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Accepting the avoidable death: The philosophy of limiting intensive care

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Abstract

Limiting intensive care is paid increasing attention. In the echoing call for physicians' ethical self-restriction, it is easily overlooked, however, that ethics needs a critical epistemological analysis before it can suffice as an emergency brake to futile treatment. This analysis is provided by the present essay. The authors suggest that the difficulties of resolving moral dilemmas related to limiting intensive care may just be due to the unclarified epistemological status of moral claims. Even if normative ethics cannot prescribe right decisions, but only draw conclusions from defined premises, the premises may or may not be true. Their intertwined descriptive and normative evidence is endorsed in an academic and political discourse. There will necessarily be various demands for rationality in prudent decisions between physicians, their patients and society. These demands are formulated dialogically through critical questions and justified answers. A good argument is the convincing one that, finally and ideally, leads to the absence of open objections. Thus, in the end the rightness of a given decision does not depend on axiomatic moral principles, but is comparative and conditional, as it is given in an omnilateral argument. Neither is it the democratic process of shared decision making that we should evaluate, but rather the argumentative state itself, when we judge the morality of health politics and clinical practice.

KEYWORDS

decision making, futility, philosophical ethics, philosophy of medicine, prolongation of life and euthanasia

1 | INTRODUCTION

Despite the many medical advances which characterize our times, death is still a relatively frequent occurrence in intensive care medicine. At intensive care units in Denmark, every tenth patient is expected to die during their stay,[1] often because it is no longer deemed meaningful to extend life, and/or because opportunities for therapeutic treatment are considered to be exhausted. For both these reasons, in accordance with Danish law, treatment may be omitted or discontinued by physicians.[2] Based on both the European ETHICUS study[3] and a survey of intensive care physicians in the Nordic region from 2008,[4] the omission or discontinuation of life-prolonging treatment can be assumed to occur so often that every intensive care physician in Denmark frequently faces two related, fundamental questions: (a) is the prognosis for the patient in question really without hope; and (b) is the decision for or against a limitation of therapy really right?

During the last 20 years, in addition to extensive research and debate from every corner of the world, the ethics of limiting

[1]Danish Intensive Database. (2016). *Annual report 2015/2016*. Aarhus, Denmark [in Danish]. Retrieved from https://www.sundhed.dk/content/cms/12/4712_did-årsrapport-2015-2016_20dec2016_endelig.pdf

[2]The Danish Ministry of Health. (2012). *The Danish Ministry of Health's guideline no. 33 2012*. Copenhagen, Denmark [in Danish]. Retrieved from https://www.retsinformation.dk/Forms/R0710.aspx?id=141135

[3]Sprung, C. L., Cohen, S. L., Sjokvist, P., Baras, M., Bulow, H. H., Hovilehto, S., … Ethicus Study Group. (2003). End-of-life practices in European intensive care units. The Ethicus Study. *Journal of the American Medical Association*, *290*, 790–797.

[4]Hynninen, M., Klepstad, P., Petersson, J., Skram, U., & Tallgren, M. (2008). Process of foregoing life-sustaining treatment: A survey among Scandinavian intensivists. *Acta Anaesthesiologica Scandinavica*, *52*, 1081–1085.

intensive care have been addressed by national legislation,[5] ministerial guidelines,[6] professional consideration[7] and expert advice.[8] Nonetheless, in this article we contend that it has not yet been clarified how the question of the right decision (b) can be answered on a rational, satisfactory basis, so that a professional, not to mention a layman, would know that the response were obvious. Very little has been written about the epistemological status to which questions (a) and (b) refer with the expression 'is … really'. Metaethics is a traditional feature of philosophy, but has not yet gained enough attention in intensive care medicine.[9] Philosophers have provided very influential ethical concepts, such as principlism or discourse ethics, and these have an epistemological foundation, but their perception in clinical ethics has usually focused on procedural aspects – probably because these aspects best fit the clinical context and because both principlism and discourse ethics appeal to a wide and implicit agreement in western culture. Still, without making the evidence explicit, discourse ethics may be misinterpreted as aiming solely for a practical consensus based on the democratic paradigm of negotiation and votes, rather than on knowledge, whereas principlism may wrongly lead to a unilateral interpretation of authoritative moral norms, such as patient autonomy or beneficence, especially when decisions on limiting intensive care are made ad hoc.

