
Discussion Questions

Dan Brock (1992) “*Voluntary Active Euthanasia*”

1. In his responses to objections against permitting euthanasia (pp. 230-234) Brock uses a device of argument called *parity of reasoning*—basically the “what’s good for the goose must be good for the gander” way of arguing.¹ In the parity-responses (the ‘goose’ being, if you will, his case for voluntary active euthanasia, and the ‘gander’ as what is considered already permissible: passive euthanasia) he is assuming that the controversial euthanasia case and the accepted policy are equivalent in the sense that consistency and generality would force one to raise the same objections to accepted policy as what are typically directed against euthanasia.² Do you think his reasoning is correct here? Could you conceive of a counter-instance to an objection he discusses (like eroding care for the sick) which could *not* be applied to accepted policy? In more general terms, do you think Brock assumes or oversimplifies too much in his view that euthanasia and accepted policy are symmetric to the extent that his parity-objection is persuasive? How could you think of a *disanalogy* between euthanasia and accepted policy that would undercut his parity-claims?
2. As Leland mentioned in lecture (Feb. 18th) nearly two decades have elapsed between Rachels and the writing of Brock. Great shifts in medicine occurred in which doctor-patient relations are nowadays conceived more in terms of patient-as-informed-consumer vs. doctor-as-service-provider, as opposed to the earlier paternalistic model, with patient’s judgment defaulting unquestioningly to the doctor-as-‘expert’. Do you see a tension in between consumer versus paternalistic model in Brock’s overall points? Do you see this affecting the very feasibility of voluntary active euthanasia he’s trying to implement? On the one hand he bases his case for voluntary active euthanasia on patient well-being and self-determination, but as a coda to his article he gives two reasons for restricting the practice of euthanasia to physicians only, all things being equal (i.e. along the lines of the four suggested policy procedures given in p. 234³) But consider specifically points 3. and 4. (footnote below): Do you think they could undermine a patient’s well-being and self- determination here? After all if only a doctor can administer the procedure, isn’t there a possibility of exploitation on the doctor’s part?

¹For instance: “[T]he same worry [regarding eroding care of dying patients] could have been directed at recognizing patient’s or surrogates’ rights to forego life sustaining treatment.” (231) “[I]f giving people the option of ending their life really makes them worse off, then we should...also take back from people the right they now have to decide about life-sustaining-treatment.” (232) “[I]t cannot be denied that it is *possible* that permitting euthanasia could have these fateful consequences [e.g. Nazi-style eugenics and elimination of the sick and weak]...[But] [a] similar *possible* slippery slope worry could have been raised to securing competent patients’ rights to decide about life support...”(233)

² I am borrowing Brock’s terminology here. ‘Accepted policy’ is passive euthanasia, and ‘euthanasia’ is voluntary active euthanasia.

³ (1.) Patient should be provided with all relevant information concerning prognosis, condition, alternative treatments and their prognoses. (2.) Procedures should ensure that the patient’s requests for euthanasia are stable and enduring. (3.) All reasonable alternatives must have been explored concerning patient’s quality of life, relief of suffering. (4.) Psychiatric examination must have been administered to ensure request wasn’t based on a psychological impairment like depression.

(Consider, for instance, a patient in dire pain and repeatedly requesting euthanasia only to be told repeatedly that (point 3.) “all options haven’t been explored,” and besides, “you’re depressed.” (4.) The last point is especially problematic: How does one draw the line between reactive depression of a terminal patient (a ‘normal’ and expected response) versus some crippling clinical depression which would presumably disable the patient’s judgment?)

3. Brock writes: “Opponents of voluntary euthanasia on slippery slope grounds have not provided the data or evidence necessary to turn their speculative concerns into well-grounded likelihoods.” (234) Is he raising the bar too high here in too ambiguous a way? In terms of raising the bar perhaps too high, how can one provide evidence for slippery-slope arguments that are based on *projected scenarios*? After all, they are ‘thought experiments’ dealing with hypotheticals. And certainly there’s obviously little concrete evidence the opponents to voluntary euthanasia can point to⁴, so does that mean that their ‘thought experiments’ shouldn’t be bothered with?⁵ In terms of the ambiguities, what makes a likelihood ‘well-grounded’?

John Hardwig (1997) “*Is there a Duty to Die?*”

1. For all the rhetorical force and eloquence of his writing, Hardwig throws in a few disclaimers concerning points he feels he should not or does not want to address.⁶ Do you think he *should* at least give *some* cursory mention to these issues (see footnote 6 below)? In other words, in more general terms, do you (or do you not) think his paper is more of a polemical piece than a developed argument?
2. Hardwig lays the blame squarely on the “individualistic fantasy” (237) which subverts or ignores our communal and inter-social nature, with its “interlocking finances....common projects and also commitments...shared histories, ties of loyalty.” (ibid) Moreover such “individualistic fantasy” gives bioethics an unrealistic approach to the grim realities of death, since “[w]e fear death too much...[w]e do not even ask about meaning in death, so busy are we with trying to postpone it.” (243) Yet are these obvious truisms of our culture’s obsession with prolonging youth and individualism even relevant regarding the conflicted approach of bioethics towards this complex subject? For instance, is it out of ‘selfishness’ that a husband who dearly loves his wife might exhaust every of his available means to stave off the inevitable death of his spouse who might be equally unwilling to die, *because* she dearly loves him? (One considers wedding vows: “In sickness and in health...to love and to cherish, until death do us part.”) Could one bring up this ‘wedding vow objection’ to argue that the conflicted bioethical approach is not so much based on some simple myth like individuality, but is a reflection on a whole host of motivations, including *communal* ones like not wanting to let one’s loved ones go? If you agree do you think that Hardwig’s oversimplification undermines his case for a duty

⁴ Except for the studies based in the Netherlands (p.231) which have their own problems—i.e. the evidential relationship isn’t so straightforward.

⁵ There are many instances when ‘thought experiments’ are all we have to go on, and there’s little or no empirical evidence. Much high-level theorizing activity in physics is one instance.

⁶ “This notion of a duty to die raises all sorts of interesting theoretical and metaethical questions. I intend to try to avoid most of them...” (235) “Who has a duty to die? And when?...I cannot supply answers here...[such] answers will have to be very particular and contextual...”(240)

to die, or is this oversimplification a relatively minor point (and hence the ‘wedding vow objection’ a red herring?)

3. Though Hardwig mentions the possibility that “[c]hronic illness...can also pull a family together,” (238) it’s more of a straw-man device since the majority of evidential claims focus on the enormous toll (emotional, financial, social) a prolonged dying process can have on the patient’s caregivers. Though Hardwig quick to point out that “I am not advocating a crass, quasi-economic conception of burdens and benefits...” (238) the fact remains the bulk of his evidential claims involve loss of resources (homes, jobs, savings). As much as one can sympathize with these obvious claims here concerning the enormous loss, isn’t one however nagged with the feeling that, for example in the case of the 55 year old daughter losing her savings and job to care for her dying 87 year old mother (239), that something is lost in Hardwig’s tallying up the results in this way? Perhaps, for instance, the *intangible* and *unquantifiable* value of the daughter spending those last several months with her mother outweighed the losses the daughter knew she would face? Do you think Hardwig’s points, as prima facie commonsensical as they may appear at a first reading, nevertheless fail to do justice to the complex tapestry of the human heart and character, with its deepest motivations and values which may end up being irresolvably conflicted in the face of such a wrenching experience as taking care of a dying loved one?