Health versus Harm: Euthanasia and Physicians' Duties

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ABSTRACT

Gary Seay's "Euthanasia and Physicians' Moral Duties" continues the author's assault on the traditional common sense that physicians as such cannot willfully kill their patients without acting contrary to the normative nature of their profession. Here, his announced aim is to cast doubt on any such unconditional duty of physicians because of both "the way in which physicians' duties arise" and also "the moral weight of countervailing duties." I will show that each of these arguments fails for several reasons, that his discussion manifests a number of additional defects, and that his position relies on dubious and undefended assumptions that, once accepted, threaten to legitimate moral enormities perhaps more outrageous than physician-performed euthanasia itself.

I. MORAL DUTIES FROM MORAL RIGHTS?

Although he talks of a person's duties possibly "aris[ing]" out of or being "explained by" another's rights, Gary Seay is not interested in the processes from which duties arise causally, but in those duties' justification.[1] In search of this, he turns to "correlativist conceptions of duty." Unfortunately, there are problems, which Seay doesn't consider, in treating correlation as justificatory explanation (p. 518). Properly speaking, the correlativity of duties and rights would entail only that someone (P1) has a duty if and only if someone else (P2) has a right, not that "duties are explained by the rights of others" (p. 520). Contrary to what Seay thinks, to "rely principally on a correlation with the rights of others to explain what duties are" is no part of the correlativity thesis, nor

[1] Gary Seay, "Euthanasia and Physicians' Moral Duties," *Journal of Medicine and Philosophy* 30 (2005): 517-33, here at p. 517, 520.

is that thesis incompatible with "tak[ing] duties as primary" (p. 520). Of course, someone who thinks duties and rights are correlative may also hold that (1) rights explain duties, as our author assumes. However, she might instead maintain that (2) duties explain rights, or that (3) some rights explain some duties but other duties explain still other rights. She might even think that (4) neither class of moral features explains the other. One reason she might hold this last is that she believes that (4a) Something Else–the greatest good of the greatest number, or the commands of pure reason, or social conventions, or God's will, or some component in our nature, or the requirements of human flourishing, or virtues, or whatever–explains both, with neither rights intervening in the process by which this Something generates and justifies duties, nor duties intervening between this factor and rights. A different reason for her to think neither rights nor duties explain the other could be that she holds that (4b) duty-talk and rights-talk are really just two equally basic ways of expressing the same moral situation. Seay himself seems to interpret correlativism this way: "to say that one 'has a right' is to say that some other person or persons have a duty toward the right-bearer; and to say that someone has a duty is just to say that some other person or persons have a right–that is, a justified claim–against him or her" (p. 518). He does not seem to notice that two expressions (E1 and E2) can be alternative ways of expressing the same state of affairs without it being the case that either explains the other. In fact, what really explains must be something in the world not just language. So E1 can neither explain nor be explained by E2. Nor can it be that the state of affairs that E1 expresses (call it S1) explains the one that E2 expresses (call it S2), since by hypothesis S1 and S2 are the *same* state of affairs. It can hardly explain itself. Finally, a correlativist might consistently reject the claim that either rights or duties explain the other because she is some sort of anti-theorist, insisting that (4c) neither class of moral features can be explained at all.

What really concerns Seay, and is relevant to our inquiry, is whether physicians' professional duties are normatively grounded, justified by, their patients' rights. If so, he thinks, doctors can have no exceptionless ("inviolable") duty not "directly and intentionally" to kill their patients. Let us leave correlativity as such aside, then, and turn to this question.

Seay considers two recent accounts of rights, which are sometimes invoked to justify certain duties (p. 520). According to the first, "the purpose of rights is to protect the interests of right-bearers." According to the second, "the purpose of rights is to protect the [right-holder's] freedom or autonomy in a certain kind of choice" (p. 521). Seay reasons that neither fully excludes physician-performed euthanasia because sometimes such a procedure can be in the patient's interest and supports her choice. I think these arguments move too quickly and do not go deeply enough.

Note first that, since the two accounts of rights he examines are one offered by twentieth-century consequentialists and a second offered by contemporary neo-Kantians, both of which camps tend generally to support euthanasia, it is not much of a surprise that both accounts can be interpreted so as to justify euthanasia. This poses problems. Seay would have done well to inquire into, say, Kant's own account of autonomy, since it's unlikely that Kant, who condemned any suicide from self-love, would have been so quick to approve mercy-killing.[2] Similarly, his argument would have profited from looking into such a beneficence-based theory as that found in the early theorists of Moral Sense, who would likely have had more misgivings about euthanasia. His chosen procedure makes things too easy and superficial. In any case, Seay's assumption that euthanasia can simply benefit its "beneficiary" while doing her no harm needs defense within a larger conception of human welfare, which is not provided. Later, I will call these claims into question.

There are also more substantive difficulties in Seay's arguments. Why ought we to follow Seay and assume that moral rights have any "purpose"[3]? Note that not all moral justification is teleological. Are rights, then, merely of instrumental significance? Isn't this the wrong way of thinking about their justification, unless we presuppose some form of

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[2] See Immanuel Kant, *Grounding for the Metaphysics of Morals* (orig. 1785) in Kant, *Ethical Philosophy*, 2nd ed. (Indianapolis IN: Hackett, 1994), pp. 30-31, for his condemnation of any suicide motivated by self-love.

