THE DUTY NOT TO HARM: NONMALEFICENCE

In this lecture, you'll be learning to do the following:

1. Define the principle of nonmaleficence, and give examples of acts that violate it.
2. Explain and apply the withhold vs. withdraw distinction, and identify problems with it.
3. Explain and apply the ordinary vs extraordinary treatment distinction, and identify problems with it.
4. Explain and apply the medical treatment vs. sustenance distinction, and identify problems with it.
5. Explain and apply the Doctrine of Double Effect, and identify problems with it.

INTRODUCING NONMALFICENCE

The principle of **nonmaleficence** states that "one ought not inflict evil or harm." Insofar as the principle is aimed at *refraining* from doing certain (e.g., it prohibits injuring people). It is distinct from the principle of beneficence that requires one to *prevent* or *remove* harm, or to actively *promote* good. This principle (along with beneficence) is mentioned in the **Hippocratic Oath** "I will use treatment to help the sick according to my ability and judgment [beneficence], but I will never use it to injure or wrong them [nonmaleficence]."

The principle of nonmaleficence helps grounds rules/guidelines that forbid us to kill, torture, imprison, maim, or steal from innocent people. It also helps explain social norms against gratuitously offending, frightening, or insulting people (even if the penalties in these cases are not as strict). Finally, the principle of nonmaleficence prohibits us from imposing **risks** of harm by acting **negligently.** This happens when you have a *duty* to behave in a certain way toward someone (a patient, your child, etc.), you *breach* that duty, and the person is *harmed* as a result. There are two types of negligence:

1. Intentionally endangering the person, perhaps for some other motive (e.g., *reckless* behavior such as ignoring failing to take a child to the hospital because you don' want to miss a concert you have tickets to.)
2. Unintentionally but carelessly endangering the person (e.g., accidentally giving a patient the wrong medicine).

While the principle of nonmaleficence is very important, it is not absolute. So, for example, actions such as "giving a patient a shot" or "performing major surgery" undeniably harm patients. (In the context of the principle of nonmaleficence, **harm** means a "thwarting, defeating, or setting back of some party's interests.") However, in these sorts of cases, the principles of autonomy (the patient *asked* to be given the shot or to undergo surgery) and/or beneficence (the end result "justifies" the temporary pain) can overrule considerations of nonmaleficence.

In the context of medical research, there have been many famous **underprotection** cases in which nonmaleficence was not emphasized enough (for example, many members of **vulnerable populations** have been harmed for the sake of "science"). More recently, there have been some cases of **overprotection** in which nonmaleficence was overemphasized, or not applied correctly (for example, the demand that hospitals get patients' consent before undertaking a program of increased medical-staff handwashing aimed at reducing infection rates.)

WHY (SOME) TRADITIONAL GUIDELINES CONCERNING HARM DON'T WORK

The principle of nonmaleficence is very old (at least 2,500 years), and thinkers from many fields (philosophers, physicians, religious thinkers, lawyers, judges, etc.) have proposed multiple guidelines and specifications aimed at clarifying this principle. However, there are good reasons to think that at least some of these guidelines are in direct conflict with the common morality, and thus ought to be revised. Here are FOUR such guidelines that are often brought up in the case of incompetent patients (who can't "tell" the medical staff what they want to do). B-C argue that all of these guidelines have significant problems.

BAD GUIDELINE 1: WITHHOLDING VS. WITHDRAWING

"While it is sometimes morally OK to withhold (i.e., not start) a life-saving medical treatment, it is never morally OK to withdraw (i.e., stop) a life-saving medical treatment once it has been started."

- EXAMPLE: Some thinkers have held that it is morally OK to withhold implanting a pacemaker, but morally wrong to withdraw ("take out") a pacemaker.
- PROBLEM: From the patient's point of view, there is no difference between withholding and withdrawing. Plus, if caregivers or surrogates adopt this as a guideline, they are likely to (1) *overtreat* some patients (because they refuse to "withdraw" treatments that are not effective) and (2) *undertreat* other patients (because they are afraid to start a long treatment process they won't be able to "stop").