In the following we will discuss evidence in relation to the two aforementioned questions, (a) and (b). The extent to which philosophy can be a beneficial aid is the key focus of this article. We are convinced that physicians, nurses, lawyers, healthcare bureaucrats and politicians should engage with the epistemological foundation of moral theory, as we will characterize it in the following, and become involved in the discussion of its plausibility and applicability to decisions concerning the limitation of intensive care.

2 | IS THE PROGNOSIS REALLY WITHOUT HOPE?

In the only survey to date of physicians' and nurses' views on what should be the actual basis for the decision on the limitation of therapy for patients admitted to Danish intensive care units, the majority stated that a patient's *prognosis* would lead to such consideration.[10] Correspondingly, researchers have been interested in whether the sum scores used by intensive care physicians for the stratification of patients collectively allow individual prognoses to be derived that are reliable enough to serve as standalone grounds for this decision. No such score has been developed yet.[11] Both the short-term prediction of poor patient outcome after admission to intensive care units and the long-term prediction of survival after discharge have been shown repeatedly to be of only moderate reliability.[12] At least two theoretical limitations are usually quoted as a reason for this:

1. The relevant characteristics of the patient in question must be represented in the surveyed population on which the score is based, which cannot be guaranteed, since not all relevant characteristics can be considered. In other words, it is impossible to determine with certainty what can be said to be representative in the actual context. What prognoses express is the composite *probability* of a qualified outcome, e.g., the probability of dying of the disease *d*. Even though the first-order probability of dying of *d* (the total point score) may be high when *d* becomes symptomatic, a given patient with symptoms of *d* would never have a 100% probability of dying of *d*. Some uncertainty will remain concerning whether the patient in question really is represented in the historical group of people who died of *d*, whether all of these people did indeed die of *d*, and about when to declare the symptoms as unmistakeable. This uncertainty touches on a second order of probability or confidence. How confident are we when applying our knowledge about *d* to the given patient? Even though our theory could in fact provide a distinct first-order probability of dying of *d*, we can be in doubt concerning its actual realization.[13]

2. The score would assume immunity to self-fulfilling prophecies, in the sense that its results would not have to be included as its premise. It actually seems that not only can various intensive care units present different outcomes based on the same point score, but the physician's subjective expectation has also proved to be a vital predictor (and confounder?).[14]

These two limitations imply that prognoses are always only approximations of the truth, supported by experience and interpretative theory that has typically provided correct, but in principle

[5]The Danish Parliament. (2016). *The Danish Health Law of 2016*. Copenhagen, Denmark [in Danish]. Retrieved from https://www.retsinformation.dk/forms/R0710.aspx?id=183932

[6]The Danish Ministry of Health, *op. cit*. note 2, p. 2.

[7]Danish Association of Anaesthesiology and Intensive Care Medicine. (2015). *Guideline. Ethical considerations on withholding or withdrawing therapy 2015*. Copenhagen, Denmark [in Danish]. Retrieved from https://www.dasaim.dk/wp-content/uploads/2015/09/vejledning_etiske_forhold_ophoer_ver6_2015.pdf

[8]The Danish Council of Ethics. (2006). *End of life. Ethical challenges and problems 2006*. Copenhagen, Denmark. Retrieved from https://www.etiskraad.dk/~/media/Etisk-Raad/en/Publications/End-of-Life-2006.pdf?la=da

[9]Misak, C. J., White D. B., & Truog, R. D. (2016). Medically inappropriate or futile treatment: Deliberation and justification. *Journal of Medicine & Philosophy*, *41*, 90–114 is a noteworthy exception.

[10]Jensen, H. I., Ammentorp, J., Erlandsen, M., & Ording, H. (2011). Withholding or withdrawing therapy in intensive care units: An analysis of collaboration among healthcare professionals. *Intensive Care Medicine*, *37*, 1696–1705.

[11]Carlet, J., Thijs, L. G., Antonelli, M., Cassell, J., Cox, P., Hill, N., … Thompson, B. T. (2004). Challenges in end-of-life care in the ICU. Statement of the 5th International Consensus Conference in Critical Care: Brussels, Belgium, April 2003. *Intensive Care Medicine*, *30*, 770–784.

