What Does it Mean to "Do No Harm"?

Brendan's Big Book of Bioethics | Brendan Shea, PhD (Brendan.Shea@rctc.edu)

In this chapter, we'll be covering issues related to harm and killing. In particular, we'll be focusing on issues at the "end of life", and what we should do for patients who are terminally ill.

1 CONTENTS

2 THE PRINCIPLE OF NONMALEFICENCE

In this lesson, 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.

2.1 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.)

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

Figure 1 The caduceus is an ancient Greek symbol of medicine and the oath to "do no harm." (Art: Brendan Shea x Dall-E).

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). However all of these guidelines have significant problems.

2.2.1 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.

2.2.2 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.

2.2.3 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).

2.2.4 Bad Guideline 4: The Doctrine of 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."

2.2.5 What is a Good Guideline?

All four of these common guidelines for distinguishing between **optional** and **obligatory** treatments FAIL. In the place of this, many bioethicists (including Beauchamp and Childress) 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.

[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/.

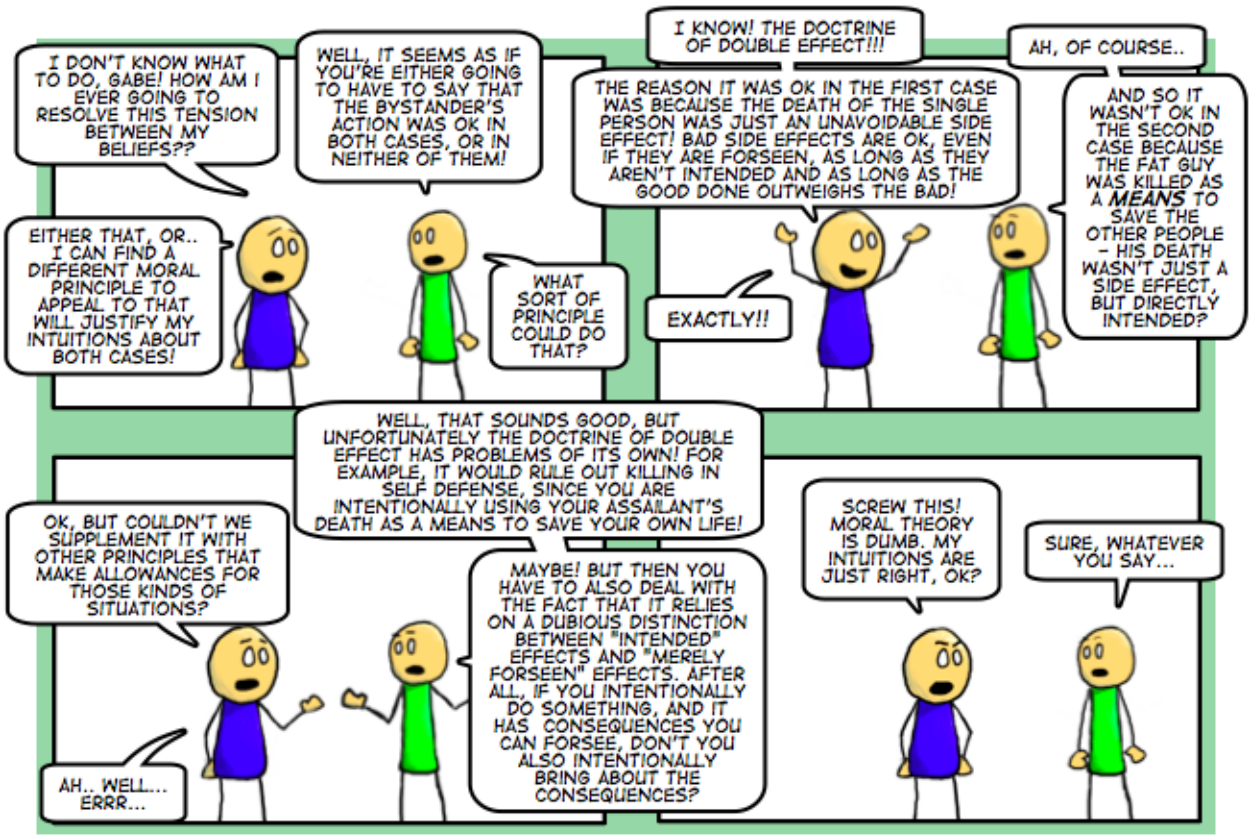

Figure 2 The Doctrine of Double Effect (from chaospet).

2.3 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 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 the idea that "we should assume a prima facie obligation to treat, but that this many sometimes be overruled (for example, by patient request or medical judgement that treatment is futile). Which do you prefer? Why?

3 KILLING AND LETTING DIE: RACHELS ON EUTHANASIA

Let's begin by considering the American Medical Association's (AMA) current (2015) position on euthanasia (they have an almost identical position regarding physician-assisted suicide):

Opinion 2.21 – Euthanasia. Euthanasia is the administration of a lethal agent by another person to a patient for the purpose of relieving the patient's intolerable and incurable suffering…It is understandable, though tragic, that some patients in extreme duress--such as those suffering from a terminal, painful, debilitating illness--may come to decide that death is preferable to life. However, permitting physicians to engage in euthanasia would ultimately cause more harm than good. Euthanasia is fundamentally incompatible with the physician's role as healer, would be difficult or impossible to control, and would pose serious societal risks.

The involvement of physicians in euthanasia heightens the significance of its ethical prohibition. The physician who performs euthanasia assumes unique responsibility for the act of ending the patient's life. Euthanasia could also readily be extended to incompetent patients and other vulnerable populations….Instead of engaging in euthanasia, physicians must aggressively respond to the needs of patients at the end of life. Patients should not be abandoned once it is determined that cure is impossible. Patients near the end of life must continue to receive emotional support, comfort care, adequate pain control, respect for patient autonomy, and good communication.

Similar positions are endorsed by the American Nursing Association. Despite these position statements, a number of U.S. states (including Oregon, Washington, California, and Vermont) have recently legalized physician-assisted suicide, and an increasing number of medical professionals (though still probably a minority) have come out in favor of it. In 2015, the Canadian Supreme Court held that citizens had a right to euthanasia, and in 2016 it became legal throughout Canada.

3.1 JAMES RACHELS' ARGUMENT FOR LEGALIZING EUTHANASIA

In a famous article in the *New England Journal of Medicine,* James Rachels argues that the AMA should change its position on euthanasia (he is discussing an older version, but the basic content is the same). He begins by differentiating between two "types" of euthanasia:

- **Passive Euthanasia** involves intentionally allowing a patient to die by withholding or withdrawing treatment, and allowing the underlying disease or condition to take its course. Rachels argues that AMA guidelines allow this, even though they don't call it euthanasia".

- **Active Euthanasia** involves "killing" a patient by means such as lethal injection. The AMA guidelines explicitly forbid this.

