Lecture 9.2: Death and Organs

Medicine at its best is concerned with healing, curing—a temporary interruption of life as usual, which then resumes, returning people to their studies, their work, their families. Our health system, our healers and curers, encounters people in extremity, and does its best for them. This is the modern medicine which we all love; the sunny side of modern medicine.

But what is best?

Sometimes people in extremity cannot be returned to health, to their ordinary lives.
--After all, all men are mortal--
So before spring break, we looked a bit at the inevitable end of that life-as-usual, death—and considered the question of-- what is best for the dying?

It's best for them sometimes that they not suffer intractable pain, or be forced to continue to face a life that is in their judgment not worth living.

What can the living do to choose the time and manner of their own death?

- They can kill themselves; suicide is an option.
- They can choose to refuse treatment.
- They can choose to have treatments that would normally (in the course of modern medicine) be provided, withheld or withdrawn.

(We've talked a lot about those options, under the heading of autonomy and self-determination; and we talk for the most part about people who can have a say as to what is in their own mind in their best interests)

(1) Surrogate decision making and its limits

They can *within limits* delegate the same choices to another. And we've talked about that too. You can sign a h/c power of attorney that gives someone the power to make those decisions on your behalf, in what you have specified as your own best interests. You can sign an advance directive.

I said 'within limits' because 2nd and 3rd person decisions are not as binding as 1st person decisions, and we've talked about cases where those decisions can (with proper procedures) be overridden.

(In fact, we've even talked about cases where 1st person decisions have been overridden—the Dax case represents an important and influential paradigm.)

Another limitation of surrogate decision making is that at its most powerful it has to be delegated as a voluntary and informed decision by a competent person. Surrogate decision making for the never-competent person (developmentally incompetent or infants) encounters a different set of procedural safeguards and limitations.

I want to talk today about another important limitation of my ability to determine the time and manner of my own death: I can delegate choices about treatment. I cannot delegate killing myself.
Suicide is an option. Having someone else kill me is not an option.

One way of talking about that is to talk about the different moral valence of the two.

From my 2nd or 3rd person point of view, not allowing someone to do what s/he wants to do (all things being equal, and depending to some extent on the nature of the act in question) is *prima facie* wrong. Each person has a right to decide what to do with their life: Dworkin, in our reading for week 8, spoke of this as my "liberty interest," and it has support in the 1st and 4th amendments. Interfering with your rights has a very strong negative moral valence.

Assisting someone to do what s/he wants to do, on the other hand, can be a good thing, an act of charity, say—or a bad thing. (The same thing is true of NOT assisting someone to do what they want to do: that too can have a positive moral valence, or a negative moral valence.

I have rights too, liberty interests: I don't have an obligation to assist you in doing what you want to do. I can—if it's legal, and I choose to do so—but I'm not morally or legally obliged. Acts of charity, or kindness, or helpfulness have a positive moral valence—but they are not obligatory.

What am I obliged to do for other people? What obligates me?

I'm sure you can see where I'm going with this. Is assisting someone who wishes to kill themselves a possibly moral action? Is doing it for them? And to talk about it, I'll invoke a vocabulary we introduced a few weeks ago: euthanasia. And I'll refer to a text I put up on the website a few weeks ago: James Rachels on killing and letting die. (Cf. his volume "The End of Life," 1986)

2. Euthanasia

Euthanasia is an emotively laden word. Literally it means "good death" but it got very bad associations when it was applied during world war II as a justification for various acts of ethnic cleansing. (Eugenics is another word with similar historical emotive baggage, that dates from about the same period and the same context, and we'll talk about that one in a few weeks.)

Rachels distinguishes active and passive euthanasia, and also between voluntary and involuntary (or: non-voluntary). Euthanasia applies to 2nd or 3rd person acts. It's something that is done to someone else.

active e: doing something that contributes to a person's death **as a primary cause.** Active euthanasia is understood as 'killing' someone.

passive e: the **primary cause** of death is some injury or disease; and an impediment to that death is withheld or removed. Passive euthanasia is understood as 'letting die.' In the US today,

Passive euthanasia is widely accepted, and is allowed by law. (We don't use the language of euthanasia; we call it withholding or withdrawing treatment.) It is the virtue, I think, of Rachel's definition; it allows us to see it as a variant of, rather than as in a different category from, it's parallel:

Active euthanasia is less widely accepted, and is not allowed by law. But saying it is less widely accepted does not mean that there is not a percentage of the population that thinks it is in some circumstances desirable, in terms of 'best interests' of the people who request it. The literature is rife with individual cases where practically anyone would agree that there are good humanitarian and charitable reasons to help someone out of an intolerable situation, *in extremis* (even though that situation is coextensive with life itself).