[12]Barrera, R., Nygard, S., Sogoloff, H., Groeger, J., & Wilson, R. (2001). Accuracy of predictions of survival at admission to the intensive care unit. *Journal of Critical Care*, *16*, 32–35; Sinuff, T., Adhikari, N. K., Cook, D. J., Schünemann, H. J., Griffith, L. E., Rocker, G., & Walter, S. D. (2006). Mortality predictions in the intensive care unit: Comparing physicians with scoring systems. *Critical Care Medicine*, *34*, 878–885; Soliman, I. W., Cremer, O. L., de Lange, D. W., Slooter, A. J. C., van Delden, J. J. M., van Dijk, D., & Peelen, L.M. (2018). The ability of intensive care unit physicians to estimate long-term prognosis in survivors of critical illness. *Journal of Critical Care*, *43*, 148–155.

[13]Savulescu, J. (1994). Treatment limitation decisions under uncertainty: The value of subsequent euthanasia. *Bioethics*, *8*, 49–73.

[14]Suter, P., Armaganidis, A., Beaufils, F., Bonfill, X., Burchardi, H., Cook, D., … Chang, R. (1994). Predicting outcome in ICU patients. *Intensive Care Medicine*, *20*, 390–397.

falsifiable, predictions. How to cope with this uncertainty? The most common answer is: collectively, by engaging in a process of shared decision making. It is anything but evident, however, that a final consensus would automatically increase the chances of the right prediction. Both individuals and groups are subject to mistakes and fallacies. This is the reason that a democratic understanding of descriptive validity, aiming for participation and integration, rather than for formal justification, is not appropriate.[15]

In his latest book, *The concept of argument*, the German philosopher Harald Wohlrapp instead emphasizes the cognition-related significance of the discourse.[16] According to him, in science the aim is to arrive at the, as yet unknown, truth, which can usually only be formulated as a provisional best explanation. Physicians and researchers may be wrong, and need to objectify and test their propositions and expose them to mutual verification and falsification attempts, laying down additional criteria for the solidity of their proofs and requiring a relation to a scientific tradition. In the final analysis, whether hypotheses can become valid will not be determined by evidence alone, but by others' well informed and critical appraisal of this evidence. Whether something can be said to be true will depend on *someone's* opinion. Knowledge will de facto always require someone to know, and truth, someone to realize. Wohlrapp states that it would not even be given beforehand *what* we actually will hold to be true in the end. But the overall principle for all 'knowledge producers', researchers as well as physicians, is that valid hypotheses are generated in the course of an argument.

Together with all other forms of social knowledge production, clinical investigation, diagnosis and prognostication can therefore be described in terms of an argumentation theory. With Wohlrapp, any such argumentation is characterized by a proponent, who opens with a hypothesis, and an opponent, who is expected to object to it. In contrast to negotiations or ballots, a more or less fresh hypothesis is here made *available* – not to win the argument by, for example, rhetorical persuasion or compromise, but in order to arrive at the truth. Unlike the votes of negotiations and ballots, the proponents and opponents in science and clinical medicine share the same interest: they wish to be better at understanding problems and their solutions. Their propositions are embedded in a practical need for orientation. This difference means that the relativity of prognoses does not turn them into random statements. On the contrary, physicians' knowledge is typically well substantiated, with good arguments, broad professional acceptance and, first of all, practical proof as a solid and substantial part of a historical medical success. In Aristotelian words: these physicians' theory is *epistemic*. But neither proof nor justification, nor any opponents' acceptance, is sufficient to validate a given proposition, when this theory is severely objected to and thereby (re)converted from being epistemic to being *thetic*. It is then, however, as Dominic Wilkinson et al. point out, not the fact of a given consensus that is crucial for this validation, but the acknowledgement of facts – usually *new* facts.[17]

A formal criterion that prevents groupthink and the impact of arbitrary motives on terminating the discourse is demanded. According to Wohlrapp, this formality applies to the state of the *absence of open objections*. In the proponents' own interest, the opponents are encouraged to be as critical as at all possible. The more critical they are, without finding significant argumentation errors, the better the hypothesis is presented and the better its ability to be true. Here, the opponents are included as an indispensable research tool. They should not be required to have a certain professional role. It is their expertise and argumentative position alone, which qualifies them for the process of decision making. Professional experts are usually the most promising addressees, but patients and proxies should not be excluded from descriptive interrogations solely because they are not professionals. They can, and eventually do, contribute reasonably to the discourse.[18]

Wohlrapp's argumentation theory can be seen as a model for how well founded hypotheses are stabilized and accumulated in a social, open and reflexive process. Medical research and general nosology, clinical diagnosis and inferential statistics are thus a social project at all levels and are determined conventionally. Knowledge is this project's ideal product: an objectified and defended reason for the correct predictions and successful interventions. Neither the sociological theory of group action nor formal logic suffices to describe the rules for its validation.

