes when she was young, the real kind made with malt and big scoops of beige ice cream. Sometimes I would bring them for her, and I brought her one the last time I saw her wear the wings. I told her I was sorry that it wasn't the real kind; I'd been in a hurry and picked up a shake from McDonalds. She drank it, one half of her face grimacing, and patted my wrist, saying it was just fine.

After that visit she seemed to retreat, and the wings vanished.

Daila was leaving

me. As she faded, I looked in her closet and under her bed, thinking that if I could get the wings for her, if she could wear them, she might improve.

But I just couldn't find those wings.

And then one day she wasn't there at all. Her belongings, diminished by her absence, fit into two cardboard boxes. I rooted through the boxes for the wings, but they were not inside. I carried the boxes, one at a time, out of the back door and to my car. As I lowered the second box into the trunk, a movement caught my eye. I looked over at a huge garbage bin that loomed in the shadow of the building. There, hanging over the open lid of the dumpster, were Daila's wings. One sawed random arcs in the breeze, as if it were waving at me. The other hung limp and lifeless, pointing toward the ground.

Its spine was broken, and the breeze could not lift it.

Sean Gupton

Emergency physician

Minneapolis, Minn.



Fred Sebastian