This article seeks to analyze the trolley problem as it pertains to life-and-death issues in medical ethics. A significant weakness is the assumptions the author makes in conducting the analysis of several versions of the trolley problem. In addition, the author’s understanding of the relationships between and among the four principles is limited. Another weakness is author’s sweeping generalizations about medical ethics and medical ethicists. Quite a few of those generalizations are either false or lack sufficient nuance. Examples of the above points follow below.

P. 1 “With some oversimplification, it could be argued that Medical Ethics is about balancing four main principles, long recognized as central in medical practice throughout the ages…”

Although this sentence begins with a caveat regarding oversimplification, it has other problems, as well. The “four principles approach” in medical ethics is only one method among many to understanding and analyzing ethical dilemmas. Therein lies the “oversimplification.” But an additional problem is reference to “medical practice throughout the ages.” The four principles were introduced in the medical ethics literature in the third quarter of the 20th century—not “throughout the ages.” Moreover, the principles are not embedded in “medical practice” but exist in the ethical analysis of moral problems in medicine.

“And indeed, its principle [“Do No Harm”] prevails above others.” This claim needs justification. Although later discussion supports this claim to some extent, utilitarians would almost certainly disagree (see below).

p. 2 “Non-maleficence may also be at odds with beneficence.…the prime principle in Medical Ethics is first doing no harm. If, by trying to address a health problem out of a concern with beneficence, the patient will end up being in an even worse condition, then that procedure should not be done.”

These sentences exhibit a misunderstanding of the principles. Non-maleficence is best understood as a sub-principle under the principle of beneficence. Whereas the former mentions only harm, the latter specifies that beneficial consequences of actions must outweigh any harmful consequences. Beneficence requires examining long-term consequences as well as those in the short-term. In the author’s example, it is the long-term consequences for the patient that must be taken into account. The doctor’s “good intentions” to do good for the patient is not the proper understanding of the principle of beneficence. The correct analysis of the situation is that both the principle of non-maleficence and the principle of beneficence line up together—they are not in conflict. By following the principle of non-maleficence, the doctor takes into account the long-term consequences. Similarly, by adhering to the principle of beneficence, the doctor takes account of the long-term negative consequences, which outweigh any short-term beneficial consequences for the patient.

The remainder of this paragraph is confusing. Of course, full knowledge of newer technologies may be lacking. The response to this problem is to conduct further research until the risks and potential benefits of these technologies are better known. That is why we have regulatory agencies, whose job it is to determine, as best they can, when application of a new technology is sufficiently studied that it can be used by doctors in medical practice. Even then, sometimes knowledge of harmful consequences may not be sufficient and harms ensue. Drugs and devices can then be taken off the market. This discussion of caution in use of new technologies requires much more analysis and an indication of when and where to draw the line.

Pp. 2-3 “Although it may be a more efficient and even just allocation of resources, it would still be a moral monstrosity to authorize such a transplant.” The application of the principle of justice in this scenario is flawed. The example illustrates the clash between non-maleficence and a utilitarian approach. Killing one healthy person to try to save the lives of five sick people is ethically unacceptable—that is what a proper analysis should show. Organs in a living individual who would have to be killed to use them are not “resources” for the purpose of transplantation. The so-called “resources” are not sitting in a bank of organs to be transplanted. A “just allocation of resources” is not the way to describe this situation.

p. 3-5 When the first trolley case is introduced, the scenario simply says: “it is set on course to run down five people who are tied to the tracks.” The description says nothing about whether the driver set the trolley on the tracks with full knowledge that there were five people tied to the tracks ahead. Yet in the ensuing discussion of the cases, it appears to be the author’s presumption that the driver had this advance knowledge. If we accept that presumption, it becomes the kind of “philosopher’s example” that is properly open to ridicule. The only way to understand the analysis of the trolley cases is to assume that the driver had no advance knowledge of the five people tied to the tracks. But the author writes (p. 4): “…the driver’s original action (setting the trolley in movement)” seems to suggest that he knew five people were tied to the tracks when he “set the trolley in motion.” Further, on p. 5: “…the driver already has done some harm, by setting the trolley on course to kill five people.” This entire analysis confuses *causal* responsibility with *moral* responsibility. On the only plausible interpretation of the trolley case, the driver did not know there were five people tied to the tracks when he set the trolley in motion.

P. 6 “Medical ethicists typically allow for passive euthanasia (as long as the patient consents), but condemn active euthanasia (even if the patient consents).” This is an example of a sweeping generalization regarding what medical ethicists believe or say. It is certainly no longer true of what is “typical” in today’s medical ethics literature. Even the distinction between so-called “active” and “passive” euthanasia has been criticized, so the distinction is no longer as clear as originally thought.

“There is a fundamental difference between murdering someone, and letting hundreds of unfed children die in some Third World country, due to our indifference. We may have the moral obligation to care for those children, but it seems that that neglect will never be morally equivalent to murder.” This is a flawed comparison. The ability and opportunity of any of us—or even all of us working together--to save hundreds—or more accurately, millions of unfed children around the world is severely limited, practically and governmentally. A better example would be standing by and doing nothing while watching a young child drown in a shallow pool of water. The latter is letting die, in contrast to the act of pushing the child’s head under water.

p. 7. “But, the bystander faces another dilemma. He was not responsible for setting the trolley on its original course in the first place…. Thus, as opposed to the driver, the bystander’s dilemma is not to kill one versus killing five, but rather, to kill one versus letting five die.” This again confuses moral responsibility with causal responsibility.

p. 8 “Most legislations follow these Kantian principles, and Medical Ethics is for the most part deontological.” An example of two sweeping generalizations. Legislation covers a wide variety of situations, including many situations in which deontological principles are inapplicable, for example, taxation, health policy, and welfare allocations. It is simply false that “Medical Ethics is for the most part deontological.” This reveals considerable ignorance of the wide variety of approaches in the field today.

“Strictly speaking, vaccinators face the dilemma of killing a few versus letting many die.” This is not “strictly speaking” at all. It is a conceptual confusion. Vaccinators administer vaccinations. Some individuals who are vaccinated die. Many others remain alive and are protected against the disease the vaccination is designed to prevent. The vaccinators have no way of knowing which individuals will live or die. Why isn’t it the manufacturers who are doing the killing? Why isn’t it the regulatory agency that licenses the vaccines for use? Why isn’t it the scientists who conducted research leading to a successful vaccine? None of these agents killed some people and let others die. This is an example of a deep conceptual confusion.

p. 13 and ff. In the concluding section, the author discusses appeals to intuition. This comes as a surprise, since throughout the article the author has reported on results of surveys—what people have thought about the trolley cases. Why include all those reports of people’s beliefs or intuitions only to question them at the end? The discussion of what utilitarians favor, and why, is oversimplified.

p. 14 “According to most utilitarians, actions should be morally judged on the basis of rules, and not acts.” The distinction between act-utilitarians and rule-utilitarians should be clearly identified and explained.

p. 15 “After all, as G.E. Moore and other moral non-cognitivist philosophers have long claimed, morality is not about facts. And, in the absence of facts when it comes to moral judgments, perhaps we ultimately have to rely on intuitions.” Moore and other non-cognitivists were not all intuitionists. Some subscribed to the emotivist position in moral philosophy.