3 | IS THE DECISION REALLY RIGHT?

Let us now imagine that the patient suffering from *d* is dependent on respiratory support. Is it, when diagnosed with *d*, then justified *by d* to withdraw the ventilator or terminate any other form of life-prolonging treatment? The patient's fatal prognosis is, at least, nearly, but not *absolutely*, certain. The answer to this question lies in our notion of how we *should* justify one decision or another, or what we judge as a sufficient justification when limiting intensive care decisions are made. How confident *should* we be when deciding and how *ought* we to measure our confidence? These are entirely and necessarily *normative* questions, although attempts have been made to interpret them descriptively.

The concept of futility can be seen as such an attempt, the one by Lawrence Schneiderman and Nancy Jecker being the most influential and cited.[19] Futility has been a medical issue since Hippocrates and it still is – especially in modern intensive care medicine with its emerging therapeutic possibilities of prolonging life. What futility should be, how to diagnose it and whom to leave the definition to

[15]Wilkinson, D., Truog, R., & Savulescu, J. (2016). In favour of medical dissensus: Why we should agree to disagree about end-of-life decisions. *Bioethics*, 30, 109–118.

[16]Wohlrapp, H. (2014). *The concept of argument. A philosophical foundation.* Dordrecht, Netherlands: Springer.

[17]Wilkinson et al., *op. cit.* note 15.

[18]The authors are grateful for one referee's remark that the Internet has already improved the layman's role as an informed agent in the physician–patient relationship. It will be up to the healthcare professionals to address this potential in an adequate manner.

[19]Schneiderman, L. J., & Jecker, N. S. (2011). *Wrong medicine. Doctors, patients and futile treatment.* Baltimore, MD: The Johns Hopkins University Press.

have all been discussed.[20] Furthermore, a given treatment may not fulfil the criterion of appropriateness, for example economically, even though it is not to be declared futile in the narrow sense.[21] The reason for the term futility still being used may be the intention to differentiate a certain situation from a merely inappropriate one, by being particularly confident, due to highly significant descriptive circumstances. Futility may thus indicate a state of clear evidence, but also the professionals' claim for legitimacy for their bypassing patient autonomy in unilateral decisions, presupposing that good evidence outdoes normative beliefs in the physician–patient relationship; or in Michael Nair-Collins' words:

> The concept of futility as a professional judgement acts as a [though problematic] corrective to the excesses of patient autonomy, providing a more suitable balance between professional integrity on the one hand, and patient autonomy rights [to demand a questionable treatment] on the other.[22]

Consequently, authors have sought to invent the term of 'physiological futility' in order to describe the causal ineffectiveness of treatments. In the end, however, treatment is a biopsychosocial event, and some effects on patients' well-being or health-related interests may be overseen or underestimated when physiological futility is applied.[23] Futility as a unilateral concept applied in order to solve a conflict between physician and patient, by the former overruling the latter, should therefore not be used.

For a long time, medicine has been understood as a joint project based on an asymmetrical relationship between professionals, patients, proxies and others. This asymmetry also concerns a dichotomy of discrimination and autonomy, and challenges decision making.[24] Where professionals are superior to their patients in terms of possessing the capability to discriminate by knowledge, patients are usually seen as being ahead of their doctors when the moral value of ownership and autonomy is addressed. It is, at least, *their* lives that are at stake when limiting intensive care questions are expressed. This dichotomy between descriptive facts and moral norms, and between empirical knowledge and moral reasoning, respectively, is a historical metaethical issue.

