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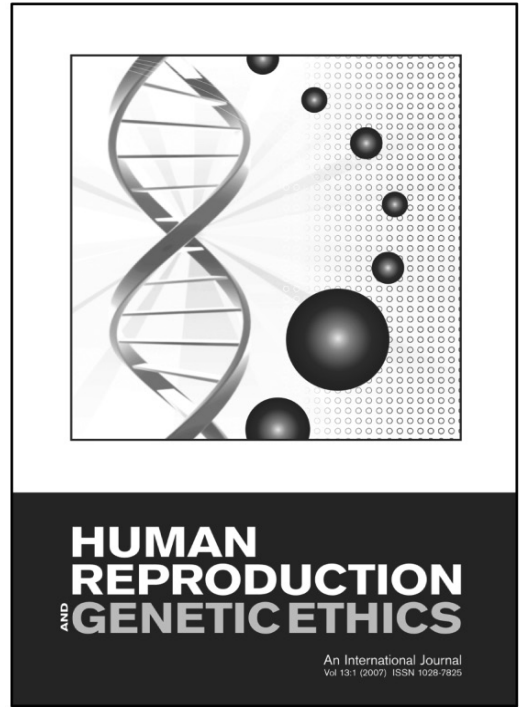
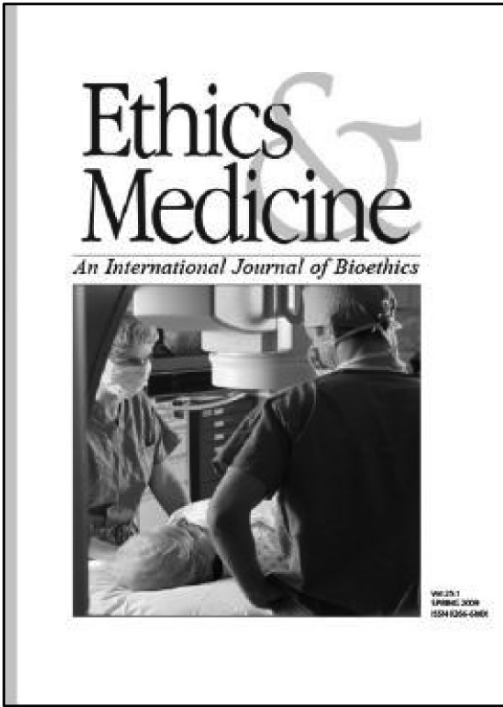
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GUEST COMMENTARY

## PULLING THE SHEET BACK DOWN: A RESPONSE TO BATTIN ON THE PRACTICE OF TERMINAL SEDATION

PATRICK T. SMITH, MDIV, MA, PHD (CAND.) AND JAMES S. BOAL, MD

### Abstract

*In this brief response essay, we address a recent claim made by Margaret P. Battin that one cannot consistently oppose physician-assisted suicide/death (PAS) and be in support of and practice terminal/palliative sedation. We articulate a more nuanced understanding of terminal sedation from the version Battin provides. Along the way, we contrast this more appropriate and less controversial understanding of the practice of terminal sedation with some of the claims made by Battin. We conclude that those health care professionals who oppose PAS while maintaining the appropriateness of terminal sedation in certain situations are not acting inconsistently.*

In an intriguing and thought provoking essay entitled “Terminal Sedation: *Pulling the Sheet over Our Eyes*,”<sup>1</sup> Margaret P. Battin argues that one cannot consistently affirm the practice of terminal or palliative sedation while at the same time rejecting physician-assisted death. She thinks that while there may be the *feel* that there is a moral difference between these two practices, its implausible defense rests on a tenuous appeal to the discerning of clinical intentions and a controversial application of double-effect reasoning. To be sure, she does not claim that the practice of terminal sedation is wrong. Instead, her issue is that it is often practiced disingenuously. The common features of the two practices are obscured or sanitized in professional discourse, Battin thinks, due to the anxiety that terminal sedation (the permissible strategy) might be confused with euthanasia and physician-assisted death (the impermissible strategy). This obfuscation is where it is claimed that “the sheet is pulled over our eyes” concerning the practice of terminal sedation.<sup>2</sup>

There are many important features of her presentation that cannot be addressed in a brief response essay. Nevertheless, we do have some misgivings about certain claims found in the piece. Most of these are centered on our primary concern, which is that much of what she writes and argues for seems to distort the normal purpose and practice of sedation in the terminally ill. After reading Battin’s essay, one could be left with an inaccurate understanding of terminal sedation. And so there is a danger that we can be distracted from those important and less controversial features of the practice that can assist us in distinguishing it from physician-assisted death. By way of response, we want to articulate a more nuanced understanding of terminal sedation from the version Battin provides. Along the way, we contrast this more appropriate understanding of the practice of terminal sedation with some of the claims by Battin.

## Understanding Terminal Sedation

Terminal sedation is the name given to a practice of sedating people at the end or terminus of their lives. These patients are unable to have their symptoms, such as pain or agitation, controlled while leaving them conscious. Medical anesthesia has for some time been able to keep people in such a complete state of unconsciousness that we are able to perform medical wonders, such as transplanting a heart or removing a cancer, without the patient feeling anything during the procedure. It is, in fact, a moral imperative to provide adequate anesthesia when painful operations are performed—few would argue with that. Palliative care and hospice physicians also think that it is a moral imperative to treat extreme pain with similar anesthetic techniques when a patient's symptoms cannot be managed while they are awake. The word 'terminal' means the end or stopping point, such as the bus terminal's being the stopping point of a bus line. Likewise, terminal patients are at the end of their lives, and terminal sedation is a palliative care technique used to care for terminal patients. Perhaps another way to put this is that the use of the word 'terminal' is to describe the when of sedation, not the why. This is the essence of terminal sedation: aggressive symptom control to the point of sedation in terminally ill patients.

Battin, however, seems to think that the purpose of terminal sedation is to *terminate* the patient. This appears to be the evident assumption underlying many of her concerns raised in the article. Regarding her concern for patient autonomy and consent being honored in the practice of terminal sedation, she writes:

The new euphemism, "palliative sedation," now often used instead of the more distressing "terminal sedation," only reinforces [the problem of patient consent being misdirected by focusing on avoiding pain and not on causing death which is where it *should* be]. By avoiding the word "terminal" and hence any suggestion that death may be coming, the most important feature of this practice is obscured and terminal sedation is confused with "palliative care."<sup>3</sup>

This seems to be a critical misunderstanding by Battin. The linguistic shift to 'palliative sedation' that many now utilize is to *clarify* the intent and application of an often misunderstood and abused practice. Contrary to Battin, the use of the term 'palliative sedation' should not be understood as being a "new euphemism" to take the edge off of a controversial practice and as an illegitimate attempt to avoid the similarities with physician-assisted death. Instead, the use of 'palliative' is to reflect the goal and intent of terminal sedation, which is to alleviate otherwise unmanageable symptoms and which *is* also the most important feature, not the hastening of death. This is not dissimilar to the shift in language to 'physician-assisted death' that many of its proponents employ from the more unfavorable 'physician-assisted suicide.' Many in support of physician-assisted death understand that the term 'suicide' can be distressing and misunderstood as well. So the use of the more preferred term 'physician-assisted death' is to connote the *intent* of the physician to care for the patient and to emphasize the goal of the practice which is to be an exercise in mercy and an expression of patient autonomy, according to its proponents.

Moreover, Battin acknowledges that terminal sedation may end pain, but also thinks that it *ends* life, which is evident in a couple of ways. First, sentient life is ended because the sedated state does not allow for "the possibility of social interaction." Second,



“because artificial nutrition and hydration are usually withheld, it also ends biological life.”<sup>4</sup> In other words, it appears that Battin is making a common distinction between biographical and biological life. We think that this, though, leads to some confusion. With respect to the first category, we are unable to discern how this sedated state brought on by palliative sedation differs from someone who is sedated in preparation for an operation. The same medicines are frequently used for both palliative sedation and standard surgical procedures. In these situations, the sentient life of the patient has ceased and social interaction is not possible, albeit temporarily. Yet we do not consider people as being dead or without “life” who are unconscious due to anesthesia. So too is the case with legitimate practices of palliative sedation. If the terminally ill patient’s pain becomes manageable, there is no reason to continue its administration and in some cases the patient regains consciousness. So the appeal to lack of social interaction and sentience brought on by palliative sedation gives the impression that the patient’s life has irreversibly ended by this procedure alone, which is not correct.

The more crucial issue is the second category where food and water have been discontinued. There needs to be clarification and qualification concerning terminal sedation while withholding nutrition and hydration for the terminally ill. In the vast majority of patients in which terminal sedation is used, at least in palliative and hospice care, eating and drinking have stopped due to the disease process or to intractable symptoms before the initiation of sedation. The lack of desire for food is common at the end of life. Adding artificial feeding or hydration in these cases can often contribute to a person’s misery and will not prolong life. Sedation started in such an individual where artificial hydration and nutrition are withheld will not hasten death, because food and water can no longer prolong it. Patients have often deteriorated to the point where natural or artificial feeding is futile and perhaps deleterious to the patient. In other cases, where food or fluids would prolong life, there is no reason that they could not be continued. It does not seem that there is anything especially controversial about sedation in the terminally ill without artificial feeding in cases where, if food and water were provided, the patient would actually be more burdened with the artificial feeding than without it. This is the most common use of palliative sedation. And so, it should be clear that terminal sedation in this scenario is very different from the purposes and goals of physician-assisted death.

This conclusion, though, varies fundamentally with Battin’s claim that “Patients who are sedated to the degree involved in terminal sedation cannot eat or drink, and without ‘artificial’ nutrition and hydration will necessarily die, virtually always before they would have died otherwise.”<sup>5</sup> Interestingly, she does not provide any data to support the claim that by not having artificial feeding the patient would almost always die earlier than they would otherwise. It does not appear that she takes seriously the option that the patient, after being sedated to treat otherwise uncontrollable pain, could die of the disease before getting to the point of dehydration, which is typical when the patient is in the active phase of dying.

### **Clarifying the Confusion**

There are other cases, however, where things are not so straightforward. For example, what do we think about a situation where the patient who has not transitioned to the active phase of dying requests sedation for an indefinite period to treat her pain, and then

refuses artificial nutrition and hydration on the basis of their being extreme measures? What are we to make of the scenario where a physician informs the terminally ill patient, who is not in the active phase of dying, that she has the option of being sedated to unconsciousness to treat her pain, actual or potential, and also has a right to refuse artificial nutrition and hydration after sedation has begun? Of course, the patient understands and the physician informs her that the inevitable result is death. Is sedation to unconsciousness appropriate for existential suffering? These are vexing questions that to many people have no easy answers. Perhaps these are the kinds of difficult cases that Battin has in mind. If so, then it seems that the aforementioned circumstances where terminal sedation is being considered for palliative care are not clearly discernible from physician-assisted death in any relevant sense. Certainly, these cases are more controversial and rightfully so.

But what follows from this? We think that what this shows is that there are some clear cases where terminal sedation is practiced that are distinct from physician-assisted death, and there are others where there are not any clear distinguishing factors between the two. This is why the need for guidelines and procedures for any institution engaged in this practice are essential. Battin suggests that in some cases physician-assisted death may even fair better than terminal sedation due to the safeguards developed for it as opposed to the lack of guidelines established for sedation of the terminally ill. According to Battin, "Terminal sedation has no institutional safeguards built in."<sup>6</sup> This statement, however, strikes us as odd. The organization with which we are affiliated has an institutional policy that establishes the proper protocol regarding the administration of palliative sedation that is to be followed along with the procedures before the sedation is to be performed. It discusses the condition of the patient for which the procedure is appropriate, discussion of nutrition and hydration and lack thereof, and informed consent among other issues. Moreover, a recent professional journal on palliative care published some brief but helpful guidelines to determine when administration of palliative sedation is appropriate.<sup>7</sup> The point here is to challenge the claim by Battin that palliative sedation is often done capriciously. Undoubtedly, there can be abuses that take place in any medical procedure. To administer terminal sedation without proper institutional safeguards is to engage in the practice irresponsibly.

We acknowledge that there are cases where terminal sedation is used as an end-around to physician-assisted death to accomplish the same goal. In these cases, we agree with Battin that there are no real legitimate distinguishing features from physician-assisted death. Therefore, those who oppose physician-assisted death should conclude that to engage in terminal sedation in these controversial cases would be inappropriate. These individuals would certainly be acting disingenuously if they knew their intent was to hasten the patient's death. We think that clinical practitioners who responsibly engage in terminal or palliative sedation do not act inconsistently while maintaining opposition to physician-assisted death. Battin does not consider an important potential concern from the other side of the equation. Do outspoken proponents of physician-assisted death practice terminal sedation hypocritically? Is abuse of palliative sedation more likely from opponents or proponents of physician assisted death? We leave these as open questions.

## Conclusion

Battin seems to suggest that it is the murky cases that are the norm for determining whether or not the practice of terminal sedation is different from physician-assisted death. So if we can accept the practice of terminal sedation when it is not clear that it is morally and practically distinct from physician-assisted death, then we should have no problem with the latter practice being a legitimate option for physicians and patients in palliative care. We disagree. Our claim is not that all cases where terminal sedation is used are clearly distinct from physician-assisted death. It is, instead, that these admittedly difficult cases do not rule out the fact that there are clearer and more common scenarios where the practice of terminal sedation constitutes appropriate palliative care measures and is distinct from physician-assisted death. Our aim in this response essay has been to show that one can engage in palliative sedation while being consistent in opposing physician-assisted death. The old dictum of jurisprudence holds true here, “tough cases, make bad law.” We ought not to examine the controversial or questionable cases of the application of sedation in the terminally ill to determine its similarity or lack thereof with physician-assisted death. Instead, it seems better methodologically to examine the clear cases and on that basis determine whether we have “crossed the line” in more difficult ones.

## Endnotes

- 1 *Hastings Center Report* 38, no. 5 (2008): 27-30.
- 2 *Ibid.*, 30.
- 3 *Ibid.*, 28.
- 4 *Ibid.*, 27-28.
- 5 *Ibid.*, 28.
- 6 *Ibid.*
- 7 Tanya Lugliani Stewart, M.D., ““To Sleep Before We Die . . .”: When is Palliative Sedation an Option for the Dying Person?” in *Journal of Palliative Medicine*, 11, no. 1 (2008): 131-132.

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GREY MATTERS

## ACCELERATED THOUGHT IN THE FAST LANE

WILLIAM P. CHESHIRE, JR., MD

The quest for speed has increasingly driven the course of progress. The history of technology records remarkable innovations to advance the cause of speed in communication and travel in particular. Emerging neuropharmaceutical technologies now introduce the prospect of accelerating the speed of thought.

In 1860, the fastest way to send a letter across the North American continent was to hire the Pony Express. A chain of riders on horses at a galloping 10 mph would deliver mail from the Atlantic to the Pacific coast in about ten days. The telegraph soon replaced the Pony Express, allowing messages to travel at the speed of electricity. These telegraph cables were laid out alongside the Transcontinental Railroad, which accommodated locomotives traveling at 20 mph. Today, jet aircraft couriers routinely deliver mail overnight to any city in North America. Senders take it for granted that e-mail messages dispatched from handheld cellular phones can instantaneously reach computers anywhere in the world.

In the historical lanes of motorized travel, the first self-propelled road vehicle was Nicolas Cugnot's steam-powered military tractor, which in 1769 crept along at 2 ½ mph. In 1885, Karl Benz was the first to integrate an internal combustion gasoline engine with a chassis and manufacture for public use a practical automobile. In 1889, Gottlieb Daimler's two-cylinder engine and four-speed transmission boosted automobile speeds to 10 mph. In the 1920s, Henry Ford's famous Model T achieved speeds of 35 mph. Today, automobile speeds on highways are typically 55-70 mph. Formula 1 race cars may exceed speeds of 200 mph. Local service trains may travel at 90 mph and high speed trains up to 300 mph. The cruising speed of a modern commercial jet airliner is near 550 mph, while the Concorde airliner travels at supersonic speeds of up to 1,350 mph. The Space Shuttle travels at 17,000 mph, and to escape Earth's gravitational pull, space vehicles exceed 36,000 mph. These feats of technology define the incrementally progressive scale of attainable speed.

What are the limits to which human intelligence can or should be hastened? The brain, in one respect, is an engine that exchanges one type of energy—carbohydrates and other forms of nutrition—for another—the neurochemical exchanges that underlie patterns of perception, thought and expression. In another respect, the brain resembles a specific type of engine—a computer—as it processes parcels of information, lays down memory, retrieves memory, answers questions, and relays abstract ideas from one person to another. Pushing the limits of engines has yielded tremendous rewards in transportation and communication. It may be tempting to think of the brain as a vehicle to be similarly modified for enhanced performance.

A smorgasbord of pharmaceutical compounds comprising stimulants and agents that promote wakefulness or modify memory has become available for treating neurologic and psychiatric disease. Further research is likely to generate increasingly selective

neuropharmaceutical agents. A number of ethicists contend that such drugs ought to be made available also for the purpose of enhancing cognitive capacity in healthy persons because of the potential benefits to individuals and to society.<sup>1</sup>

The hope of cognitive enhancement grows out of the optimism inspired by technological progress combined with the allure of neuroscience. Whereas some other fields of investigation, such as cosmology, meteorology or geology, may rival neuroscience in the sum of data or the splendor of images, the mind cannot inhabit those realms directly. Neuroscience investigates, and some lines of neurotechnology seek to influence, the very organ of human contemplation, feeling, and biography. Herein dwell the most intimate of human thoughts.

Even a cursory survey of what neuroscience reveals about the brain gives one pause when considering whether to attempt to upgrade this enigmatic cerebral engine. The evidence is overwhelming that the human brain is astonishingly more intricate than any machine of human design. Unlike the manufactured engine, the human brain is living and conscious and part of a unique person of immeasurable dignity. Moreover, certain cerebral attributes lie beyond the reach of would-be redesigners. Rigid skulls confine the number of neurons that may be fit within the cranial vault. The human genome precisely determines the delicate balance of chemical messaging systems that interact within the complex neural architecture of the human brain. The speed of neuronal conduction is also biophysically fixed. Within peripheral nerves, the propagation of signals in myelinated motor neurons is approximately 130 mph and in unmyelinated sensory and autonomic neurons 2-5 mph. Neurons are also fragile, easily injured, and difficult if not impossible to repair.

