Recta Ratio Agibilium (The Line of Reason of Those Who Act): Perspectives about Autonomy in Situations of Clinical Emergency

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ABSTRACT

Bioethicists emphasized the principle of autonomy in clinical practice as a duty of the physician and the inalienable right of the patient. However, in emergency situations, clinical judgment often privileges the principle of beneficence, in pursuit to save lives.

The authors describe three real, imminent and life-threatening clinical situations. Then, it was asked doctors, patients, family members and bioethicists about their judgment of the clinical actions taken. Doctors, patients and their families agreed on almost all answers. Bioethicists, on the other hand, had more opposing evaluations. Is bioethics swerving from patients’ will and from clinical practice reality?

Paul Ricouer’s thought deserves the authors reflexion on its phronesis dimension. Acting with prudence and providing an humanized clinical practice lead us to find the recta ratio agibilium (the line of reason of those who act).

INTRODUCTION

In their professional activity, doctors make clinical decisions which have consequences in the health and life of people and for that reason alone, these decisions are already composed of a strong ethical element. However, medicine is an exercise of probabilities both in the evaluation for diagnosis and in the therapeutic decisions and prognostics.

The exercise of medicine had traditionally as reference the principles of beneficence and non-maleficence. There have always been ethical preoccupations in the exercise of medicine which have reflected the dominant social values for each epoch [1].

The principle of autonomy in the context of the doctor-patient relationship is the basis of the modern medical ethics [2]. Ethics is important simply because it is an essential dimension of our work as doctors, with a role that has become increasingly important in clinical evaluations. Given the complexity of modern medicine, an environment which is increasingly technological and patients who are increasingly older with multiple comorbidities, it is vital to have a tool that allows the formulation of approaches to these technological, demographic and epidemiologic challenges of Modern Medicine.

Currently, the ethical implications of clinical decisions involve the diagnosis, prognostic, therapeutic alternatives and specific aspects of the patient, which means that clinical strategy is based on the evaluation of risks and benefits and on the probability of success or failure of the treatment. After performing the treatment, the doctor should ask himself if it was efficient, if there is or not reversibility, if there is the need to transit from healing measures to comfort measures, objectifying always the easing of the symptoms, of the pain and of the suffering. All these decision processes are part of the daily life of doctors and these clinical decisions have an unquestionable ethical element.

Leonard Boff wrote that “in care we find the fundamental human ethos” and “to take care of someone is to have esteem and appreciation for the person, to want their well-being in a wholesome manner” [3,4].

Pellegrino also wrote about this, saying that “wholesome care” is a moral obligation of healthcare professionals, comprising four...
elements: compassion; aid autonomy; to stimulate the desire to be helped; to place someone in the centre of the action [5].

To take care is the essence of the medical profession and it is in its essence that resides the ethical dimension of clinical practice, as if an “applied ethics”.

Bioethics comes as a new knowledge with a wider grasp than traditional medical ethics. Bioethics includes ethics in clinical research, ethics in public health, ethics in organizations, clinical ethics and biotechnology. Diverse factors contributed for the appearance and shaping of bioethics, namely: report of abuse in clinical research; advances in medical therapeutics; medical technology; complex social changes. [6].

The greatest impact of bioethics in clinical practice was the rethinking of the doctor-patient relationship, which started with the reinforcement of the patient’s autonomy through the betterment of communication and evolved to the sharing of the clinical decision [7,8].

There are, however, different factors of cultural, social and religious nature which induce regional differences in the doctor-patient relationship [9,10].

The doctor-patient relationship has specific particularities in decisions of medical urgency or emergency, where the priority is to take measures to avoid death or worsening of the clinical situation [11]. These are scenarios where often action is taken without informed consent and the consent is considered to be implied [12].

Medicine has objective preoccupations in these scenarios, imposed by the urgency of the situations. Protocols of action are established and increasingly optimized to ensure the restriction of error, avoiding death when it is a possibility [13,14].