The Argument: Rachels argues that *if* we allow passive euthanasia (which he argues that the AMA *does* allow), then we should ALSO allow active euthanasia. *Why?* Because passive euthanasia often causes much

more suffering to patients than does active euthanasia. If medical staff are genuinely interested in the well-being of their patients, they should be open to active euthanasia, at least in some circumstances.

Example: Down syndrome infants often grow up to lead perfectly happy lives. Nevertheless, many parents/physicians have chosen to allow the *intestinal blockages* often associated with Down syndrome to kill these infants (since they don't want to raise them, and there are not enough adoptive families). At the time Rachels was writing, the AMA supported the legal right of parents to make decisions "quality of life decisions" regarding the medical care of children. In years since, the AMA has states that physicians should notify ethics boards and/or government agencies in cases where parents' judgments about the quality of life for a given infant seems suspect.

Rachel's response. The AMA's original position (that it is OK to "let" these infants die, but not to kill them) is the worst of all possible worlds. If killing these infants (who might have good lives!) is wrong, then so is allowing them to die by not treating the intestinal blockage. If it *is* OK to let these infants die (perhaps out of respect to parents' choices), then it would be morally preferable to kill them painlessly (active euthanasia), rather than allow them to starve to death over an extended time period. (The AMA's revisions appear to have partly met Rachels' criticism regarding Down syndrome, though these sorts of cases—infants dying slowly over months—still occur regularly).

3.2 SMITH AND JONES: KILLING AND LETTING DIE

Rachels thinks that the AMA's position actually reflects a deeper intuition many people have: that it is *worse* to kill than to let die. He thinks that this is NOT a trustworthy intuition, and offers the following two cases in an attempt to show what is wrong with it:

In the first, Smith stands to gain a large inheritance if anything should happen to his six-year-old cousin. One evening while the child is taking his bath, Smith sneaks into the bathroom and drowns the child, and then arranges things so that it will look like an accident.

In the second, Jones also stands to gain if anything should happen to his six-year-old cousin. Like Smith. Jones sneaks in planning to drown the child in his bath. However, just as he enters the bathroom Jones sees the child slip and hit his head, and fall face down in the water. Jones is delighted; he stands by, ready to push the child's head back under if it is necessary, but it is not necessary. With only a little thrashing about, the child drowns all by himself, "accidentally," as Jones watches and does nothing.

Rachels argues that *if* the difference between killing and letting die were really of moral importance, then Smith did something morally worse than Jones. However, he argues that this isn't true—both men are equally blameworthy. After all, they both men had the exact same *motive* (personal gain) and the same *end.* He recognizes that this isn't *usually* true of killing and letting die (often, most killers really *do* want their victim dead, while those who let people die might just be ignorant or preoccupied). But this just supports his main point: we need to pay attention to the specifics of the case, and not on whether it counts as "killing" or "letting." In the case of medicine, most decisions regarding passive euthanasia *are* intentional: the physicians know perfectly well both *what* will happen if they stop treatment (the patient will die) and *why* they are doing so (it is for the patients' "own good").

Figure 3 The Arrival of Death (Brendan Shea x Dall-E).

So what position should medical professionals take on euthanasia? For medical staff, Rachels' argument cuts both ways: he argues that passive euthanasia can be deeply morally wrong (intentionally allowing an easily curable patient to die) and that active euthanasia can sometimes be morally OK (even though it involves "killing the patient'). And none of this bears on issues such as the medical/legal "cause of death": Rachels is perfectly willing to grant that letting a patient die from cancer (passive euthanasia) really is different from killing the patient with an injection (active euthanasia). He just doesn't think that this is a *morally relevant* difference.

3.3 ARGUMENTS FOR PROHIBITING ACTIVE EUTHANASIA

Not everyone is convinced by Rachels' arguments for allowing "active" euthanasia. The most commonly cited counterarguments are as follows:

1. **It undercuts physicians (and nursing staff) roles as "healers."** This criticism contends that even if patients have the right to kill themselves, physicians and nursing staff shouldn't be helping them with it. This is because doing so somehow interferes with the roles as "healers." This might happen in several ways. For example, it cause patients to lose faith in their own medical staff ("Maybe they're going to kill me!") or it might cause emotional problems for those medical staff that engaged it (e.g., maybe helping some patients die would somehow compromise their ability to "care about" other patients at the end of life, particularly those who did NOT choose euthanasia." The general idea is that there is value in having an *absolute* prohibition on medical staff killing.
2. **Risk to vulnerable populations?** In recent years, most arguments *against* legalized euthanasia have focused less on trying to show that some is "intrinsically" wrong with killing, and mor on showing the possible negative *consequences* of allowing physicians to kill. In particular, critics of legalized euthanasia (including the AMA) have argued that vulnerable populations (such as those with Alzheimer's) risk being taken advantage of by predatory family members or medical staff. They argue that, even if active euthanasia is *morally* acceptable in some cases, it should nevertheless remain *illegal.*
3. **There's little benefit to allowing it.** Finally, either/both of the above arguments are often paired with the claim that active euthanasia doesn't really deliver the benefits that are claimed. In particular, critics argue that with adequate pain control (and with access to "passive euthanasia" if needed), there's simply no need for patients to suffer at the end of life.

In general, defenders of active euthanasia have responded to all these claims by arguing that they simply get the "facts" wrong. That is, it simply does NOT seem to be true that states/countries that have allowed euthanasia have (1) made physicians/nursing less caring or (2) killed lots of "innocent" elderly people. Also, (3) there are significant limitations to current "pain management" strategies, and so active euthanasia could be a rational/ethical choice for some people.

3.4 REVIEW QUESTIONS

1. What does Rachel mean by *passive* and *active euthanasia?* Which of these does he think the AMA is OK with? In what way does he think the AMA's position should *change?* Do your best to explain Rachel's position in your own words.

2. What is a possible objection to Rachel's argument (see above)? Do you think it works?

3. All things considered, do you think that euthanasia and/or physician-assisted suicide ought to be legalized? Why? If it should be legalized, what sorts of policies/limits would be appropriate?

4 READING: THE PRINCIPLE OF DOUBLE EFFECT AND PROPORTIONATE REASON (BY NICHOLAS KOCKLER)[2]

[Brendan's Note: This short article was written to provide contemporary medical staff an idea of what the DDE is, and how it works.]

Mrs. Wilson recently discovered that she had an ectopic pregnancy—the embryo was implanted in her fallopian tube. Her physician admitted her to a Catholic medical center for treatment and scheduled a salpingostomy (a surgery that makes an incision in the fallopian tube through which the embryo is removed). But an ethics-savvy surgery center nurse questioned whether that procedure was morally permissible given the Catholic identity of the hospital. The nurse called the bioethics committee to inquire whether the doctor should perform a salpingectomy (surgical removal of the fallopian tube) instead, fearing that the Catholic Church considers a salpingostomy to be a direct abortion.

Mr. Jones has advanced metastatic liver cancer with neoplasms in his bones that cause excruciating pain. He has built up tolerance for virtually all pain medications; his doctors believe that one of the few remaining ways to alleviate his pain is to sedate him. Mr. Jones has said that he no longer wants any curative treatments. The Catholic hospital in which Mr. Jones is receiving care has a strong stance against euthanasia and physician-assisted suicide. Members of Mr. Jones's family approach his doctors and unanimously request, "Please end his life so he can stop suffering."

