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Moral progress or evolution? Lessons from narrative bioethics

¿Progreso moral o evolución? Lecciones de la bioética narrativa

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Abstract

We consider two perspectives in the analysis of clinical ethical cases from a narrative bioethics perspective: personal moral progress, and gregarious adaptation to sociocultural contexts. Our bioethical deliberations change substantially if we adopt one perspective or the other. In fact, the two perspectives can only be reconciled if we use a superior theoretical framework: hermeneutics. If we apply hermeneutics methodology to ethical deliberation, we can distinguish two phases: a) the moment of occurrence, when hermeneutics can be used to explore the motivation and intentions of moral agents with affective neutrality and a naturalistic vision, and b) the narrative reconstruction model, in which we must avoid the temptations of bioethical proposals based on models of perfection (in particular Kohlberg's model, described as a model of a "happy ending" narrative), and instead strive to describe mechanisms of moral mediocrity.

Key words: Narrative bioethics, Moral progress, Hermeneutics, Moral deliberation, Clinical practice.

Resumen

Consideramos dos perspectivas en el análisis de los casos éticos clínicos desde una perspectiva narrativa bioética: el progreso moral personal y la adaptación gregaria a contextos socioculturales. Nuestras deliberaciones bioéticas cambian sustancialmente si adoptamos una u otra perspectiva. De hecho, las dos perspectivas sólo pueden reconciliarse si utilizamos un marco teórico superior: la hermenéutica. Si aplicamos la metodología hermenéutica a la deliberación ética, podemos distinguir dos fases: a) el momento de ocurrencia, cuando la hermenéutica puede ser utilizada para explorar la motivación e intenciones de los agentes morales con neutralidad afectiva y una visión naturalista, y b) la reconstrucción narrativa, en la que debemos evitar las tentaciones de propuestas bioéticas basadas en modelos de perfección (en particular el modelo de Kohlberg, descrito como un modelo de una narración de "final feliz"), y en cambio, tratar de describir los mecanismos de la mediocridad moral.

Palabras clave: Bioética narrativa, progreso moral, hermenéutica, deliberación moral, práctica clínica.

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MacIntyre states that ordinary people become moral philosophers when they understand life as an uneven progress or have a setback in the achievement of their good (McIntyre, 2015). What kind of moral philosopher can a health professional be without specific training in bioethics and, therefore, practice in deliberation? If we consider ethical and clinical reasoning, every moral problem that arises in a consultation should be subjected to a process of deliberation and discussion, ending in a proposal that can guide our conduct. This would be the path of practical rationality, a subject that has been studied extensively by Kohlberg as a "moral progress" model (Kohlberg, 1981). The case study we propose suggests that things are not so simple. We live in an imperfect world where health professionals often make decisions that are seemingly flawless or faultless from a clinical point of view, but lack sufficient moral quality from the point of view of values. Thus, the question arises of whether the practice of clinical work means moral progress or simple adaptation to a changing cultural context and values. We will try to resolve this issue by exploring a case study.

Disconnecting a respirator and two polar interpretations

Case:

"*As a first-year intern (1980), the head of the Emergency Department told me to accompany a patient who had been permanently connected to a respirator for around 12 years, and was in the end stage of a congenital neurodegenerative disease. The transfer was made in an ambulance. "When you arrive at the patient's house," said the head, "remove the endotracheal tube. Everything has been discussed with his family; their wish is that he dies at home". I did what I was told, but for years afterwards I asked myself whether I had done the right thing, until I studied the concept of limitation of therapeutic effort (LTE). I always thought that I should have asked for more information at the time, not because of reservations about the moral rightness of removing the respirator, but to have the opportunity to discuss this decision in depth. Thanks to the concept of LTE, I managed to overcome the episode, and I can remember it without feelings of doubt and remorse*".

