

PHIL 140

§§0103 (1:00pm Armory 0103), 0106 (10:00 am Art & Soc 3221), 0107 (12:00 pm Phys 4208)

Discussion Notes

Feb. 15, 2008

Discussion Questions: Euthanasia & James Rachels’ (1975) “Active and Passive Euthanasia”¹ (Note that the ‘answers’ below are based on consensus, and so can be modified.)

General Questions:

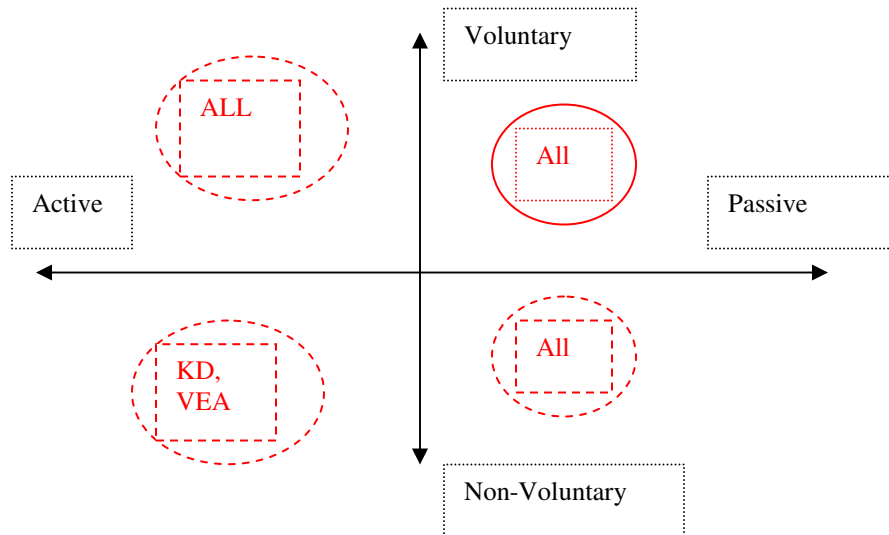
1. Recall that **Subjectivism**, **Cultural Relativism**, and **Objectivism** are **general (meta-ethical) positions** (Feb. 1). On the other hand: **Utilitarianism (Bentham-Mill)**, **Kant’s Deontology (duty-based ethics)**, and **Virtue Ethics (Aristotle)** are **specific theories of morality** (let’s abbreviate: **UBM, KD, VEA**). See table below: In which area(s) do you think the above three ethical theories (UBM, KD, VEA) are most likely to fit (or do you think some could fit in several areas: i.e. is it possible for UBM to be both objectivist and cultural relativist, for instance?)

Answer: It may *appear* consistent with UBM to adopt any of the three meta-ethical positions, depending on how one wishes to characterize pleasure/pain. If it is argued that the experience of pleasure/pain is a purely subjective matter (hence objectively impossible to rank) then one could advocate in an overall subjectivism. However, this would also defeat the purpose of the utility principle, which has some minimally objective standard (greatest happiness equitably distributed over the greatest number). Hence it’s most consistent with cultural relativism (happiness and suffering are relative to culture) or objectivism (kinds of experiences of happiness/suffering are universal—don’t depend on culture—and quantifiable.) On the other hands, KD belongs squarely in the objectivism category. (Kantian duty ethics rest on the presumably objective basis, i.e. universal and rational, of the Categorical Imperative, regardless of the consequences, whether subjective, culturally relative, etc.) VEA may *seem* to belong to all three, depending on how strong (or weak) a notion of the ‘golden mean’ one advocates. Since Aristotle argued that moral virtues (stable dispositions modeled after a standard of excellence) were acquired through *practice*, this presupposes what one means by *experience*. One can define experience in purely subjective terms, culturally relative, or objective terms. However, like in the case of the utility principle, it’s hard to imagine a ‘golden mean’ notion carrying much weight if one cannot agree on what the undesirable extremes are, outside one’s immediate and subjective experience.

Subjectivism	Cultural Relativism	Objectivism
		KD
	UBM	UBM
VEA	VEA	VEA

¹ *New England Journal of Medicine*, 292 no. 2 (Jan. 9, 1975): 78-80

2. Based on your answer to 1. above, recall the grid (Feb. 13 lecture-modified from Vaughn's article.²)



Where on the above map would you think specific ethical theor(ies) under a general metaethical position(s) would draw the line between what is morally permissible and impermissible?