When bioethics analyses general principles of medical practice in extreme situations as medical urgencies for admissions in intensive care and “life-saving” procedures, these may not coincide with the clinical decisions. The most righteous clinical decision may, therefore, not always coincide with what would be advised by bioethics.

The aim of this study was to assess what is the perspective of the doctors, of the patients, of the patients’ relatives and of the bioethicists, when confronted with three clinical situations that we will explain below, so that the main differences in the line of thought of these four groups of people can be understood. It is certain that several paradigms are inherent to bioethics. One of the limitations of this study was to find bioethicists willing to participate and who were representatives of different movements of bioethical thought.

According to P. Ricoeur, the act of caring in health is placed between virtue and duty. The first observation is to emphasize the effort of Ricoeur when it comes to the articulation that the author encourages between the teleological tradition (personified principally in Aristotle) with the deontological tradition (personified principally in Kant). It being said that both traditions have their own share of truth, given that moral life is the search of good and obedience to the norms, P. Ricoeur seeks to articulate two traditions: the search for the “good life” must involve the faithfulness to the norms which have been established by traditional culture. In this articulation, in establishing the seeking of good as first criterion of moral life, of the “good life”, of the fulfilled life, Paul Ricoeur gives protagonism to Aristotelian tradition.

P. Ricoeur is the example of the philosopher who articulates the horizon of the good life, which begins in esteem itself, passing through Aristotelian tradition with questions of justice, of distribution, of imputation and of Kantian tradition. Provided that the articulation of the two mentioned traditions by P. Ricoeur was very well accomplished, the general guidelines of his Ethics shall be presented here.

Paul Ricoeur, on what he names “Ma Petite Éthique”, distinguished three levels of moral life. Clinical care gains new hermeneutic breath, between a Aristotelian humanization and a deontological humanization (according the transcendental idealism of Koenigsberg), in the doctor-patient relationship.

AIMS AND METHODS

A questionnaire was distributed by four groups: doctors, patients, patients’ relatives and bioethicists. The questionnaire describes three real clinical scenarios, regarding which the questions made could be answered as “Yes” or “No”.

A total of 600 questionnaires were distributed: 230 doctors (different specialities), 150 patients, 150 patient’s relatives and 70 bioethicists. The answers were registered in Excel and the differences in opinion between the four groups were analysed.

RESULTS

In the first clinical case, a patient with 78 years of age, totally dependent for daily activities due to sequels of a stroke, was hospitalized due to pneumonia. The clinical aspect develops poorly, it being necessary to ponder the admission in intensive care unit for invasive mechanic ventilation (to be connected to a ventilator).

Q1-Should the patient be admitted in intensive care unit and measures to prolong life be implemented? (Extended life measures should always be instituted!)

Q2-Should this decision depend only on the doctors and not on the patient or their relatives? (That decision should remain on the doctor’s hands?) (Figure 1).

Figure 1: Extended life measures should always be instituted.
In the second clinical situation, there is a young adult female who is a Jehovah’s witness. She was admitted at the urgency service with serious haemorrhage resulting from spleen injury in the sequence of a car accident. Urgent surgery is necessary to stop the haemorrhage. In the emergency room, the patient says she does not want to receive blood transfusions but she consents to be subject to surgery. During the medical procedure, the patient suffers a cardio-respiratory arrest. Reanimation would only be successful if the patient received a blood transfusion (Figure 2).

Q3-Should doctors go against patient’s religious beliefs and wills if that is the only chance of survival? (Figure 3).

Overall, doctors replied in a very similar way to patients and patients’ relatives. The answers by bioethicists were more divergent, giving more importance to the patient’s autonomy.

In the first clinical scenario, relating to the question asking if advanced life support measures should always be implemented, although 60% of doctors said no, 40% of doctors did say yes. Patients, patients’ relatives and bioethicists, in their majority, say yes. Regarding if that decision should rely only on the doctors, patients and patients’ relative say yes, but bioethicists say clearly not.