[3] Seay, p. 521: "Thus, if the purpose of rights is to protect the interests of rights-bearers.... Suppose, on the other hand, that the purpose of rights is not [this], but to protect his or her freedom or autonomy...."

indirect consequentialism? It is revealing in this connection that Seay sides with Bennett against "unconditional obligations" and explicitly endorses a kind of rule utilitarianism. Thus Seay insists, "a system of [moral] duties is justified if the internalization by everyone of the moral code prescribing those duties would more effectively maximize the general welfare than the internalization of any similar moral code" (see n7 and n5 respectively). One wonders whence the maximization of the general welfare, even if there were such a thing and even if it could be maximized, gets such importance and how it comes to override all other moral considerations. Is this maximization an exceptionless norm? Is it the only one? What makes it so? Just why is it that this inviolable norm passes muster, while more traditional and commonsensical ones must fail?

Contrary to Seay's assumptions, welfare-based moral rights can be used to ground a moral condemnation of a physician's performing euthanasia. He writes, "the patient's swiftly ebbing life has at that point *nothing at all good* about it from the point of view of the person whose life it is.... The patient's right to life then becomes vacuous, since it is impossible to imagine how his interests could be served, or his welfare promoted, by his being made worse off" by having his non-beneficial and even harmful life extended (p. 520, emphasis added). This claim needs argumentative support that Seay doesn't provide and is, in any case, too strong. Life seems still to be *some* benefit to the patient, since being alive is a necessary part or way or aspect or form of her thriving, being well off, not just a means, an instrument to her welfare. If so, it can retains value even when it no longer produces satisfactions, pleasure, and so on. Nor is it hard to see how her interest is *to some extent* promoted by gaining a good, even if it were set back overall. Even when life is, as it almost always is, a state that brings with it such harms as pain, it is always the case that the patient as a human animal has an interest in being alive as such. It needs to be shown that this is no longer true in situations wherein life stops bringing good experiences, and it is hard to see why life would cease to be at all in a person's interest when it stops yielding such goods, unless it is assumed that life is merely a means to those benefits.

It is likely that the doctor's professional duties are restricted to

serving only certain interests of her patients, such as warding off death and restoring health, just as other professionals as such deal only with certain types and ranges of interests and not their clients' overall welfare: the accountant with their finances, the lawyer with their legal options and constraints, etc. The patient or client will then, in her proper autonomy, retain the right to decline or discontinue the service of the physician (or lawyer, or accountant, or architect) in accord with her view of her overall interests. (But note that this judgment may be incorrect and she may act wrongly, i.e., immorally, in exercising her right to decline.) None of that would ever ground a right (let alone, a duty) of a physician to kill her patient, nor of someone's accountant to loot her, and so on for the other types of professional.[4]

Similarly, autonomy-based moral rights can ground such a negative moral judgment against a physician's committing mercy-killing. "The purpose of [moral] rights is [on one important theory]...to protect his [the rights-bearer's] freedom or autonomy in a certain kind of choice.... What is essential to having a right, on this alternative view, then, is to have a justified claim to have a choice that limits human freedom to act in a certain way toward the right-bearer." According to Seay, if the patient expresses her "rational" "desire to die," it follows that "the patient has waived the [moral] right to life" (p. 521). Nevertheless, he needs not merely to invoke autonomy, but to dig deeper and inquire into the nature and grounding of a duty to respect autonomy before determining when and even whether a patient's wish to die has moral significance as legitimizing/authorizing mercy-killing. Kant, of course, grounded autonomy in inherent human dignity and status. Because these are

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[4] Seay's talk here (p. 520) of what is good from the patient's "point of view" is misleading. It may mean what is good relative to her, or what is good for her (advantageous to her), or merely how she sees what is good (what she thinks is good in some way). We can concede that someone sees no value in her own continuing to exist without committing ourselves to the claim that her remaining alive has no value. Also, compare Colin McGinn's critique of Nozick's speculations in *Invariances*, Nozick's final book, about a supposed purpose to which moral norms are instrumental and to promote which we brought them to exist. Colin McGinn, "An Ardent Fallibilist: A Review of Robert Nozick's *Invariances*," *New York Review of Books* 49 (June 27, 2002): 39-41.

inherent, they do not fade away as someone's life becomes more troubled, less pleasant.

Additionally, any plausible moral theory must recognize *limits* to autonomy, i.e., limits to anyone's moral authority to waive certain of her rights.[5] An appealing and intuitive way of setting one such limit is to hold that any of us enjoys broad and morally protected discretion in decisions over what to include within her life, or exclude from it. (That is, what goods to include in what ways, at what levels, and through what instrumentality, and also how best to exclude various evils and according to what prioritization to oppose them.) In that sense, licit autonomy extends to much of *how* to live, but not directly to *whether* to live. Often certain choices made under the first rubric will indirectly impact the latter. Still, there is a difference. While my choices now can legitimately restrict my future choices, without being thereby illicit, it remains true that, as John Locke noted in his *Second Treatise*, to choose complete subjugation or self-enslavement is beyond anyone's sphere of appropriate discretion, because such a choice repudiates the chief thing that could justify it. Just so, anyone's choice to destroy her life ends all choosing for her and repudiates the very inherent human dignity that could most adequately ground it.[6]

Finally, justifying euthanasia committed by physicians through appealing to patient autonomy presupposes controversial claims that Seay would need to, but does not, argue for. The consent of a person (let's call her S1) to the action (call it V-ing) of another person (call this one S2) then, will not normally suffice to authorize S2'sV-ing unless S1 already herself possesses the authority to V (or, at least, authority with respect to

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[5] Contrast the discussion of what Joel Feinberg calls "mandatory rights" that by definition cannot be waived. Joel Feinberg, "Euthanasia and the Inalienable Right to Life," pp. 221-151, in his *Rights, Justice, & Bounds of Liberty* (Princeton NJ:, Princeton Univ. Press, 1980).