This case can be read from at least two perspectives. The first, perhaps the most obvious, we call the moral progress perspective:

- This is a success story that demonstrates how moral concerns can continue for years as a stimulus or encouragement to pursue moral progress. We must pay tribute to this kind of moral feeling of dissatisfaction (with our own behaviour), as it may push us beyond social agreements. Precisely because the doctor achieved a deeper intellectual understanding of LTE, she will be able in the future to distinguish between:

Bioethics and Narrative Medicine is a focus of current societal and professional concern.

a) Objection of conscience and moral qualms. A reservation or moral scruple is not conscientious objection (Gracia, 2011a, 2011b). When we have a moral objection to something due to our intrinsic values (those that stand on their own and do not need justification), such an action (if done) will cause a serious setback to our way of being and acting, our dignity and self-image.

It is common to experience situations that require tolerance and reflection, for example, drug addicts requesting psychotropic pills. Such situations can be addressed by brandishing rules ("I can't give you these pills, because it is forbidden") or we could clarify the patient's needs, motives and well-being ("I'm uncomfortable with this request, because it makes me seem like a drug supplier, so I prefer to invite you to reframe this meeting by talking about your health problems."). If we look back on our professional experience, we are bound to see how tolerance can help us educate our feelings (Marías, 2005). Over the years, our judgments become less polar, more prudent and responsible, since they combine a certain amount of conviction with adequate sensitivity to particular circumstances. All this builds a vision of moral progress, because our moral feelings do not paralyse our judgment, but warn us and indicate risks and opportunities along the way.

b) A second aspect that manifests moral progress is learning about Limited Therapeutic Effort scenarios, that is, searching for a balance between therapeutic (or palliative) interventions and the benefits to patients. Obstinacy and malfeasance will increase patients' suffering with little or no benefit to their quality of life and dignity (Cambra, 2010: 501-509; Gamboa, 2010: 135-136; Herreros, 2012: 134-140). From this perspective, the case study is an example of practical rationality (Herreros, 2012: 134-140) and moral progress.

However, we could also consider the dark side of humans, which could be defined as shackled, opportunistic and selfish. It is painful to adopt this perspective, but necessary for the purposes of neutrality in hermeneutics. An interpretation of this kind, which we call the contingent advantage perspective, is described below.

- This is a story of moral failure. A moral concern does not necessarily lead to behaviour governed by intrinsic values. In fact, usually humans are governed by dictates of obedience, moral intuition and gregariousness. We can maintain moral qualms for years, or even a moral reproach, dormant in the folds of memory, without the slightest reservation or scruple to bother us. We are smart enough to build a moral story at our own convenience, without an internal censor admonishing us for the many pitfalls and the many lies we tell ourselves, (which in the end, we even end up believing). In the case study, the doctor does at all times what is socially expected of her, first disconnecting the machine without really knowing why; and eventually blocking out the episode until bioethics becomes popular and can justify her behaviour. It is doubtful that she would have aired her moral

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qualms if she had not perceived a successful end to her story, and ultimately, a reinforcement of her self-image. This apparently positive story makes us believe in a moral strength that we in fact do not possess. In other words, and without excuses, in the same way that she once obeyed the dictates of an order that she did not understand (even though she felt moral qualms), again she will take advantage of circumstances from the perspective of professional progress. Moral progress may be applied to Saints, but for most people it is a nice illusion that serves as an excuse to persevere with our gregarious behaviour, moral intuition, and professional achievements. The more we believe in moral progress, the more we favour a *shackled* lifestyle.

Hermeneutics and values

An important aspect that emerges in this discussion is that cases are generally analysed on the basis of unapparent presuppositions. The value of hermeneutics is to reveal these presuppositions, and even metaphysical hidden judgments, and see if there are other perspectives or metaphysical alternatives. Bioethics based on narratives should be bioethics based on hermeneutics (Domingo, 2013). The scenario we are analysing could be used by a Rousseau-like teacher as proof that the noble savage exists, or vice versa, by a Hobbesian ethologist, prone to comparing human moral progress to the bonobo's moral decisions (De Waal, 2004). Hermeneutics is devoted to sceptical thinkers, but also to people who delight in expanding the framework of their free judgment. However, some questions arise: isn't this Hobbesian version of human life pessimistic? Isn't it true that we are free people because we believe in freedom? Isn't it true that we become good people because we believe in goodness? Perhaps we sacrifice values to maintain a naturalistic perspective, and perhaps a Kohlbergian model could be a self-fulfilling and, in the end, useful prophecy.