In the second scenario, where it is asked if doctors should go against the patient’s belief to save his or her life, the first three groups (doctors, patients and patients’ relatives) say that in this “life-saving” situation, the religious beliefs should not be respected. Bioethicists, on the other hand, have an entirely different understanding, arguing that religious beliefs must be respected even when resulting in death.

In the third clinical situation, the majority of the people from all four groups say that the patient should be subjected to surgery even against his own will. Perhaps because the clinical circumstances suggest that the patient was not in the right condition to take a conscious decision.

DISCUSSION

In the three described clinical scenarios, the three patients survived.

In the first case, the patient was admitted in intensive care. Although the patient already had a significant diminished functional reserve combined with restricting neurological sequel from cerebrovascular disease, the issue at stake was a pneumonia which is an infectious event with potential reversibility.

Therefore, the clinical decision was to admit the patient but subjecting the patient only to non-invasive mechanic ventilation with indication to not escalate the therapeutic measures.
Often in clinical practice, there are doubts if an admission in intensive care unit is not already by itself a “therapeutic obsession”. It is not always possible to evaluate with confidence the irreversible nature of a clinical situation. The decisions are of life or death kind and hence, these are irreversible. So, it is common to admit patients in intensive care, but immediately at the time of admission, a therapeutic strategy is defined with some limitations [15,16]. For example, in the presented clinical scenario, it was said that the patient should be supported by a ventilator non-invasively, it also having been determined that, in case of poor progress or of appearance of other organ failures, there should not be a “therapeutic escalation”. For example, if the patient developed also a renal failure, the kidney would not be replaced, there would be a transition to comfort therapy [17].

Non-invasive ventilator support which was provided to the patient for 48 hours allowed a favourable development. There were no other complications and naturally, the patient survived [18].

The clinical decision in this context has relevant ethical implications. It should be noted that the patient was already totally dependent, with an important cognitive deficit and, under these circumstances, the resource to intensive care can constitute therapeutic obsession. Often, the clinical doubt which arises is if objectively the patient has indication for intensive or palliative care [19]. Meanwhile, besides the clinical aspects of the decision, one has to consider also that intensive care is a scarce and expensive resource which is vital in emergency situations to save lives. If the few beds in the intensive care unit are occupied with patients who have little or no benefit from it, then it may be the case that we are potentially denying other patients the chance to benefit in a situation that could be “life-saving” [20].

It is interesting that patients and their relatives say that the decision should be eminently a clinical one, but bioethicists say that the will of the patient should be prevalent. In situations of urgency, if there is no document with anticipated guidelines, the decision is eminently clinical. In this sense, the autonomy of the patient cannot be prevalent, although conceptually, the response of the bioethicists is expected.

In the second clinical scenario, we have the young adult female who suffered from a spleen fracture, having undergone a serious haemorrhage and because she is a Jehovah witness has refused a blood transfusion. It being predicted that there is an elevated risk of cardiac arrest during surgery if the patient was not transfused, the relatives should be asked if they agree with the transfusion if it came to be necessary [21].

During surgery the patient suffers cardiac arrest and reanimation manoeuvres are initiated, including the transfusion. The patient left the hospital a few days after and did not manifest any resent or animosity for having been subjected to the blood transfusion [22].

The respect for the autonomy of the patient requires informed consent prior to any medical intervention. It is a fundamental requisite of good medical practice. The rejection of blood transfusions implies an ethical conflict between the freedom of the patient to refuse or agree with a therapeutic measure and the doctor’s duty to guarantee the best treatment for the patient [23-25]. Bioethicists, in their vast majority, answered that the doctor’s duty is to respect the religious convictions of the patient even when they result in death, whilst the other three inquired groups in their vast majority answered the opposite. According to the principles of Beauchamp and Childress, in this case, the fundamental principles for the decision process would be those of beneficence and non-maleficence, autonomy thus loosing protagonism, even though the informed consent of the patient is present. Religious convictions, according to I. Kant, are “teonomies” (completely unrelated with the “good will of practical reason”), imposed by anthropology [26].