At the heart of human nature lies a paradox. A fundamental aspect of what it means to be human is to be a limited creature. To be human is also to look beyond limitations and to reach for the stars. Fragile in form yet bold in yearning, humans are also inclined to hubris. Limitations entice ingenuity, which thrives under challenge. Each generation ventures to break existing records, whether the four minute mile or the sound barrier.<sup>2</sup>

Given the historical pattern of human achievement, attempts to extend the quest for speed to the brain itself may be inevitable. Already, off label and diverted prescriptions for cognitive enhancing drugs are being used by students and professionals seeking a performance edge.<sup>1,3</sup> The pursuit of faster thought through pharmaceutical or, one day, through microinterface electronic technologies may prove irresistible. If the aspiration to accelerate thought artificially is to be realized, then there is much to be learned from the parallel history of transportation safety.

When developing new technologies, planning for safety often lags the pursuit of greater performance. The early automobiles, for example, were high risk contraptions. The fuel tank of the Ford Model T was mounted just beneath the driver's seat, so that only a thin tin frame separated ten gallons of gasoline from the driver. Before the physics of brain and spine injuries was well understood, the automobile chassis was built to be rigid. Modern vehicles, however, are designed with crumple zones and air bags which absorb kinetic injury, head restraints which limit cervical spine rebound extension, and seat belts which hold the driver to the seat. Safety standards are also established to guide road construction, including curve embankment, signs, and bridges. Rules of the road are established as well to ensure safety, including the requirement to obey stoplights, yield

signs, and speed limits. The consequences of ignoring safety principles are dire. Motor vehicle accidents continue to be the leading cause of death in the U.S. between the ages of 15 and 24.<sup>4,5</sup>

Early planning for safety is of paramount importance. Development of effective safety measures must draw from valid empirical data. There is much that is still unknown about the short- and long-term risks of drugs that boost cognitive performance, particularly in children. More research is needed into the patterns of use and life impact of cognitive enhancing drugs by healthy persons. Studies are needed to assess the form and style of accelerated thought and examine the content of knowledge gained and note what is ignored or unheeded. This research should assess not only retention of information but also understanding and character development—qualities that it would seem are unlikely to be improved through sheer chemical means. More studies are needed also to compare the incidence of anxiety, depression, headache, professional satisfaction, social fulfillment and suicide among those who use cognitive enhancers with their incidence in those who do not.

In assessing the need for safety standards to guide the use of cognitive enhancers, abundant empirical evidence already exists concerning the desires and tendencies that distinguish human nature. Several broad predictions may be offered. Some users will enter the cognitive fast lane in the pursuit of individual perfection. Others will roll down the gradient of narcissistic appetite. Still others will seek to enhance their capacity to serve others. Some will be conscientious and others careless. Enhanced knowledge intake might distract at least as often as it will elevate thought. Many things discoverable in the slow lanes of life may become blurry. Beauty may be overlooked and subtlety passed over as supercharged minds whiz by.

Exhilarating mental speed will occasionally collide with other mental pursuits. The crashes of racing thoughts may be expected to produce posttraumatic sequellae. A future sociology might adopt such metaphorical terms as cultural concussion, emotional whiplash, or existential hemorrhage. Caring for such casualties will challenge the healing talents even of cognitively augmented professionals. Dedicated effort will be needed to develop safety measures and ethical rules to minimize such personal and societal harms.

In a possible future in which cognitive enhancement technology is pressed to the extreme, those who choose to remain unenhanced may feel as cyclists on a bustling superhighway. Chasing after unlimited cognitive enhancement narrowly defined may place sanity itself at risk. In the words of the poet John Dryden, “Great wits are sure to madness near allied.”<sup>6</sup> The not yet counter-cultural methods of study, discipline and training remain tried and true, if not safer and surer, ways of enhancing cognitive performance.

Pony Express riders initially traveled with a pouch containing water, a Bible, and a revolver. For the sake of speed, the Pony Express later lightened the rider’s pouch by removing the Bible. The pursuit of ever faster thought risks attaining short-term gains at the expense of leaving wisdom behind. The race may not be to the swift after all.<sup>7</sup>

## Endnotes

- 1 Greely H, Sahakian B, Harris J, Kessler RC, Gazzaniga M, Campbell P, Farah MJ. Towards responsible use of cognitive-enhancing drugs by the healthy. *Nature* 2008; 456: 702-705.
- 2 The first man known to run a mile in less than four minutes was Sir Roger Bannister in 1954. Sir Roger subsequently became a neurologist at Oxford University specializing in disorders of the autonomic nervous system. This author was honored to have dinner with him in 2005.
- 3 Cheshire WP. Drugs for enhancing cognition and their ethical implications: a hot new cup of tea. *Expert Review of Neurotherapeutics* 2006; 6(3): 262-266.
- 4 National Center for Health Statistics, accessed at <http://www.cdc.gov/nchs/nvss.htm>.
- 5 Days before this essay was written, the author's teenage son was injured by a car that sped through a red light. As a helpless father's thoughts spin out, the meaning of loss and the redemption of suffering are painfully grey matters.
- 6 Dryden J. *Absalom and Achitophel*, Part 1, line163, 1681.
- 7 *Ecclesiastes* 9:11.

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CLINICAL ETHICS DILEMMAS

## ON THE PERMISSIBILITY OF A DNR ORDER FOR PATIENT WITH DISMAL PROGNOSIS

RYAN R. NASH, MD

**Editor's Note:** *The following consultation report is based on a real clinical dilemma that led to a request for an ethics consultation. Some details have been changed to preserve patient privacy. The goal of this column is to address ethical dilemmas faced by patients, families and healthcare professionals, offering careful analysis and recommendations that are consistent with biblical standards. The format and length are intended to simulate an actual consultation report that might appear in a clinical record and are not intended to be an exhaustive discussion of the issues raised.*

**Column editor:** Robert D. Orr, MD, CM, Consultant in Clinical Ethics, CBHD.

### Question

Is it ethically permissible to write a DNR order and withdraw the ventilator from this patient with a dismal prognosis?

### Story

Ann, an 86 year-old woman with past medical history of osteoporosis, was in good health until the evening of admission when she fell, hitting her head and losing consciousness. Friends observed the fall and called paramedics. Ann was intubated on site and transported to Teaching Hospital where her treatment, including ventilator support, was continued. The trauma surgery team diagnosed her with rib fractures causing a partial flail chest<sup>1</sup> and a subdural hematoma<sup>2</sup> and admitted her to the ICU. The trauma team communicated to the family that Ann would not survive this trauma largely due to her age. The treatment was continued overnight, and the following morning the trauma team met with the grieving family and together they decided to place a DNR order in Ann's chart and withdraw her from the ventilator with the help of the Palliative Care service. However, when the Palliative team arrived and evaluated her they found Ann awake and able to communicate with apparent insight. The palliative physician asked and was told that Ann had not been involved in decision-making. Thus, he requested ethics consultation.

Inquiry during the ethics consult revealed that the trauma team continued to believe that the patient would not survive despite her improved mental state. In questioning the patient, her family, and her friends it became clear that Ann was a remarkable 86 year-old. She lived independently and could easily perform all activities of daily living. She has continued to drive well and has had an active travel and social life. No definitive answer could be given as to whether her being a vibrant, elder patient would change her prognosis. Ann did not have a written advance directive or living will, nor had she previously communicated her treatment wishes.

## Assessment

Ann has suffered what appears to be a fatal injury. Her physicians and her family believe withdrawal of ventilator support and a DNR order would be appropriate. However, the patient is awake and able to communicate and has not yet been asked to give consent.

## Discussion

In the event that a patient is incapacitated, treatment decisions are made by a proxy, first turning to written documentation of the patient's wishes and/or her officially appointed decision-maker. In the absence of written documentation or an appointed proxy, we turn to a surrogate decision-maker. The initial burden on the surrogate is to make decisions using substituted judgment (how the patient would decide in the given situation) based on her previously stated wishes or an understanding of her values. Only if it is reasonably uncertain how the patient would decide can a surrogate decide using the lower standard of what would be in the patient's best interest.

On the other hand, when a patient has decisional capacity, consent for treatment is obtained not from a surrogate but from the patient herself. At times it is appropriate to include surrogates in decision-making even if the patient has decisional capacity. This is encouraged when a patient's circumstance could be viewed as decision-making under duress. Surrogates in these contexts would be advocating for the patient and helping ensure the patient's wishes are being carried out.

When a dilemma arises regarding whether to carry out a treatment requested by a patient or her surrogate when that treatment is thought to be inappropriate by the physician, we must try to determine the nature of the treatment and whether it is "futile." Futility can be divided into physiologic futility (the treatment has no possibility of achieving its goal), probabilistic futility (the treatment is very unlikely to achieve its goal), and qualitative futility (the treatment, even if effective, may not be worthwhile). Generally, a physician is under no obligation to prescribe a treatment that meets the standard of physiologic futility. Probabilistic and qualitative futility cases generally require the consent of the patient or surrogate.

In this case no documentation of an advance directive or appointment of a surrogate decision-maker appointment is available. Immediate family is present and willing to participate in decision-making. The family has had consensus and gives no clear reason to be disqualified from acting as surrogates should such be needed.

Mechanical ventilation in this case likely falls into the category of probabilistic futility. Though very unlikely to be effective, and even considered inappropriate by some, it is not physiologically futile and is thus ethically permissible. Therefore, the patient or surrogate needs to give consent for withdrawal of ventilator support. Cardiopulmonary resuscitation may or may not be considered physiologically futile in this case. If her physicians believe that her osteoporosis and flail chest make it physiologically impossible to do effective CPR, this should be explained to the patient or family, and a DNR order may be entered in her chart. If, however, they are uncertain of its effectiveness, the use or non-use of CPR should also be discussed with the patient or her surrogate.

The primary treatment team has appropriately based prognostication on research data showing poor survival in elder trauma. These data are surely helpful in communicating

expectations; however, we must beware of ageism. Ensuring that each patient is treated as an individual is also important. Further, communication with the patient should not be withheld due to either her age or her prognosis.

This patient has demonstrated enough decisional capacity to be involved in the decision-making process. She should be asked if she would like to be informed of her illness and participate in decision-making. If she chooses not to participate, then a surrogate decision should be sought. Otherwise, she should be asked her preferences in her care after sensitive and realistic explanation of potential benefits and burdens. Her family should be involved in these discussions.

### **Recommendations**

1. This patient's mechanical ventilator should not be removed until she has been involved in decision-making. Unless her physicians agree that CPR would be physiologically futile, her DNR order should be suspended pending further discussion.
2. If the patient wants to make her own treatment decisions, she should be informed of her condition and prognosis. Treatment options should be discussed, along with her physicians' recommendations.
3. If she chooses to defer treatment decisions to others, or if she loses decisional capacity before she is able to participate in these decisions, then the family should be turned to as surrogate decision makers.

### **Follow-up**

Ann was asked if she wanted to participate in decision-making. She said that she did. She was informed about her injuries, prognosis, and options. Seemingly handling the information well, she agreed to the DNR order. She gave consent for withdrawal of the ventilator if she became decisionally incapacitated. Her family and her treatment team agreed to follow this directive.

A DNR order was reactivated. Supportive measures, mechanical ventilation, and appropriate therapies were continued including antibiotics for a new pneumonia. Surgical intervention was not deemed possible for her injuries. On hospital day 3, Ann became slightly more somnolent. On hospital day 4 she became comatose and died just prior to further discussion of withdrawing the mechanical ventilator.

## Endnotes

- 1 A flail chest occurs when multiple ribs are fractured such that the chest wall is no longer fixed in position, and the changes in pressure that occur during respiration cause the chest wall to move inappropriately, seriously hampering oxygenation. Treatment includes ventilator support until the ribs heal or are mechanically fixed in place.
- 2 A subdural hematoma is a blood clot on the surface of the brain that may or may not compromise brain function depending on its size and the presence or absence of progression.

## REVITALIZING MEDICINE: EMPOWERING NATALITY VS. FEARING MORTALITY

BRENT WATERS, DPHIL

One of the great accomplishments of modern medicine is arguably the gains that have been made in extending longevity. Throughout the twentieth century, average life expectancy increased dramatically across the globe, a trend being continued in the twenty-first century with the notable exceptions of sub-Saharan Africa and Russia. For the first time in history it now seems “normal” that a person should live a long, healthy, and active life. Although the trend line is still moving up, it has started to plateau. The steep increase in longevity was achieved initially through relatively simple things such as improved nutrition and sanitation, declining infant mortality through better prenatal and postnatal care, and the development of inoculations and antibiotics. More modest gains have been achieved with the use of new diagnostic techniques and therapies for treating such life-threatening conditions as cancer and heart disease.

But the momentum in extending longevity is slowing, and many scientists believe that 120-125 years is the outside boundary that cannot be crossed. The Hayflick limit is evidently ironclad and absolute. Medical advances may be able to bring more individuals closer to this boundary, but few, if any, will cross over. Regardless of how proficient physicians may become in extending the lives of their patients, biology insists that death will still have the final word. There are some dissident scientists, however, who believe this boundary can be pushed farther out. With the advent of stem cell research and regenerative medicine, and with anticipated developments in biotechnology, nanotechnology, and bionics, there is talk of extending human life spans to perhaps 150 years, or even 175 or 200 years.<sup>1</sup> The more optimistic voices speak in terms of millennia rather than decades or centuries. The most adventurous prognosticators boldly assert that, contrary to Leonard Hayflick, the biological boundary is not absolute and can be crossed; immortality is within our grasp once we develop the appropriate technologies.<sup>2</sup>

It is tempting to dismiss these predictions as little more than wishful thinking. After all, despite the billions of dollars invested in life prolongation research, no significant advances have yet been made—except for some lucky mice and nematodes who lived three times as long as their less fortunate peers. The prospect of living longer seems at best a distant dream, and at worst an idle fantasy. It would be a mistake, however, to curtly dismiss the possibility of extreme longevity as little more than science fiction masquerading as science. In the first place, although research to date has been disappointing, this does not eliminate the possibility of dramatic breakthroughs in the future. I remember reading an article shortly before the announcement of Dolly in which the author confidently informed his readers that the technology for cloning a mammal (other than a rodent) was at least a century away if it could be developed at all. If anticipated breakthroughs are forthcoming, then it behooves us to start thinking about the subsequent moral, social, economic, and political implications—if you believe

that Social Security and Medicare are in a mess now, just imagine a world populated by sesquicentennials.

Secondly, and more importantly, the rhetoric surrounding life extension research is prompting us to regard and treat aging as if it were a disease. With the development of more effective therapies and preventive measures we are enabling many people to live longer and more active lives. The image of a pensioner dozing in a rocking chair is not the poster child of AARP. Rather it promotes and supports cheerful and energetic seniors spending their lengthening golden years endlessly playing golf in Florida. Although some of the more immodest predictions regarding life prolongation may never prove true, the research is nonetheless enabling more people to live independent and active lives as they grow older. The trick is not only to live longer, but to maintain youthful strength and vigor. Now it may be asked: what is wrong with living a long, healthy, and active life? The short answer is: nothing at all. Contrary to Leon Kass' objection that extended longevity would result inevitably in tedious boredom,<sup>3</sup> I think I could find plenty of worthwhile things to do if I could live to be 120 or more. The issue at hand is not living longer *per se*, but rather, what sense are we to make of this puzzling perception of aging as a disease that can be treated and perhaps even cured?

### Fearing Mortality

Many of the champions of regenerative medicine and life prolongation research refer to aging and death with such words as “annoyance,” “irrational encumbrance,” and “tragedy.” But how has it come to be that morbidity and mortality are somehow inimical to human flourishing when they have been very much a normal part of our history as a species? Many people have grown old, and as far as we know no one has ever lived forever. It would appear that a natural and healthy fear of death has been malformed and personified into a foe that must be vanquished. But what would waging a war against aging and death entail? What would ultimate victory mean for both medicine and its patients? And even if we fail (which I think likely) how would such an unremitting struggle shape healthcare, and how would we come to regard ourselves both as finite creatures and what we aspire to become?

Hannah Arendt can help us think about these questions. She asserts that natality and mortality—birth and death—are the defining features of the human condition.<sup>4</sup> They are the brackets or bookends, so to speak, between which we shape and live out our lives. Our work, hopes, and aspirations only have meaning within a temporal structure that has a beginning and an end. Indeed, without a beginning and end the word *life* has no real meaning.<sup>5</sup> In confronting death we encounter mortality as the “only reliable law of life” that inevitably carries “everything human to ruin and destruction.”<sup>6</sup> According to Arendt, in death we face the prospect of our disappearance from the earth and its history; our permanent separation from the families, friends, and communities which have shaped and sustained us.<sup>7</sup> In death we face the prospect of the utter and complete annihilation of who we are and what we aspire to become.

When we become fixated on mortality, is not a natural reaction to find some way to fight against, overcome, or otherwise cheat this cruel fate? And is not some type of quest for immortality a rational strategy in this respect?<sup>8</sup> That we try to achieve a kind of immortal presence among subsequent generations through things we produce or legacies we leave? Through offspring we pass on a genetic inheritance to future generations that

was bequeathed to us from our ancestors. The ancient Romans tried to build an immortal empire,<sup>9</sup> while late moderns attempt to construct an everlasting history.<sup>10</sup> Although individuals grow old and die, empires and histories purportedly live on forever. May we not say that our current fascination with employing medicine to extend longevity reflects a similar obsession with mortality? That ironically, our success in extending longevity has fixed our attention more relentlessly upon death? The principal difference is that now our gaze is cast simultaneously toward both individuals *and* larger corporate structures. We not only want to establish an immortal legacy through a lineage, empire, or history, but to live our individual lives for as long as possible, even striving to achieve personal immortality. Pursuing this twofold strategy requires a triumph of the will in which we construct our world and ourselves in the image of what we want it and ourselves to be. And the power to achieve these goals is seen most vividly in our growing use of various technologies. Consequently, we construct our children, political communities, and histories as artifacts of a corporate will, and we turn to medicine to construct ourselves individually as self-made artifacts.