[6] See Velleman's criticism of Kamm's position in J. David Velleman, "A Right to Self-Termination?" *Ethics* 109 (1999): 606-28. For Kamm, see Frances Kamm, "Physician Assisted Suicide, the Doctrine of Double Effect, and the Ground of Value," *Ethics* 109 (1999): 586-605. See also Velleman, "Against the Right to Die," *Journal of Medicine and Philosophy* 17 (1992): 665-81.

V-ing, since S1 may lack the expertise herself to V responsibly). Specifically, I cannot render your killing me morally licit by consenting to it unless (at least, *ceteris paribus*) I first have the right to kill myself. However, such a right to suicide is plainly controversial, contrary to much of traditional Western moral thinking, and it remains to be shown that my licit autonomy extends to such a right.

II. Professional Duties

That the correlativity of physicians' duties and patients' rights does not suffice to justify a doctor's committing mercy-killing still leaves it open whether such an action must violate her professional duties.[7] Unfortu

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[7] A moral duty may be one that "everyone has" and one that "we owe to all persons," but also one "that arise[s] from specific relationships between persons" and "within specific social roles." So, *pace* H.L.A. Hart, "Are There any Natural Rights?" *Philosophical Review* 64 (1955): 175-91, and Seay, their talk of professional rights and duties as "special rights" and "special duties" is misleading (Seay, p.518).

We cannot here retail all the problems with an instrumentalist conception of rights and with a general commitment to rule-utilitarianism, but here are some of the points to be made. First, the theorist who insists on the sole and absolute importance of improving the world overall is hardly in a position to criticize any theory on the grounds that the latter is absolutist. Second, deferring to someone's rights is often (and perhaps best) conceived nowadays as internal to (partially constitutive of) respecting her dignity and status as a person, rather than as a mere instrument (means) to some external goal. Thus, the one whose rights are violated is genuinely victimized, the victim of an injustice. In contrast, on an instrumentalist view of rights, the person whose rights are violated is merely a site at which the overall welfare (or some such goal) is non-maximally achieved. Third, it is worth noting, rule-utilitarianism tends to satisfy neither enthusiasts for rules nor enthusiasts for utility. The former have rightly worried that rule-utilitarianism tends to collapse into act-utilitarianism if what counts is the rule conforming to whose demands yields the best result; the latter have seen 'rule-worship' interfering with what they take to be the more important business of bettering the world. Fourth, we should also observe that any appeal to the overall good, a better world, and so on, is so vague and indeterminate, it can offer only shifting, insecure grounding for human rights. Fifth, the most appealing accounts of the way in which any goal has impersonal value appeals to more fundamental virtues of value-response. But then, it is appealing and theoretically simpler also to ground rights and duties in such virtues rather than in some vague notion of the

nately, Seay's treatment of, and claims about, professional duties are inadequate and multiply problematic. Thus, he writes, "[I]t is not obvious why medicine (or any other profession) must be seen as having just one defining purpose" (p. 524). But, plainly, this is a straw man. No one in the dispute really denies that physicians have various legitimate duties. However, there is a challenge for the theorist to explain the underlying unity within a profession and its duties, to make the various duties at least compatible, and coherent in a stronger way–even mutually supportive. Such unity is required, for without it there can be no intelligible integrity. Nor could there be unprofessional conduct and attitudes, nor adequate role-models, without a *coherent* role, for anything could fit or model an incoherent one. There is no making sense of any profession that is merely a grab-bag of duties, a historically accidental congeries.

It seems a reasonable and minimal condition on such coherence that it not be acceptable for the professional agent to pursue one duty internal to her profession by acting with the intention of doing something antipodal to another such duty. That is important for us because, in acting with the intention of causing a patient's death, the physician strives for a state of affairs in which the patient's (i) life is shortened (often radically) despite her professional duty to lengthen it, (ii) health is reduced to little or nothing despite her professional duty to enhance/augment it, and (iii) capacity for autonomous choice is eliminated despite her professional duty to respect it. Whatever account we give of the nature, basis, and unity of a physician's professional duties, those mentioned in (i), (ii), and (iii) must be assumed to enjoy a primary and secure place.

Seay writes, "[A] significant part of what doctors do today seems in fact to have very little to do with healing. Much of the work of plastic surgeons, for instance, and of doctors in fertility clinics appears to be devoted, not to healing and the conservation of life, but to the improve-

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overall good or a better world, as utilitarianism involves. (For more on these and related matters, although in a discussion I find too sympathetic to utilitarianism, see Brad Hooker, *Ideal Code, Real World* (New York NY: Oxford Univ. Press, 2000).

ment of people's quality of life" (p. 524). Surely, Leon Kass,[8] Edmund Pellegrino, and other opponents of mercy-killing by doctors are likely to view these practices as poor paradigms around which to shape our definition of medicine's essential purposes. And their position has intuitive appeal. Cosmetic plastic surgery seems to be a novel, marginal, and dubious practice, not a part of medicine so secure that, on its basis, we should reasonably reconceive medicine's purpose. In contrast, reconstructive plastic surgery and some kinds of fertility treatment are meant to restore normal and natural function, operation, and shape, posing no challenge to Kass and his allies. Likewise, Seay's examples of so-called reproductive services (IVF, etc.) are controversial, questionable, and in any case, poor models, not practices of the sort that are so venerable, established, and above criticism that any adequate account of medicine needs to accommodate them. Down this road lies endorsement of so-called "concierge medicine" and similar degrading forms of consumerist pandering by the medical profession.[9] That spells the end of the professional image of medicine as a noble and admirable calling.

