

# LIFE, MEDICINE AND HUMAN FULFILMENT

End-of-Life Decisions in Light of a Revised Natural Law Theory

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# Contents

<b>Preface</b>	<b>1</b>
<b>Introduction</b>	<b>3</b>
<b>1 New natural law theory</b>	<b>17</b>
1.1 The Grisez-Finnis new natural law theory	17
1.2 New natural law as a secular theory	21
1.3 Practical reason	24
1.4 Basic human goods	27
1.5 The problem of self-evidence's underdeterminacy	52
1.6 From practical reason to morality	54
1.7 New natural law theory and its philosophical competitors	57
1.8 Chapter summary	72
<b>2 Ethical principles</b>	<b>74</b>
2.1 Rationality and ethics	74
2.2 Intermediate moral principles	75
2.3 'Do not choose directly against any basic human good'	79
2.4 Comparing four alternative formulations	91
2.5 Intention	96
2.6 From intermediary moral principles to moral norms	102
2.7 Chapter summary	106
<b>3 Persistent vegetative state as a test case</b>	<b>108</b>
3.1 PVS as a philosophical test case	109
3.2 The vegetative state	111
3.3 The new natural lawyers' views on treatment decisions in PVS	118
3.4 The methodology of testing moral theory on intuitions	127

3.5	The empirical literature on moral intuitions towards PVS	133
3.6	Chapter summary	154
<b>4</b>	<b>The ethics of withdrawing artificial nutrition and hydration in PVS</b>	<b>155</b>
4.1	Arguments for the withdrawal of artificial nutrition and hydration	155
4.2	Arguments against withdrawal of artificial nutrition and hydration	179
4.3	Arguments about legitimate means	185
4.4	Arguments from other sources	190
4.5	A summary and appraisal of the arguments	196
4.6	A revised new natural law theory	203
4.7	Moral status and the right to life	204
<b>5</b>	<b>Euthanasia and other issues at the end of life</b>	<b>213</b>
5.1	Euthanasia and physician-assisted suicide	213
5.2	Treatment-limiting decisions	265
5.3	Palliative sedation	280
5.4	Voluntarily stopping eating and drinking	283
5.5	The minimally conscious state	286
5.6	Locked-in syndrome	288
5.7	A revised new natural law theory view of end-of-life decisions	290
5.8	Concluding remarks: potential weaknesses in the revised theory	291
	<b>Bibliography</b>	<b>299</b>

## Preface

After finishing medical school ten years ago, I developed a thirst for insight into other fields. In particular, I turned to philosophy and Christian ethics. I have often pondered questions about the relation between secular and Christian ethics. In John Finnis and Germain Grisez's 'new natural law' theory I found a secular account of ethics and action theory that was compatible with the ethics of the broad Christian tradition. Moreover, the theory highlighted the *rational structure* of the ethics of the Christian tradition. This thesis examines and revises the new natural law theory, and discusses some dilemmas in medical ethics in light of this theory.

The project would not have been realized without my many helpful supporters. First of all, I would like to thank Gudmund Nordby, Anne Marit Tangen and Bjørn Holm at Lovisenberg Diaconal Hospital for their support, decisive in the planning phase of the project. I gratefully acknowledge the financial support of the South-Eastern Norway Regional Health Authority (Helse Sør-Øst).

To be able to spend four years delving into medical ethics has been a true privilege. I could not have had a better guide into this new terrain than my main supervisor, Per Nortvedt. Per's thorough knowledge of healthcare ethics, deepened by his clinical experience, became a true asset for me as well. Per always takes the time for questions and discussions with his PhD students. Our discussions, and his suggestions, have been fertile and have helped shape my thesis and argument.

As important has been Per introducing me to the diverse activities of a busy academic centre, and the trust I have thereby been shown. I am grateful for the opportunities to try my hand at academic life, including teaching and supervision of medical students. These experiences have been rewarding, and have provided me with beginning insights into other areas of medical ethics.

I have been very fortunate to have Henrik Syse as my co-supervisor. Henrik is one of the few Norwegians who knows the field of natural law theories, having written his dissertation on the topic. Henrik's familiarity with the field, the philosophical acuity for which he is renowned and his energetic support throughout have been great assets for my project. When I look at the work presented here I see

that much of that which has a tinge of novelty or creativity has arisen from Per and Henrik's pointed criticism and our discussions.

The Centre for Medical Ethics at The University of Oslo has been a stimulating academic base, and I would like to thank all my colleagues there for our cooperation, our spirited discussions and our companionship. I have greatly appreciated the Centre's atmosphere of mutual supportiveness and tolerance of different viewpoints.

I would also like to thank Christopher Kaczor, who graciously read the manuscript at an early stage, and offered many helpful criticisms. Søren Holm has also provided me with useful tips and insights at several stages in my work. Further, I would like to thank Lars Johan Materstvedt and Morten Horn, from whom I have learned a great deal through our discussions of – and academic cooperation on – end-of-life decisions. Lars Johan read and provided helpful comments on the fifth chapter.

Finally, my greatest thanks go to my family: to Miriam, Daniel, Peter and Thomas, for the narrative that we share; and to my parents, in particular for their great practical support, which has often solved the logistic challenges of a busy family.

*Oslo, April 2014*

## Introduction

For five years I worked as a physician, most of the time in the medical department of Lovisenberg Diaconal Hospital, an inner-city hospital in Norway's capital, Oslo. Over the course of these years, I gradually realized how the provision of quality medical care depends on so much more than the medical knowledge provided by textbooks and lectures. Indeed, patients often seemed to *take for granted* that their physician possessed the necessary biomedical knowledge. The *excellent* doctor was the one who in addition would display well-honed interpersonal skills, who possessed the knowledge of the organization of the medical services necessary for their successful navigation, and who would treat his or her patients with respect and care for the whole person.

One of the areas I perceived as particularly challenging was end-of-life care. This was especially so with patients for whom important medical decisions that were not straight-forward had to be made. Should this very ill cancer patient receive ICU treatment in case of a medical emergency? Was the decision to start another round of chemotherapy really in this patient's interest, seeing the side-effects she now has to suffer? Should we attempt drainage of this patient's pleural effusion, a painful and uncomfortable procedure, as a last-ditch attempt to save his life, or should we let nature take its course, emphasizing good palliative care? Should we withhold artificial nutrition from this patient in the aftermath of a severe cerebral haemorrhage? Is this patient's current wish to be respected as genuinely autonomous, or is her judgment already too clouded from the progression of a fatal disease? Examples could continue *ad infinitum*, for variations on cases such as these were weekly occurrences in our wards. In such situations, the already complex provision of quality medical care is complicated further by questions of *what the ethically (most) appropriate course of action is*.

End-of-life care, accordingly, is often multiply difficult – medically, ethically, and humanly. It often involves decision-making in the face of uncertainty in all three of these realms.

Here, then, systematic ethical reflection has a place and a purpose. Firstly, established ethical principles provide rules of thumb to guide actual decision making.

Secondly, however, once in a while one should take a step back to scrutinize one's principles. Are they appropriate? What reasons can be given in their support, and what reasons are there to think differently? Ethical reflection helps to nuance and shape one's ethical rules of thumb. Thirdly, more systematic ethical reasoning may provide a deeper justification for ethical principles (or a deeper critique of them).

In my view, the practices and principles regarding the ethical aspects of end-of-life decision making that are generally accepted in Norwegian health care services fit reasonably well with traditional medical ethics.<sup>1</sup> However, one might suspect that these practices and principles are not necessarily *firmly* grounded among health care professionals, mainly because few practitioners are aware of any *deeper* justification for their principles. Thus consensus around current practice, e.g., the rejection of euthanasia, could be fragile.<sup>2</sup> It may turn out that challenges and influences from a diverse set of sources – political liberalism, utilitarian bioethics, the euthanasia movement, and political pressures, including constrained economic resources for the health services, among others – could change the minds and practices of the next generations of health care workers. When attitudes change, it is crucial that such changes do not happen without careful reflection. As such, further and deeper reflection on the ethics of end-of-life decisions is warranted.

There has been no shortage of bioethical attention to this field. Thousands of pages have already been produced on the ethics of decisions at the end of life. Why the need for another thesis? In my view, there is one approach to ethics that is both rationally appealing and suited to the health care field, and one that has not received sufficient attention in the literature. This is the so-called *new natural law theory of ethics*, in its explicitly secular version.

My starting point, then, has been shaped both by clinical experience and by an interest in moral philosophy. I undertook this project to explore the field of medico-

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<sup>1</sup> As, for instance, codified in the national guidelines for treatment-limiting decisions: Helsedirektoratet, "Beslutningsprosesser ved begrensning av livsforlengende behandling," (2013). However, there are aspects here that should be challenged, as will be discussed in section 5.2.

<sup>2</sup> Although widely condemned among Norwegian physicians, and explicitly disallowed in The Norwegian Medical Association's Ethical Rules for Physicians, a significant minority of future doctors support euthanasia. According to a recent survey, 31% of medical students supported the legalization of physician-assisted suicide for terminal-phase patients, whereas 19% supported euthanasia in the same situation: Magnus A. Nordstrand et al., "Medisinstudenters holdninger til legalisering av eutanasi og legeassistert selvmord," *Tidsskr nor legeforen* 133 (2013).



ethical end-of-life decisions from the theoretical vantage point I found the most attractive, the new natural law theory. The kinds of medico-ethical deliberation that are currently prevalent have been shaped by fruitful dialogues between practice and theory. For my small contribution to these dialogues, I want to bring my preferred ethical theory to the table. However, a dialogue implies that both parties to the discussion must be prepared to re-examine received wisdom and premises. My approach is to first refine the theory by challenging some of its problematic and counter-intuitive aspects (Chapters 1-4), then ultimately to use the theory to shed light on crucial end-of-life problems (Chapter 5). The upshot is, I hope, an ethic of end-of-life decisions that is theoretically sound, consonant with crucial clinical intuitions, and helpful in practice.

## New natural law theory and the persistent vegetative state

What is the new natural law (NNL) theory of ethics? An ethical theory represents a general account of the *good* and the *right*, and also of the *reasons* that should be lent weight in deliberations about what to do. An ethical theory should be able to explain – to give reasons – why actions are moral or immoral, right or wrong. A natural law theory argues that there are in fact moral truths and falsehoods, and that some of these truths can be codified in moral rules and principles.

Natural law theories are called ‘natural’ for several reasons (see 1.1), but in particular because there is a certain relation between the theory’s moral precepts and what is natural for human beings. The natural moral law is a guide towards human fulfilment and flourishing. NNL aims to aid us in living well, and to help us in the face of uncertainty about appropriate courses of action.

At its core, new natural law theory offers an account of ‘the good’ as a list of *basic human goods*, such as life and friendship. These goods motivate us and provide reasons for action. Together, the goods constitute *eudaimonia*, or the good life. Ethics is the set of principles guiding our pursuit of the goods through action. Actions that aim at the goods whilst *respecting* and not *violating* them are morally acceptable.

The *new* natural law theory is in part a response to the perceived shortcomings of the *classical* natural law theories (see 1.7.6). The classical natural law tradition in ethics, going back to Aristotle and Aquinas, has, at least to a certain extent, fallen out of favour in modernity. There are two main reasons for this: (1) such theories are

claimed to commit the is-ought fallacy (to deduce what ought to be done from merely factual premises, which allegedly cannot be done); and (2), they are claimed to trade on implicit religious premises, and thus appear less helpful in a pluralistic liberal democracy in which ethics must help us reconcile our differences. In influential Norwegian moral philosopher Arne Johan Vetlesen's recent introductory volume on ethics, natural law theories are dismissed in half a sentence.<sup>3</sup> However, in international academic circles, natural law has made something of a comeback with the NNL theory of Germain Grisez, John Finnis, and collaborators.<sup>4</sup> The theory is draped in the language of analytical philosophy, and thus suited to join the debate with other contemporary approaches to ethics.

Also, one could say, *pace* Vetlesen, that natural law in general, even in its classical form, has played a larger role in modern political thought and in modernity than what is often acknowledged, for instance, through the political ideas underlying anti-slavery and civil-rights struggles, the Nuremberg trials after the Second World War, and the United Nations Universal Declaration of Human Rights, all of which arguably reflect a natural law approach to politics.<sup>5</sup> It is, however, the *new* natural law theory – NNL – that will make up the theoretical background of my discussion.

Like the analysis I will present, Craig Paterson's recent book-length treatment of end-of-life decisions proceeds from an *explicitly secular* NNL standpoint.<sup>6</sup> While much in Paterson's book is well-argued and plausible, I believe it must be challenged at crucial points. There have also been several papers and books on aspects of end-of-life decisions from NNL perspectives that are either presented explicitly as *tethered to Christian presuppositions and a Christian worldview*, or where one may be left wondering whether there are *implicit religious premises* at work.

In the medical realm, what have been taken as the normative prescriptions of NNL are mostly in line with traditional medical ethics, and with most of the ideals of

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<sup>3</sup> '... the, in modernity, ever more outdistanced *natural law*' (my translation). A.J. Vetlesen, *Hva er etikk* (Oslo: Universitetsforlaget, 2007), 65.

<sup>4</sup> See, for instance, John Finnis, *Natural Law and Natural Rights*, 2nd ed. (Oxford: Clarendon Press, 2011); Robert P. George, *In defense of natural law* (Oxford: Oxford University Press, 1999); Germain Grisez, "The first principle of practical reason: a commentary on the Summa Theologiae, 1-2, question 94, article 2," *Natural Law Forum* 10 (1965); Germain Grisez, Joseph M. Boyle, and John Finnis, "Practical principles, moral truth, and ultimate ends," *American Journal of Jurisprudence* 32 (1987).

<sup>5</sup> Henrik Syse, *Natural Law, Religion, and Rights* (South Bend, Indiana: St. Augustine's Press, 2007), 19.

<sup>6</sup> Craig Paterson, *Assisted suicide and euthanasia. A natural law ethics approach* (Aldershot: Ashgate, 2008).

practice with which I have become familiar in the Norwegian health care system. But there are some significant exceptions, one of which will be my entry point: the case of persistent vegetative state (PVS). This state is caused by severe brain damage, and characterized by permanent loss of consciousness and, as time progresses, ever slimmer chances of recovery. The challenge is that the NNL theory offers normative guidance in the case of PVS that runs counter to common intuitions among clinicians. Specifically, NNL theory prescribes continued provision of nutrition and hydration even in situations in which many clinicians deem such treatment as not in the patient's interest, or even as harmful or meaningless.

In reading Paterson and the other NNL theorists, I have wondered whether such a stance in the PVS case is really warranted, and whether it follows necessarily from the NNL approach. Therefore, I wish to explore whether the NNL theory is really committed to this particular, restrictive view on treatment-limiting decisions in PVS. I have found that there is some leeway in the way the moral theory is constructed, leaving room for tweaking the basic precepts of the theory, thus altering the normative guidance of the NNL theory whilst retaining (or increasing) both philosophical plausibility and the theory's consistency and coherence.<sup>7</sup> This move widens the space for prudential judgments somewhat, thus bringing the NNL theory a small step closer to the classical natural law approaches.

My hypothesis, then, which will structure the bulk of the thesis, is that NNL *can* and *should* be modified so that it conforms better to actual clinical practice and to clinicians' well-formed intuitions in the case of PVS, while at the same time increasing NNL's own philosophical plausibility and consistency. This hypothesis will be put to the test in the following way. I will examine empirical evidence about health care workers' moral intuitions about treatment-limiting decisions for PVS patients, and from this attempt to draw out *considered judgments* and *moral arguments* about the case of PVS (Chapter 3). At the outset, an argument for lending weight to clinicians' *well-formed intuitions* – a controversial move within a natural law framework – will be sketched. The intuitions perform their subsequent work mainly under the guise of the *moral arguments* that underpin the intuitions. I will

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<sup>7</sup> By *philosophical plausibility* I mean the rational appeal exerted by the body of theorems constituting the moral theory when considered as a totality. A moral theory is *consistent* when its theorems or principles do not contradict each other. *Coherence* means that the moral theory's theorems and principles together constitute a mutually explanatory system.

attempt to achieve a *reflective equilibrium* between the moral arguments and the NNL theory (Chapter 4). A reflective equilibrium is a process of moral reasoning in which the relative merits of arguments and intuitions are weighed and considered. This means that some arguments will be refuted; some moral intuitions and considered judgments will have to change, and so will certain features of NNL. The process of reflective equilibrium will explore whether NNL possesses the theoretical resources to conform to – and explain – clinicians’ strong and common intuitions in the case of PVS. If a version of the theory can achieve harmony with intuitions without losing overall philosophical plausibility and consistency, then this version ought, according to the logic of reflective equilibrium, to be preferred. At the end of this process, we will be equipped with a *more plausible* secular version of the NNL theory, a revised theory that can then be used to analyze the ethical aspects of other end-of-life decisions (Chapter 5). The upshot is a revised NNL theory with a somewhat wider space for prudential judgments.

## Moral realism and reflective equilibrium

Philosophical ethics lacks the consensus about basic premises and methodology required for a field of inquiry to be a ‘science’. The nature of ethics is greatly contested. In metaethical debates, *constructivism*, the view that moral truth is produced by some sort of rational agreement, is favoured by many. *Moral realism*, the view that moral claims can be true or false and that moral truth is part of reality, is a prime competitor of constructivism. Natural law theories are considered preeminent examples of moral realist theories, attempting to deduce the most general moral norms from self-evident first principles.

It might seem somewhat contradictory to employ *reflective equilibrium*, which is the prime method of *constructivism*, within a *morally realist* framework, as I will do in Chapters 3 and 4. The apparent contradiction is this: in a process of reflective equilibrium, moral intuitions, principles and considered judgments are tested together for coherence. No single component is immune from being modified in the process of achieving the best fit between intuitions, principles and judgments. The resulting body of moral claims is, for the constructivist, the best approximation to moral truth that we can achieve. Moral realism of the natural law kind, in contrast, starts out from *first principles*, axiomatic and basic truths about what constitutes rationality in action that

cannot be challenged within the theory, and from which the body of moral claims that constitute the theory are inferred. Constructivism's reflective equilibrium and realism's inference from first principles seem to be incompatible approaches. However, in Chapter 3 I will argue that there is a limited but significant place for reflective equilibrium in the construction of an NNL theory. Chapter 4 will be an example of this approach in practice. In my argument, reflective equilibrium is not used to evaluate the moral theory in total, as the constructivist would propose. Instead, this method is used on a limited part of the theory in order to see which version of the theory achieves the best fit with considered judgments derived from moral intuitions.

## Bioethics and high moral theory

There has been much discussion in bioethics about the proper relations to moral philosophy and the 'high moral theories' (comprehensive and thoroughly developed theories with metaphysical underpinnings) such as Kantianism, consequentialism, and natural law theory. As John Arras notes, in the field of bioethics many eschew high moral theories and instead embrace eclectic approaches to bioethical reasoning.<sup>8</sup> 'Mid-level' moral theories without metaphysical or highly abstract underpinnings, such as the principlism of Beauchamp & Childress, narrative ethics, and feminist ethics, are deemed by many the most helpful theoretical frameworks for bioethics. Antitheoretical approaches, such as moral particularism, are also favoured by some.

There are several explanations for this turn away from the classical comprehensive moral theories.<sup>9</sup> First, there is the fact of ethical and religious pluralism in our societies. In the absence of any knock-down argument to prove the superiority of one of the high moral theories or any particular religious outlook, there is no reason to expect society to converge on one particular ethical theory or worldview. Better then, perhaps, to commence bioethical discussion from vantage points that are shared and at a lower level of abstraction.

Second, there is widespread scepticism towards moral truth. If moral truth is unavailable, then the next best thing is probably a moral consensus based on

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<sup>8</sup> John Arras, "Theory and Bioethics," in *The Stanford Encyclopedia of Philosophy*, ed. E.N. Zalta (2010).

<sup>9</sup> Ibid.

deliberation – certainly not the moral imperatives deduced from abstract moral systems built of shaky foundations.

Third, liberalism as a political doctrine demands equal treatment of competing conceptions of the good. If any of the high moral theories are taken as action-guiding, they inevitably constrain the conception of the good (life) that one can hold. For instance, embracing Kantian deontology imports a Kantian notion of *autonomy as decisions in accord with the moral law*, which is incompatible with the contemporary notion of autonomy as *decisions originating from the self*.<sup>10</sup> The latter notion of autonomy is central to many contemporary visions of the good life. If we are to treat competing conceptions of the good as equally worthy of respect in our bioethics, then a bioethics based on consent – a ‘bioethics for moral strangers’ – is reasonable to pursue.<sup>11</sup>

Fourth, bioethics is carried out in very different settings. Much of bioethics is directly ‘action-guiding’ in that it is geared towards solving a problem in a clinical setting, or contributing to policy formation. In these situations bioethics is called on to provide clear guidance, and so a method of reasoning starting from shared premises of ‘common morality’ and deployment of procedures for deliberation and agreement, may seem natural. In an academic setting, however, there is much more room to explore avenues of thought that will not necessarily result in normative guidance that a majority will embrace.

Fifth, many modern-day ethicists are wary of the metaphysical underpinnings of some classical high moral theories, like the metaphysics of Kantianism, or of classical natural law.

Finally, a sixth reason related to the previous one is the nature of bioethical publication.<sup>12</sup> Much work in bioethics is published as journal papers. In order to gain a large readership, and for one’s ideas to be maximally influential, authors often gain from hiding their theoretical allegiances. If one relies on fewer declared and contestable presuppositions (e.g., an allegiance to preference utilitarianism), there are

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<sup>10</sup> Aaron E. Hinkley, “Two rival understandings of autonomy, paternalism, and bioethical principlism,” in *Bioethics critically reconsidered*, ed. H.T. Engelhardt Jr, 85-95. (Dordrecht: Springer, 2012).

<sup>11</sup> As set out – and criticized – in H.T. Engelhardt Jr, *The foundations of bioethics*, 2nd ed. (New York: Oxford University Press, 1996); *The foundations of Christian bioethics* (Salem, MA: M & M Scrivener Press, 2000).

<sup>12</sup> This was pointed out to me by Søren Holm.

fewer reasons for potential readers to disregard one's arguments from the outset as irrelevant to them.

The question then is why I have chosen to go against the trends of contemporary bioethics and work with a high moral theory, that of NNL. The main reason is quite simply that I find NNL's portrayal of practical reason and the moral life persuasive. The theory's lofty ambition is to give a true description of the principles of morality and rational deliberation. In Chapter 1, I hope to convey this picture of NNL as a rationally plausible theory, whilst not hiding the theory's weak points.

NNL is a realist theory, and it seems that a commitment to moral realism renders most of the reasons given above for eschewing high moral theory unconvincing. Plainly, the fact of pluralism does not preclude the search for moral truth. Moral realism means that there is in fact such truth to be found (discovered, not invented). And one conception of the good and of the good-for-man may prove to be superior to others: better equipped to guide us towards flourishing, more in line with basic moral norms, and so on. Further, I am not in the business of inventing politically or juridically acceptable compromises, but rather of elucidating the ethics and the moral acceptability of certain medical practices and decisions.

However, my approach in this thesis is not the classical one of 'applying' a moral theory to a field of inquiry in order to derive moral rules appropriate for this field.<sup>13</sup> The influence and the interaction between theory and practice *go both ways*, as detailed in Chapter 3. Reflection in light of high moral theory (i.e., NNL) will give reasons to change particular normative conclusions in the health care realm, but reflection on particular challenges and situations in this realm may also give an impetus to revise the moral theory.

By their very nature, high moral theories entail crucial objections to the more eclectic ethical approaches. As a case in point, consider briefly the Norwegian philosopher Knut Erik Tranøy's 'common morality' approach, which has been influential in Norwegian medical ethics.<sup>14</sup> 'The common morality is the set of values, norms and virtues – with corresponding practices – about which there is open

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<sup>13</sup> An approach frequently lauded, but rarely carried out in practice: Robert Baker and Laurence B. McCullough, "Medical ethics' appropriation of moral philosophy: the case of the sympathetic and the unsympathetic physician," *Kennedy Institute of Ethics Journal* 17 (2007).

<sup>14</sup> As set out in his book, *Det åpne sinn* (Oslo: Universitetsforlaget, 1998).

consensus in a given culture at a certain time'.<sup>15</sup> There is 'open consensus' about ethical proposition p 'between two or more persons if they agree that p is acceptable and none of them think p is unacceptable'.<sup>16</sup> And finally, a proposition being 'acceptable' implies 'that it *may, but does not need to, be accepted*'.<sup>17</sup> The concept of 'open consensus' attempts to open up a space for ethical disagreement within the wider boundaries of the 'acceptable'. (However, the notion of 'acceptability' is less than helpful, because remaining undefined and vague.) Tranøy's suggestion is that we conduct our ethical debates with reference to the set of norms belonging to 'common morality' whilst eschewing ethical theories including the 'high' theories. Another way of putting it is that the common morality approach welcomes a theory pluralism – all ethically relevant factors are welcome into the debate, regardless of which, if any, ethical theory their philosophical genealogy can be traced to.

The proponent of a high moral theory would direct two significant charges at the common morality approach and related theories. Firstly, such approaches are unable to provide deep rational justification for their ethical norms when called for. Rejecting abstract moral theories arguably at the same time involves rejecting the only theoretical frameworks in which controversial ethical propositions may be thoroughly evaluated and conflicts between propositions adjudged. The reassurance that one's conclusions follow from principles belonging to 'common morality' may for lazy ethicists become a substitute for the strenuous and difficult task of providing fundamental justification of one's line of argument. Secondly and relatedly, a common morality approach introduces a pernicious moral relativism. Ethical norms are justified in the first place not through rational argument, but simply by being held to be 'acceptable' by a majority of the public. Misleading and erroneous moral intuitions may therefore secure a place in the corpus of sanctioned 'common morality' to which they are not (rationally) entitled, and from which they, once settled, are difficult to dislodge. Common morality theories arguably inherit all the usual charges to which relativist theories are susceptible, including the charge that the approach is difficult to square with the phenomenon of *true moral reform*. For instance, may support for euthanasia now be seen as part of the Dutch 'common morality'? If so, is there any way to criticize it on principle, and effectively, from within the common

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<sup>15</sup> Ibid., 158.

<sup>16</sup> Ibid., 155.

<sup>17</sup> Ibid.



morality? One suspects that the retort, ‘Ah, but *other* (equally valid) parts of common morality *lends support* to euthanasia’, is always possible, and a perpetual standoff ensues.

High moral theories, such as NNL, may offer much more robust justification for ethical principles than the eclectic approaches are capable of. If NNL theory can be shown to be plausible, it offers the prospect of a firm grounding for basic principles of medico-ethical decision making at the end of life. If there *are* true ethical principles that can withstand the changing tides of ideology and *Zeitgeist* in a way that common morality’s principles cannot, we must find them. And we must build the foundation of our medical ethics upon them, not upon the error-prone common morality. End-of-life decision making, then, must be practiced accordingly. In this way, moral realism appears to be the foundational premise that leads naturally to preferring the high moral theory path to the common morality one.

Tranøy remarks that, in his experience, health professionals often find moral philosophy to be confusing – and the parts that are understood often appear either *obviously true* or *implausible and unacceptable*.<sup>18</sup> What need is there, then, for moral philosophy in medical ethics? The moral realist would answer that the best ethical theory is the closest approximation to ethical truth, and that this theory will and must make sense of health professionals’ strong moral intuitions. Such a theory would be of great help in explaining what makes it the case that those intuitions that are true are in fact true, and what makes it the case that the others must be discarded or altered.

## Outline of the argument

The present thesis, then, undertakes the work of examining the NNL theory afresh, with a view to establishing what normative guidance the theory will provide in the encounter with medical end-of-life decisions. Special consideration will be given to what implications follow from the theory being *secular*.

Chapter 1 will set out the basic propositions of the NNL theory, outline some important intramural debates, identify weak points in the theory, and place the theory in the current philosophical landscape of ethical theories. The main contention will be that NNL is a philosophically plausible theory of ethics, although with important

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<sup>18</sup> Ibid., 136.

weak points. The theory launches from a consideration of practical reason and its first principle, ‘good is to be done and pursued’. Five basic human goods that constitute the basic reasons for action are identified. It is argued that, in a secular version of NNL, neither pleasure/the avoidance of pain, religion, autonomy, nor marriage are basic goods. Crucially, the basic goods are incommensurable: instances of these goods cannot be compared on a common scale. However, the precise meaning of incommensurability is difficult to pin down, and the contention can be challenged. Morality is the system of second-order reasons for action that flow from the basic human goods and the first principle of practical reason. The important role played by appeals to self-evidence will be discussed, and one problem with such appeals will be highlighted: *the problem of the underdeterminacy of self-evidence* is the particular problem that arises when several competing statements can make the same claim to justification by self-evidence. The appeal to self-evidence produces ‘weak spots’ at three places in the theory.

Chapter 2 homes in on the theory’s power to generate intermediary and concrete moral norms. Special emphasis will be given to the so-called seventh requirement of practical reasonableness, which is crucial in constructing moral prohibitions (negative moral norms). The problem of the underdeterminacy of self-evidence will here demand the consideration of *four competing candidate formulations* of the seventh requirement. The chapter’s main argument will be that there are several candidates for NNL’s procedure for generating the bulk of negative moral norms – and which one is chosen makes a difference for the shape and scope of these norms. Some intuition-driven test cases for gauging the relative merit of the four competing formulations will be examined.

In Chapter 3 I will outline my methodology for ‘testing’ NNL theory against the moral intuitions of health care workers in cases of PVS. A ‘standard’ NNL view of medico-ethical decisions for PVS patients is presented. I argue that the new natural lawyers are committed to a problematic view of the ethicality of treatment-limiting decisions for PVS patients: the theory demands that the patient’s biological life always be treated as a ‘benefit’, and I argue that this leads to the view that withdrawal of life-prolonging treatment is very seldom morally acceptable. This clashes with strong, prevalent and well-formed intuitions of health care professionals, as is revealed by a review and interpretation of the empirical evidence on these intuitions

and attitudes. Considered judgments and moral arguments about PVS are drawn from these data.

Chapter 4 will showcase the encounter of the extracted moral arguments with moral arguments from other sources and considerations derived from NNL theory. A process of reflective equilibrium will be undertaken. The conclusion will be that John Finnis's version of the seventh requirement of practical reasonableness ought to be replaced by another of the four candidate versions (the 'combination version'), and that this enables NNL to explain more of the strong intuitions of health care workers in the case of PVS. The combination version, like Finnis's version, rules out intentional attacks on instances of the basic human goods, but makes an exception for instances of good that *do not contribute to the person's human fulfilment*. In typical cases of PVS, I argue, this exception applies: the patient's biological existence, while formally an instance of basic good, does not contribute to any fulfilment, as clinicians' intuitions about the meaninglessness of life in PVS attest.

The reliance on the logic of reflective equilibrium can be defended by pointing out that, due to the problem of self-evidence's underdeterminacy, there is *no principled reason* for preferring Finnis's version of the seventh requirement to other competing versions – apart from intuition-driven test cases such as that of PVS. The argument will be that the NNL theory should be revised by the replacement of Finnis's version with the 'combination version' of the seventh requirement. The revised NNL theory lends itself to two different interpretations, both of which imply that treatment withdrawal in PVS is sometimes morally acceptable.

In the fifth and final chapter, now equipped with the revised NNL theory in its two interpretations, I will apply the theory to a number of end-of-life problems, including euthanasia, physician-assisted suicide, and treatment-limiting decisions. The revised-NNL treatment of these issues will be informed by empirical evidence, and supplemented and challenged by selected arguments from the bioethical literature. The chapter closes with some reflections on central counter-arguments to my overall line of argument, and on some doubts that can be raised about the plausibility of the general NNL approach.

The thesis touches on a large number of topics, ranging from moral philosophy at a high level of abstraction to concrete empirical medical observations. This makes for a dense and lengthy read. The reader who is particularly interested in how natural law theory may shed light on the ethics of end-of-life decisions, but does

not care too much about intramural debates in the natural law camp, could perhaps make do with Chapter 1, sections 2.5 and 4.7, and Chapter 5. Some readers may feel that the overall argument could have been stated much more succinctly, and that the thesis would have profited from being a hundred pages shorter!

However, I have tried to maintain a responsible level of attention to the many possible counter-arguments to my approach throughout. Whereas some may feel that no stone has been left unturned and that such an *exhaustive approach* makes for an *exhausting read*, others may feel that the overall argument contains glaring omissions, and that important counter-arguments have not been met. In the closing section of the thesis (5.8) I address some general objections that can be made. Anyway, pointed criticism of particulars or of the general approach will be much appreciated.

# 1 New natural law theory

In this chapter, I will begin a survey of the new natural law (NNL) theory of morality. The discussion will centre on the two main concepts of *practical reason* and *basic human goods*. The second chapter will complete the treatment of the basic principles of NNL theory with a discussion of a third main concept, *the requirements of practical reason*. The writings of John Finnis will be taken as a main source, but the exposition will also draw on the contributions of other NNL theorists.

The account of NNL theory will be mainly sympathetic, in line with my contention that this theory carries at least as much philosophical merit as other current contenders (such as consequentialist, deontological, and virtue ethical theories). However, a few deviations from Finnis's version of the theory will be advanced, when such changes are called for by (1) the perceived shortcomings of Finnis's version, or (2) the requirement that the theory should be secular (in a sense to be explained shortly: 1.2). Special emphasis will be lent to what I perceive to be weak points in the theory. In my view, some of these weak points can be mended, whilst others will remain as unresolved challenges to the theory's overall plausibility.

This chapter and the next will show how NNL theory, beginning in very general considerations of practical reason, is able to generate ethical guidance. I will also sketch the place of NNL theory in the landscape of contemporary ethics, and note how alleged deficiencies in competing theories appear from an NNL vantage point.

## 1.1 The Grisez-Finnis new natural law theory

Ethics is both practical and theoretical. There are two respects in which ethics is practical: The subject matter is human action (*praxis*), and the reason for doing ethics is to prepare (oneself) for right action. As Finnis points out, if we deny either the practical or the theoretical aspect of ethics, we are led into one of two unsound kinds of reductionism: we either perceive ethical truths as theoretical, straight-forwardly deducible from truths of metaphysics or considerations of human nature; or, denying

the ‘scientific’ (knowledge-yielding) character of ethics, we see ethics as purely a domain of feelings and non-rational attitudes.<sup>1</sup> Both pitfalls must be avoided.

A natural law theory of ethics attempts to set out the principles of the natural moral law. Traditionally conceived, the natural moral law is *a law* in that it gives universally applicable standards of right action, normative standards that are in accord with reason, and thus true. It is *natural* in at least three respects: natural as opposed to *posited* by human reason, and thus normative without being sanctioned by legislators or convention; natural in that it is *objective* and *true*; and natural in the sense that following its principles will *foster and enhance human well-being and flourishing*.<sup>2</sup>

A natural law theory identifies the goods that are natural for human beings, and proceeds by identifying how the goods themselves give rise to considerations about how they ought to be pursued. The resulting framework of restrictions and opportunities is what constitutes morality, and taking it as one’s guide is the key to human flourishing.<sup>3</sup>

The ‘new natural law’ (NNL) theory worked out by John Finnis, Germain Grisez, and collaborators, is a fresh take on the natural law approach to ethics.<sup>4</sup> It is a theory of practical reason, that is, reason in its mode of devising plans for securing goods through action. Goods are *instrumental* (e.g., money) or *basic* (e.g., life, knowledge). NNL states that any intelligible action is pursued for the sake of some aspect of a basic good. The basic goods are therefore *basic purposes* or *basic reasons* for action. Together the goods constitute *human fulfilment*, and the goal of morality is to guide the pursuit of these basic goods through action, in order to realize more fully the ideal of human fulfilment. From considerations of the goods, the imperative of practical reason (‘good is to be done and pursued’), and the notion of human fulfilment, Grisez and Finnis are able to argue for general restrictions on the ways in which basic goods may be sought in action (e.g., ‘do not act directly against any basic human good’). The resulting set of restrictions, the *requirements of practical reason*,

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<sup>1</sup> John Finnis, *Fundamentals of ethics* (Washington D.C.: Georgetown University Press, 1983), 1-4.

<sup>2</sup> John Finnis, “Natural law,” in *Routledge Encyclopedia of Philosophy*, ed. E. Craig (London: Routledge, 1998).

<sup>3</sup> David S. Oderberg and Timothy D. J. Chappell, “Introduction,” in *Human values. New essays on ethics and natural law*, ed. Oderberg and Chappell (Basingstoke: Palgrave Macmillan, 2004), 1.

<sup>4</sup> The theory is set out in its most mature form in Grisez, Boyle, and Finnis, “Practical principles, moral truth, and ultimate ends.”

forbid all kinds of irrationality in our pursuit of the basic human goods (Chapter 2). The upshot is that morality requires complete rationality in action; moral conduct is practically rational conduct. The requirements of practical reason then enable the construction of concrete moral norms (e.g., murder is an act directly opposed to the good of life; thus murder is morally wrong).<sup>5</sup>

The NNL theory's beginnings date back to the work of Grisez in the mid-1960s. The theory has been developed as a critical though sympathetic revision of Thomas Aquinas' paradigmatic theory of natural law. In its mature form, NNL theory retains some features of Aquinas' thinking, but has attempted to fix what it considers to be weak points therein. The language and concepts applied have been updated to make the theory better suited for engagement with contemporary analytical ethics. The theory has gained several proponents who promote it as a serious contestant, a 'third way', in the ongoing philosophical debate between deontology and consequentialism. It is fair to say, though, that the theory is not considered a serious alternative by many contemporary philosophers. It is tempting to speculate that this lack of serious attention may partly be due to the historically strong religious affiliations of natural law theories – affiliations from which NNL is not excluded.

The following pages will explore, though, whether NNL can be philosophically plausible as a theory of – not only religious people's – practical reason and morality.

### 1.1.1 NNL and contemporary philosophical ethics

It will be instructive to attempt to place NNL in the landscape of contemporary philosophical ethics. After a more thorough exposition of NNL, we will be in a better position to further explore its relations to competing ethical theories, and so this discussion will be resumed and expanded upon at the end of the chapter.

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<sup>5</sup> In Norwegian applied ethics, it is customary to distinguish between 'morality' and 'ethics' ('moral og etikk'). Morality is the norms, ideals and customs of an individual or a group, whereas ethics is the more or less systematic reflection on one's own morality, or that of others. In English the terms are often used interchangeably to cover both these senses.

#### 1.1.1.1 *Cognitivism and moral realism*

NNL is *cognitivist* in that it takes utterances with moral content to express propositions that can be true or false. Any ethical theory that claims that at least some ethical propositions are true is a *moral realist* theory. In this respect, natural law has sometimes been considered as moral realism *par excellence*. Indeed, beginning with Plato, who asserted the existence of an unchanging moral reality, natural law theories have often been proposed not as a species of moral realist theory, but as moral realism itself, as opposed to moral scepticism. This could explain why some natural law theories were relatively silent on concrete moral guidance: the theory was introduced as the credible alternative to scepticism, and its mission completed with the refutation of this meta-ethical competitor.<sup>6</sup>

In the last century of moral philosophy, moral realism has gone from being considered outdated, to again being a real philosophical contender. Metaphysics (reasoning about the basic nature of reality) was long thought by many to be irrelevant for ethics. Then, however, the pendulum turned. In particular, and as indicated above, the Nuremberg verdicts invoked the notion of *natural or higher laws* by which human actions must be judged; the Universal Declaration of Human Rights pointed out that we have *inalienable human rights* grounded in our *shared human nature*. These concepts are metaphysical notions that are right at home in a moral realist outlook.

#### 1.1.1.2 *Consequentialism and deontology*

*Consequentialism* is the view that the consequences are all that matter when an action or a proposal for action is appraised. The correct action is the one that maximizes pre-moral good (e.g., in utilitarianism: utility). Consequentialism is thus a *teleological* theory, in that the action's goal is to secure pre-moral goods – the right is defined in terms of the good. (A *pre-moral good* is something that is considered to be good in itself, apart from considerations of morality as such. For instance, morality may denounce the eating of a sandwich because it had been stolen; yet the sandwich itself is good, pre-morally.)

A *deontological* theory, on the other hand, does not define the right in terms of the good. Rather, there is no clear and constant relation between the right action and

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<sup>6</sup> David S. Oderberg, *Moral Theory. A Non-Consequentialist Approach* (Oxford: Blackwell, 2000), 162-66.



the action that maximizes the pre-moral goods.<sup>7</sup> Rights and duties are the primary notions in these kinds of theories.

Natural law theories are an interesting mix of these approaches. In accord with consequentialism, natural law acknowledges the existence of pre-moral goods: the basic human goods that are always sought in intelligible actions. The goal of any action is to provide pre-moral good, and thus the theory is teleological. But unlike consequentialism, natural law gives no sense to the notion of maximizing goods (see 1.4.10). A moral action is one that pursues the goods in a reasonable way. Moral appraisal is conducted under three headings: 1) What is the agent's intention? 2) Is the act itself morally good or indifferent? And 3) Is the act good given the particular circumstances? An action that is deficient in any of these three respects is considered practically irrational and immoral.

In line with deontological theories, then, natural law theories deny the primacy of consequences, and affirm the existence of (absolute or *prima facie*) restrictions on what kinds of actions may be performed. But unlike deontology, natural law claims that the enterprise of ethics is founded in considerations of pre-moral good, and that the foundations of duties, rights and prohibitions are to be sought here as well, rather than in purely theoretical accounts of reason and rationality.

## 1.2 New natural law as a secular theory

There has been a concern that NNL builds upon implicitly (or even explicitly) religious premises. This concern is understandable, for several reasons: The Catholic Church as an institution advocates and defends natural law theory; most writers on NNL are Catholics; and even though NNL's main proponents present the theory as secular, it is also often laid out – by the same theorists – as either *tethered to a* Christian worldview, or as an *integral part of* such a worldview.<sup>8</sup>

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<sup>7</sup> John Rawls, *A Theory of Justice*, revised ed. (Cambridge, Mass.: Harvard University Press, 1999); Nancy Davis, "Contemporary Deontology," in *A Companion to Ethics*, ed. Peter Singer (Oxford: Blackwell, 1991), 206.

<sup>8</sup> As examples, consider first Finnis, who declares no need to 'advert to the question of God's existence or nature or will' in the construction of his theory: *Natural Law and Natural Rights*, 49. However, the final chapter of the book lays out how his theory fits eminently with a belief in God. Second, there is Grisez's three-volume work in moral theology, *The Way of the Lord Jesus*, in which the NNL theory plays a prominent part. The theory is set out in the first volume: *Christian Moral Principles* (Chicago: Franciscan Press, 1983).

However, the question remains whether NNL utilizes religious premises (i) when set out as a purportedly secular theory by its main proponents; or (ii) *necessarily*, so that a purging of the religious premises would destroy the theory, or at least turn it into a new kind of moral theory. I will not concern myself with (i)<sup>9</sup>, but instead will attempt to answer (ii) in the negative, by providing a rendition of a secular NNL theory in this and the following chapter. This is, essentially, Craig Paterson's strategy as well, in his book on euthanasia considered from a secular NNL vantage point. He there states: 'By engaging in a fresh revision of natural law ethics, I hope to be able to convince the reader that not all forms of natural law are "irredeemably religious" in nature and hence "beyond the pale" for "non-believing secularists"' <sup>10</sup>.

Why the insistence on secularity? Plainly, a theory that relies on religious premises will only be plausible to those who would assent to those premises. Thus, a secular theory will often be better suited for promoting views and arguments in a public square hostile or indifferent to religion (although it would be both undemocratic and irrational to *exclude* religious arguments from the public square). Furthermore, a philosophical theory is, *ceteris paribus*, stronger if it relies on fewer contested metaphysical presuppositions. The existence of God is such a contested presupposition.

However, even if a secular NNL were to stand firmly without religious premises, it might still be the case that the theory's appeal and strength increase even

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<sup>9</sup> An interesting study examines the purported secularity of NNL: Nicholas Bamforth and David A.J. Richards, *Patriarchal Religion, Sexuality, and Gender: A Critique of New Natural Law* (CUP, 2008). The authors' main claim is that NNL in several ways trades on religious premises and content. Their argument is strongest in the case of sexual ethics. However, their attempt to show that the core framework of Finnis's version of NNL itself is religious (pp. 125-46), is in my view unsuccessful. For instance, the authors make much of the fact that Finnis presents several theological arguments for the existence of moral absolutes in his work on this topic, *Moral Absolutes. Tradition, Revision, and Truth* (Washington, D.C.: Catholic University of America Press, 1991). However, Finnis also has a purely philosophical and secular line of argument for his view (as will be examined in the section on incommensurability). The authors' contention that the NNL proponents' arguments about abortion are religious (pp. 121-24) is also unconvincing. It is true that the NNL proponents sometimes argue for restrictive views on abortion in religious terms; however, it is also the case that they have argued for the same conclusions in purely secular terms, cf. Robert P. George and Christopher Tollefsen, *Embryo: A Defense of Human Life* (Doubleday Books, 2008). Therefore, it would be wrong to affix the label of *intrinsically religious* to the NNL proponents' arguments on abortion.

<sup>10</sup> Paterson, *Assisted Suicide and Euthanasia*, 42.

further when it is placed within a Christian framework. According to Grisez, Boyle, and Finnis, a belief in God would imply taking God to be morality's ultimate end:

[I]f one believes that unqualified goodness – goodness itself – is found in God, one will regard him as the source of the goodness of all the basic goods. In this perspective, every human fulfillment is a participation in divine goodness, and every human act is for the sake of divine goodness (...) Hence, God can be considered the ultimate end of human persons and communities.<sup>11</sup>

Next, we would do well to develop the notion of *secularity* some more. What is the religiosity that the theory should avoid? Strictly speaking, an *argument* as such cannot be religious, for the process of logical inference is the same regardless of religiosity or secularity. It is premises and conclusions, not arguments, that can be religious. Let us stipulate that a premise or conclusion is secular if it is not religious in any relevant way. It then remains to define religiosity. In an influential paper, Robert Audi defines four kinds of religiosity, of which the first two are pertinent here.<sup>12</sup> *Content religiosity* occurs when the essential content of a claim is religious, such as references to God's will or scripture or a religious authority. *Epistemic religiosity*, on the other hand, means:

[The] argument is religious not because of what it says, but, roughly speaking, because of how it must be justified. Specifically, I propose to call an argument epistemically religious provided that (a) its premises, or (b) its conclusion, or (c) both, or (d) its premises *warranting* its conclusion, cannot be known, or at least justifiably accepted, apart from reliance on religious considerations, for example scripture or revelation.<sup>13</sup>

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<sup>11</sup> "Practical Principles, Moral Truth, and Ultimate Ends," 135.

<sup>12</sup> Robert Audi, "The Place of Religious Argument in a Free and Democratic Society," *San Diego Law Review* 30 (1993). Audi's fourfold definition is given a prominent analytical role in Bamforth and Richards' *Patriarchal religion, sexuality, and gender*. However, in my view only the first two kinds of religiosity are relevant to our discussion. The other two kinds are, first, 'motivational' religiosity, in which a claim is religious if it is presented in order to 'accomplish a religious purpose' (p. 682); and 'historical' religiosity, in which the claim can be traced to an implicit premise that is religious in one of the two first senses.

<sup>13</sup> Audi, "The Place of Religious Argument in a Free and Democratic Society," 680-81.

My claim, then, is that the version of NNL theory I will present will be religious in neither of these senses. Arguably, however, a version of NNL shaped by these two conditions of secularity could still be *compatible* with a Christian worldview.

A point that seems rather obvious, but that I have not seen discussed in the context of NNL, is that even though the basic theoretical framework of a moral theory might be secular in the above senses, some of the premises extraneous to the theory that are invoked to argue for a certain normative conclusion might very well be religious. That is, we have a secular theory that might need to be supplemented with religious premises in order for us to argue for the conclusion that we would like to defend.

### 1.3 Practical reason

Central to NNL theory is the distinction between theoretical and practical reason. We have one single faculty of reason, but according to the new natural lawyers it operates in two distinct modes: theoretical and practical. Theoretical reason pursues *knowledge about reality*. It is thus concerned with matters of fact and their explanation.<sup>14</sup> We reason practically, on the other hand, when we are looking to *change reality*, to ‘bring realities into being’.<sup>15</sup> Practical and theoretical reason, therefore, have different ‘directions of fit’: when reasoning theoretically, we try to make our opinions conform to reality, while practical reason attempts to make reality conform to our will. Theoretical truth is signified by ‘is’ – for instance, we may assert that object A *is* an instance of species B. But practical truth is signified by ‘is to be’ – for instance, a certain action *is to be done*. Practical reason is concerned with deliberation about action: making plans for action, conceiving suitable goals, and deciding on the proper means to attain them. When reasoning practically, we are concerned with what reasons we have for the different alternative options for action that we have identified. Practical reasoning is carried out from a first-person perspective.<sup>16</sup>

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<sup>14</sup> Finnis, *Fundamentals of Ethics*, 2; R. Jay Wallace, “Practical Reason,” in *The Stanford Encyclopedia of Philosophy*, ed. Edward N. Zalta (2009).

<sup>15</sup> Rufus Black, “Introduction,” in *The Revival of Natural Law*, ed. Nigel Biggar and Rufus Black (Aldershot: Ashgate, 2000), 4.