Answer: Though tentative, it appears as though *all* positions (UBM, KD, VEA) would support the relatively non-controversial passive voluntary euthanasia in most (if not all) cases. Also, that *all* positions would support active voluntary or passive non-voluntary in *some* instances. (For instance, as mentioned in the text, one could adopt Kant's position—the formulae for humanity-i.e., to treat all rational beings as ends, not means, and argue that that in the non-voluntary case, when someone is reduced to a permanent vegetative state, then prolonging that person's life would be treating the person as a means, not as an end. Some (**Zina Makar, §0107**) read a Kantian absolutist position into the conclusions of Rachel, echoing along this formula for humanity line. Others offered a similar defense of euthanasia (besides just passive/voluntary) invoking such a notion (**Jad Steinman, §0106**). On the other hand, also consistent according to Kant's position, others argued *against* euthanasia using Kant's notion of formula for humanity as well as morality based on 'natural law.' (**Brandon Farley, §0107**) Also, regarding Kant's notion of moral value (based on intention) most agreed that the Hippocratic Oath was primarily a document centering on clarifying what the *intentions* of the caregiver ought to be.

By far, it was the consensus across all three discussion sections that the issue of passive versus active euthanasia (whether voluntary or non-voluntary) seems to center on a clash between act versus rule utilitarianism. In other words, it is natural to read an act-utilitarian theme running throughout Rachels, since he focuses on the *suffering* of the

² Vaughn (212) draws distinctions among *voluntary* (Vol), *non-voluntary* (NVol), and *involuntary* (IVol.) euthanasia. In the last case (involuntary) it is performed against the person's own wishes, hence can be automatically morally ruled out. While non-voluntary euthanasia is the case in which it's performed based on the guardian's consent (patient incapable of or incapacitated from making such a decision)

patient (i.e., read: concrete instance, weighing in on negative hedons), as well as arguing that active euthanasia is morally justifiable in *many* (but not *all*) cases which suggests invoking a principle of utility on a case-by-case basis, in accord with act utilitarianism. (Erin Coco, §0107, Khrysta Evans, §0106, Daniel Loveland, §0103). However, Paul Van Cleef §0106 also pointed out that act-utilitarianism can cut both ways: one could argue *against* active euthanasia by pointing out (note question 1 above) that it's impossible to gauge pain subjectively experienced, and for that matter no one really knows how much pain one may suffer in the last moments of life, if given a lethal injection. Nevertheless Khrysta Evans, §0106 countered along Rachels' line of reasoning that keeping someone in agony for days and perhaps months (recall the throat cancer patient analogy offered by Rachels) may offset the latter concern regarding possibly experiencing excruciating pain in the last few moments of life during active euthanasia (let alone that usually in such cases large quantities of painkillers are administered—often acting as the chief cause of death.)

On the other hand, as was also the consensus of all three discussion sections, the 1991 AMA policy basically advocates a rule utilitarian position: ruling out [active] euthanasia by raising slippery-slope arguments concerning long term future scenarios resulting from such a precedence: “However, permitting physicians to engage in [active] euthanasia would ultimately cause more harm than good.” (E-2.21) Some have claimed in addition (Joseph Hall, §0103, Steven Fields, §0103, Brandon Farley, §0107) that adopting a rule-utilitarian position would render active non-voluntary euthanasia morally impermissible, since medicine is an inexact science and there is always the chance (however slim) one could rally out of a coma and/or improve from a terminally ill condition and proceed to lead a valuable and productive life.

Basically, it seems how seriously one takes the implication of long-term possible consequences versus the weight of a particular situation will impact on whether or not one chooses an act versus a rule-utilitarian position.

3. Do you think (as Rachels and others assume) that one must separate morality from legality? For example, in the case of voluntary active euthanasia [VAE] one should distinguish between what is morally permissible/impermissible versus what is legally permissible/impermissible? Suppose you were a utilitarian. Could you find a counterexample in an example you'd consider is legally permissible but morally impermissible, *and vice versa*? Do you think your answer would change if you were a rule utilitarian, as opposed to an act utilitarian?