Rachels is a philosopher—not a physician. He has been very influential, not least because of his strong and novel thesis that there is NO MORAL DIFFERENCE between killing (active euthanasia) and letting die (passive euthanasia). Rachel's position is that there is no conceptual basis for this distinction. If passive euthanasia is OK, then active euthanasia (in our medical context) is also OK. And if active euthanasia is NOT ok, then passive euthanasia is NOT ok either.

You can see how this is important for the context of PAS, and what arguments can be made for it. In our readings last week there were various empirical arguments made about "slippery slopes;" that if we allow 2nd or 3rd party assistance in a first-person decision, we might be on a slippery slope toward allowing active euthanasia. In terms of our discussion, if we allow physicians to help people kill themselves, then the next step is going to be to allow physicians to actually intervene—to be the primary agents, not JUST secondary agents, making available the means by which people can control their own deaths—but administering the means of death themselves.

He makes his case by way of a hypothetical example: Jones and Smith. There are two people in the same situation: both are due a large inheritance if something happens to the young nephew who is the primary heir. They both have huge debts.

> *Jones* resolves to remove the obstacle to his future comfort. He goes into the bathroom where his young nephew is taking a bath. He holds his head under water until he drowns, then runs to alert the family about this tragedy.
> *Smith* makes the same resolve. He goes into the bathroom with every intention of holding the boy's head under water, but contingently enough, he enters the bathroom just as the boy slips and bashes his head on the tub and slips under the water. He could save him, but instead stands there and watches as the boy drowns. He then runs out to alert the family about this tragedy.

Rachel's point is that the moral valence of the two acts—the commission of the death, and the failure to prevent it—is the same. If we blame Jones, we must equally blame Smith.

the 3 poles: agent/act/effect

> How can we analyze that? the consequence is the same. The intention of the agent is the same. The difference between the two is that in one case the agent acted; in the other, he failed to act. Rachels' point is that the distinction between a commission (an act) and an omission (a failure to act) makes no difference to the moral valence in the situation.

In our medical context, the intention of the agent (the doctor) is to relieve the suffering of the patient; the effect is the death of the patient. The difference is one of being an indirect, rather than direct, agent of the death.

Rachel's question: Does that difference make a difference? Does not the same set of considerations—the pain of the condition, the competent voluntary preference of the suffering person—justify direct, as well as indirect, intervention by a second party?

One of the arguments against legalizing PAS is that it might lead to legalizing PAD—physician assisted death—active euthanasia. Rachels acknowledges the existence of this 'slippery slope'—and is basically arguing that there's a little bit of bad faith going on here; that if PAS is morally justified—PAD probably is as well.

> Battin's article to some extent gives empirical evidence about the difficulty of maintaining the sharp dividing line that seems so important at this moment of the debate in this country.

3. Conscientious objection

One of the arguments against PAS in this libertarian country is the fear that if PAS becomes possible, it will gradually become obligatory. So will physicians who are NOT that committed to helping folks along the way eventually be forced to do so? We have surprisingly robust laws protecting people who do not want to provide various services that would otherwise be expected of them by virtue of their professional choices.

I said earlier that I have rights, too. I have a liberty interest in not being compelled to act in a way that I consider not in my best interests, or against my own moral scruples. I have an obligation not to interfere in your right to do what you think best for you about your own life. I don't have an obligation to assist you in doing what you want to do. I can—if it's legal, and I choose to do so—but I'm not morally or legally obliged. Acts of charity, or kindness, or helpfulness have a positive moral valence—but they are not obligatory.

So let's look at the issue of PAS from the standpoint of the physician. Need we fear it will become a forced option – on either the patients or the physicians?

One model for conscientious objection is conscientious objection to war. The medical version typically centers around socially contentious issues related to reproduction; see for instance the ongoing controversy about pharmacists and Plan B. California has the following provisions for acknowledging conscientious objection, on both the individual and institutional level:

California Probate Code:

4734. (a) A health care provider may decline to comply with an individual health care instruction or health care decision for reasons of conscience.

(b) A health care institution may decline to comply with an individual health care instruction or health care decision if the instruction or decision is contrary to a policy of the institution that is expressly based on reasons of conscience and if the policy was timely communicated to the patient or to a person then authorized to make health care decisions for the patient.

4736. A health care provider or health care institution that declines to comply with an individual health care instruction or health care decision shall do all of the following:

(a) Promptly so inform the patient, if possible, and any person then authorized to make health care decisions for the patient.

(b) Unless the patient or person then authorized to make health care decisions for the patient refuses assistance, immediately make all reasonable efforts to assist in the transfer of the patient to another health care provider or institution that is willing to comply with the instruction or decision.

(c) Provide continuing care to the patient until a transfer can be accomplished or until it appears that a transfer cannot be accomplished. In all cases, appropriate pain relief and other palliative care shall be continued.