Seay asks, "Why shouldn't a concern for the patient's quality of life be seen as among the central purposes of medicine" (p. 525)? However, each profession (law, accountancy, architecture and interior design, etc.) involves service only to *certain parts* of the quality of life rather than to its entirety, and to *certain people* (clients, patients) rather than to everyone or the majority. Seay's suggestion that medicine should include a physician's duty simply to advance the patient's QOL is thus problem-

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[8] Leon Kass, "Neither for Love nor Money," *Public Interest* No. 94 (Winter, 1989): 25-46.

[9] See Vasilios Kalogredis, "Should You Consider Concierge Medicine?" *Physician's News Digest, 2005*, reprinted in the volume of readings distributed at the Baylor Medical Ethics Conference, October 2005. What I here call 'concierge medicine,' also sometimes discussed or offered under the rubrics "retainer medicine," "boutique medicine," "executive health programs," or "platinum practices," involves providing a restricted medical practice to a small number of clients, who pay a high annual fee for such special services as priority or same-day appointments, house calls, and even having the patient's physician accompany her on visits to specialists. Such a form of practice raises obvious problems of social justice and personal compassion.

atic. If the doctor's other professional duties are systematically to give way to this general one, as Seay thinks happens in PAS, then it's not clear what work they do. Still more, Seay's listing a duty to society in general among a physician's professional duties means that even the doctor's tie specifically to her patient might get swallowed up (p. 519). Why not, then, just dispense altogether with these other, specific duties (owed only to patients), and simply say physicians ought to act in the overall interests of those they are in a position to affect? If we do that, however, we should say the same of dentists, lawyers, social workers. Why work on someone's teeth or legal case except in ways, and insofar as, that leaves us all better off? Thus, this position seems to constitute the abandonment of any distinctively professional ethic at all. At that point, we must wonder whether Seay is really taking seriously the other side of the debate. It is not clear how (or even that) Seay proposes to stop this slide into the disintegration of genuinely and distinctively professional duties.

This hints at another difficulty we find in Seay's work. He seems not to take seriously enough the dangers of unjust discrimination, and of compounding someone's suffering one misfortune with our imposing on her another, which risks are inherent in our counting a patient's poor QOL as grounds for us to kill her. Suppose that, as Pope John Paul II has recently said, an individual herself may legitimately in some circumstances consider the prospect of a certain kind of future as insufficiently appealing to warrant accepting the suffering, expense, and other burdens to herself (or others) involved in her undergoing a certain treatment.[10] Nevertheless, that would do nothing to show that *we* can avoid treating her unjustly, with disrespectful depreciation of her inherent value and dignity, when we see her life as not worth saving and not even worth living. Human dignity needs defense today chiefly in affirming the dignity that inheres in the patient, irrespective of her bodily or mental condition. Despite current hand-wringing about "a dignified death," we need to

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[10] Pope John Paul II, "Address before International Congress on Life-Sustaining Treatments and Vegetative State: Scientific & Ethical Dilemmas," Pontifical Academy for Life & World Federation of Catholic Medical Associations (Rome, Italy, 20 March 2004): www.vatican.va/holy_father/john_paul_ii/ speeches /2004/march/ documents.

remind ourselves and others–including some medical patients–that no mere physical or mental condition can violate dignity. Rather, *we* violate it when we treat some modes of life–and, more important, the people confined to them–as not only beneath our efforts to preserve but so repugnant that they warrant our termination via killing.

Note that there are two different points here. First, what it might be licit for a person to decide for and about herself may not be licit for us to decide about her, that is, there are limits to what one can genuinely authorize another to do. Second, what we would here decide is in fact quite different in its content from what the agent may licitly determine in her own case.

Professional duties are, I think, better identified with characteristic *commitments*, that is, adopted projects, rather than any list of more specific types of bodily motions. More particularly for our topic of physicians' professional duties, we need to keep it in mind that professional duties cannot be identified simply by listing various technical or mechanical behaviors. They must, rather, be approached through a defining set of resolutions and projects to whose pursuit the professional as such commits herself. Someone's fulfilling her professional duties is not so much a matter of her various actions then, but rather of her *conduct*–of how, that is, by what objectives and within what constraints, the agent guides herself.[11] Such talk of guiding oneself toward objectives, within constraints, and consistent with resolutions and commitments, of course, can only be understood by looking rigorously to the intentions with she acts.