<sup>16</sup> This account of practical reasoning and practical truth should be nuanced, according to Ralph McInerny. He admits grades of ‘practicability’: ‘Practical truth applies only to completely practical knowledge, the knowledge embedded in the singular act’ (“Portia’s Lament: Reflections on Practical Reason,” in *Natural Law & Moral Inquiry*, ed. Robert P.

When theoretical and practical reasoning are contrasted in this way, one sees that there must be separate sets of norms to guide their application: namely, the norms for acquisition of true beliefs for the one, and the norms for the performance of right actions for the other.<sup>17</sup>

Reason's two modes are governed by different basic rules or first principles. *The principle of non-contradiction* is fundamental to all reasoning about matters of fact. The status of this principle as a first principle and a fundamental normative rule is *self-evident*, in that anyone who comes to understand the principle and gives the matter sufficient attention will come to realize that it is true. No deductive or inductive argument can be given for its truth, yet a denial of its truth would be meaningless. Its function is to prohibit incoherence in all thought. It does not itself appear as a premise in arguments, but is an underlying requirement that must always be respected.

According to the NNL proponents, practical reason has its own self-evident first principle of the same fundamental status and importance. The principle is 'good is to be done and pursued'.<sup>18</sup> This principle establishes that the purpose of action – any meaningful action – and of practical reason itself, is to pursue good: in any of its forms, in any guise, and in any way. The function of this principle is to avoid pointlessness; in other words, to prevent practical reasoning from being irrelevant.

NNL theorists take the first principle of practical reasoning to imply that any action that we will regard as meaningful is performed for the sake of obtaining some good, or something perceived by the agent to be good. Is this assertion self-evidently true?

Even though an appeal is made to self-evidence, rational argument may still have a place in justifying the assertion. Specifically, argument may perform two tasks: First, it may explain and demonstrate how the data of human experience provides evidence that the assertion is true. Consider any action: was it performed to obtain some good, for the agent himself, for other persons, or for society's common good?

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George (Washington, DC: Georgetown University Press, 1998), 97). One may contrast the practical judgment of the theoretician with the practical knowledge in the full sense had by the one who considers performing a concrete action. If the theoretician's practical judgment is true, this truth is theoretical truth – knowledge about reality.

<sup>17</sup> Wallace, "Practical Reason."

<sup>18</sup> Grisez, Boyle, and Finnis, "Practical Principles, Moral Truth, and Ultimate Ends," 119f; this principle, however, does not originate with the NNL authors, but is inherited from Aquinas.

Consider even actions that are not *morally* good: a thief steals valuable property. The act is, we stipulate, evil – but is it done for the sake of good? Yes, it is done for the sake of obtaining a non-moral good (the valuable property). Though evil, the action certainly is not pointless; it does conform to the first principle of practical reason.

Second, rational argument may analyze and dispel counter-examples. Consider the action of drumming one's fingers on the table while distracted by daydreaming, for instance. This action does not secure any good. The reason why it is not a counter-example to our alleged principle of practical reason, though, is that the action described is not really an *action* at all, in the relevant sense. It is rather a 'doing', something engaged in sub-consciously or at least less than fully consciously. The actions of interest here, on the other hand, are those wherein the agent applies her practical reason, that is, deliberates. This distinction is sometimes presented in terms of *human action* (acts knowingly and willingly done) versus *acts of a human being* (acts we perform unknowingly and/or unwillingly, such as digesting food or circulating blood in our bodies).

The NNL philosophers' contention that every meaningful human action conforms to the first principle of practical reason is a bold claim. However, it is eminently testable. As with the proverbial black swan, only a single counter-example is needed to disprove the contention. The challenge to critics, therefore, is to come up with an example of a human action that is not done for the sake of any good, but which will yet be perceived as meaningful.

The invocation of the notion of self-evidence will seem suspect to many, and indeed, in my view, this leads to weak points in the NNL theory. At three stages in the construction of the theory, appeals are made to self-evidence, and, as will be shown, this leads to criticism that is not easily dispelled. A *general problem with self-evidence in the context of NNL* is the following: if a proposition is claimed to be justified by self-evidence, there will likely be other propositions that are similar but slightly different, and that seem to be self-evident in just the same way and to the same extent. There may or may not be any further reason for singling out any of the competing formulations as the most plausible or singularly correct one. This becomes a problem especially when the alternative propositions lead to substantial changes in the theory that are, ultimately, reflected in the theory's normative guidance when

applied to concrete moral dilemmas. I shall term this problem *the problem of self-evidence's underdeterminacy*.<sup>19</sup>

This problem rears its head for the first time in the present discussion of the first principle of practical reason. Further discussion of the problem will be deferred until the concept of basic human goods has been introduced; there the problem will make its second appearance, and there the two first instances of the problem will be discussed in full.

## 1.4 Basic human goods

These considerations of practical reason and the ubiquitous pursuit of the good should lead one to ask what the good consists in. How can the good be characterized? According to NNL, instead of *a* good we must speak of many kinds of good. And some goods are more fundamental than others – *the basic human goods* – in that they provide ultimate reasons for acting.

### 1.4.1 Basic and instrumental reasons for action

An NNL inquiry into the nature of human goods can start by asking, of any particular action, ‘Why?’. E.g., ‘Why are you reading that book?’ ‘Because I want to freshen up my knowledge of astronomy’. The acquisition of knowledge is here offered as the reason for performing the action. If one asks again, ‘Why do you want that?’, the answer may well be, ‘I just take an interest in astronomy’. In that case one has got no further. Knowledge seems to be the *basic reason* for this person’s reading the book on astronomy.

On the other hand, she might instead answer ‘I need to read this book to prepare myself for the science classes I am to teach next week’. ‘Why?’ ‘Well, obviously, in order to be able to give good lectures on the subject’. If I repeat my question, ‘Why?’, the teacher might very well lose her patience with me. It seems that we have reached a point where asking ‘why’ does not make much sense. And the reason is that the teacher has already given us another basic reason for action –

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<sup>19</sup> There is another meaning of ‘underdeterminacy’ with which my intended meaning must not be confused. This is the underdeterminacy of the application of a norm to a practical dilemma. A general norm may be (and typically is) so general that its precise application to a concrete case is underdetermined, requiring further deliberation, premises, and prudence.

*performing one's work well* – which there is normally no need to analyze or justify further. In addition to the identification of another basic reason for action, there is one more thing to be learnt from this example. Note the different role played by knowledge in this second example compared with the first. In the first example, knowledge was the basic reason justifying the action. When this was made apparent, the quest for further underlying reasons ceased to be worthwhile. In the second example, the reason for acquiring knowledge allowed further questioning. This time, knowledge was not a basic reason, but an *instrumental* reason for action. So reasons that sometimes figure as basic reasons may at other times be merely instrumental.

On the other hand, there are innumerable goods that cannot in themselves justify the action, and thus are not 'basic'. These goods are instrumental. Money is never a good in itself, but always only a means to pursue further ends (as Aristotle and Aquinas insisted).<sup>20</sup> While acting for the sake of earning money usually seems like a perfectly rational thing to do, this is, natural law would argue, because money typically can be converted into instances of basic goods. An amply supplied bank account can also in itself provide a measure of safety, which is a basic good (often subsumed under the heading of 'life and health'). However, acting *merely for the sake of money* is irrational. Consider the miser who exalts money to the status of a supreme good. His wealth-promoting actions remain intelligible if they are performed with a view to eventually spending the money on some further good (a basic good or a good that may be instrumental to securing a basic good). To the extent that the miser truly acts with no further end than the money itself, I think one could say that his actions not only are irrational, but in a way cease to be intelligible. We would pity such a man and find his actions morally deplorable, but that is not all: we would also be inclined to say that something has gone awry with this man's practical reasoning. His condition is not merely pitiable, it is pathological.

Morally bad actions are also carried out for the sake of some good, and in the final analysis for one or more basic goods. Consider the thief who steals silverware. Why does she do this? To sell it for money. And money, again, is an instrumental good that may be used to secure basic goods. Another example could be a spy who breaks into a foreign country's computer network in order to get hold of information of military value; in other words, to secure *knowledge*.

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<sup>20</sup> Aristotle, *Nicomachean Ethics*, I, 5; Thomas Aquinas, *Summa Theologica*, I-II, q. 2, a. 1.



Are there really no actions that are not ultimately done for the sake of basic goods? Consider Anscombe's case of the man who wanted a saucer of mud.<sup>21</sup> Suppose that he went on to act to acquire such an object. Asked what he wanted it *for*, he replied, nothing – he just wanted it (i.e., for its own sake). His wish and his acquisition are truly unintelligible, because we cannot conceive of any goodness, basic or instrumental, that would make them intelligible to us. So there may well be human actions that do not secure basic or instrumental goods, but these actions do not conform to practical reason's imperative to pursue good, and so stand out to us as unintelligible.

The NNL theorist's contention is that any intelligible action may be analyzed in the fashion illustrated above, and that all such analyses, when carried out to their ends, will point towards one or more of the basic human goods. As all intelligible actions are done *for* basic goods, all and only basic human goods are *ultimate reasons for actions*. In other words, each of the basic human goods *specify* the general formula of the first principle of practical reason. The principle demands that good is to be pursued, and the principle is specified by each good into *practical principles*, or *primary precepts of natural law*.

#### 1.4.2 The catalogue of basic human goods

The basic goods provide ultimate reasons for any intelligible action. In my view, a secular natural law theory should recognize five basic goods: life and health, knowledge, excellence in work and play, friendship, and practical reasonableness. The claim is that any intelligible action, morally good or bad, is ultimately performed for the sake of aspects of one or more of these five goods. Correspondingly, all ultimate and intelligible purposes for action must, if the theory is correct, allow analysis in terms of the five basic goods; that is, the ultimate purposes must all turn out to be aspects of one or more of the basic goods.

The lists of basic goods given by different NNL philosophers are all fairly similar. Finnis, in his 1980 'Natural Law and Natural Rights', lists life, knowledge, play, aesthetic experience, sociability, practical reasonableness, and religion.<sup>22</sup> He later came to hold that aesthetic appreciation is a subspecies of knowledge, whereas

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<sup>21</sup> G.E.M. Anscombe, *Intention* (Cambridge, Mass.: Harvard University Press, 2000), 70-71.

<sup>22</sup> Finnis, *Natural Law and Natural Rights*, 86-90.

artistic creation could be classified within skilful performance (excellence) in work and play. In addition, a new good, marriage, was included in subsequent lists.<sup>23</sup> I will discuss the significance of this ‘discovery’ below.

David Oderberg lists life, knowledge, friendship, work and play, the appreciation of beauty, and religious belief and practice.<sup>24</sup> Timothy Chappell gives a slightly different list (life, truth and the knowledge of truth, friendship, aesthetic value, physical and mental health and harmony, pleasure and the avoidance of pain, reason, rationality and reasonableness, the natural world, people, fairness, achievements, and the contemplation of God (if God exists)).<sup>25</sup> Grisez, Finnis and Boyle end up with a different-looking but fundamentally similar list when they structure their list by the distinction between substantive and reflexive goods.<sup>26</sup> The three substantive goods are the ones whose instantiations do not themselves involve choices. They are life, health and safety; knowledge and aesthetic experience; and excellence in work and play. The four reflexive goods are different kinds of harmony. They include in their instantiations the choices by which they are produced, in that the kinds of harmony are partly constituted by the harmony-producing acts themselves: harmony between individuals and groups of persons; harmony between feelings and judgments and choices (‘inner peace’); harmony between judgments, choices and actions carried out; and peace with God or some other ‘source of meaning and value’.

Compiling lists of basic goods is a pastime that is not exclusive to philosophers in the natural law tradition. Examining the endeavours of philosophers from other traditions can shed some light on the NNL project. Martha Nussbaum, for instance, attempts to describe ‘truly human functioning’ through a list of ‘central human functional capabilities’ that does not presuppose ‘any particular metaphysical view of the world, any particular comprehensive ethical or religious view, or even any particular view of the person or of human nature’.<sup>27</sup> Entries include life, bodily health, bodily integrity; senses, imagination, and thought; emotion, practical reason,

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<sup>23</sup> Ibid., 448.

<sup>24</sup> Oderberg, *Moral Theory*, 34-45. Oderberg’s version of natural law theory, however, more closely approaches the classical versions.

<sup>25</sup> Timothy D.J. Chappell, *Understanding Human Goods: A Theory of Ethics* (Edinburgh: Edinburgh University Press, 1998), ch. 2. Chappell has since repudiated NNL theory, and indeed every normative ethical theory. Instead, he favours what he calls ‘moral outlooks’: *Ethics and Experience. Life Beyond Moral Theory* (Durham: Acumen, 2009), see esp. ch. 11.

<sup>26</sup> Grisez, Boyle, and Finnis, “Practical Principles, Moral Truth, and Ultimate Ends,” 107-8.

<sup>27</sup> Martha C. Nussbaum, *Women and human development: The capabilities approach* (CUP, 2001), 76-80.

affiliation, other species, play, and control over one's environment (with each gloss beginning with 'being able to...'). However, as Finnis objects,

Her conceptions of flourishing give the list an evaluative quality that in many instances removes it from the level of first principles to the level of an already at least partly moralized set of conclusions from them – and moralized, in some instances, quite questionably.<sup>28</sup>

As a case in point, consider 'having opportunities for sexual satisfaction and for choice in matters of reproduction', given by Nussbaum as part of the explication of the capability of 'bodily integrity'.<sup>29</sup> In constructing the natural law framework, Finnis and collaborators have taken care to not import *moral premises* at the *pre-moral stage*; that is, when detailing the basic goods to which our practical reason responds. Nussbaum's capabilities, on the other hand, in some cases appear to be *already normative*.

The scope of my project does not necessitate a full account of the contents of the basic goods. However, two goods will play a particularly important role when I am later to argue towards ethical conclusions: life and health, and practical reasonableness. The former will be discussed extensively in Chapter 4, the latter will appear later in the present chapter (1.4.5).

### 1.4.3 Happiness and the basic goods

The question naturally arises how one should characterize the relationship between the basic goods. Are they all aspects of a more general kind of good? That is, are they reducible to a single underlying good? They are not. The goods resist *reduction*, but they are all *constituents* of happiness or human flourishing.

This is not meant to be a substantive claim in need of vindication by philosophical argument. Rather, it is a conceptual claim: participation in the basic goods to a sufficient degree is what is meant by 'happiness'. Or, more precisely, it corresponds to the old Greek term *eudaimonia*, which is an imperfect synonym for 'happiness'. In order to pin down the meaning of *eudaimonia*, the notions of *human*

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<sup>28</sup> John Finnis, Introduction to *Reason in Action*, Collected essays Vol. I. (Oxford: Oxford University Press, 2011), 11.

<sup>29</sup> Nussbaum, *Women and human development*, 78.

*fulfilment* and *flourishing* are often invoked. The basic goods are all options for human fulfilment. They are ‘opportunities of being all that one can be’.<sup>30</sup> Strengthening one’s health through exercise, coming to learn a new skill or theoretical subject, experiencing a virtuosic artistic performance, spending time with friends – all these activities are fulfilling for human beings. Indeed, ‘The basic human goods define the possibilities that a human being can pursue through choice. Human fulfilment comes as a person pursues those possibilities’.<sup>31</sup> A person who experiences fulfilment in these diverse ways is said to be flourishing. She is *eudaimon*.

Happiness is not an *underlying good* to which the basic goods can be *reduced*. Rather, the basic goods together *constitute* and *define* human fulfilment, *eudaimonia*. This insight allows us to make a further point: the basic goods are *reasons for action* because they are aspects of our fulfilment. This is why the goods have such fundamental rational appeal. Practical reason grasps that basic goods fulfil us and are rationally desirable. In this way, the basic goods constitute reasons for action.<sup>32</sup> This is also why no further questioning is intelligible when our reiterative ‘why’-question has received a basic good as its answer: we have reached the bedrock of rational motivation. A basic good is also a basic reason for action, and, it is claimed, further reasons are neither needed nor available.

Is the list of basic human goods unduly biased in the direction of the Western way of life? Would philosophers from other cultures construct radically different lists? Finnis dismisses this concern.<sup>33</sup> Anthropological research, he says, does not justify the claim that people of any non-Western culture have faculties of practical reason that function wholly differently and acknowledge different sets of goods from their Western counterparts. On the contrary, all cultures value life and health in that they act to preserve their own lives; all value friendship; all ensure that valuable knowledge is imparted to their young; and so on. Surely there is considerable moral and cultural diversity, but the claim is that this diversity in specific moral principles and practices is not found at the higher level of generality with which we are now

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<sup>30</sup> Finnis, *Fundamentals of Ethics*, 124.

<sup>31</sup> Black, “Introduction,” 9.

<sup>32</sup> Grisez, Boyle, and Finnis, “Practical Principles, Moral Truth, and Ultimate Ends,” 114.

<sup>33</sup> Finnis, *Natural Law and Natural Rights*, 83.

concerned: practical reason's basic reasons for action. The basic reasons are, arguably, universal.<sup>34</sup>

#### 1.4.4 Constructing the list of basic goods

A number of critical questions should be asked of the procedure for constructing the list of basic human goods. A certain simple philosophical experiment, that is, reiteration of the question *why* a given intelligible action was done until further questioning became unintelligible, has seemed to be an effective method for identifying the goods. Then, an additional assertion was made: the goods are what make actions rationally appealing. That is, practical reason constructs proposals for action that offer the desirable prospect of attaining a certain instance of basic good. The basic goods function as practical rationality's *motivating reasons* for any action. That is why Grisez et al. call the basic goods 'first principles of practical reasoning',<sup>35</sup> for one or more of these must be present as a premise in any instance of practical reasoning.

How does one justify the claim that for any basic good, this good *is* in fact a basic good and a first principle for one's faculty of practical reason? Being principles of *practical* reason, they cannot be conclusions from theoretical reasoning. And being *first* principles, in the manner of the law of non-contradiction, there are no logically prior truths from which to deduce them with the aid of a middle term. Rather, according to NNL, the basic goods are *self-evident*. A proposition, like 'knowledge is a basic good', is self-evident if you are justified in believing it just by understanding the proposition and attentively considering it.<sup>36</sup> What place is there then for argument and appeals to experience, like when one asserts that universal human experience testifies to the status of just these goods as basic goods and basic reasons for action? Arguments and appeals to experience are useful in helping a reader understand just what is meant by the proposition that certain goods are basic, thus aiding the reader in

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<sup>34</sup> Some cultures place far less emphasis on *individual* flourishing than do the Western cultures. However, taking the family's or clan's flourishing to be the main measure of success still implies acting for the sake of basic human goods; one's actions may instantiate basic human goods in one's own life, or in another's.

<sup>35</sup> Grisez, Boyle, and Finnis, "Practical Principles, Moral Truth, and Ultimate Ends," 105f.

<sup>36</sup> Russ Shafer-Landau, *Moral Realism. A Defence* (Oxford: Clarendon Press, 2003), 247.

making a proposition that is in fact self-evident *in itself*, self-evident for her also.<sup>37</sup> Argument is also useful in showing that there are no valid counter-examples.

In the same vein, as the basic goods are first recognized as such in the practical, not in the theoretical perspective, the device that follows is of use in defending the status of the goods.<sup>38</sup> Ask yourself hypothetical questions of the form, ‘Imagine that you would have access to all the necessities of life, but lacked friendship and other genuine human companionship; would you settle for this?’ You would answer ‘No’, and you would also do so, the claim goes, if the good of friendship were substituted for any of the other basic goods, and suitable alterations to the question made. Such a class of hypothetical questions is posed not to theoretical but to practical reason. For if the questions were not hypothetical, but actual, practical questions, requiring actual deliberation and choice, they would work the same way. This thought-experiment corroborates the claim that the basic goods constitute human flourishing. For, again, would we not say that a life as sketched in these questions is seriously deficient, that assent to such a question would describe a life short of flourishing, short of *eudaimonia*?

How can the basic goods be self-evident when different philosophers’ lists of goods differ? First of all, the lists that natural law theorists offer are not all that different from each other. Second, the insight that a certain good is a basic human good is not offered ready-made to our theoretical reason. Instead, *particular instances* of *components* of basic goods are what are offered to our practical reason as ‘to-be-pursued’. Thus the work of constructing a coherent list is not straight-forward. Third, the borders between goods are somewhat arbitrary. Thus, on one list, certain aspects of play may be subsumed under the heading of ‘friendship’, or aspects of practical reasonableness under different kinds of ‘harmony’, for instance. Such differences can hide an underlying substantial agreement. Fourth, rational argument can attempt to show that some items on some lists do not really belong to the basic goods category.

Oderberg has proposed two criteria for inclusion on the list.<sup>39</sup> The first is that the good to be listed is to have maximum *generality*. The more general good is also

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<sup>37</sup> ‘A thing can be self-evident in either of two ways: on the one hand, self-evident in itself, though not to us; on the other, self-evident in itself, and to us.’ Aquinas, “Summa Theologica,” I, q. 2, a. 1.

<sup>38</sup> As used in Finnis, *Fundamentals of Ethics*, 16-17, building on Henry Veatch.

<sup>39</sup> David S. Oderberg, “The Structure and Content of the Good,” in *Human Values*, ed. Oderberg and Chappell (Basingstoke: Palgrave, 2004), 140-41.

the more basic one. Why are ‘marriage’ or ‘family’ not basic human goods?<sup>40</sup> Because they may plausibly be said to be species of a more general genus: friendship or sociability. As Oderberg points out, the species-genus relation is also *explanatory*. The goodness of a particular instance of good is explained by the general good under which it is subsumed. Why is performing a twice-yearly checkup of one’s fire alarm a meaningful activity? This act is done for the sake of *safety*, which again is meaningful because it promotes and is part of the good of *life and health*.

The second criterion, according to Oderberg, is whether the good in question corresponds to the activity of a *single human faculty*, ‘whether there is an active power or faculty the proper operation of which fulfils human nature’.<sup>41</sup> This criterion presupposes a notion of ‘human nature as normative’ not available to NNL theorists. Oderberg, on the other hand, as a natural law theorist in the more classical vein, rejects the ‘fact-value distinction’ (see 1.7.6). His criterion enables him to criticize several of the items on Chappell’s list. Thus he goes on to argue that, for instance, ‘truth’ cannot be a basic good; *knowledge* of truth, on the other hand, is. ‘The natural world’ is not a basic good, as it is external to human faculties. It is only an instrumental good. And ‘respect for human beings’ is not a good; rather, it is a duty that originates from another basic good, life.

Oderberg’s second criterion is valuable for our purposes as well. The idea of the goods corresponding to human faculties may also be vindicated in an NNL approach, although not by invoking the normativity of human nature directly. As Grisez et al. write,

The diversity of the basic goods is neither a mere contingent fact about human psychology nor an accident of history. Rather, being aspects of the fulfillment of persons, these goods correspond to the inherent complexities of human nature, as it is manifested both in individuals and in various forms of community.<sup>42</sup>

Viewed this way, it is not surprising that the goods should each correspond to a human capacity. For the goods are aspects of human fulfilment, and what other way

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<sup>40</sup> Suggested as such in, e.g., Germain Grisez, *Living a Christian Life* (Franciscan Press, 1993), 555-69, and Alfonso Gómez-Lobo, *Morality and the Human Goods* (Washington, DC: Georgetown University Press, 2002), 13-14.

<sup>41</sup> Oderberg, “The Structure and Content of the Good,” 140.

<sup>42</sup> Grisez, Boyle, and Finnis, “Practical Principles, Moral Truth, and Ultimate Ends,” 107.

should human fulfilment come about than by skilled activity of the human faculties? Our theoretical reason is fulfilled by the process of learning, our capacity for *poiesis* (production) by excellence in work, our ability for *praxis* (conduct, action) by practical reasonableness, and our social skills by friendship in its diverse forms.

#### 1.4.5 Practical reasonableness is a basic good

Practical reasonableness is both a virtue and a basic human good. Agents participate in the good of practical reasonableness when they correctly and efficiently deliberate about means and ends, thus choosing actions, projects, commitments, and lifestyles, and constituting their character. When emphasizing its role as a virtue, one may define practical reasonableness as excellence in deliberation and choice.<sup>43</sup>

All>NNL proponents agree that practical reasonableness is a basic human good and an aspect of human fulfilment. However, (the classical natural law theorist) Oderberg disputes its status as a basic human good. Instead, he says, practical reasonableness is only a virtue, although a highly important one. He suggests that it is its ubiquity in the life of action that leads some to regard it as itself a basic motive for action.<sup>44</sup> As a virtue, practical reasonableness is instrumental to the pursuit of the goods. The virtues are prerequisites for seeking the goods, but they are not themselves ultimate motives for action. Rather, ‘Virtues are *what agents have* when they pursue the goods’.<sup>45</sup>

I disagree with Oderberg’s view for three reasons. First, practical reasonableness can, like the other goods, be seen to be an aspect of human flourishing, *eudaimonia*. An excellent moral character and harmony between judgments, choices and actions are ingredients of the fulfilled life. Second, Oderberg’s own methodology for putting together the list of basic goods gives cause to reconsider whether practical reasonableness may not be a basic good. Finally, a closer look at the place of practical reasonableness in the moral life should also cause us to reconsider. The two latter reasons are examined below.

Recall that a certain good may be a basic human good if it corresponds to the activity of a single human faculty. Practical reason is a conceptually distinct human

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<sup>43</sup> Grisez, Boyle, and Finnis, “Practical Principles, Moral Truth, and Ultimate Ends,” 108; Finnis, *Natural Law and Natural Rights*, 88.

<sup>44</sup> Oderberg, “The Structure and Content of the Good,” 137-40.

<sup>45</sup> *Ibid.*, 138.



faculty, our power of reason operating in practical, action-oriented mode. Thus, if the operations of virtuous practical reason are seen to yield unique goods that are good intrinsically and not merely instrumentally, then practical reasonableness is itself a basic good.

Some actions are chosen *for the sake of practical reasonableness*. Consider someone's desire for justice. This desire can motivate action. Indeed, the agent may choose the just action even when he has a motive to choose unjustly. The unjust action may offer some instance of a basic good. That the agent in spite of this chooses the just action is testimony to his *rational insight that justice is intrinsically good*. Here, justice, a sub-species of practical reasonableness, is a basic reason for action.<sup>46</sup>

Morally good choices perfect the agent not just through participation in the goods that the choices yield. By making a morally good (practically reasonable) choice, the agent participates in the good of practical reasonableness. The goods obtained are character, peace of conscience and harmony among judgments, choices and actions.

Because human beings have free will, human actions have, in Finnis's terms, both *transitive* and *intransitive* effects.<sup>47</sup> The transitive effects are the instances of goods that result. The intransitive effects are the effects of the action on one's character. For instance, by choosing compassionate actions, I constitute myself as a person who does compassionate actions. Actions shape my identity and character. Because humans act for reasons, and because reasons are in their nature not personal but universal, a certain action commits me to the reasons (the 'maxims', in Kant's parlance) from which I acted. This means that I am predisposed to act in the same way the next time I am confronted with a choice in relevantly similar circumstances. My previous actions have a grip on me as an agent. To choose in discord with my previous choices, I must, in a way, *repent* of the past action.<sup>48</sup> This means that my choices of actions, projects and commitments constitute me as the person I am today.<sup>49</sup> This line of thinking shows the importance of practical reasonableness.

We usually, though, choose for the sake of the *other* goods, not for the sake of successful self-constitution, for virtue or for moral principles. What motivates our

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<sup>46</sup> Robert P. George, *Making Men Moral* (Oxford: Clarendon Press, 1993), 179.

<sup>47</sup> Finnis, *Fundamentals of Ethics*, 137-44.

<sup>48</sup> *Ibid.*, 139-40.

<sup>49</sup> *Ibid.*, 141.

actions is the prospect of cultivating goods in our own life or in the lives of others. I may realize that my good action is both in accordance with moral principles, and able to preserve or strengthen my moral character – but these reflections usually do not contribute to my motivation. Along with every choice for a certain good, however, there comes a choice for or against (the basic good of) practical reasonableness, as Finnis explains:

[E]ach serious and deliberate choice, made with awareness of what is being chosen, and directly affecting a basic human good, is itself a fundamental option for or against practical reasonableness or, if you prefer, against virtue. It is fundamental because it makes a change in the self by which all future choices will be made, whether reasonably (virtuously) or unreasonably (wrongly).<sup>50</sup>

In order to guide deliberation and action, practical reasonableness must be specified into principles or ‘requirements’. The requirements of practical rationality and the moral norms they create are the main topic of Chapter 2.

#### 1.4.6 Pleasure and the avoidance of pain are not basic goods

As seen above, Chappell included ‘pleasure and the avoidance of pain’ on his list of basic goods. The position taken on Chappell’s suggestion will influence the treatment of particular ethical questions later on, and so this question is important. How so? For instance, if ‘avoidance of pain’ is a basic human good and a basic reason for action, then, arguably, carrying out euthanasia for the sake of avoiding pain could be morally appropriate in certain circumstances; the damage to the basic good of life could perhaps be accepted as an unintended side-effect (see 5.1 for the full discussion of euthanasia).<sup>51</sup>

‘Pleasure’ is an ambiguous term. Chappell points out that the senses of pleasure that are appropriate candidates for inclusion on the list of goods are, first, ‘purely physiological sensation[s]’, and second, ‘something close to ‘delight’ or

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<sup>50</sup> Ibid., 144.

<sup>51</sup> However, because the damage to the good of life (i.e., the euthanasia) would be the means by which pain was avoided, the proposal would, arguably, fall afoul of the principle of double effect’s injunction to not intend evil so that good may come (see 2.5).

‘happiness’ ... pleasure can be either a mood or an emotion’.<sup>52</sup> To show that pleasure and avoidance of pain are able to figure as ultimate explanations of action, and thus basic reasons for action, he gives several examples. Here, the following two will be discussed: first, a sequence of actions involving walking into a shop, then out again without making a purchase, is done just for the pleasure of the delightful smell of coffee inside the shop; and second, taking an aspirin may be done just to avoid the pain of headache.<sup>53</sup>

There is no doubt that intuition is, initially, firmly on Chappell’s side here. Indeed, he goes so far as to claim, ‘No one except a philosopher could deny that the prospect of pleasure is, in the absence of special circumstances, something that gives us a prima-facie reason to act’.<sup>54</sup> The actions in the examples seem to be well explained by the motives of *pursuit of pleasure* and *avoidance of pain*, respectively. It is intelligible that the actions were done for no further reason. But the initial judgment that pleasure and the absence of pain are basic goods and basic reasons for action can be challenged by five arguments to the contrary.

First, there is what I will term ‘the reduction argument’. Different kinds of pleasure very often accompany our participation in the basic goods.<sup>55</sup> Watching or participating in well-played sports brings pleasurable feelings. So does being in the company of friends and thereby participating in the good of friendship. These pleasures are not sought *for their own sake*; rather, the participation in the goods is the true purpose of the action, and the pleasurable feelings merely *a welcome accompanying effect*. That these activities regularly provide their own characteristic kind of pleasure is, says Rufus Black, an integral ‘aspect of their reality as human goods, which are not participated in fully unless their goodness is experienced as such’.<sup>56</sup>

Still other instances of pleasure can be subsumed under other basic goods:<sup>57</sup> some pleasures can plausibly be said to be sought for the good of harmony (physical or mental), itself a species of the good of life and (physical and mental) health. Other pleasurable activities, like wine tasting, are done to increase phenomenal knowledge.

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<sup>52</sup> Chappell, *Understanding Human Goods*, 7-8.

<sup>53</sup> *Ibid.*, 38.

<sup>54</sup> *Ibid.*, 36.

<sup>55</sup> Black, “Introduction,” 11.

<sup>56</sup> Finnis, *Natural Law and Natural Rights*, 96.

<sup>57</sup> Oderberg, “The Structure and Content of the Good,” 131.

Both of these explanations may be relevant in Chappell's 'coffee-smelling' case. In this way, the relevant acts may plausibly be said to have been done not only for pleasure, but for (a) further reason(s). We see that the strategy of the reduction argument is to reduce all instances of pursuit of pleasure to aspects of basic human goods. If this is successful, pleasures are not basic goods in their own right.

As far as avoidance of pain is concerned, the strategy is similar. The action of taking aspirin to relieve pain may be said to have been done for the sake of physical and mental functioning, a part of the good of life and health; or, because pain is an obstacle to mental focus and physical effort, it could be said that the medication is taken to remove an obstacle to the pursuit of any of the basic goods.

Second, several of the NNL authors deploy Robert Nozick's philosophical thought-experiment 'the experience machine' to show that seeking pleasure in itself, for no further reason, is unreasonable.<sup>58</sup> Imagine that a machine has been constructed that taps directly into your brain to give you the pleasures normally accompanying delightful activities and personal and professional successes. You are offered a lifetime of such pleasures if you plug into the machine. Your actual self, though, will not perform any of those successful activities. Our intuition, Nozick says, is that we would not hesitate to turn the offer down. That verdict is supposed to show that we do not desire pleasures for their own sake; we want to perform certain actions and be certain kinds of persons, not just have the experience of performing or being them.

I agree that we have a strong intuition not to plug into the machine – but does this show that pleasure is not a basic reason for action? Life inside the machine consists in pursuing pleasure only, and none of the basic goods. The reason why, I surmise, we would reject the offer of being plugged into the machine is not that the pleasurable experiences are unintelligible as reasons for action, but that we would reject a way of life in which *no other* basic good is pursued. So the thought-experiment shows that a life in which pleasure is *the only* good sought is to be rejected. However, it fails to establish that pleasure may not be *a* basic good amongst others.

A third argument, advanced by Oderberg, is that no basic good has instances that are in themselves bad, but certain pleasures may be intrinsically bad, and

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<sup>58</sup> Grisez, *Christian Moral Principles*, 121; Finnis, *Natural Law and Natural Rights*, 95-97. The thought experiment is originally described in Robert Nozick, *Anarchy, State, and Utopia* (New York: Basic Books, 1974), 42-45.

therefore pleasure cannot be a basic good.<sup>59</sup> For instance, some kinds of knowledge may be used for bad purposes, but the knowledge itself is neutral or good. However, ‘taking pleasure in the sight of an animal’s being tortured is bad *because of its very content*, because of the nature of the activity in which pleasure is taken. Hence pleasure cannot be a good in itself’.<sup>60</sup>

Fourth, there is the ‘human faculty argument’. Oderberg’s second methodological principle for constructing the list of goods was that a basic good must be the outcome of the proper functioning of a human faculty. Pleasure and the avoidance of pain do not fit this pattern.<sup>61</sup> Pleasure as such is not the result of proper functioning, and pain as such is not the result of malfunction – indeed, that certain stimuli should elicit painful responses is vital for bodily life.

Finally, when my list of basic human goods was completed, it was noted that the goods all were constituents of human fulfilment or happiness. Pleasure and the avoidance of pain arguably do not fulfil human nature, and therefore do not seem to be basic goods. Patrick Lee and Robert P. George argue that pursuing pleasure ‘as isolated from genuine fulfillment ... always involves to a certain extent a retreat from reality into fantasy. Preferring mere experience to what is genuinely fulfilling is an escapism ... a disordered pleasure’.<sup>62</sup> In my view, Lee and George will have a hard time convincing that Chappell’s coffee shop case exemplifies ‘disordered pleasure’. However, the suggestion becomes more plausible if one imagines that the pursuit of such pleasures came to occupy a sizeable proportion of the agent’s time and attention. Then it may rightly be said to involve preferring mere appearances to the genuine goods. If this goes far enough it will have become a disordered pleasure.

However, the present argument seems to fail because begging the question: one cannot demand of any putative basic good that it fulfils human nature as long as it is not established independently that all basic human goods must fulfil human nature.

To summarize, three of the arguments discussed (the reduction argument, the argument from intrinsically bad pleasures and useful pains, and the human faculty argument) provide justification for resisting Chappell’s inclusion of pleasure and the avoidance of pain on the list of basic goods. I believe the reduction argument is

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<sup>59</sup> Oderberg, “The Structure and Content of the Good,” 131.

<sup>60</sup> Ibid.

<sup>61</sup> Ibid.

<sup>62</sup> Patrick Lee and Robert P. George, *Body-Self Dualism in Contemporary Ethics and Politics* (New York: Cambridge University Press, 2008), 112.

successful in the case of pleasures, as they can all be reduced to aspects of basic goods. In the case of avoidance of pain I am not fully convinced. Arguably there is a strong intuition that avoiding pain often suffices for the rational justification of an action. Avoidance of pain is a common motive for action. A nurse administers morphine to a patient in severe pain. What is the deepest justification of this action? Is it to remove an obstacle to the patient's pursuit of basic goods? Or is it, rather, *to remove the pain*? It seems strained to say that all actions done to avoid pain are *really* done to preserve health and other faculties, so that the pursuit of other goods may continue. However, it may be argued that acting for the removal of pain will only make sense against a backdrop of normal functioning and participation in the basic goods. And again, though the absence of pain is a motive for action, an *absence, something that is not there*, is hardly a likely candidate for a basic human good and a component of human flourishing.

In sum, there are good reasons for rejecting the claim that pleasure and the absence of pain are basic human goods, but an unresolved puzzle remains: *removing pain* seems to be a sufficient action-explanation; that is, a basic reason for action.

#### 1.4.7 Is religion a basic human good?

Writers on natural law usually include the good of religion on their lists of basic goods.<sup>63</sup> Let Oderberg explain what this good consists in:

[R]eligious belief and practice are an integral part of the happy life. Religion is as old as humanity itself and has been practised by the overwhelming number of people in all places and at all times (...) Moreover, many who would call themselves atheists nevertheless readily testify to an appreciation of some sublime principle of the cosmos that surpasses understanding, but is real, and dwells behind everything that happens (...) It would be wrong simply to class this sort of apprehension as aesthetic, though an appreciation of the beauty of nature overlaps it. It is, then, reasonable to regard such an experience as truly spiritual or religious, and the practice that follows from it as distinctive, as rooted in all cultures at all times, and as thereby reflecting an innate and special tendency of the human being. And when this religious tendency is taken together with man's quest for truth mentioned earlier, we can see that what

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<sup>63</sup> Craig Paterson is an exception; see *Assisted Suicide and Euthanasia*, 69, n. 32 and n. 41.

perfects human nature is not mere religious belief and practice of one sort or another, but only *true* belief and the practice which best expresses it.<sup>64</sup>

The basic good of religion, then, consists in true belief and appropriate practices. The case for considering religion as a basic good may be strengthened further if one concedes that mankind has a distinct spiritual faculty, a distinct ability to communicate with God. To this faculty there should correspond, by way of the second methodological rule detailed above, a basic human good: religion.

The debate on whether the existence of God is necessary to preserve the coherence and normativity of ethics has gone on for millennia. As noted, the purpose of the present treatise is to outline a secular theory of morality – secular in the sense of not taking a stand on whether any religious worldview is correct. I will claim that the thesis may remain silent on the questions of the existence of God and a spiritual faculty without severely damaging the coherence of the system of morality it presents.

Oderberg rightly takes religious belief and practice to be a near-universal human phenomenon. But he is, arguably, incorrect in supposing that it cannot meaningfully be partitioned into components that may then be subsumed under the basic goods: religious and existential knowledge are forms of knowledge; relationship with God is a form of friendship; religious practices incorporate elements of friendship, work and play. That religious goods are construed as subspecies of other basic goods in this way does not imply anything about their importance. This move is compatible with religion being a highly important pursuit and phenomenon.

The ultimate justification for religious practices is God's existence. Arguably, if God does not in fact exist, actions performed as part of religious practices are not really meaningful. It seems, then, that actions done for the sake of the purported good of religion either can be said to be done for the sake of other basic human goods, or are not truly meaningful after all. Either way, it is unnecessary to posit a separate basic good of religion. In this secular version of NNL, then, religion is not a basic good.

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<sup>64</sup> Oderberg, *Moral Theory*, 44.

#### 1.4.8 Autonomy is not a basic good

A thorough treatment of autonomy is given by the NNL theorist Robert P. George.<sup>65</sup> He develops his position in critical dialogue with Joseph Raz. Raz sees autonomy as a ‘constituent element of the good life’;<sup>66</sup> that is, in natural law parlance, a basic good and a basic reason for action. An act is autonomous if it is rightly said to be the agent’s own creation. An immoral choice may very well be autonomous, but according to both Raz and George it has no intrinsic value; as George puts it, ‘Choosing an immoral option makes the chooser morally worse; yet the chooser gains nothing of value in terms of the autonomy he exercises in making it’.<sup>67</sup> Let this point be illustrated by an immoral action that is performed for a genuine human good: a spy decides to steal some valuable documents. He goes through with his plan. The actions that constitute the theft are truly autonomous. The theft results in the spy and his employer having gained knowledge, thus increasing their participation in this good. However, stealing the documents was an immoral action that ought not to have been done. The spy’s exercise of autonomy in this case in itself does not contribute to the moral value of the action.

This points to a contradiction between Raz’ assertions, which George exposes. If autonomy is a basic good, then it must always be valuable in itself. But autonomy is worthless when, as in the above example, it is used to perform immoral choices, and thus it is *not* always valuable in itself. Hence autonomy cannot be a basic good, but is rather an instrumental good. Autonomy just *appears* to be intrinsically valuable, because good actions that are done fully consciously and after serious deliberation are naturally more highly praised than actions that are done unthinkingly or in mindless submission to authority. The faculty that is exercised in this kind of choice, though, is, according to George, not autonomy, but the related faculty of practical reasonableness (see 1.4.5).

Autonomy is never an ultimate reason for action, but is instrumental: when promoted, it enables participation in basic goods. Even though it is not a basic good, it is very important: autonomy, the freedom from internal compulsions and external constraints, is a condition for the free exercise of practical reason.<sup>68</sup>

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<sup>65</sup> George, *Making Men Moral*, 173-82.

<sup>66</sup> Quoted in *Making Men Moral*, 173.

<sup>67</sup> *Ibid.*, 175.

<sup>68</sup> *Ibid.*, 177-81.



#### 1.4.9 Marriage is not a basic good

In recent versions of the list of basic human goods Finnis has included *marriage* as a distinct good. Although whether marriage is a basic human good is not relevant to end-of-life dilemmas, this question is of some importance to us because it 1) leads to questions about the methodology of elucidating the list of basic human goods; and 2) throws light on the question of whether NNL is a secular or a religious theory of morality. In two essays by Finnis, marriage is defined and described as follows:

Marriage is a distinct fundamental human good because it enables the parties to it, the wife and husband, to flourish as individuals and as a couple, both by the most far-reaching form of togetherness possible for human beings and by the most radical and creative enabling of another person to flourish, namely, the bringing of that person *into existence* as conceptus, embryo, child and eventually adult fully able to participate in human flourishing on his or her own responsibility.<sup>69</sup>

[T]he sexual association of a man and a woman which, though it essentially involves both friendship between the partners and the procreation and education of children by them, seems to have a point and shared benefit that is not reducible either to friendship or to life-in-its-transmission and therefore (...) should be acknowledged to be a distinct basic human good.<sup>70</sup>

If Finnis succeeds in establishing that marriage is a basic human good, there are huge consequences for NNL's sexual ethics. In short, if marriage is indeed a basic human good then the intermediary moral norms (Chapter 2) will be brought to bear on this good as on the others. Injunctions to not arbitrarily discount, or, especially, to not intentionally act against the basic human goods will also have full normative force in the case of the good of marriage. From this basis, an account of sexual ethics resembling Roman Catholic teaching on the subject could be constructed.<sup>71</sup> That a theory of pure practical reason is capable of establishing the normative truth of that

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<sup>69</sup> John Finnis, "Marriage: A Basic and Exigent Good," *The Monist* 91 (2008).

<sup>70</sup> John Finnis, "Commensuration and Public Reason," in *Incommensurability, Incomparability, and Practical Reasoning*, ed. R. Chang (Harvard University Press, 1997), reprinted in *Reason in Action. Collected Essays Volume 1*, p. 244 n. 1.

<sup>71</sup> As, indeed, it has been: see, for instance, John Finnis, "Law, Morality, and 'Sexual Orientation'," *Notre Dame Law Review* 69 (1994). In short, any kind of extra-marital or contracepted sexual activity could constitute an act against the good of marriage, and thus be immoral.

particular set of moral norms is something that will make critics question the theory's purported *secularity*. However, the arguments must be considered on their own merit.

If NNL is to remain a secular theory of morality, it should not rely on religious accounts of the nature of the institution of marriage. Finnis's account of marriage is not religious in this respect. However, it may be challenged and found to be less plausible than competing views. For instance, Finnis's critics may very well grant that marriage is an institution that furthers the twin purposes of procreation and a special kind of friendship between the spouses, while denying that marriage has 'a point and shared benefit that is not reducible' to these two purposes.<sup>72</sup>

Consider Chappell's critique of Finnis on this point:

We do not complete any action-explanation by saying that the action to be explained is aimed *at marriage*. It is perfectly intelligible to go on and ask why marriage is a good thing, in a way that it is arguably not intelligible to go on and ask why friendship and knowledge are good things. Moreover, what makes marriage a good thing is nothing separate from its instantiation of other basic goods, such as, say, friendship, self-integration, play, aesthetic good (...), physical health and well-being – and even, dare one say it, *physical pleasure*.<sup>73</sup>

Finnis responds by stating, 'The action of marrying (which in a certain sense extends through the entire marriage and everything done for the sake of it (...)) is sufficiently explained by saying that it is the beginning of the actualizing of this intrinsic good itself'.<sup>74</sup> However, I think that Chappell's view is the more persuasive here. The act of marrying is inherently meaningful, but still 'transparent' to the goods to be brought on by marriage: procreation and a special kind of friendship. Marriage is surely a valuable social institution, but one that is *instrumental* in bringing about more

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<sup>72</sup> Consider, for instance, pro-marriage campaigner David Blankenhorn's definition of marriage, putatively derived from 'a large and growing mountain of scholarly evidence': 'In all or nearly all human societies, marriage is socially approved sexual intercourse between a woman and a man, conceived both as a personal relationship and as an institution, primarily such that any children resulting from the union are – and are understood by the society to be – emotionally, morally, practically, and legally affiliated with both of the parents'; *The future of marriage* (New York: Encounter Books, 2007), 91. Note that Blankenhorn's definition centres on friendship and procreation, without any invocation of 'a point and shared benefit that is not reducible' to either of these.

<sup>73</sup> Timothy Chappell, "Natural Law Theory and Contemporary Moral Philosophy," in *The Revival of Natural Law*, ed. N. Biggar and R. Black (Aldershot: Ashgate, 2000), 38-39.

<sup>74</sup> Finnis, *Reason in Action*, I, 9.

fundamental goods, and not itself basic. As an analogy, consider another valuable social institution: a well-functioning state. All actions for the sake of furthering this institution, e.g., paying one's taxes, obeying its laws, or bequeathing money to it, will be actions that help it flourish, but that ultimately are for a further end: the common good, which the well-functioning state is instrumental to furthering.

I contend that it is not practically irrational to treat marriage as (merely) an *instrumental* good through one's actions. To say this is not to demean the institution of marriage. Marriage may not be a basic good and an ultimate reason for action, while still being crucially important for a well-functioning society.

#### 1.4.10 The basic goods are incommensurable

A further thesis of natural law theory insisted on by its proponents is that the basic human goods are incommensurable.<sup>75</sup> This means, in Finnis's strong version, that (1) the basic goods as such are not organized in a hierarchy, they are equally important; (2) two instances of basic good as such cannot be compared in importance or value on a common scale; and (3) even two instances of the *same* basic good cannot be compared on a common scale. NNL proponents argue for incommensurability in the following way:

The basic goods are basic reasons for action, and are not underpinned by further reasons. When I act for the sake of friendship, there is no *more basic* or *fundamental* reason that can explain or justify my action. The same goes for all the other basic goods, and this is why they are incommensurable. If they were commensurable, they would have to be *reducible* to an underlying good, the amount of which could then be assessed or perhaps measured in some way. But if the goods were reducible in this way, they would not constitute *basic* reasons for action: the further reason to which they were reduced would be a common, basic reason. Since the goods are irreducible, they are incommensurable.<sup>76</sup> A corollary is that 'the basic

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<sup>75</sup> *Natural Law and Natural Rights*, 114-17; Grisez, Boyle, and Finnis, "Practical Principles, Moral Truth, and Ultimate Ends," 110.

<sup>76</sup> Even the good of life is not always more important than the other goods. We praise as moral heroes certain people that in effect sacrifice their lives for the sake of other goods (truth, practical reasonableness). And, arguably, subjecting one's life to considerable risks for the sake of excellence in play, as in certain dangerous kinds of sport, need not be irrational. However, according to Chappell, we should grant that some *instances* of basic goods are always more important than other instances. His example is that the good of life, or

goods of diverse categories are called “good” only by analogy’.<sup>77</sup> For the goods have no *common* quality that makes our practical reason perceive them as desirable.

Should I play tennis or read a book tonight? The first choice looks to realize instances of play, friendship and health through exercise. The second, knowledge, and perhaps play and health through mental recreation. Which option should be chosen? *The goods themselves* do not provide any hint of an answer. The contention is that there is no way that the instantiations of goods as such offered by the two possible plans for action, can be commensurate.