How does one begin to make sense of these cases? What morally viable options are available for the patients and health care professionals? The principle of double effect enables bioethicists and Catholic moralists to navigate various actions that may or may not be morally justifiable in some circumstances. The questions in this essay are the following: What are the principle of double effect and its proportionate reason condition? How do they function in clinical situations—at both the beginning of life and at the end of life? Despite historical and contemporary debates on the interpretation and application of these concepts, the principle of double effect developed within the long history of Catholic moral theology as a conceptual tool for determining the moral permissibility or justification of actions that have both good and bad (evil) effects. Proportionate reason is one of four conditions of the principle of double effect. In various ways, the principle of double effect and proportionate reason assist decision makers in moral analysis in both Catholic and non-Catholic health care settings.

4.1 THE PRINCIPLE OF DOUBLE EFFECT

The history of the principle of double effect dates at least as far back as the work of St. Thomas Aquinas. Although St. Thomas did not use the term "double effect" or refer to the principle, he used the concept in justifying killing in self-defense [1]. In so doing, he recognized the bad effect (death of the assailant) and the good effect (preservation of the victim's life). Can one justifiably kill an attacker to save his or her life? St. Thomas answered in the affirmative. Likewise those who use the principle of double effect today attempt to discern the rightness or wrongness of actions that will have both good and bad (evil) effects.

To make such a determination, one must analyze an action on the basis of four conditions; all of which must be met for the action to be morally justifiable. The conditions of the principle of double effect are the following [2]:

[2] Nicholas J. Kockler, "The Principle of Double Effect and Proportionate Reason," *AMA Journal of Ethics* 9, no. 5 (May 1, 2007): 369–74, https://doi.org/10.1001/virtualmentor.2007.9.5.pfor2-0705.

1. The act-in-itself cannot be morally wrong or intrinsically evil [3].
2. The bad effect cannot cause the good effect.
3. The agent cannot intend the bad effect.
4. The bad effect cannot outweigh the good effect; there is a proportionate reason to tolerate the bad effect.

In analyzing acts within the framework of the four conditions, one considers that, if the act satisfies the four conditions, then the act is *indirect* and, therefore, morally licit **[Here 'morally licit' means it is morally OK')**. If, however, the act does not fulfill these four conditions (or, according to some interpretations, just the first two conditions) the act is *direct* and, therefore, the act is not morally licit [4]. Some theologians argue that application of the four conditions depends on several factors, not the least of which are how one formulates the conditions and how one describes the act. In fact, some argue that the first three conditions are three statements of the same moral proposition: the act cannot be intrinsically evil.

By analyzing our example cases we can appreciate why certain acts are permissible and others are not. In Mrs. Wilson's case, a traditional application of the principle indicates that salpingostomies are *direct* abortions whereas salpingectomies are *indirect* abortions. This conclusion is not without controversy, especially given the development of salpingostomy as the standard of care for ectopic pregnancy [5]. Salpingostomy "directly" attacks the developing embryo, so it does not satisfy the first condition. A surgeon performing a salpingectomy, however, removes the *pathological* tissue (fallopian tube), which does fulfill the first condition. The death of the embryo does not cause, in and of itself, the good effect—preservation of the mother's life; it is the removal of the pathological tissue that causes the good effect, thus fulfilling condition 2. The agent (physician or mother who consents to the procedure) does not intend the death of the embryo, but rather intends the cure of the ailment, thus fulfilling condition 3. The last condition, whether there is a proportionate reason to tolerate the unintended bad effect, asks if the good effect (preserving the life of the mother) outweighs the bad effects—death of the embryo, and, incidentally with salpingectomy, reduction or elimination of the mother's fertility. I will examine proportionate reason more closely below.

In Mr. Jones's case, a traditional application of the principle of double effect indicates that one can administer pain medicine *even if the patient's death is a foreseen, unintended consequence*. How is this justifiable? Is this not euthanasia? The key for Catholic moralists in distinguishing **palliative sedation** (or allowing to die) from euthanasia (or killing) is the way in which the Catholic tradition understands intentionality. Here, the administration of pain or sedative medicine is not, in and of itself, morally wrong (fulfilling condition 1). The death of Mr. Jones, were it to happen, does not cause his relief of pain (fulfilling condition 2)—the sedative medicine accomplishes this. The agent, the physician or Mr. Jones's surrogate decision maker, does not intend on the death of Mr. Jones (fulfilling condition 3). This last statement may seem to contradict the statement provided by the patient's family. Nevertheless, a close examination of the intent behind their statement is his relief from suffering caused by his pain. Arguably, Mr. Jones's family sees his death as the only means to achieve this end or is unable to distinguish between pain relief and death. Again, is there a proportionate reason for tolerating the bad outcome that would permit sedating Mr. Jones? I now turn to that question.

[Brendan's Question: In your own words, what is the argument that pain medicine (even if kills Mr. Jones!) meets the first three conditions of DDE?]

4.2 PROPORTIONATE REASON

As mentioned above, proportionate reason grounds the fourth condition of the principle of double effect. How does one determine whether the good effect outweighs the bad effect? The phrasing of this question is

immediately problematic. One of the main critiques of proportionate reason is its mathematical connotation: how can a good effect *outweigh* a bad effect, especially in end-of-life decisions where the bad effect is often death? **Proportionate reason** is a moral principle that one may employ to determine objectively and concretely the rightness or wrongness of actions [6]. Given the other conceptual problems with the principle of double effect, many Catholic theologians and moralists have appealed to proportionate reason in an attempt to delineate a more useful interpretation of the principle or to replace it entirely [7]. Thus, proportionalism developed in response to the more problematic approaches to the principle. One should note, however, that even in the traditional formulations of the principle, proportionate reason is a central feature of the four conditions, so traditional interpretations require a concept of proportionality [8].

One should not understand proportionate reason in purely mathematical terms, but rather as a balance between values and disvalues in determining whether the means (an act) is *proportionate* to the intended end or *reason*. The "reason" (*ratio*) here is not "some serious reason" that an agent identifies to justify the evil effect of the act; alternatively, what many commentators "mean by 'reason' [is] a concrete value which is at stake in the act of an agent" [9]. The term "proportionate" means a formal relation between the reason for the act and the premoral values and disvalues in the act [10]. "More specifically, the term signifies a proper structural relation (*debita proportio*) of the means to the end or of the end to further ends" [11]. Thus, the proper understanding of proportionate reason contains these two dimensions: the reason (*ratio*) and the proper structural relation (*debita proportio*) of the premoral values and disvalues involved in the action. Proportional*ism* is the general analytic structure for determining the rightness or wrongness of actions within which one appeals to proportionate reason [12]. Scholarship on the principle of double effect, proportionalism and proportionate reason is immense and complex. Unfortunately, I can only treat it cursorily here.