The duties of a professional, P–and therein her duties *as* a P–are thus internally linked to (her) being (or acting as) a good/bad P. Someone's violating one such professional duty one time, of course, may not suffice to make her a bad P, all things considered. Still, it means that she was *acting badly* (in her capacity) as a P and, whether or not it causally contributes, it *counts towards* her being a bad P. Now remember that there is an internal link between health-conservation and life extension, because

[11] Recall that the term 'conduct' derives from a Latin word meaning to lead or direct.

death is the limit case of health's diminution. It follows that the physician's professional duties of conserving (or restoring) health and of extending life are continuous. (Perhaps they are not two distinct duties, but only one.) The same could not be true of a general duty of physicians to relieve pain, which must be a separate and additional duty, and therefore less closely related to (that is, further removed from) the central and defining function of medicine as a healing profession. In my view, then, Pellegrino concedes too much in allowing that a duty to relieve suffering is equally fundamental within medicine with a duty to conserve life.[12] Suffering discomfort matters chiefly as an indicator of dysfunction, ill health (p. 525). We can reasonably speculate that doctors, because of their training in the body's systems, came to possess the knowledge and skills to relieve suffering, and thence devolved a quasi-professional duty to do so. However, the latter duty, like the knowledge itself, was and remains derivative, conditional, and subordinate.[13]

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[12] I will restrict myself here to Pellegrino's work. See Edmund Pellegrino, "Doctors Must Not Kill," in *Euthanasia: The Good of the Patient, The Good of Society*, ed. R. Misbin (Frederick MD: Univ. Publ. Group, 1992), pp. 27-41; and "Physician-Assisted Suicide: Rebuttal of Rebuttals," *Journal of Medicine and Philosophy* 26 (2001): 93-100. For fuller, more contextualized treatments see also his *Physician and Philosopher: The Philosophical Foundation of Medicine: Essays*, ed. R. J. Bulger and J. P. McGovern (Charlottesville VA: Carden Jennings Publ., 2001); and *The Philosophy of Medicine Reborn: A Pellegrino Reader*, ed. T. Engelhardt and F. Jotterand (Notre Dame IN: Univ. of Notre Dame Press, forthcoming).

[13] Note that Brandom and, following him, Rorty suggest that physical ("mammalian") suffering may be important chiefly for interfering with rationality in theorizing, deliberation, choice. (For references and a critical discussion of this view, see Simon Blackburn, "Professor of Complacence: A Review of *Rorty & His Critics*," *New Republic* (August 20, 2001): 39-42, here at p. 42.) Moreover, while a physician normally has a duty to relieve suffering, the proponent of physician euthanasia needs to show both that this duty persists in situations when the elimination of suffering doesn't free the patient for better life experience and that this persistent duty is such as to form an exception to the physician's more fundamental duty to act for, rather than against, health. It is worth noting that an anonymous reviewer thinks it pertinent to my position here to ask whether a doctor's conscience should be allowed to trump her patient's "health needs." My point, however, is that a patient's death, as a limit case of the diminution of her

In any case, whether or not derivative, a physician's duty to relieve suffering is less fundamental, further from the heart of medicine, which is devoted to conserving and restoring health (and therein postponing death, which is the dearth of health). For that reason, among others, it needs to be understood as containing crucial exceptions. Pain usually indicates dysfunction and, *because of that*, pain-relief matters. So, it is doubtful that there exists a professional duty of a physician as such to seek mere *cessation* of pain. For the end of pain that comes in death is not really pain-*relief*, and it is only relief of pain to which a physician is professionally committed. The dead stop feeling pain, of course, but therein they experience no relief. It is difficult to see why that sort of end to pain counts as much of a benefit, when it doesn't enhance her experience or improve her life.

Accepting a professional duty of physicians to increase net overall quality of life (QOL), as Seay and others would do, threatens to *homogenize* all professions. (And to submerge professional within general, non-professional duties). This would spell the end of a genuine and distinctive professional ethics. Likewise, any professional duty to relieve pain cannot sensibly extend to ending it by putting the patient to death, which I pointed out brings her no relief, and must give way to inherent, central, and more significant duties of a physician, especially the duty to extend life, which follows from the physician's defining duty to maintain or restore a patient's health.

III. Resolving apparent conflicts of duties

Seay's assumption that apparent conflicts between or among a physician's professional duties must be resolved by determining and comparing the "relative moral weight of these two duties" is both premature and dubious (p. 519). Henry Richardson has persuasively argued against the metaphor of 'balancing' on the grounds that it is: (1) dubiously rational (yielding possibly inconsistent outputs for same inputs in different minds, at different times or places, etc.), (2) undesirably inarticulate because it fails

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health (indeed, a naturally permanent limit), cannot sensibly be said to serve her "health needs."

adequately to articulate what justifies the judgment, (3) speciously quantitative, masking the qualitative and questionable as quantitative and determinate, (4) often arbitrary, providing only the rhetoric and appearance of justification without its substance. Because of all this, it (5) tends to serve as mere rationalization, and (6) is in danger of collapsing putatively pluralistic moral theories into a shallow and implausible monistic consequentialism.[14]

It is better, then, to reject Seay's metaphor of "weigh[ing]" and approach the resolution of apparent conflicts through fuller interpretation and refinement of pertinent norms, by appeal to the history of interpretations, to the traditional purpose of those within a profession, to our current need for those occupying it, and similar factors. I have begun that process here, though much would remain to be done in grounding an understanding of professional duties and their interrelation within a fuller philosophy of medicine. In any case, if a physician's duty to relieve suffering is merely accidentally added on to those that centrally define and shape medicine as a profession and the role of the physician, then it needs to be explained how it can regularly take precedence over them in the case of many patients, as the proponents of physician euthanasia think it does.