> Narrative Medicine needs hermeneutics to complement current ethical deliberation methodology. Moral progress is not linear, and theoretical knowledge of bioethics does not ensure mature decisions.

Considered in this way, bioethics could become an exercise to exalt human greatness or depreciate (or even despise) human nature. Is there no middle ground? Could we or should we avoid neutral hermeneutics, in order to avoid moral relativism?

This argument ignores the fact that no philosophy can survive within the boundaries of moral correctness. Human thought is nurtured in the boundaries of the thinkable (for example, in Trías's philosophy of the limit), and moral progress, if it exists, is progress made in situations that challenge us. No moral progress exists without moral pain, without rectification, even without (sometimes) transgression. Hermeneutics is the telescope that helps us see what unapparent events are under the surface of many scenarios. In this sense, hermeneutics is not a microscope but a telescope, because it is positioned to observe horizons of meanings, not details.

Therefore, there are two moments in philosophical hermeneutics that should be distinguished for better use: a first moment when a thinker passes through the

boundaries of the thinkable, oblivious to the calls for prudence from our moral being. This is a moment of perplexity, a moment where we recognize ignorance, and become eternal apprentices who discover new sights in our profession. This is also the time of creative wit, courage (because there is no occurrence that does not involve implicit courage to believe in it, and give it a try). This is something that a health professional with a normative orientation, more concerned with "right-thinking" and the opinion of her colleagues than her own, does not know.

In a second step, we must consider how these occurrences could transform us. This is not a mere play on words. Let us return for a minute to our scenario: what would have happened if the intern had challenged the instruction to disconnect the machine? How could this have affected her personal and professional relationship? What kind of consequences would it have had?

This second step has intellectual and emotional complexities that are beyond the boundaries of this article, but we would like to mention the dynamic relationship between living with risk, and building genuine moral values. Only someone who is convinced about her values can overcome the inertia in moral beliefs in which she has been educated. However, to make a moral being, risky decisions need to be taken with courage and, sometimes, with deliberation. In this case, the image is of a person who is compassionate because she breaks the inertia of comfort (Mèlich, 2010), sensitive because she breaks the inertia of the standard, and unethical because she builds values continuously. When you stop doing this, you become simply a "good" person, but perhaps also a less "narrative" person (in the sense of building a coherent and consistent biography) than we would like (Strawson, 2004: 428-452).

Practical consideration of moral deliberation

This reflection would be of little value to health professionals if we could not translate it into decisions in their environment. Health professionals make so many decisions on a normal day that they scarcely can reflect on each one. The use of electronic medical records leads to the appearance of multiple automatic alerts (generally linked to aspects of clinical safety, including drug interactions), which may distract professional attention. So physicians and nurses must discard unchecked alerts, and assume the risk of getting weighed down by minor aspects that would divert them from the patient's fundamental problem (Borrell, 2014). The same happens in the field of ethical decisions: not all challenges and conflicts should be analysed carefully. The speed at which events occur forces us to make decisions that may leave us unsatisfied, sometimes without a clear reason for this (we may be left with a vague feeling of unfinished business).

> We should avoid the temptations of bioethical proposals based on models of perfection (in particular Kohlberg's model, described in our article as a model of a "happy ending" narrative), and instead strive to describe mechanisms of moral mediocrity.

We therefore should dismiss models which propose creative reflection on each daily challenge: it is simply outside of human capabilities. Instead, challenges are often solved by decision habits. Healthcare professionals search their memory for similar situations

or a situation that ideally could be taken as a reference, to apply the same or a similar solution. Over the years, more complex decisions are transformed into more intelligent rules, more intelligent decision habits, and faster and smarter decisions, in the end. But faster does not imply a lack of complexity: behind apparent simplicity there is a vast capital of accumulated reflection.