This twofold strategy for conquering death, however, is comprised of diametrically opposite goals, leading to inevitable tensions, conflicts, and contradictions. If, on the one hand, individuals are dedicated to reengineering themselves to live as long as possible, perhaps even achieving personal immortality, there is no compelling reason why they should invest their time and energy to projects that are designed to outlive them. Why should individuals invest themselves in building an immortal lineage, empire, or history if the goal is to live forever? Such tasks simply detract attention away from achieving the objective of personal survival. The more time and money I spend on my daughter, for instance, means I have less to spend on myself. This is especially a waste of time and money if the goal is to develop medical care that wards off the ravages of aging so that I can remain independent rather than depending on my daughter (or anyone else for that matter) to care for me as I grow older. On the other hand, if we are dedicated to constructing lineages, empires, and histories that are intended to outlive us, extending the survival of most individuals, much less achieving personal immortality, is irrelevant and may even prove inimical. Individuals are expected to sacrifice their interests for the sake of the future. Investing in personal longevity wastes resources that could be better applied to these more expansive tasks. If, for example, I invest heavily in improving my cardio-vascular system but contract Alzheimer's disease and linger on for decades, I no longer contribute to but detract from the task of building the very corporate future in which I am supposed to be immortalized. It would be better for all concerned if I would go sooner with heart disease than later with dementia.

This conflict I have sketched out between what may be characterized, respectively, as *selfishness* and *altruism* is admittedly little more than a caricature of the more complex relationship between these seemingly contradictory behaviors. A key tenet of evolutionary psychology, for instance, contends that the two are intricately related; indeed, that altruism presupposes and is dependent upon selfishness. The reason I am inclined to sacrifice my own desires and spend my limited financial resources on my daughter is that she carries my genes. Through her I will live on after I die. In this respect, it is in my self-interest to be altruistic. It is only in my fear of death that I am motivated to invest in my daughter's future. Although proponents of evolutionary psychology overstate their case (not all of our behavior can be reduced to selfish genes), they nonetheless offer the salient insight that morality cannot be casually separated from biology. If in fact evolutionary

psychology is correct in this regard, might our medical war against aging and death create some unwanted and troubling consequences? Again risking oversimplification the dilemma can be stated as follows: if I am dedicated to living for as long as possible, and perhaps forever, will I not lose my motivation to invest in my daughter's future, or even produce and raise offspring? Conversely, if altruistic behavior is grounded in selfishness, should we take the risk of waging a war against aging and death if it lessens, or even removes, the fear of death as an underlying motivation?

Some of the more pronounced implications of this dilemma can be seen with greater clarity by focusing on some of the ethical issues at the beginning and end of life. At the beginning of life, great advances have been made in prenatal and neonatal care. Many infants who would ordinarily not have survived or would have suffered chronic conditions due to poor prenatal care or premature birth are now able to live happy and productive lives. With the assistance of various reproductive technologies, many infertile couples are able to have children. To the casual observer, it would appear that we are a very child-friendly, even pro-natalist, culture. Appearances, however, can be deceiving. An increasing number of individuals are choosing to remain childless, a goal that is assisted by various contraceptive techniques and easy access to abortion. More effective screening and testing (e.g., amniocentesis and preimplantation genetic diagnosis) is enabling parents to prevent the birth of children with deleterious conditions or other unwanted characteristics, select desirable traits (e.g., sex), and perhaps in the future to produce so-called designer babies. Not only have these techniques resulted in the destruction of many fetuses and embryos, but with the prospect of embryonic stem cell research and therapeutic cloning, prenatal life may come to be perceived as a biological resource or commodity that can be exploited in developing better healthcare, especially in respect to treating aging as a disease. Again, to the casual observer, it would appear that we are a culture that is at best indifferent to children, and at worst hostile.

These contradictions are played-out with an alarming symmetry at the end of life. Tremendous strides have been made in treating, and in some cases curing, a growing range of diseases which a few decades ago were tantamount to a death sentence. We now, for example, talk about surviving cancer as a possibility rather than a desperate hope. By in large we assume that with a combination of healthy lifestyles and proper medical care, virtually anyone can live a long and active life. Moreover, improved pain medication and palliative care has made the prospect of an "easy passing" more readily available. To the casual observer, it would appear that we are a culture that cherishes life and have developed a healthcare system that is devoted to its prolongation. Yet again, appearances can be deceiving. Under the banner of "quality of life" we also promote death as a means of exercising the right to control one's fate. When an individual has determined that the quality of her life has reached such a low ebb that continued existence is no longer desirable, then she should be able to control the time and means of her death. Hence the growing public tolerance, if not acceptance, of euthanasia and assisted suicide. Moreover, exercising this personal choice to "die with dignity" has also created a subtle expectation that the dying should not be assisted in lingering too long and become a burden on others. Again, to the casual observer, it would appear that we are a culture with little tolerance for morbidity and little patience for the care of the dying.

How may we account for these apparent contradictions at the beginning and end of life? The strategies I have summarized are, I think, quite rational within the following



scheme: although we have launched some initial forays in a war against aging and death, we are not placing all our eggs in this basket but hedging our bets. Declining birth rates tacitly acknowledge that in striving to live long and active lives, children are both an encumbrance upon one's lifestyle and a drain on financial resources. Offspring are now more an option than a necessity, as reflected in the growing and puzzling perception of children as a means of their parents' self-fulfillment. Hence the growing recourse to and anticipation of "quality control" techniques that help parents obtain the kind of children they want.

Yet there is also a grudging admission that offspring remain a necessity should the war against aging go badly. As people grow older they may still need their children, not to care for them directly but to be productive taxpayers. The late modern phenomenon of lengthy retirements coupled with declining birth rates is a recipe for long term financial disaster. A shrinking cohort of young workers simply cannot support an expanding collection of unproductive pensioners. Consequently, some European countries are now paying women or providing other economic incentives to have children, and even China has admitted that around 2050 a shrinking population will displace overpopulation as its principal social and political problem. In short, children are becoming both an artifact of their parents' will and an insurance policy for the future.

A similar hedging strategy is also at play at the end of life. We are investing heavily in medical treatments and technologies which are designed to extend life for as long as possible while also maximizing certain values such as mobility and independence. But if medicine should fail to deliver the proffered goods, then we want to exercise the options of euthanasia or suicide should the quality of our lives become burdensome or undesirable. Even if we lose the war against aging and death, we can at least have a final, defiant gesture by choosing when and how we die. In this respect, our deaths are also artifacts of our will.

The seemingly contradictory strategies we are employing at the beginning and end of life become more explicable when the war against aging and death that we are undertaking is placed within the larger late modern project of asserting greater mastery over nature and human nature.<sup>11</sup> As late moderns we have come to believe that we must construct our world and ourselves in an image of what we want to become in order to be more human and humane; our lives and our future are largely what we make of them. To be human has become virtually synonymous with being the masters of our own destiny. We assert this mastery through technology in general and medicine in particular. To assert ever greater control over the beginning and end of life is to exert greater mastery over our lives. In this respect, death remains the final, and most elusive, object of our mastery.

If I were to end on this note, I think we might be rather despondent, for the world I have described is the one envisioned by that troubled and troubling philosopher Friedrich Nietzsche; a world of restless and anxious nihilists. But fortunately I have concentrated on only half of Arendt's depiction of the human condition, that of mortality. To complete the picture we need turn our attention to her account of natality.

## Empowering Natality

Arendt insists that if we fixate on death, then anything which may be said to be genuinely human ends in ruin and destruction. We become locked into Nietzsche's eternal recurrence of the same, for there is no purpose or direction to human life over time.<sup>12</sup> Some kind of principle is needed to disrupt this deadly pattern, and Arendt proposes *natality* as a promising candidate. By "natality," she means something more than physical birth although this act symbolizes the disruptive power to break the pattern of mortality. Each new baby embodies a hope of new possibilities; something new is started, and is thereby also renewing. More broadly, natality entails the acknowledgment that there are fundamental limits inherent to what it means to be human. In other words, to be human is necessarily to be finite and temporal. It is only within the imposition of given limits that we are liberated to break the pattern of death and be genuinely creative, or better *procreative* in the sense that we create social and political structures that are greater than ourselves and enable human generations to flourish over time. Yet it must be stressed that we can only embrace natality by accepting, while also refusing to fixate on mortality. The creative and renewing potential of birth can only be effective by consenting to the inevitability and necessity of death. Withholding such consent in favor of a longing for personal immortality distorts the moral ordering of human life, because it removes the limits which give morality its meaning and purpose. This is the trap, Arendt notes, that the immortals or gods of ancient Greek mythology fell into. The pantheon of the gods was populated by beings that could point to their birth but did not face an impending death; they lived deathless lives of endless time. And in the absence of death the ensuing void was filled with an insatiable appetite for power and mastery. The immortals were objects of fear, but certainly not models to be emulated. More often than not they were vain, capricious, and cruel. The gods magnified every conceivable human vice while belittling virtue. The quest for immortality, Arendt suggests, leads inevitably to moral decay, for what is lacking is any "rule of an eternal God."<sup>13</sup>

To consent to, rather than warring against, the inevitability and necessity of mortality redirects our attention back to natality, and in redirecting our gaze we discover the common life that binds us together over time. The renewal which natality offers provides the social and political bonds that embody, in Arendt's words, "what we have in common not only with those who live with us, but also with those who were here before us and with those who will come after us."<sup>14</sup> It is also through the possibilities engendered by natality that we preserve the moral precepts and virtues (such as self-denial and regard for others) which enable us to live together peaceably, especially across generational divides.<sup>15</sup> Consequently, natality, rather than mortality—birth instead of death—should provide the principal metaphor for ordering our common life.<sup>16</sup>

### *Theological Groundwork*

I find Arendt's argument to be highly suggestive, and below I want to explore some avenues for revitalizing medicine by turning our attention away from mortality and toward natality. We must first, however, take a preliminary step of preparing some theological soil in which her philosophical argument may be planted. This is needed, for although Arendt has correctly identified the fateful late modern fascination with death, she cannot quite bring herself to identify an eternal good or God which would help redirect our attention toward birth. The best she can offer is a politics based on justice

that endures and improves over time as the highest good that humans can attain. This is a noble and worthwhile goal that should not be easily dismissed or despised, but it can neither be attained nor sustained. Her project depends upon a strength of will which all too often is too weak to stay the course. The temptation to become fixated on mortality is too compelling to be resisted on our own accord. Rather, those of us who are Christians believe that the highest good is fellowship with God through one's life in Christ, which is in turn a life of grace instead of one's will to power.

In preparing this theological soil it should be admitted upfront that although the medical war against aging is motivated by the fear of death, this fear is not irrational or cowardly. As St. Paul reminds us, death is the final enemy,<sup>17</sup> and when confronting any formidable enemy fear is a normal and healthy response. It should also be admitted that the desire to live a long and active life is neither wicked nor perverse. Again as Scripture reminds us, a long life is a blessing from God evoking praise and thanksgiving. The issue at hand is *how* we should confront the old enemy of death, and *how* we should fulfill the desire of living long and active lives. For those of us who are Christians, thinking about this "how" may start with the Incarnation. In Jesus Christ God became a human being; the Word was made flesh.<sup>18</sup> The Creator became one with his creatures, complete with their temporality and finitude. As attested in Scripture and affirmed by the creeds, Jesus was born of Mary and died on the cross. In these acts we may say there is an affirmation of both natality and mortality. The gospel, however, does not end with Good Friday. Death does not have the final word, for in resurrecting Jesus Christ from the dead life is renewed within the eternal life of the triune God. Easter Sunday is the ultimate act of natality. We face death, then, as a powerful but already defeated enemy. Like all such enemies it should be respected while not granting it finality, for in death we are raised with Christ into the eternal life of God. This is not an easy moral and religious stance to take, for make no mistake, death is real and cannot be cheated. Jesus did not avoid death, and neither will we. Death remains an enemy that should never be warmly embraced, but it should be struggled against on God's terms and not our own. This is why regarding aging as a disease that can be treated, and perhaps cured, is not only futile but also misdirected. Waging a war against aging and death is misguided because there is nothing inherently unnatural, irrational, inconvenient, tragic, or unjust in the reality that we grow old and die; indeed the wellbeing of our descendents requires that we do so. Aging is not a disease, but a sign of our status as temporal and finite creatures. Christ did not come into the world to rescue us from finitude, but to welcome us to eternal fellowship with our Creator.

In treating aging as if it were a disease we make a fateful mistake in confusing immortality and eternity, for the two are not synonymous. In brief, immortality entails a beginning but no end, whereas eternity has no beginning or end. I am not invoking a fine semantic distinction so that over-educated people such as myself can remain gainfully employed. The difference is important and has grave practical implications. The quest for immortality requires a world of endless time. Is this a bad world? Yes! It is a world of frenetic and constant work without rest, because there is no end to or purpose of our labor. It is world of ceaseless and often pointless construction, deconstruction, and reconstruction. A world in which our births, our deaths, our very lives are reduced to artifacts of frenzied willing. It is world devoid of the good and the true, and filled with values of our own making. It is a world populated by frustrated souls in search of a perfection that will always elude them, for the goal is a projected fabrication that is itself

always changing and moving, somewhat like Alice's wonderland in which you can have jam yesterday or tomorrow but never today. In short, it is Nietzsche's world of the will to power that has gone beyond good or evil, and therefore, a world predicated on raw power rather than love.

What a quest for endless time fails to recognize is that temporal and finite creatures, such as ourselves, require a beginning and an end if their lives are to have meaning, direction, and purpose. The realms of natural necessity and human history are bracketed by eternity; the eternal serves as bookends to the story of human existence. Christ is the *alpha* and *omega* of creation and its creatures precisely because he is also the eternal Word of God. It is also the eternal which is the source of the true and the good which are revealed in the Incarnation, and it is in Christ that we gain inklings of what is good and true entails, and we should conform our lives accordingly. Ironically, to strive relentlessly after more and ultimately endless time is to become fixated upon death, for to paraphrase Simone Weil's beguiling observation, the realm of necessity—the realm of finitude and mortality—may be beautiful, but it can never be good.<sup>19</sup>

As St. Augustine reminds us, a properly ordered life is one that desires to know and be embraced by the good and the true; a life that seeks fellowship with the eternal God. He likens this fellowship to the eighth day of creation; an eternal Sabbath rest.<sup>20</sup> Any other desire can only frustrate and disappoint, for our hearts remain restless until they find their rest in God.<sup>21</sup> It is properly God alone that should be the object and goal of what we ultimately love and desire. To reemphasize once again, the desire to live a long and active life is not an evil or wicked desire, but if it is pursued for the sole purpose of extending longevity within a quest for endless time, it corrupts this otherwise good desire. Again as St. Augustine reminds us, the problem of sin, more often than not, is not that we desire bad things but that we love good things badly.<sup>22</sup> May we not say, then, that trying to live for as long as possible by any available means is a disordered desire because it means we desire our own survival more than we desire God? Moreover, does it not also mean that we fear our own deaths more than we fear or love God? If true, then a promising possibility presents itself: what would medical care look like if rather than seeing it as a means of prolonging life we perceived it as a means of preparing ourselves for eternity? Or to use Arendt's metaphors, how would medicine be practiced if our fixation upon mortality were displaced by attending to natality, particularly at the beginning and end of life? In the first place, we would be better enabled to resist the temptation of regarding birth and death as artifacts of our own creation. Rather, we would see life as a gift that properly is not subject to our mastery and control. The concept of life as a gift has been developed in some detail by such theologians as Karl Barth,<sup>23</sup> Gilbert Meilaender,<sup>24</sup> and John Kilner,<sup>25</sup> and I can only summarize briefly the more salient features of their portrayals.

Starkly put: our lives are not our own; they belong to God. Life is not a product we produce or own, but a gift that is entrusted to us, and we are to care for and use this gift in accordance with God's expectations and commands. This sentiment is captured most vividly in the sacrament of baptism.<sup>26</sup> When parents present their child to be baptized, they simultaneously accept the divine charge to love, cherish, and protect this life that has been entrusted to their care, and they in turn commend their child back to the love, grace, and care of God in Christ as the origin and end of life itself. The child is not, in Meilaender's apt but chilling phrase, the outcome of a reproductive project, but

the beneficiary and recipient of their fellowship as wife and husband. In this respect, parents are not so much producers or creators of new life as they are trusted stewards or custodians. Consequently, an orientation toward natality as opposed to mortality will reject the notion of children as artifacts. On the one hand, although being a parent may prove rewarding, a child is not properly a means of parental self-fulfillment. If this were the case, then a child could not embody the kind of hope and possibility that Arendt envisions. It is precisely because a child is *both* like and unlike her parents that genuine fellowship between generations is established and honored. If she is merely an avenue of personal fulfillment, then she is like any other instrument that is used in constructing one's lifestyle; an object exhibiting the will of its creator. It is only in recognizing the similarity and otherness of a child that mortal bonds are forged while the fateful drift into mortality is broken.

On the other hand, although children should care for their parents as they grow older, they are not properly insurance policies. Placing one's hope for the future upon any child (save one) is to impose a burden no child can bear. Again if this were the case then a child would be little more than the sum total of parental aspirations. Such a prospect is bound to prove barren for both child and parent, for the latter is not the slave of the former. Particularly those of us who are Christians know that God, and God alone, is the only proper object of our hope. It is in placing our hope in God that we are freed to consent to our death, and in such freedom our children are empowered to pass on to a new generation the gift of life. Counter intuitively, is in consenting to the necessity and inevitability of death that each generation is free to turn its attention toward natality and away from mortality.

### *Medical Appropriations*

What would it mean for healthcare at the beginning of life to be oriented toward promoting natality? Three suggestions: first and foremost, providing easily accessible prenatal, neonatal, and pediatric healthcare. It makes little sense to affirm procreation but remain indifferent to the health of children.

Second, policies should be strengthened or enacted which support parents in fulfilling their duties and obligations. It makes little sense to perceive children as embodying future possibilities if they are not given the resources to fulfill this potential. Having said this, however, it must be stressed that this responsibility is properly lodged with parents instead of the state or other social service agencies which should play a supportive rather than leading role. In this respect, tax and legal codes, as well as other economic incentives and support mechanisms that protect and empower marriage, family, and educational choice should be regarded as public health issues.

Third, greater respect for prenatal life needs to be exhibited. I am aware that many (including myself) have grown weary over the endless and acrimonious debates over abortion, embryonic stem cell research, and so-called therapeutic cloning. I do not believe that an adequate political consensus exists to offer anything approaching a definitive resolution. Nonetheless, I think it is incumbent, particularly upon Christians, to keep pressing these issues, if for no other reason than raising public awareness. How we treat the most vulnerable members of the human community tells us a lot about our moral convictions as a society and where we are placing our hope and confidence for the future. Casually destroying and exploiting prenatal life for either the sake of convenience

or their potential to develop medical treatments should, at the very least, give the public some pause. If we are to be genuinely oriented toward natality, can we continue to neglect and prey upon the future?

