Irreconcilable Conflicts in Bioethics

by William J. Winslade

Abortion, physician-assisted suicide, and euthanasia create irreconcilable conflicts in bioethics. These issues challenge our concepts of personhood and personal liberty. They also bring out underlying value conflicts that reveal uncertain sources of authority for resolving the conflicts. As a result, ambivalence about these practices is prevalent. This essay explores the reasons for the irreconcilable conflicts and how to negotiate solutions to the problems without resolving them in only one way.

Nearly everyone agrees that killing innocent persons is wrong. But it happens—in wars, by accident or mistake, and as a result of intention or recklessness. Still, killing of innocent persons is not only bad, but also morally wrong, if not evil. It is not surprising that the topics of abortion, assisted suicide, and euthanasia provoke controversy in bioethics. These practices appear to be classic cases of the killing of innocent persons, but further reflection brings out irreconcilable conflicts about key concepts and values.

These issues provoke interminable debates. The parties to the disputes not only disagree but also stand in polar opposition to each other. The conflicts among them are irreconcilable because of fundamental differences about how to interpret key concepts such as personhood, individual liberty or professional duty and integrity.

A further problem concerns lack of consensus about the ranking and relative weight of sources of authority and value. Law, ethics, religion, economics, politics, and personal preferences may claim authority but none can justify final or ultimate authority. I see no way to resolve conceptual or evaluative conflicts between the polarized positions on abortion, euthanasia, and physician-assisted suicide. Each position has some merit, but ultimately the conflicts are irreconcilable. Those of us pulled toward both polar opposites feel ambivalent about how to decide these issues. I write this essay from the standpoint of cognitive as well as emotional ambivalence about abortion, euthanasia, and physician-assisted suicide. I do not consider my position, though inconclusive, to be weak or untenable. In fact, I think it is more responsive and realistic about the nature of the issues *themselves.* As we approach the twenty-first century, these irreconcilable conflicts—abortion, euthanasia, and physician-assisted suicide—must nevertheless be negotiated. Our response must include respect, tolerance, reasonableness, and civility—all fragile values. Their preservation requires our patience and persistence. But powerful impulses and dogmatic beliefs tend to overwhelm reasonableness. It is my hope that bioethics will continue to promote reasonable discussion and responsible action. If that is achieved, we can endure irreconcilable conflicts.

Conceptual Boundary Disputes

When does human life begin or end? How do we distinguish persons from nonpersons? What are the limits of individual liberty? How far do professional duties extend? How much control can patients or professionals exercise over personal

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decisions about life and death? These questions require that conceptual boundaries be drawn. Where they are drawn, by whom, and by virtue of what criteria significantly affects the shape and scope of key concepts.

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Open-textured boundary disputes in bioethics typically result in ambiguities because the concepts in question are textured and have blurred edges. For example, disagreement arises over the criteria for personhood. Is a fetus a person or only a potential person? Is capacity for consciousness necessary for or merely a quality of personhood? Is permanent loss of consciousness a sufficient reason to disqualify an individual from the status of personhood? We do not need to answer these questions to realize that the answers given will expand or restrict the concept.

Decisions about where to mark the boundaries of the concept of a person are disputed because the choice of criteria is linked to values that often conflict with each other. For example, the relationship of consciousness to personhood directly affects the abortion and euthanasia controversies. If a fetus is not a person, then abortion is not the killing of a person. If a permanently unconscious patient is a person, then withholding or withdrawing nutrition may be euthanasia. The ambiguity of, or at least disagreement about, the concept of a person clouds the abortion and euthanasia debates.

Similarly, arguments about the proper limits of individual liberty underlie the controversies about physician-assisted suicide. The liberty issue concerns both the personal freedom of patients and the professional responsibility of physicians. Setting the limits is not easy. Ethics, law, religion, and politics often pull us in different directions with varying degrees of force. The idea of individual liberty is an essentially contested concept, a concept whose scope and limits are shaped by arguments and values that cannot be reconciled by consensus. For example, one might argue that individual liberty should include the right of competent adults to determine the time, place, and manners of their death, especially if they are suffering from a terminal illness. Should individual liberty also include the right to request physician assistance in exercising that liberty? The answer is not self-evident. It must be sought by interpreting complex traditions, theories, principles, and practices. The key concept of individual liberty is inextricably linked to a cluster of other contested, often ambiguous ideas.

Conceptual ambiguity invites caution but may also create frustration and impatience. It is tempting to insist that boundaries be stipulated to eliminate ambiguities and settle controversies. But no central authority is recognized as the arbiter of bioethical conceptual boundary disputes. Courts, legislators, religious leaders, prominent bioethicists, health professionals, other policy makers compete for recognition as authoritative voices. No single voice is accepted as definitive or final. Thus, we more often hear a cacophony than a harmony. It is important to discern and listen to the many voices that speak forcefully on bioethical issues, even those with which one disagrees.