In an inquiry made in 1991 which was distributed amongst European intensivists, 63% of doctors said they would donate blood to a patient if he or she was in life danger, even with the knowledge that the patient had religious beliefs that forbade him or her from received blood transfusions [27]. Needless to say that it is, nevertheless, a 27 year old study referring to a time when a paternalistic perspective would have had an impact on clinical reasoning.

The majority of the doctors alleged that they were morally obliged to avoid an easily avoidable death.

One thing is the theological fundament of a religious confession. Another thing are rational and positive creations of that same religion. This distinction in phenomenology of religion, unfortunately, are not present in the religious experiences of each confessional practicing individual [28].

It is very difficult for a doctor to witness a death when, with a simple procedure, it could have been avoided. But it is the doctor’s duty to respect the wills and convictions of the patient. However, this clinical duty has its limits when confronted with the “sources of morality” imposed by the natural law: end, object and circumstance. In a context of serious acute trauma, the patient would not be in the best condition to express her will. The parents and brothers, belonging to the same religion, agreed that in the context of reanimation, the medical team should be able to perform blood transfusion if it came to that. Hence, many believers are capable of distinguishing between natural elements and positive elements of a religion, leading, in these cases, to the performing of a blood transfusion. After being healed, the patient did not express animosity toward the taken medical decisions. The respect for the autonomy of the patient, particular in life or death scenarios, must be very well pondered and, every time that it is possible, it should be respected [29,30].

The third clinical case was the one which determined greater consensus between the four inquired groups, given that most people answered that in this specific situation, surgery should be carried out even against the patient’s will [31].

In the exposed clinical scenario, the patient would not be in a clinical condition enabling him to take a conscious decision and hence, an emergent surgery to avoid death should not be discarded. In this sense, it was everyone’s belief that the autonomy principle should not prevail when the capacity of the patient to make decisions is questionable and his or her life is at risk [32,33].
So, the doctor has the duty, in these cases, to assess if the patient has his or her decision-making capacity in good condition, via the application of the other principles of Beauchamp and Childress [19]. There are defined methodologies to perform this assessment. However, in scenarios of clinical urgency, the viability of their application is arguable [34,35].

P. Ricoeur indicates the ethics and the search of the good life as a criterion to solve these conflicts. It being observed that each of the traditions (arethological and deontological) has its own share of truth, because moral life is the search of good and obedience to the norms, P. Ricoeur aims to articulate the two traditions: the search for the good life must involve the faithfulness to the norms that cultural tradition has established. In this articulation, in establishing as primordial criterion of the moral life and the search for goodness, for the good life, for the fulfilled life, Ricoeur gives greatest importance to the Aristotelian tradition [36,37].

Emphasis should be given to the distinction between the three levels of moral life – the ethical, the moral and the practical wisdom-which P. Ricoeur presents. The closer look at these three levels and their articulation allows us to see with better clarity the moral life and to thus find solutions to face the problems with which the moral subject is confronted [38-40].

The last level is fundamental to consider in ethical reflection. Morality is the action and it is for Morality that reflection must prepare the moral subject. The third observation is to mention something vital for the elaboration of the applied ethics [41,42].

Following the thought of P. Ricouer, the doctor-patient relationship in healthcare receives a new paradigmatic form, which dialectically speaking we can call of “phronetic deliberation”. We can understand that it combines the “hipocratic-aristotelian paternalism” and the “Kantian deontology”. [43-45] Here we have a new creative form of presenting the value of hermeneutic sense of humanization in healthcare, which in its manner of action, has as its chore the casuistic application of “practical wisdom”. “Practical wisdom” is manifested as a compass for the experience of the doctor-patient relationship, as a criterion and as a fundament [46-48].