Answer: This question didn't come up explicitly, however interesting comments regarding the issue of what is *legally* permissible versus what is *morally* permissible. Some objected to Rachels' somewhat glib assessment in his final conclusion (that a *legal* policy should be changed, i.e. the AMA should allow for active euthanasia, to reflect what he considers is basically *morally* permissible—that there's supposedly no moral difference between killing and letting die). In the case of virtue ethics, for instance, just as Kantian ethics can introduce a conflict of duties, so a conflict of virtues can arise when wrestling with issues of active euthanasia. (Zina Makar, §0107) Specifically, what may prove to be the morally permissible act in the Terry Schiavo case, that her husband (as primary guardian) results in a murkier *legal* battle, since he was divorced from her and Terry's parents may have assumed the role of primary caregivers. In other words, in terms of the morality/legality issue, it may not be as clear-cut as Rachels would hope

(that the latter should reflect the former). The rule-utilitarian policy of the 1991 AMA document could be read this way as well, i.e. as holding firm to a legal policy to avoid unpleasant unintended consequences resulting from what may be morally justifiable action (of carrying out active euthanasia in a particular circumstance). **Daniel Loveland §0103** also suggested that the killing versus letting die distinction may only be *legally* (but not *morally*) equivalent. Daniel gave the example of parents refusing life-saving treatments for their child because of religious beliefs³ and the child dies as a result. *Morally*, based on the *intentions* of the parents, one could argue that they didn't *kill*, since from their standpoint they were, all things considered, acting on the belief of what they felt was their child's best interest. But the *law* might still hold them responsible for negligent homicide, at the very least.

Specific Questions:

4. Recall your instructor's depiction of Rachels' overall argument:

P1 (Non-moral) AMA justifies passive euthanasia (PE) by drawing on *moral* distinction between killing/ letting die (K/LD)

P2 (moral) There is no moral distinction however, regarding K/LD

P3 (Conclusion 1) Therefore PE cannot be *morally* justified on K/LD

P4 (non-moral) PE justified only when a doctor adopts end that death is no worse for the patient (continuing to live would only prolong unnecessary suffering)

P4 (nonmoral) AE would achieve that end more quickly and humanely than PE

∴ (Overall conclusion) In many instance AE preferable to PE

According to Rachels' article, he uses the *bare differences* argument to support P2 in three cases. (The bare differences method is a way of arguing in which all morally relevantly similar conditions hold—except for one case in which active killing took place as opposed to the other in which letting die was the chief cause.) He concludes that in all three arguments (via bare differences) K/LD is based on morally irrelevant grounds. Do you agree that his arguments are morally analogous to an actual dilemma involving AE (whether voluntary or non-voluntary) Recall his arguments: Down's Syndrome, Smith & Jones, doctor withholding treatment because he's "too busy." Consider the case of *physician-assisted suicide* (PAS). Is this a clear cut example of active or passive euthanasia? Or does it fall outside the scope of P2?

Answer: Many in the three sections had problems with some (if not all) of the analogies Rachels used in his bare-differences argument to support his Premise 2.). **Rikki Studely §0103** for one pointed out (along the lines of the comment made by a student in Feb. 13th lecture) that the Smith-Jones scenario isn't representative because the *intentions* of the 'killers' certainly weren't equivalent to those of a health-care practitioner who swears by the Hippocratic Oath (let alone that this thought experiment involves a case of *involuntary* euthanasia, as pointed out by the student Feb 13th—automatically ruled out ethically).

5. Recall the AMA policy and the Hippocratic Oath. Do you agree with Rachels' claim that "the law is forcing upon them [doctors] a moral doctrine that may well be indefensible." (Vaughn 224). What about the issue of intentions (recall Kant's distinction of moral worth versus correctness) and also (Feb. 13 lecture):

³ Consider, for example, Jehovah's Witnesses' refusal to consent to blood transfusions.

	Doing vs allowing	Intention	Cause of death
Active	Taking direct action	Ending life of patient	Lethal substance
Passive	Allowing to die by withholding treatment	Death is viewed as 'side-effect'	Underlying disease

Answer: The above question wasn't asked directly, but aspects of it were addressed (and discussed) in the previous questions. Basically, the dilemma involving active euthanasia has a lot to do with consequentialism (whether pitting act versus rule utilitarianism) but not entirely. Duty and intentions enter into this issue in various ways also, hence possibly drawing on Kant and Aristotle. In the end, however, no single ethical theory seems to resolve this hard problem—made even harder based on advances of technology introducing disease (e.g. Alzheimer's) 'slowly diminishing the person but keeping the body intact' (recalling Leland Saunder's remark in Feb. 13th lecture) as introducing ambiguity in how one defines the condition of clinical death. For instance: should death be defined as a cessation of all brain activity, making life support necessary, or a cessation of brain activity just rendering consciousness an impossibility? Depending on how one draws the line here will also influence which the scope of cases one considers euthanasia morally permissible.