Psychological Ambivalence

It is difficult to avoid conflicting feelings about certain controversies in bioethics. By "ambivalence" I mean strong, incompatible feelings toward the same thing. Ambivalence may sometimes involve a conflict between conscious and unconscious emotions, such as a child's conscious love and unconscious hate toward a parent. But ambivalence may also refer to equally strong, conscious but opposing feelings toward issues such as abortion or euthanasia. One might, as I do, feel that abortion is a killing that is bad, but a choice

that sometimes should be tolerated out of respect for individual liberty. Euthanasia is not good in itself, but only a lesser evil than prolonged, unwanted suffering. One might feel that euthanasia is sometimes permissible, but an evil nonetheless because it hastens the death of a person whose life has value, perhaps intrinsic value. About this delicate issue it is natural to feel ambivalent.

Uncertain Sources of Authority

In addition to conceptual ambiguity, value differences, and psychological ambivalence, other factors contribute to intractable controversies in bioethics. One such factor is tension between personal values and professional roles; this tension arises for health professionals when their patients make a controversial choice. For example, a health professional might empathize with a woman's decision to abort a fetus even though the professional personally opposes abortion. The professional might also perform the abortion even though personally opposing the practice. The tension in this case, but not all cases, is resolved in favor of a professional duty to respect a patient's individual liberty.

A further problem that plagues professionals and patients is the complexity of the existential dramas of illness, suffering, and death. Individual psychology, family dynamics, interpersonal and interprofessional relationships often complicate already difficult situations. The nuances and uniqueness of particular cases, especially problematic cases, have challenged the ingenuity and skills of patients, professionals, and their consultants. But real life decisions must be made, often despite an incomplete analysis of facts, values, and feelings.

Another factor that compounds our concern about abortion, euthanasia, and physician-assisted suicide is a persistent uneasiness about the negative consequences of controversial actions that become widespread practices. The abortion controversy preexisted *Roe v. Wade,* but it was muffled by the illegality of the practice. When Roe *v. Wade* made abortion legally permissible, abortion floodgates opened despite the cautious and careful, even paternalistic, language of the United States Supreme Court. More than twenty years of acrimonious debate about abortion has evolved into a vindictive and sometimes violent reaction to the widespread practice of abortion. The abortion controversy is symptomatic of the erosion of authority in America; law, ethics, religion, and politics often fail to reconcile or regulate the value conflicts. I think an underlying fear, warranted or not, about euthanasia and physician-assisted suicide is that these practices, if legally permitted, will become as socially and politically divisive as abortion. Few courts have been willing to endorse physician-assisted suicide, much less euthanasia, as a matter of policy. The currently enjoined Oregon Physician-Assisted Suicide statute passed by a voter referendum may become the first explicit legalization of physician-assisted suicide in America. At the same time, in trials of physicians charged with euthanasia or physician-assisted suicide, juries have been unwilling to convict individual defendants. Our reluctance to pass policies to permit physician-assisted suicide or euthanasia is matched by our reluctance to convict individual physicians who have performed it. This ambivalence is also understandable. General policies may open floodgates; individual cases command attention to the nuances of the situation. We can more easily tolerate controversial acts in particular cases than we can when controversial practices become widespread.

Conceptual boundary disputes, psychological ambivalence, and uncertain sources of authority cause conflicts about abortion, euthanasia, and physician-assisted suicide to remain unresolved. What are proper responses to such apparently intractable conflicts? It seems clear that current violent responses to the abortion controversy are a dangerous omen. At the same time disregard of individual liberty about matters so personal and private is also a dangerous omen. It is not easy to discern which is truly a lesser evil.

Permanently Unconscious Patients.[1]

Deliberate killing of a human being—person or not, at their request or not—produces ambivalence even if such a decision is permissible in a

particular situation. Consider, for example, the controversy about patients, like Karen Quinlan, Helga Wanglie, or Nancy Cruzan, in a chronic persistent vegetative state. This problem illustrates how intractable value conflicts create both clinical quandaries and policy paralyses. I offer a possible pragmatic solution that does not require that the value conflicts be resolved.