IV. Double-Effect Reasoning

I have shown why intentions are crucial to understanding and specifying a physician's professional duties. Appeal to the moral significance of a distinction between what an agent does and does not intend, even when she expects what results, has, within medical ethics, usually been articulated in terms of a kind of moral analysis that we can designate "double effect reasoning" (hereafter, DER). Seay recognizes this sort of reasoning as an important obstacle to his defense of doctors' committing mercy-killing. I wish to conclude by looking at DER and his criticisms of

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[14] Henry Richardson, "Specifying, Balancing, and Interpreting Bioethical Principles," *Journal of Medicine and Philosophy* 85 (2000): 285-307.

it.[15] Let us begin this final section's inquiry with the question, Is the patient's death always an evil? The position that Seay affirms is, I hope to show, both inadequately-defended in his article and problematic in its own right. Thus, he writes, "[L]ess suffering is better than more" (p. 527). But this is too simple. The issue is not how bad suffering is but whether death is an evil for someone–and, more to the point, a bad thing for someone to wish, want, like, or choose to befall her–even when she is in dire straits. Seay only asserts (albeit repeatedly) that life in such circumstances is no benefit at all. Even if he could show that, however, life might still be valuable in other ways: good in itself, for example, or as a condition (and not just a means) for enjoying anything else that is valuable.

Considering a patient in whose future suffering looms large, Seay writes, "[I]t is hard to see why active euthanasia would be wrong in such a case even if the patient is 'innocent'.... The days of life remaining to him can hold nothing but unbearable suffering" (p. 528). However, this claim about life is surely an overstatement and manifests an undefended (and probably indefensible) instrumentalist view of life's value. According to Seay, what matters is "[w]hether death is the worst possible alternative..." (p. 521, n25). Yet this is not the issue. What matters is whether the patient's death is and remains a bad thing (for her).

"[W]hat of the patient who *does not want* to approach death drugged into insensibility? Are there not some who would prefer simply to be done with at once and avoid the spectacle of lingering on...?" Seay wonders (p. 526, emphasis retained). His emphasis (both orthographic and philosophical) in posing this query on preferences is instructive, but troubling. What are the limits, we need to ask, to a medical doctor's subjection to her patient's autonomy? Does Seay similarly think that the physician must continue treatment even when it is futile, inappropriate, pointless, even *harmful*, simply because the patient wants it? If not, then how does Seay justify these limits, but not others? Why think that the relevant issue is what the patient happens to prefer, rather than what is actually in her

[15] Still, I should state clearly that nothing in my argument to this point relies on or presupposes DER.

medical interest? If we must assume that someone is always and necessarily the best judge of her medical interest, then why should anyone seek medical advice at all? (And does this subjectivist account of interest-determination also apply to someone's legal, financial, spiritual, and other interests as well? If so, how can any profession, and its distinctively professional ethics, survive?)

Seay's talk here of the patient's "avoid[ing] the spectacle" of a certain way of dying seems to refer to an aesthetic taste of hers (and an affected, fussy one at that), rather than an ethical choice. Isn't it a sad irony that an interior designer or architect is admired for her integrity when she draws the line, refusing to do what the client prefers when and because it runs egregiously contrary to the aesthetic goals to which she is professionally devoted, but nowadays a physician is maligned for refusing to turn her skill to ending the life (and therein reducing to nothing the health) of a patient because of the commitments inherent to her profession? It is, I think, a sad irony when this criticism comes from today's credentialed ethics experts, indeed, our medical ethicists.

Now let us turn to a different set of issues in Seay's objection to the theory and application of DER to mercy-killing by physicians. He closely follows an argument of James Rachels's that purports to show the moral irrelevance of intentions. I will show that Profs' Seay's and Rachels's arguments against DER's claims about permissible action are reversible, undermining any account of moral permission, and are also question-begging (p. 527). Let me explain.

Rachels thinks that making the moral permissibility of an agent's conduct hang on her intentions has to breach the principle of rationality and morality that like cases be treated alike. To prove this, he invites us to consider Jack and Jill, both of whom visit their "sick and lonely grandmother"–she with the plan of so ingratiating herself as to win inclusion in the old woman's will, Jack simply from the benevolent desire to lift her spirits. Rachels states, "Jack's intention was honorable and Jill's was not. Could we say on that account that what Jack did was right but what Jill did was not right? No: for Jack and Jill did the very same thing, and if they did the same thing in the same circumstances, we cannot say that one acted rightly and one acted wrongly. Consistency requires that we assess similar actions similarly." He draws his conclusion, "the

traditional view says that the intention with which an act is done is relevant to determining whether the act is right. The example of Jack and Jill suggests that, on the contrary, the intention is not relevant to deciding whether the act is right or wrong, but is instead relevant to assessing the character of the person who does it, which is another thing entirely."[16]

