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John Dossetor Health Ethics Centre
Health Ethics Seminar

University of Alberta
October 21, 2016

Constraints on Harming and Health Care I: The Doctrine of Doing and Allowing

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Constraints on Harming

- **Constraints on harming**: some harmful upshots of our conduct are particularly difficult to justify
  - **Doctrine of Doing and Allowing [DDA]**: all else held equal, there are stronger intrinsic moral reasons against doing harm than there are against allowing harm
  - **The Doctrine of Double Effect [DDE]:** All else held equal, there are stronger intrinsic moral reasons against doing *or* allowing harm as a means to an end than there are against doing or allowing harm as a side-effect
- Sumner (2011): plausible constraints on harming do not support a traditionally conservative stance towards end-of-life decision making
  - Elaborate this argument; explore its limitations

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Motivating the DDA

- Plausible: it's harder to justify doing things that harm some individuals in order to benefit others than it is to simply benefit some individuals instead of others
  - *Choice Between Rescues*. You are hurrying in your jeep to save five individuals from drowning when hear of another individual who will drown if you don't change course
  - *Living Roadblock*. You are again hurrying to save five individuals from drowning, when you notice an individual trapped on the narrow road ahead. If you do not drive over the individual ahead the five will drown (Foot 1984)
- Plausible that the greater benefits to the five justify helping them rather than the one
  - But that they don't justify benefitting them at the one's expense by doing something that kills her

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End-of-Life Decision Making

- Treatment options that (are believed to) hasten death:
  - **Non-treatment**: withdrawal / withholding of life-sustaining treatment
  - **Conventional palliative care**: providing / administering analgesics or sedatives that may cause death as a foreseen but unintended effect
  - **Assisting suicide**: providing a patient with means she will use to cause death with the intention of causing it
  - **Euthanasia**: administering treatment to a patient with the intention of causing her death
    - Voluntary, quasi-voluntary, non-voluntary

'Assisted death'

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The Traditional Moral View

- **The Traditional Moral View**: There is a deep intrinsic moral difference between assisted death and other death-hastening treatment options
  - makes current practices of non-treatment and conventional palliation permissible but assisting death wrong in (almost) all cases
- Often assumed: this is supported by constraints on harming – and in particular the DDA
  - Assisting death actively inflicts the harm of death, while death-hastening non-treatment merely allows it
  - Two main problems with this: (1) assumes that death is a harm, (2) assumes that consent doesn't undermine the DDA's applicability

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How Death Might Not be Harmful

- **A Common Philosophers' Moral View (Sumner)**: What makes killing someone *or* allowing her to die wrong (when it is) is (a) its harming her, and / or (b) its violating her autonomous wishes about her own life
  - **The Deprivation Account of Death's Harm**: death harms individuals by depriving them of future goods that would have outweighed the future bads they would have experienced
    - Goods / bads: cf. theories of well-being – enjoyments, ordinary experience, activities, etc. vs. pain / suffering
    - Entails that death doesn't harm but rather benefits individuals when it deprives them of a future where future bads would have outweighted future goods

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What if Death Isn't A Harm?

- **First main problem** with appealing to the DDA to justify the traditional moral view: it assumes that death is a harm in assisted death cases
  - In cases where death really *is* a harm, we should be pretty worried about death-hastening non-treatment, not just assisted death
    - *Especially* if the patient is incompetent with no known wishes (if the Groningen protocol is problematic because it harmfully kills infants, so is a regime of selective non-treatment that with equal certainty allows them to die)
  - Those who argue that assisted death is permissible in the same sorts of cases as death-hastening non-treatment typically take these to be cases where death is a benefit rather than a harm

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What if Death Isn't A Harm?

- If death really is a net benefit rather than a harm
  - (And the patient either voluntarily consents or can't give competent informed consent)
  - The DDA simply does not entail that ending her life is harder to justify
- The DDA doesn't seem plausible as a constraint against doing lesser harm to a patient for her own greater good
  - Amputating leg to save life = fixing heart instead of reattaching leg
  - Plausible idea embodied in the DDA: it's harder to justify inflicting harm on *some* in order to benefit *others*

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What if the Patient Consents?

- **Second main problem** with appealing to the DDA to justify the traditional moral view: it assumes that consent can't undermine the applicability of the DDA
  - The only cases in which it might be permissible to *harmfully* hasten death via non-treatment or lethal palliation would be at the patient's competent informed request
- But it seems that autonomous consent to be harmed at least weakens the applicability of the DDA
  - Suppose that the one in Living Roadblock was an autonomous adult who begged you to drive over him to save the five
    - Would it then be permissible to proceed?

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Limitations of the Argument

- Sumner: in the typical cases legally permitted by regimes of assisted death (like C-14), death will be both (i) beneficial and (ii) chosen with competent informed consent
  - So the DDA will not militate against its permissibility
- Reasons to skeptical about both (i) and (ii)
  - Analgesia is capable of controlling physical suffering 80-98% of cases
  - Palliative sedation and as a last resort terminal sedation is capable of controlling it in the rest
- Main reasons for assisted suicide requests in Oregon:
  - Loss of independence / control, "indignity", lost sense of self, diminished ability to engage in meaningful activities

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Respecting vs. Supporting Autonomy

- Even if competent informed consent may weaken the applicability of the DDA,
  - reasons to *actively support* a self-harming decision might be *weaker* than reasons *not to interfere* with such a decision
- *Non-interference*. Your ask your neighbour what he is up to and he tells you that he is going to pull out his teeth with special pliers. You are about to take away his pliers (which would effectively stop him), when he shows you a certificate from his psychologist, certifying that he has made an autonomous decision to pull out his teeth to make a necklace, having been appraised of all material information and free of coercion & manipulation. He says, "I'm an adult, and it's my body, so leave me alone!"
  - Should you leave him alone?

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Respecting vs. Supporting Autonomy

- *Request*. You are the only person around who has the ability to make pliers capable of removing teeth. Your neighbour shows you the certificate from his psychologist and asks you to make him pliers so he can remove his teeth and make a necklace. You know that if you refuse he will be unable to remove his teeth. If that happens he will eventually forget about trying to do this
  - Should you refuse to make him pliers?
- If patents' consent is competent & informed *but* death is a harm
  - Supporting assisted death with a health care system like ours may be like making pliers for your neighbor
  - While respecting patients' self-harming non-treatment decisions is like simply omitting to take his pliers away

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How Autonomous is the Consent?

- Another worry: many patients may seem to be requesting death out of something like competence-undermining clinical depression
- Sumner: But our current policies permit people to refuse life-sustaining treatment under similar conditions (indeed, even if they're non-terminal)
  - Yes, and that might be a good reason to change these policies too (e.g. try to prevent "silent suicide," have more stringent standards for competence in these cases)
  - That said, allowing assisted death (even in only terminal cases) under these conditions may just *exacerbate* the problem by *increasing* the incidence of dubiously autonomous, self-harming decisions

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