An orientation toward natality as opposed to mortality will also reject any notion of death as an artifact. Life is a gift that is entrusted to our care, but *not* our keeping. The gift is also a loan with a foreclosure date; the life given by God also returns to God. Surrendering this gift and loan back to its rightful owner does not diminish St. Paul's teaching that death remains the final enemy. But in our current crusade against aging, we often fail to resist this enemy properly. To use a crude analogy, we are tempted to either wage a fruitless struggle, to grasp tightly to the loan for too long, or to capitulate too early, surrendering the loan before it is due.

A long and bitter, though ultimately fruitless, struggle against death has been made possible by recent medical advances in prolonging life. This blessing, however, is also a curse. The modern image of death is a patient lingering in a hospital attached to various tubes and monitors. A death at home in the company of friends and family has been exchanged for a sterile room surrounded by machines and healthcare professionals. This is the kind of death we wish to avoid, for it seemingly strips us of our dignity. We cannot recite with much enthusiasm a petition from the Great Litany which reads, "from dying suddenly and unprepared, good Lord deliver us," for we rightfully fear the prospect of dying in pieces.<sup>27</sup> What this failed strategy of prolonging life at any cost fails to recognize is that there is a subtle, yet profound difference between extending life and delaying death.

Given this prospect the second temptation of succumbing too early is understandable and perhaps more prevalent today. When the quality of one's life has deteriorated to an unacceptable level, one should be allowed and assisted to relieve the burden or put an end to the lingering life of an unconscious person. Is this not a preferable option to dying in pieces; an act of mercy in the face of prolonged pain and suffering? What this seemingly compassionate strategy fails to recognize, however, is that there is a subtle, yet profound difference between allowing a person to die and hastening death.

In waging a war against aging, both of these acts are defiant gestures against an adversary that cannot yet be vanquished. We can either wage a desperate but heroic struggle to the bitter end or end it on our own terms at a time of our choosing. Both options purportedly provide the satisfaction of somehow cheating death, but in fact they cheat life. In attempting to dictate how and when we die, we implicitly deny the sovereignty of God who is the Lord of life. But let us also admit that, given our present circumstances, these options are not irrational or perverse. Once again it is a case of disordered desire. There is nothing wrong in desiring a good death (which is the literal meaning of "euthanasia"), but how that good end is achieved is what is at stake. Since our lives are not our own, then neither are our deaths. Rather, we are called to be stewards of life, ordering our lives in obedience to God's will and commands. Exercising such stewardship is a challenging and perilous enterprise, for as sinners we more often than not fail to discern correctly what the obedient ordering of our lives means and requires of us, particularly when our lives are coming to an end.

An admittedly imperfect principle which can guide our deliberation is that we seek to prolong life in ways which do not merely delay death, and allow death to occur while

not hastening its arrival. Consequently, Christians must steadfastly resist policies which allow or promote assisted suicide and euthanasia. Although these are certainly lively options, they are not acts that affirm life. Yet our resistance must always be tempered with humility and compassion, avoiding the acrimony and recriminations that often characterize the state of contemporary moral debate. Barth's teaching on suicide is helpful in this regard. He insists that although suicide is wrong, the person committing it should not be condemned, for we can never know what God's final command might have been, and neither are we in a position to dictate the limits of God's mercy and forgiveness.<sup>28</sup> In resisting assisted suicide and euthanasia we encounter the perennial task of hating the sin while loving sinners. In this respect, those of us who are Christians should spend far more time bearing witness to what a genuinely good death means and entails, rather than denouncing what we oppose.

Modeling what we believe a good death to be is an urgent task: how do we allow death to occur without either hastening or delaying it? How should we die in ways that are life affirming? In this respect, Paul Ramsey's observation is apt that the problem at hand is not the fear of death, but the fear of dying alone and abandoned.<sup>29</sup> Christians should take the lead in promoting and assisting greater access to advance directives and durable power of attorney, improved palliative care and hospice services. Most importantly, we should strive to maintain and strengthen the bonds of fellowship with the dying to insure that they are not abandoned. Especially within the church, greater attention needs to be directed toward how the dying are included within the life and ministry of the community which gathers in Christ's name.

## Conclusion

Once again I must stress that there is nothing wrong with living a long and active life (a belief I hold more strongly with each passing year); indeed it is a blessing that should inspire praise and thanksgiving. But it is not surviving—living a long life *per se*—that makes this blessing a good gift. It is rather the extended opportunity to worship and serve Christ, to love God and neighbor that makes this gift good. Our attempt to wage a medical war against aging and death, however, is tantamount to refusing this gift, for in our fixation on avoiding death we are forgetting how to affirm life. Ironically, medicine is being used increasingly to promote a culture of death rather than life. I have suggested that Arendt's emphasis on natality offers a potentially helpful metaphor for revitalizing medicine and redirecting its underlying culture. Yet those of us who are Christians can make a stronger claim: we need not use medicine to wage a war against death, for in the fullness of time it has already been defeated. We may affirm along with St. Paul: "O death where is your victory? O death where is your sting."<sup>30</sup> This is not merely a pious platitude, but an assurance and starting point for being good stewards of the gift of life that has been entrusted to our care.

## Endnotes

- 1 For an overview see Stephen S. Hall, *Merchants of Immortality: Chasing the Dream of Human Life Extension* (Boston, MA and New York: Houghton Mifflin, 2003).
- 2 See Immortality Institute, *The Scientific Conquest of Death: Essays on Infinite Lifespans* (Buenos Aires: LibrosEnRed, 2004).

- 3 See Leon R. Kass, *Toward a More Natural Science: Biology and Human Affairs* (New York and London: Free Press, 1985), 299-317, and *Life, Liberty and the Defense of Dignity: The Challenge for Bioethics* (San Francisco, CA: Encounter Books, 2002), 257-274.
- 4 See Hannah Arendt, *The Human Condition* (Chicago and London: University of Chicago Press, 1998), 8-9.
- 5 See *ibid.*, 97.
- 6 *Ibid.*, 246.
- 7 See *ibid.*, 96-97.
- 8 See *ibid.*, 19-20.
- 9 See Charles Norris Cochrane, *Christianity and Classical Culture: A Study of Thought and Action from Augustus to Augustine* (Indianapolis, IN: Amagi Books, 2003).
- 10 See George Grant, *Time as History* (Toronto and London: University of Toronto Press, 1995).
- 11 See, e.g., George Grant's essay, "Thinking about Technology," in *Technology and Justice* (Notre Dame, IN: University of Notre Dame Press, 1986).
- 12 See *The Human Condition*, 84-85.
- 13 *Ibid.*, 18.
- 14 *Ibid.*, 50.
- 15 See *ibid.*, 221.
- 16 See *ibid.*, 10-11.
- 17 See 1 Corinthians 15:26.
- 18 See John 1:1-4; see also Philippians 2:5-11.
- 19 See Eric O. Springsted, ed. *Simone Weil* (Maryknoll, NY: Orbis, 1998), 73.
- 20 See St. Augustine, *City of God*, XXII/30.
- 21 See St. Augustine, *Confessions*, I/1.
- 22 See St. Augustine, *City of God*, XIV.
- 23 See Karl Barth, *Church Dogmatics*, III/4.55.
- 24 See Gilbert Meilaender, *Bioethics: A Primer for Christians* (Grand Rapids, MI: Eerdmans, 1996), 24-25.
- 25 See John F. Kilner, *Life on the Line: Ethics, Aging, Ending Patients' Lives, and Allocating Vital Resources* (Grand Rapids, MI: Eerdmans, 1992), 65-69.
- 26 See Brent Waters, "Welcoming Children into our Homes: A Theological Reflection on Adoption," *Scottish Journal of Theology*, (55:4) 2002.
- 27 See David C. Thomasma and Glenn C. Graeber, *Euthanasia: Toward an Ethical Social Policy* (New York: Continuum, 1991), 85-86.
- 28 See Barth, *Church Dogmatics*, III/4, 400-409.
- 29 See Paul Ramsey, *The Patient as Person: Explorations in Medical Ethics* (New Haven, CT and London: Yale University Press, 1970), 134.
- 30 1 Corinthians 15:55.

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## BOONIN'S DEFENSE OF THE SENTIENCE CRITERION: A CRITIQUE

MATTHEW FLANNAGAN, PHD

### Abstract

*Defenders of the permissibility of feticide commonly argue that killing an organism is not homicide unless the organism's brain has developed enough for it to acquire sentience: the capacity for consciousness and the ability to perceive pleasure and pain. In this paper I critique one of the more sophisticated versions of this argument, proposed by David Boonin in A Defense of Abortion. First, I sketch some prima facie problems faced by any appeal to sentience. Second, I examine Boonin's attempt to defend an appeal to sentience against these problems by constructing a modified future like ours (FLO) account of the wrongness of killing. I argue that Boonin's modified FLO defence of sentience fails. Both his argument for the modified FLO account and his application of this account to feticide rest on ad hoc arbitrary manoeuvres, manoeuvres which mean that the modified FLO account is a plausible criteria for the right to life only if one already grants that feticide is not homicide.*

Common in literature defending the permissibility of feticide is the contention that killing an organism is not homicide unless the organism's brain has developed enough for it to acquire sentience: the capacity for consciousness and the ability to perceive pleasure and pain. In this paper I criticise perhaps the most sophisticated version of this claim—that proposed by David Boonin. I first sketch some prima facie problems faced by any appeal to sentience, followed by an examination of Boonin's attempt to defend an appeal to sentience against these problems. I argue that his defense fails.

Some terminological issues need to be noted. I use the term *fetus* in a technical sense to refer to the product of human conception from eight weeks gestation until separation from the mother at birth. From birth, I refer to this organism as an *infant*. Prior to becoming a fetus at eight weeks gestation, I use the term *embryo*. *Feticide* means the killing of a fetus, *infanticide* the killing of an infant. Finally, when I talk of a fetus as a human being, by 'human being' I mean a being, the killing of which constitutes homicide. The term 'human' is ambiguous and has different definitions in different contexts, whether biological, legal, sociological or moral. When I discuss the moral question of whether feticide is unjustified homicide, I am not interested in whether a fetus falls into any given biological or sociological definition of human. I want to know whether it is one of the beings that the rules against homicide, or the rules allowing homicide in various circumstances, covers.

## The Appeal to Sentience: Some Initial Problems

Common in the literature on feticide is the argument that killing an organism is not homicide unless the organism's brain has developed enough for it to acquire sentience, the capacity for consciousness and the ability to perceive pleasure and pain. Despite its pervasive appeal, there are some *prima facie* problems with such an account. In chapter 3 of *A Defense of Abortion*, Boonin reviews various accounts and notes that they all fail for similar reasons. Boonin notes that those who attempt to ground humanity in the amount of brain development an organism has undergone face a dilemma: "Any appeal to what a brain can do at various stages of development would seem to have to appeal to what the brain can already do. Or to what the brain has the potential to do in the future."<sup>1</sup>

Either option leads to problems for a defender of the permissibility of feticide who does not also want to endorse infanticide. This is because "by any plausible measure dogs, and cats, cows and pigs, chickens and ducks are more intellectually developed than a new born infant."<sup>2</sup> Suppose, then, one takes the first horn and appeals to what the brain can already do. However, unless one wishes to affirm that cats, dogs and chickens are human beings, "appeals to what the brain can already do" will "be unable to account for the presumed wrongness of killing toddlers or infants."<sup>3</sup>

Suppose, then, one takes up the second horn of the dilemma and appeals to "what the brain has the potential to do in the future."<sup>4</sup> Boonin notes that this will entail that feticide is homicide. "If [such an account] allows appeals to what the brain has the potential to do in the future, then it will have to include fetuses as soon as their brains begin to emerge, during the first few weeks of gestation."<sup>5</sup>

The challenge for a person who wants to limit homicide to include only sentient beings is:

[T]o identify a reason for holding that the potential of a human brain is morally relevant after the fetus has organized electrical activity in its cerebral cortex [when a fetus begins to acquire sentience] but is not morally relevant before that point, a reason that is not itself merely an ad hoc device for reaching the conclusion the defender of [the sentience criterion] wishes to reach.<sup>6</sup>

To include infants and toddlers but not fetuses, the defender of feticide must ground the right to life in an actual psychological capacity that the former possesses and the latter lacks. Sentience seems to be the only plausible candidate. To rule out animals such as cats and dogs, an appeal to sentience must also include appeal to the potential an organism has to things such as self-awareness, rationality, and the like. However, in order for this to avoid attributing a right to life to fetuses, such potential must become morally relevant *after* the fetus is sentient and not before. Moreover, there must be reasons for this, reasons that are not just an "ad hoc device for reaching the [desired] conclusion."

## Boonin's Defence of Sentience

In *A Defense of Abortion*, Boonin attempts to circumvent the above difficulty by making two distinctions. The first is between an occurrent and dispositional desire, "A desire of yours is occurrent if it is one you are consciously entertaining."<sup>7</sup> Boonin gives an example: "If this discussion is striking you as tedious, for example, then you may right now be experiencing an occurrent desire to put this book down."<sup>8</sup> A dispositional desire

is "a desire you do have right now even if you are not thinking about it right at this moment." He states, "I suspect, for example, that when you began to read this sentence you really did want to live beyond tomorrow evening, even though it is unlikely that you were entertaining just that desire consciously as you began to read this sentence."<sup>9</sup>

The second distinction is between an actual and an ideal desire. An actual desire is one "that you in fact have."<sup>10</sup> Boonin notes that a person's actual desires can be formed under conditions where they "lack accurate information"<sup>11</sup> or "under duress"<sup>12</sup> or while they are "upset"<sup>13</sup> and "not reflecting on the situation calmly."<sup>14</sup> Ideal desires are the desires we would have had were we not subject to various distorting influences of this sort; the desires we would have had were we calm, rational and accurately informed.

These two distinctions avoid the counter-examples mentioned above. An unconscious person does not have an actual desire, but he or she has a dispositional ideal, a desire to live. Similarly, an infant, while lacking an actual desire to live, would desire to live if it were rational and fully informed.

Understanding desires as ideal dispositional desires as opposed to actual occurrent desires, Boonin goes on to suggest, "Killing people like us is the severe wrong that it is not just because it thwarts a desire that we have, but because it thwarts a particularly important desire that we have; the desire to preserve a future like ours."<sup>15</sup> This understanding of what makes killing wrong leads him to give the following account of a right to life: "If an individual P has a future-like-ours *and* if P now desires that F be preserved, then P is an individual with the same right to life as you or I."<sup>16</sup>

By 'a future like ours' (FLO), Boonin means a future existence like that of a typical human person such as you or I. FLO constitutes the "experiences which lie ahead of a typical human being."<sup>17</sup> Boonin refers to this as "the modified future like ours account," which he uses to argue that a fetus does not have a right to life and hence killing a fetus is morally permissible. A pre-sentient fetus, Boonin maintains, lacks ideal desires to preserve FLO and consequently lacks a right to life. If one adds that the rule against homicide protects only beings with a right to life, a position Boonin appears to affirm, it follows that killing a pre-sentient fetus is not homicide.

Much could be said about Boonin's reasoning here,<sup>18</sup> so I will limit myself to one line of criticism. Boonin himself acknowledges that any attempt to ground a right to life in sentience must "identify a reason" for holding this position. Further, this reason must not be "merely an ad hoc device for reaching the [desired] conclusion," hence, the first question one must ask is what reasons Boonin gives for adopting the modified FLO account. Below I argue that he does not provide such reasons and under examination, his position does appear to be an "ad hoc device for reaching the [desired] conclusion."

### *Boonin's Argument for the Modified FLO account*

Boonin develops his argument for the modified FLO account as part of a critique of Don Marquis's widely anthologised essay, "Why Abortion is Immoral."<sup>19</sup> In this article Marquis contends that "the best explanation for the wrongness of killing is that killing deprives us of our futures of value."<sup>20</sup> Where a future of value consists "of all of the goods of life we would have experienced had we not been killed."<sup>21</sup> Marquis's account has the implication that feticide is homicide. "Fetuses have futures like ours, for their futures

contain all that ours contain and more. Therefore, (given some defensible assumptions and qualifications) abortion is seriously wrong on almost all occasions.”<sup>22</sup>

Boonin’s approach is to sketch an account of the wrongness of homicide that both explains the wrongness of killing human beings in a series of cases better than Marquis’s account does and that, according to Boonin, entails that feticide is not homicide. Before criticising this argument, it is worth noting at the outset that even if it is substantially correct, it would not provide grounds for accepting Boonin’s position. The fact (if it is a fact) that his account is better than Marquis’s account does not show that Boonin’s account is correct or that it is the best theoretical account of the wrongness of killing. It merely shows it is better than one other account, that of Don Marquis. The fact that it is better than one account does not mean it is better than all accounts.

Boonin’s argument provides an opponent of feticide with reasons for opposing feticide only if the proponent accepts Marquis’s account. If one argues against feticide without embracing such an account, his argument has little or no cogency. Despite this, it is worth examining whether Boonin is successful in showing his account is better than that of Marquis. Boonin contends it is because it can account for the wrongness of killing in various cases in a manner that is (a) more parsimonious than Marquis’s account; and, (b) more salient. In addition to explaining why it is wrong to kill in these cases in a superior manner, he argues, (c) Marquis account is subject to counter examples that his account is not subject to. Below I examine each of these three contentions.

### Parsimonious

Boonin argues that his account can explain the wrongness of killing in various cases in a manner that is more parsimonious than that suggested by Marquis. He argues as follows,

- [i] His own account appeals to only to one property of an individual to explain the wrongness of killing;
- [ii] Marquis account however appeals to two properties; and,
- [iii] Appealing to one property is more parsimonious than appealing to two.

Premises [i] and [iii] are correct, Boonin appeals to only one property—that of having an ideal desire to live. Moreover, it is correct that appealing to one property to explain something is more parsimonious than appealing to two. The crucial premise here is [ii], Boonin states that Marquis’s account appeals to two properties to explain the wrongness of killing. Boonin characterises Marquis as holding to the following proposition.