Our daily work as healthcare professionals involves a succession of challenges and response habits, but sometimes challenging moral feelings emerge. These feelings, for better or for worse, will remain in our biography as milestones, signifying threat, shame, injustice or reservations, among others. We probably did what was expected of us, but these feelings may remain for years. In the case study, this occurred with the resident's moral qualms. Depending on the feelings that predominate in the memory of this moment, we will try to redirect it to another kind of feeling.

In our case, if feelings of reservations are predominant, we may feel motivated to explore the boundaries of our conduct, what we could have done and what we had the courage to do (e.g. hugging a patient who was in pain, or taking the risk of giving a psychotropic drug to a drug addict under certain assumptions).

However, if a feeling of danger, regret or remorse predominates, we will try to preserve our image at all costs, and we will not hesitate to:

a) Forget or reconstruct situations that cause us discomfort. Some strategies would be: believe we were forced to obey and exaggerate aspects of the story; believe that we were less free than we really were (Sartre called this mental strategy "bad faith" (Sartre, 2007)); consider that everyone would have done the same in similar circumstances, or simply deny that we did what we did and how we did it.
b) b) Devalue the importance of a decision. We can convince ourselves that the situation was not important, or that the patient was responsible for our wrong decision (for instance, because she/he concealed important clinical information); we can claim that the situation was not our business; we can assert that we simply applied our company's rules or our code of ethics.
c) All this creates a very interesting model in which moral feelings lead to enriched or degraded ethical choices. It also reminds us of the importance of managing these feelings, as a complementary part of, and even previous to, more formal (and rational) deliberation.

> Increased communication skills could enhance or diminish a person's degree of freedom, and therefore, the quality of her ethical decisions.

Kohlberg's models and the contingent advantage model

Let us revisit Kohlberg's model. From this perspective, everything said so far could have been interpreted as a conflict between a socially established norm (obey your superior), and moral qualms. Kohlberg would have called the intern's behaviour "conventional" (simply obeying the superior), and the opposite behaviour "post-conventional", that is, confronting or questioning the order. Conventional behaviour is conduct marked by social

conventions or norms, compared with post-conventional behaviour, which is guided by universal principles (Kohlberg, 1981).

The intern's behaviour should be interpreted as conventional behaviour as far as it is based on the conviction that the boss is always right. The issue is not whether the medical staff were right or not in our scenario. The key question is the following: a good choice for medical staff (the dignified death of a patient, surrounded by his family) was not automatically a good choice for the intern. Moral scruple forces us to analyse competing values and elucidate the basic argument that conveys our feeling.

If we were practicing a sort of "happy ending" bioethics, we would bet that this intern, due to the persistence of moral feelings of dissatisfaction, would progress towards a form of "post-conventional" reasoning. In this sense, Kohlberg's model – like any perfection model – invites us to embrace a self-fulfilling prophecy.

However, it may be more fruitful to rethink the clinical case from the model of contingent advantage. From this perspective, the intern did not dare to raise her moral objections to the order that she received, because to do so required some assertiveness and communication skills that she did not have. There is no moral imperative that could lead her in the future to oppose a specific order, but her ability to counter-argue it with social success is an important factor, because human beings are actors not only on the moral stage, but also on the stage of community life.

Therefore, we can assume that our good professional wanted to express her moral qualms, but lacked the tools to do so in a reasoned way, and perhaps therefore preferred to keep quiet and obey her boss. It may be that communication skills enhance or diminish a person's degree of freedom, and therefore, the quality of her ethical decisions. From this perspective, we should provide the person with analytical instruments and behavioural skills, which enable her to face conflicts as a complement to her bioethical education. It will also be part of her learning to convert feelings of fear into feelings of reservation and compassion.

Moral progress is not linear, and theoretical knowledge of bioethics does not ensure mature decisions. In this sense, it is wiser to talk about evolution and adaptation, conceding on this point a certain advantage to moral intuitionist thinkers (Haidt, 2001) (Strawson, 2004). In the end, communication habits as well as deliberation skills will play a key role in resolving ethical challenges. Moral agents need to live within the limits of their convictions, and betray some intuitions to acquire reasoned beliefs. This is a process that requires more courage than loyalty.

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Competing Interest

The authors declare that they have no competing interests.

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