One can easily imagine the problems that emerge in the analysis of moral dilemmas using proportionate reason. Nevertheless, several thinkers have offered criteria for whether proportionate reason obtains. Walter describes some candidates:

> *(1) a non-contradiction between the means and the end or between the end and further ends, (2) the means do not undermine the end, (3) the means do not cause more harm than is necessary, (4) in the action as a whole the good outweighs the evil, (5) the means are in a necessary causal relation to the ends, and (6) the means possess the inherent ability to effect the end [13].*

Considering first the definition of proportionate reason and second the criteria that establish it, one should recognize that there are various ways of knowing whether proportionate reason obtains. Walter suggests that there are two general ways of knowing: pre-discursive and discursive knowing. His discussion relates to moral epistemology (i.e., the study of moral knowledge), which need not be discussed in detail here. It suffices to say that several modes of knowing exist, from the intuitivist modes to those of discursive reasoning (i.e., analysis and argument) [14], all of which give one insight as to whether the criteria for proportionate reason have been fulfilled.

Pope John Paul II's encyclical, *Veritatis Splendor*, explicitly condemned proportionalism as a normative ethical theory [15]. But some Catholic theologians suggest that the pope's understanding of proportionalism may not have been entirely accurate [16]. The pope categorized proportionalism as a species of consequentialism, which the church condemns because, using consequentialist reasoning, a desirable end can justify any means. No Catholic moralist or theologian would agree with this extreme position. Like consequentialism, proportionalism is teleological, but one can distinguish it from consequentialism precisely because proportionalism accounts for both *means* (the *debita proportio*) and *ends* (the *ratio*). Moreover, proponents of proportionalism, so-called proportionalists, did not develop proportionalism explicitly as a normative ethical theory. Rather, it was an attempt to expand the fourth condition of the principle of double effect. Whether

proportionalism evolved into a normative ethical theory is subject to further theological and philosophical inquiry beyond the scope of this essay.

In terms of our cases, one sees that proportionate reason exists in both. In Mrs. Wilson's case, one may claim that a salpingectomy fulfills the fourth condition because the good effect (preservation of her life) outweighs the bad effect (death of the embryo). Because the means (removal of pathological tissue) is indirectly ending the early life of the embryo, such means are proportionate to the intended end; there is a non-contradiction between the means and the end. What about a salpingostomy? Or administering methotrexate? The permissibility of salpingostomy requires a re-interpretation of the act in question and a determination of whether it passes the first two conditions. Is a salpingostomy a *direct* abortion?

In Mr. Jones's case, one may argue that terminal sedation fulfills the fourth condition because the good effect (relief of pain) outweighs the bad effect (death of Mr. Jones). Here, the means (palliative sedation) is proportionate to the end (relief from pain) insofar as it is the last remaining option. The question of alternatives can help physicians and surrogate decision makers discern what the true intentions behind certain requests are. Thus, a physician might ask Mr. Jones's decision maker, "If there were any other way to relieve Mr. Jones of his pain, would you want to pursue that option?" If he or she answers yes, then one can claim that his or her intent is not in the death of Mr. Jones, but relief of Mr. Jones's pain. The agent cannot intend both to cause the patient's death and relieve his pain. In this hypothetical case, if there are no alternatives to relieving his pain except for sedating him, there is a proportionate reason to do so, and such an act is not euthanasia (*direct* killing of Mr. Jones).

[Brendan's Question: In your own words, what is the argument that pain medicine (even if kills Mr. Jones!) meets the first fourth/proportionality condition of DDE? Can this same sort of reasoning be applied to Mrs. Wilson?]

4.3 CONCLUSION

In both example cases, one finds justification for certain actions by applying the principle of double effect, which relies upon specific criteria to establish proportionate reason. Though controversial and subject to various interpretations, the principle of double effect and proportionate reason allow sensitivity to various moral issues in health care, especially from a Catholic perspective; they inform the moral reasoning behind several moral norms in Catholic teaching (e.g., in the *Ethical and Religious Directives for Catholic Health Care Services*); and they represent useful analytical tools for resolving complex moral dilemmas confronted by providers in a variety of health care contexts, Catholic or non-Catholic.

4.4 REFERENCES

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4. Kelly, 111-112.
5. Kelly, 113-116.
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10. Following Walter, I use the term "premoral" here to signify real value or disvalue that is present prior to an agent's moral judgment or decision; such premoral values and disvalues are relevant for moral judgment and decisions but do not determine the morality of an action.
11. Walter, Proportionate reason, 394-395.
12. Walter, The foundation, 131.
13. Walter, Proportionate reason, 397.
14. Walter, Proportionate reason, 399-403.

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5 READING: ACTIVE AND PASSIVE EUTHANASIA (JAMES RACHELS)[3]

Abstract The traditional distinction between active and passive euthanasia requires critical analysis. The conventional doctrine is that there is such an important moral difference between the two that, although the latter is sometimes permissible, the former is always forbidden. This doctrine may be challenged for several reasons. First of all, active euthanasia is in many cases more humane than passive euthanasia. Secondly, the conventional doctrine leads to decisions concerning life and death on irrelevant grounds. Thirdly, the doctrine rests on a distinction between killing and letting die that itself has no moral importance. Fourthly, the most common arguments in favor of the doctrine are invalid. I therefore suggest that the American Medical Association policy statement that endorses this doctrine is unsound. (N Engl J Med 292:78-80, 1975) .

…

The distinction between active and passive euthanasia is thought to be crucial for medical ethics. The idea is that it is permissible, at least in some cases, to withhold treatment and allow a patient to die, but it is never permissible to take any direct action designed to kill the patient. This doctrine seems to be accepted by most doctors, and it is endorsed in a statement adopted by the House of Delegates of the American Medical Association on December 4, 1973:

The intentional termination of the life of one human being by another -mercy killing - is contrary to that for which the medical profession stands and is contrary to the policy of the American Medical Association.

The cessation of the employment of extraordinary means to prolong the life of the body when there is irrefutable evidence that biological death is imminent is the decision of the patient and/or his immediate family. The advice and judgment of the physician should be freely available to the patient and/or his immediate family.

However, a strong case can be made against this doctrine. In what follows I will set out some of the relevant arguments, and urge doctors to reconsider their views on this matter.

To begin with a familiar type of situation, a patient who is dying of incurable cancer of the throat is in terrible pain, which can no longer be satisfactorily alleviated. He is certain to die within a few days, even if present treatment is continued, but he does not want to go on living for those days since the pain is unbearable. So he asks the doctor for an end to it, and his family joins in the request.

Suppose the doctor agrees to withhold treatment, as the conventional doctrine says he may. The justification for his doing so is that the patient is in terrible agony, and since he is going to die anyway, it would he wrong to prolong his suffering needlessly.

[3] James Rachels, "Active and Passive Euthanasia," *New England Journal of Medicine* 292, no. 2 (January 9, 1975): 78–80, https://doi.org/10.1056/NEJM197501092920206.