The difference between these two sets goes back to what is formulated very clearly by 'Hume's guillotine'. David Hume and his peers claim that normative propositions cannot logically follow from descriptive premises, and vice versa.[25] From the phrase 'therapy limitation reduces suffering' it thus cannot be directly concluded that 'therapy should be limited' without understanding 'suffering' as a value-loaded concept, which refers to the action already formulated in the conclusion. Accordingly, it has been shown how value-loaded 'objective' judgements of physicians appear to concern patients' attitudes,[26] capabilities[27] or needs.[28] Molewijk et al.[29] demonstrate how normative aspects play an important role in the concept of health and disease, and in data collection and presentation. Fundamentally, all that Hume says is that descriptive statements (about what is), and prescriptive or normative statements (about what ought to be) are logically independent of each other. This is not much and, in particular, Hume's guillotine does not say what the 'normative' actually *is*. As a consequence, many ethicists, Hume included, have proclaimed a semantic coincidence of normative and descriptive attributes. The term 'suffering', for instance, implies a normative as well as a descriptive meaning, without these different understandings being logically transmittable into each other. Countless, highly varying moral theories are based on this coincidence. Each of them is characterized by the claim that normative propositions go, in one way or the other, with an axiom that is available to our senses (feelings for Hume) or reason, without the normativity of these propositions being just the same as or inferable from descriptive facts. At any rate, despite concerted intermediation attempts, there is still no agreement concerning how distinct axioms should be reconciled with each other, or how the relation between norms and facts should be understood.

In view of a society's multifarious needs for ethical guidance, persistent disagreement on the most adequate moral theory is naturally a problem, however, and may also have provoked some ethicists' lack of faith in philosophical solutions. Matti Häyry, for example, seems to doubt whether philosophy can be of much help in medical–ethical conflicts, if the underlying moral concerns are impervious to arguments – and so they often were.[30] Has philosophy failed here? Are there alternatives to the inadequate syntactical and the disputed semantic method which can rehabilitate philosophy? It seems at least indisputable that a well founded underlying moral theory of an action is indispensable. Our convictions can be hidden or unconscious; a decision on whether or not to limit therapy would at least be suspect if no reason was given, and a reason requires a theoretical framework. Häyry contests that moral concerns cannot necessarily be reduced to something that is responsive to

[20]Michael Nair-Collins gives a brief and critical comprehension of the history and the different concepts of futility in Nair-Collins, M. (2015). Laying futility to rest. *Journal of Medicine & Philosophy*, *40*, 554–583.

[21]Murphy, D. J. (1997). *The economics of futile interventions*. In M. B. Zucker & H. D. Zucker (Eds.), *Medical futility: And the evaluation of life-sustaining interventions* (pp. 123–135). Cambridge, UK: Cambridge University Press.

[22]Nair-Collins, *op. cit*. note 20, p. 556.

[23]Ibid.

[24]Lelie, A., & Verwej, M. (2003). Futility without a dichotomy: Towards an ideal physician–patient relationship. *Bioethics*, *17*, 21–31.

[25]Hume, D. A. (1740). *A treatise of human nature*. T3.1.1.27. Oxford, UK: Clarendon Press. Retrieved from https://www.davidhume.org/texts/thn.html#T3dot1dot1dot27

[26]Rydvall, A., Juth, N., Sandlind, M., & Lynøe, N. (2014). Are physicians' estimations of future events value-impregnated? Cross-sectional study of double intentions when providing treatment that shortens a dying patient's life. *Medicine, Health Care & Philosophy*, *17*, 397–402.

[27]Hermann, H., Trachsel, M., & Biller-Adorno, N. (2015). Physicians' personal values in determining medical decision making capacity: A survey study. *Journal of Medical Ethics*, *41*, 739–744.

[28]Björk, J., Lynøe, N., & Juth, N. (2015). Are smokers less deserving of expensive treatment? A randomised controlled trial that goes beyond official values. *BMC Medical Ethics*, DOI 10.1186/s12910-015-0019-7.

[29]Molewijk, A. C., Stiggelbout, A. M., Otten, W., Dupuis, H. M., & Kievit, J. (2003). Implicit normativity in evidence-based medicine: A plea for integrated empirical ethics research. *Health Care Analysis*, *11*, 69–92.

[30]Häyry, M. (2005). Can arguments address concerns? *Journal of Medical Ethics*, *31*, 598–600.

arguments. On the other hand, according to Häyry, an adequate response in the form of action, reassurance and deliberation would also mean an acknowledgement of the concerned party through the idea of the autonomous status of the individual. Furthermore, we cannot exclude alternative explanations for philosophy's incapacity, a debate that has led to such a vast body of literature, including medical literature, that it can be difficult for the individual philosopher to achieve an overview and make a contribution. These explanations do not indicate a failure in principle, however.