If an individual P has a future-like-ours F *and* if either (a) P now desires that F be preserved, *or* (b) P will later desire to continue having the experiences contained in F (if P is not killed), then P is an individual with the same right to life as you or I.<sup>23</sup>

Unfortunately, Boonin provides little justification for this interpretation of Marquis. His claim relies on two citations from Marquis’s work. The first comes from Marquis’s paper, “Why Abortion is Immoral,” where Marquis states,

When I am killed, I am deprived both of what I now value which would have been part of my personal future, but also of what I would have come to value, Therefore when I die I am deprived of all the value of my future.<sup>24</sup>

On the face of it, this citation suggests Marquis does understand a future of value in the way Boonin suggests. He understands a future of value to consist of both what one presently values and what one will come to value. The problem with this interpretation is that, as Boonin himself notes, later in the same essay Marquis explicitly repudiates this understanding. He states, "we desire life because we value the goods of this life, The goodness of life is not secondary to our desire for it."<sup>25</sup> Marquis concludes, "It is strictly speaking, the value of a human's future [rather than the human's future valuing of it] which makes killing wrong on this theory."<sup>26</sup> At best then, the evidence from Marquis is ambiguous, and at worst, he explicitly rejects the position Boonin attributes to him.

Boonin's second citation of Marquis is from a more recent paper, "Reply to Shirley."<sup>27</sup> In this paper Marquis had previously been challenged to "produce an account of what it would mean to say that an individual's future is of value to him."<sup>28</sup> Here Marquis's answer is:

Consider some class of individuals at  $t_1$ . Consider the hypotheses that those human individuals have a future of value of them at  $t_2$ . Verify this by asking those individuals at  $t_2$  whether they believe their lives are worth living at  $t_2$ . Those who answer in the affirmative have a future of value at  $t_1$ .<sup>29</sup>

Boonin takes this citation as offering support for his interpretation of Marquis. He seems to think that Marquis suggests here that what constitutes a future of value is either that one now desires it or will come to desire it. This is dubious. Nowhere in this quote does Marquis say anything about a present desire and a future desire; it states merely that a person has a valuable future if they would at a future time consider their life worth living. Moreover, it is unclear whether Marquis considers this to constitute what a future of value is or whether it *confirms* that someone has one. In a later article, Marquis suggests that the former is correct as follows,

How does killing victimize them? It harms them. Killing harms its victims by depriving them of all of the goods of life that they otherwise would have experienced. In other words, killing them deprives them of their futures of value. Their futures of value consist of whatever they will or would regard as making their lives worth living.<sup>30</sup>

Here Marquis construes a future of value in terms of what a person will, in the future, regard as worth living. Boonin then rests [i] on insufficient evidence.

Interestingly in his most recent article, Marquis makes it clear that he does not hold to the conjunctive account Boonin attributes to him. He states that his account,

[M]akes reference only to the value of one's future, not to the value of one's present or past. Accordingly, the lack of parsimony that Boonin find in the future of value account is really a function only of Boonin's statement of that account of the wrongness of killing, not the account itself. Because there is no good reason to include present desires in the statement of the future of value account, other than for the purpose of rejecting the account on grounds of parsimony, I shall discard the unwieldy locution of present or future desires and refer the to the account Boonin rejects as a future of value account.<sup>31</sup>

Boonin's argument here appears to attack a straw man. Premise [ii] is false and without [ii] Boonin's parsimonious argument is unsound. Both Boonin and Marquis appeal to a single property.

## Salience

Boonin's second argument is that his account is more "salient."<sup>32</sup> By this he means that "it enables us to account for the prima facie wrongness of killing by understanding killing as one instance of a more general category of acts that are prima facie wrong: acts that frustrate the desires of others."<sup>33</sup> In support of this, Boonin cites a case of Hans who "has been dumped by his girlfriend and has plunged into a deep depression. He can think about nothing else and has no desire to go on living."<sup>34</sup> Boonin suggests that his account makes sense of this case in a straightforward manner. Hans would desire to live if he thought about his future rationally with full information in the absence of distorting influences like depression. On the other hand, he suggests that Marquis's future of value account does not account for the case of Hans in a straightforward manner: "on [Marquis's] account, the wrongness of killing is not explained by appealing to a feature that accounts for the wrongness of a more general class of wrongful actions. The wrongness of killing however becomes an anomaly."<sup>35</sup>

This objection, like the previous one, appears to be based on a misinterpretation of Marquis's position, as Marquis points out:

The future of value account makes killing Hans wrong for the same reason it is wrong to kill almost all other human beings. To kill Hans is to make him worse off than he otherwise would have been. To make him worse off than he otherwise would have been is to harm him.

On the future of value account the wrongness of killing is based on the harm of killing. A present action cannot affect one's past. Strictly speaking, a present act of harming does not make another worse off in the present either, for the present is instantaneous and harm, involving, as it does, causation, requires at least a small temporal interval for its effect to occur. A present act of harm affects the victim's future. It makes someone worse off in the future. To make someone worse off is to reduce that person's welfare, to reduce the quantity or quality of the goods in his future that she would otherwise have possessed. On the future of value account killing is wrong because it harms a victim.<sup>36</sup>

Marquis's account, then, "enables us to account for the prima facie wrongness of killing by understanding killing as one instance of a more general category of acts that are prima facie wrong,"<sup>37</sup> that is, the category of acts that harm others. Moreover, I am inclined to think Marquis's account provides a more plausible category of acts than that of Boonin's. It seems to me far more obvious that killing is wrong because it harms another than that it is wrong because it prevents someone from doing something in the future that they presently desire to do.

However, there is a way of reading Boonin that leads to the conclusion that *both* he and Marquis understand killing as a subclass of the duty not to harm others. It is common in the literature to define an individual's welfare in terms of what they would 'ideally desire'. Philosophers such as Richard M. Hare and Richard Brandt for example have defined welfare in this way. Consider Marquis's claim, "To make someone worse off is to reduce that person's welfare, to reduce the quantity or quality of the goods in his future that she would otherwise have possessed." If Boonin is understood as adopting an ideal account of welfare, then to reduce a person's desires is to frustrate their ideal desires. On this reading, both accounts are equally salient. Both understand killing as

harming a person and reducing his or her welfare, they simply disagree as to how welfare is defined.

### Counter-examples

Boonin's third argument is that his account "is able to account for a counter example that Marquis's version is unable to account for."<sup>38</sup>

[C]onsider, the case of Hans' even more depressed brother, Franz. Like Hans, Franz does not currently value his personal future even though, as also in the case of Hans, his personal future contains many of the sorts of experiences that we take to be distinctively valuable. Due to a permanent and irreversible chemical imbalance in his brain, however, Franz is, and will always remain, completely unable to value the experiences that he has. Although he has a future-like-ours, he has no actual occurrent desire to preserve it and he never will have such a desire.<sup>39</sup>

Regarding this case Boonin suggests three things:

[i] That it would be wrong to kill such an individual;

[ii] That Marquis's account entails that it is not wrong to kill such a person; and,

[iii] That his own account, the ideal desire account, entails it is wrong to kill such a person.

Curiously, in his most recent article Marquis concedes [ii]; he grants that his account does have this implication but he suggests that [i] is false.<sup>40</sup> I think this move is unnecessary on Marquis's part. By citing this as a counter example, Boonin assumes that Marquis holds that possession of a future of value is a *necessary* condition for possessing a right to life. This assumption is false. In *Why Abortion is Immoral*, Marquis made it clear that he was contending that a possession of a future of value was only a *sufficient* condition for possessing a right to life. Given this, it is simply false to claim that it is permissible to kill a person who lacks a future of value. All it affirms is that it is wrong to kill those who have such a future.

Elsewhere, Marquis has argued there can be good reasons for extending the rule against homicide to cover those who do not have futures of value.<sup>41</sup> While it may be true that an individual act of killing a person does not harm them, deprive them of a future of value, social endorsement and acceptance of a rule allowing such killing will harm people and, hence, for this reason, a rule against killing in situations like this is justified.

Boonin does have a possible reply to this response, while Marquis's account does not entail it is permissible to kill Franz, it fails to account for the wrongness of killing Franz and needs to be supplemented in order to succeed. Hence, if Boonin's account can explain killing in this context, his account is better. The crucial question then is whether [iii] is correct. Is it the case that Boonin's account does entail that it is wrong to kill Franz? Boonin argues that it does.

[O]n the "present ideal dispositional desire" version of the future like ours principle, things look very different. For surely Franz's desires about his

personal future would include the desire that it be preserved if his desires were formed in the absence of the chemical imbalance that prevents him from having this desire. Although he has no actual desire to go on living, that is, it does make sense to attribute this desire to him as an ideal desire. And given this, my version of the principle implies that Franz does have the same right to life as you or I. . . . [M]y version of the future-like-ours principle is superior to Marquis's.<sup>42</sup>

Here I think Boonin conflates two separate questions. The first is the question of what Franz's ideally rational self would choose for itself (i.e., the ideally rational Franz), and what Franz's ideally rational self would choose for Franz's actual self (i.e., his non-ideally rational self).<sup>43</sup> If one asks the former question, then Boonin is correct; Franz would not choose to die. Franz's ideally rational self would not suffer from depression and so would not desire to die.

The answer to the second question is not so clear. Here we ask what an ideally rational self would choose if it knew that it would in fact have a future filled with miserable suffering and depression and be unable to enjoy any of the experiences that lie ahead. It is certainly not obvious that an ideally rational person would value a future made up of such circumstances.<sup>44</sup>

The question then arises as to which of these two questions is the appropriate one to ask. Carson argues that is the latter and not the former that is pertinent.

Suppose I have an irrational fear of dogs. A friend asks me to take care of his dogs while he is away on vacation. My ideally rational self would not fear the dogs and would not hesitate to look after them. Given my intense fear of dogs, however, things are likely to turn out badly if I look after the dogs. Why should I care that my ideal self wouldn't be afraid of dogs? Wouldn't it still be foolish for my actual self (with all of its phobias) to take care of the dogs? I might be incapable of adequately caring for them.<sup>45</sup>

Carson's point is that something in a person's future is not valuable to them if it is something their ideal self would choose for their ideal self; many such choices would be harmful to them. Only if ideal desires are understood in the latter sense can it be plausibly maintained that what a person ideally desires is valuable to them. On the face of it, then, it appears that Marquis's account does not entail this counter example whereas Boonin's account does, that is, at least if he intends his account to lay down both necessary and sufficient conditions needed for a right to life.<sup>46</sup>

At this point the defender of Boonin could make the following reply. Suppose one grants Marquis's claim that there are good reasons for extending the rule against homicide to cover those who do not have futures of value. Presumably, a fully informed person would be aware of these reasons and, hence, Franz would, if fully informed, refuse to endorse a rule that allowed him to be killed. Franz would accept that his own future lacked value and was going to be miserable but he would also note that other people would be harmed if a rule allowing him to be killed were accepted and, hence, Franz would have an ideal desire not to be killed. If this response is cogent, then, one again, Boonin and Marquis's accounts appear to be on par. Neither by themselves provide a reason for why it would be wrong to kill Franz and both can account for the wrongness of killing Franz when supplemented with Marquis's other arguments on the topic.



Boonin's contention that his account provides a better explanation of the wrongness of killing appears mistaken. Both Boonin and Marquis's accounts explain various paradigms of unlawful killing. Both appeal to a single property in doing so, "possession of a future of value." Both explain killing in terms of reducing a person's welfare and hence harming them. Both, by themselves, do not provide an explanation of why it is wrong to kill Franz and both can explain this when supplemented with the same further argument. The main difference between Boonin and Marquis is how they construe a 'future of value'. Boonin understands this in terms of a future one has, a present ideal desire to preserve one's future. Marquis understands this in terms of a future one will come to actually value in the future. The only other differences between them, at least on the factors Boonin cites, is that one entails that a fetus is human and the other does not. If one is to prefer one to another on the grounds Boonin provides, one can do so only by appealing to one's beliefs about feticide. It seems, then, that Boonin has failed to provide a reason that is not itself "merely an ad hoc device for reaching the conclusion the defender of [sentience criterion] wishes to reach."

### *Boonin's Conclusion*

A precisely analogous problem occurs when Boonin applies the modified FLO to the issue of feticide. Suppose, for the sake of argument, I grant that the modified FLO account provides necessary and sufficient conditions an organism must meet to possess a right to life. Why does it follow that a *fetus* does not possess a right to life? While it is true that fetuses lack actual desires to preserve their FLO's, it is not at all clear that fetuses lack an ideal desire to do so. Marquis plausibly suggests that "If a fetus were rational and fully informed, it would desire to live" and concludes, "It follows that fetuses have an ideal desire to live."<sup>47</sup> Boonin takes exactly this line with infants. While infants lack the cognitive capacity to have any actual desire to exist, they have a right to life because they would have such desires if they were fully rational and able to engage in higher cognitive activities. Why can the same not be said of pre-sentient fetuses?

Boonin's response is to define ideal desires a particular way. He states that "ideal desires . . . are simply the content of actual desires corrected to account for the distorting influences of imperfect circumstances."<sup>48</sup> Once this definition is granted, it follows that only beings with actual desires can have ideal desires. And hence only a sentient fetus can have a right to life. This is however precisely where the problem arises. There are rival definitions of ideal desires proposed in the literature and, as Marquis points out,<sup>49</sup> Boonin gives little or no argument for adopting this particular definition. Moreover, nothing in his arguments for the modified FLO account requires this particular definition of ideal desires to be adopted. This last point is important. Boonin makes use of 'ideal desires' to avoid various counter-examples to the desire account of the wrongness of killing, and he argues for the modified FLO account on the basis of its ability to plausibly explain certain paradigms of wrongful killing. However, nothing in this line of argument requires Boonin to adopt one definition of ideal desire over another. Almost any definition of ideal desires on offer will get around the counter examples aforementioned and most such accounts will explain the paradigms Boonin appeals to. Consequently, Boonin's argument appears arbitrary. He recommends his account on the grounds that it explains various cases better than a rival account which he assumes is the best available. However, there are other versions of the modified FLO account available which utilize other definitions of ideal desires, these accounts explain the cases equally

as well as Boonin's does. Some of these other versions entail that a fetus does have ideal desires. In the absence of some reason for preferring Boonin's account over the others, the only factor that seems pertinent in deciding which version is correct is the accounts' implications for feticide. It seems then that person's beliefs about feticide will do most if not all the work in deciding which version to adopt. Once again, it appears that Boonin has failed to provide a reason that is not itself "merely an ad hoc device for reaching the conclusion the defender of [sentience criterion] wishes to reach."

### Conclusion

In my first section, I noted that a defender of the permissibility of feticide who does not also want to endorse infanticide and who defends the sentience criterion must "identify a reason for holding that the potential of a human brain is morally relevant after" the fetus acquires sentience "but is not morally relevant before that point." I also noted that this reason must be "not itself merely an ad hoc device for reaching the conclusion the defender of [sentience criterion] wishes to reach."<sup>50</sup> It appears this challenge has not been met. Boonin's argument for the modified FLO and his application of it to the issue of feticide appears arbitrary. His account is plausible only if one grants that feticide is not homicide from the outset.<sup>51</sup>

### Endnotes

1 David Boonin, *A Defense of Abortion* (Cambridge: Cambridge University Press, 2003), 125.

2 Boonin, *A Defense of Abortion*, 121.

3 Ibid.

4 Ibid.

5 Ibid.

6 Ibid., 122.

7 Ibid., 122.

8 Ibid.

9 Ibid.

10 Ibid., 123.

11 Ibid., 71.

12 Ibid.

13 Ibid., 72.

14 Ibid.

15 Ibid., 126.

16 Ibid., 64.

17 Ibid., 56.

18 For example, Boonin's claim that a fetus lacks ideal desires follows only because he chooses to define ideal desires as "simply the content of actual desires corrected to account for the distorting influences of imperfect circumstances." However, Thomas Carson in *Value and the Good Life* (Notre Dame IN: Notre Dame University Press, 2000), 222-239, has offered powerful criticisms against defining ideal desires in this fashion.

19 Don Marquis, "Why Abortion is Immoral," in *The Abortion Controversy: 25 Years after Roe v Wade, A Reader*, ed. Francis Beckwith & Louis Pojman (Belmont, CA: Wadsworth Publishing Company, 1998), 339-355.

20 Don Marquis, "Abortion Revisited," *Oxford Handbook of Bioethics*, ed. Bonnie Steinbock, (New York: Oxford University Press, 2007), 399.

21 Ibid.

- 22 Ibid.
- 23 Boonin, *A Defense of Abortion*, 63.
- 24 Marquis, "Why Abortion is Immoral," 345.
- 25 Ibid., 350.
- 26 Ibid.
- 27 Don Marquis, "Fetuses, Futures, and Values: A Reply to Shirley," in *Southwest Philosophy Review* 6.2 (1995): 263-265.
- 28 Boonin, *Defense of Abortion*, 60.
- 29 Marquis, "Fetuses, Futures, and Values," 263-265.
- 30 Don Marquis, "Abortion and the Beginning and End of Human Life," *The Journal of Law, Medicine, and Ethics* 34.1 (2006): 23.
- 31 Don Marquis, "Abortion Revisited," 410
- 32 Boonin, *A Defense of Abortion*, 67.
- 33 Ibid.
- 34 Ibid., 70.
- 35 Ibid., 76.
- 36 Marquis, "Abortion Revisited," 411
- 37 Boonin, *A Defense of Abortion*, 74.
- 38 Boonin, *A Defense of Abortion*, 76.
- 39 Ibid., 76.
- 40 Marquis, "Abortion Revisited," 413.
- 41 Don Marquis, "The Weakness of the Case for Legalizing Physician Assisted Suicide," in *Physician Assisted Suicide: Expanding the Debate*, ed. Margaret P. Battin, Rosamond Rhodes and Anita Silvers (New York: Routledge, 1998), 267-278.
- 42 Boonin, *A Defense of Abortion*, 76-77.
- 43 This distinction comes from Carson, *Value and the Good Life*, 226.
- 44 This is particularly the case when one considers that as Boonin defines ideal desires they are "simply the content of actual desires corrected to account for the distorting influences of imperfect circumstances." It seems that there are plenty of actual people who when informed they will live for the rest of their lives in misery decide they do not want to continue living. Note the question here is not whether it is morally right to kill people with such desires, it is whether people with such desires exist.
- 45 Carson, *Value and the Good Life*, 226.
- 46 There is some ambiguity as to whether Boonin is proposing the modified future of value account as a sufficient or a necessary condition for possession of a right to life. In the earlier sections of *A Defense of Abortion*, Boonin appears to be proposing only the former. Boonin introduces his account on p. 64 where he states, "If an individual P has a future-like-ours and if P now desires that F be preserved, then P is an individual with the same right to life as you or I." However, this states that the present possession of ideal dispositional desires is a *sufficient* condition of a right to life, not that they are a necessary condition.
- Moreover, Boonin appears to confirm this interpretation later on p. 84 where he states, "On the account I have been defending, then, all that is required for the newborn infant to satisfy the conditions sufficient for having the same right to life as you or I is that he has a future like ours and that he have actual conscious desires". This only states that the account is intended to lay down a *sufficient* and not a necessary condition.
- Similarly, the argument Boonin provides for his account supports only a sufficient and necessary condition. His argument consists of providing an explanation of why it is wrong to kill in certain paradigm cases. He does not attempt to show that it explains why it is permissible to kill in paradigmatic cases of licit killing. No such cases are even mentioned.
- He spells his method out on p. 57: "Identify the property that most plausibly accounts for the wrongness of killing in cases B-E, and then determine whether that property is possessed by the individual in case A. If it is, then the best account of the wrongness of killing in general provides

a sufficient reason to conclude that the fetus has the same right to life as you or I. If it is not, then the best account of the wrongness of killing provides no such reason (though this will still leave open the possibility that killing the fetus is wrong for reasons other than the reasons that best explain why killing you or me is wrong).”