But now notice this. If one imply withholds treatment, it may take the patient longer to die, and so he may suffer more than he would if noire direct action were taken and a lethal injection given. This fact provides strong reason for thinking that, once the initial decision not to prolong his agony has been made active euthanasia is actually preferable to passive euthanasia, rather than the reverse. To say otherwise is to endorse the option that leads to more suffering rather than less, and is contrary to the humanitarian impulse that prompts the decision not to prolong his life in the first place.

Part of my point is that the process of being "allowed to die" can be relatively slow and painful, whereas being given a lethal injection is relatively quick and painless. Let me give a different sort of example. In the United States about one in 600 babies is born with Down's syndrome. Most of these babies are otherwise healthy -that is, with only the usual pediatric care, they will, proceed to an otherwise normal infancy. Some, however, are born with congenital defects such as intestinal obstructions that require operations if they are to live. Sometimes, the parents and the doctor will decide not to operate, and let the infant die. Anthony Shaw describes what happens then:

...When surgery is denied (the doctor I must try to keep the infant from suffering while natural forces sap the baby's life away. As a surgeon whose natural inclination is to use the scalpel to fight off death, standing by and watching a salvageable baby die is the most emotionally exhausting experience I know. It is easy at a conference, in a theoretical discussion, to decide that such infants should be allowed to die. It is altogether different to stand by in the nursery and watch as dehydration and infection wither a tiny being over hours and days. This is a terrible ordeal for me and the hospital staff - much more so than for the parents who never set foot in the nursery.

I can understand why some people are opposed to all euthanasia, and insist that such infants must be allowed to live. I think f can also understand why other people favor destroying these babies quickly and painlessly. But why should anyone favor letting "dehydration and infection wither a tine being over hours and days?" The doctrine that says that a baby may be allowed to dehydrate and wither, but may not for given art injection that would end its life without suffering, seems so patently cruel as to require no further refutation. The strong language is not in. tended to offend, but only to put the point in the clearest possible way.

My second argument is that the conventional doctrine leads to decisions concerning life and death made on irrelevant grounds.

Consider again the case of the infants with Down's syndrome who need operations for congenital defects unrelated to the syndrome to live. Sometimes, there is no operation, and the baby dies, but when there is no such defect, the baby lives on. Now, an operation such as that to remove an intestinal obstruction is not prohibitively difficult. The reason why such operations are not performed in these cases is, clearly, that the child has Down's syndrome and the parents and doctor judge that because of that fact it is better for the child to die.

But notice that this situation is absurd, no matter what view one takes of the lives and potentials of such babies. 1 f the life of such an infant is worth preserving, what does it matter if it needs a simple operation? Or, if one thinks it letter that such a baby should not live on, what difference does it make that it happens to have an unobstructed intestinal tract? In either case, the matter of life and death is being decided on irrelevant grounds. It is the Down's syndrome, and not the intestines, that is the issue. The matter should be decided, if at all, on that basis, and hot be allowed to depend on the essentially irrelevant question of whether the intestinal tract is blocked.

What makes this situation possible, of course, is the idea that when there is an intestinal blockage, one can "let the baby die," but when there is no such defect there is nothing that can be done, for one must not "kill"

it. The fact that this idea leads to such results as deciding life or death on irrelevant grounds is another good reason why the doctrine should be rejected.

One reason why so many people think that there is an important moral difference between active and passive euthanasia is that they think killing someone is morally worse than letting someone die. But is it? Is killing, in itself, worse than letting die? To investigate this issue, two cases may be considered that are exactly alike except that one involves killing whereas the other involves letting someone die. Then, it can be asked whether this difference makes any difference to the moral assessments. It is important that the cases be exactly alike, except for this one difference, since otherwise one cannot be confident that it is this difference and not some other that accounts for any variation in the assessments of the two cases. So, let us consider this pair of cases:

In the first, Smith stands to gain a large inheritance if anything should happen to his six-year-old cousin. One evening while the child is taking his bath, Smith sneaks into the bathroom and drowns the child, and then arranges things so that it will look like an accident.

In the second, Jones also stands to gain if anything should happen to his six-year-old cousin. Like Smith. Jones sneaks in planning to drown the child in Ills bath. However, just as fie enters the bathroom Jones sees the child slip and hit his head, and fall face down in the water. Jones is delighted; he stands by, ready to push the child's head back under if it is necessary, but it is not necessary. With only a little thrashing about, the child drowns all by himself, "accidentally," as Jones watches and does nothing.

Now Smith killed the child, whereas Jones "merely" let the child die. That is the only difference between them. Did either man behave better, from a moral point of view? If the difference between killing and letting die were in itself a morally important matter, one should say that Jones's behavior was less reprehensible than Smith's. But does one really want to say that? I think not. In the first place, both men acted from the same motive, personal gain, and both had exactly the same end in view when they acted. I t may be inferred from Smith's conduct that he is a bad man, although that judgment may be withdrawn or modified if certain further facts are learned about him - for example, that he is mentally deranged. But would not the very same thing be inferred about Jones from his conduct? And would not the same further considerations also be relevant to any modification of this judgment? Moreover, suppose Jones pleaded, in his own defense, "After all, I didn't do anything except just stand there and watch the child drown. I didn't kill him; I only let him die." Again, if letting die were in itself less bad than killing, this defense should have at least some weight. But it does not. Such a "defense" can only be regarded as a grotesque perversion of moral reasoning. Morally speaking, it is no defense at all.

Now, it may be pointed out, quite properly, that the cases of euthanasia with which doctors are concerned are not like this at all. They do not involve personal gain or the destruction of normal healthy children. Doctors are concerned only with cases in which the patient's life is of no further use to him, or in which the patient's life has become or will soon become a terrible burden. However, the point is the same in these cases: the bare difference between killing and letting die does not, in itself, make a moral difference. If a doctor lets a patient die, for humane reasons, he is in the same moral position as if he had given the patient a lethal injection for humane reasons. If his decision was wrong - if, for example, the patient's illness was in fact curable -the decision would be equally regrettable no matter which method was used to carry it out. And if the doctor's decision was the right one, the method used is not in itself important.

The AMA policy statement isolates the crucial issue very well; the crucial issue is "the intentional termination of the life of one human being by another." But after identifying this issue, and forbidding "mercy killing," the statement goes on to deny that the cessation of treatment is the intentional termination of a life. This is where the mistake conies in, for what is the cessation of treatment, in these circumstances, if it is not "the intentional termination of the life of one human being by another?" Of course it is exactly that, and if it were not, there would be no point to it.

Many people will find this judgment hard to accept. One reason, I think, is that it is very easy to conflate the question of whether killing is, in it, worse than letting die, with the very different question of whether most actual cases of killing are more reprehensible than most actual cases of letting die. Most actual cases of killing are clearly terrible (think, for example, of all the murders reported in the newspapers), and one hears of such crises every day. On the other hand, one hardly ever hears of a race of letting die, except for the actions of doctors who are motivated by humanitarian reasons. So one learns to think of killing in a much worse light than of letting die. But this does not mean that there is something about killing that makes it in itself worse than letting die. for it is not the bare difference between killing and letting die that makes the difference in these cases. Rather, the other factors - the murderer's motive of personal gain, for example, contrasted with the doctor's humanitarian motivation -account for different reactions to the different cases.