Nevertheless, in everyday life we do judge between proposals for action and the instances of good promised therein, and we would insist that at least some of these judgments are rational. How is this experience compatible with incommensurability? If preferring the-goods-promised-by-one proposal for action over the-goods-promised-by-another is the outcome of a rational process, there must be *reasons* for our preference. What are these reasons and where do they come from? Arguably, the three kinds of *incommensurability* do not exclude rational *comparability*.<sup>78</sup> A choice between rationally appealing alternatives can be made by discerning *other* reasons for action in addition to the first-order reasons constituted by the instantiations of goods themselves. Such reasons can spring from the agent’s prior commitments, interests, life-plan or abilities. Facing the choice between two university courses, a student may realize that both promise the good of knowledge to roughly the same degree, but that his own particular talents and interests make the one a more rational choice than the other. The external reason can also be a moral reason for action, a *second-order reason for action*, a concept that will be examined in Chapter 2. Finally, the external factor may be sub-rational: the agent’s feelings and desires. Thus this factor is not really a (normative) reason for action at all, but might still be the factor that makes the agent prefer one plan for action over another.

In my view, there are two reasons to question Finnis’s strong incommensurability thesis. The first is that the thesis leads to some rather troubling

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knowledge, is always more important than simple games like Noughts and Crosses (“The Polymorphy of Practical Reason,” in *Human Values. New Essays on Ethics and Natural Law*, ed. Oderberg and Chappell (Basingstoke: Palgrave Macmillan, 2004), 111.).

<sup>77</sup> Grisez, Boyle, and Finnis, “Practical Principles, Moral Truth, and Ultimate Ends,” 110.

<sup>78</sup> Henry S. Richardson, “Incommensurability and Basic Goods: A Tension in the New Natural Law Theory,” in *Human Values. New Essays on Ethics and Natural Law*, ed. Oderberg and Chappell (Basingstoke: Palgrave, 2004). George, *In Defense of Natural Law*, 94.

counter-examples, such as the following, originally presented by Russell Pannier:<sup>79</sup> You sit down to drink a cup of coffee, but then you see through the window that a friend is drowning in the nearby lake. At stake here is the good of health, including internal harmony (drinking the coffee); and the goods of life and friendship (the drowning friend). It is obvious that only one line of action is rationally (and emotionally) appealing and morally acceptable: immediately running to the lake in order to rescue the friend. However, on Finnis's strong incommensurability thesis, how can one explain that the one set of goods obviously outweighs the other?

The point of cases like these is to juxtapose two instances of basic good in such a way that it is strongly counter-intuitive to label them as rationally incomparable or of equal importance. It is obvious that only one line of action is acceptable. Following George's suggestion, one could explain the compelling need to choose the life of the friend above the coffee by one's prior committal to friendship, by second-order reasons like the golden rule, and so on. However, does it not seem more reasonable to attribute the universal preference of the life of the friend to the relative importance of *the goods that are at stake* as such? Some instances of basic good just *are* more important than other instances because of the nature of these instances themselves, and not because of any of the external reasons that George invokes. In Pannier's case, isn't the relatively greater importance of the friend's life something that we would expect any rational agent to affirm, regardless of disposition, life-plan or prior commitments? If so, then it seems reasonable to attribute this greater importance to *the intrinsic value of the goods themselves*.

Pannier's case can be strengthened further if we say that the drowning person is not a friend, but a stranger. In this case, I cannot appeal to my commitment to friendship and the particular friend's welfare to justify why rescuing the person is of overriding importance. Here, the NNL proponent cannot claim that there is a prior commitment to certain goods or life-plans that settles the case. NNL has trouble explaining why rescuing the person is the obvious, only acceptable action.<sup>80</sup>

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<sup>79</sup> Russell Pannier, "Finnis and the Commensurability of Goods," *The New Scholasticism* 61 (1987): 443.

<sup>80</sup> See also David Luban's two Pannier-style counter-examples in "Incommensurable Values, Rational Choice, and Moral Absolutes," *Clev. St. L. Rev.* 38 (1990): 75-76, and Finnis's reply: "Concluding Reflections," *ibid.* Luban calls these cases examples of 'large-small tradeoffs' between basic goods. However, Luban's examples (the first of which involves a college athlete who contemplates increasing the training regimen in order to improve athletic performance, leading to the neglect of academic effort) are constructed in a way that lets

The second reason to question the incommensurability thesis is the following: if there is an over-arching goal of human life, then this goal can constitute a scale on which instances of good can be ranked in relative importance. Many writers in the natural law tradition have considered God, or the Christian faith, to be such a goal.<sup>81</sup> My secular approach rules out this answer, and it is difficult to see other likely candidates for an over-arching goal – except one: *human flourishing*. As we have seen, the basic human goods together constitute human flourishing, and because all actions aim at basic goods, then all actions also aim at human flourishing. It seems both possible and reasonable, therefore, to judge which of several competing proposals for action realizes the ideal of human flourishing to the fullest extent. Different proposals for action can be thought to realize one instance of basic good to different degrees, or with different probabilities, and the proposals can then be rationally evaluated and compared. But different proposals for action can also realize different instances of (the same or different) basic goods. In that case, it seems that it is possible to judge the proposals in terms of *to what extent they promote or frustrate the ideal of human flourishing*. The suggestion, then, is that we in at least some cases are able rationally to perceive one instance of basic good as *intrinsically preferable* to another.

These considerations seem to imply the possibility of rational comparison of instances of basic human good, contrary to the incommensurability thesis. Finnis's strong incommensurability thesis (1) was: the basic goods are incommensurable in that there is no hierarchy of basic goods and that two instances of basic good cannot be compared on a common scale without appeal to further reasons external to the goods themselves. However, reasons for considering an alternative, weak commensurability thesis (2) have just been given. (2) can be given as: the basic goods are in themselves equal, and cannot be compared on a common scale, but two instances of good can sometimes be compared rationally without recourse to external reasons and be shown to be of unequal value. I leave it as a challenge to NNL theorists whether the former thesis can be vindicated and the latter refuted.

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Finnis too easily off the hook: Finnis plausibly rebuts both examples by stating that the goods involved can indeed be commensurated by reference to a prior commitment (e.g., to athletic excellence, or to scholarship).

<sup>81</sup> Pannier, "Finnis and the Commensurability of Goods," 453-54.

#### 1.4.11 The common good

When we later consider the ethics of certain end-of-life practices (esp. Chapter 5), the consequences of these for others besides the people directly involved (patient, relatives, health care workers) will be of moral importance. Natural law has a well-developed concept that is central to this analysis: *the common good*. This concept again builds on the concept of the basic human goods.

There are three senses of ‘the common good’ relevant here.<sup>82</sup> First, each of the basic goods are good for every person. Life, knowledge, friendship, work and play, and practical reasonableness contribute to every person’s flourishing, and in this respect they are *common* goods. Second, for any community (defined broadly – e.g., a family, a friendship, a club, participants in a sport, or the political community), there is a good or a set of goods aimed at by the coordinated activity of the participants. This good is the *common good* of the particular community. Third, the common good can be understood as the *set of conditions* required for the community to pursue the goods for which it exists. For instance, free speech is a common good of the political community, because it is among the factors that enable citizens to pursue their goals.

#### 1.4.12 The basic goods and cultural diversity

A strength of the NNL theory is the plausible way in which it underwrites the value of diversity of cultures and lifestyles.<sup>83</sup> Mainly, two features of the theory are responsible for this. First, the basic human goods are diverse; they have many parts and infinitely many actual instantiations in people’s lives. Second, incommensurability ensures that an agent may legitimately pursue some goods rather than others, according to her interests and inclinations. Many life-forming choices, like the choice of a career, are rationally underdetermined, in that practical reason does not dictate which option to pursue. Cultures and individuals may give different weight to sub-kinds of goods and to practical norms for choice, and this gives rise to cultural and individual diversity. Natural law theory, with its insistence on a set of universal human goods, might be thought to have unacceptable paternalistic implications, to be imposing a certain Western view of morality – but this is not so. Rather, it turns out that the diversity of the goods and the infinite ways in which they may be pursued is

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<sup>82</sup> Finnis, *Natural Law and Natural Rights*, 154-56.

<sup>83</sup> Black, “Introduction,” 9-10.

the basis for affirming a certain practical pluralism. The goods are aspects of human well-being and they are universal in being pursued in all human societies, but societies pursue them in different ways. Nevertheless, no unsound cultural relativism is introduced: as will be shown (Chapter 2), the theory does generate concrete moral norms, which provide the basis for criticism of morally unsound elements in a given culture's practice.

## 1.5 The problem of self-evidence's underdeterminacy

The discussion about the general problem with appeals to self-evidence will now be picked up again. The basic contention was that if one proposition is claimed to be self-evidently true, there are likely to be formulations of the proposition that are similar, yet with significant differences or implications, that could make the same claim to self-evident justification. Generally, if proposition  $A_1$  has a valid claim to epistemic justification through self-evidence, there are likely to be a set of related propositions  $A_2$ - $A_x$  that can equally validly claim self-evident justification – *a family of self-evident propositions*. There may or may not be any further reason for singling out any of the competing formulations as the most plausible or singularly correct one. The first two instances of this problem will be discussed below.<sup>84</sup>

Grisez, in a 1965 paper, endorsed Aquinas' own formulation of what Grisez termed the first principle of practical reason: 'do good and avoid evil'.<sup>85</sup> But above, we saw that twenty years later the principle had become, 'good is to be done and pursued'; '*et malum vitandum*' had been jettisoned. It seems several formulations of the principle are possible, each with slightly different nuances. For instance:

Good is to be done and pursued.

Do good and avoid evil.

Do nothing but good.

Above all, avoid all evils.

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<sup>84</sup> This first instance of the problem, that is, self-evidence's problem in choosing between competing formulations of the first principle of practical reason, was first pointed out by Timothy Chappell: "Natural Law Theory and Contemporary Moral Philosophy," in *The Revival of Natural Law*, ed. Nigel Biggar and Rufus Black (Aldershot: Ashgate, 2000): 32-33.

<sup>85</sup> Grisez, "First Principle of Practical Reason."



Such examples can be multiplied. It seems that which formulation is correct or ought to be chosen is underdetermined by self-evidence. The different formulations are not all consistent: for instance, doing evil seems consistent with the first one, whereas not with the others. Yet what reason could we possibly have to prefer one formulation to the others as ‘more self-evident’ than its competitors?

What is the significance of this underdeterminacy of self-evidence? As shown and as will be discussed further in Chapter 2, the basic human goods and the reasons and principles for action that follow from these form the backbone of the NNL theory. But if avoiding evils were as crucial to an agent as doing good, one might expect a corresponding set of ‘basic human evils’ that were to be avoided and that would have as large a normative significance as the corresponding goods.<sup>86</sup> For instance, we might take *suffering indignities* to be a basic human evil, the avoidance of which would constitute a basic reason for action. Perhaps this line of thought could justify euthanasia and other medical killings in certain circumstances. This point will not be pursued, as the point here was merely to illustrate that self-evidence’s underdeterminacy can indeed have significant normative consequences. To recapitulate, which version of a self-evident principle we embrace can shape the moral theory’s normative guidance; and if there is *no principled reason* to prefer one competing version of a self-evident principle to another, this constitutes a puzzle and a weakness in the NNL theory itself, reducing its philosophical plausibility as a theory of ethics.

A further, potentially very dangerous problem here is the following.<sup>87</sup> Consider two related propositions  $A_x$  and  $A_y$  that are mutually inconsistent. If I am justified in accepting *both* propositions through self-evidence, then a contradiction has arisen. My holding both propositions must be self-refuting – and so I must be mistaken in holding that both are justified through self-evidence: either only one, or none, must be self-evidently true. But if there is no principled reason to accept the one but not the other, the entire strategy of justification of these principles by self-evidence starts to look very problematic. This challenge will not be pursued here, but must be dealt with by NNL proponents.

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<sup>86</sup> If, however, we accept Aquinas’ notion of evils as nothing other than privations of the good, we would have a principled reason to treat the basic human goods as primary for the considerations of practical reason, and relegate evils to a secondary role.

<sup>87</sup> I owe this point to a discussion with Søren Holm.

The second stage in the development of the basic precepts of NNL where self-evidence is appealed to is that of the basic goods. Putatively, they are self-evident. Practical reason views the instances of basic good that could be realized in a certain line of action as self-evidently good. However, the problem of self-evidence's underdeterminacy does not cause as much trouble this time, for there is also a procedure for ascertaining whether a certain instance of good is indeed basic that does not rely on self-evidence. This is the reiterative questioning of *why* a certain action was (or ought to be) carried out. Therefore, basic goods can be established as basic both by self-evidence *and by argument*. The underdeterminateness of self-evidence seems to come into play here only when it comes to the naming, labelling or delineating of the different basic goods. However, this does not lead to intractable problems: whether a certain good (e.g., friendship) is named as a separate category of basic good or whether it is subsumed under one or more other categories (e.g., sociability) does not make a difference for the good's nature as properly basic. And so the problem of the underdeterminacy of self-evidence is not much of an issue in the case of the basic goods. However, in Chapter 2, the third point where NNL appeals to self-evidence will be examined – and this time the appeal is much more problematic.

## 1.6 From practical reason to morality

In recognizing the diverse basic human goods, NNL is led to acknowledge a whole panorama of worthwhile pursuits for human beings. The next natural question is how these goods should be pursued. Another analogy with theoretical reason is helpful here: If we are to gain knowledge through conducting a scientific experiment, the experiment must conform to the principles of scientific reason. Thus, in the case of practical reason, if we are to act, deliberation must conform to the principles of practical reasoning.<sup>88</sup> So we are searching for the principles that govern practical reasoning.

These principles can, according to NNL proponents, be reached in two ways: by deriving them directly from considerations of practical reason in the light of human experience, or by first arguing for a 'first principle of morality' as a specification of the first principle of practical reasoning, 'good is to be done and

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<sup>88</sup> Black, "Introduction," 13.

pursued'.<sup>89</sup> I will follow Grisez et al. in first specifying morality's first principle. In Chapter 2, I will then examine the particular principles that flow from this principle, and show how concrete moral norms can be derived.

Above it was shown that 'good is to be done and pursued' operates as a first principle of practical reasoning, informing all deliberation while not itself figuring as a premise. The principle embodies the directiveness of practical reason: all practical reasoning has 'to-be-pursued-ness' built into it. The purpose of the principle is to *forbid pointlessness* in the pursuit of the goods.<sup>90</sup> Such pointlessness, like deliberating about alternatives that are not really available (e.g., the unfortunate choice has already been made and cannot be rectified) or alternatives that do not seem to lead to any good, is practically unreasonable. The principle does not *prevent* pointlessness in practical reasoning, but it makes a rational demand that pointlessness should be *eliminated* once it is discovered.

The prohibition of pointlessness amounts to a demand to reason practically in the following way: deploy any of the basic goods and choose a plan for action that will instantiate this good. This minimal requirement on practically reasonable deliberation leaves open any option that aims at any instantiation, however small, of any basic good. It also does nothing to prohibit immoral choices, for such choices also do secure some instance of good. Grisez et al. then invite us to consider another, far stronger, principle: 'allow *nothing but* the principles corresponding to the basic goods to shape your practical thinking as you find, develop, and use your opportunities to pursue human fulfillment through your chosen actions'.<sup>91</sup> The demand here is that deliberation and action should be *entirely reasonable*.

Grisez et al. endorse this stronger principle, and then, as will be shown shortly, reformulate it as 'morality's first principle'. Consider the kinds of actions and choices the two principles prohibit. The first principle of practical reason, 'good is to be done and pursued', excludes pointless actions. These are not just practically irrational, they are plainly unintelligible (recall obtaining a plate of mud *for its own sake*). The stronger principle excludes all possible choices that the first principle excludes, but in addition excludes the *immoral* choices.

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<sup>89</sup> The first route is taken in Finnis, *Natural Law and Natural Rights*; the second in Grisez, Boyle, and Finnis, "Practical Principles, Moral Truth, and Ultimate Ends."

<sup>90</sup> "Practical Principles, Moral Truth, and Ultimate Ends," 120.

<sup>91</sup> *Ibid.*, 121, italics added.

The stronger principle, then, has a crucial role in performing the philosophical work in elucidating the moral norms (Chapter 2). But how can this move from ‘good is to be done and pursued’ to the stronger principle be justified? Firstly, the notion that practical thinking must be carried out for the sole sake of human fulfilment may be justified in this way: from the first principle of practical reasoning we know that all practical reasoning is for the sake of the good, and the different forms of good are all aspects of human fulfilment; thus practical reasoning is always for the sake of human fulfilment.

Secondly, we turn to the requirement of complete reasonableness, where the stronger principle implies that to be morally good is to be completely reasonable: ‘*Right reason is nothing but unfettered reason*’.<sup>92</sup> No premise external to our considerations of practical reason is smuggled into this move. The stronger principle (or something very like it) follows if we consider that practical reason working at its very best must be eminently practically *reasonable* – that is, reason must operate freely, without hindrances: ‘unfettered reason’.

Immoral choices are never fully rational in this way. When sub-rational inputs, like feelings, determine which plan for action to adopt, the choice is not fully determined by reason. This is where the moral ‘ought’ comes in:

When practical knowledge is confronted with the tendency of feeling to restrict it by urging a possibility whose choice would fetter it, the is-to-be of practical knowledge becomes ought-to-be. The *directiveness* of practical knowledge *becomes normativity* because what is to be might not actually come to be and yet still rationally is to be.<sup>93</sup>

In other words, it is possible to act intelligibly against the requirement of complete reason in action. However, practical reason demands complete reasonableness, and there is then the danger that actions are not fully rational, even though they *ought to be* fully rational. This ‘ought’ is the moral ought.

One can now see what makes immoral choices practically irrational: they do not live up to the demands of the first principle of practical reason as well as moral choices do. The first principle demands that the basic goods be pursued. Morally right choices respect the totality of the principles of practical reason; that is, they respect

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<sup>92</sup> Ibid.

<sup>93</sup> Ibid., 125.

the directiveness of all the basic goods. Morally wrong choices, on the other hand, pursue an instantiation of good in some way, but by not respecting all the other goods such choices fail to be fully reasonable. Immoral acts only pursue some aspects of some of the goods, while not respecting the totality of the basic goods. Thus these acts do not live up to practical reason's demand to be fully reasonable.<sup>94</sup>

Grisez et al.'s final formulation of the first principle of morality is: 'In voluntarily acting for human goods and avoiding what is opposed to them, one ought to choose and otherwise will those and only those possibilities whose willing is compatible with a will toward integral human fulfillment.'<sup>95</sup> Or, in Black's simple summary: '[To be] moral is nothing less than being completely practically reasonable in the making of decisions about how to pursue human fulfilment'.<sup>96</sup>

Further specification of this principle into requirements of practical reason and, finally, concrete moral norms, is begun in Chapter 2.

## 1.7 New natural law theory and its philosophical competitors

Having sketched the theoretical foundations of the new natural approach to ethics, we are now able to see in more detail how alternative theories of ethics could be considered from the NNL perspective. Such an undertaking has three merits: first, it will highlight certain central concepts and presuppositions in the NNL theory. Second, arguing against the philosophical alternatives is a way of indirectly arguing *for* the plausibility of the NNL theory. Third, special features of NNL enable the conception of philosophically novel arguments against the other theories, arguments that may not be proposed, or at least not proposed with the same force, from other theoretical standpoints.

However, it is misleading to portray different ethical theories purely as 'enemies'. The theories are all attempts to describe and make sense of the incredibly complex field of human attitudes, deliberation and action. Because the theories share this same goal, there is substantial overlap between them. In addition, because the theories all view this field from their own unique perspectives, each is able to point out salient insights which are not as readily perceived from the perspectives of the

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<sup>94</sup> Ibid.

<sup>95</sup> Ibid., 128.

<sup>96</sup> Black, "Introduction," 15.

other theories. Ethical theories may therefore complement each other. If a particular ethical theory aspires to being the singularly correct theory, it must be able to absorb the particular insights of the other theories.<sup>97</sup> When an ethical theory acknowledges and incorporates a feature of the moral life that has been pointed out by another theory, the former theory is strengthened, not weakened. An example of this is when NNL attempts to encompass a theory of the virtues (see 1.7.5).

It is important to point out from the outset two features about the discussion that follows. First, the arguments against alternative moral theories are mainly outlines of arguments, presupposing the verity of the NNL theses, and should not be taken to be conclusive in the form in which they are presented. And second, the alternative moral theories are portrayed very briefly, without taking into account the nuanced and finely tuned versions that most philosophers are likely to hold. Some of the arguments presented, then, may lose force when applied to these refined versions of the theories criticized.

### 1.7.1 An NNL critique of consequentialism

Natural law proponents agree with consequentialists that the good may be characterized before identifying the morally right. That is, there are non-moral goods, the basic human goods, that can be seen to be good before the moral perspective detailing how the goods should be pursued is introduced. Against consequentialism, natural law theory does not agree that morally good actions must *maximize* pre-moral good. NNL's pluralist account of the good entails that ethics cannot demand that we be maximizers.<sup>98</sup> It is impossible to pursue all the different goods maximally: if I devote myself fully to a life of study, pursuing knowledge, I can still pursue friendship and the other goods, but I cannot *maximize* this pursuit.

Indeed, natural law proponents go one step further than this: from their perspective, the notion of maximizing the good is not only very difficult or even impossible, it is *senseless*. However, this line of criticism depends on the strong form of incommensurability that was detailed above but that I found reasons to question.

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<sup>97</sup> When formulated in this way, the project of constructing 'the singularly correct ethical theory' may appear extremely ambitious (see also 5.8).

<sup>98</sup> Chappell, *Understanding Human Goods*, 70-74.

For a consequentialism-style computation of the amount of pre-moral good promised by alternative proposals for action to be carried out, the goods that humans pursue must be commensurable. The goods must be good in the same way, univocally and not just by analogy. Only if the goods are reducible to some underlying good will we be able to compare two instances of good on a common scale.<sup>99</sup> But, according to NNL, the basic goods that humans pursue are, in fact, incommensurable. They are not good in the same way, and there is no underlying good to which they all can be reduced. Two instances of basic good cannot be assigned a numerical value and participate in the consequentialist calculus. The upshot is not, then, that this comparison is unfeasible; rather, it is impossible on principle. You could choose with an eye to optimizing consequences only if the different forms of good constitutive of human fulfilment were commensurable, in that they allowed the weighing and comparison that the consequentialist requires.<sup>100</sup>

There is a further striking implication of this conclusion. Consequentialists claim to be able to sum up or at least compare the amount of pre-moral good promised by each alternative plan for action. This enables them to rank the alternatives – the choice that promises the most pre-moral good is the morally right one. But if this calculation and ranking is impossible on principle, how is the ranking constructed? According to Finnis, the ranking must necessarily be performed by mere rationalization of wishes and prejudices.<sup>101</sup> If the calculation is impossible on principle, some other principle(s) must be responsible for the final ranking. A consequentialist argument will never do what it promises to do, for the allocation of numerical values to consequences of actions, followed by adding up the numbers, is an impossible procedure. However, one must justify one's choice in some way. The road lies open, therefore, for the sub-conscious application of other principles, especially non-consequentialist moral principles or feelings. In practice it is easy to conceive of possible consequences, immediate or remote ones, that put one's favoured line of action in the best light.

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<sup>99</sup> Germain Grisez, "Against Consequentialism," *American Journal of Jurisprudence* 23 (1978): 29; Finnis, *Natural Law and Natural Rights*, 113.

<sup>100</sup> George, *Making Men Moral*, 89.

<sup>101</sup> *Fundamentals of Ethics*, 94.

Another argument points to a counter-intuitive implication of consequentialism.<sup>102</sup> Imagine for the sake of argument that the consequentialist weighing of alternatives and reduction of basic goods to a common ‘pre-moral currency’ were possible. For any choice, there could be constructed a list of alternative plans for action, and each one allocated a number indicating the sum of good and bad consequences. In a ranked list of alternatives, only the top one would, according to the consequentialist, be the morally good choice. The others would be morally deficient. Now, what *reasons* does the agent have for the choice of any of the alternative actions on the list? It seems she only has reason to choose the top-ranked action. She has *no* reason to choose any of the other actions, for all the good promised by any of these inferior actions is also promised by the morally good action. The top-ranked action includes all the good offered by the inferior actions, and more. The agent then has no reason to choose any of the morally deficient actions; any such choice would be to settle for a lesser amount of good than was available to her. Such a choice would be *irrational*; it could be motivated by feelings or other sub-rational factors, but not by reasons.

This implication is profoundly counter-intuitive in that we commonsensically take the agent to have *reasons* for choosing all of the alternative actions, even alternatives that we hold to be morally deficient. This feature of practical rationality can be explained by a natural law view, but not, it seems, by consequentialism. In a natural law perspective, each alternative offers some real good: instances of one or more basic goods. These goods constitute our reasons for action. The attractiveness of these alternative actions would be lost if the agent were to see one alternative as offering all the other actions could offer, and more.

Consequentialism is often criticized for ignoring the importance of the impact on the agent’s character in the moral assessment of actions. Taking on the consequentialist’s mantle, you become an instrument for producing the greatest net benefits. Thus you make yourself a certain kind of person, one ready to commit whatever kind of action is necessary to achieve the goal of maximization.<sup>103</sup> When undertaken from a natural law perspective, this familiar critique takes on a particular flavour. As discussed above (1.4.5), actions have ‘intransitive’ effects in that they

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<sup>102</sup> George, *Making Men Moral*, 88-89; Finnis, *Fundamentals of Ethics*, 89-90.

<sup>103</sup> See, for instance, J.J.C. Smart and Bernard Williams, *Utilitarianism: For and Against* (Cambridge: Cambridge University Press, 1973), 116-17.



mould the agent's character. In Finnis's words: 'Since a choice is free precisely inasmuch as it is settled by nothing whatever except the chooser's own act of choosing, it has a truly originating, creative, soul-making significance.'<sup>104</sup>

Agents thus have a practical reason to preserve their character and practical reasonableness, a reason that stems from the reflexivity or intransitivity of moral choice. The natural law twist on this argument is to reinforce the point: The consequences on the agent's character cannot be commensurated with the other consequences of one's actions.<sup>105</sup> This, then, gives a sense to the adage that one should not choose evil that good may come of it; for in choosing evil, one makes oneself a certain person; plainly, a person ready to do evil. And this consequence cannot be commensurated with or outweighed by the good consequences of the act.

### 1.7.2 NNL and Kantian ethics

Immanuel Kant famously commences his *Groundwork* on ethics by saying that 'It is impossible to think of anything at all ... that could be considered good without limitation except a good will'.<sup>106</sup> The Kantian 'good will' corresponds to what here has been called practical reason. A problem for Kant's theory stems from the fact that he recognizes this basic good and indeed considers it the highest, but does not recognize the other basic goods.<sup>107</sup> He goes on to characterize the good will without any prior conception of what the goals of practical reasoning are.<sup>108</sup> Arguably, this weakens the theory's ability to generate moral norms. You should 'act only in accordance with that maxim through which you can at the same time will that it become a universal law' (the 'universal law' formula of the categorical imperative);<sup>109</sup> that is, the side-constraints on your actions stem from considerations of 'pure' practical reason, not from the richer conception in which practical reason is informed by the other basic goods that constitute human flourishing. Kant's conception of

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<sup>104</sup> Finnis, *Moral Absolutes*, 22-23.

<sup>105</sup> *Ibid.*, 21.

<sup>106</sup> Immanuel Kant, *Groundwork of the Metaphysics of Morals*, trans. Mary Gregor (Cambridge: Cambridge University Press, 1997), 7.

<sup>107</sup> *Ibid.*, 10.

<sup>108</sup> Onora O'Neill, "Kantian Ethics," in *A Companion to Ethics*, ed. Peter Singer (Oxford: Blackwell, 1991), 176.

<sup>109</sup> Kant, *Groundwork of the Metaphysics of Morals*, 31; Christine M. Korsgaard, "Introduction," in *Groundwork of the Metaphysics of Morals* (Cambridge: Cambridge University Press, 1997).

practical reason fails to accommodate *transparency*, the notion that practical reason works for the sake of securing the other goods.<sup>110</sup>

Kant's 'formula of humanity' reads 'So act that you use humanity, whether in your own person or in the person of any other, always at the same time as an end, never merely as a means'.<sup>111</sup> The 'humanity' we are to respect in this way is merely practical reason, the other person's rational nature. When Kant urges respect for other basic goods, including life, this is only, according to Finnis, because of the goods' instrumental role in upholding one's own or other people's rational nature.<sup>112</sup> However, when 'humanity' is read as 'the goods constituting human fulfilment' in a natural law sense, one can see how much the formula of humanity starts to resemble the 'first principle of morality' stated above – which, in our simplified version, reads 'make your choices open to human fulfilment'.

Some may ask whether this Kantian respect for a person's rational nature can mount a sufficiently robust defence of the moral worth of persons with reduced cognitive function. Does Kantian ethics elevate reason to such an extent that protecting human life just means protecting reason and cognitive abilities? If yes, then NNL seems to provide a more comprehensive defence of human dignity (see esp. Chapter 4).

There are indeed resemblances between a Kantian and an NNL analysis of morality. For both, rational actions are performed for *reasons*. Natural law theory can share the Kantian conception of autonomy, in that only such rational actions, done in accord with the moral law, are truly autonomous. Acting from subrational motives like feelings and inclinations is, in the Kantian term, 'heteronomous'. Such motives are not reasons for action. These actions do not display any valuable kind of autonomy.

### 1.7.3 NNL and Rawlsian constructivism

The philosopher John Rawls is known for his inventive approach to (in particular, political) ethics.<sup>113</sup> Starting out from the traditions of Kant and social contract theories, Rawls develops the notion of 'veil of ignorance' to characterize the 'original

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<sup>110</sup> Finnis, *Fundamentals of Ethics*, 74.

<sup>111</sup> Kant, *Groundwork of the Metaphysics of Morals*, 38.

<sup>112</sup> Finnis, *Fundamentals of Ethics*, 122.

<sup>113</sup> Rawls, *A Theory of Justice*.

position' in which basic ethical principles should be constructed (as opposed to *discovered*, as a moral realist would advocate). When placed behind the veil of ignorance one has no knowledge of one's own particular talents, ideological or religious worldview, or one's standing in life. This enjoins one to choose basic, reasonable ethical principles that are neutral towards differing conceptions of the good.

Rawls gives the following list of 'primary social goods' that are good for all: liberty, opportunity, income and wealth, and self-respect.<sup>114</sup> Rawls proposes his list as part of a 'thin theory' of human good; that is, a theory that only counts as basic those goods that any human being would need, whatever her life-plan. A thin theory tries to remain neutral towards rivaling conceptions of worthwhile lives. There is an affinity between Hume's instrumental view of reason and modern-day thin theories of the good. For Hume, reason is a slave of the passions, merely instrumental in securing whatever the agent desires. This fits well with the logic behind thin theories: The basic goods detailed in thin theories are what any human being would need, regardless of her further desires, in order to fulfil those desires.

NNL, on the other hand, insists on (practical) reason's ability to identify basic human goods that are intrinsically good, universally pursued, and constitutive of man's universal end, *eudaimonia*. When one accepts NNL's richer picture of practical reason and human fulfilment, one may reject Rawls's demand to put down one's conception of human fulfilment when entering behind the veil of ignorance. The conditions of Rawls's original position ensure that the principles of justice chosen do *not* favour life-plans that guide one towards fuller participation in *eudaimonia*.<sup>115</sup> A life-plan involving the pursuit of genuine friendship and knowledge would not be favoured over a life-plan geared towards fulfilling whatever (more or less rational) desires one happens to have. This is a deficiency in Rawls's theory.

Rawls concocts his original position so that any unfair bias is excluded in the choice of principles of justice. However, the original position excludes too much, including an NNL conception of the good life. The choice of principles that would favour life-plans geared towards *eudaimonia* would not, in truth, be a biased choice; it would not involve any unfair partiality. That this is so should be especially clear when

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<sup>114</sup> Ibid., 54.

<sup>115</sup> Finnis, *Natural Law and Natural Rights*, 109.

it is remembered that the basic goods of NNL theory are so general that they will figure in all truly worthwhile life-plans.

Lastly, one should note, as does Finnis, that the decision procedure involved in Rawls's social contract could be seen as a kind of operationalization of NNL's requirement of impartiality, one of the specific principles of practical reasonableness to be examined in the next chapter (2.2.2).<sup>116</sup>

#### 1.7.4 NNL and principlism

Tom Beauchamp and James Childress's (B&C) extremely influential approach to medical ethics is set out in their book now in its seventh edition.<sup>117</sup> Known as principlism, B&C's project consists at its core in the identification of four clusters of ethical principles (respect for autonomy, nonmaleficence, beneficence, and justice), which are brought to bear on ethical decisions in medicine. These abstract principles are made useful in concrete cases by *specification* ('a process of reducing the indeterminate character of abstract norms and generating more specific, action-guiding content')<sup>118</sup> and *balancing* (deciding which of the conflicting norms should prevail in a given case, based on the reasons that can be given for each).

The metaethical underpinnings of principlism is a peculiar mix of *foundationalism* and *coherentism*. The method of reflective equilibrium, of the kind detailed by John Rawls and Norman Daniels, governs the processes of specification and balancing.<sup>119</sup> That is, one should strive for ever-greater coherence between our considered moral judgments and our moral principles, and rules at all levels of generality. In addition, though, B&C propose *common morality* as the foundation of the corpus of coherent moral principles and judgments. Common morality is defined as 'the set of norms shared by all persons committed to morality'.<sup>120</sup> This common morality is universal and consists of only a small number of general moral norms, the four principles included. The four principles are secured in their universal applicability and play a foundational role through being part of common morality,

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<sup>116</sup> Ibid.

<sup>117</sup> Tom L. Beauchamp and James F. Childress, *Principles of Biomedical Ethics*, 7th ed. (New York: Oxford University Press, 2013).

<sup>118</sup> Ibid., 17.

<sup>119</sup> Rawls, *A Theory of Justice*; Norman Daniels, "Wide Reflective Equilibrium and Theory Acceptance in Ethics," *The Journal of Philosophy* 79 (1979).

<sup>120</sup> Ibid., 3.

which itself is foundational for morality.<sup>121</sup> Common morality contains both ideals of moral character and moral rules. All *particular moralities* share the precepts of the common morality, but in addition include specific norms that spring from other sources, including cultural and religious sources. As to the source and normativity of common morality, in principlism,

Moral normativity is established historically or pragmatically through the success of these norms in all times and places in advancing the cause of human flourishing. Their account is thus historicist, but unlike most historicisms it does not embrace moral relativism. The norms of the common morality, they insist, are universally binding.<sup>122</sup>

The moral norms that result from specification of the four principles and balancing, then, are justified (1) by their place in a coherent corpus of moral rules, i.e., by reflective equilibrium; and (2) by their relation to the precepts of common morality, themselves exempt from potential revision in the process of reflective equilibrium.<sup>123</sup>

An>NNL-flavoured critique of principlism could raise the following points. First, common morality can be an insecure foundation for ethics. According to B&C, the precepts of common morality have become universally accepted because of their usefulness throughout human history. All persons committed to morality hold these precepts to be true. But it is still not clear why the precepts of common morality are really *normative* for us. Accepting these precepts as normative *because* they lead to human flourishing seems to commit the is-ought fallacy. And further, even though we assent to the principle of respect for autonomy, we may not assent to the specified form of the principle in its final, balanced form in a particular case. Why should our commitment to the abstract form of the principle commit us equally to its controversial, specified forms (e.g., ‘autonomy’ as utilized in a justification of euthanasia)?

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<sup>121</sup> Peter Herissone-Kelly, “Determining the common morality’s norms in the sixth edition of Principles of Biomedical Ethics,” *Journal of Medical Ethics* 37 (2011): 584.

<sup>122</sup> John D. Arras, “The hedgehog and the Borg: Common morality in bioethics,” *Theoretical Medicine and Bioethics* 30 (2009).

<sup>123</sup> Oliver Rauprich and Jochen Vollmann, “30 Years *Principles of biomedical ethics*: Introduction to a symposium on the 6th edition of Tom L Beauchamp and James F Childress’ seminal work,” *Journal of Medical Ethics* 37 (2011): 582.

Second, how can we be certain of universal assent to the precepts of common morality? An NNL theorist could be sceptical of the claim that there is universal moral agreement at the level of general moral norms. Rather, the claim to universality appears much more plausible at an even higher level of abstraction, namely at the level of the pre-moral principles of practical reason. These principles, too, can be claimed to have been shaped by humanity's evolutionary history.

Third, principlism's lack of a theory of the good life could cause its normative pronouncements to be misleading. However, one reply might be that theories of the good life could enter and be considered in the wide reflective equilibrium wherein normative principles are established.

Fourth, the justification for according foundational status to the four principles is inadequate. For instance, assertions that a principle of 'respect for autonomy' belongs to the corpus of norms that all persons committed to morality would accept are dubious. As we have seen, NNL's theory of the basic goods leads to specific views on when autonomous choice is laudable or not, views that conflict with the liberal conception of autonomy elucidated by the principlists.<sup>124</sup> That a set of moral principles is universally accepted by all who are committed to morality, is a bolder claim – and thus arguably more difficult to defend – than NNL's insistence that human beings' faculty of practical reason recognizes the intrinsic desirability of a set of basic goods.

Finally, when principles, duties and interests collide, the 'weighing up' of these, as B&C advocate, is not the obviously right procedure. As Joseph Shaw points out, 'weighing' is not the only possible response to apparent conflicts of principles; in fact, 'weighing' is incompatible with traditional ethics and its reliance on the intention-foresight distinction and the principle of double effect (see 2.5).<sup>125</sup> The proposal that different considerations should be 'weighed' implies, according to Shaw, proposing a wholly new theory of rationality. This theory has been insufficiently argued for, and its traditional alternatives likewise remain unrefuted.

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<sup>124</sup> Beauchamp and Childress, *Principles of Biomedical Ethics*, 99-148.

<sup>125</sup> Joseph Shaw, "Double effect in Beauchamp and Childress," *Catholic Medical Quarterly* 62 (2012).

### 1.7.5 NNL and virtue ethics

Virtues are moral ideals or valuable character traits. In my view, a sufficiently well-crafted and refined natural law theory should aspire to make virtue ethics *theories* redundant. There is ample space for an elaborate conception of virtue to fit within an NNL framework.<sup>126</sup> In a sense, the rise and popularity of virtue ethics theories reflects the failure of traditional theories of ethics to paint a convincing picture of the moral life with the virtues in their deserved place of prominence. Let me point to some ways in which the NNL theory may encompass a virtue perspective.

Virtue ethics takes questions like ‘Who should I be?’ to be the starting point of ethical investigation, as opposed to the ‘What should I do?’ of other theories.<sup>127</sup> NNL attempts a resolution of these competing perspectives by emphasizing the reciprocal relationship between character and choice:<sup>128</sup> ‘Virtues and vices are considered to be both a residue of one’s previous acts and dispositions to engage in further acts similar in moral quality to those which gave rise to the dispositions’.<sup>129</sup> As noted above, actions have intransitive, lasting effects on the agent’s character. Ethics is, crucially, about formation of character. NNL shares this insight with virtue ethics.

Finnis points out that an agent who regularly pursues the basic goods in a practically reasonable way, observing the requirements of practical reason (see 2.2.2), is Aristotle’s *phronimos*, and has Aquinas’ *prudentia*.<sup>130</sup> When acting reasonably in this way, the agent will secure instantiations of basic goods and participate in *eudaimonia*. Only seldom will a certain plan for action be singled out by practical reason as the only obviously acceptable one. Decisions are often rationally underdetermined, and there is then ample room for the exercise of prudence in awareness of the complex totality of the relevant circumstances. In these cases one must, according to Grisez, ‘Determine how well possibilities otherwise judged good comport with the rest of one’s individual personality’,<sup>131</sup> and here one’s emotions will be important. A certain plan for action promises improved harmony between emotions

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<sup>126</sup> Pace Russell Hittinger, who contends that ‘the virtues are an afterthought, and play second, if not third, fiddle in this [new] natural law method’: *A Critique of the New Natural Law Theory* (Indiana: University of Notre Dame Press, 1987), 59.

<sup>127</sup> Rosalind Hursthouse, “Virtue Ethics,” in *The Stanford Encyclopedia of Philosophy*, ed. Edward N. Zalta (2009).

<sup>128</sup> Black, “Introduction,” 21; Nigel Biggar and Rufus Black, “Preface,” in *The Revival of Natural Law*, ed. Biggar and Black (Aldershot: Ashgate, 2000), xiv.

<sup>129</sup> Grisez, *Christian Moral Principles*, 58, quoted in Black, “Introduction,” 21.

<sup>130</sup> Finnis, *Natural Law and Natural Rights*, 102-03.

<sup>131</sup> Grisez, *Living a Christian life*, 292, quoted in Black, “Introduction,” 20.

and other dimensions, and so this action may be the best one in the situation, all things considered. Emotions, then, play a positive role and sometimes guide action in NNL theory, as they do in virtue ethics. Having said this, a more thorough exploration of moral psychology and the place of emotions in NNL is, I think, needed.

A final point is that knowledge of the relevant moral principles is in itself insufficient for acting well. For: ‘A moral decision is not a decision about a principle, but about the relationship of circumstances, intentions, and ends to a principle’.<sup>132</sup> The virtues are necessary for applying moral principles to concrete situations. The virtues are also necessary not just for knowing intellectually what the right thing to do is – virtues, especially practical wisdom, are also necessary for actually performing the right action in practice.

#### 1.7.6 NNL theory and medieval and early modern natural law theories

Among medieval natural law theories, there were *intellectualist* and *voluntarist* variations.<sup>133</sup> The main protagonist of the intellectualist strand is Thomas Aquinas. For Aquinas, the natural law springs from God’s plan for the universe, the eternal law. The precepts of natural law can be grasped by reason unaided by revelation. The natural law is indeed a *law*, fulfilling Aquinas’s four-part definition of law: it is an ordinance of reason, for the common good, made by one who has care for the community (i.e., God), and promulgated (‘written on the heart’, as Paul said: Romans 2,15).<sup>134</sup> However, in Aquinas’s *Summa Theologica*, the treatment of the natural moral law as *law* is brief, whereas the bulk of the discussion of ethics emphasizes virtues, discursive reasoning, and prudential judgments.

The main medieval voluntarist is William of Ockham. As a nominalist, he eschews talk of God’s eternal law. God does not govern by unchanging principles that we can get to know through unaided reason; instead, the natural law is grounded in God’s will. However, this will is steady enough that moral principles (of natural law) can be discerned from the scriptures.

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<sup>132</sup> Edmund D. Pellegrino and David C. Thomasma, *The virtues in medical practice* (Oxford: Oxford University Press, 1993), 23.

<sup>133</sup> In the following exposition of the historical varieties of natural law theories I rely on Syse, *Natural Law, Religion, and Rights*.

<sup>134</sup> Aquinas, *Summa Theologica*, I-II, q. 90.



As Henrik Syse argues, for the early modern thinkers Thomas Hobbes and John Locke, the goal was to develop a political philosophy suitable for an age of upheaval and religious and moral pluralism.<sup>135</sup> In their theories, *natural rights* emerges as a key concept. For the medievals, the emphasis was on natural law as a guide towards virtuous living and thus happiness. Hobbes and Locke, on the other hand, speak little of the good for man. Instead, and in order to accommodate different conceptions of the good life, the emphasis is shifted towards each person's rights, individual will, and consent.

NNL theory sees itself as the rightful heir of Aquinas and the medieval tradition. Whether or not God is brought in as a guarantor of the normativity of the natural law, the focus is indeed on natural law, that is, morality, as a guide *for* human action and *towards* the good life. However, the prominent place of basic goods in the NNL theory leads to the idea that one has a *natural right* to pursue these goods.<sup>136</sup> As Syse warns, there is the risk that in NNL, the language of 'goods' and 'rights' might displace 'duty', 'virtue', and the 'common good' from the central places they occupy in Aquinas's theory.<sup>137</sup>

I will now contrast NNL with other natural law theories in the tradition descended from Aquinas – the classical natural law theories. Classical theories of natural law are diverse, but some prevailing characteristics can be identified. Most retain features of the pre-modern worldview, notably the notion of *teleology*: all things are directed to ends that are natural for them ('final causality'). Classical natural law also relies on *essentialism*, the notion that things have essences or natures that are not human inventions or illusions conjured by language.

Much attention has been given to the 'fact/value' or 'is/ought' distinction, the failure to respect which allegedly involves a 'naturalistic fallacy'.<sup>138</sup> The point is that inferring normative conclusions ('ought') from purely factual premises ('is') is impossible, in that it would involve getting something in the conclusion that was not contained in the premises. This point is clearly true. The classical natural law theorist,

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<sup>135</sup> Syse, *Natural Law, Religion, and Rights*, 198.

<sup>136</sup> Finnis sees the language of rights as perfectly compatible with the new natural law framework: *Natural Law and Natural Rights*, 221.

<sup>137</sup> Syse, *Natural Law, Religion, and Rights*, 142-43; see also Ernest L. Fortin, "The New Rights Theory and the Natural Law. Review of *Natural Law and Natural Rights* by John Finnis," *The Review of Politics* 44 (1982).

<sup>138</sup> Christopher Martin, "The Fact/Value Distinction," in *Human Values*, ed. Oderberg and Chappell (Basingstoke: Palgrave, 2004).

however, denies committing any such fallacy. Her argument may take several routes, of which I will note three: firstly, claiming that what moderns see as ‘purely factual premises’ actually contain implicit normativity (for instance, the factual assertion that ‘he is a sea-captain’ does seem to imply the normative ‘he *should* do whatever a sea-captain should do’).<sup>139</sup> Secondly, denying that the fact/value distinction can be cogently made.<sup>140</sup> Thirdly, working from the presuppositions of teleology and essentialism to claim that there is no fallacy in deriving ‘ought’ from ‘is’. In this view, the enduring problem of normativity in ethics was created when the moderns discarded teleology and essences.<sup>141</sup>

NNL is often considered to have adopted the modern views in the disputes on teleology and the fact/value distinction. In my opinion, it is more correct to say that NNL remains *neutral* on these points of contention, and relying on fewer contested presuppositions while preserving the crucial content is a strength for any theory.

Classical natural law theorists, relying on the notion of teleology, can argue from the facts of our natural faculties to a set of basic goods.<sup>142</sup> For instance, humans have intellects; the natural end of the intellect is acquiring knowledge; thus knowledge fulfils my nature and is a good. Furthermore, I ought to pursue the goods that fulfil my natural faculties. This is so because, given my nature, I can do no other than to do and pursue good, in accordance with Aquinas’ first principle of practical reason. So I ought to pursue knowledge, which is a good. This line of reasoning reveals that ‘both the content of our moral obligations and their obligatory force are determined by natural teleology’.<sup>143</sup> This argument tries to establish the primacy of facts about normative human nature in our practical reasoning. Our nature is normative for us, and can be characterized by theoretical reason. Practical reasoning must then start from considerations of our normative nature; that is, from matters of fact, presented by theoretical reason. The ‘is to be’ of practical reason is deduced from the ‘is’ of theoretical reason’s conception of our normative human nature. Acts that

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<sup>139</sup> Alasdair MacIntyre, *After Virtue*, 2nd ed. (Indiana: University of Notre Dame Press, 1984), 54.

<sup>140</sup> See Martin, “The Fact/Value Distinction.”

<sup>141</sup> See, for instance, Edward Feser, “Classical Natural Law Theory, Property Rights, and Taxation,” *Social Philosophy and Policy* 27 (2010): 22.

<sup>142</sup> See, for instance, Ralph McInerny, *Ethica Thomistica*, revised ed. (Washington D.C.: CUA Press, 1997).

<sup>143</sup> Feser, “Classical Natural Law Theory,” 31.

conform to the *telos* of human nature are morally good; those that do not are morally bad.

NNL theorists cannot help themselves to the notion of normative human nature in this way. Instead, that the basic goods are to be pursued is taken to be a self-evident fact grasped by practical reason. Universal human experience shows these goods to be both constitutive of human fulfilment and the natural results of virtuous activity of our natural faculties. This is where the notion of human nature enters the picture; if our nature were different, so would the catalogue of basic goods. In that case, our practical reason would identify as self-evidently good a different set of basic goods. So, in NNL theory, morality is grounded in human nature in the following way: practical reason sees basic goods as providing reasons for action. The basic goods are such because they fulfil our nature. Thus goods that fulfil our human nature provide reasons for action.<sup>144</sup> The starting point is already normative, the ‘is to be’ of practical reason. There is no need for inferences from prior truths of theoretical reason (‘is’).<sup>145</sup> For an NNL theorist, then, human nature is normative in a different and weaker sense than it is for the classical theorist.

Classical natural law theories may take human nature to be normative in a strong way, leading to moral prohibitions on actions that go against this conception of our nature. A problem, however, according to Grisez, is that classical natural law theories usually do not have the theoretical resources for providing *positive* guidance for action:

What does not conform to human nature can be forbidden absolutely. What does conform cannot be absolutely required, since people cannot possibly do everything which is permissible ... Thus scholastic natural-law theory is far more adept at issuing a few prohibitions than at directing people’s lives toward growth and flourishing.<sup>146</sup>

Grisez also objects that the focus on prohibitions makes the theories ‘legalistic’. Moral norms become mere strictures on living, and not principles to guide people

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<sup>144</sup> Robert P. George, “Natural Law and Human Nature,” in *Natural Law Theory. Contemporary Essays*, ed. Robert P. George (Oxford: Oxford University Press, 1992), 34-36.