CONCLUSION

The obtained replies allowed to conclude that for the bioethicists, the autonomy of the patient must always prevail except if it is a clinical situation threatening the life of the patient and his or her decision-making ability is questionable. The majority of doctors claim that for each clinical situation, the benefit of the use of advance life support techniques should be pondered, suggesting their concern in avoiding “therapeutic futility”. Doctors also showed reluctance in accepting an easily avoidable death due to religious convictions on behalf of the patient. In these scenarios, the decision must be purely and simply a just and conscious decision of the medical practitioners and not a decision of the patient, because one should follow the maxim of common morality: primum vivere, deinceps philosophari (first live, then think), for the best clinical action and for the good of everybody involved.

The patients and their relatives favoured the clinical decision (one made by the doctors) rather than the respect for the autonomy. But it is important to note that the three clinical scenarios proposed in this study implied an imminent life threat. Therefore, in the context of life or death, these two inquired groups accept a hipocratic-aristotelian exercise of medicine.

One could say there is a selective tolerance to a more paternalistic medicine on behalf of the patients and their relatives, in imminent risk of death scenarios. This means that the relatives and the doctors opt to follow arethological and eudemonological ethics, rather than deontological ethics, although there is a significant “critical respect” for the principle of autonomy as narrated by I. Kant as the fundamental principle of morality.

In the more complex and serious clinical cases, it will always be permitted to opt for moral elements from the two forms of ethics, thus creating a hermeneutic and dialogic ethics, as described by P. Ricoeur. Thus, we can start by saying that in the doctor-patient relationship, there is a dual relationship between a “good life” (arethological teleology) and a “moral obligation” (moral deontology), expressed in normativity.

If it is considered, at first glance, that there is a total rupture between the teleological and eudemonistic traditions of Aristoteles and the deontological and formalistic traditions of Kant, P. Ricoeur shows that this rupture is not a complete one and that each of these traditions is related to the other to a certain extent, when he states: “Without denying in any way the rupture operated by Kantian formalism in relation to the great teleologic and eudemonistic tradition, it is not inappropriate to denote, on the one hand, the lines on which the latter is directed towards formalism and, on the other hand, the lines on which the deontological conception of morality remains connected to the teleologic conception of ethics”. To demonstrate this, P. Ricoeur analyses two fundamental concepts of morality: universality and obligation.

P. Ricoeur considers that we find implicit anticipations of universalism in teleological tradition, when Aristoteles claims that the term “medium” (mésotès) is a criterion for all virtues, when Ricoeur himself gave an implicit universal sense to the capacities of the moral subject such as the initiative to take action, the choice of reasons, the prediction and assessment of the aims of the action, “as being that in whose virtue we take them as being predicted and appreciable, and so are we as an addition”.

Obligation has bonds with the “visée” of the good life. As claimed by Duchêne: “there is a connection between the Aristotelian optative and the Kantian imperative” because, as claimed by Ricoeur: “the will takes, in Kantian morality, the position taken by the reasonable desire in Aristotelian ethics”. However, despite this connection, there are important differences because “the desire is acknowledged in its “visée”, and the will in its relationship with the law”. Furthermore, for Kant, desire is “pathological”. Ricoeur advocates that the Kantian moral man is more divided than the Aristotelian moral man because, in the relationship commandment-obedience, the
german philosopher rejects the sensitive inclinations, because they constitute a threat to universality. Kant thinks that desire is hostile to reason, but Aristoteles argues that desire can be rational.

From this last difference arises the rigorism of Kantian morality and the opposition with which autonomy and heteronomy arise in this morality (the moral law is associated with the notion of auto legislation, without any relation towards the natural law and the other causes). “The opposition between autonomy and heteronomy is [...] constitutive of the moral ipseity”. For Aristotle, the relations between autonomy and heteronomy are not so exclusive; he accepts what some call a heteronomous autonomy or an autonomous heteronomy. If the teleological tradition anticipates formalism, Kantian morality, in its impasses, hints towards teleological morality.