Boonin accepts if the “property” that “most plausibly accounts for the wrongness of killing” is not possessed by a fetus this “will still leave open the possibility that killing the fetus is wrong” for other reasons. However, when Boonin returns to this account 37 pages later he states that a fetus does not have a right to life because it lacks such desires. This is a fallacious inference. Such a conclusion follows only if Boonin is offering a necessary condition. Boonin has, it appears, committed the fallacy of denying the antecedent. The only charitable way to escape this conclusion is to understand Boonin as offering both a necessary and sufficient condition.

- 47 Marquis “Singer on Abortion and Infanticide,” *Singer under Fire*, ed., Jeffrey A. Schaler (Chicago: Open Court Publishing, forthcoming 2009).
- 48 Boonin, “A Defense of Abortion.”
- 49 In “Abortion Revisited,” 413-414
- 50 Boonin, *A Defense of Abortion*, 122.
- 51 I thank to Don Marquis for his assistance in writing this paper.

# A VIRTUE-ETHICAL APPROACH TO SUBSTITUTED JUDGMENT

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## Abstract

*According to the substituted judgment standard, the surrogate ought to make the decision that the patient would have made, had he or she been competent. Normally, this standard is thought to protect the patient's right to autonomy in a situation where the patient is no longer capable of exercising this right on his or her own. This idea could, however, be questioned. It could, for example, be argued that since merely hypothetical decisions are not real decisions, respecting these is not enough for the protection of autonomy. Moreover, it could (and has) been argued that surrogates are quite inept when it comes to identifying the relevant hypothetical decision. Hence, there are theoretical as well as practical problems in assuming that the substituted judgment standard protects patient's right to autonomy. The purpose of this paper is to explore a way to make sense of the intuitive appeal of the substituted judgment standard, without having to deal with the problems mentioned above. For this reason an alternative way of morally justifying the substituted judgment standard is introduced, namely in terms of respect for persons as an important human virtue. It is argued that this approach has several interesting consequences for issues such as how to choose among different interpretations of the standard, and the importance of surrogate accuracy.*

**Key words:** substituted judgment, surrogate decision making, medical decision making, virtue ethics

## Introduction

Patients who are considered to be incompetent, or decisionally incapacitated, need a surrogate decision maker to make important health care decisions for them. A few different standards for decision making have been proposed, to serve as a criterion for what makes a surrogate decision the right one, and possibly also to practically guide the surrogate in his or her decision making. One of those is the so-called Substituted Judgment Standard (SJS). According to this standard, the surrogate ought to make the decision that the patient *would* have made, had he or she been competent. Most commentators see SJS as protecting the patient's right to autonomy in a situation where the patient can no longer exercise this right on his or her own<sup>1</sup>, and for this reason, among others, the standard has found wide appeal.

SJS is not without problems. The most frequently voiced misgiving is that in many cases it seems impossible or at least very difficult to *know* what the patient would have decided, if competent. Whatever *is* known about the patient is seldom enough, the objection goes, to let us make a reliable inference about what the patient would have chosen to do.<sup>2</sup> Even on a traditional understanding of what SJS is all about, it is not clear

that this epistemic objection is quite as damaging as some commentators appear to think. But however this may be, we have ourselves challenged SJS on other accounts too. For one thing, the standard is less determinate in content than what is usually acknowledged. It says that the surrogate ought to make the decision that the patient would have made if competent, but it does not say *how* competent the surrogate ought to imagine the patient to be. Nor does it specify what else ought to be assumed about the patient in the relevant hypothetical scenario. Which of the values, for example, that the person may have subscribed to at some point in his or her life, should we ascribe to the patient in the hypothetical situation we are asked to imagine?<sup>3</sup> Even more importantly, we believe that there are reasons to be skeptical about the traditional way of morally justifying SJS. It has largely been taken for granted that this standard extends the patient's opportunities for self-determination (as offered, e.g., by traditional informed consent procedures), but we have elsewhere argued that this view cannot be defended.<sup>4</sup>

In the light of these difficulties, one might be tempted to reject SJS. One should not, however, be too quick in doing so, especially since the other standards, with which SJS competes, have problems of their own.<sup>5</sup> If nothing else, viewed as a practical rule of thumb SJS may have various positive effects. Perhaps it could help surrogates to not lose sight of the interests that might be peculiar to the patient, as may happen if one is prone to think of the patient's interests as exhausted by what is reflected in standardized quality-of-life measures. But in addition to there possibly being such instrumental benefits to SJS as a tool, we believe there may also be a non-consequentialist way of justifying this standard, which appeals neither to the patient's right to self-determination, nor to some other interests that the patient might have that need protection. In what follows we shall provide the outlines of such an approach. The intention is not to offer an approach that shows that SJS based decision making ought to be mandatory for the surrogate. Rather, we try to make sense of the intuitive appeal that SJS no doubt has to many of us, various theoretical difficulties notwithstanding, without portraying us as merely confused. In that sense, our normative ambitions are fairly modest. In fact, we are not even committed to the moral point of view that we appeal to in making sense of SJS, although we do think it has merits. Should it turn out that this point of view is mistaken, and thus cannot confer any justification to SJS, it may still go some way towards *explaining* the intuitive appeal of this standard.

We like to think of our approach to SJS as in a broad sense *virtue-ethical*. It accounts for the moral status of a surrogate decision in terms of the appropriateness of having or expressing certain attitudes (motives, sentiments, commitments, or the like), or in terms of the appropriateness of having a certain character, which typically brings forth the relevant attitudes and their expression. For central cases of decision making for the incompetent (see below) the idea is not only to impose as a necessary condition on morally justified surrogate decisions that these reflect certain attitudes towards the patient, but also to consider the soundness of these attitudes as sufficient to warrant SJS in these cases. Thus, whether or not the patient (or others concerned) will benefit in some way from the relevant responses is not what matters on this virtue-ethical account.<sup>6</sup>

The proposal is not meant to rule out that there are other cases where the adoption of SJS is better justified or explained in some other way. The kind of situation that we primarily have in mind when suggesting a virtue-ethical approach is where loss of competence is certain or likely to be permanent, as in the increasingly common cases

of dementia. The case where the patient is expected to regain full competence, and thus put the surrogate in the situation where he or she subsequently may have to justify the decision *to* the patient, may or may not be an example of a case which is better accounted for in some other way.

The next section outlines the account. Basically, we will discuss ways to make sense of SJS in terms of respect for person. In the section that follows, we lay out some implications of this virtue-ethical approach for, among other things, the importance of surrogate accuracy and the issue of whether all surrogates have the same obligations with regard to SJS. The paper ends with some concluding remarks.

## Respect for Person

Even on the assumption that SJS is ultimately a matter of a virtuous mind-set, most likely the standard will not be a codification of one attitude alone. If we were forced to summarize what is expected of the virtuous surrogate, however, it could well be *respect for person*. This sounds familiar enough, and may seem like old news. Respect for person, respect for autonomy, and respect for dignity often alternate as the buzz words of choice in the ethics section of health care policy documents. In these contexts, however, the notion of *respect* is virtually void of psychological substance. Patients are taken to have an interest in being and expressing their own self, in autonomy and dignity, and these things supposedly deserve respect simply in the sense that they ought not to be violated. What we have in mind here, however, is the idea of respect as an attitude, a mind-set or sensibility, constituting the core of the moral justification for SJS.

There are many distinctions to be made between different kinds of respect, and also many different philosophical views on what each variety of respect involves. There are also different views concerning which characteristics, if any, warrant our respect. We do not address all these issues, and we take what little we have to say on the ones we do address to be quite non-committal, as far as philosophical analysis goes. The following sketch of what respect *for person* comprises is intended to be fairly close to how it would be rendered by our pretheoretical intuitions.

To have or feel respect for a person will as a minimum involve certain tacit acknowledgements. It seems plausible that it involves an acknowledgement of the other as having a standing comparable to your own, a place in a community of (what should be) independents and equals. And it could be argued that such an acknowledgment is a consequence of an even more fundamental recognition, namely that of a “perspective” other than our own. What makes up a perspective remains to be settled. But respect for person presumably involves a preparedness to inform ourselves about this other outlook, if possible, and to seriously consider its merits. It involves a recognition that there is a person “who she is”<sup>7</sup>, and will involve a sensitivity to this person’s particularity, as far as it can be ascertained.<sup>8</sup> With respect may also come a kind of *charity* in how we understand the other’s perspective, and a charity in what examples of his or her particularity we select as especially worthy of our attention. That is, in respecting you, I “hold you to your best”. This may or may not have to do with the possibility that a person’s self-conception should play a special role in what respect calls for.

A minimal form of respect is manifested in our conduct merely by our staying away from blatantly *dis*respectful behavior. It might be a question of not making tasteless jokes

about a seriously ill person, or a question of not exposing a severely retarded patient in the nude (just because this patient may not realize or care). Among other things, doing so would be to egocentrically exploit the patient's vulnerability in a way that would be inconsistent with submitting to this other person's outlook. In making a substituted judgment, on the other hand, the surrogate could be said to *positively* express respect. Such respect is likely to come in different shapes, depending among other things on the nature of the relationship between the surrogate and the patient. Below we shall sketch what it could consist of in two different cases: as felt and articulated somewhat from a distance, simply as a fellow human being perhaps, and as felt and articulated from someone who has been deeply involved in — and in a way continues — a close relationship with the person on whose behalf a decision now has to be made.

*Basic respect for another human being. Substituted judgments as gestures*

When a surrogate does not know the patient well, and they have no personal relationship, the making of a substituted judgment is likely to be a *symbolic gesture*. Gestures are common in many areas of life. We invite our best friend to the party even if we know that he or she will not be able to come. A government suggests a “vision zero” for traffic safety — the goal that no-one shall die in traffic accidents — while surely realizing that in this society there will always be fatal accidents. These are cases where an act can be expected to fail to meet its ostensible purpose, but nonetheless succeed in signalling good will of one or another kind. Often the point of such gestures depends on there being addressees who can recognize and appreciate the symbolic meaning of the relevant act, but sometimes gestures are made without there being anyone there to “consume” it (other than the agent). As a gesture of respect we may, for example, read a poem at somebody's grave, without anyone else knowing.

What does a certain gesture “say”? Nothing very precise perhaps. And if something precise, then certainly very hard to pin down. Still, we might profit from a hint at least, about what is conveyed by means of a substituted judgment. In deciding as we think the patient would have decided if competent, we convey, in effect, our recognition of the other's perspective, and honor it by letting it govern the decision at hand. We let it make its mark on this decision not necessarily because we agree with it, or think that a choice based on it will benefit the patient, but because we wish to affirm this person's standing as a source of a point of view — a point of view which moreover should be given a special status when it comes to issues affecting his or her life in particular. In doing so we may not be able to protect any rights that one might want to afford this person, but we pay respect, even tribute perhaps, to the person who we think she is, or was, and in highlighting her assumed values, beliefs etc. in this way we simultaneously manage to admit the fact that our own outlook has no claim to superiority just because it happens to be ours. As morally well-functioning people we will be disposed to this kind of conduct, in part because honestly meant substituted judgments reflect an insight into our own standing as individuals limited by a necessarily subjective and fallible point of view. There is thus a place for this kind of public recognition, we suggest, regardless of whether the patient could be said to be a beneficiary.

Applying SJS could be a gesture without primarily being a case of respectful recognition of a person's particularity, values, commitments etc. One possibility worth



considering is that by applying SJS we could make manifest our recognition of, and discontentment with, this individual's vulnerable predicament. When people cannot speak for their own cause, our moral response to this vulnerability is often to step in as their advocate and speak for this cause (whether we agree with what is in their interest or merely respect their diverging viewpoint). But instead of taking as our primary aim to speak for this cause, we may primarily be concerned with expressing our solidarity with these people by expressing our moral discontentment with *their inability to speak for it* themselves. We may feel that the fact that a once competent person now is incompetent is a wrong, an unfair state of affairs, which the person didn't deserve, and which he or she with a little luck might have escaped. From this perspective, making any decision *for* this patient seems wrong, because making such a decision is a necessity that is morally upsetting in itself. In fact, even if we have no intention of taking advantage of the situation by making a decision that serves our own interests rather than the patient's, making the decision in any other way than applying SJS might feel like an inappropriate exploitation of the patient's state of incompetence. Applying SJS could on this view be a way — perhaps the only way that does not feel like only paying lip service to our moral offense — of saying that it is simply wrong that we, or society, should be making the relevant decision rather than the patient.

Regardless of what one takes to be the main message, why should respect be expressed in the form of a substituted judgment? One can indeed without contradiction imagine an individual conveying the kinds of message just described, and thus pay respect, in an entirely different way. Showing one's respect for a fellow human being by making the same decision as this person would have made if competent nonetheless makes sense, if nothing else for the reason that the context is one in which a decision has to be made. Treatment or no treatment — there is no way of escaping this choice. SJS offers a way of settling the issue that simultaneously allows the surrogate to manifest his or her respect for the incompetent patient as a person. In this way the inevitability of practical action suggests the means for showing one's recognition and solidarity.<sup>9</sup>

### *The psychology of healthy close relationships*

Arguably a central tenet of any personal relationship is the adoption of what Stephen Darwall calls the second-person standpoint.<sup>10</sup> When taking up a second-person standpoint towards one another we relate as a Me to a You, addressing each other directly by making claims upon one another's free will, and are accountable *to* one another for the way we handle this relationship. The mutual recognition intrinsic to this accountability is a fundamental form of respect between individuals who have some kind of personal relationship, a close one in particular. Such relationships are very different from those where we relate to some other individual not as a You, but as a living creature who may or may not deserve to be an object of our care or concern. But they are also different from the ones discussed above, where we do acknowledge that someone is a *subject* worthy of being recognized and respected as such, but where we do not relate to her second-personally.

Merely by having a second-personal relationship we may not be committed to much else than recognizing that in addressing claims to one another we thereby give us a (defeasible) reason to respect these claims. But by recognizing this, we typically end up being committed to relating to one another in further ways, connected to what exactly we

demand, or expect, of one another. For instance, we are as a rule committed to the other's right to be self-determining. This involves a presumption that you should normally get your way on issues that do not to any significant extent concern others. And with the kind of second-personal relationship that we often enough see in family relations, partnerships and friendships also come other mutual expectations that make us accountable to one another: expectations that we care for each other, make and keep promises, engage in a dialogue, etc.

In many cases of someone turning permanently incompetent, she will no longer be able to relate to others in the way characteristic of close relationships. But the other party, who still possesses this second-personal competence, will typically not stop relating in this way. When a loved one dies, for example, we keep having certain feelings, and conduct ourselves in certain ways, typical of an ongoing close relationship. We feel guilt, disappointment or gratitude towards the deceased; we repent, forgive or try to communicate our appreciation (in thought at least). Demonstrably we normally do exhibit a certain "inertia" in our response to the other's transformation from an autonomous person to someone who no longer has the relevant capacities. Under normal circumstances we simply cannot approach someone close to us as a non-person the moment this individual turns undeniably incompetent, and often such a transition will never take place. A personal relationship does not, in other words, end immediately when and just because the abilities that define personhood are lost on the one part.

This lastingness of personal relationships, and the fact that we would find it morally disturbing if someone could easily make the switch from seeing a patient as a person to seeing him or her as a non-person, may have several sources. It could be argued, for instance, that implicit in a personal relationship is a kind of *promise* of a certain longevity, a promise that one should as far as possible keep relating second-personally to the other even when the latter is no longer able to respond in the same fashion. Alternatively one might wish to argue that a morally well-functioning individual will on consequentialist grounds keep relating to the now incompetent patient in ways that are in some sense second-personal. The kind of instability that someone would display when prepared to end the second-personal relationship with the onset of incompetence, could well be a serious liability in other interaction too, for instance. Or the virtue in question could simply be morally fundamental (as on an *agent-based* view of virtue-ethics, as Michael Slote puts it<sup>11</sup>). Regardless of what theoretical foundation one is inclined to appeal to when thinking about virtues like these, the fact remains that to normal people it would be alien to think that one could function in any other way without exhibiting a serious defect.

As on the gestural account, SJS based thinking is on this story a natural expression of a certain moral character, in this case the virtue of nurturing a close relationship by thinking and acting *as if* the other's second-personal capacities were still in place. The incompetent patient may or may not have something to gain, in terms of surviving "critical interests"<sup>12</sup>, by a decision that he or she would have made if competent. But a surrogate who acts in accordance with the *fiction* that the patient still makes a second-personal demand, or acts in accordance with SJS in order to do whatever she can to "uphold" their close relationship, may by doing so manifest a virtue, a way of being that is morally admirable or even required, regardless of whether the patient could be said to have such critical interests.

Substituted judgments, we thus suggest, may have slightly different roles in the case where the surrogate and the patient do not have a personal relationship and in the case where they do. Such judgments are certainly united by the fact that they both embody respect for person. In both cases they aim to convey a charitable recognition of another's particular perspective and its standing as an equal among perspectives. When made from the standpoint of someone who has no personal relationship with the patient, however, the substituted judgement may function primarily as symbolic gesture, a more or less optional tool among others that on conventional grounds could serve to convey respect. Whereas in the case where the surrogate has had a close relationship with the patient, the substituted judgement may be more automatic and mandatory. Such a surrogate may feel that he or she is engaged in a still ongoing dialogue with the now incompetent person, where sensitivity to what this person would have decided is intrinsic to the nurturing of a surviving relationship.