<sup>145</sup> See also Henry Veatch and Finnis’s illuminating discussion of this topic: Veatch, “Natural Law and the ‘Is’–‘Ought’ Question,” *Catholic Lawyer* 26 (1981); Finnis, “Natural Law and the ‘Is’–‘Ought’ Question: An Invitation to Professor Veatch,” *ibid.*

<sup>146</sup> Grisez, *Christian Moral Principles*, 105-06, quoted in Black, “Introduction,” 2.

towards fuller, richer living. Grisez's criticism is, I think, overstated. Classical natural law theories also guide towards love, towards the virtues, and towards growth in the moral life. This conception is rich, and not so thin as merely to forbid a few kinds of actions.<sup>147</sup> In a way, classical natural law theories were teleological more than deontological, and therefore difficult to sum up in universal rules. Perhaps Grisez's criticism has more bite against certain desiccated versions of scholasticism than against Aquinas's approach.

As was shown in the section on cultural diversity, NNL provides the theoretical tools for the affirmation of any truly fulfilling life-style and cultural practice. For this important feature, the theory's conception of the principles of practical reasonableness is crucial. These principles help specify positive and proscriptive moral guidance, and it is to these that we turn in the next chapter.

## 1.8 Chapter summary

The first, 'pre-moral' half of the theoretical framework that is new natural law theory has been examined. The theory starts from the distinction between theoretical and practical reason, and from the first principle of practical reason. This principle is capable of specification by each of the basic goods. What it means for the theory to be secular, that is, not dependent on premises that exhibit content or epistemic religiosity, was also discussed. Reasons were given for including five basic human goods in the catalogue of basic goods. Important problems for NNL theory were also identified; notably, the puzzle of whether pleasure or the avoidance of pain can be basic motives for action; challenges to Finnis's interpretation of incommensurability; and the problem of the underdeterminacy of self-evidence.

Nevertheless, several features of the NNL theory together make it a rationally appealing moral theory that is worthwhile to consider. The theory strikes an intriguing balance between consequentialist and deontological theories, attempting to rectify the imbalances of each. The concept of basic human goods arguably comports well with human experience, and the theory opens up for a plethora of worthwhile life-plans and diverse ways of pursuing the goods that together fulfil our lives. As a full-fledged

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<sup>147</sup> This was pointed out to me by Christopher Kaczor.

competitor to mainstream ethical theories, NNL supplies novel perspectives from which to point out flaws or problems with the other theories.

## 2 Ethical principles

The next step in the construction of the new natural law theory is to examine the implications of the first principle of morality, which was introduced in Chapter 1. The principle can be ‘specified’ into a set of requirements of practical reason, also called intermediary principles of morality. Of these requirements, one is particularly central to the construction of moral prohibitions (negative moral norms). This requirement, the seventh in Finnis’s list, is supposedly justified by self-evidence. However, this justification is susceptible to the problem of the underdeterminacy of self-evidence. Three competing formulations that at first glance could make an equal claim to be self-evident will be detailed. Strengths and weaknesses of each candidate formulation will be examined. The question of which one ought to be incorporated in our>NNL theory is important, for the seventh requirement plays a crucial role in shaping the normative demands of the theory.

### 2.1 Rationality and ethics

In the previous chapter, the journey from basic human goods to ethics commenced. Ethics is the investigation of *how* the basic goods should be pursued through action. It was shown that considerations of the basic human goods and the first principle of practical reason lead to a ‘first principle of morality’. Grisez et al.’s version of this principle is, ‘In voluntarily acting for human goods and avoiding what is opposed to them, one ought to choose and otherwise will those and only those possibilities whose willing is compatible with a will toward integral human fulfillment’.<sup>1</sup>

Any morally upright action, then, is ‘compatible with a will toward integral human fulfillment’. Actions can be divided into three categories according to how well they live up to the demands of the first principle of practical reason and Grisez’s principle. *Fully rational actions* are the morally upright actions. They are in keeping not only with the first principle of practical reason, but also with the first principle of morality: fully rational actions treat the basic goods as action-guiding reasons. Since one *ought* to be rational, it follows that one *ought* to perform *fully* rational actions,

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<sup>1</sup> Grisez, Boyle, and Finnis, “Practical Principles, Moral Truth, and Ultimate Ends,” 128.

whereas one *ought not* to act on proposals for action that are *rationally deficient* in any way. The latter kind of choices would imply not being ‘open to integral human fulfillment’.<sup>2</sup>

The second category is that of *minimally rational actions*. Such actions satisfy the demand made by the first principle of practical reason, that the action be done *for the sake of some good*. However, these actions are in some way rationally deficient, and thereby do not fully live up to the demands of Grisez’s principle. The third category is that of *unintelligible actions*, which live up neither to Grisez’s principle, nor to the first principle of practical reason’s demand that the action be done for the sake of some good.

Note, then, that according to NNL, an action is morally acceptable if and only if it is also fully rational. An action that is rationally deficient in any way fails to live up to morality’s demand, and is therefore *immoral*. This use of the terms may seem quaint. In the following sections the rationale for using the terms in this way will become clearer.

## 2.2 Intermediate moral principles

What kinds of action does the first principle of morality rule out? It rules out actions that are less than fully rational, that are incompatible with the ‘will towards integral human fulfillment’ in one or more ways. The first principle of morality can be specified into more concrete (although still quite general and abstract) intermediate moral principles. These principles are variously called ‘modes of responsibility’ (Grisez et al.) or ‘requirements of practical reason’ (Finnis).<sup>3</sup> The basic reasons for action, constituted by the basic goods, are *first-order practical reasons* for action. Correspondingly, the intermediary principles that are about to be discussed are *second-order practical reasons*, reasons for action that do not spring directly from the goods themselves, but from reflection upon the goods and their demands.

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<sup>2</sup> Finnis, *Fundamentals of Ethics*, 76.

<sup>3</sup> Grisez, Boyle, and Finnis, “Practical Principles, Moral Truth, and Ultimate Ends”; Finnis, *Natural Law and Natural Rights*.

### 2.2.1 How the intermediate principles are established

The first principle of morality demands that choices are made with ‘a will toward integral human fulfillment’. The intermediate moral principles represent an unpacking of what this good will consists in. The principles cannot be deduced formally, but they are seen to be true – they are self-evident – in the light of human experience. Here, yet again, an appeal is made to the notion of self-evidence. Again, this might seem suspect and in need of further justification. Arguably (as readers can attest for themselves), the resulting intermediate moral principles will, for the most part, have just the qualities argued to be possessed by self-evident claims: they are ‘seen to be true’ without the need for deductive argument involving further premises. Furthermore, they are not readily refuted by counter-examples. However, the problem of the underdeterminacy of self-evidence arises here as well, in its third and most pernicious installment, as will be shown later on.

According to Finnis, whose account I will mostly be following, some background knowledge or premises are required in order to elucidate the intermediate moral principles.<sup>4</sup> One needs to know something about the basic human goods and the ways humans pursue them, and about human nature. The intermediate moral principles are specifications of the first principle of morality, the function of which is to guide us towards *human fulfillment*. Black’s summary of the ten most significant points of ‘background knowledge’ in Finnis’s analysis is helpful:<sup>5</sup>

1. any significant pursuit of worthwhile activities (or goals) in human life will often involve substantial amounts of time and energy, and sometimes material resources;
2. human life is limited by finite time and personal energy;
3. human life is subject to changing circumstances, including the possibility of unpredictable and (highly) disruptive events;
4. the different worthwhile activities of human life are distinct and cannot be compared with one another (incommensurability);
5. integral human fulfillment is constituted by all the basic human goods;

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<sup>4</sup> *Natural Law and Natural Rights*, 100-27.

<sup>5</sup> Black, “Introduction,” 16.



6. the realising of many worthwhile goals in human life will require cooperation with other people;
7. material resources are limited;
8. each person is unique, including in his/her skills, capacities and circumstances;
9. all humans share the same essential nature; and human persons are multi-dimensional beings, having at least rational, emotional, existential (choice-making), inter-personal, and cultural dimensions; and
10. a person's feelings and emotions can be in harmony or conflict with his/her reasoning and choosing.

These, then, are essential features of human life. Any system of morality, such as Finnis's requirements of practical reason coming up next, must be shaped by this 'background knowledge' of the human condition.

### 2.2.2 Finnis's requirements of practical reason

These are the requirements of practical reason that Finnis lists:<sup>6</sup>

1. 'have a harmonious set of orientations, purposes and commitments';
2. 'do not leave out of account, or arbitrarily discount or exaggerate, any of the basic human goods';
3. 'do not leave out of account, or arbitrarily discount or exaggerate, the goodness of other people's participation in human goods' (cf. the golden rule);
4. 'do not attribute to any particular project the overriding and unconditional significance which only a basic human good and a general commitment can claim';
5. 'pursue one's general commitments with creativity and do not abandon them lightly';
6. 'do not waste your opportunities by using needlessly inefficient methods, and do not overlook the foreseeable bad consequences of your choices';
7. 'do not choose directly against any basic human good';
8. 'foster the common good of your communities';

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<sup>6</sup> Finnis, *Fundamentals of Ethics*, 75-76.

9. 'do not act contrary to your conscience, i.e., against your best judgement about the implications for your own action of these requirements of practical reasonableness and the moral principles they generate or justify'; and
10. 'do not choose apparent goods, knowing them to be only the simulations of real goods, even when simulation brings real emotions or experiences, real satisfactions'.

How is one to judge whether these 'requirements of practical reason' are indeed self-evidently true? One way would be to ask oneself whether the negation of a principle could ever be rational (in Finnis's sense). For my own part, when I perform this exercise, the negations of each of the principles appear decidedly unappealing (with the exception of the seventh requirement, which I will scrutinize in detail later).

Might it be that one reason why the requirements appear true is that, to a considerable extent, they rely on 'thick descriptions', i.e., terms with an in-built moral or rational judgment? If 'murder' is defined as *unjustified* killing, then of course one ought not to commit murder; 'unjustified' is a thick description implying the judgment that the action to which it is affixed is unacceptable. In the same vein, of course one should not 'arbitrarily discount or exaggerate' (2, 3), 'abandon lightly' (5), use 'needlessly inefficient methods' (6), and so on. The presence of thick descriptions in the wording of the requirements makes the requirements indecisive. Practical judgment is needed to deem when a given action implies, e.g., *arbitrarily exaggerating* the importance of a basic human good, abandoning one's project *too lightly*, *needless* inefficiency, and so on.

To illustrate the application of the principles, consider the sixth. Any task of construction, say of building a fence, involves actions that are at least minimally rational ('I choose to build a fence around my garden in this way, with these materials, for the sake of protecting my property'). However, there are several ways in which the actions that constitute the construction of the fence may be less than fully rational: the chosen materials may be known to be of poor quality ('inefficient method'), or the construction may take time away from much more pressing matters, the negligence of which leads to 'foreseeable bad consequences'. By in one way or another violating the sixth requirement (or any of the other requirements) on fully rational action, the set of actions that make up constructing the fence would fail to live up to the moral standard of complete rationality, the adequate response to the various

demands of practical rationality. Other theories of practical rationality and approaches to ethics could agree that a fence could be built in a practically unreasonable and irrational way. However, they would typically categorize this irrationality as a non-moral, technical irrationality. In NNL, on the other hand, the domain of morality appears to overlap fully with the domain of practical rationality. No choice is ever ‘only technical’ and non-moral, for basic goods are always at stake, at least indirectly. Therefore, NNL deems an action immoral if it fails to live up to the full demands of practical rationality.

Recall the contention that these requirements are self-evident in light of universal human experience. If this is truly the case, the requirements do not stand in need of further underpinning by rational argument for their justification. Indeed, such arguments may not even be available. However, dialogical argument may have a role in *convincing* about the truth of self-evident propositions and dispelling counter-arguments.

Finnis points out that several of these principles individually or combined have been taken by philosophers and theologians as expressing the core of ethics (e.g., #3, ‘do unto others’).<sup>7</sup> This should be unsurprising, given that each principle constitutes a part of what is commonly meant by ethics. In an NNL perspective, however, true ethics encompasses the *totality* of these ethical principles. Ill-conceived ethical guidance may stem from a too-limited appreciation of the second-order principles.

### 2.3 ‘Do not choose directly against any basic human good’

The seventh principle on Finnis’s list merits special interest. This principle plays a crucial role in generating concrete moral norms pertinent to medical ethics. Many of the other requirements of rationality give rise to positive norms: one should, for instance, ‘have a coherent plan of life’. Positive norms such as these, though, do not severely constrict the range of available actions. The seventh principle, on the other hand, gives rise to negative norms, prohibitions. A prohibition on killing innocents, for instance, could arise from the application of the seventh requirement to the basic

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<sup>7</sup> Finnis, *Natural Law and Natural Rights*, 126-27.

good of life. A fair part of the action-shaping force of NNL, therefore, springs from this seventh requirement.

In the course of discussing the seventh requirement, Finnis also makes use of other formulations that are presumably meant to be essentially synonymous to ‘do not act directly against any basic human good’: ‘one should not choose to do any act which *of itself does nothing but* damage or impede a realization or participation of any one or more of the basic forms of human good’, and ‘respect for every basic value in every act’.<sup>8</sup> Finnis also points out that the precise sense of the prohibition stated in the seventh requirement will partly be shaped by the complete set of requirements of practical rationality. This point, combined with the subtle differences between the various formulations, makes the intended sense of Finnis’s seventh requirement less than perfectly clear. However, based on how Finnis uses the requirement in other contexts, I think this interpretation is precise: we should not ‘choose directly against any basic human good’; to ‘choose directly’ means *to intend*, and so one should not intend to damage instantiations of basic human goods, neither as a goal in itself nor as a means to a perceived ‘greater good’.<sup>9</sup> As Christopher Tollefsen puts it, ‘one intends destruction [of a good] when either the state of affairs pursued or the means chosen are *desirable precisely insofar* as they include a privation of a good’ (my emphasis).<sup>10</sup>

As discussed, all reasons for action must spring from the basic human goods. Further, the goods are incommensurable in that they do not alone establish any hierarchy among themselves, and in that they are irreducible to a common, underlying value (see 1.4.10). According to Finnis, these two theses together logically entail the seventh requirement.<sup>11</sup> If one considers any plan for action that involves intentional damage to any of the basic goods, one will see that there is *no reason* to adopt it; that such an action is *irrational*. For, first, the damage intentionally incurred to a basic good cannot be ‘outweighed’ by other aspects of basic goods gained as a consequence of the action – such weighing of consequences and goods is senseless; and second,

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<sup>8</sup> *Natural Law and Natural Rights*, 118; Grisez calls the principle the ‘eighth mode of responsibility’, which he defines as ‘One should not be moved by a stronger desire for one instance of an intelligible good to act for it by choosing to destroy, damage, or impede some other instance of an intelligible good’ (Grisez, *Christian Moral Principles*, 205-22).

<sup>9</sup> This is also the interpretation that Finnis embraces in his most recent treatment in the postscript to the second edition of Finnis, *Natural Law and Natural Rights*, 454-56.

<sup>10</sup> Christopher Tollefsen, “Intending Damage to Basic Goods,” *Christian Bioethics* 14 (2008): 276.

<sup>11</sup> Finnis, *Natural Law and Natural Rights*, 118-19.

there are no *other* reasons-for-action that could be invoked, reasons that do not spring from the basic goods. The proposal to destroy an instantiation of a basic good can therefore never be for the sake of a ‘greater good’; instead, the proposal must involve assuming that (or acting as if) a basic human good is in fact not a basic human good. Thus the proposed action is irrational and immoral. An example helps clarify this line of argument and shows how the seventh requirement performs its work.

Bernard Williams’ classic critique of consequentialism includes the case of a traveller who gets the choice to either shoot and kill one innocent Indian, thereby saving nineteen other innocents who the guard promises to release; or abstain from killing, and being forced to watch the killing of all twenty.<sup>12</sup> In consequentialist terms, the choice seems obvious: there are nineteen innocent lives to be spared here.<sup>13</sup> From the>NNL outlook, however, the killing of one of the innocents constitutes a direct attack on the good of life, and is thus immoral. But does not the act effect a tremendous gain of life as well? No. Even though saving the lives of nineteen innocents is the further intention of the act of shooting the one Indian, this consequence is causally remote from the act of shooting, relying on another agent’s action (the guard’s keeping his promise to release the other Indians). So the act of shooting the innocent *in itself* does nothing but kill the Indian – thus destroying an instance of the good of life.

Finnis’s seventh requirement can be put to the test by searching for counter-examples where actions that go directly against basic goods nevertheless are obviously morally acceptable and perhaps morally obligatory. R. George Wright has suggested that interrupting a game of golf for the sake of saving a child’s life would constitute acting directly against the good of play, and thus be immoral in Finnis’s scheme.<sup>14</sup> However, the interruption of the game is not chosen *for its own sake*, it is not intended; rather, it is an unintended side-effect of coming to the child’s aid. Wright’s example, then, is not of an action performed directly against a basic human good.

James M. Dubois provides a more powerful counter-example:

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<sup>12</sup> Smart and Williams, *Utilitarianism: For and Against*, 98-99.

<sup>13</sup> However, some consequentialists appeal to hidden consequences to avoid the conclusion that killing the innocent is justified; e.g., giving in to a tyrant’s demand may foster worse consequences in the long term.

<sup>14</sup> Discussed in George, *In Defense of Natural Law*, 92.

Two brothers are habitually late for school, are negligent in doing their household chores, and get too little exercise because they love to play chess and they play whenever they get the chance. Their school bus will arrive in 2 minutes. They have nevertheless just started a game of chess in which they are wholly immersed (...) Just as one brother moves his bishop against a knight, his father calmly picks up the chessboard and empties the pieces into the box—ruining the whole game. He informs them that he is confiscating their chessboard for a week.<sup>15</sup>

The father's action here is one of intentionally stopping the game. He has come to realize that playing chess for the time being no longer contributes to his sons' human fulfilment (rather it is hampering education, exercise, etc.). It seems that the brothers have given the good of play an undeserved place of prominence in their lives, to the exclusion of other goods. They have thus acted against Finnis's second requirement of practical reasonableness by arbitrarily exaggerating the importance of the good of play. Quite clearly, however, the father's action goes 'directly against a basic human good' as an attack on an instance of the good of play. Equally clearly, the action is morally justified – it is entirely consonant with the father's duty as a loving parent. The father does not merely have the brothers cease pursuing one good in order to pursue other goods – which would have been unproblematic on Finnis's account. No, the father deliberately puts a stop to playing chess as such. The intention and act-description under which he acts crucially involves stopping the game in which the brothers are involved. The action in itself does nothing but destroy an instance of basic human good.

Of course, Finnis would agree that the father's action is justified. The good of play currently occupies an unreasonably large place in the brothers' lives, and so they morally ought to cease playing. However, Finnis' theory is formulated in a way that rules out the father's reasonable intervention, and this is a problem for the theory.

Examples can, it seems, be multiplied. Consider a hacker who is in the process of downloading highly sensitive classified information; the police arrive at his building and immediately cut the building's power supply. Only then do they proceed to make the arrest. Cutting the power was done first in order to prevent the hacker

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<sup>15</sup> James M. Dubois, "How Much Guidance Can A Secular, Natural Law Ethic Offer? A Study of Basic Human Goods in Ethical Decision-Making," in *The Death of Metaphysics; The Death of Culture: Epistemology, Metaphysics, and Morality*, ed. Mark J. Cherry (Springer, 2006), 189-90.

from learning highly sensitive secrets of state. This intervention is morally justified, but as long as it is done with the intention of *hindering the hacker's acquisition of knowledge* it is difficult to justify in Finnis's framework: although morally justified, it appears to be a direct attack on the pursuit of knowledge. A defender of Finnis's position would perhaps argue that this does not adequately describe the police's intention in pulling the plug. Perhaps the defender would say that they acted *for the sake of justice* or *for the sake of preventing a crime*. However, in my view this interpretation is strained. Rather, hindering the hacker's acquisition of knowledge is *exactly* what the action is for. At the very least, cutting the power is *intended as a means* to the further goals of justice or crime-prevention.

Briefly, a final, third example: Two teenagers have become friends, but the one's parents view the relationship as destructive. It is a true friendship, but the parents deem it not to be in the teenagers' interest. Therefore, they demand that the teenagers cease meeting each other and take measures to prevent this from happening. Thus, the parents act intentionally against the good of friendship, but may be morally justified in doing so.

The general lesson is that Finnis's seventh requirement seems to be too strong. It rules out some morally justified intentional attacks on instances of basic human good. A general point seems to be this: Let X be an instance of pursuit of a basic human good. There are cases in which X either does not contribute to the person's fulfilment, or, in addition, is significantly morally wrong. In some such cases, other persons can be justified in – or even have an obligation to – *intentionally* bringing X to a halt.<sup>16</sup>

Therefore, I take the chess case, the hacker case, the destructive friendship case and analogous cases to be powerful counter-examples against the requirement never to act directly against any basic human good: these cases show that there are

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<sup>16</sup> However, there are cases that, on the face of things, appear to be potent counter-examples to Finnis's seventh requirement, but that in reality are not, like the 'ceasing to play golf' case above. Consider for instance a missionary who pursues his calling with great zeal, thus neglecting his children's basic need. He damages the children's basic goods, but not *intentionally* so. Consider also the hermit who moves to the wilderness and avoids contact with other people for the rest of his life. Most likely he gives up friendship only as a *side-effect* of pursuing other goods that are best pursued in solitude. In these two examples, basic goods are damaged, but not intentionally ('directly').

times when *direct acts against instances of basic human good* are not only morally acceptable but even *morally required*.<sup>17</sup>

As with the other requirements, the injunction not to intend damage to basic human goods is supposed to be self-evident in the light of human experience. However, as mentioned, that a proposition can be established as self-evident does not preclude it being established by way of a deductive argument as well. In this case, I believe that Finnis's proposition can also be reached by a deductive argument:

P1: Basic human goods are valuable in themselves.

P2: It is irrational to intentionally act against that which is valuable in itself, unless the damage can be outweighed by other consequences of the action.

P3: Intentional damage to basic goods cannot be outweighed.

C: It is irrational to intentionally act against the basic human goods.

This argument relies on two purportedly self-evident premises (P1, P2), but the argument itself is deductive, and thus does not rely on the grasping of its conclusion as a self-evident truth. P3 follows from the incommensurability thesis discussed in Chapter 1. It seems, then, that Finnis's version of the seventh requirement can be reached by way of a deductive argument that reveals two (purportedly) self-evident premises one step further back. However, this does not preclude Finnis's proposition being justified by self-evidence as well. Detailing the deductive argument is instructive because it shows the three premises of which any competing versions of the seventh requirement must deny one or more.

### 2.3.1 The seventh requirement and the problem of the underdeterminacy of self-evidence

If one takes the chess case, the hacker case and analogous test cases to be powerful counter-examples to Finnis's formulation of the seventh requirement, then one may want to search for an *alternative* seventh requirement. At this point the problem of the

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<sup>17</sup> Christopher Kaczor suggested yet another example to me, an example that deviates from the structure of the previous three. Imagine that a deranged tyrant captures you and your family. He demands that you play chess with him, and suggests that if you win then you and your family will be killed. Therefore you deliberately throw the game, thereby acting directly against the good of play.



underdeterminacy of self-evidence will rear its head again – and it may turn out to be not only a problem, but also a strength, as will be seen.

Finnis’s formulation aspired to justification by self-evidence. However, as the discussion of the first two instances of the problem of self-evidence emphasized (see 1.5), whenever self-evidence is invoked, one should be wary of *other* likely candidates to inference by self-evidence. Are there competing formulations of the seventh requirement available? The *problem* of self-evidence means that there may very well be; but seeing as we have detected problems with Finnis’s formulation, we may *welcome* such competition.

Therefore this is the third iteration of the problem of self-evidence: if the proposition ‘do not choose directly against any basic human good’ makes a claim to justification by self-evidence, there may be alternative formulations that are close but not entirely synonymous that could make an equal claim to self-evidence. What are the alternatives, which ought to be preferred and incorporated in the theory, and why?<sup>18</sup>

### 2.3.2 ‘Never intentionally act against a real aspect of a human being’s fulfilment’

In a 2006 paper, James M. Dubois proposes an alternative formulation of the seventh requirement.<sup>19</sup> His contention is that instantiations of basic goods sometimes are not good *for* the person. In such a situation, the instantiation of basic good does not contribute to the person’s fulfilment or flourishing. It makes little sense to forbid actions directly against basic goods in the abstract – rather, it is *basic goods as real aspects of human beings’ fulfilment* that it is practically reasonable to pursue, and practically unreasonable to destroy. And so the seventh requirement should be formulated as ‘never intentionally act against a real aspect of a human being’s fulfilment’.

Dubois accepts the natural law thesis that one does not have any other reasons for action than those that spring from the basic goods. However, this does not imply that *all instantiations of basic goods give rise to reasons*. Specifically, there may be

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<sup>18</sup> The other requirements of practical reasonableness could most likely be challenged in the same way; however, this is not attempted here.

<sup>19</sup> Dubois, “How Much Guidance Can A Secular, Natural Law Ethic Offer?”

instantiations of goods that are not part of the person's fulfilment. Thus it is consonant with the first principle of morality's injunction to always act with a will to integral fulfilment to disregard (or perhaps even directly act to destroy) such instantiations of goods.

Dubois gives three points in support of his thesis (which I will call the 'real aspect thesis'). First, in our moral deliberation, the basic human goods are relevant as *concretely instantiated*, not as *abstract* goods. When one rescues a drowning child, the motivation is obviously the need to save the child's life, not the need to avert damage to the abstract good of human life as such. Second, the moral importance of basic human goods stems from their *actual contribution to human fulfilment*, not from their *intrinsic value as goods*. For instance, in the case of knowledge, Dubois notes, 'It is not the phenomenological description of knowledge as intrinsically valuable in the abstract as a 'pure perfection' but rather as an aspect of human well-being, as a human possibility that is good to actualize'.<sup>20</sup> Third, an instance of basic human good can actually *cease being beneficial to a person*. We have already become familiar with Dubois' case of the chess-playing brothers.<sup>21</sup> In this situation, playing chess (which instantiates of the good of play) plainly seems to have ceased being beneficial to the brothers. The game currently interferes with their fulfilment. The father's act of stopping the game is not an attack on the abstract good of play, but on the concrete instance of play that currently is not beneficial to the brothers. One need not resort to consequentialist weighing of consequences to perceive that this instance of the good of play currently does not contribute to the brothers' integral human fulfilment.

Dubois's 'real aspect thesis' implies that it is only unreasonable to act directly against a basic human good as long as the good actually is beneficial to a person; that is, as long as it contributes to the person's fulfilment. Thus the thesis is compatible

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<sup>20</sup> Ibid., 188.

<sup>21</sup> Dubois gives two other examples of situations where he thinks that instances of basic human goods have ceased being beneficial to the person. However, these examples are problematic in a way that the chess example isn't, and so I will not discuss these cases in full here. Briefly, the first example involves medical anaesthesia in connection with surgery as an attack on a boy's consciousness, and thus on the good of knowledge. Dubois' contention is that during surgery, consciousness ceases to be good for the boy, and so a direct attack upon it is not unreasonable. I think, however, that Dubois goes wrong by linking the capacity of consciousness to the good of knowledge here. A direct attack on consciousness need not be an intended attack on the good of knowledge. The other example involves a woman undergoing sterilization because another pregnancy would be life-threatening to her. The moral prohibition on sterilization is contentious, in a secular natural law theory especially, and so the example is not well suited for the present discussion.

with the first principle of morality's injunction to always act with a view to integral human fulfilment. In fact, one may find it to be a more reasonable specification of morality's first principle than Finnis's formulation of the seventh requirement.

Another consequence of the real aspect thesis is that basic human goods are only *prima facie* good to the person. If this is so, it is merely *prima facie* irrational to intentionally act against the basic human goods. Dubois thus denies P1 in Finnis's argument above: basic goods are not *always* valuable.

The real aspect thesis influences the way *moral absolutes*, that is, exceptionless moral norms, are formulated. For it is now only *prima facie* wrong to act intentionally against instances of basic human goods. Grant for the sake of argument that there are some true material moral absolutes: for instance, it is wrong to tell a lie. According to the real aspect thesis, the moral absolute must specify that the attacked good in question is actually a good *to* a person: 'it is wrong to tell a lie *when the knowledge thereby withheld from the other person would constitute a real good to him or her.*'

The relevance for the discussion of end-of-life decisions that is to come is perhaps obvious. Has life itself ceased to be beneficial, ceased to be an aspect of human fulfilment to a suffering, imminently dying patient or a patient in the vegetative state? Should the traditional moral absolute against killing innocents be modified to exclude the killing of people for whom life has ceased to be beneficial? This will be a core question of the next two chapters.

More generally, the real aspect thesis reduces the scope of NNL's negative moral norms. Fewer actions will be prohibited by the theory; specifically, some actions directly against an instance of a good that is judged not beneficial to a person, will no longer be prohibited. Of course, if the theory would be wrong to prohibit these things, this change will turn out to be a virtue of the theory. The real aspect thesis version of the NNL theory might be the one that squares better with moral truth. Another important consequence of the real aspect thesis is noted by Dubois:

Because this framework introduces a new question into the realm of ethical decision-making, it places a greater burden on prudential reasoning. As such it also opens the door to rationalizations. (...) Rationalizations are a threat, but that is simply the human situation, and it remains a threat even within the confines of Finnis's version of natural law given that there is some flexibility in how [ends and means] are defined

and when double effect may be invoked. Ultimately, there can be no substitution for integrity and prudence.<sup>22</sup>

A new question for prudential judgment is whether the good in question is a real aspect of a person's fulfilment.

Dubois's 'real aspect thesis' is, then, one of the variations on the seventh requirement that must be taken into consideration. There is another competitor on the scene as well, as the next section will show.

### 2.3.3 'Respect each basic good in every action'

It is no coincidence that many suggested counter-examples to Finnis's formulation involve the good of play. For many would consider play as decidedly less important than many of the other goods. It seems implausible that setting aside instances of play for the sake of other goods should be outlawed by a general moral rule.

This consideration may give rise to the thought that the goods make *different demands* on rational agents. The latter is the gist of Chappell's suggestion that what is demanded by rationality is that each basic good is *respected* in every action; and that what constitutes respect varies between the goods.<sup>23</sup> Chappell seems to intend his suggestion as a gloss on Finnis's formulation (*acting directly against* means *not respecting* the good),<sup>24</sup> but I will treat it as a competing version of the seventh requirement, with not merely semantic but substantial differences from Finnis's version.<sup>25</sup>

Chappell provides an instructive analysis of the different attitudes one may take towards the basic goods. When you seek to instantiate a good through action, you are *pursuing* the good. The goods you are not currently pursuing, you must *respect* or *honour* (these are intended as synonyms). Failure to respect or honour a basic good is irrational, for a lack of respect implies treating a basic good as if it were not a basic good. Not respecting a basic good is *violating* the good. Pursuing and

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<sup>22</sup> Ibid., 193.

<sup>23</sup> Chappell, "The Polymorphy of Practical Reason," 112-24; *Understanding Human Goods*, 84-91.

<sup>24</sup> "The Polymorphy of Practical Reason," 113.

<sup>25</sup> As does Paterson: *Assisted Suicide and Euthanasia*, 83.

respecting/honouring, then, are the attitudes that NNL allows us to have towards the basic human goods.

This can be contrasted with consequentialism. For the consequentialist, only one attitude towards the good(s) is appropriate: *promotion*, in the sense of maximization. The consequentialist will find the attitude of respecting goods unintelligible. To him, all goods have a common denominator, enabling the calculation (at least in principle) of a moral sum, which ought to be maximized through every action. Therefore, morally adequate action only leaves room for promoting goods. However, the natural law incommensurability thesis implies that it is, rather, the talk of ‘moral sums’ that is unintelligible. And it follows from this that a given action typically cannot pursue all goods. Rationality demands that the goods that are not pursued be at least respected.

What does respect for the basic goods imply? First, respect may be shown not only in action, but also in attitudes and dispositions.<sup>26</sup> A thoroughgoing unfriendliness is regarded as a vice. The unfriendly disposition involves a lack of respect for friendship as an objective good. Thus unfriendliness seems to be irrational and immoral even as a disposition, considered apart from actual choices or actions.

Second, some goods are violated by being intentionally destroyed. For instance, proper respect for the good of life (arguably) means never intentionally destroying innocent human lives.

Third, it seems intuitively right that sometimes a certain instance of good may permissibly be intentionally damaged for the sake of another good. This is illustrated by Chappell’s ‘*Mona Lisa* problem’: ‘Given a choice between the deaths of my children and burning the *Mona Lisa*, I burn the *Mona Lisa* every time’.<sup>27</sup> It seems that intentionally destroying the *Mona Lisa*, even for the sake of another good, as here, constitutes a direct action against the basic good of aesthetic experience (which, in Finnis’s newest approach, is a sub-good of knowledge). Therefore, it would be ruled out by Finnis’s version of the seventh requirement. Will it not also fail to live up to Chappell’s notion of minimal respect? No, argues Chappell; in this situation the

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<sup>26</sup> Chappell, *Understanding Human Goods*, 85-86.

<sup>27</sup> *Understanding Human Goods*, 86. Chappell has a more Platonist view of the goods, considering art itself as a basic good; for Finnis, a work of art would not in itself constitute a basic good; the act of experiencing the work of art, on the other hand, could. Nevertheless, the example could be changed somewhat in order to comply with Finnis’s view of the basic goods, and would then still convey its general point. I persist in using Chappell’s original example so that his illuminating quote, coming up next, can be provided.

demands of aesthetic experience are not *overridden* by the demands of the good of life. Rather, in this particular situation, the good of aesthetic experience (or ‘the good of art’, as Chappell says) *does not make any demand* to the effect that the picture should not be burned:

This isn’t a verdict that emerges from some consequentialist process of commensuration of different goods, the output of which is to show that human lives are ‘worth more’ than pictures. It is a verdict that emerges from reflection on what commitment to the good of art itself involves. Art is certainly the sort of good to demand of us openness, attentiveness, listening sympathy, emotional engagement. But it certainly isn’t the sort of good to demand of us that at all costs we do not deliberately destroy its innocent exemplars; whereas humanity is. So the point isn’t the relative importance (in some ranking-and-measuring sense) of the two goods of art and humanity. It is the different natures, and hence different demands, of those two goods.<sup>28</sup>

Paterson, following Chappell’s suggestion about respect for the basic goods, treats another stock example case that illuminates this same point about the different demands made by the different goods.<sup>29</sup> A Nazi officer inquires whether you have hidden Jews, which you have in fact done. How should you answer? The truthful answer leads to the apprehension and wrongful death of the Jews, whereas a lie seems to violate the good of knowledge or integrity. However, Paterson argues, it seems that the good of knowledge simply *does not demand of us* that the complete truth should always and in every situation be told. The fact that you are hiding Jews is not a fact that the Nazi officer has any moral right to know. And so it seems that withholding this information from the officer, deceiving, or perhaps even outright lying, is compatible with proper respect for the good of knowledge. Lying can then be construed as the justified deception of a person who has no moral right to the truth.<sup>30</sup>

How does Chappell’s notion of respect square with Dubois’s chess case? Plainly, the father’s act of clearing the chess board does not seem to violate the true

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<sup>28</sup> *Understanding Human Goods*, 87.

<sup>29</sup> Paterson, *Assisted Suicide and Euthanasia*, 66-67.

<sup>30</sup> Grisez condemns lying in all situations as a kind of action that intentionally damages the speaker’s own integrity. Mental reservation is acceptable when there is no intention of deceiving. So is refusing to answer questions where the interlocutor has no right to the answer: Grisez, *Living a Christian life*, section 7.B.6.

demands of the good of play. This good does not demand of us that we never choose to thwart play as a goal in itself or as a means for achieving other goods. Chappell's 'respect thesis', like Dubois's 'real aspect thesis', deals better with this counter-example than Finnis's formulation of the seventh requirement does. The same goes for the hacker case: here, the police's action of cutting the power in order to hinder the hacker's acquisition of classified information appears not to involve disrespect for the good of knowledge.

#### 2.3.4 'Respect each real aspect of a human being's fulfilment in every action'

Finally, it is possible to combine Dubois's and Chappell's insights into a fourth formulation of the seventh requirement. As shown, Dubois stresses that it is instances of basic goods as components of our fulfilment, not the basic goods in the abstract, that ought to be respected in action, whereas Chappell points out that the proper attitude towards the goods is respect, and that the meaning and precise content of proper respect varies between the goods.

A combination of these insights would yield something along the lines of, 'respect each real aspect of a human being's fulfilment in every action'. Let this be called the 'combination thesis'. In principle, such a combination may retain both the virtues and the vices of its progenitors.

## 2.4 Comparing four alternative formulations

There are now four alternative candidates for the seventh requirement of practical reasonableness: The direct action thesis, the real aspect thesis, the respect thesis, and the combination thesis. The seventh requirement is supposedly self-evidently true. However, as the four candidates have conflicting implications, they cannot all be true. This means, further, that they cannot all be *self-evidently* true.

If one of the theses could be shown to be *rationally preferable* to the others, one might nevertheless be justified in incorporating it into the NNL theory. How can the theses be compared? In two ways: by a comparison of their theoretical coherence, and by exposing them to test cases. Coherence means that the moral theory's theorems and principles fit together and constitute a mutually explanatory system.

Test cases expose the theses to strong moral intuitions that we would be unwilling to change.

#### 2.4.1 Theoretical coherence

There is one particularly important challenge for the respect thesis and the combination thesis: how do they elucidate the content of ‘respect’ in the case of each good? According to Chappell, committal to a good involves reflection on the demands the good makes of you. Maybe the meaning of ‘respect’ is partly shaped by one’s intuitive grasp of the concept, and partly by one’s experience and acquaintance with the good in question. Chappell admits that when delineating ‘respect’, ‘we are close to the intuitive bedrock of ethics’.<sup>31</sup> Which intuitions about the proper shape of ‘respect’ should win out, and how does one decide? Does Chappell – and Paterson, who follows Chappell fully on this point – leave too much room for intuitions and interpretation?

Consider, as a case in point, Paterson’s discussion of the demands of the basic good of life and health.<sup>32</sup> According to Paterson, the relevant norm is: ‘Do not intentionally inflict a significant harm upon yourself or others unless there is a compelling reason to do so’.<sup>33</sup> A ‘compelling reason’ could be the mountaineer whose hand is trapped, and who has to cut it off in order to free himself. However, when it comes to intentional killing of the innocent, no reason can be sufficiently compelling, according to Paterson:

Innocent human life, whether in our own person or the person of another, can never, without compelling reason, be intentionally destroyed. Since, however, practical reason, *viz.* its grasp of each primary good and the unique demands generated by each good, will, in the case of human life, admit of no truly ‘compelling reason’ to ever intentionally destroy an innocent person, any action that intentionally kills an innocent person can never rightfully be chosen with a view to action.<sup>34</sup>

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<sup>31</sup> Chappell, *Understanding Human Goods*, 90.

<sup>32</sup> Paterson, *Assisted Suicide and Euthanasia*, 79-85.

<sup>33</sup> *Ibid.*, 79.

<sup>34</sup> *Ibid.*, 81. Paterson’s argument seems to be exactly the same as Chappell’s on this point: *Understanding Human Goods*, 87-88.



However, the precise justification for this judgment remains opaque. Paterson relies on strong intuitions deployed in a set of test cases. But the basic justification, it seems to me, must again be the appeal to self-evidence. Self-evidence, for Finnis, justifies the prohibition on direct actions against basic goods. For Paterson and Chappell, self-evidence seems also to play a role in the justification of *the precise content of the respect* owed to each basic good.

A great deal hinges on the precise shape of the ethical prohibition on killing that results. In Paterson's case, his wholesale prohibition on the intentional killing of the innocent settles the ethical case against euthanasia; his two chapters on euthanasia mainly consist in refutations of counter-arguments to his conclusion that it is always morally unacceptable. The challenge, then, which can be pressed by critics, is whether the content of 'respect' can be tailored so that the resulting moral norms correspond with the very intuitions one would be happy to affirm. For instance, could one not come to the conclusion, *pace* Paterson and Chappell, that *great suffering at life's end* is a 'compelling reason' for allowing intentional attacks on the good of life?

In addition, can the proper notion of respect for each good vary from case to case? In that case, the inclusion of Chappell's respect thesis might threaten>NNL's ability as an ethical theory to give sufficiently clear moral guidance. As the combination thesis inherits the concept of respect for the goods, the present challenge is carried over to the combination thesis as well.

However, in my view, these worries about the respect and combination theses, while warranting serious attention, are not as damning as they may appear, for three reasons. First, the space for interpretation is reduced by insisting that the content of 'respect', although differing among the goods, does not change between concrete situations involving the same basic good. The content of 'respect' must be constant for each good. Second, and most importantly, it might well be the case that morally virtuous and practically reasonable people could agree on the content of 'respect' in the case of each good. When pondering the conditions of proper respect for a good, one is not without guidance: the ideal of integral human fulfilment must shape one's reflections. The good of life occupies a special role; once one realizes this, how can intentionally destroying it ever be compatible with integral human fulfilment? There are reasons, then, for accepting Chappell and Paterson's interpretation of the demand of the good of life. Third, as was argued about the real aspect thesis above, the

introduction of a wider space for prudent judgment is not necessarily a weakness for the theory.

A related worry is the following. The introduction of the qualifiers ‘real aspect’ and ‘respect’ does indeed introduce a new level in which discernment and judgment must be applied. But do they also smuggle *already moralized* judgments into the theory? In 1.4.2 it was argued that Nussbaum’s capability approach makes just this mistake: moralized conceptions of how life ought to be lived are introduced at the pre-moral stages of the theory, stacking the cards in favour of the author’s moral prejudices. However, I think the real aspect and respect theses do not commit a similar mistake. First, the judgment of whether an instance of good constitutes a *real aspect* of the person’s fulfilment *is* made at the pre-moral stage, with genuinely ‘pre-moral premises’: e.g., what is the nature of the good in question? How does it contribute to human fulfilment? Second, with the judgment about what constitutes *proper respect* for a good, such an assessment may draw on common human experience about the very nature of the basic human goods, arguably without privileging any preferred moral norms. It seems, then, that the qualifiers ‘real aspect’ and ‘respect’ do not necessarily allow for contentious smuggling of already moralized premises.

To sum up, the respect, real aspect and combination theses introduce the need for more rational discernment and judgment compared to the direct action thesis. However, this does not seem to reduce theoretical coherence (to be precise: the coherence of>NNL theories in which each of the competing theses are substituted for the direct action thesis) by opening up spaces for the importing of moralized definitions or moralized premises.

#### 2.4.2 Test cases

I have already treated Dubois’s chess case and shown how both the real aspect thesis and the respect thesis make sense of our strong intuitions. The same goes for the combination thesis, which adjudges the chess case in line with its progenitors. On the other hand, the case poses a challenge to the direct action thesis, which does not seem able to deal convincingly with the case.

The second test case was the hacker case. The police cut the power with the intention of hindering the hacker’s acquisition of knowledge. This action is,

obviously, morally acceptable. However, the action seems to go directly against the basic human good of knowledge, and so is problematic on the direct action thesis. Further, the acquisition of knowledge seems to be a real aspect of the hacker's fulfilment, and thus is ruled out by the real aspect thesis as well.<sup>35</sup> The respect and combination theses, on the other hand, could say that cutting the power with the intention of hindering the hacker's knowledge is not incompatible with *proper respect* for the good of knowledge. In that case, it seems that the latter theses are able to explain our strong intuitions in the hacker case in a way that the direct action and real aspect theses cannot.

As another test case, consider a critic of abortion who holds that the foetus has intrinsic human value from conception and onwards. Given the abortion critic's metaphysical commitments, would he be able to uphold his stance towards abortion in all four versions of the seventh requirement? The direct attack thesis would construe (the typical) abortion as a direct attack on life. The real aspect thesis could consider the life of the foetus to constitute a real aspect of the foetus's fulfilment, and thus rule abortion to be unacceptable. With the respect thesis, would aborting the foetus constitute disrespect for the good of life? Yes, the killing of a human being is the paradigmatic case of disrespect for a human good (life). Finally, with the combination thesis, abortion involves disrespect for a real aspect of the foetus's fulfilment. The critic of abortion has an equally plausible case with all four interpretations of the seventh requirement.

To sum up, then, four competing formulations have been considered in relation to three cases. In the first two we were interested to see whether the theses would make sense of strong intuitions. The results are summarized in Table 1. In the final case (abortion) we wanted to see whether the theses could explain a moral verdict and analysis prevalent among>NNL proponents. It turned out that they all were able to preserve the stance of a typical critic of abortion.

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<sup>35</sup> One might object that the acquisition of knowledge from hacking cannot be a real aspect of the hacker's fulfilment because it is immoral. However, this objection fails because one cannot presuppose notions of morality on the current stage of theory construction. The hacking indeed constitutes a real aspect of the hacker's fulfilment, in being pre-morally good (by bringing about knowledge).

**Table 1.** *Are the theses in line with our strong intuitions in the test cases?*

	Chess case	Hacker case
Direct action thesis	No	No
Respect thesis	Yes	Yes
Real aspect thesis	Yes	No
Combination thesis	Yes	Yes

Behind the respect thesis lies the notion that there are important differences between the goods, affecting what would constitute a real violation. The respect thesis is compatible with the intuition that *life* occupies a privileged position among the basic human goods. The wrongness of killing is widely acknowledged. However, acting directly against the other basic human goods is not considered to be as morally serious. The respect thesis explains this fact, and allows for treating the goods differently, thus giving rise to differentiated moral rules on intentional attacks on basic goods. In this way, killing may be incompatible with proper respect for the good of life, whereas hindering someone in the acquisition of knowledge may still be compatible with proper respect for the good of knowledge. Arguably, because in line with common intuitions, this differential treatment of the goods is a virtue of the respect thesis, a virtue that is also inherited by the combination thesis.

In the next two chapters, the four alternative formulations are challenged by a test case from medical ethics, a case that will be treated extensively. First, however, it is time to complete the exposition of how normative verdicts are generated in the NNL theory. I begin by exploring a concept crucial to the interpretation of all four versions of the seventh requirement: intention.

## 2.5 Intention

Intention is a tough, sophisticated and serviceable concept, well worthy of its central role in moral deliberation, analysis and judgment, because it picks out the central realities of deliberation and choice: the linking of means and ends in a plan or *proposal-for-action adopted by choice* in preference to alternative proposals (including: to do nothing). What one intends is what one chooses, whether as ends or as means. Included in one's intention is everything which is part of one's plan

(proposal), whether as purpose or as way of effecting one's purpose(s). The parts of the plan are often picked out by phrases such as 'trying to', 'in order to', 'with the objective of', 'so as to' or, often enough, plain 'to'.<sup>36</sup>

Intention is a core concept in the natural law tradition of ethics. According to this view, humans possess free will and must take responsibility for their actions. In practice, everyone accepts that one is more responsible for events that are one's *intended actions* than for events that are mere 'doings', i.e., performances that are not premeditated or undertaken in full consciousness. Intention is specified 'not by what is wished for, but by precisely what is chosen, that is, the object of the act proposed through practical reasoning'.<sup>37</sup> The intention, or the 'moral object' chosen, involves both proximate intention (i.e., the intention to carry out the action) and further intention (i.e., the intention to bring about the desired consequences). In other words, intention involves not only the ends but also the means to bring about these ends. Acting with a certain intention does not necessarily imply that one entertains the conscious thought, 'I am doing this action for *this* particular reason'; the intention is a mental state that may be inherent in the action regardless of the agent's conscious thoughts.

An action has *intended consequences*. These consequences may come about, or they may not. For instance, an oncologist injects a patient with a dose of chemotherapy with the intention of slowing the progression of the cancer. Regardless of this intention, the chemotherapy may or may not actually inhibit the cancer's progression. Actions also have *unintended consequences*. For instance, perhaps the drug has unpleasant side effects, or maybe it constitutes a large financial cost for the patient or the hospital. It may even turn out to cause the patient's death through side effects such as an infection or an allergic reaction. Unintended consequences thus may be *foreseen* or *unforeseen*. Their occurrence may be certain or uncertain, and, likewise, wanted or unwanted. Ethically, however, the most salient distinction is between intended and unintended consequences. How can the moral importance of this distinction be argued for? The crucial point is that the intended consequences are the ones we plan for. They are the ones we aim at with our action; our choice is

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<sup>36</sup> John Finnis, "A Philosophical Case Against Euthanasia," in *Euthanasia Examined*, ed. John Keown (Cambridge: Cambridge University Press, 1995), 26.

<sup>37</sup> Germain Grisez, *Difficult moral questions* (Franciscan Herald Press, 1997), Q.84.

undertaken to bring these consequences about. A choice involves synthesizing your will with the plan for action. You necessarily embrace the maxims or principles inherent in the action. The action's maxims or principles are closely related to the action's intention, as when a choice to shoplift implies the principle 'it is sometimes right for me to steal' and the intention 'I choose to take this object which is not mine'. Through intending X, then, you make yourself into the kind of person who would do X. Actions thus may have lasting effects on one's character.<sup>38</sup>

Agents, therefore, carry special responsibility for the intended consequences of their actions. In addition, agents are always responsible for the unintended consequences, but often to a lesser degree, determined by the actual circumstances. Whether the consequences were foreseen, or ought to have been foreseen, by the agent is especially important.