P. Ricoeur characterizes these impasses, showing the impossibility to found morality in the concept of autonomy and auto legislation. The philosopher considers that Kant forgot, or rather, did not thematize, the dimension of the passivity of the moral subject present in his philosophy. It being observed that Kant acknowledges that autonomy is “a fact of reason” in which pure reason becomes practical and, in the formulation of the categorical imperative, implies that one should treat other people as an end, that the respect is not for the law but for the others who are people, Ricoeur asks: “is there not, dissimulated under the pride of the assertion of autonomy, the confession of a certain receptivity in the extent that the law, determining freedom, does affect it?”.

Furthermore, for Kant, respect is a sentiment of practical reason and, as a sentiment, also evokes passivity. Autonomy ends up being a sentiment of practical reason. But autonomy of practical reason is not everything in morality, as it is conditioned by disinformation, by ignorance, by absence of freedom, etc.

In the doctor-patient relationship there is always virtue (Aristotelian ethics) and duty (Kantian ethics). Here, one cannot be without the other. One needs only to grasp where to start, if from duty or from virtue. Sometimes, one starts from moral obligation which will lead to the autonomy of the clinical care. Other times, one starts from virtue, hence, the doctor-patient relationship becomes an arithmetical teleologism.

In transiting from the requirement of the esteem for the self to the dimension of solicitude and for the esteem for another individual, one needs to present the challenges of the Golden Rule, which can be formulated in the negative form-“do not do to the other individual what you would hate to be done to you”- and in the positive form-“what you want men to do, do it to them too”.

The negative formulation “leaves open the array of unforbidden things, thus giving rise to invention in the order of the permitted”. The positive formulation makes the seeking of beneficence clearer, “which leads to the doing of something for the advantage of the other individual”. Both formulations evoke “a norm of reciprocity”.

This “required reciprocity is emphasized by the presupposition of an initial dissymmetry between the protagonists of the action-a dissymmetry which places one protagonist in the role of the agent and the other one in the role of patient”.

To P. Ricoeur, Kantian morality is incapable of gifting the respect for the other individual its true dimension and, in this philosopher’s understanding, this is due to two weaknesses in Kantian deontological morality: its exaggerated suspicion towards the world of sentiment; it incapability to assume alterity through compassion for the Other (patient).

Solicitude is a fundamental element in the doctor-patient relationship, giving it shape and quality. In the understanding of P. Ricoeur, the source of these conflicts is “not only the unilaterality of characters” but the unilaterality itself of “the moral principles confronted with the complexity of life”. When this happens, as claimed by P. Ricoeur, “prudence (phonesis) is the virtue by excellence of practical wisdom, for it is not an escape to devotion but “the will to apply the general rule to the particular case”. As P. Ricoeur states, according to Aristotle, “the man of wise judgement determines simultaneously the rule and the case”. The medical practitioner should behave like so in clinical life.

The moral subject is characterized by the imputation which is defined by the adscription of the action to its subject under the condition of the ethical and moral predicates. In addition, the imputation implies the restoration to the self of the esteem for the self, mediated by the path involving ethics, morality and practical wisdom.

The moral subject is characterized also by the responsibility that is restored to the empirical persistence of the subject and, above all, to the maintenance of the self in the daily life and in the present. The responsibility restores also to temporality: it assumes and prolongs the past but also turns towards the future in the extent that it depends on the subject. A new fundamental model, which is determined for the humanization in healthcare based on the thought of Ricoeur, resides in the phronetic dimension. It is at the heart of prudence. It was described by Saint Thomas Aquinas as recta ratio agibilium (the line of reason of those who act, and shall be the compass in the most complex clinical decisions, as in the case of the three clinical cases studied here.

REFERENCES