## Implications

The moral foundation for SJS is not only of interest for its own sake, but will typically have implications for various problems that have been thought to plague this standard, and for various policy issues. Let us briefly address some of the implications of the virtue-ethical approach delineated in this paper. It is noteworthy that to a significant extent these implications are independent of the details of the approach. The fruitfulness of this way of thinking about SJS is thus not seriously limited by the rather loose contours of our account.

### *Accuracy*

Perhaps the most salient implication of a virtue-ethical approach to substituted judgment is that the *accuracy* of such judgments will not be nearly as important as it is on the traditional justification of SJS. The received view seems to be that it is both sufficient and necessary that the decision made is the one that the patient would have made had he or she been competent. This view is to be found in the empirical literature on surrogates' accuracy in predicting patient preferences, where it is typically assumed that there is no reason for complaint as long as one actually proceeds in the way that the patient would have done.<sup>13</sup> This research aims to assess to what extent surrogates can accurately predict what kinds of treatment, if any, patients would want in various hypothetical future scenarios. Most studies allegedly show that surrogates' prediction accuracy is far from impressive, and against this background other procedures for getting the right answer are sometimes proposed. So-called actuarial models, or modal preference models, for instance, are statistically based models aimed to determine what the patient would likely have decided. They are based on established preferences in communities of patients satisfying certain medical and other criteria. Such models, it is sometimes claimed, are at least as good, if not better, at identifying patients' hypothetical choices than surrogates' substituted judgments are, even with the help of advance directives.<sup>14</sup> "Promoting the development and implementation of actuarial prediction models and other alternatives to traditional advance directives may seem impersonal and dehumanizing at first glance", Renate Houts and co-writers (who champion the actuarial method) admit.<sup>15</sup> However, the assumption that deciding as the patient truly would have done is the goal to pursue, and the one to ground SJS and the use of advance directives, apparently makes them

ignore the objection. “Clearly”, they say, “if the goal of end-of-life planning is to carry out patients’ wishes accurately, then encouraging more individuals to complete ADs [i.e. advance directives, our remark] is of questionable utility. If further studies confirm that actuarial models based on modal preferences can accurately predict the wishes of an individual patient, then actuarial models represent at least a supplement and *perhaps even an alternative to* [our emphasis] advance directives.”<sup>16</sup>

Just as important for present purposes, the standard objection to SJS in the literature (and, it seems, from those who for the first time reflect upon the issue) presupposes that the moral justification of SJS depends on surrogates being reliably accurate in their substituted judgements. Can we really know what the patient would have decided?, the skeptical question goes, and it carries with it the assumption that if surrogates make decisions that the patients actually would not have made themselves, this would be a serious moral failure, and a reason for looking for a replacement for SJS.

On the virtue-ethical approach introduced here, accuracy will neither be sufficient nor necessary. It will not be sufficient since it is deemed morally important on this approach to be a certain kind of person, one who feels and expresses an attitude of respect. To put it drastically, if we are not that kind of person, an “infallible substituted judgment machine” — a device that would always correctly tell us what the patient would have decided — could not morally compensate for this. And statistical estimations of patient preferences, however reliable, will not be able to replace substituted judgements that have come about in the right way either, precisely because such models would as replacements be “impersonal and dehumanizing”. On the present suggestion, being such that one is inclined to feel and signal respect is what counts, and is not a dispensable luxury.

According to the virtue-ethical approach neither will accuracy be necessary, epistemic worries to the contrary. Since SJS on the approach presented here makes no claim to protect the patient’s interests, in any substantive sense, no such interests will be violated just because the surrogate happens to make a decision that the patient would not have made, had he or she been competent. A surrogate could come to believe that an old and steadily deteriorating patient would nonetheless have chosen to continue dialysis, for instance, and act in accordance with this belief, while as a matter of fact the patient would not have decided to continue dialysis, had he or she been able to rationally address this issue. This by itself would give us no grounds for thinking some moral damage is being done, since on our proposal the crucial question is whether the surrogate by the application of SJS makes manifest a disposition to be respectful of the person on whose behalf the decision is made. If there is an attitude of respect, there is according to this line of thought nothing more to ask for, as far SJS is concerned.

Now, it is important to understand that this does not imply that it would be morally unproblematic if a surrogate is indifferent to what the patient actually would have decided. On the contrary, *aiming* for accuracy will on this view still be imperative. The reason for this is that a surrogate who wouldn’t be concerned with getting it right would intentionally fail to comply with what SJS asks of him or her, and would thereby demonstrate disrespect. That no harm was inflicted upon anyone, and no moral wrong was done, when the surrogate happened to come up with the wrong answer to what the patient would have decided, is something we can state in retrospect, or from a metaethical

point of view — not something that could be acknowledged by a surrogate in the actual process of decision making, or in close connection to it.<sup>17</sup>

### *Agent-relative obligations*

A seldom discussed assumption in the debate on decision making standards is that the normative status of the candidate standards will be the same regardless of whether the surrogate is, say, a long-time partner, a more recent friend, a legal guardian or the patient's physician. That is, if a standard (SJS e.g., or the best interest standard) is found to be morally superior to other standards, it is supposed to morally govern the conduct of all surrogates alike. This is just what one should expect given the outcome-oriented nature of the discussion, where the common denominator is that all competing standards supposedly serve to protect certain interests of the patient (past, present or future). However, on the present virtue-ethical approach, this agent neutrality should no longer be seen as a given. We have indeed suggested that one and the same virtue (respect for person) might justify SJS, regardless of who the surrogate might be. But our proposal also suggests ways in which different surrogates could have quite different obligations within this framework. Those who have been very close to the patient may be obligated by SJS in a much stronger way than others (for whom this standard is a morally viable alternative too). The former may not count as virtuous in the relevant regard unless they really try to figure out what the patient would have decided, and act on this as if compelled by the same moral authority as a demand from the person herself would have had. From a long-time partner, for example, we may expect nothing less than the fullest regard for what the now incompetent person would have decided, had he or she been competent. For the latter, i.e. those surrogates who do not have as personal and close a relationship with the patient, SJS could be more optional. It could remind those surrogates of a consideration that might help them not to show disrespect by making a decision that the patient would not under any circumstances have made, a consideration that may not require the same involvement and careful attention to the patient's perspective. For those surrogates, a virtuous response need not in fact take the form SJS-based thinking at all, as long as this negative, less demanding, constraint is met. While the patient's physician, for example, would be morally justified in trying to do what the patient would have done, for just the reasons we have suggested, the physician would perhaps be equally virtuous if he or she was prone to apply a *reasonable-person* standard<sup>18</sup> — provided, of course, he or she would not thereby intentionally make a decision that the patient would never have done. However this may be, on a virtue-ethical approach to SJS, built upon a notion like respect for person, there is no apparent reason to believe that what is required of a well-functioning individual must be exactly the same, regardless of the nature of relationship between this individual and the patient.

### *The underdetermination problem revisited*

As mentioned above, the standard formulation of SJS, stating that the surrogate ought to make that decision which the patient would have made, had he or she been competent, leaves certain questions unanswered. Roughly, how competent should the patient be imagined to be, and what else should be assumed about his or her hypothetical outlook and circumstances? By not clarifying these things, SJS could be said to be underdescribed, or underdetermined. On a traditional outcome-oriented account of SJS, where it is assumed to be important to make that decision which the patient actually

would have made, had he or she been competent, and the standard is taken to serve the purpose of extending the patient's opportunities for self-determination, we should expect there to be some kind of answer to the relevant questions. And not having the resources to "solve" the underdetermination problem in a non-arbitrary fashion must be seen as a weakness of the account.<sup>19</sup>

On the present virtue-ethical approach to SJS, the underdetermination problem virtually disappears. More precisely, this approach can explain why certain completions of the relevant hypothetical scenario should be morally ruled out, and simultaneously explain why no particular completion is required. Let us begin with the former. Choosing as the patient would have chosen if he or she had been competent may sound reasonable enough. However, choosing as the patient would have chosen if minimally competent but affected by a migraine, sloppy thinking, and the rhetoric of a friend on whom the patient has been too dependent for his or her own good, seems not acceptable, morally speaking. This and similar ways of filling in the hypothetical scenario referred to by SJS should be morally rejected on anyone's view. But why? The virtue-ethical approach introduced here accounts for this in terms of disrespect. To knowingly decide as the patient would have decided under conditions that are so clearly unfavorable would arguably be a sign of disrespect. How could one show respect if one chooses to highlight a disposition that may neither "summarize" the person's perspective particularly well, nor be one that this person would regard highly? Doing so would plainly run against the basic charity that does seem to be part of respect for person.

But the "opposite" way of supplementing the relevant hypothetical scenario will be equally disrespectful. To deliberately decide the way one believes that the patient would have decided if he or she had been massively educated about things he or she in fact never knew, regarding everything from logic to what is *really* worth caring about, would be to show disrespect for the person concerned. It would be so because it would in effect be an attempt to disregard everything peculiar to this person and replace it with one's own, allegedly more enlightened, perspective. In this way the virtue-ethical idea of respect for person defines certain constraints on what would count as a morally justified augmentation of the traditional formulation of SJS.

At the same time, the present approach also implies that no particular way of adding scenario information to the scanty SJS formulation is needed. There are two reasons for this. First, in applying SJS a surrogate could embody the virtue of feeling and expressing respect without imagining any detailed circumstances at all, under which the patient would have made his or her decision. A surrogate could come up with an answer to "what the patient would have decided" through an imagined dialogue with no or little concrete detail filled-in, for example, or may simply have an immediate association when prompted by this phrase. How this might work, psychologically speaking, is presumably open to empirical investigation. The present point is that no detailed specification of the circumstances under which the patient would have decided as assumed is required in order for respect to be felt and articulated in a substituted judgment.

Second, different ways of actually enriching the hypothetical scenario would do equally well when SJS-based decision making is an expression of respect, as long as the basic constraints discussed above are met. Consider for instance two of the possibilities<sup>20</sup>: that the surrogate decides as the patient would have done the last time he or she was competent, or that the surrogate decides as the patient would have done when he or she

was “at the peak” of his or her abilities. On the present account, either of those two ways of specifying which “version” of the patient the surrogate ought to have in mind might do. The reason is that both of them capture the basic idea of there being a person who she is, a perspective other than one’s own that deserves recognition, and in many cases both of them could be said to comply with the charity requirement on proper respect.

### *SJS in the law*

Decision-making for the incompetent is an area that many countries have found reason to regulate, and along with other standards SJS has found its way into health care legislation. Are there any implications of the virtue-ethical approach to SJS, for the proper role of this standard in the legal regulation of decision making for others? This is really too complex a topic to address in a serious fashion here. It involves the general question of the appropriateness of legally codifying our views on what has been called “harmless wrongdoing”<sup>21</sup>, the question whether such legislation could function as intended only under the *pretense* that it serves to protect certain interests of those professedly concerned, and the question whether SJS in particular is fit for inclusion in the law, given a moral justification that draws upon the idea of felt and expressed respect. Let us just offer a few words on this last issue.

It makes little sense to legally demand that people have a morally virtuous character, or have certain attitudes. But by including rules according to which surrogates are supposed to make health care decisions that meet SJS, a legal framework for decision-making for the incompetent seems, at least, to *allow for* and *encourage* the kind of response that we have suggested is central to the moral justification of SJS. Whether the law could do so as successfully in terms of permissions rather than obligations is difficult to say, and would seem to depend on a whole range of empirical matters. In order for SJS legislation to harmonize with a virtue-ethical approach to its moral foundation, however, a number of things need to be ascertained. For example, it is imperative that cases where surrogates, while doing their best, fail to comply with SJS due to necessarily inadequate knowledge about the patient, are handled in an appropriate way. The importance of correctly determining what the patient would have decided cannot be explicitly downplayed, but especially on the virtue-ethical approach it would at the same time seem misplaced and unfair to hold surrogates responsible for not making accurate substituted judgments when those surrogates have conveyed the respect they feel, but have done so with no realistic chance of finding out what the patient truly would have decided. We also have in mind the importance of not having a legal solution that works against its own virtue-ethical purpose, by effectively encouraging surrogates to “go through the motions” of substituted judgment rather than cultivate and express genuine respect.

### **Conclusion**

Decades of ethical and legal discussion about the proper role of SJS in decision making for incompetent patients have resulted in an overall picture. The picture is one of a standard that serves to protect the patient’s continued right to self-determination, or autonomy. We believe this picture needs to be challenged, and we have done so in various places and in various respects. But challenging a picture is not the same thing as replacing it with a more convincing one, which we eventually also have to do. In this paper we have suggested the beginnings of an alternative account of what substituted judgments are

about. It is obvious that it is just the beginnings, since we have neither elaborated the details nor argued for the foundation. However, tentative beginnings may be just what we need in a discussion that would benefit from just opening its eyes to the *possibility* that SJS is something other than a prosthesis allowing patients to be self-determining even when they have turned incompetent. In the words of Rosalind Hursthouse, who once sketched a virtue-ethical approach to a different issue in bioethics (abortion), “[t]he time has come to try to offer an alternative; a way of thinking ethically which, if it does not deliver simple good answers, at least not deliver simplistic bad ones.”<sup>22</sup> Does respecting the patient’s hypothetical decisions promote the same values as respecting his or her actual decisions? Ought it be a major worry that a surrogate is ill equipped to accurately identify what the patient would have decided, had he or she been competent? Does SJS have the same normative status for all surrogate decision makers, regardless of their relationship to the patient? If the proposals offered here are underdeveloped and vague, they are still sufficiently substantial to suggest that we need to rethink our position on these and related issues.

## Endnotes

- 1 See e.g. President’s Commission for the Study of Ethical Problems in Medicine and Biomedical and Behavioral Research, *Deciding to Forego Life-Sustaining Treatment: A Report on the Ethical, Medical and Legal Issues in Treatment Decisions* (Washington D.C.: Presidents Commission, 1983): at 136; A.E. Buchanan and D.W. Brock, *Deciding for Others: The Ethics of Surrogate Decision Making* (Cambridge: Cambridge University Press, 1990): at 112; J.V.M. Welie, “Living Wills and Substituted Judgments: A Critical Analysis,” *Medicine, Health Care & Philosophy* 4, no 2 (2001): 169-183, at 170-171; R.S. Olick, *Taking Advance Directives Seriously: Prospective Autonomy and Decisions near the End of Life* (Washington D.C.: Georgetown University Press, 2001): at 7.
- 2 See e.g. P.R. Sailors, “Autonomy, Benevolence, and Alzheimer’s Disease,” *Cambridge Quarterly of Healthcare Ethics* 10, no 2 (2001): 184-193; S. Bailey, “Decision Making in Health Care: Limitations of the Substituted Judgement Principle,” *Nursing Ethics* 9, no 5 (2002): 483-493.
- 3 We describe and discuss this problem in L. Broström, M. Johansson, and M.K. Nielsen, “‘What the patient would have decided’: A fundamental problem with the Substituted Judgment Standard,” *Medicine, Health Care and Philosophy* 10, no 3 (2007): 265-278.
- 4 L. Broström and M. Johansson, “Extending Autonomy by Substituting Judgment: A Case of Mistaken Identity.” In Broström, L. *The Substituted Judgment Standard. Studies on the Ethics of Surrogate Decision Making* (2007) (doctoral dissertation).
- 5 For a general discussion of these, see e.g. Buchanan and Brock (1990) (see note 1).
- 6 If it does not ring true that the point of SJS based decisions should merely be one of having or expressing certain sentiments, remember that in the cases we are discussing SJS is supposed to enter when the issue of welfare protection has already been addressed. Just as in cases where competent patients are allowed to make their own health care decisions, considerations of well-being have already been operative in the framing of the issue. Patients or surrogates are never given a *carte blanche* to settle any health care issue they want, in any way they want. The issues on which the decision is left for them to make, and the options between which they are allowed to choose, are determined only after an assessment of what is at stake for these patients, and what welfare risks society ought to allow them to be put to. Moreover, it should be noted that the particular attitudes that we shall focus on in the following do not exhaust the virtues. That she for example *cares* for the other, i.e. attends to the other’s well-being, is something we also expect of the virtuous person.
- 7 Cf. E.V. Spelman, “On treating persons as persons,” *Ethics* 88, no 2 (1978): 150-161.
- 8 As Spelman mentions, appropriate respect may imply a humble approach, where one admits that one’s chances of fully knowing who a person is are seriously limited. In a minimal sense of



respect, Spelman argues, “[y]ou will be able to keep from not treating me as the person I am, by not making presumptions about me.” (op cit, at 161)

- 9 One alternative way of conveying respect that deserves to be mentioned is suggested in the work of those who build their normative account of surrogate decision making on the notion of *narrativity*. Jeffrey Blustein’s proposal, and the commentary by Mark Kuczewski, are good examples, see J. Blustein, “Choosing for Others as Continuing a Life Story: The Problem of Personal Identity Revisited,” *Journal of Law, Medicine & Ethics* 27, no 1 (1999): 20-32.; M.G. Kuczewski, “Commentary: Narrative Views of Personal Identity and Substituted Judgment in Surrogate Decision Making,” *Journal of Law, Medicine & Ethics* 27, no 1 (1999): 32-37. Blustein suggests that instead of making decisions in accordance with SJS, surrogates ought to “regard themselves as *continuers* of the life stories of those who have lost narrative capacity” (at 21). Following M. Schechtman, *The Constitution of Selves* (Ithaca: Cornell University Press, 1996), he claims that a person’s identity, in the sense that is of moral concern, is constituted by an individual’s self-conception, and that this self-conception is narrative in form. Blustein argues that people have an interest in “having their identities maintained by those who act in their behalf” (ibid.) and that surrogates succeed in protecting this interest (at least figuratively) when in the context of decision making they continue this life story in a way which is coherent with what has already been narrated by the person concerned.