Some theorists deny that the intention-foresight distinction can be cogently made; in particular, if the foreseen consequence is certain to happen, must it not belong to the intention? Beauchamp and Childress, for instance, endorse an account wherein 'intentional actions and intentional effects include any action and any effect specifically willed in accordance with a plan, including tolerated as well as wanted effects'.<sup>39</sup> However, consider the following case, which is sometimes given in reply.<sup>40</sup> A student goes up to the podium to address a large audience with a speech. He suffers from an uncontrollable stutter. As a consequence, the student both gives a speech, and stutters in front of the audience. The stuttering was foreseen as a certain consequence. However, it was *no part* of the student's proposal for action, the plan embraced. The stuttering was a side-effect, foreseen but *unintended*. The case shows, as Finnis et al. note, that even an integrated part of the behaviour by which one carries out one's intention can be an unintended side-effect.<sup>41</sup> Examples in the same vein can be multiplied indefinitely, and show the ubiquity of the intention-foresight distinction in making sense of everyday actions.

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<sup>38</sup> These principles of action theory form the core of the Finnis-inspired theory of moral integrity I put to use in "When should conscientious objection be accepted?" *Journal of Medical Ethics* 38 (2012).

<sup>39</sup> Beauchamp and Childress, *Principles of Biomedical Ethics*, 167.

<sup>40</sup> For instance in John Finnis, Germain Grisez, and Joseph Boyle, "'Direct' and 'indirect': A reply to critics of our action theory," *The Thomist* 65 (2001), a paper which in my view does an excellent job of defending a natural law account of intention, in particular through eight examples. See also Joseph Shaw, "Intention in Ethics," *Canadian Journal of Philosophy* 36 (2006).

<sup>41</sup> "Direct and indirect," 7.

This point is of great importance for medical ethics, in particular for the ethics of treatment-limiting decisions (see 5.2). For instance, a patient in an advanced stage of ALS (amyotrophic lateral sclerosis, a degenerative neurological disease causing paralysis), reliant on a ventilator, now finds the treatment intolerable, and wants to be allowed to die. The physician disconnects the ventilator, and the patient dies peacefully within an hour. Did the physician intend the patient's death? Not necessarily. How can we say that when death was a *fully predictable consequence* of the physician's actions? We can say that because intention, a primary factor in the moral evaluation of an action, must be assessed from the first-person perspective; the intention *just is* the plan embraced by the agent, regardless of how it may appear for an onlooker. Even though the physician *caused* death, he did not (necessarily) *choose* death; he did not kill.

This analysis, of course, has the unintended side-effect (*sic.*) of opening a door to post hoc rationalizations and dishonest reports of what one's intention really was. It also means that two actions that in their outward appearance are indistinguishable may flow from two very different intentions, and thus may not be morally on par. Indeed, in disconnecting the ventilator, the physician can be either intending the patient's death, or not – instead, typically, intending that burdensome treatment be discontinued, or that the patient's request to withdraw treatment be respected. The former is condemned in the natural law tradition, whereas the latter two intentions are accepted.

Another challenge to the above analysis of the ALS case is the following: Typically, both patient and physician would wish for or welcome the patient's death, which comes as a consequence of disconnecting the ventilator. Is it not, then, mere sophistry to say that death was not part of the intention? In reply to such challenges Joseph Shaw brings forth the following case, in order to demonstrate that wishes and intentions are separate mental states:

The classic example of this is the censor who is told to read naughty books. The censor may have a desire to read them anyway: a desire he has no thought of satisfying in normal circumstances. The fact that he is subject to this temptation of the flesh does not allow us to conclude that, when ordered to read the books as part of his

job, he is doing so with the intention of satisfying his impure desire. His intention may simply be to do what he is told, and carry out his job.<sup>42</sup>

The case shows that what is wished for not always belongs to the intention. Even though a certain consequence may be desired and welcomed, it may still be outside the agent's intention.

Some criticize natural law theorists for artificially construing case descriptions so that only the morally acceptable or neutral consequences are intended, whereas the morally problematic or bad consequences are merely foreseen. However, the intention is what it is, giving rise to the real structure of the action. One cannot alter the intention by selectively focusing mental attention on the acceptable consequences, or telling oneself that one really intends the action under a euphemistic description. Christopher Kaczor proposes four criteria that indicate that an effect is included within the intention:

- (1) the achievement of the effect presents a problem for the agent that occasions deliberation;
- (2) the achievement of the effect constrains other intentions of the agent;
- (3) the agent endeavors to achieve the effect, perhaps being forced to return to deliberation if circumstances change; and
- (4) the failure of the agent to realize the effect is a failure in the agent's plan.<sup>43</sup>

Briefly, let the use of the criteria be illustrated by the ALS case detailed above. The contention was that the physician's intention in discontinuing ventilator treatment need not include the patient's death. Kaczor's criteria corroborate this view. (1) The physician does not deliberate about how to bring about the patient's death; (2) the physician does not perform other actions that ensure that death is brought about, or abstain from actions that would prevent it; (3) if the patient were to linger on after the ventilator is withdrawn, treatment to palliate any symptoms would be provided; the physician would not contemplate how to bring about death; (4) finally, if the patient was not to die this would hardly constitute a failure of the physician's plan; the patient has still been ridden of burdensome treatment, as was the intention.

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<sup>42</sup> Shaw, "Double effect in Beauchamp and Childress," 23.

<sup>43</sup> Christopher Kaczor, *Proportionalism and the natural law tradition* (Washington, D.C.: CUA Press, 2002), 109.



In sum, Kaczor's criteria are helpful in bringing out the plausibility of (1) the view that a treatment-limiting decision need not involve intending the patient's death; and (2) the intention-foresight distinction more generally.

The difference in moral relevance between intended and unintended consequences underlies the traditional 'principle of double effect' (PDE). The PDE exists in many different formulations. The point is to aid decision-making in morally complex cases where an action results in both good and bad effects. The principle asserts that *intending* evil is never allowed. However, negative consequences of actions can be *accepted* when the negative effect is neither the intended end nor the means to accomplish the intended end. In other words, the (good) end does not justify the (evil) means. Further, no other alternative that avoids or reduces the negative effects should be available. In addition, the negative effect must not be out of proportion with the positive, intended effect. As Reichberg and Syse point out, several formulations here, notably 'out of proportion', are open-ended and open to interpretation.<sup>44</sup> This means that responsible use of the PDE requires honesty and prudence.

Within the NNL camp, the principle of double effect is controversial. According to Grisez, a proper analysis of the concept of intention will capture the crucial distinctions and render a fully elaborate PDE superfluous.<sup>45</sup>

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<sup>44</sup> Gregory M. Reichberg and Henrik Syse, "The idea of double effect – in war and business," in *Responsibility in World Business. Managing Harmful Side-effects of Corporate Activity*, ed. Lene Bomann-Larsen and Oddny Wiggen (2004), 24-25.

<sup>45</sup> Grisez, *Christian Moral Principles*, 307-09. Another question that need not detain us now is the debate about the *scope* of the agent's intention. The relevance of this question comes to the starkest light in the so-called 'craniotomy case': in earlier times, a delivery would turn life-threatening for both mother and child when the child's head got stuck in the birth canal due to the mother's pelvis being too narrow. The only option to avoid the death of both mother and child would then be to crush the child's head (craniotomy) while in the birth canal. This would invariably kill the child. The procedure seems to be an intentional killing of the child to achieve the further end of saving the mother's life. According to Finnis et al., however, our analysis of the doctor's intention should be 'narrow' (see "Direct and indirect"). The doctor's intention does not include the death of the child, merely the restructuring of the child's anatomy with the further end of facilitating its removal from the birth canal. The death of the child is accepted as an unintended, although foreseen as certain, side-effect. Needless to say, this verdict is very controversial.

## 2.6 From intermediary moral principles to moral norms

There are positive and negative moral norms. Both kinds spring from the first principle of morality as specified in the intermediary moral principles, from the basic human goods, and often from additional premises. For instance, a scientist should fulfil the positive norm that ‘you should seek to contribute new knowledge to your society’. This norm can be derived from the intermediary moral principle that one should foster the common good of one’s society (8), from the insight that knowledge is a basic good that forms part of the common good, and from the special obligations that come with the scientist’s role in society.

Negative moral norms forbid the violation of the first principle of morality or one of its specifications. A proposal for action violates a negative norm if it is incompatible with a will towards integral human fulfilment; that is, if it violates a requirement of practical reason. The seventh requirement of practical reason may serve as an example (here, using the ‘respect thesis’ version):

P1: It is morally wrong to disrespect a basic human good.

P2: The good of knowledge is a basic human good.

P3: Action X involves disrespecting the good of knowledge.

C: Action X is morally wrong.

Arguments that generate negative norms can take the general shape seen here: the argument starts out with one of the intermediary principles, and then involves one of the basic human goods.<sup>46</sup>

### 2.6.1 Underdeterminacy and the place for practical wisdom

There are many different and worthy paths that could be chosen in life, and a practical choice one is faced with may often be open-ended, with several morally acceptable alternatives. The ethical theories that unreasonably narrow the scope of available actions may be called *overdeterminate*. They forbid alternatives that are not really immoral. The opposite error is *underdeterminateness*. That is, the ethical theory allows or remains silent about alternatives that really are immoral. The ideal ethical

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<sup>46</sup> Finnis, *Natural Law and Natural Rights*, 126-27.

theory would commit neither error; however, it is arguably not a weakness for a moral theory to leave a wide space for the exercise of practical wisdom, as long as some guidance regarding how this virtue should be practiced is provided. Some moral truths may be accessible to the virtuous moral agent, and yet be irreducible to the determinate conclusions of a general ethical theory.

The ideal ethical theory will not be an algorithm that can be applied to identify the morally ideal alternative in every situation. There will be scope for the application of the virtue of practical reasonableness. There are at least four ways in which an ethical theory does not straight-forwardly give a determinate answer to what should be done. Here, practical wisdom is essential. First, practical wisdom enables one to identify topics, areas and choices as fit for moral attention and deliberation. Second, practical wisdom is needed to identify all the morally salient features of a situation. Third, one must identify which positive and negative norms apply in the situation. Fourth, one must determine *how* the norms apply. Evidently, then, the work of moral deliberation, though sometimes aided by knowledge of a sound ethical theory, is nevertheless very seldom a completely straight-forward endeavour, not even for the one who possesses a good grasp of this theory.

If either the respect, real aspect or combination formulation of the seventh requirement are accepted, then the resulting ethical theory must cede more to the province of sound judgment. It is generally straight-forward to decipher what ‘not acting directly against a good’ means, but what does ‘proper respect for a good’ entail? Or is the instance of basic good that we consider attacking really a good to the person presently? As Dubois himself notes, if one is to accept his ‘real aspect’ thesis, one opens up a door to more options for rationalization of evil actions.<sup>47</sup> This introduces, as he says, a ‘heightened burden on prudential reasoning’. However, in itself this arguably does not count against a ‘real aspect’-style natural law theory.

### 2.6.2 The prohibition on killing innocents

The traditional natural law corpus of moral norms contains a small number of absolute negative norms. Among these is the crucial prohibition on the intentional killing of innocents. This alleged moral absolute will be very important in the discussion of medical choices at the end of life in the chapters to come.

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<sup>47</sup> Dubois, “How Much Guidance Can A Secular, Natural Law Ethic Offer?” 193.

The prohibition on killing is sometimes construed not to encompass the killing of the *non*-innocent. In that case, the moral absolute is not defined solely by a description of a physical act (killing a human being), but also includes morally salient circumstances – the moral innocence of the victim. The exclusion of the killing of the non-innocents has been defended in various ways; for instance, the perpetrator of a very serious crime may be said to have forfeited his right to life; or he deserves death by retributive punishment.

Innocence and non-innocence may be construed as *moral* or *material*.<sup>48</sup> The morally innocent has not done anything wrong to deserve death, whereas the morally non-innocent *may* have. The materially non-innocent, on the other hand, is someone who, through no moral fault of his own, threatens the life of another. A stock example from moral philosophy is of the fat man stuck in the cave-mouth while the water inside the cave is slowly rising. The fat man is blocking the only escape route for the others inside the cave. Without his removal all inside will die; however, he can only be removed by being blown up by dynamite. In this situation, the fat man is a material non-innocent. Those who accept this controversial concept sometimes go on to accept that the intentional killing of the fat man is not prohibited by the moral absolute on killing innocents.<sup>49</sup>

In an NNL theory, the absolute norm against intentional killing of innocents is generated by the seventh requirement of practical reasonableness.<sup>50</sup> Four alternative formulations of this requirement were discussed above. They give rise to four alternative moral norms (Table 2).

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<sup>48</sup> Paterson, *Assisted Suicide and Euthanasia*, 82-85.

<sup>49</sup> Another possible analysis, relying on a narrow account of intention, is that setting off a dynamite explosion that kills the man does not intend the man's death, only his removal; the death is accepted as a tragic but necessary side-effect.

<sup>50</sup> So the reason why one should not kill an innocent human being is that it damages or shows disrespect for the basic human good of life. This, however, is hardly a promising line of argument for public debates about, e.g., abortion and euthanasia. As one influential critic, Russell Hittinger, wrote: 'Given [Grisez's] system, abortion can only be wrong because it violates what we find attractive about the good of life rather than the ontological, much less moral, status of the one who lives. This should immediately strike one as the worst possible way to go about making an argument about abortion'. Hittinger, *A Critique of the New Natural Law Theory*, 72. It could be replied, however, that NNL shows a fundamental reason why killing is wrong and attempts to prove the line of argument from first principles; and yet this deep justification of the norm is compatible with several other approaches and ways of framing the question that would hold much greater promise rhetorically. The abortion critic may surely, employing NNL, argue from the moral status of the foetus, as well as from the deeper justification of the norm against the killing of innocents.

**Table 2.** *Alternative moral norms regarding intentional killing.*

<b>Thesis</b>	<b>Author</b>	<b>Seventh requirement</b>	<b>Norm on intentional killing</b>
‘Direct action’	Finnis	‘Do not choose directly against any basic human good’	Do not kill innocent human beings
‘Real aspect’	Dubois	‘Never act intentionally against a real aspect of a human being’s fulfilment’	Do not kill an innocent human being whose life is a real aspect of their fulfilment
‘Respect’	Chappell	‘Respect each basic human good in every action’	Respect human life in every action (i.e., do not kill innocent human beings)
‘Combination’		‘Respect each real aspect of a human being’s fulfilment in every action’	Respect (i.e., do not take) human life when it constitutes a real aspect of the person’s fulfilment

A main point of going into detail on the four alternative formulations of the seventh requirement should now be apparent: the choice of preferred formulation – and thus the moral norm on killing – may turn out to have wide-ranging practical consequences. Finnis’s formulation straight-forwardly yields the classical moral absolute against intentionally killing innocents. Chappell’s formulation, however, initially gives the more ambiguous injunction to ‘respect life’. As shown above (2.4.1), in his view, which was shared by Paterson, killing an innocent human can never be compatible with proper respect for the good of life. Dubois’s formulation yields a norm that might look like it is merely *prima facie*: killing is prohibited, but not when the life of the person to be killed does not contribute to his fulfilment. However, the norm may also be taken to be a moral absolute in which ‘life being a real aspect of fulfilment’ is an essential, act-defining circumstance, in the same way that moral innocence is. More important than the classification of the norm as absolute or *prima facie*, however, is its content: the question naturally arises whether

a person's life may ever cease to be a real aspect of the person's fulfilment. If yes, then perhaps intentional killing is morally legitimate in some such cases. This question will be a main and recurring one in the remaining chapters.

## 2.7 Chapter summary

The transition from considerations of the pre-moral (basic human) goods to morality was examined. The first principle of morality could, aided by reflections on human nature and the conditions of human action, be specified into several requirements of practical reason. These are moral precepts and second-order reasons for action. Their justification, purportedly, is by self-evidence. However, the problem of the underdeterminacy of self-evidence here appears in its third and most powerful iteration. In particular, the seventh requirement was examined. This requirement plays a crucial part in the theory in shaping important negative moral norms (prohibitions). According to Finnis, it is self-evident that one should not act directly against a basic human good (direct action thesis). However, three closely related but competing formulations – the respect, real aspect, and combination theses – could also make a claim to be self-evidently true, a claim that at first glance is just as convincing. The four competitors were compared when exposed to test cases. The three challengers all outperformed Finnis's version, as the latter led to strongly counter-intuitive moral guidance in the test cases. It was also argued that, even though the three competitors introduce a greater reliance on prudence, this does not affect the theoretical coherence of the NNL theory.

Some reasons why the four alternative formulations of the seventh requirement of practical reasonableness are not equally rationally appealing were presented. Which one of these properly belongs in an NNL theory? In Chapters 3 and 4, this question will be investigated by putting the formulations to a new, comprehensive test.

In my view, the 'classical' NNL theory (making use of Finnis's direct action thesis) is in trouble when normative guidance on clinical decisions for patients in the condition known as *persistent vegetative state* (PVS) is demanded. In the next two chapters, I will argue that if it can be shown that NNL is unable to make sense of prevalent, strong and well-founded moral and clinical intuitions and judgments in the case of PVS, then this is a serious blow to the NNL theory as a whole. I will argue

that this is in fact the case: NNL proponents all struggle not to provide strongly counter-intuitive moral guidance in the case of PVS. However, there may be no compelling reason to accept the ‘classical’ NNL theory equipped with the direct action thesis: there are three competitors to Finnis’s version of the seventh requirement, which could replace it in the NNL theory. Therefore, I propose a process of reflective equilibrium to find out whether any of the competing formulations would yield a theory that harmonizes with strong intuitions, considered judgments and philosophical arguments in the PVS case. This process of reflective equilibrium is carried out in Chapters 3 and 4. The resulting, revised NNL theory is presented at the end (4.6), and is then used to analyze other moral dilemmas at the end of life in the final chapter.

### 3 Persistent vegetative state as a test case

On May 16, 2000, Inger E. Johnsen, a 29-year-old Norwegian woman suffering from recurrent psychological problems, attempted suicide.<sup>1</sup> After several hours, she was found by her father and rushed to hospital. When admitted to hospital she was unconscious, was found to have blood glucose below the measurable threshold, and was put on a ventilator. She did not recover consciousness. However, when the ventilator was later removed, she was able to breathe spontaneously. In the following weeks, Inger's condition was stable – she had alternating periods of sleep and wakefulness, but no interaction with her environment. She had a feeding tube placed, and was eventually discharged from hospital to a nursing home. The hospital doctors stated that the brain damage was most likely permanent.

At first, Inger's mother, who frequently visited her daughter at the nursing home, hoped for and believed in recovery. Inger was given physiotherapy, sensory stimulation, and good nursing care. She received food and water through the feeding tube. However, Inger did not make any recovery. She was unable to fix her gaze and could neither speak nor interact with her mother or the nursing staff in any other way. She was presumed to have no consciousness at all.

As the years went by and Inger did not make any progress, her mother gradually lost hope for her daughter's recovery. By 2005, Inger's parents both agreed that treatment should cease. Inger's mother later declared, 'If Inger were able to open her mouth, she would immediately say that she did not want to lie like this'.<sup>2</sup>

From then on the parents, aided by palliative medicine specialist Stein Husebø, solicited for the withdrawal of Inger's treatment. This process would turn out to be slow and arduous. The nursing staff and several doctors at the nursing home turned down the parents' request. Among the reasons the health professionals gave for their decision was fear of the withdrawal of treatment amounting to a kind of murder both ethically and legally.

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<sup>1</sup> Inger's case is one of few Norwegian PVS cases to be covered thoroughly in the news media. My source for her story is Johannes Morken, "Halden kunstig i live i år etter år," *Vårt Land*, 21.06.2008.

<sup>2</sup> *Ibid.*, 22; my translation.



In March 2007, Inger was transferred to another nursing home. An ethical advisory committee was congregated, concluding that the provision of food and water was a life-prolonging treatment that the patient herself most likely would have rejected. One hour after the meeting the head doctor removed the feeding tube and ordered the administration of pain medication. Inger died a week later from pneumonia.

Inger's mother later stated:

In a way, Inger died twice [at her suicide attempt, and after artificial nutrition and hydration were withdrawn seven years later] ... what I pray and hope is that no-one should be placed in the same situation as Inger, and I would not wish for anyone to have to see their daughter sit the way Inger did.<sup>3</sup>

Although the term was not used in the newspaper article, it seems likely from the description that Inger was in a *persistent vegetative state (PVS)*. Although a rare condition, Inger's story is not unique. When there is disagreement and heated controversy on how a certain PVS sufferer should be treated, the stories may surface in the media. All over the Western world, though, there are patients in this state for whom very difficult treatment decisions must be made. Treatment for PVS includes nutrition and hydration through a feeding tube, in addition to nursing care. A crucial ethical question regarding the treatment of these patients is whether and under which conditions it is ethical to withdraw artificial nutrition and hydration (ANH) and let the patient die.

### 3.1 PVS as a philosophical test case

A peculiar feature of contemporary analytic philosophy is the frequent employment of thought experiments in order to test a hypothesis by teasing out our intuitions and judgments. According to most philosophers, the hypothetical and sometimes highly implausible character of the thought experiments does not render them philosophically useless. Thus the philosophical literature is littered with experience machines, fat men stuck in cave mouths, supremely knowledgeable inhabitants of colourless worlds, people drinking XYZ in the belief that it is plain water, and so on.

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<sup>3</sup> Ibid., 27.

If, however, one is looking to test how a theory of normative ethics fares in the medical realm, such imaginative invention is not necessarily needed. No, nature and modern medicine have conspired to create a tragic condition that in its absurdity matches the figments of philosophers' imagination: the persistent vegetative state (PVS).

My hypothesis is that strong and widely held intuitions regarding PVS do not square with the moral guidance outlined by proponents of NNL. Specifically, my contention from the outset is that many health care workers would consider a life in PVS not worth living, continued life-prolonging treatment in cases of PVS futile, and thus cessation of treatment generally to be morally permissible, or in some cases even obligatory. On the other hand, new natural lawyers hold that continued treatment in cases of PVS typically *does* provide a benefit for the patient, and that such treatment is usually *morally obligatory*.

In this and the next chapter, PVS will be treated as a *test case for NNL theory*. I will start by presenting relevant medical knowledge about PVS. Then the standard NNL position on the ethics of treatment decisions for PVS patients will be examined, as this position is set out by four different authors. It will be argued that this position is not defensible in light of the basic NNL theoretical commitments; instead, the authors will be pressed into endorsing an even more radical and unpalatable view. This view, which will be detailed, is radically out of touch with clinicians' intuitions.

Next, the methodology of testing the NNL theory against common intuitions in the PVS case will be set out in depth. The empirical data on moral intuitions towards the PVS case will then be examined. The chapter will conclude with an attempt at drawing out *arguments* that underpin these intuitions.

In Chapter 4, the arguments drawn from the intuitions are joined by arguments from the philosophical literature as well as other arguments, and then discussed and evaluated in an NNL framework. There will turn out to be serious disagreement between NNL and the most plausible arguments, as will be highlighted. The question then becomes whether a version of NNL modified with one of the alternative formulations of the seventh requirement of practical reasonableness will turn out to fit the arguments better. This extended argument will be an instance of *reflective equilibrium*, and the upshot will be the version of the NNL theory that achieves the best 'fit' with intuitions and arguments whilst preserving theoretical coherence and consistency.

### 3.2 The vegetative state

*The vegetative state* is a clinical condition characterized by loss of consciousness with partial or complete preservation of the functions of the brain stem and hypothalamus ('vegetative functions'). The patient undergoes cycles of sleep and wakefulness. The patient opens her eyes for prolonged periods, breathes spontaneously, and the functions and autonomic control of the internal organs are preserved. She may even smile, shed tears, grunt and exhibit non-purposeful movements. But she does not show any signs of *awareness* of self or surroundings.<sup>4</sup>

The vegetative state must be distinguished from coma and from the minimally conscious state. *Coma* is a state of unconsciousness and unresponsiveness in which wakefulness is also lacking. In *the minimally conscious state*, on the other hand, the patient shows some small but definite signs of awareness of self or surroundings.<sup>5</sup>

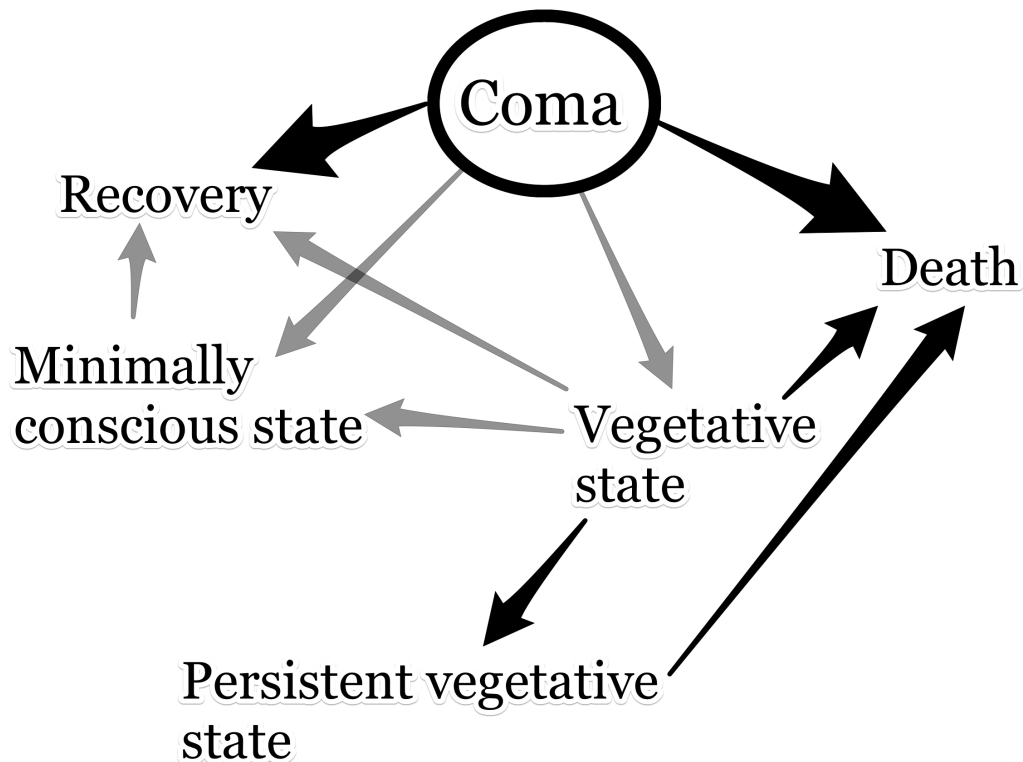
There is a regular temporal relation between these three clinical conditions (Figure 1): diseases or injuries affecting the brain may lead to coma. Patients who become comatose may wake up and recover more or less fully; may die; or may wake up with either no signs of awareness (the vegetative state), or minimal signs of awareness (the minimally conscious state). Patients may then recover from vegetative and minimally conscious states, although almost always with severe disabilities. Alternatively, these states may become permanent. It is important to make the correct categorization, as the prognosis differs widely between these conditions.

A sometimes-encountered confusion is that vegetative patients are brain dead. However, *brain death* implies the permanent destruction of all brain functions, including those of the brain stem, leading to loss of spontaneous breathing. In vegetative patients the brain stem is intact, preserving spontaneous breathing and circulation. The functioning brain stem keeps the vegetative patient alive.

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<sup>4</sup> The Multi-Society Task Force on PVS, "Medical Aspects of the Persistent Vegetative State," *New England Journal of Medicine* 330 (1994); Bryan Jennett, "The vegetative state," *Journal of Neurology, Neurosurgery & Psychiatry* 73 (2002); Jennett, *The Vegetative State. Medical facts, ethical and legal dilemmas* (Cambridge: Cambridge University Press, 2002).

<sup>5</sup> J.T. Giacino et al., "The minimally conscious state: Definition and diagnostic criteria," *Neurology* 58 (2002).



**Figure 1.** *The relation between coma and vegetative and minimally conscious states.* Arrows indicate the most common paths of progression.

### 3.2.1 The vegetative state: etiology, diagnosis and prognosis

Numerous conditions can lead to a vegetative state. Among adults the two most important groups are the *traumatic brain injuries* (e.g., due to motor vehicle accidents, gunshot wounds, etc.) and the *non-traumatic brain injuries* (e.g., neuronal death due to lack of oxygen, from cardiac arrest or hypotension; or from cerebral haemorrhage, infarction or infection).<sup>6</sup>

Estimates of the frequency of the vegetative state are variable and inexact. Prevalence in the USA is reported to be between 64 and 140 per million population, of which one third are children. The incidence from acute injuries in different countries is given as from 14 to 67 per million population at one month after the injury, and five to 25 per million at six months.<sup>7</sup> I have been unable to find Norwegian data, but would expect the numbers to be comparably low, based on my perception of

<sup>6</sup> Multi-Society Task Force, “Medical Aspects of the Persistent Vegetative State.”

<sup>7</sup> Jennett, “The vegetative state.”

Norwegian intensive care units' policies on withdrawal of treatment (discussed below).

The vegetative state can be diagnosed based on seven criteria: lack of awareness and interaction, lack of voluntary behaviour, lack of language comprehension or expression, presence of sleep-wake cycles, preserved brain stem autonomic functions, bowel and bladder incontinence, and preservation of cranial nerve and spinal reflexes to variable degrees.<sup>8</sup> The criteria have been operationalized in comprehensive guidelines for diagnosis. However, a certain diagnosis is difficult to make. It has been estimated that as many as up to 40% of patients receiving the diagnosis of vegetative state are found to be minimally conscious when re-examined by specialists.<sup>9</sup> One reason for this is that the patient may have disabilities and organ dysfunctions (e.g., blindness) that mask signs of residual awareness.<sup>10</sup> Another is that behavioural signs of consciousness may occur only briefly and infrequently, and may be missed during clinical examination.

This large margin of error will also decrease the reliability of outcome data. When assessing the available prognostic data, one would like to know how many patients recover, at what stage, and to what level of function. Generally, as the duration of the vegetative state increases, the chance of regaining consciousness decreases.<sup>11</sup> However, very late recoveries are reported to have occurred. A study found that 54% of trauma patients vegetative after one month had regained some consciousness at 12 months, as opposed to only 14% of non-trauma patients.<sup>12</sup> For trauma patients vegetative at six months, 19% had regained consciousness at 12 months, whereas only 1% of non-trauma patients had. The prognosis for recovery after 12 months is fraught with uncertainty and controversy. Many think that such late recovery is exceedingly rare, whereas Childs' and Mercer's re-examination of the available data suggests that up to 14% of patients vegetative at 12 months may ultimately recover.<sup>13</sup> It is important to realize what this 'recovery' consists in,

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<sup>8</sup> Multi-Society Task Force, "Medical Aspects of the Persistent Vegetative State."

<sup>9</sup> Joseph Giacino and John Whyte, "The Vegetative and Minimally Conscious States," *Journal of Head Trauma Rehabilitation* 20 (2005): 39.

<sup>10</sup> Martin M. Monti, Steven Laureys, and Adrian M. Owen, "The vegetative state," *BMJ* 341 (2010).

<sup>11</sup> Giacino and Whyte, "The Vegetative and Minimally Conscious States," 37.

<sup>12</sup> Multi-Society Task Force, "Medical Aspects of the Persistent Vegetative State."

<sup>13</sup> Nancy L. Childs and Walt N. Mercer, "Late Improvement in Consciousness after Post-Traumatic Vegetative State," *New England Journal of Medicine*, 334 (1996).

however: those who do recover some degree of consciousness will typically remain severely physically and cognitively disabled. Currently, in Giacino and Whyte's judgment, it is not possible to predict the chances of recovery for particular patients with the desired accuracy to support clinical decision-making.<sup>14</sup>

Late recoveries from the vegetative state are sometimes reported in the press. What should be made of these reports is controversial. These patients are most often at nursing homes, not at specialist centres, and so whether they have really been in the vegetative state can be contested. The lesson is, perhaps, that unless the entire anatomical substrate for consciousness is destroyed (ascertained through imaging studies or 'flat line' EEGs, for instance), one can hardly be absolutely sure that a certain vegetative patient will never regain consciousness.

There is also controversy about whether one can ever say for certain that a given PVS patient is really unconscious. There is no certain method for ascertaining the absence or presence of consciousness. In practice, researchers and clinicians have relied on observable behaviour as an indicator of consciousness, and the absence of certain behaviour as an indicator of unconsciousness. Thus, as Morten Overgaard points out:

In the absence of a verifiable or merely consensual operationalisation of consciousness, clinical assessment currently relies on the strictly pragmatic principle that people can only be considered to be unequivocally conscious if they can report that this is indeed the case. Thus, the discrimination between (...) states of conscious and unconscious being, depends upon such communication. Quite obviously, this approach is seriously flawed and represents a central, if not the crucial, problem in the study of decreased levels of consciousness.<sup>15</sup>

However, a new paradigm may be on the horizon. Recently, some studies have reported the detection of signs of consciousness by fMRI (functional magnetic resonance imaging) in patients who were diagnosed clinically as being in PVS. For instance, a 2010 study indicated that four out of 23 patients in a vegetative state were

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<sup>14</sup> Giacino and Whyte, "The Vegetative and Minimally Conscious States," 37.

<sup>15</sup> Morten Overgaard, "How can we know if patients in coma, vegetative state or minimally conscious state are conscious?" *Progress in Brain Research* 177 (2009): 13.

able to wilfully modify their brain activity.<sup>16</sup> Two of these four patients had been in VS for more than a year; that is, they were in PVS. One of the patients could use this wilful modification of brain activity to answer yes-or-no questions.

What should be made of this is all very tentative. However, it seems that the customary battery of bedside tests is incapable of picking up all patients who in fact have some degree of consciousness. There may be a small subset of patients who fit the traditional criteria for PVS who are in fact minimally conscious. Perhaps future technological advances will enable these patients to interact with the environment.<sup>17</sup>

For the sake of the ethical discussion to come I am particularly interested in the cases where the PVS patient is truly and permanently unconscious. This condition will be presupposed in the discussion.

### 3.2.2 Health care for vegetative patients

In the initial stages of their disease, patients who become vegetative after acute injuries are treated in intensive care units. When their condition has stabilized, they may be transferred to a regular hospital ward, and then later to a nursing home facility. At this stage, the treatment these patients require is merely general nursing care and ANH, through a nasogastric tube or, more likely, a percutaneous gastroenterostomy (PEG; a tube through the abdominal wall directly into the stomach). This care can be provided by relatives, and therefore some patients are taken home for further care.

While the initial intensive care, sometimes including surgery and other costly medical interventions, is very expensive, once the patient is stabilized in a vegetative condition the costs of care are more moderate. In Norway, a day in hospital costs about 40,000 NOK (€ 5,000) on average,<sup>18</sup> whereas nursing home residence costs roughly 2,300 NOK (€ 300).<sup>19</sup> In addition, there are the costs of artificial nutrition. In

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<sup>16</sup> Martin M. Monti et al., “Willful modulation of brain activity in disorders of consciousness,” *New England Journal of Medicine* 362 (2010).

<sup>17</sup> Martin M. Monti, “Ethics, Neuroimaging and Disorders of Consciousness: What Is the Question?” *AJOB Neuroscience* 4 (2013); Andrew Peterson et al., “Assessing Decision-Making Capacity in the Behaviorally Nonresponsive Patient With Residual Covert Awareness,” *AJOB Neuroscience* 4 (2013).

<sup>18</sup> Helse- og omsorgsdepartementet, “Ofte stilte spørsmål”. <http://www.regjeringen.no/nb/dep/hod/tema/sykehus/nokkeltall-og-fakta---ny/ofte-stilte-sporsmal.html?id=534086>.

<sup>19</sup> Abelia. “Eldreomsorg kun et spørsmål om sykehjem?” <http://abelia.no/arena-ny-omsorg/eldreomsorg-kun-et-spoersmaal-om-sykehjem-article1646-136.html>.

the USA in 1999, the lifetime costs of care for patients severely brain damaged after injury was estimated as between \$600,000 and \$1,875,000.<sup>20</sup>

### 3.2.3 Withdrawing nutrition and hydration for vegetative patients: the UK and Norway

Consider two quite different examples of how treatment-limiting decisions may be approached – in the UK and Norway, respectively. In the UK, when the patient's vegetative state is labelled 'permanent', this has important legal repercussions.<sup>21</sup> This label will be considered after the condition has lasted 12 months, or six months in some cases like anoxic brain damage. The clinician or the patient's family may then start a legal process to have ANH withdrawn. This decision must be sanctioned by the High Court. The applicant must give evidence in the support of three claims: the patient must be 'unaware of self and environment' (complete unconsciousness); there must be 'no reasonable prospect of improvement' (hence the importance of the diagnostic-prognostic label 'permanent'); and the continuation of treatment, including ANH, must be 'not in the patient's best interests'.

If the request is granted, the patient's PEG or nasogastric tube is removed. Nutrition, hydration and most drugs are discontinued. The patient will then die, most likely within 14 days.<sup>22</sup> Given that the diagnosis of complete lack of awareness is correct, the patient will not experience any pain or discomfort from the lack of food and water.

In Norway, official guidelines on treatment-limiting decisions mention 'PVS' as one of several conditions in which cessation of life-prolonging treatment may be considered.<sup>23</sup> The directions given are no more specific than this. In a case evaluation, the Norwegian Health Supervision Authority (Helsetilsynet) stated, 'However, it is generally agreed that it is ethically justifiable to terminate life-sustaining treatment if

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<sup>20</sup> Giacino et al., "The minimally conscious state," 349.

<sup>21</sup> Derick T. Wade and Claire Johnston, "The permanent vegetative state: practical guidance on diagnosis and management," *British Medical Journal* 319 (1999); Tak Kwong Chan and George Lim Tipoe, "The best interests of persistently vegetative patients: to die rather than to live?" *Journal of Medical Ethics* (2013); J.C. Sheather, "Withdrawing and withholding artificial nutrition and hydration from patients in a minimally conscious state: re: M and its repercussions," *Journal of Medical Ethics* 39 (2013).

<sup>22</sup> Wade and Johnston, "The permanent vegetative state," 844.

<sup>23</sup> Helsedirektoratet, "Beslutningsprosesser."



the patient is deeply unconscious and the prognosis indicates that the condition is irreversible and without a view to improvement.<sup>24</sup>

In addition, the submission authored by Rikshospitalet (The National Hospital) in response to an earlier draft of the official guidelines on life-prolonging treatment merits interest.<sup>25</sup> The draft stated that vegetative patients should be kept alive for three to 12 months before a decision to remove life-prolonging treatment should be made. The Rikshospitalet submission strongly warns against retaining this point in the document; indeed, ‘For the large majority of patients with irreversible neurological injuries, treatment should be withdrawn at a much earlier stage, even though cerebral circulation has not ceased.’<sup>26</sup> If the Rikshospitalet document is a reliable guide to the practice of Norwegian intensive care units, then it seems that few patients would reach a PVS, as life-prolonging treatment most often would be discontinued before this stable state was established. This speculation on my part is supported by the document’s contention that PVS is ‘a rarity’.<sup>27</sup>

To sum up, in the UK, decision-making must involve the courts, whereas in Norway it is up to the doctor’s discretion, with, however, the general legal requirement that the patient’s presumed views and the views of the relatives must be taken into account. These examples illustrate different medical cultures and different approaches to legal regulation of decision-making for PVS patients.

### 3.2.4 Terminology

It was argued above that unless it can be ascertained that the neuroanatomical substrate for consciousness is destroyed, the labelling of a vegetative state as ‘permanent’ can never be completely certain. An unexpected late recovery of consciousness may occur, although the patient will remain severely disabled.

For my purposes, I will adopt a modified UK terminology. After four weeks, the vegetative state is said to be *continuous*. If sustained for either 6 or 12 months, depending on the etiology, the vegetative state is said to be *permanent*. I prefer the

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<sup>24</sup> Helsetilsynet, *Forsvarlig helsehjelp i Kristina-saken*. <http://www.helsetilsynet.no/no/Toppmeny/Presse/Nyheiter-2007/Forsvarlig-helsehjelp-Kristina-saken/>

<sup>25</sup> Rikshospitalet, *Utkast til Nasjonal veileder for beslutninger om livsforlengende behandling hos alvorlig syke og døende. Høringsuttalelse fra Rikshospitalet HF, Anestesi- og intensivklinikken*, 2008.

<sup>26</sup> *Ibid.*, 4.; my translation.

<sup>27</sup> *Ibid.*

term *persistent*, yet one must acknowledge that most patients in this state are in reality permanently vegetative. As of yet we are perhaps capable of identifying a few vegetative states as permanent beyond a doubt, but for the most part we are unable to do this with the desired accuracy. In this and the next chapter, then, I will speak of the *persistent* vegetative state.

### 3.3 The new natural lawyers' views on treatment decisions in PVS

In order to grasp the new natural lawyers' views on the morality of treatment-limiting decisions in PVS, the accounts of this question given by four authors will now be examined. In the present section the views are presented, whereas in the next section they are criticized.

Let us begin with Joseph Boyle, who summarizes the main dilemma thus:

On the one hand, the persistence of the vegetative state suggests that efforts to sustain the lives of patients in PVS have about them a kind of futility. But on the other hand, the decision to forgo these efforts, in effect to let these patients die, seems without precedent since the patients can be kept alive without apparent harm to them or excessive burden to others. In short, there is reason to consider withdrawing the care which keeps patients in PVS alive, and there is reason to resist that consideration.<sup>28</sup>

According to Boyle, PVS patients are persons and must not be intentionally killed; if ANH is withdrawn, it must be in a way that is consonant with the distinction between (morally acceptable) limiting of treatment and (immoral) intentional killing. Boyle goes on to reject the claim that the PVS sufferer is not benefited by the continued supply of ANH, because continued life is in itself a benefit, however small.<sup>29</sup> The view that a person's life only has instrumental value is rejected. Continued care for

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<sup>28</sup> Joseph Boyle, "A case for sometimes tube-feeding patients in persistent vegetative state," in *Euthanasia examined*, ed. John Keown (Cambridge: Cambridge University Press, 1995), 190.

<sup>29</sup> To the new natural lawyers, a 'benefit' is a technical term, designating the participation in a basic good that is the intended result of an action: Grisez, Boyle, and Finnis, "Practical Principles, Moral Truth, and Ultimate Ends," 104. As provision of ANH results in the patient's continued participation in the basic good of life, provision of ANH produces a benefit by definition.

the PVS patient provides another benefit as well: the maintenance of human solidarity. This benefit is ‘interpersonal, a good realized not only in the person cared for but within the community of patient and care givers’.<sup>30</sup> Accordingly, there are some benefits to continued provision of ANH. If ANH may be withdrawn, then, this must be settled by a *comparison of the burdens and benefits* of treatment. If the benefits are disproportionate to the burdens, ANH may be withdrawn. However, Boyle finds that it is not necessarily the case that the burdens outweigh the benefits, as neither the PVS condition itself nor the treatment can be said to be burdensome for the patient. Therefore, withdrawing ANH from a PVS patient cannot be said to be morally acceptable in general. But in a given case the burdens of continued treatment may seem to loom larger than the benefits when compared rationally.

Boyle suggests two situations in which burdens can be said to outweigh benefits. The first is the case where continued care cannot be reconciled with other duties of the care providers; the care drains their resources (time, money, etc.). In this case the burdens of care could outweigh the benefits. The second is the case where the PVS sufferer’s prior will is known to go against continued treatment. This could be the case with an advance directive or other reliable testimony of the patient’s prior will. Boyle contends:

The prior rejection of the artificial provision of food and water by the patient appears decisive, that is, it establishes a requirement to withdraw this form of care. The reason why prior refusal should be honoured is that continued care is significantly, if not completely, motivated by the intention to maintain solidarity with the patient and show respect for his or her human dignity. The decision to limit care drastically on the basis of the patient’s refusal, therefore, has an altogether different human significance from withdrawing it without such direction.<sup>31</sup>

Germain Grisez sets out his opinion on the question of ANH in PVS in a 1989 paper.<sup>32</sup> Generally, according to him, patients in PVS should receive ANH and nursing care. This ‘affirms their dignity as persons, expresses benevolence toward

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<sup>30</sup> Boyle, “A case for sometimes tube-feeding patients in persistent vegetative state,” 194.

<sup>31</sup> “A case for sometimes tube-feeding patients in persistent vegetative state,” 198.

<sup>32</sup> Germain Grisez, “Should nutrition and hydration be provided to permanently unconscious and other mentally disabled persons?” *Issues L. & Med.* 5 (1989).

them, and maintains the bond of human communion with them'.<sup>33</sup> As life 'is an intrinsic good to the person', so 'any choice to kill a person is a choice contrary to his or her good'.<sup>34</sup> Grisez points to two cases in which one could rightly withdraw ANH. First, ANH can be withdrawn when available resources are scarce, which in our Western societies they generally are not. Grisez rejects the moral relevance, in this case, of *emotional* burdens to the PVS sufferer's relatives. The only truly relevant burden, he states, is the financial cost. Second, ANH can be withdrawn in the presence of an advance directive against being sustained in PVS. In this latter case, the choice made by the competent person is not to kill oneself; rather, it is 'choosing both to avoid being kept alive by a method toward which they feel psychological repugnance and to free others of the burden of the cost of caring for them'.<sup>35</sup>

However, Grisez states that being fed by a tube neither constitutes an indignity nor imposes any other burden on the unconscious patient.<sup>36</sup> Further, he rules out the withdrawal of ANH with the intention of ending the patient's life: '[T]o decide not to feed a comatose person in order to end the burden that his or her loved ones experience is to choose to kill that person in order to end the miserable state in which he or she now lives.'<sup>37</sup>

Christopher Tollefsen in general shares the views espoused by Boyle and Grisez.<sup>38</sup> He discusses and rejects the view that *the burden of the PVS condition itself* may be counted among the burdens that it is admissible to avoid through ending ANH. For how is one to get rid of the burden of the vegetative condition? This *end* can only be achieved by an illicit *means*: by ending the patient's life. Ending ANH in such a case, then, would amount to an *intentional* ending of the patient's life; a direct attack on the good of life, an unjustified killing, according to NNL theory. The moral object chosen (as a means to a further end) would be the death of the patient. For the same reason, a *caregiver* cannot choose to end ANH in order to be relieved of the burdens of care, for here also the cessation of ANH would be carried out with the unacceptable intention of killing the patient.

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<sup>33</sup> Ibid., 168.

<sup>34</sup> Ibid., 174.

<sup>35</sup> Ibid., 176.

<sup>36</sup> Ibid., 170-71.

<sup>37</sup> Ibid., 171.

<sup>38</sup> Christopher Tollefsen, "Ten Errors Regarding End of Life Issues, and Especially Artificial Nutrition and Hydration," in *Artificial Nutrition and Hydration*, ed. Tollefsen (Dordrecht: Springer, 2008).

As to the patient's (prior) decision whether to forgo treatment – in PVS as in other end-of-life scenarios – Tollefsen points to the crucial role of the weighing of burdens and benefits. It is 'always unreasonable for an agent to refuse a treatment whose benefits were proportionate [to the burdens]'.<sup>39</sup> However, if the burdens outweigh the benefits, then refusing further treatment is a morally legitimate option. Tollefsen thinks that a person could choose (in advance) to forgo life-sustaining treatment in PVS as an act of charity, in order to spare one's family of the burdens of care. Such a choice would be morally acceptable. Further, because a choice to forgo ANH in PVS *can* be morally upright, and other people do not have direct access to the patient's reasons and thus usually cannot evaluate these, this autonomous choice must be available to patients:

Indeed, it seems not only permissible to respect [the prior wishes of patients], but, *ceteris paribus*, obligatory; doctors and family members are not judges over patients, and they violate the autonomy of those patients by being overly paternalistic. When a patient has made explicitly clear, by some advanced directive, that she does not wish to receive this or that form of treatment, it is the doctors' and family members' obligation to refrain from providing it.<sup>40</sup>

Tollefsen concurs that the burdens to the patient of being sustained in PVS are few. Treatment, on the other hand, provides a benefit: namely, continued life.

Craig Paterson agrees that it is morally permissible to withdraw ANH when the prior will of the patient is known, as with an advance directive.<sup>41</sup> He holds that the PVS condition in itself is not undignified; he notes, however:

Whilst I think it gravely mistaken to say that the provision of hydration and nutrition via tubes is somehow 'inherently undignified', it is not unreasonable to accept that being the subject of such treatment can be held intrusive and undignified for a given patient.<sup>42</sup>

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<sup>39</sup> Ibid., 219.

<sup>40</sup> Ibid., 222.

<sup>41</sup> Paterson, *Assisted Suicide and Euthanasia*, 143-48.

<sup>42</sup> Ibid., 145.