Ought we to accept Rachels's argument and his conclusion that intention is irrelevant to whether an action is morally right or wrong? I think not. This sort of argument brazenly begs the question. Consistency does not require that things in *any* way alike be treated similarly, only that cases *relevantly* similar be treated alike. Advocates of an intention-sensitive account of moral permission hold that the intention with which an action is done is pertinent to its moral permissibility. Rachels's argument merely assumes that this is not true; it offers no grounds on which to reject it. We could use parallel reasoning to 'prove' that consistency rules out any moral theory, e. g., act utilitarianism. Suppose that, out of affection, Hansel and Gretel both visit their sickly and rather grumpy grandfather. Because the old man detests Hansel but loves Gretel, Hansel's visit brings about less pleasure than his staying home would, but Gretel's visit brings more pleasure into the world than anything else she could have done. The act-utilitarian judges Hansel's action impermissible but Gretel's right. However, we could say, they did "the very same thing" (visit grandfather) in the same circumstances (his sickness), and so it would follow that the utilitarians' judgment violates consistency in just the place that Rachels thinks the judgment of the advocate of an intention-sensitive account of moral permission violates it. Obviously, this argument merely presupposes that the acknowledged difference in the effects of Hansel's and Gretel's actions makes no moral difference. This consistency argument against utilitarianism does not prove false the utilitarian thesis that effects are relevant; it simply presupposes that it is false. In precisely the same way, however, Rachels's consistency argument simply presupposes that the acknowledged difference in the intentions behind Jack's and Jill's actions makes no moral difference. It

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[16] James Rachels, *The End of Life* (New York NY: Oxford Univ. Press, 1986), pp. 93, 94.

assumes that the thesis of intention-sensitivity is not true instead of showing it isn't.[17] Because this sort of argument is completely reversible, capable of being turned against moral criterion, and because it patently begs the question, I set it aside without further comment.

Instead, I wish to ask Seay what shows that, as he claims, guilt and innocence are "irrelevant" to the permissibility of mercy-killing (as is the color of the victim's eyes), that DER is "otiose," and that it involves a "category-mistake?" (What are the categories and what is the mistake?) Why not instead think that the patient's preferences are irrelevant? Is guilt irrelevant to the morality of jailing or fining or exiling someone? Why, then, is it irrelevant to that of killing her? In contrast, is someone's preference for imprisonment or banishment, even in circumstances where we can to some extent understand it (and it is thus perhaps in some sense "rational", to be expected), sufficient to justify imprisoning or banishing her? Why think it even relevant? Even if we suppose that it would reduce some of her discomfort, why think that fact material to justifying our actions?[18]

We need to affirm and take to heart the fact that it is its connection to an intention that makes an event into a human action, as Davidson pointed out. What she intends is often crucial to determining what kind of moral action (e.g., theft, rape, murder, fraud) someone has performed–*what* she is to be credited with, or condemned for, doing. What the agent does or doesn't intend is often an aggravating or mitigating factor, making an action morally worse or less bad. (Intention, of course, also plays a role in making some actions (more) admirable, praiseworthy.) Whether its agent intended a certain result is, moreover, an important

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[17] For additional arguments against intention-sensitivity, some of them similarly question-begging, see Judith J. Thomson, *Rights, Restitution, and Risk* (Cambridge MA: Harvard Univ. Press, 1986), and Robert Holmes, *On War and Morality* (Princeton NJ: Princeton Univ. Press, 1989). For criticisms of Thomson's and Holmes's reasoning, see J.L.A. Garcia, "Intentions and Wrongdoing," *American Catholic Philosophical Quarterly* 69 (1995): 605-17; and "Intention-Sensitive Ethics," *Public Affairs Quarterly* 9 (1995): 201-13.

[18] We also need further clarification. In what way is the patient's desire to die supposed to be "rational," as Seay thinks it is? Instrumentally?

factor in judging the level of blame attaching to an action. In short, it is for moral purposes nothing like, in Seay's analogy, being blue-eyed. Little is more "relevant"–indeed, crucial–in moral reasoning than intentions. What the agent does and does not intend in acting is also critical in determining *whether*, and not just *how grievously* and *which type of* moral wrong is done.

Richardson reasonably insists that moral norms ought to make their justification explicit in their content.[19] Similarly, Judith Thomson reminds us that nothing is simply good or bad but only good or bad in some specific "way."[20] Even what is morally fitting or objectionable, then, must be characterizable in what philosophers, following Bernard Williams, call 'thicker' moral terminology. *Pace* Jonathan Bennett however, many of the most important thick moral terms (again, think of theft, rape, murder, and fraud) can be imputed only (at least, in part) on the basis of the agent's intentions.[21] As G. E. M. Anscombe noted, even such intra-institutional duties as those violated in theft or fraud take on moral significance only insofar as they manifest, or stand opposed to, moral virtues.[22] But intention is obviously critical to classifying an action as virtuous or vicious (either in general or as manifesting and characterized by some specific virtue or vice).[23] What sense could we make of such familiar

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[19] Richardson, 2000.

[20] Judith J. Thomson, "The Right and the Good," *Journal of Philosophy* 94 (1997): 273-98.

[21] Jonathan Bennett, *The Act Itself* (New York NY: Oxford Univ. Press, 1995), ch. 11.

[22] G. E. M. Anscombe, "On Promising and Its Justice," *Ethics, Religion, and Politics: Collected Philosophical Papers*, Vol. 3 (Minneapolis MN: Univ. of Minnesota Press, 1981), pp. 10-21.

[23] Here I reject as utterly implausible Thomson's claim that, at least in their application to actions, such virtue terms as 'generosity' and justice, and such vices as "stinginess" and injustice are "objective" in the sense that they are independent of what the agent believes, chooses, intends, etc. See Judith J. Thomson, *Goodness and Advice* (Princeton NJ: Princeton Univ. Press, 2001),
pp. 64-65. Her claims run counter to our ordinary use of these terms and concepts. The idea of somebody's accidentally acting kindly, honestly, cruelly,

virtues as conscientiousness, fidelity, truthfulness, and steadfastness–not to mention, benevolence and respect–without attending to their subject's intentions?