I have argued that killing is not in itself any worse than letting die; if my contention is right, it follows that active euthanasia is not any worse than passive euthanasia. What arguments can be given on the other side? The most common, I believe, is the following:

"The important difference between active and passive euthanasia is that, in passive euthanasia, the doctor does not do anything to bring about the patient's death. The doctor does nothing, and the patient dies of whatever ills already afflict him. In active euthanasia, however, the doctor does something to bring about the patient's death: he kills him. The doctor who gives the patient with cancer a lethal injection has himself caused his patient's death; whereas if he merely ceases treatment, the cancer is the cause of the death."

A number of points need to be made here. The first is that it is not exactly correct to say that in passive euthanasia the doctor does nothing, for he does do one thing that is very important: he lets the patient die. "Letting someone die" is certainly different, in some respects, from other types of action - mainly in that it is a kind of action that one may perform by way of not performing certain other actions. For example, one may let a patient die by way of not giving medication, just as one may insult someone by way of not shaking his hand. But for any purpose of moral assessment, it is a type of action nonetheless. The decision to let a patient die is subject to moral appraisal in the same way that a decision to kill him would be subject to moral appraisal: it may be assessed as wise or un rise, compassionate or sadistic, right of wrong. If a doctor deliberately let a patient die who was suffering from a routinely curable illness, the doctor would certainly be to blame for what he had done, just as he would be to blame if he had needlessly killed the patient. Charges against him would then be appropriate. If so, it would be no defense at all for him to insist that he didn't "do anything." He would have done something very serious indeed, for he let his patient die.

Fixing the cause of death may be very important from a legal point of view, for it may determine whether criminal charges are brought against the doctor. But I do not think that this notion can be used to show a moral difference between active and passive euthanasia. The reason why it is considered bad to be the cause of someone's death is that death is regarded as a great evil - and so it is. However, if it has been decided that euthanasia - even passive euthanasia - is desirable in a given case, it has also been decided that in this instance death is no greater an evil than the patient's continued existence. And if this is true, the usual reason for not wanting to be the cause of someone's death simply does not apply.

Finally, doctors may think that all of this is only of academic interest - the sort of thing that philosophers may worry about but that has no practical bearing on their own work. After all, doctors must be concerned about the legal consequences of what they do, and active euthanasia is clearly forbidden by the law. But even so, doctors should also be concerned with the fact that the law is forcing upon them a moral doctrine that may well be indefensible, and has a considerable effect on their practices. Of course, most doctors are not now in the position of being coerced in this matter, for they do not regard themselves as merely going along with what the law requires. Rather, in statements such as the AMA policy statement that I have quoted, they are endorsing this doctrine as a central point of medical ethics. In that statement, active euthanasia is condemned

not merely as illegal but as "contrary to that for which the medical profession stands," whereas passive euthanasia is approved. However, the preceding considerations suggest that there is really no moral difference between the two, considered in themselves (there may be important moral differences in some cases in their *consequences,* but, as I pointed out, these differences may make active euthanasia, and not passive euthanasia, the morally preferable option). So, whereas doctors may have to discriminate between active and passive euthanasia to satisfy the law, they should not do any more than that. In particular, they should not give the distinction any added authority and weight by writing it into official statements of medical ethics.

Brendan's Questions:

1. According to James Rachels, how might active euthanasia lead to less suffering than passive euthanasia?
2. What is the point of Rachels' example about Smith and Jones and the drowning baby?
3. Do you agree with Rachels that IF we allow passive euthanasia ("letting patients die") the we should also allow active euthanasia? Why or why not?

6 READING: IF YOU COULD CHOOSE, WHAT WOULD MAKE FOR A GOOD DEATH? (BY DANIEL CALLCUT)[4]

One day you wake early, walk into town, and a large advertising billboard attracts your attention. The image on the poster is mysterious but appears to depict a ceremony in a forest. *You didn't choose to come into this world*, says the text across the middle, *but you can choose how you leave*. To the bottom right of the poster is a company name, *Designer Endings*, and contact details. You call the number and confirm that what is being offered is indeed the chance to die in just the way you would like.

The description is fiction – there aren't currently any **designer euthanasia** organisations or companies – but it's worth wondering why it isn't yet fact. Many people no longer hold the kind of religious views according to which our time of death is not allowed to be of our choosing. There are an increasing number of countries where physician-assisted suicide and euthanasia is permitted in a medical context. But why think that the right to choose our ending is given legitimacy only, if at all, on health grounds? Why don't we have the right to end our lives not just when we want to but to also do so in style?

The word 'euthanasia' comes from the Greek for a 'good death'. However, this idea of a positively good death can easily be lost in contemporary debates over euthanasia where the emphasis is typically on the rights of a person in very dire health. I will touch on the familiar questions of medical ethics in what follows. But my larger goal is to liberate discussion of the right to die from the medical settings in which it is now most familiar. To do so allows us to think about euthanasia – a good death – in less bleak circumstances.

We don't ever, strictly speaking, get to experience death, as death is the end of experience. As the Austrian philosopher Ludwig Wittgenstein wrote, death is not an event in life. But there's no reason why death couldn't be an event in the sense that a wedding is an event. You could decide the date and make extensive arrangements for the location and the nature of the ceremony. You could draw up a guest list. You might plan for friends to read farewells and lines of verse. You could give a speech of your own or, for the karaoke-inclined, sing 'My Way'.

[4] Daniel Callcut, "If You Could Choose, What Would Make for a Good Death?," *Aeon*, January 14, 2020, https://aeon.co/essays/if-you-could-choose-what-would-make-for-a-good-death.

You might not have many family or friends – or not want them there in any case. No doubt a company such as my fictitious 'Designer Endings' could provide staff for the ceremony you have in mind. This could cause controversy: no doubt some people's visions for their death ceremony would be bacchanalian and orgiastic. You can imagine the many corny ideas about how to go not with a whimper but with a bang. People might look for inspiration from pagan festivals such as Burning Man in Nevada. Others would no doubt look to film and literature in designing the stage for their exit. Tastes, especially once allowed to flourish, would vary: we differ in how we want to leave as much as in how we want to live. Some want the intensity of chemsex, others want the calm of a cup of tea. The very wealthy might try to hire singers such as Lana Del Rey for their goodbye ceremony. Others might opt for a death metal band.

We are not short of examples of imaginative funerals and creative posthumous plans. In 2005, the US writer Hunter S Thompson's ashes were fired from a cannon at an elaborate $3 million event funded by the actor Johnny Depp. Audience members such as fellow actors Bill Murray and Benicio del Toro watched as Thompson's remains were launched in the air to the tune of 'Spirit in the Sky' and 'Mr Tambourine Man'. Sir Clough Williams-Ellis, the creator of the Italianate village Portmeirion in North Wales, also had his ashes propelled into the air by marine rocket in 1998. That's just one idea about what to do after you go. Consider all the ways that a person's death has been marked by cultures around the world and throughout history. There's no reason to think that people's euthanasia plans might not be just as inventive. The sky's not the limit.