So a person pondering a hypothetical future existence in PVS could reasonably consider ANH – although not the life in PVS in itself – undignified and a burden that could weigh heavily and potentially be decisive in the balance of burdens and benefits. The emotional and financial burdens to caretakers could also be considered in this balance. However, this weighing and the potential self-sacrifice must be voluntarily chosen by the patient him- or herself, and ‘cannot be required or insisted upon’ by others.<sup>43</sup>

### 3.3.1 Critiquing the NNL writers’ views on PVS

The four writers are in more or less full agreement about the morality of treatment decisions for PVS patients, as has been seen. Let their views be summarized in five salient points. (1) They consider continued life in PVS as itself a benefit, however small. (2) The patient is in principle not burdened by the treatment or by the condition, because these are not consciously perceived (although there was some dissent on whether these may still be burdens to the patient). Withdrawing treatment is only legitimate on one of two conditions: (3) great financial or other practical burdens on the caretakers; or (4) the patient’s prior will against being kept alive in PVS. The writers differ somewhat as to what degree of evidence should be accepted as sufficient for accepting that limitation of treatment is indeed in accord with the patient’s wish (e.g., whether a written advance directive is needed or whether reports of informal discussions with relatives or close friends suffice). (5) If neither condition is fulfilled, treatment must in principle continue as long as the patient is not in the process of dying.

Now, this view may seem to allow for the discontinuation of treatment in a substantial number of instances. However, as I will argue presently, the view relies on some inferences and premises that are problematic given the writers’ own NNL framework. When these premises are exposed and removed, what results is a view more in line with basic NNL presuppositions. However, this view involves *a much stronger presumption to continue treatment*, and as such is substantially out of touch with clinicians’ strong and widely held moral intuitions, as will be shown in the last part of the chapter.

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<sup>43</sup> Ibid., 146.

Great financial or practical burdens on the caretakers may indeed justify limitation of treatment, but in affluent Western societies, how often will this situation occur? In many countries, for instance Norway, treatment is funded in its entirety by the state. In others, it is funded by insurance. Care is primarily carried out by professionals, most often in nursing homes. In some remaining cases, treatment for the PVS patient is not covered by insurance, and must be paid for and/or carried out by relatives. In affluent societies, this situation will be *uncommon*, and thus so will the first of the two conditions that can justify withdrawal of treatment.

The writers contend that a patient's prior stated will against being sustained in PVS must be respected. As a practical matter, and a matter of law, they are perhaps right. However, we are here primarily interested in the *ethics* of such decisions, not whether they ought to be respected in practice as a practical matter. And as long as we are speaking of morality, an action being autonomous does not necessarily add to its worth; specifically, even if an immoral choice is performed fully autonomously, it remains morally worthless (see 1.4.8). If a person's choice against being sustained in PVS has moral value, this must be due to the intrinsic moral uprightness of the choice, not to *the exercise of autonomy involved*. One might therefore suspect that the NNL view of autonomy in this case has been exchanged for a notion of autonomy foreign to NNL – for instance, the notion employed by Beauchamp & Childress (B&C).<sup>44</sup> B&C endorse an understanding of autonomy wherein choices shaped by non-rational feelings and inclinations as well as downright morally false reasoning can sometimes deserve the label 'autonomous'. Moreover, in the realm of health care, all such autonomous choices constitute *prima facie* claims on the physician, according to B&C. This goes against the NNL notion of autonomy, where a choice being morally autonomous is not a sufficient condition for it being morally upright or a reason for action for the health care providers.<sup>45</sup>

Because of this, it will not do to issue a blanket ethical approval of 'autonomous' advance decisions to forgo ANH in PVS. One must investigate the morality of each motive that could lead to a choice against being sustained in PVS. Three such potential motives are mentioned by the NNL writers: to avoid the burdens

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<sup>44</sup> Beauchamp and Childress, *Principles of Biomedical Ethics*.

<sup>45</sup> The difference between a Kantian notion of autonomy and B&C's notion is discussed in Hinkley, "Two Rival Understandings." Hinkley contends that B&C's concept of autonomy is problematic particularly insofar as it relies on the same justification as the radically different Kantian concept; namely, respect for persons.

of receiving ANH; to avoid the burdens of PVS itself; and to spare one's family of the burdens of care. Let each motive be discussed in turn.

A person pondering the prospect of a future in PVS could decide to forgo ANH because of *the burdens involved in receiving ANH*. Forgoing treatment because burdens outweigh benefits is an acceptable choice within an NNL framework. However, one might question whether there really *are* any burdens involved in receiving ANH in PVS. Unpleasant conscious experiences certainly cannot be among them, for the PVS patient is incapable of conscious experience. But an even deeper problem is that what troubles us about the prospect of life in PVS is surely not *the mode of receiving nutrition and hydration*, but rather *being in the condition of PVS itself*. The motive of avoiding the burdens of receiving ANH, although in principle morally acceptable, seems not to motivate choices in practice.

Let me clarify and defend these points, as they are central to my line of argument. Think about the day-to-day life of PVS patients. They are incapable of any conscious experience. They lie in bed and are completely dependent on caretakers for changing position or bodily movement. They are entirely at the mercy of the caretakers – if someone was to treat the patient in an undignified manner, the patient could neither resist nor experience this. The patients have no will, no desires. They are dependent on basic nursing care, including for personal hygiene like diaper changes. Food and water are provided through a tube directly into the stomach. Now, many people truly fear ending up in this condition (as the empirical data examined later on shows). Among Norwegians, an often-heard saying is, 'I don't want to end up as a vegetable', referring to PVS-like conditions. What is it about this portrayal of life in PVS that people fear? Surely it is not *the manner in which food and water is provided*. What reasons are there to single out that particular, minor part of life in PVS – and proceed to say that this is what we fear, this is what is undignified, this is what is burdensome? The provision of ANH is not experienced by the patient, and when used for other patient groups, ANH is not typically considered to be undignified. Rather, when people fear PVS and state that they would not want to be maintained in such a condition, it is *not* ANH they fear, but rather the PVS condition itself and all that it entails – in particular, the loss of mental and physical abilities. This is why I think it is correct to say that actual advance decisions to abstain from ANH in PVS are motivated not by any burdens of ANH, but by the burdens of being in PVS itself.



What, then, can be said about the morality of the decision to forgo ANH in PVS *in order to avoid the burdens of PVS itself*? As several of the NNL writers discuss, such a decision would be morally unacceptable from an NNL perspective. Tollefsen states, ‘The choice to remove ANH in order to eliminate the burdens of the condition itself is a homicidal choice, when made by a proxy, *and a suicidal choice, when made by someone contemplating the possibility of PVS*’ (emphasis added).<sup>46</sup> The choice would involve a direct attack on the good of life, a suicide, as a means to the goal of not having to live on in PVS.

Finally, one could forgo ANH in PVS in order to spare one’s family from the burdens of care. This would, in NNL analysis, be a morally acceptable act of charity provided that the burdens are substantial. However, as discussed above, in most instances in affluent countries the financial burdens would not be borne by the patient’s relative, but by the state or an insurance company. The ‘burdens’ that remain are then the emotional burdens. I believe there is reason to think that this motive – sparing others of the emotional burdens of having a loved one in PVS – is not typically what motivates decisions to forgo treatment in practice. One could also ask whether the emotional burdens are sufficiently large to warrant forgoing life and the (ex hypothesi) benefit of continued life. There are four reasons to think not. First, if continued life is truly a benefit, then it is hard to see how the merely emotional burdens – that is, the sorrow and grief for the patient’s condition and serious disability – can outweigh the benefits. Second, the decision to forgo treatment leads to death, but how does this death relieve the relatives’ emotional burden? Their loss is now even greater – their loved one, when dead, no longer has even the benefit of continued life. If it really *is* better for the relatives that the patient is dead, then this must be because death is also to be preferred *for the patient*, must it not? In this case, why should the emotional burdens to the relatives – rather than the burdens of PVS itself – motivate the forgoing of treatment? Third, it may be argued that the relatives morally *ought* to bear the emotional burdens.<sup>47</sup> Fourth, even apart from the above considerations, it may be ethically problematic to relieve one’s loved ones of the

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<sup>46</sup> Tollefsen, “Ten Errors Regarding End of Life Issues,” 223.

<sup>47</sup> For the view that such burdens should be borne and involve profound meaning, consider Gilbert Meilaender: ‘Is this not in large measure what it means to belong to a family: to burden each other—and to find, almost miraculously, that others are willing, even happy, to carry such burdens? Families would not have the significance they do for us if they did not, in fact, give us a claim upon each other.’ Meilaender, “I Want To Burden My Loved Ones,” *First Things* 1991.

emotional burdens of one's care *by a choice that leads to one's death*. These, then, are four reasons to think that it is morally unacceptable to choose to forgo treatment in PVS for the sake of sparing loved ones of emotional burdens.

To sum up: I have argued that, of the two conditions the NNL writers accept as justifying a choice to withdraw ANH, the first, financial and practical burdens on the caretakers, rarely occurs in Western countries; whereas the second, a prior, autonomous decision to forgo ANH were one to enter PVS, cannot be accepted wholesale, but each possible *motive* for this decision must be scrutinized. Of these motives, I argued that 'avoiding the burdens of ANH' is *not* what motivates such choices in practice, and that the more likely motive of 'avoiding life in PVS' is ethically unacceptable because it involves suicidal intent. The final possible motive, sparing one's relatives of the emotional burdens of care, might be thought to be ethically acceptable as motivating an act of charity; however, I pointed to four counter-arguments that preclude the acceptance of this motive. In addition, I contend that it is the second, ethically unacceptable, motive of avoiding life in PVS that is the most prevalent in practice; this contention will be corroborated by the empirical data presented later on.

If my line of argument is sound, there are reasons to rethink the moral guidance provided by the NNL writers in this case. When they take the theoretical presuppositions regarding autonomy to which they are committed seriously, a much more restrictive and unpalatable view of treatment-limiting decisions for PVS patients results. It seems that NNL proponents are committed to the view that continued ANH is *always* morally obligatory for the PVS patient, unless (1) the patient is in the process of dying; or (2) the financial or practical burdens of care are too high; or, perhaps, (3) the patient has made a prior, autonomous choice to forgo ANH with the charitable motive of sparing relatives of the emotional burdens of care.

Because (2) and (3) seldom apply, this view seems to imply that withdrawing ANH would be morally acceptable in *only very few* actual cases. In addition, it goes against prevalent and strong moral intuitions (to be examined later in the chapter): when people want to forgo ANH in PVS, *it is not primarily to spare their relatives of the emotional burdens, but for their own sake to escape a condition that is perceived as meaningless*, and perhaps in some sense undignified.

The rest of this chapter will show that the view that the NNL writers are really committed to goes against strong and widely shared moral *intuitions* of health care

workers; the next chapter will show that there are also strong moral *arguments* against it. The goal of this and the next chapter is to see whether another view of treatment-limiting decisions in PVS is more plausible; and whether such view can, after all, be accommodated in a (revised) NNL theory.

### 3.4 The methodology of testing moral theory on intuitions

By ‘intuition’ I will refer to moral judgments that the person has not analyzed thoroughly. ‘Intuition’ thus captures a range of moral judgments – from those formed spontaneously, which may, for instance, be reported as ‘I just see/feel immediately that that must be wrong’ – to judgments arrived at after some conscious consideration of arguments.

The intuitions to be examined further in this chapter are the ones held by health care workers, the general population and patients’ relatives towards the condition of PVS. More specifically, the intuitions regard the condition of PVS itself, PVS patients, and the treatment of PVS patients. There is a relative scarcity of quality studies, but what is there is, by and large, illuminating and interesting. From this survey I will attempt to draw out *ethical arguments underpinning the intuitions*. In the next chapter, these arguments will then be joined by other arguments from diverse sources, and their relative merits discussed.

Some strands of natural law theory have a special affiliation for moral intuitions. Natural law ethics has usually gone together with a certain philosophical anthropology: man has a rational nature, and is well equipped – by his creator or by nature – to grasp the ‘eternal fitnesses and unfitnesses of things’.<sup>48</sup> Often this is taken to mean that only the most general precepts of the natural moral law are grasped or ‘intuited’ reliably, as when NNL theory speaks of our natural practical knowledge of the basic human goods. Sometimes, however, the scope of our faculty for intuitive moral insight is taken to encompass more particular moral truths as well. This latter view on the origin of moral intuitions accords them an elevated epistemic status: well-formed moral intuitions are *guides towards moral truth*.

I think this view is basically sound, and will briefly argue for it by examining how certain moral intuitions come to be held by health care workers, and what it takes

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<sup>48</sup> As Hume puts it in his critique of natural law ethics: David Hume, “A Treatise of Human Nature,” ed. David F. Norton and Mary J. Norton (Oxford: Clarendon Press, 2000), B3.1.1.

for these intuitions to be well-formed. I offer a sketch of the genesis of well-formed intuitions that is informed by Aristotelian notions of practical reasonableness. Five factors work together for health care workers to acquire well-formed intuitions. First, the health care professional must have received a quality professional *education by wise instructors*. The theoretical and practical instruction prepares the student for her line of work, inculcates appropriate attitudes, and initiates her in the professional morality of the health professions.<sup>49</sup> Second, a *virtuous character* is a prerequisite both for benefiting from the education and for good practical deliberation in professional life.

Practical wisdom is excellence in deliberation. In Aristotle's view, practical wisdom consists of understanding, judgment, and cleverness.<sup>50</sup> *Understanding* and *judgment* are the third and fourth of the factors relevant here. The health care worker's understanding and judgment of the features relevant to deliberation in a certain clinical situation come from practical and theoretical education; from clinical experience with similar situations, with patients, procedures and treatments; and from interaction with colleagues.

Fifth, practical reasonableness is cultivated through *practice*. Health care workers are continuously faced with having to make decisions. Through experience and repeated deliberation about the best way to act in clinical situations, health care workers exercise their practical reasonableness, and thus step by step *become* practically reasonable in matters pertaining to their line of work.<sup>51</sup> Their intuitions, therefore, are thoroughly shaped by practice – they are not the intuitions of Hume's disinterested observer.

Moral intuitions aspire to be a kind of practical knowledge, knowledge of what to do. When moral intuitions are well-formed by being shaped by the five factors listed, they contribute to *sound professional judgment*. Although there is

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<sup>49</sup> A critic of abortion could protest at this stage – has the professional morality of health professions and teachers not been significantly corrupted by the embrace of abortion on demand? If we grant that abortion is really a moral evil, then perhaps so – to some extent. However, professional integrity is hardly an all-or-nothing phenomenon. It could be argued that it is abortion that is the anomaly here, at odds with the professional ethics practiced (or at least assented to) in other situations.

<sup>50</sup> J.O. Urmson, *Aristotle's Ethics* (Oxford: Blackwell, 1988), 81-83.

<sup>51</sup> As nurses spend more time with the vegetative patients than the doctors do, one might argue that the nurses' moral intuitions could be more well-formed due to this greater accumulation of practically relevant experience. Thus their intuitions may be more reliable and even more pertinent to our inquiry than the physicians' intuitions.

certainly no guarantee that an intuition formed in this way is not erroneous, it is still reasonable to regard a well-formed moral intuition as a guide towards truth, which ought to be accorded some weight in ethical discussions, at least until compelling reason to disregard it is found. In other words, a well-formed moral intuition is a *prima facie* guide to moral truth.

Of course, the intuitions recorded in the empirical literature on health care workers' intuitions concerning PVS may be deficient in one or more ways. For instance, there is no independent way of assessing the virtue of the respondents in the studies, or the quality of the education they have received. If a large proportion of the respondents have seriously deficient moral characters or are influenced by strong cultural biases, then too much trust should not be placed in their intuitions. In addition, one cannot rule out collective 'moral blind spots'. The presence of such factors cannot readily be assessed. This is another reason why it would be perilous to take the results of the empirical studies as direct guides to moral truth.

The moral intuitions of health care workers regarding PVS will influence the discussion in three ways. First, by pointing to this topic as worthy of consideration in the first place. The perceived conflict between the NNL view on treatment-limiting decisions in PVS and what will be shown to be the strong and widespread intuitions of health care workers merits consideration. Secondly, health care workers' intuitions are *prima facie* guides to moral truth in this question, because they can be thought to be well-formed in the sense discussed above. Thirdly, and most importantly, the intuitions are underpinned by *reasons* that can be evaluated rationally. Why do the health professionals think what they think? Some studies shed light on reasons directly, whereas others do so indirectly. From the empirical studies, I will therefore attempt to draw out not intuitions alone, but the ethical arguments and reasons that underpin those intuitions. The arguments will then be considered together with philosophical arguments from other sources (Chapter 4). The arguments will be scrutinized in detail, with the NNL outlook on morality as the backdrop for the discussion. Thus the moral intuitions from the empirical studies will have an important place in the ethical deliberation of the next chapter. There, though, they will not only carry weight *qua* intuitions, but also through their representative, the moral arguments underlying them.

The intuitions of patients' relatives and the general population concerning PVS are also interesting, and so will be referenced in what follows. However, because

these intuitions are not reliably well-formed in the way health care professionals' intuitions can be, they should not be accorded the same weight.

There are two reasons why health care workers' intuitions in the case of PVS may not be as helpful in the search for moral truth as one could hope. The question of whether ANH should be withdrawn from PVS patients may be thought not to generate reliable intuitions. For, first, the problem is so *complex* that one cannot expect health care workers to develop simple, unambiguous moral intuitions that guide towards truth, as one could in, e.g., a case of the infliction of gratuitous suffering. And second, the PVS is very *strange* and unlike other situations encountered by health care workers and laypersons. When one deliberates and forms one's intuitions, an important source of practical wisdom is experience with situations that bear similarities. But as PVS is so strange, intuitions from related situations may not be available or relevant or helpful. Thus, the complexity and strangeness of PVS could make the intuitions formed about it less reliable. However, these considerations at least strengthen our reason to give more deference to the intuitions of health care professionals than to those of laypersons.

### 3.4.1 Reflective equilibrium between intuitions, arguments and theory

The question of what the relationship between moral intuitions and ethical theory in general should be has been thoroughly debated. John Rawls' view, employed in his method of reflective equilibrium, is widely shared and applied.<sup>52</sup> His method involves working back and forth between intuitions and moral theory, making changes to either in order to increase the coherence of the two sets of 'data'. Norman Daniels develops this method further, and points to an instructive distinction between 'narrow' and 'wide' reflective equilibriums. When we 'simply settle for the best fit of [moral] principles with [moral] judgements', a narrow equilibrium results.<sup>53</sup> This, Daniels objects, typically accords our moral judgments or intuitions a far too important role. If one is to secure the best fit between principles and intuitions in this way, the principles may not necessarily provide a sufficient impetus to discard the erroneous intuitions. A wide reflective equilibrium, on the other hand, involves a different

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<sup>52</sup> Rawls, *A Theory of Justice*; Rawls, "Outline of a Decision Procedure for Ethics," in *John Rawls: Collected Papers*, ed. S. Freeman (Cambridge, Mass.: Harvard University Press, 1999).

<sup>53</sup> Daniels, "Wide Reflective Equilibrium," 258.

attitude towards our moral intuitions. No intuition is sacred, not even the ones we consider the strongest, the ones we would think are most likely to mirror ethical truth. No intuition is in principle above criticism and revision. In the process of wide reflective equilibrium, even competing moral theories are brought to bear on moral principles and intuitions. There is no guaranteeing beforehand that a certain strong intuition will be retained in the final equilibrium.

A problem with this move from ‘narrow’ to ‘wide’, though, was pointed out by Peter Singer: ‘The price for avoiding the inbuilt conservatism of the narrow interpretation [of reflective equilibrium], however, is that reflective equilibrium ceases to be a distinctive method of doing normative ethics’.<sup>54</sup> If the equilibrium is to contain ‘everything’, then what separates the method of wide reflective equilibrium from other methods? Singer’s criticism is important.

The relationship between moral intuitions and theory has also been examined in bioethics specifically. Here the question has often been framed as: what is the relationship between ethical theory and empirical investigations into moral aspects of medical practice? Insight into the moral intuitions of health care workers is one kind of data that may result from such empirical investigations. Bert Molewijk and collaborators identify five possible relationships between ethics and empirical data.<sup>55</sup> The first is ‘prescriptive applied ethics’, in which medical ethical questions are decided by more or less directly applying an ethical theory thought to be correct. In this model, empirical data supply only the descriptions of the situations and practices to be considered. The second is the ‘theorist’ approach, considering empirical data with the sole aim of improving moral theory. Next up is ‘critically applied ethics’, in which the goal is both to improve practice in light of the guidance from abstract ethical theory, and to have empirical data interact with the ethical theory in order to improve the theory. Neither ethical theory nor empirical data has an overriding ethical authority. Whether the one will have to yield to the other, or the other way around, is not decided from the outset. This approach corresponds to the method of reflective equilibrium. The authors state a problem with this approach, noting: ‘Critical applied ethicists have caused discontent because they fail to present some clear criteria for

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<sup>54</sup> Peter Singer, “Ethics and Intuitions,” *The Journal of Ethics* 9 (2005): 347.

<sup>55</sup> Bert Molewijk et al., “Empirical data and moral theory. A plea for integrated empirical ethics,” *Medicine, Health Care and Philosophy* 7 (2004).

determining whether the morality of a social practice or the moral theory has to be adjusted'.<sup>56</sup>

A fourth approach is the 'particularist', in which abstract ethical theory has no place. The fifth model is 'integrated empirical ethics', 'in which ethicists and descriptive scientists cooperate together intensively ... [and] the fundamental interdependence between facts and values and between the empirical and the normative' is recognized.<sup>57</sup>

My proposed method most closely resembles the third of these approaches, 'critically applied ethics'. It is also a kind of reflective equilibrium. Arguments springing from NNL theory, from the intuitions of health care workers and others, are welcomed into the reflective process. So are arguments that may owe their origin to other sources and make sense across different ethical theories. The process will take for granted the most basic precepts of NNL. Apart from this, however, no intuitions or arguments are from the outset immune from critical scrutiny, revision, and the risk of being discarded altogether. Thus what I am about to undertake is an exercise in critically applied ethics, and a narrow reflective equilibrium. The 'narrowness' allows the method to steer clear of Singer's criticism – it *is* a distinctive method of 'doing ethics', a method in which empirical data (moral intuitions), arguments and theory mutually fertilize and mould each other. One might worry with Molewijk et al. that the decision of whether one or the other of theory and intuitions ought to yield would be arbitrary. However, most of the normative work of the intuitions will be performed in the guise of moral arguments, which can be evaluated rationally.

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<sup>56</sup> Ibid., 57.

<sup>57</sup> Ibid. The details of this fifth model are less clear than is desirable. It also seems to lead to a self-contradiction, for when there no longer is a distinction between the descriptive and the normative, there cannot be a fruitful *dialogue between* the two perspectives, as Molewijk et al. repeatedly call for. This is pointed out in C. Leget, P. Borry, and R. De Vries, "'Nobody tosses a dwarf!' The relation between the empirical and the normative reexamined," *Bioethics* 23 (2009): 231.



### 3.5 The empirical literature on moral intuitions towards PVS

A literature search was conducted in order to identify empirical studies concerning attitudes towards PVS.<sup>58</sup> In total, 36 papers are treated in the below summary of the literature.

#### 3.5.1 The moral intuitions of health care workers

Demertzi et al. surveyed the attitudes of European physicians and other health care workers towards PVS.<sup>59</sup> To the question, ‘Do you think that it is acceptable to stop treatment (i.e., nutrition and hydration – ANH) in patients in chronic VS [vegetative state]?’ 67% of both groups answered yes. To the question ‘Would you like to be kept alive if you were in a chronic VS?’ only 19% of physicians answered yes, compared to 12% of the other health care workers. Religious respondents more often wanted treatment. There were differences between northern, central and southern regions of Europe that were for the most part explained by differences in religious affiliation. In another paper from the same study, 56% of medical doctors agreed that patients in a vegetative state can feel pain.<sup>60</sup> This finding is relevant, as the belief that the PVS patient can feel pain and thus, by implication, be conscious could justify a presumption to treat. For our purposes, belief in the PVS patient’s being conscious constitutes a ‘bias’. This will be discussed in more detail in the summary below (3.5.4).

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<sup>58</sup> The main search string employed was (‘persistent vegetative state’ AND attitudes). Searches were carried out in October 2010, and repeated in January 2014. In 2014, the main search gave 208 results in PUBMED. Of these, 15 were deemed relevant judging from title and abstract, and were evaluated in full text. The same search in Google Scholar yielded 6,540 results. The first 400 were evaluated based on title, and 41 were deemed relevant. Some further articles were identified by supplemental searches, and some by searching the reference lists of relevant articles. Some articles are also included that do not pertain to PVS directly, but nevertheless shed light on our topic. Of the papers evaluated in full text, some were not included because the data were not relevant to the topic, or because the methodology was judged to be too weak. The literature survey was not intended to be exhaustive.

<sup>59</sup> A. Demertzi et al., “Attitudes towards end-of-life issues in disorders of consciousness: a European survey,” *Journal of neurology* 258 (2011).

<sup>60</sup> A. Demertzi et al., “Different beliefs about pain perception in the vegetative and minimally conscious states: a European survey of medical and paramedical professionals,” *Progress in Brain Research* 177 (2009).

Payne and collaborators surveyed the attitudes of American neurologists and nursing home medical directors towards PVS by a questionnaire study.<sup>61</sup> The two specialties were selected because they are often involved in the treatment of PVS patients. Of respondents, 94% thought that PVS patients 'would be better off dead'. Among medical directors and neurologists, respectively, 54% and 44% thought that PVS patients 'should be considered dead'. Of these respective groups, 34% and 22% would treat infections aggressively, whereas fewer would provide aggressive treatment for life-threatening medical crises such as respiratory failure, cardiogenic shock or renal failure (varying between 4% and 7% among the two groups and the three conditions listed). As for ANH, 29% and 47% respectively agreed that this 'should generally be provided'. One could speculate that the higher proportion of positive answers among neurologists reflects the fact that these physicians treat vegetative patients at an earlier stage, when the hopes for recovery are higher. On the other hand, only 10% and 13% would want ANH for themselves, were they ever to enter PVS. In both groups, 89% and 88% agreed that it is ethical to withhold or withdraw ANH 'when requested to do so in a living will or by an appropriate surrogate decision maker'. Of all respondents, 20% saw it as ethical to 'hasten the patient's death by lethal injection'. Note also that 13% of respondents thought that PVS patients 'have awareness of self or environment', and that 25-35% thought that the patients can experience pain.

Asai and colleagues used a postal questionnaire to assess the attitudes towards patients in PVS of Japanese physicians working at teaching hospitals.<sup>62</sup> The questions were preceded by a clinical vignette, depicting a male patient in his 70s, who has been in PVS for two years, with 'extremely slim' chances of recovery. If the patient's values and wishes were not known, only 3% of physicians would withdraw ANH. On the other hand, 34% would withhold treatment for pneumonia, and 81% would not institute dialysis for renal failure. If the patient were known not to want ANH, and the family were to concur, 17% would withdraw this treatment, and 71% and 93% would refrain from treating pneumonia and renal failure, respectively. Personal experience with caring for patients in PVS correlated with unwillingness to withdraw nutrition.

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<sup>61</sup> K. Payne et al., "Physicians' attitudes about the care of patients in the persistent vegetative state: a national survey," *Annals of internal medicine* 125 (1996).

<sup>62</sup> A. Asai et al., "Survey of Japanese physicians' attitudes towards the care of adult patients in persistent vegetative state," *BMJ* 25 (1999).

The respondents were asked what they would want if they themselves were in PVS (with other circumstances like in the vignette). Of respondents, 40% would not want ANH, 70% would not want antibiotics, and 95% would not want dialysis; 78% of respondents agreed that the dignity of a patient is offended by the PVS condition itself, and 91% thought that an advance directive would influence their decisions. The authors' speculation as to why Japanese doctors are less willing to terminate life-sustaining treatment for PVS patients than their Western colleagues is interesting:

Together with the combined influence of Buddhism and Confucianism, Shintoism, which governs Japanese spirituality, long ago established the Japanese view of death: death is a curse, the corpse is polluting and the spirit of the deceased is frightening. Life and this world have been highly valued and death has been denied and abhorred. Japanese seldom consider death as an invitation from the Creator. This abhorrence of death could still reside in the mind of the Japanese and might facilitate reluctance towards any kind of termination of life ... some Japanese physicians think their primary obligation is to prolong the life of a patient under any circumstances.<sup>63</sup>

However, it should also be noted that only 12% of respondents stated having religious beliefs. It might be significant that respondents were asked what course of action they would actually recommend in the proposed situations, and not, as in other studies, asked what treatment decisions *could* be morally acceptable. The answers given might then be shaped by respondents' views of relatives' and society's expectations and mores, more than their own values and views on the PVS condition. This speculation is supported by the authors' statement that 'fear and anxiety of a lawsuit filed by the patient's family for murder may foster their unwillingness to forego [life-sustaining treatment] for PVS patients'.<sup>64</sup> On the other hand, the influence of external expectations on the respondents should be mitigated in the question about what the physicians would want for themselves, but, as shown, only a minority (40%) would want to forgo ANH for themselves.

Hodges et al. assessed American internists' views on tube feeding in three scenarios where patient preferences were not known.<sup>65</sup> Of respondents, 98% would

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<sup>63</sup> Ibid., 306.

<sup>64</sup> Ibid.

<sup>65</sup> Marian O. Hodges et al., "Tube Feeding: Internists' Attitudes Regarding Ethical Obligations," *Arch Intern Med* 154 (1994).

initiate tube feeding in acute pneumonia, whereas 84% and 80% would withhold artificial nutrition in advanced dementia and PVS of one year's duration, respectively. The question on PVS was phrased thus: 'If you did not have to be concerned with any legal or institutional pressures, how would you feel about withdrawing nasogastric tube feedings in Ms R.?' Of the 80% who favoured withdrawal of tube feeding in PVS, 84% gave as the most important reason that 'the patient may have irreversible disease and is not likely to recover significant function'. Of the remainder, 7% gave 'patient has poor quality of life', and a further 7% 'patient would not want tube feeding'. Of those who opposed withdrawal of tube feeding in PVS, 42% gave as their main reason that 'the physician's role is to sustain life', while 16% gave 'nutrition reduces suffering', 13% that 'all patients deserve to be fed', and 11% that the 'patient has a reversible disease'. Also of note, 16% considered artificial nutrition to be 'basic humane care', whereas 84% considered it to be medical treatment.

Elpern and colleagues surveyed the moral distress of nurses working in intensive care units in the USA.<sup>66</sup> PVS is not directly mentioned, but the answers given are nevertheless interesting for our topic. The questionnaire listed several clinical situations deemed to be problematic. The authors then constructed a moral distress ranking of these situations according to the perceived intensity of moral distress of each situation, and to the frequency with which it occurred. Interestingly, the top five situations all pertain to over-treatment for very sick patients, e.g., to 'continue to participate in care for hopelessly ill person who is being sustained on a ventilator, when no-one will make a decision to "pull the plug"'; to 'follow a family's wishes to continue life support even though it is not in the best interest of the patient'; or to 'initiate extensive life-saving actions when I think it only prolongs death'.

Montagnino & Ethier conducted qualitative interviews with eight American nurses caring for children in PVS.<sup>67</sup> They found that the nurses had considerable qualms about the provision of life-sustaining treatment and care. Although ambivalent, negative attitudes seemed to have prevailed. Some of the statements made by the nurses were:

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<sup>66</sup> E.H. Elpern, B. Covert, and R. Kleinpell, "Moral distress of staff nurses in a medical intensive care unit," *American Journal of Critical Care* 14 (2005).

<sup>67</sup> B.A. Montagnino and A.M. Ethier, "The experiences of pediatric nurses caring for children in a persistent vegetative state," *Pediatric critical care medicine* 8 (2007).

Nurses commented on the unresponsiveness of children in a PVS, referring to them as “going nowhere.” Furthermore, “caring for the living dead,” as one nurse put it, described how nurses perceived the child in a PVS as “technically alive” but essentially without life. “You are taking care of someone that is dead in a way . . . they’re alive, but they are dead.” Nurses referred to caring for the child in a PVS as “watering and growing” a “vegetable garden” or “flower,” or used comparisons to inanimate objects in describing their experiences, such as “dressing a doll,” “bandaging a ship with holes that goes out to sea,” “rolling around a carcass,” and “hooking up a cadaver to a ventilator.” (...) While most nurses felt sorrow for the once-well child in a PVS, some nurses expressed relief coupled with sadness when a child in a PVS died. As one nurse described it, “My relief was for [the child’s] sake, that finally he’s resting and finally the family can rest, and I was sad for the family because it seems that their lives revolved around [the child].” (...) The majority of nurses interviewed repeatedly voiced grave concern about the powerless feeling of being required to continue what they perceived as medically inappropriate life-support measures for the child in a PVS. They agonized over and questioned the escalation of care. As one nurse said, “When they’re all broken inside . . . and the doctors have charted this, yet we [place a permanent airway tube] and keep them alive, what do we do now?” (...) Feelings of moral distress were illustrated by another participant’s comment, “As a nurse, as a doctor, we are so focused on preserving life as much as we can . . . we forget or just do not know when to stop . . . but then where is the line between using technology for good quality of life or using technology for just prolonging pain?”<sup>68</sup>

The authors emphasize the nurses’ ambivalence:

While nurses spent the major portion of their interviews describing the negative aspects of caring for these children and their parents, they briefly, almost as an afterthought, mentioned ways they found to momentarily mitigate the negativity by focusing on some of the more positive aspects (e.g., grateful parents, personal gratitude). Despite the grim reality of the child’s situation, nurses serendipitously benefited from these experiences.<sup>69</sup>

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<sup>68</sup> Ibid., 443.

<sup>69</sup> Ibid., 444.

Also of note is that some of the respondents sometimes described the PVS children as ‘dirty, unnatural, and repulsive’, and as ‘inanimate objects’. Overall, the authors conclude that providing nursing care for PVS children is ‘emotionally stressful and ethically challenging’, and that ‘the eight nurses in this study experienced caring for children in a PVS as a predominantly negative experience.’<sup>70</sup>

Gillick and co-investigators examined the preferences for end-of-life decisions among nurses and physicians in an American teaching hospital.<sup>71</sup> Respondents were asked to indicate what medical interventions they would want, were they ever to fall ill conforming to one of six case descriptions. The scenario of interest to us was described as coma or PVS, with consensus among the physicians in charge that there is no ‘hope of regaining awareness and higher mental functions’. For our purposes it is not ideal that coma and PVS have been conflated. On average, the 11 interventions were refused in 89.5% of cases in the coma/PVS case. The article does not give refusal rates for ANH specifically. Older respondents and men wanted more interventions. In the coma/PVS case, there were no differences between the nurses’ and the physicians’ responses. Overall, the authors concluded that ‘physicians and nurses, who have extensive exposure to hospitals and sick patients, are unlikely to wish aggressive treatment if they become terminally ill, demented, or are in a persistent vegetative state’.

Sibbald and colleagues conducted semi-structured interviews with physician directors, nurse managers and respiratory therapists from Canadian intensive care units, in order to elucidate what kind of medical treatment these groups would perceive as futile.<sup>72</sup> Some of the results are relevant for our purposes. The respondents opined on what would characterize the patients for whom intensive care would typically be futile. Among these characteristics were poor quality of life, bleak prognosis, and brain death and PVS. The reasons given for these judgments were that the patient is in the process of dying, has no meaningful quality of life, that no benefit is derived from the resources spent, and that the patients’ lives are filled with pain and suffering. From the interviews, the authors constructed a tentative definition of ‘futile care’ as ‘the use of considerable resources without a reasonable hope that the patient

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<sup>70</sup> Ibid., 445.

<sup>71</sup> M.R. Gillick, K. Hesse, and N. Mazzapica, “Medical technology at the end of life: What would physicians and nurses want for themselves?” *Archives of internal medicine* 153 (1993).

<sup>72</sup> Robert Sibbald, James Downar, and Laura Hawryluck, “Perceptions of ‘futile care’ among caregivers in intensive care units,” *CMAJ* 177 (2007).

would recover to a state of relative independence or be interactive with his or her environment'. The most common reason for providing futile care was pressure from the patient's family. The respondents felt that this pressure often originated from cultural or religious perceptions that 'everything must be done', and from an unrealistic perception of what intensive care can achieve.

Grubb et al. surveyed the opinions of British physicians in relevant specialties (neurology, neurosurgery, orthopaedics, rehabilitation) towards PVS with a questionnaire.<sup>73</sup> Of respondents, 54% had been involved in treating PVS patients. A third of these had been involved in a decision whether to withdraw ANH. While 90% agreed that it may sometimes be appropriate not to treat infections or other life-threatening conditions, 73% thought that withdrawing ANH may be appropriate. Interestingly, among the doctors with the most experience in treating PVS patients, more considered it never appropriate to withdraw ANH (35%) than among doctors who had seen fewer (25%) or no such patients (22%). Of those who considered withdrawal of ANH to be sometimes justified, 94% stated that the vegetative state being truly permanent would justify this. Only 22% thought withdrawal of ANH to be justified if the patient's predicted outcome was severe disability but with the ability to communicate, although without speech. The authors hypothesize that the higher figures for acceptance of ANH withdrawal in the American surveys is due to the fact that the public debate had been going on for a longer time in the US than in the UK at the time of the survey (1994).

Dierickx and colleagues surveyed the attitudes of Belgian neurosurgeons, neurologists, and rehabilitation specialists with a postal questionnaire.<sup>74</sup> The response rate was 52%. Of respondents, 88% thought it was 'sometimes appropriate not to treat acute infections or other life-threatening conditions' in PVS, and 56% thought it to be 'sometimes appropriate' to withdraw artificial nutrition. Overall, the attitudes of French- and Dutch-speaking physicians were similar. Among the 56% who thought it to be sometimes appropriate to withdraw feeding, nearly all agreed that this could be appropriate if it was established as certain that the patient would remain vegetative. On the other hand, in the case that the patient 'will be severely disabled, able to speak,

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<sup>73</sup> A. Grubb et al., "Survey of British clinicians' views on management of patients in persistent vegetative state," *The Lancet* 348 (1996).

<sup>74</sup> K. Dierickx et al., "Belgian doctors' attitudes on the management of patients in Persistent Vegetative State (PVS): ethical and regulatory aspects," *Acta neurochirurgica* 140 (1998).

but totally dependent on carers yet with sufficient insight to be aware of his/her situation', only 6% would see withdrawal of artificial nutrition as justified, whereas 82% would not. Most doctors agreed that a patient's advance directive or a 'previous informal expression of opinion' should contribute to the decision to withdraw artificial feeding (84% and 72%, respectively).

The two studies referred to above form the UK and the Belgian components of a larger study spanning seven European countries. The findings are summarized in Grubb et al.<sup>75</sup> Several methodological shortcomings reduce the validity of the findings. First, response rates were low, varying from 17% (Greece) to 60% (Ireland). Second, for some countries, the number of doctors surveyed is very low (e.g., 15 Irish and 50 French respondents). Third, in France the surveyed group was essentially self-selecting. Respondents were asked whether treatment-limiting decisions (not treating infections or other life-threatening conditions, or withdrawing ANH, respectively) would ever be appropriate in PVS. Responses were markedly different among countries. These results can lead one to label as 'permissive' the UK, Belgium, The Netherlands and Ireland. Among these, British doctors were most likely to approve of the limitation of treatment (as shown, 90% approved of not treating infections or other life-threatening conditions, 73% of withdrawing ANH). In the 'restrictive' countries, a minority considered it sometimes appropriate to withdraw ANH (16% of German, 23% of Greek, and 14% of French doctors). Greek doctors also spoke against withholding treatment for infections and other life-threatening conditions (only 21% approved of treatment-limiting decisions), whereas the majority among German and French doctors approved of this. The authors point to cultural and religious factors as explanative of this European divide.<sup>76</sup>

Brunetti and colleagues studied American physicians' willingness to discuss end-of-life decisions such as preferences for cardiopulmonary resuscitation with their

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<sup>75</sup> A. Grubb, P. Walsh, and N. Lambe, "Reporting on the Persistent Vegetative State in Europe," *Medical Law Review* 6 (1998).

<sup>76</sup> And, as two of the Greek co-investigators are quoted as saying, in their country 'no public debate has taken place concerning the nature of ANH, preventing thus the "fermentation" of opinions necessary for the adoption of a certain policy'; T. Garanis-Papadatos and G. Stranjalis, quoted in "Reporting on the Persistent Vegetative State in Europe," *Medical Law Review* 6 (1998): 213. In addition, a German commentator states that in his country, 'The fear of a new rise of misuse of medicine has led to very different sensitivities concerning biomedical ethics than in other European countries'; L. Honnefelder, quoted in *ibid*.



patients.<sup>77</sup> A question on the physician's own preferences for ANH if they themselves were to enter a permanent vegetative state was included, and 92% of respondents would not want ANH in this situation.

Kuehlmeier and colleagues surveyed the attitudes of German neurologists towards treatment-limiting decisions in PVS.<sup>78</sup> The response rate was only 16%. If the patient was known to be opposed to being kept alive in PVS, 96% of respondents would limit life-prolonging treatment. If there was no improvement after one year or more, 53% would limit treatment, whereas 21% would not. If there was no chance for recovery of consciousness, 66% would limit treatment, whereas 19% would not.

The ETHICATT study surveyed the attitudes of physicians and nurses in six countries (Czech Republic, Israel, The Netherlands, Portugal, Sweden, and the UK) towards end-of-life decisions.<sup>79</sup> One of the questions was what kind of treatment the respondent would want if in a state of 'permanent unconsciousness'. Of physicians and nurses respectively, 7% and 13% would want to be treated in an intensive care unit, 3% and 7% would want cardiopulmonary resuscitation in the case of cardiac arrest, 4% and 9% would want to be put on a ventilator if necessary, whereas 40% and 50% would want 'active euthanasia'. The results are of limited value for our purposes, as the clinical condition was not specified as PVS, and the question of whether to provide ANH or not was not raised. The article does not break down the results by the nationalities of participants.

Lavrijsen and colleagues reviewed five PVS cases from a Dutch nursing home over the period 1978-2005.<sup>80</sup> The first author was involved in the management of all patients. The article states that 'the role of the physicians has changed over time: from reacting to complications to a proactive role in which evaluation of the total treatment, including ANH, has become the starting point'.

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<sup>77</sup> L.L. Brunetti, S.D. Carperos, and R.E. Westlund, "Physicians' attitudes towards living wills and cardiopulmonary resuscitation," *Journal of general internal medicine* 6 (1991).

<sup>78</sup> Katja Kuehlmeier et al., "Diagnostic and ethical challenges in disorders of consciousness and locked-in syndrome: a survey of German neurologists," *Journal of neurology* 259 (2012).

<sup>79</sup> C.L. Sprung et al., "Attitudes of European physicians, nurses, patients, and families regarding end-of-life decisions: the ETHICATT study," *Intensive care medicine* 33 (2007).

<sup>80</sup> J. Lavrijsen et al., "Events and decision-making in the long-term care of Dutch nursing home patients in a vegetative state," *Brain Injury* 19 (2005).

Marik et al. surveyed the attitudes of physicians at different kinds of hospitals in the US by postal questionnaire.<sup>81</sup> The response rate was only 40%. Respondents were asked to evaluate certain scenarios. Only 1% agreed that health care workers ‘should never remove or withhold life-sustaining therapy’, whereas 11% agreed that such removal or withholding would be morally wrong ‘in the absence of terminal illness’. Of respondents, 95% would want life-sustaining therapy to be discontinued if they were in coma or PVS with no hope of improvement in cognitive function and awareness, and 38% would want euthanasia if they were to have advanced motor neuron disease.

Lisker et al. surveyed a sample of Mexican physicians.<sup>82</sup> One of the questions was, ‘A patient is in a persistent vegetative state (PVS). The family asks the physician to remove all forms of treatment and let him (her) die. If the answer is yes, would you agree with the physician?’ Of respondents, 48% answered yes, 35% no. Of those who answered yes, most gave the avoidance of suffering as the main reason; of those who answered no, most cited what the authors call ‘other ethical and religious considerations’, whereas only 7% of this group cited legal reasons.

### 3.5.2 The moral intuitions of relatives of patients in PVS

Tresch et al. found that patients in PVS constituted approximately 3% of the population of four nursing homes in Milwaukee, Wisc., USA.<sup>83</sup> Thirty-three relatives were interviewed. Of respondents, 90% believed the PVS-stricken relative to have some limited consciousness, which should perhaps make us question whether the PVS diagnosis really was correct in the cases studied. The majority did not expect the patient’s condition to improve. A majority would also want medical intervention in case of medical emergency, including surgery.

The ETHICATT study referenced above also surveyed close family members of patients who had recently been treated in an intensive care unit.<sup>84</sup> They were asked about their preferences for treatment if permanently unconscious. Of respondents, 32-

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<sup>81</sup> P.E. Marik et al., “Physicians’ own preferences to the limitation and withdrawal of life-sustaining therapy,” *Resuscitation* 42 (1999).

<sup>82</sup> R. Lisker et al., “Physician-assisted death. Opinions of a sample of Mexican physicians,” *Archives of medical research* 39 (2008).

<sup>83</sup> D.D. Tresch et al., “Patients in a persistent vegetative state: attitudes and reactions of family members,” *Journal of the American Geriatrics Society* 39 (1991).

<sup>84</sup> Sprung et al., “Attitudes of European physicians, nurses, patients, and families.”

40% would want admission to an ICU, ventilator treatment and cardiopulmonary resuscitation, while 51% would want active euthanasia.

The Lavrijsen et al. study referenced above quotes a few ‘key statements’ made at meetings between the PVS patient’s relatives and the caregivers.<sup>85</sup> The two quotes from patients’ parents are:

We recognize that our son would never have wanted this situation to continue like this; who would? With hindsight, it would have been better for him if he had died in hospital. We hope that he doesn’t realize in which situation he is.

This is a fate worse than death, but we don’t want to lose him.

A British qualitative study among 51 relatives of patients in PVS or minimally conscious state (MCS) provides particularly rich findings.<sup>86</sup> First, it must be noted that the results may be marked by selection bias. It seems that the selection process was more likely to recruit informants whose afflicted relative was still alive, thus potentially leaving out relatives who were comfortable with a withdrawal of ANH at an early stage of the disease.

Two-thirds of respondents thought that their relative was better off dead or would have preferred death to continued living in the afflicted state. However, this view was typically reached only when the potential for rehabilitation and recovery was thought to be exhausted. In the first years it was generally thought that it was ‘too early to give up’. Interestingly, the view that life in a truly permanent PVS (or MCS) was meaningful or of acceptable quality was, from what I gather, not found in the material. The attribution of a meaningful life was always tied to the potential for recovery, not to the patients’ current condition.

Many respondents rejected the withdrawal of ANH as an unacceptable way of bringing about death, thinking it as undignified and as involving suffering for patient and family. One respondent’s statement illustrates the perceived dilemma: ‘We all thought [ANH withdrawal] was barbaric. But then being kept alive that way is

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<sup>85</sup> Lavrijsen et al., “Events and decision-making in the long-term care of Dutch nursing home patients in a vegetative state,” 72.

<sup>86</sup> C. Kitinger and J. Kitinger, “Withdrawing artificial nutrition and hydration from minimally conscious and vegetative patients: family perspectives,” *Journal of Medical Ethics* (2014).

barbaric'.<sup>87</sup> Many had instituted 'ceilings of care', meaning that ANH was continued whereas potential complications such as infections and cardiac arrest would not be treated. The omission to treat complications was perceived by many as more acceptable than actively withdrawing ANH.

Finally, many thought that killing the patient by lethal injection ought to be an available alternative. These respondents saw such killing as preferable to a protracted dying process following upon withdrawal of ANH. Some respondents had even contemplated killing the patient themselves.

### 3.5.3 The moral intuitions of patients and the general public

Siminoff and colleagues interviewed residents of Ohio, USA, about attitudes towards definitions of death and organ donation.<sup>88</sup> Respondents were presented with three scenarios, one of which was a patient in PVS. Of respondents, 34% thought of PVS patients as dead.

A Japanese study found that among the general population, 78.5% would not want ANH if they were to enter PVS, whereas 6.9% would want their life to be prolonged as far as possible.<sup>89</sup>

The ETHICATT study referenced twice above also surveyed patients who had recently been treated in an intensive care unit.<sup>90</sup> They were asked about their preferences for treatment if permanently unconscious. The response rate was only 22%. Of respondents, 38-47% would want admission to an ICU, ventilator treatment and CPR, and 46% would want active euthanasia.

Frankl and colleagues surveyed the attitudes of 200 medical inpatients at a US hospital.<sup>91</sup> Only 6% of patients would want intensive care and 'life-support treatment' if they would remain comatose or in a PVS, while 16% would want treatment if the prognosis was 'hopeless', and 90% would want treatment if it could restore their health to the usual level.

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<sup>87</sup> Ibid., 3.

<sup>88</sup> L.A. Siminoff, C. Burant, and S.J. Youngner, "Death and organ procurement: Public beliefs and attitudes," *Social Science & Medicine* 59 (2004).

<sup>89</sup> H. Miyata, H. Shiraishi, and I. Kai, "Survey of the general public's attitudes toward advance directives in Japan: How to respect patients' preferences," *BMC Medical Ethics* 7 (2006).

<sup>90</sup> Sprung et al., "Attitudes of European physicians, nurses, patients, and families."

<sup>91</sup> D. Frankl, R.K. Oye, and P.E. Bellamy, "Attitudes of hospitalized patients toward life support: a survey of 200 medical inpatients," *The American Journal of Medicine* 86 (1989).