Another explanation might be that the disagreements are in reality due to deeper, implicit discrepancies specifically concerning the nature of the evidence for the premises applied by the respective moral theory. Häyry himself distinguishes between the internal validity (logical consistency) and external soundness (factual correctness) of moral theories.[31] This perspective focuses on the meta-level of ethics, at which a third aspect of normative propositions, the alternative to the syntactical and semantic, may possibly provide a solution. This is the pragmatic aspect: how we use normative statements in practice. Here, there is, moreover, an analogy to scientific–empirical statements, since both typically arise from a need for orientation in relation to a practical problem. This may concern the question of the prognosis for a given patient with symptoms of the aforementioned fatal disease *d*, but it may also concern the question of whether the treatment of the patient should continue or not. In both cases, there is something more certain (e.g., the historical mortality of *d* and 'Hume's guillotine') and something less certain (e.g., the patient's actual prognosis and the morally correct decision). A falsifiable theory-based hypothesis would typically be used to consolidate the uncertain, by exposing this hypothesis to various tests (such as a treatment attempt and a confrontation with moral intuitions). The goal might thereby be to achieve coherence between our empirical theory and our observations, on the one hand, and between our normative theory and our moral intuitions on the other, as proposed by many scientific theoreticians and ethicists following John Rawls.[32]

A problem with regard to the coherence theory is how highly complex conditions can be comprehended and included in an overall evaluation, how circular reasoning can be avoided, and what exactly coherence entails in a social context. In contrast to the discourse ethics, for Wohlrapp validation is not given by the agreement between the discourse participants, as we saw, but in the right arguments, the absence of open objections, and the resulting orientation potential of the hypotheses. For Wohlrapp, this applies to descriptive, as well as to normative, propositions. Moreover, Wohlrapp's theory proves to be open towards irrational motives, Häyry's concerns, so long as they can be upheld in the discourse on an empathic basis. If not, there is no alternative to explicit arguments, however. This also applies to patients who, in relation to their wishes and expectations, are dependent on what can be recognized from an *objective* perspective, i.e., from a perspective that is not bound to a *specific* position, but solely to the argumentative process in which the preferences are tested for their authority.

4 | CONCLUSIONS

In this short article, we have defined the dilemma of limiting intensive care as decisions which leave at least some of the affected agents (patients, proxies, professionals, the general public) with unresolved moral concerns. Regardless of whether all of these dilemmas can actually ultimately be solved in practice, we believe that morality is, and should be, a matter of rational judgement. Just as there is no realistic alternative to moral theory in moral judgement, there is probably no alternative to normative ethics in order to formulate a moral theory. However, philosophical normative ethics should not define moral means, but solely clarify the relation between premises and conclusions. If consensus is still missing in a given debate, the discrepancies might be hidden in the nature of the premise: the dilemma might not consist of a conflict between moral principles, as suggested by many ethicists, but of the amount of descriptive, predictive and normative uncertainty, or a misunderstanding of empirical and moral knowledge.

In contrast to Humes' differentiation between descriptive and normative propositions, there are important conceptual and pragmatic similarities to be noted. For both empirical science and ethics, the role of the claiming, questioning and justifying individual is crucial. Finding the morally right answer to a specific dilemma presupposes a formal agreement on the soundness of arguments, as exemplified by Wohlrapp, in the absence of open objections and in the expected probability of resulting practical orientation and semantic coherence. Given that all the involved, deliberating and optimally informed and motivated agents (physicians, patients, proxies and the general public) decide about limiting intensive care without open objections, this decision should be morally imperative and should not need any other quality for justification. Accordingly, any given decision on limiting intensive care is morally fully legitimized by not provoking any such (normative or descriptive) objections, which the opponent would, in turn, be able to justify without open objections. Thus, in the end, the idea of authoritative moral principles or values might become superfluous and abandoned in favour of what, comparatively, seems the best thing to do. A moral principle, such as autonomy or beneficence, would not be regarded as absolute, but relative to its recognition as a defended argument in an open discourse. All other moral concerns, such as consideration of justice or the difference between making and letting happen, respectively, or between requiring a treatment to be given or withdrawn, are understood to be subjects of this discourse.