A physician's intentions are central to her living out (acting consistently with, and in support of) defining commitments. If it is licit for a medical doctor sometimes to act with the intention of immediately (and in a way that is naturally permanent) ending life in pursuit of a duty of relieving pain (or honoring autonomy, or enhancing overall quality of life), we should ask Seay to explain, then why isn't it also sometimes permissible for her to pursue her some of her professional duties–say to prolong the patient's life, or to serve the interests of her profession, healthcare institution, or wider society (all of which he affirms at p. 519)–by acting intentionally to inflict severe and long-term pain (by mutilation and torture), or radically to restrict her patients' autonomous choice (e.g., by enslavement), or greatly to reduce their overall QOL (p. 525)? Does Seay think these latter actions are absolutely forbidden to physicians but their intentionally acting to end a patient's life is not? If so, what reasoning is it that shows just these duties are never (and can never be?) defeated, and how would it square with his intellectual sympathy for Bennett's dismissal of all unconditional norms?[24] If not, what becomes of the patients' trust in their care-givers, the desire to protect which so motivates Kass, Pellegrino, and others, once every physician literally stands open to *doing anything* to *anyone* at *any time* whenever some suitable benefit looms on the horizon?[25]

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disrespectfully, and so on, is incoherent.

[24] For Seay's sympathy for Bennett's radicalism, see n7 above.

[25] For these thinkers' emphasis on trust, see Seay, sec. III, p. 9. Sidgwick, notoriously, thought a society could and should maintain people's moral motivation, even when its leadership had accepted the utility principle as morality's sole justifying principle, by keeping this moral foundation a secret from the masses, hiding it behind promulgation of more traditional rationales, though the *cognoscenti* no longer credit them. Henry Sidgwick, *Methods of Ethics*, 7th ed. (New York NY: Dover, 1966 [1907]). Even if such a mendacious stratagem could work and, in a society of medical euthanasia, patient trust in physicians could be preserved by resort to some similar utilitarian guile of the sort that Sidgwick

As I have asked, if medical doctors can legitimately kill their patients with intent, then what keeps this line of reasoning from also licensing lawyers to thwart justice, teachers to lie to their students, parents to try to harm their children, and so on with the other professional and nonprofessional roles?

Conclusion

Etymologically, of course, *eu-thanasia* should be a good death. Perhaps there was a time in our past when many people had a sensible understanding of what this could mean. They would have recognized death itself always and inherently to constitute a misfortune for the person who died, something that harms her, the natural end to a living being. Still, people saw that we could face death in better or worse ways. They could say their valedictories, get their affairs in order for those taking up their loads, and prepare their souls for whatever they thought lay beyond. They could face death with the moderation that constitutes virtue, neither cowering in despair nor arrogating to themselves authority to which they had no claim, but approaching death with courage in face of the unknown, affirmation of humanity's inherent (hence, non-instrumental) dignity and life's own inherent value, and some sense of awe, standing humbled in the face of mystery. Though often this occurred in a religious context, it is shallow to think only people of faith can and should respond with wonder and humility to life's beginning and end.

In contrast, the mercy-killing that the term now denotes, characteristically involves quite a bad death indeed. Voluntary euthanasia compounds someone's despair with her presuming to hold authority over the time and means of her life's end. It denies the inherent value of humanity and of human life by trading life for comfort. (Though, remember, it adds no comfort to the life of its supposed beneficiary.) Moreover, it masks with specious 'authorization' the injustice inherent in an agent's violating an innocent person's right to life. As I have elsewhere argued, mercy-

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suggested, would the trust be justified?

killing is at best a dubious mercy.[26] What I have here tried to illuminate is that and how, when physicians become mercy-killers, they add to this the shame of unprofessional conduct.

It is a commonplace among the socially observant that the West is today mired in what some call a culture of death. To offer just one illustration, at the beginning of 2005 three of the most-praised films were *Vera Drake*–with its story of a lovable, grand-motherly abortionist in the supposedly dark days before legalization, *Million Dollar Baby*–about an old man who puts to death his surrogate daughter after an accident paralyzes her, and *The Sea Inside*–whose protagonist campaigns for his own termination. It is worth noting that, in the latter two, the recipient of the euthanasist's untender mercies are alert, rational people, free from significant physical pain. When they cruelly demand aid in self-destruction, they flee not suffering but boredom, dashed dreams, and the indignities (both real and imagined) of extreme dependence. These movies hail from Britain, the United States, and Spain, feature acclaimed stars or none, are products of Hollywood or of foreign and independent cinema. What they share is enthusiasm for medicalized homicide. In this sea of like-mindedness, we badly need a medical ethics that is counter-cultural, reaffirming a value and dignity in humanity and human life that paralysis cannot rob, that acknowledges the limits to autonomy that inhere in its justification, and that helps protect medicine as a healing practice against those who would invert its aims. Unfortunately, I hope to have shown, we find in Seay's writings an inverted "bioethics," one that advocates the unethical and turns against life. Down that path lies bad medicine indeed.

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[26] See J. L. A. Garcia, "Better Off Dead?" in *APA Newsletter on Philosophy and Medicine* 92 (1993): 85-88; and "Beyond Biophobic Medical Ethics" in *Proceedings of the Twentieth World Congress of Philosophy*, Vol. 1: *Ethics*, ed. Klaus Brinkmann (Bowling Green OH: Philosophy Documentation Center, 1999), pp. 179-88.