Emanuel and colleagues surveyed outpatients of general practitioners, as well as members of the general public, in the Boston area.<sup>92</sup> Of respondents, 80% would not want ANH if they were in PVS. The rate of treatment refusal was about the same for the other treatment modalities listed (range 76-83%). Of note, preferences for treatment could not be predicted from demographic variables or self-reported state of health; 93% of outpatients and 89% of members of the public desired advance directives.

Rodriguez & Young interviewed male elderly outpatients and their care providers from a US army veteran medical centre about preferences for end-of-life treatment.<sup>93</sup> Among the findings was that

In most cases, treatment was roughly defined as futile if it would keep a particular patient alive but would not allow the patient to function at a level that he or she would personally find acceptable ... Most patients and healthcare providers believed that decisions on whether to attempt or forgo the initiation of interventions to sustain life include value judgements about what constitutes an acceptable [quality of life].<sup>94</sup>

Gray and colleagues surveyed 55 Americans' views of the value of life in PVS.<sup>95</sup> Confronting respondents with a scenario in which one outcome was PVS and the other death, respondents rated PVS as significantly worse than death both for themselves and for relatives.

#### 3.5.4 Summing up the moral intuitions about PVS

When examining the available empirical evidence on health care workers' attitudes and intuitions towards PVS, a geographical and cultural divide becomes obvious. On the one hand, the US, the UK and The Netherlands display what in this context may be called a 'permissive culture'. Southern Europe, Germany, and Japan, constitute a 'restrictive culture'. Although there are quite a few dissenters in both cultures, the

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<sup>92</sup> Linda L. Emanuel et al., "Advance Directives for Medical Care – A Case for Greater Use," *New England Journal of Medicine* 324 (1991).

<sup>93</sup> K.L. Rodriguez and A.J. Young, "Perceptions of patients on the utility or futility of end-of-life treatment," *Journal of Medical Ethics* 32 (2006).

<sup>94</sup> *Ibid.*, 446.

<sup>95</sup> Kurt Gray, T. Anne Knickman, and Daniel M. Wegner, "More dead than dead: Perceptions of persons in the persistent vegetative state," *Cognition* 121 (2011).

overall picture is clear: in the permissive countries, most health care workers seem to think that ANH generally could or even should be withdrawn from PVS patients; an even larger percentage would not want ANH if they themselves were to enter PVS.

**Table 1.** *Proportion of respondents who think it is sometimes appropriate to withdraw ANH. Surveys among physicians.*

USA (Payne) <sup>96</sup>	89%
USA (Hodges) <sup>97</sup>	80%
UK (Grubb) <sup>98</sup>	73%
The Netherlands (Grubb) <sup>99</sup>	70%
Europe in general (Demertzi) <sup>100</sup>	67%
Belgium (Dierickx) <sup>101</sup>	56%
Greece (Grubb) <sup>102</sup>	23%
Japan (Asai) <sup>103</sup>	17%
Germany (Grubb) <sup>104</sup>	16%
France (Grubb) <sup>105</sup>	14%

However, there appear to be no less than *six biases* that can have influenced the respondents' answers and that all go in the direction of *rejecting* withdrawal of ANH in PVS. The numbers must be interpreted in light of these biases. (1) In a culture in which there is a presumption to treat, there may be strict or ambiguous legal regulations of end-of-life practices. Doctors may fear the legal consequences if treatment is withdrawn. (2) For many health care workers and relatives there is a lingering hope of recovery from PVS. This highlights a methodological problem for

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<sup>96</sup> Payne et al., "Physicians' attitudes about the care of patients in the persistent vegetative state."

<sup>97</sup> Hodges et al., "Tube Feeding."

<sup>98</sup> Grubb et al., "Survey of British clinicians' views on management of patients in persistent vegetative state."

<sup>99</sup> Grubb, Walsh, and Lambe, "Reporting on the Persistent Vegetative State in Europe."

<sup>100</sup> Demertzi et al., "Attitudes towards end-of-life issues in disorders of consciousness."

<sup>101</sup> Dierickx et al., "Belgian doctors' attitudes on the management of patients in persistent vegetative state (PVS)."

<sup>102</sup> Grubb, Walsh, and Lambe, "Reporting on the Persistent Vegetative State in Europe."

<sup>103</sup> Asai et al., "Survey of Japanese physicians' attitudes towards the care of adult patients in persistent vegetative state."

<sup>104</sup> Grubb, Walsh, and Lambe, "Reporting on the Persistent Vegetative State in Europe."

<sup>105</sup> Ibid.

my approach: ideally, I am interested in the intuitions generated from a PVS that is *truly permanent*, and *known to be irreversible*. However, the intuitions sampled in the studies reviewed are generated from PVS as it is (or rather, as it is perceived to be) in clinical practice. (3) Quite a few respondents believe that the PVS patient can have conscious experiences. This bias is closely related to the previous one; ideally, we would like to inspect intuitions towards a PVS known to definitely involve unconsciousness. (4) As is well known, a strong presumption to treat and to preserve life has been ingrained in the medical culture. It is only in the last decades, with the advent of new technology and treatment modalities enabling us to preserve life much more efficiently, that this presumption has been challenged in some cases. The presumption to preserve life is still a strong component of the medical ethos. When confronted with PVS, the presumption constitutes a bias towards preserving the PVS patient's life. (5) As several of the study authors claimed, the restrictive countries are also, in general, notable for a relative lack of debate on PVS, in contrast with the permissive countries, and especially the US. Several hypothesize that a lack of debate creates a bias towards preserving the PVS patient's life. The report from Lavrijsen and collaborators supports this: as public and professional awareness of PVS and end-of-life decisions rose, the doctor involved in the reported cases saw his role changed from being someone whose unquestioned duty was to uphold life, to someone who should evaluate the totality of the treatment, included whether it was justified at all.<sup>106</sup> (6) Finally, there is the general phenomenon of a status quo bias. Humans tend toward preferring the current situation (here: upholding both the policy of preserving life when possible, and continuing treatment for the particular patient) to novelty and change.

All these biases, then, work in the same direction: towards continuing ANH for PVS patients. The biases may have influenced survey respondents to express more restrictive attitudes towards treatment-limiting decisions in PVS. The influence exerted by the biases cannot be quantified from the empirical data examined. However, it was shown that for many Western countries there was a substantial majority in favour of the view that *withdrawal of ANH for PVS patients is sometimes acceptable*. The majority is even larger when health care workers consider a scenario in which they themselves have become PVS patients. Keeping the potential influence

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<sup>106</sup> Lavrijsen et al., "Events and decision-making in the long-term care of Dutch nursing home patients in a vegetative state."

of the biases in mind, it is fair to conclude that *the moral intuition that the withdrawal of ANH is morally legitimate in a large proportion of cases* is strong and widely held (although far from universal) among health care workers.

My interpretation of the findings is as follows. The permissive health care workers underpinned their attitudes with the judgment or intuition that PVS patients are better off dead. Indeed, some even thought that they are, as a matter of fact, dead. Expressions used were, for instance, that the PVS patient is a ‘living dead’, only ‘technically alive’, and ‘dead in a way’. The PVS patients’ participation in the fullness of human life may have been judged to be so minimal that it does not constitute any benefit for them; at least, not a benefit that can outweigh the negative aspects of living on in their dependent state.

When asked for reasons why ANH should or could be withdrawn, most permissive health care workers pointed to the fact that the PVS patient was unlikely to recover significant function. This corroborates what was just said: that continued existence in PVS is *itself* taken to be without value, and pointless. As long as there is no realistic prospect of regaining a higher level of human functioning, then, continued life is not in the patient’s best interest.

It was shown that for health care workers, providing treatment that is pointless, that is not in the patient’s best interest, and that only serves to prolong death is not a morally neutral option, but rather a source of moral distress. Indeed, these situations were the most important sources of moral distress overall in the daily work of a set of American ICU nurses. It seems, then, that health care workers who think that ANH ought to be discontinued do not perceive the prospect of treatment status quo, that is, continuing to provide ANH and treat any complications that arise, as a morally neutral alternative. Instead, in circumstances when their judgment is that ANH ought to be withdrawn, continued treatment is *morally wrong*. One reason given, widely agreed to even in conservative Japan, is that the PVS patient’s dignity is offended by the condition (however, note that the studies typically did not define ‘dignity’, leaving respondents to interpret the term as they wished). Another reason not made explicit, but perhaps figuring as an underlying assumption, is that treatment that is judged to be pointless is not compatible with the purposes and ethos of medicine.

A further reason given for the permissive judgment on ANH in PVS is the lack of benefit from the resources spent; again, an underlying opinion is that continued life



in PVS does not constitute a benefit. Furthermore, treatment is unwarranted because the patients do not have any real hope for independence and interaction.

Most agree that the patient's previous expressed wish, if known, should be given significant although not overriding weight.

A substantial minority accept the medical killing of these patients as an acceptable or even morally preferable option. (Note that in accordance with the terminology I will employ throughout, such medical killings would not constitute *euthanasia*, as they are performed without the patient's competent request. See 5.1.1.) Most of those who consider PVS patients to be better off dead would not condone the medical killing of these patients. This points to a widespread intuition or judgment that even though a certain outcome would be preferable (in this case, death as preferable to continued existence in PVS), the actions that would lead to such an outcome may be morally prohibited.

In permissive countries, a minority think that ANH in typical cases cannot be withdrawn even when the patient was known to be against it. Some reasons given are that all patients, regardless of condition and circumstances, deserve to be fed, and that ANH does not constitute medical treatment, but basic, humane care. Which, one presumably might add, is something that is owed to all living persons, regardless of their condition or level of function. One might imagine that restrictive respondents disagree with the prevalent permissive opinion that life in PVS is meaningless in some way, but it is important to note that this is speculative and not directly supported by any of the data. Some restrictive respondents could agree that life in PVS is meaningless, but believe that there is no morally acceptable way of ending that life, that withdrawal of ANH would constitute causal contribution to the patient's death, and thus is immoral.

There is no consistent difference in attitudes between nurses and physicians across studies, and no demographic variables that consistently predict attitudes. In some studies, doctors who were experienced in treating PVS patients were more reluctant to withdraw ANH, but this finding was not consistent.

In the restrictive countries, most doctors agree that ANH should generally be provided, whereas a minority think that withdrawal of ANH may sometimes be justified (nurses in these countries have not been surveyed). Some reasons given for the majority view have been stated above. In addition, Japanese physicians commonly think that physicians always or almost always have an obligation to prolong life.

Note again that *an intuition that life in PVS is intrinsically valuable* does not arise from the empirical data. In the studies where opponents of treatment-limiting decisions are asked to give reasons for their view, other reasons are mentioned, but the view that life in PVS is a benefit to the patient is not. This contention, then, so central to NNL, is not reflected in the intuitions surveyed.

Consistently, respondents would be more willing to withhold other kinds of treatment, like antibiotics for acute infections, than to withdraw ANH. This constellation of answers points to a principle underlying the intuitions for some of the respondents: that it is more acceptable to let nature take its course without intervening (i.e., not treat life-threatening complications) than to influence the causal chain more actively (by actively withdrawing nutrition). That is, to some of the respondents omissions seem more acceptable than commissions.

The studies on patients' relatives provide a few additional important intuitions and judgments. Life in PVS was described as 'a fate worse than death', implying that death early on in the acute illness would be preferable to survival in PVS for the patient. Importantly, the intuition does not imply that it would be better (morally, and/or for the patient) that his life in PVS were to be ended, either actively through medical killing, or by withdrawal of ANH. On the other hand, some relatives stated that they did not want to lose their PVS-stricken relative; implying that they still maintain a certain relationship to the patient, even though she is unresponsive and unconscious: the patient is still alive and a member of human society.

An additional point can be extracted from the studies on patients and the general population. It is interesting to note that nine out of ten who are confronted by descriptions of PVS and other debilitating conditions would want an advance directive directing non-treatment in such situations. This seems to imply that the respondents see life in PVS as profoundly negative, as something that one should take active precautions to avoid – even though the alternative to PVS is death. Death, then, might be preferred to PVS.

When it comes to explaining the divide between permissive and restrictive countries, it must be noted initially that this enterprise will be speculative more than empirically grounded. It is tempting to join Grubb et al. in speculating that public debate on PVS and treatment-limiting decisions *in itself* promotes permissive

attitudes.<sup>107</sup> In particular, in the US there has been widespread medical, ethical, and legal debate, beginning with landmark court cases in the 70s.<sup>108</sup> Some of the countries notable for conservative attitudes in the question of ANH in PVS are also notable for a lack of public debate about this and related topics, as Asai et al. confirm in the case of Japan.<sup>109</sup> A factor that was shown to explain much of the European divide of attitudes is the influence of religious ethics. And, as was seen, the German attitudes can be interpreted as part of a cautious, restrictive approach to end-of-life questions generally, partly brought about by awareness of past transgressions. In addition, there must be cultural differences in attitudes towards death and end-of-life questions that are not directly connected to religion, but that also shape the attitudes of doctors raised and trained in that culture.

In sum, I believe I have made good on my promise to show that clinicians have intuitions that are strong and prevalent (although far from universal) and that go against the NNL view on treatment-limiting decisions in PVS. The strong and prevalent intuitions are a *prima facie* guide towards moral truth, as per the account of well-formed intuitions given above; however, especially considering that health professionals are far from unanimous on the issue, the intuitions must be judged in light of arguments and reasons that count for or against them. Even strong and prevalent intuitions will have to be discarded if arguments to this effect carry sufficient rational strength.

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<sup>107</sup> Grubb et al., "Survey of British clinicians' views on management of patients in persistent vegetative state."

<sup>108</sup> For a summary of the first court cases involving treatment-limiting decisions for PVS patients, see C.L. Sprung, "Changing Attitudes and Practices in Forgoing Life-Sustaining Treatments," *JAMA* 263 (1990).

<sup>109</sup> Asai et al., "Survey of Japanese physicians' attitudes towards the care of adult patients in persistent vegetative state."

**Table 2.** *Arguments concerning withdrawal of ANH from patients in PVS*

<p><b>Arguments that ANH should or could be withdrawn in PVS</b></p> <ol style="list-style-type: none"> <li>1. The PVS patient is dead or almost dead</li> <li>2. Continued treatment in PVS is pointless because there is no potential for improvement</li> <li>3. Life in PVS itself does not constitute a benefit; it is valueless, pointless</li> <li>4. The PVS patient is better off dead</li> <li>5. Quality of life is of decisive importance in deciding whether treatment should continue; PVS patients have abysmal quality of life; thus treatment should be discontinued</li> <li>6. Continued treatment in PVS is pointless; pointless treatment is incompatible with the purposes and ethos of medicine; thus continued treatment is not morally neutral, but morally wrong</li> <li>7. The good of continued life in PVS does not outweigh the burdens</li> <li>8. Continued life in PVS offends the patient's dignity</li> </ol>
<p><b>Arguments that ANH should not be withdrawn in PVS</b></p> <ol style="list-style-type: none"> <li>1. The PVS patient is alive and remains a member of human society</li> <li>2. All human beings, PVS patients included, deserve to be fed</li> <li>3. ANH constitutes basic humane care owed to all people, not 'medical treatment'</li> <li>4. Continued treatment in PVS is not pointless when it is in accordance with the patient's preferences</li> <li>5. Physicians have an obligation to prolong life</li> </ol>
<p><b>Arguments about legitimate means</b></p> <ol style="list-style-type: none"> <li>1. Even though death would be preferable to continued life in PVS, bringing about death is morally prohibited</li> <li>2. It is better that a PVS patient's death is caused by an omission than a commission</li> <li>3. Death is preferable to continued life in PVS, and withdrawal of ANH is an acceptable way of bringing about death</li> <li>4. Death is preferable to continued life in PVS, and medical killing is an acceptable way of bringing about death</li> </ol>

### 3.5.5 Extracting arguments

From the preceding summary, I have extracted the arguments listed in Table 2. These arguments will be expanded upon, explained, defended and attacked in Chapter 4. Note that several of the arguments were voiced only by a minority of respondents. I shall call the resulting propositions ‘arguments’, even though many of them are simply premises that need additional premises in order to form complete arguments about how PVS patients should be treated. Note also that the process of extracting arguments is far from infallible; I attempted to analyze the intuitions and judgments I perceive to lie behind the views expressed and reasons given by the study participants. I then tried to find the arguments and premises that seem to underpin these intuitions and judgments.

### 3.5.6 The need for further research

At this point, one should take the time to evaluate the quality of the available empirical material. What information do we lack? What would we like to know, and what kinds of study designs could provide that knowledge? Quantitative and qualitative study designs complement each other. Where quantitative designs allow us to map the prevalence of certain opinions, and, to a limited extent, the main reasons used to justify those opinions, qualitative designs enable deeper probing into reasons and arguments, and may lead to the discovery of new reasons and intuitions.

Data is lacking from many countries on health care workers’ opinions and practices. Such data would be interesting in itself, and, in addition, would help test the hypothesis that the divide between ‘restrictive’ and ‘permissive’ countries correlates with other cultural and religious fault lines. In addition, more qualitative research exploring the experiences and intuitions of health care workers who have extensive experience in dealing with PVS patients would be very interesting. For instance, do they concur in the view presented by some reports, that life in PVS damages the patient’s dignity? Do health care workers think that this insult to dignity happens no matter what, or is it preventable by, e.g., care being carried out in a maximally respectful way? What is the experience of nurses and doctors involved in the decision to withdraw ANH, in the actual carrying out of that decision, and in the care given for the last days of the patient’s life? Similar studies being carried out in different countries would strengthen the relevance and external validity of the evidence.

### 3.6 Chapter summary

In this chapter, PVS and its role as a test case for evaluating the NNL theory was introduced. *Treatment-limiting decisions in PVS* was chosen because the moral guidance given by the NNL theory here is at odds with prevalent moral intuitions among clinicians. First, the views of four NNL writers were examined. It was argued that they are really committed to an even more restrictive view on treatment-limiting decisions in PVS than what they acknowledge themselves. Then, a methodology for judging the theory in light of the intuitions of health care workers was set out. This process constitutes a narrow reflective equilibrium. An account of well-formed moral intuitions among clinicians was sketched. The empirical literature on intuitions pertaining to PVS was then examined. Six important sources of bias were identified, all in the direction of a presumption to continue treatment. The data were varied, identifying a cultural-religious divide, with ‘permissive’ and ‘restrictive’ countries respectively. However, all in all, intuitions that withdrawal of ANH is sometimes acceptable can be said to be prevalent and strong among clinicians. Seventeen arguments and premises about the morality of treatment-limiting decisions in PVS stemming from the empirical findings were identified.

In the next chapter, the reflective equilibrium will be conducted. Here, the arguments underpinning the intuitions will encounter arguments from other sources, and be scrutinized in light of the NNL theory. In particular, the next chapter will examine whether any of the four alternative versions of the seventh requirement of practical reasonableness discussed in Chapter 2 will ‘outperform’ the others in achieving a fit between intuitions, arguments, and the NNL theory.

## 4 The ethics of withdrawing artificial nutrition and hydration in PVS

The time has now come to examine arguments for and against the morality of withdrawing artificial nutrition and hydration (ANH) for persistent vegetative state (PVS) patients.<sup>1</sup> First the arguments and premises that were inferred from the empirical studies on attitudes towards PVS (Chapter 3) will be scrutinized. Then additional arguments are examined. The arguments are all evaluated from a NNL standpoint; however, the NNL theory is not itself immune from criticism stemming from the arguments discussed. Indeed, the upshot of the *reflective equilibrium* between arguments, theory and intuitions will be a proposal to exchange an abstract rule that is crucially important to the NNL corpus, the seventh requirement of practical reasonableness, for one of its three competing formulations detailed in Chapter 2. The weighing of the arguments will result in a set of puzzles that cannot be resolved by NNL unless the combination thesis is allowed to replace the direct action thesis. At the close of the chapter, we shall have been equipped with a *revised* NNL theory.

### 4.1 Arguments for the withdrawal of artificial nutrition and hydration

The treatment of each argument will commence with attempting to find a reasonable interpretation, which is then explored. The views expressed at this stage should not be taken to be the present author's own, but rather as elaborations on the arguments extracted from the empirical findings on attitudes towards PVS in Chapter 3. The argument is then challenged by counter-arguments from NNL theory or other vantage points. Each section concludes with an overall appraisal of the argument.

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<sup>1</sup> I will be talking about withdrawal of ANH throughout, but the moral principles discussed are also for the most part applicable to the decision to forgo, e.g., antibiotic treatment for intercurrent infections, and other treatment for medical complications.

#### 4.1.1 The PVS patient is dead or almost dead

In the debates about criteria for death, there are four main positions.<sup>2</sup> First, some argue that the cessation of breathing and circulation are the only sure signs of the disintegration of the organism, and thus advocate the so-called circulatory-respiratory criteria of death. Second and third, there are those who maintain that either loss of functioning of the entire brain ('whole-brain death') or of the entire brain stem ('brain stem death') should be taken to imply death. They point to the crucial function of the brain in maintaining integral bodily functioning. Most Western societies and clinicians accept one or the other of these two positions. Fourth, as a functioning cerebral cortex is a prerequisite for consciousness, some argue that irreversible loss of all cortical function should also be taken to imply death ('higher-brain death').

Within the first three conceptions of death, the PVS patient is certainly not dead. However, higher-brain death covers the PVS patient. There are reasons, though, to think that the conception of higher-brain death cannot be sustained. The brain plays a crucial role in maintaining integral bodily functioning, and the brain stem carries on these functions even after the death of the cerebral cortex. Thus, it seems that in higher-brain death the human organism has not necessarily lost its integral functioning; human bodily life continues. In Paterson's view,

Higher-brain death advocacy is really a fiction created in order to justify the removal of organs from those who are really living (anencephalic infants and PVS patients) for the benefit of others. Higher-brain death is a means of getting around the current 'dead donor rule' which stipulates that vital organs may only be harvested from patients who are declared dead.<sup>3</sup>

Of course, as is well known, the whole-brain and brain stem death criteria were *also* introduced partly in order to facilitate organ donation from severely injured and dying patients. However, these definitions have a lot more going for them: as stated, the brain does have a special role in orchestrating the functioning of the diverse bodily

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<sup>2</sup> Paterson, *Assisted Suicide and Euthanasia*, 129-32.

<sup>3</sup> *Ibid.*, 131, summarizing Peter Singer's point in *Rethinking Life and Death* (New York: St. Martin's Press, 1994), ch. 3; Singer's suggestion, however, is that we simply accept that organs for donation may be removed from living patients with these conditions, (morally justifiably) killing the patients in the process.



systems of the organism. When the whole brain is destroyed, bodily life usually quickly ends.<sup>4</sup>

In PVS, then, the human organism is alive. But could it be said that *the person* is dead? Some argue for a ‘psychological continuity view’ of personhood.<sup>5</sup> Such a view implies that the human person comes to be when consciousness or self-consciousness begins, and that the person’s continued existence is secured by psychological continuity with his former self. When the capacity for consciousness is lost, as in irreversible PVS, the human person is gone, although the body lives on. This squares with the intuition sometimes encountered among health professionals or relatives that in PVS, ‘there is no longer *a person* inside the body’.<sup>6</sup>

This might lead one to propose a radical new definition of death: death means the loss of the capacity for consciousness. In this view, the PVS sufferer is in fact dead. However, a simple thought experiment arguably refutes this definition:<sup>7</sup> if we were to discover a cure that would restore the PVS sufferer’s brain function, would we be curing the PVS patient, or creating a new human person? We would, it seems, be curing the patient. But in that case, PVS cannot imply the death of the person.

So the PVS patient is not dead. And neither is he dying. When a patient is dying, a disease process reduces the body’s integral functioning until death ensues. The classical causes leading to PVS, however, reduce the patient to a *low but stable* level of functioning. With simple nursing care, nutrition and hydration, the PVS sufferer can live on for years. It is incorrect to say that the PVS patient is dying. Although crucial and specifically human functions are severely impaired, the patient’s condition is stable.

Daniel Callahan disagrees with this viewpoint with an interesting argument:

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<sup>4</sup> However, brain failure criteria for death and the special integrative role of the brain may be challenged; see Seema K. Shah, Robert D. Truog, and Franklin G. Miller, “Death and legal fictions,” *Journal of Medical Ethics* (2011), in which it is argued that whole brain death criteria should be regarded as ‘legal fictions’. Anyway, a full discussion of the relative merits of the three first definitions of death is not required for the present purposes.

<sup>5</sup> As criticized in Lee and George, *Body-Self Dualism*, 22-38.

<sup>6</sup> For an example of such an account, see Jeff McMahan’s ‘Embodied Mind Account of Identity’ set out in *The Ethics of Killing: Problems at the Margins of Life* (Oxford: Oxford University Press, 2002), esp. p. 446.

<sup>7</sup> B.A. Fisher, “Why do Unresponsive Patients Still Matter?” in *Artificial Nutrition and Hydration: The New Catholic Debate*, ed. Christopher Tollefsen (Springer, 2008), 10-11.

Technological change leads us to redefine some basic concepts (...) it is perfectly reasonable to refer *still* to people in PVS as biologically dying, not simply disabled. The fact that we can arrest, or suspend, the underlying fatal condition for a time, even a long time, does not change the underlying biological reality: a PVS patient has been captured by a fatal condition which, if we do not artificially stop it, will kill the patient. It is only technological prowess (and maybe some hubris) that has led us to redefine 'dying': nature will not presume to tell us who is dying; we will leave that to our technology.<sup>8</sup>

It is true that the PVS patient is in need of medical assistance, namely ANH, in order to live on. Without access to ANH technology, PVS patients would in fact be dying. Callahan seems to urge a definition of 'dying' as 'afflicted by condition that untreated would lead to death'. However, as an explication of the term 'dying' in common usage, this definition is unsatisfactory, because it leads to counter-intuitive results. Patients with diabetes mellitus type 1 or acute urinary retention due to benign enlargement of the prostate would both be dying under this understanding of the term. Interestingly, Callahan's point that which patients belong to the category 'dying' seems to be partly dependent on the current state of medical technology, seems to be correct: before the advent of insulin treatment, the diabetic would be dying. However, common usage of 'dying' dictates a somewhat technology-relative understanding of the term. In this sense, the PVS is not correctly described as dying.

What then should be made of the proposition that the PVS patient is dead or almost dead? It has been argued that, when interpreted as saying that the PVS patient is in the process of dying or actually dead, this proposition is erroneous. A plausible remaining interpretation is that although the PVS patient is by definition living, his life is without meaning, value, or human significance. With this interpretation the argument becomes synonymous with arguments III-V, treated below.

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<sup>8</sup> Daniel Callahan, "The Sanctity of Life Seduced: A Symposium on Medical Ethics," *First Things* (1994).

#### 4.1.2 Continued treatment is pointless because there is no potential for improvement

I have assumed for the sake of argument that PVS really is permanent with no hope for meaningful improvement. In that case, is there really any point in continuing nursing care, hydration and nutrition? That all depends on the value of the PVS sufferer, the value of life in PVS, and the morality of stopping these forms of care. In other words, the argument is dependent on other arguments that will be treated below.

#### 4.1.3 Life in PVS is without value

The contention that life in PVS is valueless, without meaning, and pointless, and does not constitute a benefit to the patient takes us straight to the core of the matter. What is the value of life in PVS and the moral status and value of the PVS sufferer? Recall the defining features of the vegetative state. The patient is believed to be (and I will suppose that he definitely is) unconscious, and thus has no experiences at all; neither thoughts, feelings, or sensations. The patient's grimacing, movements, eye-opening and eye movements are all driven by reflexes, that is, even though they may be elicited by external stimuli, the patient experiences neither the stimuli nor the resulting behaviour. I have also presupposed that PVS is indeed permanent, irreversible.

A basic tenet of NNL theory is that any intelligible action can be analyzed in terms of the instrumental or basic goods intentionally pursued. One could then ask why basic care, nutrition and hydration are provided to the PVS patient. These actions seem to serve two ends. Firstly and most obviously, they are done for the sake of preserving the patient's life and health. Secondly and arguably, they are also done to preserve human solidarity with a badly damaged member of the human community.<sup>9</sup> Do nursing care and feeding become *unintelligible actions* once one gives up hope for the patient's recovery? They do not. Further analysis may conclude that ANH *ought not* to be provided, but this does not mean that the action of providing nutrition ceases to have an intelligible purpose.

Does the fundamental intelligibility of providing health care for PVS patients prove that the goods aimed at are basic? No. Consider a person praying to a deity that

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<sup>9</sup> Grisez, "Should nutrition and hydration be provided," 175.

we, unlike the person himself, know to be non-existent. The act of prayer remains intelligible because it has a *presumed* basic good as its intended object, regardless of whether any instance of good actually ensues. Analogously, the act of providing ANH to a PVS patient has the presumed basic good of life and health as its intended object. Even if it is shown that the patient's instantiation of life is *not* an instance of basic good, the action remains intelligible. The intuition that providing ANH for PVS patients is intelligible and meaningful therefore cannot establish that the patient's life is an instance of basic human good.

The consensus among NNL writers is, as shown (3.3), that the PVS patient indeed *instantiates the basic good of life*, and that his life really is valuable. Kevin O'Rourke is among those who take issue with this view.<sup>10</sup> Contrary to NNL proponents, he argues that the PVS patient is not benefited by continued life in PVS. This contention is based on a premise about the purpose of human life, which, according to O'Rourke, is *friendship with God*. Human acts, that is, acts of the intellect and will, presupposing consciousness, are necessary in the pursuit of this goal. These acts are contrasted with 'the physiological acts of the body which are not subject to rational activity, such as circulation of blood and digestion'.<sup>11</sup> Acts belonging to this second class are not meaningful in themselves. As long as the truly human acts cannot be performed now or in the future, the pursuit of the goal of human life is not possible, and the person is not benefited by having his existence in this deprived state extended.<sup>12</sup> O'Rourke therefore concludes that there is no moral obligation to prolong life in irreversible PVS.

One response to O'Rourke along NNL lines would be to deny his account of human goods. Although a secular version of natural law would reject or remain agnostic on whether friendship with God is truly a supreme good, an explicitly religious version could embrace this view. However, in both a secular and religious natural law theory, one would be wrong to deny the value of the other human goods. Even in a situation in which this alleged supreme good could not be pursued, it would still be *meaningful* to pursue the other goods, the 'merely bodily' goods, which would

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<sup>10</sup> Kevin O'Rourke, "Reflections on the papal allocution concerning care for persistent vegetative state patients," *Christian Bioethics* 12 (2006).

<sup>11</sup> *Ibid.*, 94.

<sup>12</sup> This view of the human good does not imply dualism: O'Rourke's anthropology subordinates the purely bodily goods to the intellectual goods, but this does not imply that the mental and the bodily realms stem from separate substances.

include the good of life. For a person who cannot reciprocate God's friendship cognitively, pursuit of the other goods would still contribute to his human flourishing.

Discussing the benefits of continued treatment for PVS patients, Boyle writes:

It is clear that (...) the benefits of keeping a person alive who has no prospect of recovering from the radically impaired consciousness of PVS are small. The condition of these people is one of extreme deprivation; their condition, though stable, is one of radically impaired functioning; and they cannot experience any benefit from their continued existence. However, these uncontroversial judgments are not equivalent to the judgment that continued life is of no benefit to patients in PVS. And the inference from the former to the latter has not been shown to be valid.<sup>13</sup>

Boyle is right to point out that PVS patients cannot *experience* any benefit. These patients have, as repeatedly stressed, no conscious experiences at all. However, as Boyle states, this does not imply that nursing care, ANH or continued life are not benefits to the PVS patient. One might very well be benefited without having the conscious experience of being benefited, or any knowledge of the beneficial action at all. For instance, a newborn child is benefited when he receives needed medical treatment, but the newborn is not aware of being benefited. Aristotle discusses the seemingly paradoxical case of being benefited or suffering injury after one's death.<sup>14</sup>

Michael Degnan, among several other authors, notes that the care and feeding provided to PVS patients may rightly be said to constitute benefits to them.<sup>15</sup> Physiotherapy prevents contractures and maintains the integrity of the musculoskeletal system. Food and water maintain the homeostasis of the bodily systems. If the person *is* his body, then he is benefited by whatever benefits his body and injured when bodily integrity is violated. In addition, actions not constituting care or treatment may benefit or injure the PVS patient. He is benefited by a spouse maintaining marital fidelity, and injured by the contrary. It therefore seems that, in principle, the PVS patient *can* be benefited. It remains to be decided, however, whether *life in PVS itself* can be said to benefit the patient.

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<sup>13</sup> Boyle, "A case for sometimes tube-feeding patients in persistent vegetative state," 192.

<sup>14</sup> Aristotle, "Nicomachean Ethics," I, 11, 1.

<sup>15</sup> M. Degnan, "Are We Morally Obligated to Feed PVS Patients Till Natural Death?" in *Artificial Nutrition and Hydration: The New Catholic Debate*, ed. Christopher Tollefsen (Dordrecht: Springer, 2008), 50.

Another take on the task of characterizing the good of life is to ask whether it is good in itself, or whether it is merely an instrumental good. The human organism's being alive is an obvious prerequisite for its pursuit of all other goods. Life, then, is obviously valuable in the typical case, but establishing that it is *intrinsically* good, and not merely good in virtue of facilitating the pursuit of all the other goods, seems to be no straightforward task.

One might argue that PVS is the perfect test case for the question of whether human life is of intrinsic or merely instrumental value, for in this situation the human organism is living, but is unable to pursue any of the other characteristically human goods; neither friendship, knowledge, work and play, nor practical reasonableness. Even the patient's participation in the good of life itself is minimal. In PVS, then, the patient's good of life is *not instrumental* to the pursuit of any other good. If the patient's life is of any pre-moral value at all it must then be *intrinsically valuable*.

Grisez presents a *reductio* argument against the contention that life is merely an instrumental good.<sup>16</sup> If a person's life is not inherently good (that is, not a basic human good), then it is only good insofar as it contributes to the pursuit of other goods that are truly basic and inherently good. If the PVS sufferer truly derives no benefit from being kept alive, then killing him would not harm him. So, according to Grisez, in the view that life is merely an instrumental good, not only must the withdrawal of useless treatment (e.g., nutrition and hydration) be acceptable, but the active, intentional killing of the patient must be morally legitimate as well. This is an unacceptable consequence.

In order to work, Grisez's argument presupposes that intentionally killing the PVS patient actually *is* wrong. Indeed, most people might have a strong intuition that intentional killing of a PVS patient is wrong.<sup>17</sup> Most of us would perhaps rather cling to this intuition and reject the moral theory that prescribes its violation than the other way around. However, that killing the PVS patient is wrong is part of what I am in the process of evaluating. It is something *I* cannot presuppose without begging the question.

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<sup>16</sup> Grisez, "Should nutrition and hydration be provided," 174.

<sup>17</sup> Although, as shown, in one study 20% of doctors found it ethically appropriate sometimes to intentionally hasten the PVS patient's death by lethal injection: Payne et al., "Physicians' attitudes about the care of patients in the persistent vegetative state."

There is another reason why Grisez's argument is not decisive. Even if it is granted that intentional killing of the PVS patient is morally wrong, this does not necessarily imply that a basic human good is harmed in the killing. The killing could be wrong mainly because it damages the moral integrity of the killer, or because of the effects on others.<sup>18</sup> There could be an absolute moral prohibition on intentional killing even though not all intentional killings damage basic human goods.

Whether a person *is* his body is an important question that will now be examined. The NNL theorists who have addressed this topic reject dualism and agree that a human being really *is* an animal: an organic, bodily being. However, this view does not really rest on premises from the NNL theory of morality, but introduces new premises. The main competing views are refuted in a monograph by Patrick Lee and Robert P. George.<sup>19</sup> As they state in the introduction, 'Profoundly important ethical issues turn on the question whether biological life is an essential and intrinsic aspect of a human person or is only an extrinsic instrument'. Their line of argument is briefly sketched below.

Lee and George's main positive argument for the thesis that human beings are animals is the following:<sup>20</sup>

1. Sensing is an essentially bodily action performed by a living being.
2. Therefore, the agent who performs the act of sensing is a bodily entity, an animal.
3. But in human beings, it is the same agent who performs the act of sensing and that performs the act of understanding.
4. Therefore, in human beings, the agent who performs the act of understanding is a bodily entity, not a spiritual entity making use of the body as an extrinsic instrument.

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<sup>18</sup> However, the contention that killing the PVS patient damages the killer's moral integrity would require supplemental premises. If the patient is *benefited* by being killed and no basic human good is harmed thereby, why does the killing damage the killer's moral integrity? Presumably, if killing aids the one killed, if life is sometimes not a good, then it would not undermine the moral integrity of the killer to kill such a person.

<sup>19</sup> Lee and George, *Body-Self Dualism*.

<sup>20</sup> *Ibid.*, 4-16. The main positions argued against are, first, mechanism, the view that 'sensation is not a unitary action at all, but an aggregate of electrical and chemical reactions'; second, 'eventism' or 'perdurantism', the view that reality should be analyzed in terms of events, not substances; and third, substance dualism, the position that the mind is a separate immaterial substance wherein sensation occurs.

As Lee and George's position is accepted by the other NNL writers, for the sake of this thesis I shall accept their conclusion that humans are animals and *are* their bodies. One would do well to bear in mind, however, that if the conclusion that human beings are their bodies should come to be undermined, then so will an important premise of the overall argument presented here.

This should be the backdrop for evaluating such claims as that the continued provision of ANH to PVS patients does nothing but preserve mere physiological function.<sup>21</sup> For, by a non-dualist account, preserving physiological function means simply *preserving the life of the person*. Whether this is morally good or obligatory remains to be settled, but the attempt to drive a wedge between 'mere physiological function' and human life properly defined arguably is shown by Lee and George's arguments to be misguided.

The goal of human life is flourishing, that is, participation in the basic human goods. However, as Lee and George point out, if I view my bodily life as merely instrumental to this flourishing, I am identifying myself with something other than my bodily life.<sup>22</sup> This would be a mistake, though, because I am in fact my body, and thus would be wrong to see bodily life as merely instrumental. Insofar as a person's life is valuable, then his bodily life is in fact intrinsically good, good in itself, an instance of basic human good.

There is an important ambiguity here in what 'intrinsically good' should be taken to mean. The PVS patient is a human being with, arguably, the same moral status as other humans. He is a *rights-bearer*. However, this does not imply that the PVS patient's bodily life is (*pre-morally*) *valuable*. Most would agree that the patient is entitled to respect by virtue of his humanness, and in this respect his life is intrinsically good or valuable. In another respect, however, bodily life may have ceased to be valuable to the patient, ceased to be a reason for action.

The NNL writers' view is that human bodily life *is* a basic human good at all times and in all instances. Perhaps, though, it can cease being good *to* – and thereby cease being a basic reason for action *for* – a person in certain circumstances? It does

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<sup>21</sup> As, for instance, discussed in W.E. May, "Caring for Persons in the 'Persistent Vegetative State' and Pope John Paul II's March 20 2004 Address 'On Life-Sustaining Treatments and the Vegetative State,'" in *Artificial Nutrition and Hydration: The New Catholic Debate*, ed. Christopher Tollefsen (Dordrecht: Springer, 2007), 66.

<sup>22</sup> Lee and George, *Body-Self Dualism*, 161.



seem paradoxical – but may it still be the case? – that even though the PVS sufferer’s bodily life is a basic human good, his existence is not valuable to him because it does not contribute to his human fulfilment. His bodily life seems to have lost much or all of its pre-moral value.

This is how far the current line of argument has brought us, and so the above-stated paradox will, rather unsatisfactorily, be the tentative conclusion in this section. However, the paradox will be resolved at the end of the chapter.

In the much-publicized British case of PVS sufferer Tony Bland, the juridical majority opinion was that ANH may legitimately be withdrawn. The reason given, however, was not that ANH was burdensome, but that Bland’s life (according to the judges) was plainly not worth living. Sir Thomas Bingham wrote, ‘Looking at the matter as objectively as I can, and doing my best to look at the matter through Mr Bland’s eyes and not my own, I cannot conceive what benefit his continued existence could be thought to give him’.<sup>23</sup> The question now becomes whether the PVS patient really derives any benefit from living, or whether he is in fact *better off* not living.

#### 4.1.4 The PVS patient is better off dead

One might argue that the PVS patient, although he is alive and although his continued existence might be an instance of a basic human good and even good-in-itself, is nevertheless better off dead. It is a common intuition that death sometimes comes as a relief, as a benefit.<sup>24</sup> Some reasons for thinking that the patient is better off dead are, first, that his participation in the human goods that constitute flourishing is very minimal; second, that he himself probably would not have wanted to live on in such a severely damaged condition had he been given the choice; third, that we who consider the plight of PVS patients ourselves would not want to be maintained in such a condition; and fourth, that continued life in PVS is undignified and a negation of the person the patient was when conscious and healthy (this reason will be evaluated in the section on dignity).

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<sup>23</sup> Quoted in Singer, *Rethinking Life and Death*, 66.

<sup>24</sup> However, some would argue that death itself is always an evil, whereas e.g. the relief of suffering is a good.

The first reason can be formulated in terms of *quality of life*, and as such it will be considered in the next section. However, the first reason can also be used directly as a premise, for instance:

P1. PVS patients' human flourishing is minimal.

P2. If a person's human flourishing is minimal, then the person is better off dead.

C. The PVS patient is better off dead.

The issue then becomes whether P2 is correct. How would one go about finding out whether that is the case? One way would be to appeal directly to people's considered judgments, preferences or intuitions (examples of which were given in Chapter 3). In that way, the first, second and third reasons for thinking that the PVS sufferer is better off dead join forces, resulting in intuition-based support for the conclusion, C. However, arguments justifying P2 that are not based on intuition are also desirable.

An influential account of people's interests or welfare is *comparativism*.<sup>25</sup> With this theory, some event *E* being in my interest means that *E* produces an overall benefit to me, that is, it makes my life better than it would have been if *E* did not occur. Steven Luper fleshes this out by according a numerical value, positive or negative, to *E*.<sup>26</sup> When *E*'s value for me is positive, *E* is in my interest and produces an overall benefit to me. The comparativist hedonist could say that a given death may be in the person's interests, because his future prospects imply more pain than pleasure. For the PVS patient, death would perhaps be neutral, as there is neither pain nor pleasure to look forward to. This strategy will not work in NNL theory, due to its rejection of hedonism. Different events will yield different tokens of instrumental and basic goods, and in the case of the latter, according numerical values to the event's various consequences is senseless (cf. the incommensurability thesis, 1.4.10); furthermore, in the case of deliberation on competing proposals for action, it yields an air of pseudo-precision to the choice.

Events and plans for action can, however, be compared rationally by the practically reasonable in light of his projects and prior commitments, and thus a version of comparativism may be rescued. One might employ 'possible worlds'

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<sup>25</sup> Steven Luper, "Death," in *The Stanford Encyclopedia of Philosophy*, ed. E.N. Zalta (2009).

<sup>26</sup> Ibid.

terminology, and ask whether the world  $W_1$ , in which the PVS patient is dead, is preferable to the world  $W_2$ , which is like  $W_1$  in every respect except that the PVS patient lives on. Which world,  $W_1$  or  $W_2$ , would be better for the PVS patient?

This thought experiment reveals a challenge to the concept of being ‘better off dead’. There is reason to doubt that the concept is even coherent. At death, the person passes from existence to non-existence. Paterson writes, ‘A person simply cannot be harmed or benefited when they cease to exist, for there is no *ontological existent* to be harmed or benefited’.<sup>27</sup> Yet there are two reasons to think that Paterson’s argument is not decisive. First, it seems correct (although paradoxical) to say, as Aristotle did and as mentioned above, that one might be benefited or harmed after death. If that is the case, ceasing to exist could perhaps also, in principle, benefit one. Paterson attempts to counter this objection by construing ‘posthumous harms and benefits’ not as harms and benefits to the person, but to the ‘legacy’ of the deceased person.<sup>28</sup> Second, and more important, the question of whether the person is better off dead is most naturally assessed when he is still living, still existing. At this stage there *is* an ontological existent that can be harmed or benefited. And it seems likely that most people consider the question of whether a certain living person would be better off dead to be coherent and meaningful – no *obvious* incoherence in the concept of being better off dead is detected.

It should also be mentioned here that the judgment that a certain person is better off dead might entail a certain *hubris*.<sup>29</sup> One does not know what happens after death. In a secular world-view, one often supposes that the person ceases to exist, but one does not *know* for sure whether this is correct. It may be that post-mortal existence entails suffering that makes the pre-mortal existence preferable.

Return now to the possible-worlds version of comparativism. Is  $W_1$ , rather than  $W_2$  as detailed above, to be preferred? From the NNL outlook,  $W_2$  entails a minimal kind of flourishing, whereas  $W_1$  entails the destruction of the person. There are no theoretical concepts in NNL theory itself that could underpin the conclusion that  $W_1$  is to be preferred. On the contrary, a minimal flourishing should be preferable to no flourishing at all. NNL theory identifies basic human goods, but there are no corresponding ‘basic human evils’ that it is always practically unreasonable to avoid.

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<sup>27</sup> Paterson, *Assisted Suicide and Euthanasia*, 105.

<sup>28</sup> *Ibid.*, 106.

<sup>29</sup> Per Nortvedt pointed this out to me.

If  $W_1$  is preferable, it must be due to reasons that are external to the natural law perspective. Moreover, it seems to be flatly contradicted by NNL.

In sum, the argument that the PVS patient is better off dead seems to be merely stating a conclusion, without providing acceptable arguments for it. Therefore, the argument has no independent force.

#### 4.1.5 The PVS patient has an unacceptably low quality of life

The PVS patient has perhaps the lowest quality of life possible; in NNL terms, he is unable to participate in any human good other than continued life itself. One might argue that once quality of life falls irreversibly below a certain threshold, life ought not to be sustained. Again, it is difficult to see how the existence of such a threshold could be established on independent grounds, without simply appealing to other arguments, intuitions and prevalent judgments. One would certainly feel that the death of a person who has very low quality of life due to incurable disease is less of a loss to that person than would be the death of a person with average quality of life to *that* person. And so one might even feel that some lives are of such low quality that death would come as a relief, and constitute a benefit. In this way the ‘low quality of life’ argument assimilates to the ‘better off dead’ argument treated in the previous section. The ‘low quality of life’ argument, then, does not carry independent weight.

#### 4.1.6 Continued treatment is pointless, and thus forbidden by the ethos of medicine

*Pointless* medical treatment ought never to be provided. Clinicians sometimes point to a borderline case, namely situations in which the patient is irreversibly dying and the relatives are thought to need more time to come to grips with the fact. Even though certain treatments like intravenous fluids are medically pointless in these situations, it might still be right to continue treating so that the relatives do not get the impression that the patient is ‘given up on’ prematurely. In this case, treatment that is *medically pointless* may not be *humanly pointless*. However, truly pointless medical treatment ought not to be provided. Performing pointless treatment is a species of irrational action, forbidden by practical reason.

The question now becomes whether ANH in PVS is truly a pointless kind of treatment. The argument is often made in terms of *futile care*. One might argue that ANH in PVS is a form of futile care; that futile care ought never to be provided; and that therefore ANH should be withdrawn in PVS.

Ranaan Gillon identifies four categories of futile care.<sup>30</sup> First, treatment ‘that cannot produce the intended physiological changes’; second, treatment that produces the physiological changes but that does not result in any benefit to the patient; third, treatment that does provide some benefit to the patient, but where the benefit is so minimal that the treatment is judged futile; and fourth, treatment that benefits the patient minimally or moderately, but where there is harm that outweighs the benefits.

Tollefsen argues that only treatment in the first category is properly characterized as futile.<sup>31</sup> He contends that treatment is only futile if it fails to achieve its intended end, narrowly construed. As ANH normally does nourish the PVS patient and maintain fluid and electrolyte balance, it is successful, not futile, as such. In my view, this is a semantic point that should be kept in mind, but it does not invalidate discussion within Gillon’s schema. Tollefsen’s point should be taken to remind us that judging treatment to be futile in the second, third or fourth sense always implies a moral judgment, and is never a conclusion that follows from medical or factual premises alone. The ‘futility’ label can obscure important and controversial underlying value judgments. Since the term is, in addition, ambiguous, then it ought generally to be avoided, and to be replaced by more precise and transparent premises.

Will the provision of ANH in PVS be deemed futile in Gillon’s three remaining senses? The treatment does not seem to produce any major harms that would make it futile in the fourth sense. ANH does indeed perform its function, that is, delivering nutrients that are then absorbed and digested by the PVS patient, leading to nourishment and maintenance of fluid and electrolyte homeostasis. If one presupposes the view that continued life in PVS is a benefit, then ANH is not futile in the second sense, for ANH does indeed help to prolong life. However, the benefit of prolonged life is minimal, and clinicians and relatives may therefore consider

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<sup>30</sup> Ranaan Gillon, “Persistent vegetative state and withdrawal of nutrition and hydration,” *Journal of Medical Ethics* 19 (1993).

<sup>31</sup> Tollefsen, “Ten Errors Regarding End of Life Issues,” 216-17.

treatment to be futile in the third sense.<sup>32</sup> Again, it is important to realize that this is not a purely medical judgment, but a moral judgment regarding the value of the PVS sufferer's life, which is preserved through treatment.

The futility argument therefore reduces to the two previous arguments. It is because continued life in PVS is deemed not to be of *significant benefit* to the patient, either because quality of life is unacceptably low or because the patient is better off dead, that continued ANH is judged futile. The futility argument does not carry independent weight apart from these considerations.