We believe this could indeed capture a way of treating an incompetent patient with respect. And the “continuer view” has affinities with our own account, in its rejection of the establishment view of patient autonomy as the primary value to be protected in surrogate decision making, and in its explicit appeal to the idea of respect and treating persons as persons. However, as a general approach to surrogate decision making, it commits us to too much, on our view. Blustein’s account assumes that the patient has certain non-experiential interests that need to be protected by the surrogate, whereas the present take on SJS tries to make sense of the merits of this standard without making this problematic assumption. And Blustein’s suggestions depend on a fairly contentious theory of what makes us the persons we are, something which the present approach succeeds in avoiding. (For recent criticism of this and related narrativity theses, see G. Strawson, “Against Narrativity,” *Ratio* 17, no 4 (2004): 428-452). Moreover, if interpreted as a proposal about how the surrogate ought to think — “to conceive of his task as a continuer” of a life story (Kuczewski, op. cit., at 33) — it seems significantly more strained and difficult to understand for the typical surrogate, than regular SJS-based thinking. The present account tries to justify and explain a kind of thinking that appears natural to surrogate decision makers, while there may be many obstacles to implementing Blustein’s continuer view as a tool in the hands of surrogates.

- 10 S. Darwall, “The Value of Autonomy and Autonomy of the Will,” *Ethics* 116, no 2 (2006): 263-284; S. Darwall, *The Second-Person Standpoint: Morality, Respect, and Accountability* (Cambridge, Mass: Harvard University Press, 2006).
- 11 M. Slote, *Morals from Motives* (New York: Oxford University Press, 2001).
- 12 See e.g. R. Dworkin, *Life’s Dominion: An Argument About Abortion, Euthanasia, and Individual Freedom* (New York: Vintage Books, 1994): at 201-208.
- 13 For an overview, see D.I. Shalowitz, E. Garrett-Mayer, and D. Wendler, “The Accuracy of Surrogate Decision Makers: A Systematic Review,” *Archives of Internal Medicine* 166, no 5 (2006): 493-497.
- 14 See e.g. R.M. Houts, W.D. Smucker, J.A. Jacobson, P.H. Ditto, and J.H. Danks, “Predicting Elderly Outpatients’ Life-Sustaining Treatment Preferences over Time: The Majority Rules,” *Medical Decision Making* 22, no 1 (2002): 39-52.
- 15 Houts et al. (2002), at 50 (see note 14).
- 16 Ibid.
- 17 Cf. the parallel reasoning in Slote (2001), at 34 (see note 11).
- 18 That is, a standard according to which the surrogate ought to decide as “a reasonable person” would do in the patient’s circumstances.
- 19 We argued this at length in Broström et al. (2007) (see note 3).
- 20 Outlined in Broström et al. (2007) (see note 3).

- 21 J. Feinberg, *Harmless Wrongdoing: The Moral Limits of the Criminal Law*, vol. 4 (New York: Oxford University Press, 1988).
- 22 R. Hursthouse, *Beginning Lives* (Oxford: Blackwell, 1987): at 218.

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## AN APPROACH TOWARDS APPLYING PRINCIPALISM

JEFFREY W. BULGER, PHD

Writing a case study is not a difficult task if you have a basic paradigm. Principlism with its four basic principles of autonomy, nonmaleficence, beneficence, and justice provides such a paradigm and also benefits in being recognized both nationally and internationally by Constitutional rights and liberties and by a variety of codes of ethics.<sup>1</sup>

Principlism is a unified approach in that each moral principle seems to converge into each of the other three principles. For example, it can be argued that Principlism, as a comprehensive moral approach, is just another term for justice. To the extent that justice is socially valued because of how it effectively establishes autonomy, nonmaleficence, and beneficence, both personally and socially, it can be argued that Principlism only needs its fourth principle—justice, in order to fulfill its moral function. However, this argument can also be made with regards to each of the four principles as each principle seems to be able to include each of the other three principles. Personal autonomy results in the maximization of personal benefits, beneficence, and the minimization of personal burdens, nonmaleficence, within a legitimate social structure, justice. Likewise, nonmaleficence is maximized by maximizing autonomy, beneficence, and justice, and beneficence is maximized by maximizing autonomy, nonmaleficence, and justice.

The fact that each of the four principles can be argued to be the supreme moral principle further validates the Principlistic approach towards moral decision-making. In other words, Principlism is a unified moral approach in which the addition of each principle strengthens the legitimacy of each of the other principles to the extent that each principle is specified and balanced using independent criteria and yet each principle still supports each of the other principles.

Science illustrates the importance and necessity of such unification. For example, if several academically distinct fields converge on a unified position, then that would generally give more credence towards that position. On the other hand, if one academic discipline has a hypothesis that contradicts several or all of the other academic disciplines, then that would be reason either to reject that hypothesis or at least to give it some pause. One example of such unification would be the comparison of evolution vs. (young earth) creationism. Evolution converges in several academic fields, such as Biology, Microbiology, Astronomy, Cosmology, Geology, Paleontology, Oceanography, Pathology, Medicine, Anthropology, and more. Creationism, on the other hand, is based on the non-academic discipline of religious faith and is not supported by any of the empirical academic disciplines. As a result, creationism does not have the same academic stature as evolution and is therefore not considered as a plausible option by any of the empirical or rational academic disciplines. Therefore, other than creationism being a curious sociological, anthropological, or psychological phenomena of culture, religion, and/or belief, creationism has no place in academic empirical rational discourse. Of

course academic sciences are by definition limited to empirical and rational discourses and some knowledge is clearly not of that category. For example, intersubjective experiences of sense data, such as sight, taste, smell, touch, hearing, and emotional states, such as love and faith, are real and true experiences, yet they elude rational and/or empirical quantification. However, since creationism claims to be an academic empirical conclusion, then it is legitimate to hold creationism to academic standards of universal academic consistency.

Principlism validates itself with its universally recognized moral principles of autonomy, nonmaleficence, beneficence, and justice. These principles are distinct moral attributes that converge and unify moral decision-making even within pluralistic environments.

The goal in moral decision-making is ultimately to specify and balance each of the four principles, recognizing that there is no set hierarchical order of principles in that one or more moral principle may override one or more other moral principle depending on the circumstances. Specifying is the narrowing down or making the broad moral principles relevant for a particular decision, and balancing is the attempt to maximize, as much as possible, all of the contributing or competing moral principles.

The following is an approach that can be used towards applying Principlism to a particular case.<sup>2</sup>

### **Determine the Relevant Parties**

- a. Specifying The Relevant Parties:
  - i. Positive Rights (obligation of others to provide something):
    1. Subject, guardian, or social institutions
    2. Relatives
    3. Community
    4. State government
    5. Federal government
    6. International government
    7. Other
  - ii. Negative Rights (obligation of others to not interfere):
    1. Subject, guardian, or social institutions
    2. Relatives
    3. Community
    4. State government
    5. Federal government
    6. International government
    7. Other

- b. *Balancing the Relevant Parties*: If appropriate, put the relevant parties in hierarchical order and/or indicate if one or more party has more compelling interests over one or more of the others.

## Autonomy

- a. *Specifying Autonomy* (relate to negative and positive rights if relevant):
  - i. Personal Authorization
    - 1. Intention: usually communicated by Express, Implied, or Tacit Consent
    - 2. Substantial knowledge: usually provided using the Professional Practice Standard, Reasonable Person Standard, or Subjective Standard
    - 3. Substantial freedom: usually effected by such aspects as Persuasion, Coercion, and Manipulation
  - ii. Institutional Authorization
    - 1. Intention: usually implemented by a signed document
    - 2. Substantial knowledge: usually provided by a written document based on the Professional Practice Standard and/or the Reasonable Person Standard
    - 3. Substantial freedom: If the document is not signed then the services are usually not provided
- b. *Balancing Autonomy*: Balance the above by putting the obligations in hierarchical order and/or by indicating if one has a more compelling interest over the other.

## Nonmaleficence

- a. *Specifying Nonmaleficence*:
  - i. What are the burdens of the various options for the subject and/or relevant parties?
  - ii. What personal and social rights need to be considered?
    - 1. Positive Rights: obligation(s) of others for preventing or alleviating a harm
    - 2. Negative Rights: obligation(s) of others to not interfere in a potential or actual harm
- b. *Balancing Nonmaleficence*: Balance the above by putting the obligations in hierarchical order and/or by indicating if one has a more compelling interest over the other.

## **Beneficence**

- a. *Specifying Beneficence:*
  - i. What are the benefits of the various options for the subject and/or relevant parties?
  - ii. What personal and social rights need to be considered?
    1. Positive Rights: obligations of others for providing a potential or actual benefit
    2. Negative Rights: obligations of others to not interfering in a potential or actual benefit
- b. *Balancing Beneficence:* Balance the above by putting the obligations in hierarchical order and/or by indicating if one has a more compelling interest over the other.

## **Justice**

- a. *Specifying Justice:*
  - i. What are the legal or social issues with regards to the subject and/or relevant parties?
    1. Personal Rights and Liberties as provided by the State, Federal, or International social structures
    2. Social Rights and Liberties as provided by the State, Federal, or International social structures
    3. Political Rights and Liberties as provided by the State, Federal, or International social structures
  - ii. How do the above issues relate to positive rights (obligations of others to provide) and negative rights (obligations of others to not interfere)?
- b. *Balancing Justice:* Balance the above by putting them in hierarchical order and/or by indicating if one has a more compelling interest over the other.

## **Balancing the Four Principles**

- a. How many of the four principles are relevant for this case?
- b. In this particular case, which principles are most influential and why?
- c. Is it possible to maximize most or all of the four principles or do one or more of them override one or more of the others and why?

## **Conclusion**

Summarize the specification and balancing within each of the four principles and then summarize the reasoning behind the balancing of the four principles and present the

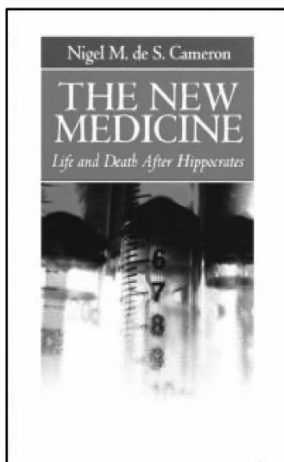
reasons why the chosen moral decision would have a higher probability of accomplishing the balancing end rather than some other decision.

### **Endnotes**

- 1 Examples such as the Nuremburg Code 1948, Belmont Report 1979, and numerous Medical and Profession codes of ethics.
- 2 For a detailed discussion of Principlism please refer to Teaching Ethics, Vol. 8, #1, Fall 2007 pp. 81-100.

## THE NEW MEDICINE: LIFE AND DEATH AFTER HIPPOCRATES

By Nigel M. de S. Cameron



ISBN 0-9711599-3-9  
0-9711599-0-4

In this reprinting of a very important book for our current times, Dr. Cameron links the rise of the "new medicine" and the fall of the Hippocratic tradition to society's increased acceptance of the practices of euthanasia and assisted suicide. He states that "the medical profession is liable to follow any fundamental shift in society's values" and points to the relationship between Nazi Germany and the Nuremberg "medical crimes" as an example. In the absence of the Hippocratic prohibition against the killing of patients by their physicians, the fundamental value of protecting life is displaced. The desires of society to avoid suffering, financial burden, and inconvenience then lead to increasing support for physician-assisted suicide and euthanasia. The author contends that it is imperative for the medical profession to return to its Hippocratic roots.

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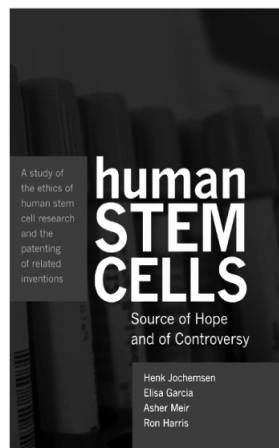
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## BOOK REVIEWS

### **The New Medicine: Life and Death After Hippocrates**

Nigel M. de S. Cameron, Chicago and London: Bioethics Press, 2001.

ISBN 0-9711599-0-4; 187 PAGES, PAPER, \$21.95

Painted with a broad brush, *The New Medicine: Life and Death After Hippocrates*, by Nigel M de S Cameron was first published in 1991 and remains as relevant as ever. The second edition of this book, published a decade later, is warmly welcomed and remains a must for any student of bio-medical ethics. Elegantly written from a Christian and Hippocratic perspective, it is directed at readers of any conviction. The questions raised by Hippocrates in 400 BC seem even more urgent today as we witness a world-wide destruction of human life by abortion and, in some countries, the taking of life by euthanasia – practices prohibited in the Hippocratic Oath. If alive today, Hippocrates and his associates would also have prohibited such practices as the deliberate creation and destruction of human embryos for research. Indeed, they might have shuddered more at this practice than at any other because it expresses a thoroughly instrumental attitude towards what is undeniably human life – albeit in the earliest stages.

As shown by Cameron, the Hippocratic tradition of medicine arose in a society as pluralist as ours and as a reaction to the destructive practices at the time. As noted in the Foreword by C. Everett Koop (former US Surgeon-General) Cameron's respect for the Hippocratic tradition stems from his understanding that the medical profession heals rather than of harms. This understanding fits well with Christian ethics. Hence, to quote John Peel (former President of the British Medical Association) in the Introduction to the first edition: 'although pagan in origin, the Hippocratic tradition gradually became strengthened through Judaeo-Christian belief in the sanctity of life' (19-20). The Hippocratic tradition also fits well with Christian ethics because it represents (as shown in the pivotal second chapter) a threefold covenant. Not a mere technician nor a businessman nor a civil servant, the doctor in the Hippocratic tradition swears loyalty to his colleagues as well as respect for the integrity and sanctity of human life – doing so before God. Medicine in the Hippocratic tradition is a vocation and the moral commitments of the physician are the essence of his practice. By contrast, the Declaration of Geneva, drafted in 1949 by the newly founded World Medical Association – in the wake of the Second World War and Nazi atrocities – is secular and pallid. Cameron writes: 'By abandoning the transcendent and covenantal character of the Oath, those who drafted this reformulation of Hippocratism have turned the principles of medical ethics into one long composite motion to be debated year on year at representative medical assemblies' (88).

Cameron finds the most radical challenge to Hippocratism in 'Singerism.' By coining the concept of 'specism,' Peter Singer has sought to equate the sanctity of human life to racism. Singer argues that moral status depends on the possession of certain intellectual capacities. His concept justifies the exercise of power over those members of the human family most in need of protection – namely the youngest, the sickest and the oldest. When autonomy and intellectual ability are of prime value and medicine focuses on the relief of suffering rather than on the sanctity of life, the result is a power play, according to Cameron. For instance, in abortion, the interest of the mother is set against that of the foetus. Equally, it is shown in the case of euthanasia, whether the patient has requested it or not. For the physician's decision to shorten the life of the patient, be it by act or omission, is based on his, or her, view that the patient's life is not worth living. Even when euthanasia is requested by the patient, the physician is the ultimate arbiter and executioner.

Cameron argues: 'The new medicine emerges as a re-statement of those values which the Hippocratic physicians consciously sought to displace with their reforming manifesto' (162-163). While staunchly defending the Hippocratic tradition, Cameron does not argue from a theological perspective. Rather, at the end of the book there is an appendix entitled *Towards a Theology of Medicine* in which Cameron explores the implications of the *Imago Dei*, showing that it is applicable to every member of the species *Homo sapiens*. Hence, 'for the Christian, the patient is someone who bears the divine image.'(174). Here he also observes – or concedes – that although the true aim of the medical tradition is healing,

ultimately ‘all healing, however it comes about—is a blessing of the world to come’ (180). Thus seen from a Christian and eschatological perspective, healing is a ‘partial realisation in the here and now of something that will finally be accomplished there and then’ (181).

This book is invaluable for a proper understanding of the shift that has taken place in medical ethics in tandem with an increasingly secular outlook in Western society.

**Reviewed by Agneta Sutton, PhD**, who is a Senior Lecturer at Chichester University and a Visiting Lecturer at Heythrop College in the University of London, both in the UK.

### **End-of-Life Decision Making: A Cross-National Study**

Robert H. Blank and Janna C. Merrick, Editors. Cambridge, MA: MIT Press, 2005.

ISBN 0-262-02574-4; 266 PAGES; HARDCOVER, \$32.00

This volume examines what is the very basis of bio-ethical study: end-of-life issues. In the words of Blank, ‘This book is an attempt to provide a foundation for more in-depth study of the issues by placing end-of-life decision making in a comparative context.’ (5) End-of-life policies and population characteristics from twelve countries (Brazil, Beijing, Germany, India, Israel, Japan, Kenya, Netherlands, Taiwan, Turkey, United Kingdom and the United States of America) were included. Experts from each country were given a list of research questions, varying in focus from governmental policies and costs of end-of-life care to cultural factors that impact family and/or individual decision making at the end-of-life. The title of Chapter 13, ‘Death and Dying: The American Experience,’ is a misnomer since it concerns only the United States of America and does not address end-of-life in South America, Latin America nor Canada.

One of the strengths of this book is that native experts present data from their home country. However, for those who tend to look at cultures other than their own as homogeneous in thought and beliefs, this could actually be a weakness since the information presented may be erroneously understood as universally accepted in those represented countries. Participating experts were free to emphasize individual questions as they wished, resulting in disparate emphases on end-of-life issues. For example, only Kenya addressed the shortage of health care professionals administering specialized end-of-life care. Kenya also was the only chapter that addressed how a specific cause of death (HIV/AIDS) has changed the way their culture views death and how it treats those who are dying. The chapter on the United Kingdom did not mention the inclusion of family members in decision-making, while India and Kenya cite heads of families or groups as surrogate decision-makers and Turkey touted the necessity of including family members in the end-of-life decision making processes.

Blank concludes the book by writing, ‘We hope that this book will lead to more in-depth comparative studies of end-of-life issues in these and other countries.’ (253) I do not agree that comparative studies are needed. Global data about end-of-life care – wherever it takes place – is valuable as stand-alone information.

**Reviewed by Claretta Yvonne Dupree, RN, PhD**, who is an assistant professor at the Milwaukee School of Engineering, Department of Nursing. She also serves as an ethicist on the Data Safety Monitoring Board of the National Institute of Allergy and Infectious Diseases, as a Director-at-Large for the American Society of Bioethics and Humanities and as a Fellow of the Center for Bioethics and Human Dignity. She is a Captain in the United States Navy Nurse Corps Retired Reserves.

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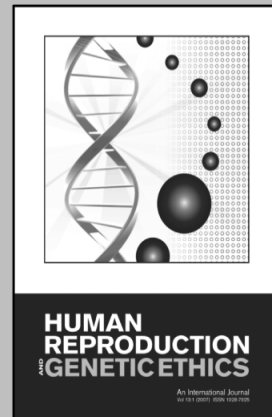
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