Traditional arguments for assisted suicide and euthanasia appeal to compassion and individual liberty. Think, first, of the case for compassion. Sometimes 'death is a kindness', as the gang-leader-turned MP Tommy Shelby says in the BBC drama *Peaky Blinders* (2013-). Consider how we treat other animals. Why insist that humans must go on suffering – after they have made clear that they don't want to – when we would relieve a dog or a horse? So empathy and compassion could lead you to defend the right to assisted suicide and euthanasia. And it could lead you to defend the right to choose the setting for one's end. If a human being is helped to die, then there is no reason why the end must always be in a hospice or hospital even if, for practical reasons, this will be necessary sometimes.

The value of individual liberty **[Brendan's Note: This is what we've called "autonomy."]** also points in favour of the right to end one's life. The most central idea of liberal individualism is that your life is your own and that you have the right to live it as you see fit – you decide your job, your religion, whether you want your hair blue, and so on. This individualistic ideal, perhaps most impressively articulated by the English social liberal John Stuart Mill in his essay *On Liberty* (1859), has clearly had an enormous influence on many contemporary societies. And it's surely in keeping with the spirit of this compelling ideal that the right to lead your life as you wish includes the right to end it when you wish. That is to say: you have a right to die.

Mill thought that individual liberty had to include the right to do as one likes with one's own self – even harming it (whether intentionally or not) through drinking, gambling and so on. That, for Mill, is just what it means to be a free person. **Brendan: This is called Mill's "Harm Principle."]** So it's hard to see how a liberal can oppose the right to take one's life given that such a right is perhaps the ultimate expression of one's unique rights *vis-à-vis* one's self. This is true even if one acknowledges that the claims of individual freedom always have to be balanced with other claims. Mill, for example, qualified his position to allow that society might be justified in intervening in self-harming cases when a person has dependents (such as children). And a plausible position on the right to die will allow for carefully considered social interventions in the case of suicidal mental illness.

The ideal of individual freedom has already overturned many social and sexual taboos: why not death?

Mill argued that a free person had the right to do as he likes so long as he doesn't harm other people. But surely, one might object, Mill's 'harm principle' must outlaw euthanasia, for death is a harm. Doctors who

oppose euthanasia, after all, often do so precisely on the basis that the Hippocratic oath requires that they do no harm. Indeed, some draw an ethical line between the permissibility of assisted suicide and that of euthanasia, for this reason. When it comes to assisted suicide, even if a person is helped to take his life, the final action (eg, swallowing pills) is his own. Assisted suicide remains, ultimately, suicide. And Mill's 'harm principle' allows you to harm yourself. But, in euthanasia, the action that takes someone's life (eg, a lethal injection) is not performed *by* the patient but *for* him. Euthanasia is ultimately an act of killing, even if performed in accordance with the dying person's wishes.

[Brendan's Question: Do you agree with Mill's Harm Principle—the idea that people should be able to do whatever they want, provided it doesn't harm others? Why or why not?]

It might be argued in response that, even if euthanasia involves killing, death isn't always a harm. Perhaps to be alive in some situations is a fate worse than death, and death in such circumstances would be a benefit. Some might argue that allowing assisted suicide and yet not allowing euthanasia is unfair to those who are physically incapable of taking their own lives. Others might add that, in a free society, it should be left to individuals to decide what constitutes a harm or a benefit *vis-à-vis* their own lives. Finally – and this is perhaps the strongest rejoinder of all – it could be argued that the standard that matters in liberal societies is not harm but adult consent. If two or more adults are respecting each other's freely given consent, then they should be able to do as they like.

Many of us already live in societies that allow consenting adults to harm one another: think about boxing, for example, and forms of BDSM sex that involve consensual injury. Consider, more mundanely, the sale and consumption of those sugary drinks we all know are harmful to health. *It's your life*, as we say, *it's up to you*. If, to adapt Cole Porter, anything (consensually) goes, then it's hard to see why individuals shouldn't have the ability to form agreements with companies such as Designer Endings. Governments shouldn't, as the US libertarian philosopher Robert Nozick wrote in *Anarchy, State, and Utopia* (1974), 'forbid capitalist acts between consenting adults'.

The idea of designer euthanasia naturally flows out of what many consider a positive development in the modern world – the enormous value placed upon free choice and the voluntary. The ideal of individual freedom has already overturned many social and sexual taboos: why not death? And if the worry is that legalising designer euthanasia would send everyone rushing to arrange their death, then I think we should worry about why we have this worry. Have we made life on Earth so dire that death presents a welcome alternative? Do we have to keep all appealing escape routes unavailable? The upshot of anxiety about the idea of Designer Endings should be to take greater responsibility for the social world that we have created. It's undesirable, in a free society, to make people prisoners of existence.

But is the way forward to turn death into a marketplace? Many of us already live in business-obsessed cultures that threaten to turn life into one long sales pitch. Capitalism, as Marxists have long observed, grows in part by colonising aspects of life once thought too precious to be framed as a business opportunity. These business opportunities are often celebrated as new freedoms – as when a religious day of rest is opened up for shopping – but can be met with a sad sense that life has become entirely owned by commercial activity. Thus, the idea that people should design their death in coordination with euthanasia businesses perhaps sounds like one more dystopian capitalist possibility of the near-future. The prospect might produce not just moral outrage but aesthetic horror – akin to hearing of proposals to beam advertising on to the Moon.

Karl Marx marvelled at capitalism's creative upheaval: he was an admirer as well as a critic. But if the idea of turning euthanasia into a business is what you find most objectionable about designer euthanasia, then think of Designer Endings as a cooperative nonprofit run by a group of friendly anarchists. The point, ultimately, is to liberate discussion of euthanasia from its standard medical context, and to cultivate our sense of possibilities with regards to death. We can't, for practical medical reasons, always take euthanasia away from

doctors but it's nonetheless worth thinking of how euthanasia might be liberated from medicine in the same way that, say, weddings have been liberated from religion. There is a wide and wild range of ways that we might want to have the freedom to die. Chosen death need not always be desperate or despairing or the best of one's bad options.

Consider why a person might reasonably decide that now is the right time to die, and not for immediate medical reasons. Perhaps someone looks at the shape of her life and wants not to hang on, as it were, to the bitter end but thinks that this is a good time to go. She wants to die happily. Who is to say that this cannot be a shrewd assessment made with a clear-headed comprehension of the fact that we must all go at some time? We can imagine other, more controversial cases. What about a couple who wish to arrange a *Liebestod* or 'love death'? Should they be permitted to design a romantic and erotic end together, as is their wish? What about those who want to die young? Or die fighting?