- A BETTER GUIDELINE: When time is short, err on the side of giving treatment. Then, take time to gather facts, talk to the patient (or his/her surrogates), and decide on the best option. If this means withdrawing treatment, that's OK.

BAD GUIDELINE 2: EXTRAORDINARY VS. ORDINARY

"While it sometimes morally OK to withhold/withdraw **extraordinary** measures to save a patient's life, one is required to treat using **ordinary** measures."

- EXAMPLE: Some have held that caregivers are morally REQUIRED to try "ordinary" treatments like CPR, but are NOT morally required to undertake "extraordinary" treatments like open-heart surgery.
- PROBLEM: There is no good, objective distinction between "ordinary" and "extraordinary." For example, many of the treatments that would have seemed extraordinary 50 years ago seemed ordinary today.
- A BETTER GUIDELINE: Don't worry about whether a treatment is ordinary or extraordinary. Worry about things like effectiveness, risk, cost, pain, and so on.

BAD GUIDELINE 3: SUSTENANCE VS. MEDICAL

"While it sometimes morally OK to withhold or withdraw **medical** treatment needed to save a person's life, one is required to carry out treatments aimed merely at **sustenance**."

- EXAMPLE: Some have held that caregivers are morally REQUIRED to make use of sustenance technologies that provide nutrition and hydration, but are NOT required to use medical treatments.
- PROBLEM: There is no difference to the patient, and it can actually lead to some terrible results (e.g., in cases where providing nutrition and hydration simply extends the painful suffering of a terminally ill patient).

BAD GUIDELINE 4: THE DOCTRINE DOUBLE EFFECT (DDE)

"While it is never OK to intentionally cause a person's death (no matter how good one's "goal" is), it is sometimes morally OK to act in a way that foreseeably causes a person's death (provided that one has a good enough "goal."). This is so-**called doctrine of double effect**[1] (usually attributed to Thomas Aquinas), and it has been highly influential in military ethics, bioethics, and certain areas of the law. Roman Catholic hospitals follow a version of this rule, and it comes into play in the way they deal with a variety of issues.

- REQUIREMENTS: An act is morally justified only if (1) the act itself is not intrinsically immoral, (2) the agent **intends** only the good effect, while any bad effects are merely foreseen, (3) the bad effect cannot be a **means** to the good effect, (4) the good effect is at least **proportional** to the bad effect.
- EXAMPLE 1 : Roman Catholic teaching holds that it is OK to perform a hysterectomy to save a pregnant woman's life (and thereby kill the fetus) but is NOT OK to perform an abortion to save the life of a woman with a severe cardiac problem (who faces life/health risks if she attempts to carry the pregnancy to term).
- PROBLEM: There is no good, objective way of distinguishing between what you "intend" and what you merely "foresee"; in fact, it seems like these things change depending on the way an act is described.
- A BETTER GUIDELINE: In general, the *motives* of caregivers and surrogates should be "to help the patient" and not "to save money" or "to look out for my own selfish interests."

WHAT IS A GOOD GUIDELINE?

All four of these common guidelines for distinguishing between **optional** and **obligatory** treatments FAIL. B-C argue that we should instead assume that there is a **prima facie** ("at first glance") obligation to treat, but that this can sometimes be overruled. We'll talk more about this next time.

REVIEW QUESTIONS: APPLYING THE DOCTRINE OF DOUBLE EFFECT (DDE)

1. Apply the doctrine of double effect to the following pairs of cases (adapted from McIntyre 2019). Which actions are permissible? Which are not? Why?
    a. The terror bomber aims to bring about civilian deaths in order to weaken the resolve of the enemy: when his bombs kill civilians this is a consequence that he intends. The tactical bomber aims at military targets while foreseeing that bombing such targets will cause civilian deaths. When his bombs kill civilians this is a foreseen but unintended consequence of his actions Suppose that it is equally certain that the two bombers will cause the same number of civilian deaths, and each

[1] For an introduction to the DDE see Alison McIntyre, "Doctrine of Double Effect," in *The Stanford Encyclopedia of Philosophy*, ed. Edward N. Zalta, Spring 2019 (Metaphysics Research Lab, Stanford University, 2019), https://plato.stanford.edu/archives/spr2019/entries/double-effect/.