Wohlrapp's pragmatic dialectical approach is a promising alternative to relativistic or absolutistic concepts and allows directly derived requirements to be made at the *philosophical*, *scientific*, *political* and *clinical* level concerning therapy limitation at intensive care units. Applied at the philosophical level, this means that normative ethics are implicitly founded on ethical assumptions of a second

[31]Häyry, M. (2015). What do you think of philosophical bioethics? *Cambridge Quarterly of Healthcare Ethics*, *24*, 139–148.

[32]Wulff, H. R., Pedersen, S. A., & Rosenberg, R. (1990). *Philosophy of medicine: An introduction*. Oxford, UK: Blackwell Scientific Publications.

order, which should be clarified in the event of ethical conflict. Philosophers should contribute a concept of (un)certainty in terms of descriptive, predictive and normative propositions and their handling. Applied at the scientific level, this means that researchers are encouraged to consistently identify and quantify prognostic parameters for individual intensive care medical diagnoses, as has already been done paradigmatically for individual medical conditions.[33] Applied at the political level, this means that politicians and lawyers need to create clear and consistent legislation and conditions for the general public's participation in the debate, which must not be closed as long as there is disagreement between interested groups in society.[34] Neither should agents be excluded from the discourse prematurely.

In Denmark, the focus must be shifted from the inevitably dying (where therapy limitation can be seen as almost redundant in an ethical sense) to non-inevitably dying patients and their demands in relation to the *opportunity costs* of their treatment. What qualifies human life for tremendous medical expenses? The legitimate expectation of regaining consciousness when lost? The probability of hospital discharge, as suggested by Schneiderman and Jecker?[35] A minimum life expectancy or quality of life? How likely should that 'minimum' be and who is to define it? Economic considerations should have their place as arguments and be explicit, so that they cannot be a hidden, though decisive, factor in the final conclusion. Applied at the clinical level, this means that hospitals and wards must ensure frameworks to facilitate dialogue between physicians. Physicians must have an awareness that an argument actually requires an active effort in terms of information, listening, language structuring and mutual recognition, and be directed specifically at those peers, patients and others who, in relation to the clinical problem, have the most relevant background knowledge and also the greatest doubts, which typically include different medical specialties. The greater the practical impact a decision entails and the more uncertain the assumptions made, the more important the consultation will be. In physician–patient contact, patients take the role of proponents, since they have knowledge concerning *inter alia* their own preferences and epectations, which is not immediately known to the physicians. They must be involved in the discourse as early as possible and, if mentally incapacitated, must be represented by guardians with the help of the law, natural empathy and mutual dialogue. The right of self-determination must be understood as a duty to formulate one's subjective motives, so that they can be generally understood and accepted.[36]

At all of these levels, the agents should recognize the epistemological function of the arguments in the deliberative process, if these are presented under conditions of mutual respect and independence of arbitrary interests, and do not solely serve rhetorical purposes. The pluralism of hypotheses can be accepted if it does not block the dialogue and everyone's efforts to achieve an absence of open objections, new orientation and semantic coherence. Intentions might be an inseparably integrated aspect of descriptive facts, but are less confusing and more contestable once they have been identified and made explicit. Efforts should be made to optimize the discourse and to choose the right participants according to their expertise and critique, and not by their social role or position. This applies in particular to the patients, who not only have a special expertise in being themselves, but also often have very valuable rational normative or descriptive concerns about their treatment; it also applies to politicians, who should be able to defend any rationing act against those affected.

At first glance, our suggestion may seem redundant, since it appears to solve the moral question by seeking a state in which the dissent is already settled. Yet this interpretation would disregard what lies in between: the epistemological input of the argument required. We analysed the evidence of truth as a collectively addressed quality in descriptive, as well as in normative contexts, the open argument's objection and defence being the best indicators of its rightness. Where the absence of open objections cannot be achieved, mediation, representation, negotiation or a court decision may be necessary, but should never substitute or contradict the efforts to create an ideal and omnilateral dialogue.

CONFLICT OF INTEREST

The authors declare no conflict of interest.

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[33]Suter et al, *op. cit.* note 14.

[34]The role of the public is clearly seen by Misak et al., *op. cit.* note 9.

[35]Schneiderman & Jecker, *op. cit.* note 19.

[36]Savulescu, J. (1994). Rational desires and the limitation of life-sustaining treatment. *Bioethics*, *8*, 191–222.