The poor might continue to die painful, unchosen deaths while the wealthy have grand farewell parties

Discussions of the right to die tend to draw a distinction between negative rights and positive rights. So-called negative rights are simply rights to noninterference. A right to die, understood in this light as a negative right, is simply a right that requires others to keep out of your business. Positive rights, by contrast, are entitlements to active help. Thus, a child's positive right to education might be construed as a right to free schooling. You have to be careful, when politicians tell you that you have the right to something, which kind of right they have in mind. Think of the debate over healthcare in the United States. A right to medical care could mean a positive right to be provided with free healthcare, or it could simply mean the negative right to purchase healthcare without interference – in the same way that you have a right to buy a Ferrari if you can afford one.

[Brendan's Question: What is the difference between positive and negative rights? Can you give examples?]

New freedoms and new abilities often generate new inequalities. Many will think that, if there is a right to die, then it is a negative right: simply a protected space for you to decide to end your life as you like without interference. Designer euthanasia, in such circumstances, could be legal – the question would then be, if you want it, can you afford it? Death, as the old saying goes, is the great leveller, and at least one of the insights packed into this expression is the thought that none of us gets to control when or how we die. But designer euthanasia would change this. The poor might continue to die painful, natural, unchosen deaths while the wealthy have grand farewell parties. This is not necessarily an argument against permitting chosen endings: after all, it's also an argument for a fairer distribution of wealth. But it's undoubtedly one of the potential consequences of legally allowing people to choose and control the time and manner of their death.

A free society ought to recognise one of the most basic freedoms of all: the freedom to die when one chooses. What I have argued is that the liberal grounds for permitting medical euthanasia are also grounds for permitting chosen death more broadly – ie, not just for medical reasons, and not necessarily in a medical setting. We can think more expansively about what kinds of endings we might choose if given the social and political freedom to do so. There is room to be far more active and imaginative, and less passive and resigned, in relation to death. We have the ability to transform what might seem like fantasy into a live, practical question: if you could choose, what would make for a good death?

Imagine a routine scan reveals that you have incurable cancer. The medical consultant estimates you have three months left to live at most. You remember the poster from Designer Endings. Six weeks later – and after some quick planning – you are partying in a forest. You have swallowed a cocktail of drugs that will end your life in a matter of hours. The only side-effect is a mild euphoria that you would be experiencing anyway. The music pulses through your body for what will be the last time. You chat and hug with friends. You kiss your children. The sunlight turns golden through the trees. You experience the feeling of oneness with the

Universe that Sigmund Freud referred to as oceanic. You are glad, as tears fill your eyes, that this is how you get to say goodbye.

[Brendan's Question: What do you think of the idea of allowing "designer euthanasia" for anyone/everyone who wants it, and not just the terminally ill? Has the author convinced you? Why or why not?]

7 CASE STUDY: HURRICANE KATRINA AND DR. POU (ETHICS BOWL)

From: High School Ethics Bowl Regional Ethics Bowl Cases Season 2014-15, Authored By: Sam Reis-Dennis Jason Fishel Katelin Kaiser Chris Ng, Daniel Pigeon Abby Reimer

During Hurricane Katrina, Memorial Hospital in New Orleans lost power and running water, and was flooded. Dr. Anna Pou and two nurses remained behind to stay with the patients who were too sick to be evacuated from the hospital. After the storm, forty-five bodies were found in the hospital in a makeshift morgue. Critics accused Dr. Pou and the nurses with hastening the death of some patients. After the investigation in July 2006, nearly a year after the storm, Dr. Pou and the nurses were arrested for the deaths of four patients.

Investigators determined that at least 17 patients were injected with morphine or the sedative midazolam, or both. A number of these patients were extremely ill and might not have survived being moved. Several were almost certainly not near death when they were injected, according to medical professionals who treated them at Memorial. An internist's review of their charts and autopsies were commissioned by investigators, but never made public.

Dr. Pou defended her actions, stating that her job during a crisis of that proportion was to ease the pain of her patients.

Dr. Pou was indicted with second-degree murder charges, but a grand jury in Orleans Parish refused to indict her; the two nurses were found not guilty of murder.

Today Dr. Pou is an advocate of changing standards of care during emergency situations like those experienced during hurricane Katrina. She stated that informed consent is impossible during disasters and that doctors need to be able to evacuate the sickest or most severely injured patients last—along with those who have Do Not Resuscitate orders—an approach that she and her colleagues used as conditions worsened after Katrina.[1]

Study Questions:

1. Did Dr. Pou and the nurses do the right thing in hastening the death of some of their patients during Katrina?
2. Should doctors be held to different standards of care during emergency situations?
3. Should the sickest be evacuated from hospitals first in emergency situations like Katrina, or should they be last because healthier patients have a better chance of surviving?

8 CASE STUDY: HEART ATTACK GRILL (ETHICS BOWL)

From: High School Ethics Bowl Regional Ethics Bowl Cases Season 2014-15, Authored By: Sam Reis-Dennis Jason Fishel Katelin Kaiser Chris Ng, Daniel Pigeon Abby Reimer

John Alleman, the fifty-two year old unofficial spokesman for the restaurant Heart Attack Grill, died of a heart attack in February 2013. A regular of the restaurant since it opened in October 2011, he genuinely enjoyed the food and advocated for the restaurant even though he was never on the payroll. Alleman reportedly ate at the restaurant nearly every day, despite owner "Doctor Jon" Basso's warnings that Triple Bypass Burgers really weren't everyday food. In fact, in February 2012, a man in his forties went into cardiac arrest while trying to finish a Triple Bypass Burger, and was wheeled out to an ambulance.[1]

The Heart Attack Grill's slogan is "a burger to die for." It gives free meals to people who weigh more than 350 pounds, and has a warning sign that reads "Caution: This establishment is bad for your health," according to the Associated Press (AP).

Basso is cited as saying that Alleman's death was a wake-up call of sorts, but said that it would not stop him from selling the calorie-laden burgers. One advantage of his establishment, according to Basso, is that people can feel comfortable at the grill and not worry about being judged because of their unhealthy menu choices. For his part, Basso argues that people are free to buy or not buy the food. In an interview with reporter Betty Liu, he stated "The end result of our eating habits is all around us. It's an obesity epidemic that is killing the world. Do I want others to die at my restaurant? No. Actually I want to wake up one morning and open the door and have no one ever come in again, because maybe the world would have learned the truth. Now, I make good money joking about how bad my food is. But at least I'm honest."

After the first incident, the AP reports, officials for the Physicians Committee for Responsible Medicine, a Washington DC based group, sent a letter to the Heart Attack Grill's owner asking him to "declare moral bankruptcy" and close the restaurant. Advocates of the Heart Attack Grill's right to operate and sell whatever food they like disagree, citing Basso's honesty about how bad the food is for one's health, the clearly labeled caloric content of the food posted where it is easy to see, and warning signs at the entrance of the restaurant.

Study Questions:

1. Should Basso continue to operate the Heart Attack Grill despite the deaths?
2. Do people have the right to eat whatever food they want, even if it kills them?
3. Does Basso have an obligation to close the restaurant in light of his statement concerning the obesity epidemic?