will do the same amount of "good" (by helping to win the war for the "good guys."). What does DDE say about each act?

b. One doctor intends to hasten the death of a terminally ill patient by injecting a large dose of morphine. Another doctor with a terminally ill patient intends to relieve the patient's pain with that same dose and merely foresaw the hastening of the patient's death. Suppose the effects on each patient are the same (i.e., they both die from the morphine). What does DDE say?

c. A judge is hearing two cases. In the first case, the defendant killed a person whom they knew was plotting to kill him. In the second case, a defendant killed an aggressor in self-defense, after the aggressor had already attacked. What does DDE say about each case?

2. Compare and contrast DDE to B-C's alternative approach. Which do you prefer? Why?

CASE STUDY: BUSH V. SCHIAVO (2005)

Theresa Marie Schindler was born on December 3, 1963, and lived with or near her parents in Pennsylvania until she married Michael Schiavo on November 10, 1984. Michael and Theresa moved to Florida in 1986. They were happily married and both were employed. They had no children. // On February 25, 1990, their lives changed. Theresa, age 27, suffered a cardiac arrest as a result of a potassium imbalance. Michael called 911, and Theresa was rushed to the hospital. She never regained consciousness. //Since 1990, Theresa has lived in nursing homes with constant care. She is fed and hydrated by tubes. The staff changes her diapers regularly. She has had numerous health problems, but none have been life threatening….

For the first three years after this tragedy, Michael and Theresa's parents, Robert and Mary Schindler, enjoyed an amicable relationship. However, that relationship ended in 1993 and the parties literally stopped speaking to each other. In May of 1998, eight years after Theresa lost consciousness, Michael petitioned the guardianship court to authorize the termination of life-prolonging procedures. By filing this petition, which the Schindlers opposed, Michael placed the difficult decision in the hands of the court…

The evidence is overwhelming that Theresa is in a permanent or persistent vegetative state. It is important to understand that a persistent vegetative state is not simply a coma. She is not asleep. She has cycles of apparent wakefulness and apparent sleep without any cognition or awareness. As she breathes, she often makes moaning sounds. Theresa has severe contractures of her hands, elbows, knees, and feet.

Over the span of this last decade, Theresa's brain has deteriorated because of the lack of oxygen it suffered at the time of the heart attack. By mid 1996, the CAT scans of her brain showed a severely abnormal structure. At this point, much of her cerebral cortex is simply gone and has been replaced by cerebral spinal fluid. Medicine cannot cure this condition. Unless an act of God, a true miracle, were to recreate her brain, Theresa will always remain in an unconscious, reflexive state, totally dependent upon others to feed her and care for her most private needs. She could remain in this state for many years…

In the final analysis, the difficult question that faced the trial court was whether Theresa Marie Schindler Schiavo, not after a few weeks in a coma, but after ten years in a persistent vegetative state that has robbed her of most of her cerebrum and all but the most instinctive of neurological functions, with no hope of a medical cure but with sufficient money and strength of body to live indefinitely, would choose to continue the constant nursing care and the supporting tubes in hopes that a miracle would somehow recreate her missing brain tissue, or whether she would wish to permit a natural death process to take its course and for her family members and loved ones to be free to continue their lives. After due consideration, we conclude that the trial judge had clear and convincing evidence to answer this question as he did [by granting the husband's wish to have treatment discontinued].

This case was widely covered in the media at the time, and became highly politicized (somewhat to the surprise of bioethicists, as similar cases both before and since had attracted little political attention). Florida Gov. Jeb Bush (the brother of then-President George W. Bush) tried to prevent Terri's treatment from being discontinued, partially by signing "Terri's Law," which would have made it a crime to stop treatment. The U.S. courts ruled this unconstitutional, however. The decision played a (relatively minor) role in the 2006 election campaign.

A few questions: (1) Do you agree with the Court's decision to honor Michael's request, and (2) Why do you think this particular case attracted such interest?