

Editorial

Practical wisdom in medicine and health care

How do professionals in medicine and health care know what to do? How should they make the right or a wise decision in morally complex and uncertain situations? And what is the role of the patient in this decision making process? The first five articles in this issue focus on these and similar questions, be it in very different ways.

Ricca Edmondson returns to the classic Aristotelian notion of practical wisdom. References to this notion are rather an invitation to further reflection on morally right behaviour than a concrete guideline to follow. Aristotle describes prudence or practical wisdom (*phronesis*) as “knowing the right thing to do in a particular circumstance through understanding the circumstance rightly, knowing what matters, and effective means-end reasoning to bring about what matters.” Thinking in terms of wisdom refers to forms of reasoning and deliberation in which knowledge, reflection, attitude and life experience are combined with emotional, social, and ethical capacities. The author argues for a threefold ‘wisdom-based’ approach. Central to Ricca Edmondson’s approach is her focus on the capacities of the *self* (that is, the professional doing the reasoning), the capacities of the *other* (patient, colleagues), and the demands of the *problem* itself. Dan Egonsson also deals with the classic notion of wisdom. He offers an analysis of so-called hypothetical approval, either in the form of preferences or consent. He takes the problem areas prudence, euthanasia and coercive psychiatric care as examples to illustrate his argument. By ‘prudence’ he refers to the sphere of personal value or self-interest. An object has prudential value for someone when it makes someone’s life better, independently of whether it makes any difference for others and independently of its moral value. The problem, however, is that there are several understandings of the concept of approval. Dan Egonsson discusses three main alternatives, approval as an actual preference, as a rational preference and as consent.

Regarding the problem of how to arrive at a wise decision in a morally complex situation, it is common standard in bioethics to use a framework

with four phases. If patients are competent, they should be adequately informed and decide for themselves. If they are incompetent, an advance directive might be helpful. If there is no advance directive, caregivers may try to come to a substituted judgement or act according to the best interest principle. Sigurdur Kristinsson’s paper is about the first phase, that is, the informed consent standard, especially in the area of research ethics. He critically reviews the Belmont Report from 1979 and argues that if this report is to be based on a conception of autonomy that generates moral justification, it will either have to be interpreted in a Kantian way or coupled with something like Mill’s conception of individuality. He comes to the conclusion that the justification should be along the lines of Kantian autonomy and not Mill’s individual autonomy. Linus Broström and co-authors focus on the third phase, the substituted judgement standard. They argue that the current formulation of the substituted judgement standard is incomplete and offers those who must make a surrogate decision little or no guidance. In their view, the principle of substituted judgement cannot be seen as well defined as long as it remains unclear under what conditions the patient is supposed to make his or her decision. Their paper discusses this problem of underdetermined decision conditions. Kristin Zeiler, finally, also deals with decision making and focuses on the notion of shared decision making. She distinguishes between a shared decision making process and a shared *autonomous* decision making process. In her analysis she focuses on the area of new reproductive medicine (IVF, PGD) and clinical genetics. Possible gender differences in shared decision making are also discussed.

The following two papers might be put under the umbrella of the notion of harm and the principle of non-maleficence. Michael John McNamee examines the concept of *Schadenfreude*. This German term is difficult to translate. Taken literally it means something like ‘harm joy’. It refers to the experience of feeling pleasure in another’s misfortune and being harmed. Based on Aristotle’s and Kant’s thoughts

about rationality and emotions McNamee argues that feeling *Schadenfreude*, especially in the course of health care work, is evidence of an objectionable emotion and a deficient character. Linda Scheirton and co-authors deal with harmful practice errors in occupational and physical therapy. Using predominant bioethical theories, ethical principles and professional codes of ethics they analyse six harmful cases reported by occupational and physical therapists in focus group interviews. It is known from the literature that a significant number of ethical issues evoked by these errors continue to trouble the reporting therapists. The authors conclude that the only way towards a culture of safety is an attitude of openness, a principle willingness to reveal one's errors, and moral courage. Several patient safety strategies are suggested that might have prevented the events described in these six cases.

The next two papers are about death and dying, and a person's rights after his or her death. Carlo Legget retrieves the medieval *ars moriendi* tradition. North Atlantic culture, he argues, lacks a commonly shared view on the good death that helps dying people, their family members and caregivers to cope with the dying process. He presents an updated version of the *ars moriendi* tradition that meets the demands of present day secularized and pluralistic society. In his model 'inner space' is a central phenomenon. Five themes that are central to this new art of dying are: autonomy and the self, pain control and medical intervention, attach-

ments and relations, life balance and guilt, death and afterlife. Part of the medieval *ars moriendi* tradition is the idea of an encounter between the living and the dead symbolized in the so-called 'dances of death'. Malin Masterton and co-authors explore a modern version of this encounter. They analyse our moral intuition that the dead can have some kind of moral claim on the living and that we have moral duties towards the dead. They argue that there are indeed posthumous interests and that one such interest, the interest in one's good name, has moral significance. This view has practical consequences when it comes to the use of body material after death and the reputation of historic persons.

The final paper in this issue addresses the role and function of complementary and alternative medicine (CAM). Marcel Mertz analyses possible and plausible ethical justifications for the general use of CAM. His paper provides a systematic analysis of principles, concepts and values that can be relevant to the debate about CAM without aiming at final answers to all questions posed. His findings show that beneficence and non-maleficence are central issues for an ethical justification of CAM as a practice, while freedom of thought and religion are central notions regarding CAM as a belief system.

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