Patients in a chronic persistent vegetative state (CPVS)—popularly called permanently unconscious patients—lack any ability to think, feel, or interact with others. Although their organic life sometimes can be prolonged for many years (Rita Greene survived over forty years), their conscious life can never be restored. One might assume that decisions to withhold or withdraw life support for such patients are easy to reach and carry out. Indeed, a growing, if not an established, consensus exists in the bioethics community that it is morally permissible to terminate life-sustaining care for CPVS patients. Numerous judicial decisions, including the famous Quinlan and Cruzan cases, legally permit termination of artificial life support in certain circumstances. Yet an apparent consensus in ethics and law has not settled the controversy. Why does the debate continue? Why does nearly every new case cause clinical boundaries? Why have hospital, legal, and public policies concerning CPVS been so slow to be formulated?

To answer these questions it is helpful to consider a number of obstacles that create ambiguity about the status of CPVS patients. This ambiguity contributes to our ambivalence about how to respond to patients who are extremely vulnerable and totally unable to communicate. Finally, care of CPVS patients throws us into the midst of the continuing controversy about euthanasia.

The ambiguity about the status of CPVS patients is partly a consequence of the fact that the diagnosis of PVS is based on inferences from clinical observation rather than a proven diagnostic test. Furthermore, a reliable diagnosis of PVS does not necessarily lead to a prognosis of *chronic* PVS. Even though after a year or more of PVS it is extremely unlikely that a patient will regain consciousness, clinicians have been mistaken. Thus, there is ambiguity surrounding the validity of the diagnosis.

Another ambiguity concerns the personhood of CPVS patients. Some commentators argue that the permanent loss of consciousness undermines personhood. Others argue that persons endure even though permanently unconscious. Still others insist that physical life alone is sufficient for a member of the human species to count as a person. My aim here is not to settle the dispute. I merely note that the disagreements create ambiguity as well as intractable value conflicts.

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Finally, because CPVS patients often can be kept alive for years, to terminate life support, such as artificial nutrition and hydration, appears to be euthanasia to those who perceive an inseparable continuity between physical and personal life. Despite a pronouncement of the American Medical Association and a suggestion by the United States Supreme Court that artificial nutrition and hydration are like any other form of life sustaining technology, others disagree. The person—physician, nurse, or family member—who terminates the life-support knows that his or her act is the proximate cause of the patient's death. If it looks like euthanasia, feels like euthanasia, and causes a patient, who is not otherwise dying, to die, then it is euthanasia—unless, of course, we simply stipulate that it is not. Regardless of which side of the controversy one endorses, the specter of euthanasia haunts decisions to terminate life-support for CPVS patients.

Even when patients have clearly expressed their preferences in an advance directive concerning termination of life-support, carrying out these preferences is another matter. Legal and ethical consensus exists that patient preferences articulated in advance directives should be respected. However, for the health professional or family members called upon to act, psychological resistance comes to the surface. Health professionals are taught to respect and to seek to preserve life; to deliberately cause death pulls against deeply entrenched vitalist values. Yet respect for patient autonomy, including the right to refuse treatment, exerts a powerful pull in the other direction. Patients' preferences do not by themselves eliminate *our* ambivalence.

The ambiguous status of the CPVS patient and the ambivalence we all—especially health professionals—feel in the face of death helps to explain our hesitation, uncertainty, and indecision. The debate continues because of intractable disagreements about the reliability of diagnosis and prognosis, the nature of personhood, and the practice of euthanasia. The hopeless quest for unilateral policies based on consensus about the care of CPVS patients should be abandoned. Policies that disregard value conflicts or seek to impose one set of values on all situations are also doomed to failure. Instead we must establish flexible policies to provide general guidance while permitting variation in the management of particular cases. For example, a hospital or legislature might adopt a general policy that presumes that CPVS patients would not prefer to have their lives extended by artificial means. This presumption could then be rebutted by sufficient evidence to the contrary. The burden to make one's preferences known would, however, be shifted to patients. One might go further and require that life-extension in such situations must be financed by private rather than public funds. This policy preserves individual liberty but does not impose vitalist values on unwilling patients, families, health professionals, or the public. Not perfect, but it is a practical solution to an otherwise intractable problem.

I am distressed by the growing rancor in discussions about euthanasia, physician-assisted suicide, and related issues about the end of life. Increasing intolerance for ambiguity, impatience with ambivalence, and demands for fixed and final rules ignore the inherent tension these issues create. A better response is to acknowledge inherent and intractable value conflicts. We should tolerate without endorsing or encouraging abortion, euthanasia, or physician-assisted suicide. It seems unwise for the government to try to regulate such intensely personal choices. Nor should the government dogmatically condemn individual acts of compassion done in good faith. Policies that try to settle in only one way intractable value conflicts arising out of individual cases way will inevitably fail. Worse yet, they may exacerbate the problems.

Endnotes

1. Some of the material in this section of my essay was taken from an editorial I wrote for the University of Texas Medical Branch publication *Biomedical Inquiry* (summer 1995), p.24.