#### 4.1.7 The good of continued life in PVS does not outweigh the burdens

The good of continued life in PVS has been identified as a minimal participation in human flourishing through remaining alive (and, arguably, a maintenance of the good of human solidarity, which is a specification of the basic good of friendship). The argument now is that these goods are in some way outweighed by the burdens incurred.

This argument was touched upon in the previous chapter (3.3). There it was found that>NNL allows the comparison of the burdens and benefits of a particular *treatment*, but that it does not allow the destruction of a basic good (here: life) because participation in the good is burdensome.

Nevertheless, the argument currently under consideration is supported by common intuitions and thus is important to evaluate. The evaluation can begin with analysis of the different potential burdens involved. There are three parties that potentially are burdened by the patient being in PVS: the patient, the patient's relatives, and society, including health care workers. What are the burdens to the patient? First of all, as noted repeatedly, a PVS patient will not have any conscious experiences, including pain. So the patient will have no experience of his debilitated condition.<sup>33</sup> His extreme disability, though severely constricting his pursuit of human goods, is therefore perhaps not a *burden*. However, a potential burden is the alleged *indignity* that comes from continued life in PVS. The dignity argument is examined in a later section.

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<sup>32</sup> As do the authors in K.R. Mitchell, I.H. Kerridge, and T.J. Lovat, "Medical futility, treatment withdrawal and the persistent vegetative state," *Journal of Medical Ethics* 19 (1993): 74.

<sup>33</sup> Ibid.

According to W. E. May, medical treatment preserving life, ANH included, should in general be considered excessively burdensome

if benefits offered are not worth pursuing for one or more objective reasons: too painful, too damaging to the person's bodily life and functioning, too restrictive of the patient's liberty and preferred activities, too suppressive of the person's mental life, too expensive, etc.<sup>34</sup>

However, ANH burdens the PVS patient in neither of these ways.

The patient's relatives suffer two potential burdens, as discussed (see 3.3). First, they suffer the emotional burden of watching a loved one in a profoundly damaged state. And yet, in PVS, death is not imminently forthcoming; the patient's sorry state is stable and can last for many years. Second, in some countries, relatives will take part in the day-to-day care of the patient, either through having brought the patient home to assume care, or through paying the costs of continued care, or both. This can put great strains on the relatives, taking money, time and energy away from other worthwhile pursuits.

Finally, when society assumes the costs of care, it is burdened. In addition, as shown in Chapter 3, health care workers may experience the toil of continued care as devoid of meaning and contrary to the purposes of medicine.

In sum, the burdens involved to relatives, society and health care workers may be considerable. The burdens may very well be thought to outweigh the meagre benefits, a view that was seen to be prevalent among health care workers. This judgment creates a presumption in the direction of stopping ANH for the PVS patient. However, as argued (see 3.3.1), NNL theorists seem committed to a very restrictive view on when withdrawal of ANH is morally acceptable. Most treatment-limiting decisions involve *using the death of the PVS patient as a means* of avoiding the burdens. This is, as was seen, outlawed by the NNL approach. There is here, then, a significant discord between prevalent intuitions and the NNL view. Later in the chapter a resolution will be attempted.

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<sup>34</sup> May, "Caring for Persons in the 'Persistent Vegetative State'," 67.

#### 4.1.8 Continued life in PVS offends the patient's dignity

It has been argued above that as the PVS patient is unable to consciously experience any discomfort, the condition itself and the treatment are not burdensome to the patient. However, it can be argued that the PVS patient's existence is *undignified*, and that in this respect he *suffers* from or is *burdened* by being maintained in his condition. The treatment could be seen as undignified; however, much more likely, as argued previously (see 3.3.1) and above, it is the PVS condition itself which is considered undignified.

However, 'dignity' is a problematic term, used in many contexts with varying content.<sup>35</sup> The expression stems from the Latin 'dignitas', meaning merit. One common dictionary gives three definitions or interpretations:<sup>36</sup>

1. The quality or state of being worthy, honored, or esteemed.
2. a. High rank, office, or position.  
b. A legal title of nobility or honor.
3. Formal reserve or seriousness of manner, appearance, or language.

Can dignity come in degrees and be lost or increased? According to one view, dignity is a quality inherent in every human being. This links dignity closely with moral status. In this view, certain human actions may be undignified, that is, unseemly for a human being to carry out, below one's standards. But a person may never lose his dignity as a human being, in the same way that he never loses the high moral status that pertains to being a human person. In the alternative view, a person may lose some of his dignity by acting or being acted upon in an undignified way, or by losing the abilities from which his dignity stems.

In the debate on euthanasia and physician-assisted suicide, both those who would allow and those who would prohibit such practices commonly employ a 'rhetoric of dignity'. Those in favour speak of certain deaths, especially those in which the patient suffers physically and psychologically and loses control of bodily functions and cognitive abilities, as undignified. Medically assisted death, on the other hand, would constitute an alternative that *preserves* dignity by allowing the person to

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<sup>35</sup> In my view, the Norwegian equivalent 'verdighet' has roughly the same role as 'dignity', and the same accompanying problems.

<sup>36</sup> Merriam-Webster Dictionary, <http://www.merriam-webster.com/dictionary/dignity>.



die in accordance with his autonomous will. Those against would consider medical killing as *an affront to the patient's dignity*. A death as described above, with suffering and loss of cognition, need not be undignified; on the contrary, the patient's attitude in facing the hardships of this kind of death, and the efforts of health care workers and caregivers, may make this death a quite dignified one.

Such contradictory uses of the term have led some theorists, among them Ruth Macklin, to question whether the concept of dignity is helpful or even coherent.<sup>37</sup> It could seem that appeals to dignity are primarily used to sway audiences, and that other, more precise terms can often be substituted. For instance, as Macklin shows, 'dignity' is sometimes used as a synonym for autonomy. Additionally, in statements such as 'Killing the patient through euthanasia is incompatible with respect for their human dignity', 'dignity' seems to be synonymous with moral value or moral status. Is the term 'dignity', therefore, redundant, and can it be readily replaced by other terms? Or are appeals to dignity mere rhetorical ploys that can and should be avoided and not accorded any weight?

I think the answer to both questions is no, and I find Doris Schroeder's attempt at untangling the concept of dignity most helpful.<sup>38</sup> She identifies four more or less distinct senses of the term. First, *the Kantian sense*, in which dignity is inherent in each human person because humans are rational, self-legislating beings. As Schroeder notes, the application has most often been extended to also cover human beings that are not presently self-legislating or autonomous in Kant's sense. As this kind of dignity is inherent, others' actions cannot deprive the possessor of this dignity. However, in common usage, dignity is something that *can* in fact be lost. This indicates that the Kantian sense cannot be the whole story about dignity. And indeed, Schroeder identifies three additional kinds of dignity.

Second, *aristocratic dignity* is 'the outwardly displayed quality of a human being who acts in accordance with her superior rank and position.'<sup>39</sup> This sense of dignity is arguably irrelevant to bioethics and will not be treated further. Third, *compartment dignity* is 'the outwardly displayed quality of a human being who acts in

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<sup>37</sup> Ruth Macklin, "Dignity is a useless concept," *BMJ* 327 (2003).

<sup>38</sup> Doris Schroeder, "Dignity: Two Riddles and Four Concepts," *Cambridge Quarterly of Healthcare Ethics* 17 (2008).

<sup>39</sup> *Ibid.*, 233.

accordance with society's expectations of well-mannered demeanour and bearing.<sup>40</sup> Everyone knows people of whom this characterization would be appropriate. Finally, *meritorious dignity* latches on to Aristotelian ideals of character and is defined by Schroeder as itself 'a virtue, which subsumes the four cardinal virtues and one's sense of self-worth.'<sup>41</sup> The person who has meritorious dignity tackles life's misfortunes (and fortunes) in the best possible way. Mandela and Suu Kyi are examples that would spring readily to mind for many.

In a 2010 paper, Suzy Killmister attempts to develop Schroeder's dignity concepts further.<sup>42</sup> Killmister's paper is worthy of attention because of her bold attempt at unifying Schroeder's dignity concepts into a single concept. In my view, her project is ultimately unsuccessful, but instructively so. She leaves aristocratic dignity to the side as irrelevant to bioethics. Comportment and meritorious dignity together involve

an inability to realise one's values of, perhaps, self-reliance, grace, courage, or even basic personal hygiene. Situations that constrain the individual to act in ways they find abhorrent or demeaning will undermine that individual's ability to live according to their own standards.<sup>43</sup>

Killmister then proposes to subsume these two concepts of dignity under the name of 'aspirational dignity', which she defines as 'the quality held by individuals who are living in accordance with their principles'.<sup>44</sup> This definition does not yet accommodate the Kantian conception of dignity, in which dignity is something inherent and inalienable. Killmister's final proposal for a unified definition of dignity, accommodating both the Kantian and the aspirational concepts, becomes: 'Dignity is the inherent capacity for upholding one's principles.'<sup>45</sup>

However worthwhile the effort to construct a unified concept of dignity, the proposal is unsatisfactory for two reasons. First, Killmister performs a relativizing move in shifting the focus from *society's* mores, virtues and principles to the person's

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<sup>40</sup> Ibid., 234.

<sup>41</sup> Ibid., 235.

<sup>42</sup> Suzy Killmister, "Dignity: not such a useless concept," *Journal of Medical Ethics* 36 (2010).

<sup>43</sup> Ibid., 161.

<sup>44</sup> Ibid.

<sup>45</sup> Ibid., 162.

own principles. One could easily imagine persons acting in accordance with their own principles of conduct but still behaving in an undignified way. It seems that it is *we collectively* and not each and every one of us that define the principles of conduct that outline the realms of dignified and undignified behaviour. This judgment is strengthened further by what I take to be the failure of one of Killmister's examples. According to her, a racist patient would suffer injury to his dignity by having to undergo treatment by a black physician.<sup>46</sup> Although the racist thereby does experience events that are not to his liking and go against some principles of his, I submit that it is plainly not plausible that his *dignity* thereby suffers. Second, Killmister's theory of dignity is problematic in that it leads to permanently non-autonomous patients not having any dignity. A person who has lost the capacity for autonomous choice no longer has 'the inherent capacity for upholding' his principles. This would imply that the PVS patient has lost his dignity. However, this implication does not in itself count against Killmister's account, as some, at least among philosophers, would accept this consequence. But other implications, such as that a patient with moderately advanced dementia by this account would have lost all or most of his dignity, would contrast sharply with common intuitions and judgments.

These considerations are reasons to discard Killmister's theory of dignity. Instead, I suggest we embrace Schroeder's account of the three senses of dignity relevant to bioethics as the one most faithful to common conceptions of dignity and common usage of the term.

In what sense, then, can the PVS condition or its treatment be considered as undignified? Which of the three senses of dignity, if any, could be applicable to the PVS patient? Clearly, when one speaks of existence in PVS as undignified, one does not intend the Kantian sense of dignity. Perhaps some would argue that the patient has lost his worth as a human being, and thus his Kantian-style dignity, but it is not this that the typical argument raised is trying to establish. Meritorious dignity, on the other hand, is relevant here. The patient, being unconscious, is unable to handle his situation in a virtuous way. In his current situation he lacks meritorious dignity.

What about comportment dignity? The PVS patient has lost control over bodily functions and is completely dependent on the caregivers' help. Now it is not obvious whether this aspect of the condition is *undignified* or merely highly

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<sup>46</sup> Ibid., 163.

undesirable, tragic or pitiable. It seems that some health care workers' and lay people's intuition is that it is indeed undignified in the comportment sense, whereas some others' intuition is that it is not (see 3.5). Furthermore, given that treatment and care are delivered in a respectful matter, treatment and care in PVS do not seem to give rise to indignities in themselves. If being maintained in PVS involves indignities, it must be due to *the condition itself*.

One influential strand of argument has been brought forth by Ronald Dworkin. He argues that conditions like PVS may indeed be undignified, in what here has been called the meritorious sense. In *Life's Dominion*, Dworkin only occasionally explicitly makes reference to PVS, but much of his argumentation about a dignified death and the role of autonomy is applicable to the present discussion. Dworkin points out that 'the emphasis we put on dying with "dignity" – shows how important it is that life ends *appropriately*, that death keeps faith with the way we want to have lived'.<sup>47</sup>

The PVS sufferer, when conscious and healthy, had a conception of himself and thoughts about which norms, principles and virtues – *values* for short – were important to him; these were partly *constitutive of his identity*.<sup>48</sup> As far as these values are currently *negated* by continued existence in the PVS condition, the patient's dignity is harmed. Indeed, a lingering existence in PVS may to some seem undignified because it is

stunningly inadequate to the conception of self around which their own lives have so far been constructed. Adding decades of immobility to a life formerly organized around action will for them leave a narrative wreck, with no structure or sense, a life worse than one that ends when its activity ends.<sup>49</sup>

On the other hand, Dworkin acknowledges that some people might have opposite values and preferences of this kind; continued survival and clinging to life 'expresses a virtue central to *their* lives, the virtue of defiance in the face of inevitable death'.<sup>50</sup> For such people, continued existence in PVS would not be undignified in the meritorious sense.

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<sup>47</sup> Ronald Dworkin, *Life's Dominion: An Argument about Abortion and Euthanasia* (London: Harper Collins, 1993), 199.

<sup>48</sup> We here glimpse the close relationship between dignity and integrity, as also pointed out by Dworkin, *ibid.*, 205.

<sup>49</sup> *Ibid.*, 211.

<sup>50</sup> *Ibid.*, 213.

Dworkin continues to stress that the patient's conception of whether life with the medical condition in question is contrary to his 'values' determines whether it really is undignified. Does he not then fall in the same trap of relativism that I have argued Killmister does? I do not think so. Dworkinian 'values' and conceptions of worthwhile lives are not *any* conceptions and values. They are all among the ones commonly entertained in our societies, and thus are consonant with the concept of dignity as commonly employed. Dworkin's relativism is, therefore, a limited and healthy one, which keeps his usage of 'dignity' within the bounds erected by common understanding of the concept. Dworkin concludes the chapter with the oft-quoted: 'Making someone die in a way that others approve, but he believes a horrifying contradiction of his life, is a devastating, odious form of tyranny'.<sup>51</sup>

Certain proponents of traditional answers to ethical end-of-life questions are too quick to reject arguments that life in PVS is undignified. They reject these arguments by pointing to the fact that PVS is not undignified in the Kantian or religious sense. But here I have argued, following Schroeder, that 'dignity' has three meanings relevant to bioethics, and that two of these may be compatible with the claim that life in PVS is indeed undignified.

For an example of the quick rejections I criticize, consider Oderberg:

Whereas the court saw [the PVS sufferer] Tony Bland's life as undignified, its proper response should have been to recognize that there is nothing whatsoever undignified in living with disability or even total incapacity, but that true indignity lies in the thinly disguised contempt with which some human beings regard others.<sup>52</sup>

The concept of dignity that Oderberg appeals to is the Kantian concept. He is wrong to disregard the other two senses of dignity, for these also belong to the common-usage concept of dignity. Oderberg has not presented further argument for the rejection of the other senses of dignity. A secular NNL theory cannot disregard senses of dignity that belong to common usage of the term.<sup>53</sup>

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<sup>51</sup> Ibid., 217.

<sup>52</sup> David S. Oderberg, *Applied Ethics* (Oxford: Blackwell Publishing, 2000), 81.

<sup>53</sup> Unless, of course, those commonly used senses of 'dignity' are shown not to belong to a proper concept of 'dignity', or to be morally irrelevant. I have yet to see any attempts at establishing such conclusions that go beyond simple assertion.

In a similar vein, Daniel P. Sulmasy outlines and discusses three senses of dignity.<sup>54</sup> One is the Kantian notion of intrinsic dignity, whereas the other two are ‘attributed dignity ... that worth or value that human beings confer upon others by acts of attribution’, and ‘inflorescent dignity’, which applies to ‘individuals who are flourishing as human beings – living lives that are consistent with and expressive of the intrinsic dignity of the human’.<sup>55</sup> However, in the subsequent discussion, Sulmasy seems to treat dignity as more or less a synonym for *moral status*. He goes on to argue that humans have intrinsic dignity, and that the other two senses of ‘dignity’ therefore fail as accounts of the moral status of human beings. This is fair, but he thereby fails to take account of competing senses of ‘dignity’ as still relevant for expressing certain aspects of human life and moral evaluation. In particular, Sulmasy’s point that all human beings have intrinsic dignity and thus equal moral status is *compatible* with the notion that certain forms of conduct are undignified. For one may use ‘dignity’ in Schroeder’s senses without speaking of moral status. In short, Sulmasy’s discussion fails to establish that there cannot be senses of ‘dignity’ that are complementary to his own preferred sense, senses that may be morally relevant.

The NNL writers themselves sometimes show a certain regard for the other senses of dignity. As a case in point, Grisez thinks that a person, without acting immorally, may sign an advance directive against being treated in PVS in order to ‘avoid being kept alive by a method toward which they feel *psychological repugnance*’ (my italics).<sup>56</sup> Grisez too, then, seems to indirectly acknowledge that there can be indignity involved in being sustained alive for years in PVS.

To sum up, life in PVS can plausibly be seen as undignified by appeal to two common conceptions (‘comportment’ and ‘meritorious’) of what constitutes dignity and indignity. As indignities are truly harmful to the person and ought to be avoided, there is here a powerful argument to the effect that the PVS patient is harmed by continued existence in PVS.

Summarizing the current main section about the arguments for the withdrawal of ANH, I have made the tentative conclusion that life is indeed a basic human good, and that the PVS sufferer’s life is an instance of this basic good. In this respect, his

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<sup>54</sup> Daniel P. Sulmasy, “Dignity and Bioethics: History, Theory, and Selected Applications,” in *Human Dignity and Bioethics* (Washington, D.C.: President's Council on Bioethics, 2008).

<sup>55</sup> *Ibid.*, 473.

<sup>56</sup> Grisez, “Should nutrition and hydration be provided,” 176.

life does seem to provide him a minimal kind of flourishing and participation in the human purpose. However, contradicting this view, I have also pointed to reasons to hold that the PVS sufferer's life is not necessarily of value *to him*, and thus does not really constitute a practical reason, a basic motive, a reason-for-action. Furthermore, it has been shown that many of the arguments discussed in this section do not carry independent weight, but are reducible to each other. One strong argument supporting the withdrawal of ANH emerges from the discussion: life in PVS can be said to be undignified in two senses of the term as it is commonly employed. As far as it is injurious to a person to be the subject of repeated and continuous indignity, this counts in favour of ceasing to provide ANH.

## 4.2 Arguments against withdrawal of artificial nutrition and hydration

### 4.2.1 The patient is a living member of our community

It was found that the PVS patient is alive according to commonly accepted definitions of death. As such he is still a member of our community. These considerations form the background for three arguments for the continued preservation of the PVS sufferer's life, and against the removal of ANH.

First, certain duties are owed towards living members of our communities. For instance, there might be *a moral duty to always feed human beings* in need of our care, whenever possible. This argument will be treated in the next section. The related alleged duty of always providing *basic humane care* will be treated thereafter.

Second, the 'signal argument' comes into play: death by withdrawal of ANH could give a certain, dangerous signal to other members of society. Even conceding that the PVS sufferer's quality of life is very low, one might still think that the decision to withdraw ANH due to futility or to the belief that the patient is better off without it would signal to others (and to disabled and chronically ill people in particular) that society does not value their lives unconditionally. It would be perilous and unhealthy if there were circumstances in which society would deem that you would be better off dead – and, possibly, that *the rest of us* would be better off without *you*.

However, it could also be said that if the withdrawal of ANH were to be carried out, the true purpose could be the benefit of the patient. The benefit of society (e.g., financially) need not be a contributing reason. And so the signal sent by the decision to withdraw ANH might more aptly be said to be that society is prepared to act in your genuine interest when you become incapable of guarding those interests yourself.

Additionally, it might be thought that *not* allowing the option of withdrawal of ANH would fail to signal proper respect for human life – on the contrary, it would signal that society is prepared to go against your current, competent will and your future best interests by keeping you alive in situations where you would not yourself desire it. As shown, 80% of lay Americans would themselves not want ANH in PVS.<sup>57</sup> The signal argument, therefore, appears to fail.

Third, the continued provision of ANH serves to uphold human solidarity with the patient. As has been argued, human solidarity in this case would be a concrete instance of the basic human good of friendship. Arguably, it makes sense to say that the patient participates in the good of solidarity even though he does not do so consciously. However, it may be objected that *if* it is established that continued life in PVS is not in the patient's best interest, then *neither* does it lead to instantiations of true human solidarity, for we do not display or create solidarity towards a person *by acting against what is truly his best interest*. Thus the argument that ANH should be continued for the sake of upholding human solidarity fails if it can be shown that continued life in PVS is not in the patient's best interest.

This unpacking of the argument in the current section, then, has revealed no argument that carries weight on its own, but two further arguments that will be examined in the next two sections.

#### 4.2.2 All human beings deserve to be fed

Food and drink have great *symbolic value*. Denying or withdrawing from someone the basic nourishment needed for survival could then, correspondingly, be an act of great negative symbolic value. However, withdrawing nourishment from someone for whom continued provision is not considered in his best interest would be, as noted, an act done with that person's interests in mind. The action may be morally appropriate

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<sup>57</sup> Emanuel et al., "Advance Directives for Medical Care."



even though it may in practice be difficult to entirely shed the negative symbolism attached to that action.

I am, therefore, unable to construct a successful argument with independent force from the premise that all human beings deserve to be fed.

#### 4.2.3 ANH constitutes basic humane care owed to all people, not 'medical treatment'

If ANH is a form of medical treatment, then it makes sense to explore whether withdrawing ANH in PVS could be justified by established norms about withdrawing useless or futile medical treatment (see 4.1.6). However, some argue that ANH should rather be thought of as a *basic form of care that is not medical treatment*. If this is the case, deliberations about withdrawing ANH could be informed by norms other than those governing medical decisions. It may be that withdrawing ANH would never or only rarely be justified. This is essentially Michael Degnan's argument. He contends that

ANH for [vegetative state] patients must be understood as basic care, not medical treatment. While the insertion of a feeding tube through the nose or the stomach is a medical act, the subsequent delivery of food and water through a tube is not. It is simply giving food and water.<sup>58</sup>

He goes on to quote the physician Keith Andrews:

If tube feeding is treatment, what is being treated? Surely not the [patient's] brain damage. The food is not being given to correct any abnormal biochemical or pathological process, but to provide nutrition to normal tissues. To my mind the tube is simply a tool for daily living, similar to the specially adapted spoons that enable arthritic patients to feed themselves. The relevance of this is that in identifying tube-feeding as treatment we have found a convenient method of shortening the life of a disabled person.<sup>59</sup>

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<sup>58</sup> Degnan, "Are We Morally Obligated to Feed PVS Patients Till Natural Death?" 49.

<sup>59</sup> K. Andrews, "Letting vegetative patients die," *BMJ* 305 (1992).

The last sentence highlights the more-than-semantic relevance of this discussion. John Finnis also provides an interesting argument:

The judgments all seem to embrace a fallacious inference, that if tube-feeding *is* part of medical “treatment or care”, tube-feeding is therefore *not* part of the non-medical (home or nursing) care which decent families and communities provide or arrange for their utterly dependent members. The non-sequitur is compounded by failure to note that although naso-gastric tube-feeding will not normally be established without a doctor’s decision, no distinctively medical skills are needed to insert a naso-gastric tube or maintain the supply of nutriment through it.<sup>60</sup>

According to Finnis, then, ANH can sometimes be part of non-medical care.

However, the arguments *for* ANH being medical treatment are stronger. I would argue that one must consider the *daily feeding part* of ANH as an integrated part of a larger procedure that must be classified as medical treatment: it is a physician who determines that the patient’s underlying pathology necessitates tube-feeding. Contrary to Finnis’s assertion, placing a nasogastric tube – and, especially, a gastrostomy (PEG) tube – should only be performed by personnel with the requisite (medical) training and the necessary (medical) equipment. The food itself is produced especially for the purpose of tube-feeding, and the necessary kind and amount must be determined by a physician or a clinical nutritionist. Nurses or physicians must monitor possible complications to ANH, and every once in a while the tube needs replacement; also a task for health care workers.

In sum, I contend that it is only when the feeding part is viewed in isolation that it can seem at all plausible that ANH is not a kind of medical treatment, and, further, that it is unreasonable to view the feeding part in isolation in this way. ANH is indeed a form of medical treatment. I will let Alfonso Gómez-Lobo’s fitting summary conclude this section:

Since the day-to-day feeding, which is the ordinary care part of the process, is only possible because of the prior, medically accomplished insertion of the feeding tube, it seems to me, as a matter of logic, that the procedure as a whole should be deemed to be ‘medical treatment’. In fact, a medical intervention provides the *necessary*

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<sup>60</sup> John Finnis, “Bland: crossing the Rubicon?” *The Law Quarterly Review* 109 (1993): 335.

conditions for the inception of the ordinary care, and medical monitoring is part of a responsible continuation of the care. (...) The classification of ANH as medical treatment does not, by itself, resolve the ultimate moral question whether its provision is obligatory or optional. It does help to sharpen the issue by inviting us to consider the traditional criteria for inception, continuation or cessation of treatment, namely its benefits and burdens.<sup>61</sup>

#### 4.2.4 Continued treatment in PVS is not pointless when in accordance with the patient's preferences

The NNL writers on this topic all seem to take for granted that as long as continued treatment is in accordance with the PVS sufferer's presumed or prior stated will, continued treatment is appropriate and, in most cases, morally obligatory. Scrutinizing this presupposition is very important. Let this be the version of the proposition to be examined: when the PVS patient's preference is for continued treatment, then treatment is not pointless.

The question now is whether this thesis is true on the presupposition that continued treatment in PVS is *not in itself* valuable, that is, it is not capable of bringing about any real or valuable instance of basic good. In other words, does the fact that the PVS patient's preference is for continued treatment make any difference ethically? Can this fact in itself change the meaningfulness of providing the treatment?

First, is it correct to ascribe preferences to PVS patients? In one scenario, the later-to-be-in-PVS patient has clearly stated his preference to be maintained in PVS if he were to enter that state. In another, the patient's preferences are assumed with some degree of certainty from his other core values, preferences, or worldview. In both scenarios, it may be problematic to say that the PVS patient actually *has* these preferences. If having preferences depends on having the requisite neurobiological apparatus for entertaining the preferences consciously – or for developing such a capacity – then the PVS sufferer cannot be said to have any preferences whatsoever. However, it is not obvious that having preferences presuppose these neurobiological features. For instance, we do find it meaningful to honour a person's preferences for

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<sup>61</sup> Alfonso Gómez-Lobo, "Quality of Life and Assisted Nutrition," in *Artificial Nutrition and Hydration: The New Catholic Debate*, ed. Christopher Tollefsen (Dordrecht: Springer, 2008), 106-07.

funeral arrangements. Either way, to make the argument under examination as strong as possible, let it be assumed that the PVS sufferer is rightly said to be capable of having preferences.

Allowing someone to follow his preferences very often makes sense. We want people to exercise their autonomy, and want to avoid overriding their autonomous decisions, *ceteris paribus*. However, the exercise of autonomy is not a basic good in itself (see 1.4.8). Autonomous choice is only morally good when it is for an instance of good, and a proposal to pursue this good in a morally appropriate way. If, then, continued treatment for PVS fails to achieve any instance of basic good, the mere fact that the treatment is in accordance with the patient's preferences (or the relatives', for that matter) does not change this fact. And so, if continued treatment is pointless, it remains pointless and cannot be morally obligatory, even though the patient would prefer it. The argument, then, fails.

#### 4.2.5 Physicians have an obligation to prolong life

Medical treatment often leads to longer and better lives. But do physicians really have an *obligation*, founded in their professional role, to prolong life? If that is really the case, then this obligation differs sharply from the views of most of today's physicians. If physicians really had an obligation to prolong all patients' lives, *all of the time*, then current medical practice would have to be changed in many and profound – and, indeed, tremendously expensive – ways. It is often technically possible to prolong the life of a dying patient, but it is widely considered wrong to do so when the patient's quality of life becomes sufficiently low, and death seems inevitable.

The ethos of medicine does not include the proposed norm of always prolonging life. Rather, medicine is for healing, the alleviation of suffering, and comforting, not for prolonging life as such. It is incorrect to say that physicians have an obligation to prolong life as such; more likely, their obligation is to promote health, which often leads to longer lives of higher quality.

To sum up this main section: five lines of arguments against the withdrawal of ANH have been examined. I have pointed to strong counter-arguments, which I take to be conclusive, against all five lines of argument.

### 4.3 Arguments about legitimate means

Among the moral intuitions apparent in the empirical data on attitudes towards PVS, there were intuitions about morally legitimate and illegitimate means. In this main section, these intuitions and the corresponding arguments are discussed in light of the NNL theory of morality.

#### 4.3.1 Even though death would be preferable to continued life in PVS, bringing about death is morally prohibited

Generally, given that situation B is preferable to our current situation A, there may or may not be any morally legitimate means to bring about B. It could be the case that no action can bring us to B without violating an important moral norm. PVS might be like that: granted that death is to be preferred to continued life, it may be that when different ways of bringing about death are examined, they are all morally deficient in one way or another and thus unacceptable.

In what ways can the PVS patient's death be brought about? First, through cessation of ANH or through the decision not to treat infections and other life-threatening complications. Second, through active killing, by medical (e.g., intravenous injections of lethal compounds) or non-medical means. In order to decide whether these means of bringing the PVS sufferer's life to an end are acceptable given that his death is to be preferred, these actions must be examined further. Characterization of the action types they exemplify will be a crucial component of this analysis. In particular, how will the 'orthodox' version of the NNL theory, incorporating the 'direct action' version of the seventh requirement of practical reasonableness, analyze such actions? The next sections will shed light on this question.

#### 4.3.2 It is better that a PVS patient's death is caused by an omission than by a commission

Cessation of ANH would be (arguably) an omission, whereas active killing is an action by commission. Some moral philosophers have maintained that whether an action is a commission or an omission *sometimes makes a moral difference*.

Consequentialists typically deny this. In the field of bioethics, the *locus classicus* for this debate is James Rachels' paper 'Active and Passive Euthanasia', and my discussion will start with three points raised in Rachels' paper.<sup>62</sup> First, Rachels points out that even though a failure to act (an omission) is not an action properly speaking, omissions insofar as they are conscious decisions should be regarded on a par with actions for the purpose of ethical analysis. This is surely correct. Second, Rachels suggests that a patient's 'being allowed to die' caused by not instituting life-saving treatment (an omission) sometimes leads to a prolonged dying process filled with pain and suffering, whereas actively killing the patient also allows him to die, but may avoid meaningless suffering. Third, according to Rachels, the act-omission distinction is morally irrelevant. To argue this point, Rachels constructs what has become a famous thought-experiment. Consider the case of Smith who drowns his cousin in the bathtub to acquire his inheritance, and Jones who, for the same purpose, watches his cousin drown while idly standing by, refraining from helping. Rachels' point is that if the distinction were morally relevant, we would consider Jones' failure to act as morally less blameworthy than Smith's commission. However, it is most likely that anyone considering the thought experiment will judge the two actions as equally despicable.

However, David Oderberg presents an analysis that refutes Rachels.<sup>63</sup> First, Oderberg points out that although there are cases in which whether the action under moral appraisal is an act or an omission is morally irrelevant, there are also many cases in which it *is* relevant. His example, borrowed from Philippa Foot, is that sending poisoned food to starving people in another country is morally worse than not travelling there to aid them directly (presupposing that both the act and the omission would result in the exact same consequences, including the same number of lives lost). Second, an essential point is that the culpability associated with some omissions results from *not performing one's duty*:

When assessing whether or not an omission to do something is culpable, we need to see the notion of *failure* as central. A culpable omission is not merely a refraining

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<sup>62</sup> James Rachels, "Active and Passive Euthanasia," *New England Journal of Medicine* 292 (1975).

<sup>63</sup> Oderberg, *Moral Theory*, 134-37.

from doing something, but a failure to act; and a failure to act implies that there is a *pre-existing duty* to act.<sup>64</sup>

When an otherwise healthy, young diabetic develops ketoacidosis, a life-threatening complication, the physician's intentional omission to treat, leading to death, would be just about as culpable as actively killing the patient. Here, the physician's omission is a failure to act; the physician does not fulfil his pre-existing duty to act.

As for Rachels' second point above, construing the doctor's omission as intentionally allowing the patient to die is misleading. It seems Rachels is here mixing up the intention-foresight and the act-omission distinctions. According to traditional natural law reasoning, *intentionally* bringing about the patient's death through an omission would be as morally blameworthy as causing his death by positive act (see 5.2).<sup>65</sup> The virtuous doctor, natural law theory would claim, does not limit medical treatment at the end of life with the patient's death as the intended goal; rather, treatment is withdrawn or withheld because it is judged to be futile, meaningless or too burdensome, all things considered. Oderberg writes,

If a doctor refrains from saving a patient in particular circumstances, with the result that the patient dies, he may or may not have intended to bring about death. If he did not, then he may or may not be culpable, according to whether he had a duty to save *in those circumstances*. If he is not culpable, *it does not follow* that it would have been permissible for him to take active steps to kill the patient ...<sup>66</sup>

I have yet to see persuasive counter-arguments to Oderberg's analysis. My view, therefore, is that the act-omission distinction is sound and sometimes important in moral philosophy and medical ethics.

Now, it is my personal impression that many physicians feel that the distinction between acts and omissions is of special import in the decision to limit treatment at the end of life. As shown (3.5), some of the empirical evidence examined supports this contention. In the case where treatment is limited because it is judged futile or too burdensome, some clinicians would feel it easier, e.g., to *withhold*

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<sup>64</sup> Ibid., 134.

<sup>65</sup> Finnis, Grisez, and Boyle, "'Direct' and 'indirect.'"

<sup>66</sup> Oderberg, *Moral Theory*, 137.

ventilator treatment than to *withdraw* ventilator treatment already begun. However, the preceding analysis of the act-omission distinction does not support this opinion.

First, let the intention be to withhold or withdraw treatment that is too burdensome. In this case there can be no moral duty to treat, and therefore the treatment-limiting action is acceptable, whether an act (withdrawing) or an omission (withholding). Second, let the intention be to bring about the patient's death. In this case the intention is, according to NNL, morally unacceptable. Therefore, so is the action, whether an act or an omission. In the case of withholding vs. withdrawing treatment, it is *intention* and not the *act-omission distinction* that is the decisive moral concept on which the analysis hinges.

Thus there is reason to think that the act-omission distinction sometimes is morally important, but that it is not important in the case of withdrawing ANH in PVS: if ANH is withdrawn with a morally good intention, it is of no moral import that the withdrawal is a kind of omission and not a commission. A common intuition has here been shown to be misguided.

#### 4.3.3 Death is preferable to continued life in PVS, and withdrawal of ANH is an acceptable way of bringing about death

If granted for the sake of argument that death is to be preferred to continued life for the PVS patient, would physicians be justified in withdrawing ANH? In an NNL analysis of this question, the crucial point is how the intention should be characterized. What is the physician's intention in withdrawing ANH (or the relatives' intention in requesting its withdrawal)? There seem to be four main possibilities, which will be analyzed in turn.

First, the doctor's intention in withdrawing ANH can be to bring about the patient's death; in plain language, killing the patient. Now this intention, though carried out for a further goal perceived to be good, is regarded as morally flawed by the NNL moralists. The action is a *direct attack on an instance of basic human good*, namely, the patient's life. In other words, it is an intentional killing of an innocent human being. That the killing is achieved by a kind of omission (treatment withdrawal) makes no difference morally. The seventh requirement of practical rationality, which forbids direct attacks on instances of basic good, is violated. The NNL theorists, therefore, consider the action immoral.



Second, the intention can be to remove the burdens involved in PVS, for the patient's sake. As discussed above, removing ANH in order to remove burdens means intending the death of the patient as a means to achieve the further end of removing burdens. The burdens of living cannot be eliminated *without eliminating the person*. Thus, if it is indeed correct that intending the patient's death is immoral, then so is the proposed line of action: killing the patient through an omission for the further end of removing the burdens of living.

Third, ANH can be removed not to benefit the patient, but to relieve the burdens to relatives. But here also, the death of the patient would be used as a means to bring an end to the relatives' suffering. As with the second category of intention, this must be ruled out as immoral.

Fourth, ANH may be removed because it is medical treatment that does not accomplish its goals, that it is futile, meaningless; or, because the burdens involved are too great. In this case, the patient's death is not (or, at least, need not be) part of the intention. Rather, the patient's death is a foreseeable, possibly welcomed but unintended consequence of the action of removing ANH. The removal of ANH in this case does not breach the seventh requirement by constituting a direct attack on the good of life. *If* the removal of ANH could be chosen with the intention of removing futile, meaningless or overly burdensome treatment, then it would be morally acceptable.<sup>67</sup> As the previous three intentions are unacceptable by an NNL interpretation, this fourth intention, then, is the only acceptable intention for a treatment-limiting decision in the PVS case.

#### 4.3.4 Death is preferable to continued life in PVS, and medical killing is an acceptable way of bringing about death

One might imagine procuring the PVS patient's death through active killing, for instance with an injection of a lethal drug. Again, accepting that the PVS sufferer's life is indeed an instance of basic good, and that the seventh requirement forbids direct attacks on basic goods, such a medical killing of the PVS patient is readily seen

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<sup>67</sup> However, as has been argued, this line of reasoning is closed to the NNL proponent as long as further existence in PVS is indeed a benefit, and continued ANH is not a burden to the patient.

to be morally unacceptable. For in the case of active killing, the intention is the patient's death – an intention ruled immoral by the seventh requirement.

In sum, it has been found that, when presupposing 'orthodox' NNL theory, the PVS patient's death can be brought about in moral (withdrawing ANH because it is futile or overly burdensome) and immoral (withdrawing ANH for the sake of the relatives' suffering or for the sake of the patient's suffering, or actively killing the patient) ways. Furthermore, the distinction between acts and omissions is sound and sometimes morally important, but not morally relevant in the PVS case.

#### 4.4 Arguments from other sources

Finally, arguments and premises that are pertinent to the comprehensive moral appraisal, but that were not derived from the empirical evidence, must now be considered. They will be discussed under three headings: arguments pertaining to abstract moral theory; arguments from the nature of medicine; and, finally, some more pragmatic points and arguments.

##### 4.4.1 Arguments pertaining to moral theory

In this section, two arguments will be examined: first, that PVS is a situation that is so peculiar, unnatural and tragic that one cannot expect a moral theory to produce sensible normative conclusions about it; second, that the traditional distinction between ordinary and extraordinary medical treatment is cogent and provides relevant moral guidance for our questions about PVS.

PVS is indeed a very strange situation. One might think that an adequate ethical theory, yielding sound ethical guidance in more common circumstances, could still fail to be sufficiently helpful in illuminating the morality of the alternative lines of actions in our PVS case. The reason for this failure could be that PVS is so *unnatural* and so *far from the regular occurrences of our moral lives* that the ethical theory, shaped by humanity's common reflection on common experiences, fails to account for the choices that must be made regarding PVS. However, there are strong reasons to expect an adequate ethical theory to be helpful even in this special case. First, everyday moral deliberation may be comparatively easy without the aid of an abstract ethical theory; it is for the special cases, the perplexing borderline cases, that

help from an ethical theory is called for. Without being able to aid us here, the ethical theory would fail a prime task for which it has been constructed. Second, the adequate ethical theory must contain an appropriate rendition of the principles of sound practical reasoning. Why think that these principles should not be applicable in unusual cases also? Third, as argued in the previous chapter, although PVS is a strange situation, it might be said to be a fitting philosophical test case. You say that life is always valuable and should be protected; well then, what if biological life – and health and bodily function just above what is required for survival – is all you have, with no other kind of human flourishing and no prospect of improvement? Does your contention about life's value still hold? And is it still meaningful and morally obligatory to preserve this vestige of life? There is good reason to hold, then, that an adequate ethical theory should be able to guide us in the case of PVS.

This challenge can also take on a different shape. Some theorists within deontology claim that no moral norm is absolute. Even norms commonly held to be very important and part of the central fabric of moral life, like the norm against killing innocents, may be overruled, outweighed or in some way set aside in certain, uncommon circumstances. In other words, moral norms have 'escape clauses'.<sup>68</sup> Applied to the present case, the contention would be that PVS is such a special and tragic case that one norm usually constricting the physician's actions, the norm against killing innocents (or, in NNL parlance, against acting directly against instances of the basic human good of life), should be set aside. The negative consequences of *not* overturning the prohibition on killing the patient are overwhelming and demand the application of an escape clause. However, there are two problems with this argument, pointed out by Paterson.<sup>69</sup> First, 'escape clause' reasoning may be incompatible with NNL or deontological reasoning. The 'escape clause' logic would imply that deontological principles should govern moral reasoning in the normal case, whereas consequentialist 'safety valves' should be activated when the negative consequences of following the deontological principles loom sufficiently large. If a full-blown consequentialism is brought in to justify the escape clause, then the agent must switch between *incompatible conceptions of practical reason* (see 1.7.1) when moving to and fro between the escape clause and

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<sup>68</sup> Paterson, *Assisted Suicide and Euthanasia*, 95-97; Fortin, "The New Rights Theory and the Natural Law," 604.

<sup>69</sup> Paterson, *Assisted Suicide and Euthanasia*.

the normal situation. This would bring us a ‘mixed theory’ of ethics that would most likely struggle in vain to be philosophically sound. However, against Paterson it may be said that *the consequences of actions* are very relevant, not only in consequentialism, but in NNL moral appraisals of actions as well. An action’s consequences for *the conditions for the pursuit of the basic human goods* are of the highest import. It is true, however, that in its ‘orthodox’ form, NNL provides moral absolutes that cannot be overruled by any appeal to such consequences – so Paterson’s argument holds.

Second, there is the problem of limits. At what point should an escape clause come into play? When are the consequences bad enough for deontological constraints on actions to be overturned? There is no principled way to tell. And so the ‘escape clause’ move, in introducing consequentialist reasoning, paves the way for the rationalization of immoral choices, in the same way a full-blown consequentialism would (1.7.1).

Are some medical interventions *ordinary*, and therefore morally obligatory, and some *extraordinary*, and can therefore be forgone? Among those who insist that there is a distinction of moral import between ordinary and extraordinary treatment for the prolongation of life is David Oderberg:

Ordinariness consists in the maintenance, by oneself or by others for oneself, of normal, everyday means of sustenance [including food and drink]. (...) On the other hand, extraordinary actions are ones that are overly burdensome, futile, or involve serious dangers to the person treated or others.<sup>70</sup>

The label of ‘extraordinary’ is attached to a medical intervention deemed not to be morally obligatory. Arguably, the designation arises not as a premise to be considered during moral deliberation, but as the *conclusion* of the endeavour to find out whether certain medical treatment is morally required in a specific situation. As such, the ordinary/extraordinary distinction does not itself perform any work in the moral deliberation. Additionally, because the distinction has been drawn in a number of conflicting ways, its use generates confusion. For these reasons, there are doubts about the usefulness of this distinction. Instead of appealing to ordinariness or its contrary, the parties to the discussion should state whether they find the medical

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<sup>70</sup> Oderberg, *Applied Ethics*, 80-85.

intervention in question to be morally obligatory or not, and their reasons for thinking so.

In sum, the two arguments in this section, viz. the argument from the strangeness of PVS, and the ordinary/extraordinary distinction, are refuted and will not play any further role in our reflective equilibrium.

#### 4.4.2 Arguments from the nature of medicine

As a backdrop for the discussion, let it be pointed out that not only a proposed *withdrawal* of treatment, but also *continued treatment*, stands in need of a medico-ethical justification. It would be wrong to regard continued provision of ANH to the PVS patient as a default stance that is morally obligatory until proven otherwise.

An argument from the nature of medicine could look like this: it is wrong (or at least not morally obligatory) to provide medical treatment when *medicine's objectives* cannot be achieved. ANH may well be effective treatment in that it provides nourishment and secures homeostasis in the PVS patient's body. In this way, ANH does achieve its purpose. However, one might question whether keeping a severely disabled patient alive is rightfully a task for medicine at all. An argument to the effect that it is not may be constructed from certain views of medicine's purpose.

As an example of such a view, consider an article by Luke Gormally.<sup>71</sup> He recognizes that life/health is both an instrumental and a basic or intrinsic good. However, he states: 'If a living human body has been so severely damaged that it no longer makes sense to speak of a continuing capacity to share in human goods other than life itself, then what is integral to what we value in health is no longer achievable.'<sup>72</sup> Furthermore, according to Gormally, it is no part of the purpose of medicine to try to achieve a mere prolongation of life as long as the good of health is unachievable: 'Prolongation of life is not an independent goal of medicine; it makes sense as long as one can sustain a degree of organic well-functioning sufficient to allow for some sharing, however minimal, in other human goods.'<sup>73</sup>

Gormally's claim, then, is not exactly that mere continued existence is meaningless, but rather that it is no part of the ethos of medicine to promote mere

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<sup>71</sup> Luke Gormally, "Walton, Davies, Boyd and the legalization of euthanasia," in *Euthanasia Examined*, ed. John Keown (Cambridge: Cambridge University Press, 1995), 117.

<sup>72</sup> Ibid.

<sup>73</sup> Ibid.

continued life when the proper goal of medicine, *health*, is unachievable. Mitchell et al. concur: '[T]he ultimate goal of any medical intervention should be improvement of prognosis, comfort, well-being, or, general state of health'.<sup>74</sup> In the same vein, Finnis thinks:

It is reasonable to treat medicine's objectives as limited, generally, to (i) the maintenance and restoration of health (the well-functioning of the human organism as a whole) or some desirable approximation to health, and (ii) the palliation of suffering. For [PVS patients] the first objective is unattainable, and the second is irrelevant; such a patient stands to benefit in only a very limited way from many sorts of medical treatment.<sup>75</sup>

It is true that the objective of *restored health* is out of reach for the PVS patient, and that the treatment cannot be said to *maintain* health if the patient does not really *have* health.<sup>76</sup> It is also true that the patient experiences no suffering that needs palliation.

However, the question still remains whether it is right to say that the PVS patient does not really possess any 'health' that is maintained by ANH and nursing care. If 'health' presupposes a more-than-minimal human flourishing, then the PVS patient does not have any 'health' to maintain. An account of health can be constructed from O'Rourke's statement that 'health care seeks to help people strive for the purpose of life, not merely to function at the biological level'.<sup>77</sup> However, in the natural law view, just participating in the basic human goods *is* fulfilling the purpose of life. If the PVS patient's biological life is an instance of basic good, then ANH is a kind of health care that helps fulfil the purpose of life – in other words, the PVS patient *has* (some) health – and ANH is thus consonant with the purpose of medicine. Thus the argument is reduced to the question about whether biological life is a basic good, a question that has been treated above (4.1.3).

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<sup>74</sup> Mitchell, Kerridge, and Lovat, "Medical futility, treatment withdrawal and the persistent vegetative state," 73.

<sup>75</sup> Finnis, "Bland: crossing the Rubicon?" 335.

<sup>76</sup> Is Finnis right to say that the treatment's ability to maintain the patient's health is enough to say that it achieves a purpose of medicine? Or should one rather demand *improvement of health* in order to say that a given treatment performs the purpose of medicine? Finnis is right, as many commonplace examples will confirm. One need only mention the treatment of diabetes mellitus type 1 with insulin injections; this treatment maintains health without improving it.

<sup>77</sup> O'Rourke, "Reflections on the papal allocution," 94.

However, if Finnis is right in defining ‘health’ as ‘the well-functioning of the human organism as a whole’, then his conclusion that treatment for PVS can neither restore nor maintain health is probably correct. This leads to the further conclusion that ANH in the setting of PVS is either prohibited or at least not demanded by the norms of medicine. Finnis’s own view, however, is that ANH is still often morally obligatory because it is also a kind of ‘the *non-medical* (home or nursing) care which decent families and communities provide or arrange for their utterly dependent members’ (my italics),<sup>78</sup> and in this context not regulated by the norms specific to *medical treatment*. However, reasons were found above to reject the view that ANH can be other than medical treatment (4.2.3).

Therefore, Finnis’s definitions of health and of the purpose of medicine lead to the conclusion that ANH in the setting of PVS is either morally prohibited or at least not obligatory. However, Finnis’s definitions are contentious, and it is difficult to see how the debate on these concepts can be settled decisively. In my view, one should therefore be reluctant to accord this line of argument too much weight. The debate on ANH in PVS should not be settled solely by an appeal to a contentious definition of health.

#### 4.4.3 Some final pragmatic points and arguments

An argument from limited resources is voiced by, among others, Raanan Gillon.<sup>79</sup> When the state pays for the PVS patient’s treatment, is this treatment really of the kind that should be prioritized when resources are scarce? Gillon writes,

[I]n the context of scarce and relatively fixed health-care resources, such as those of national health-care systems (...) justice requires consideration of the opportunity costs both to other potential recipients of those scarce resources, and to those who provide the funding for those resources (...) Many such people will consider that expenditure of significant resources on prolonging permanently unconscious lives is a waste of those resources. (...) It is probably also safe to predict that treatment to prolong the lives of patients reliably diagnosed to be in PVS will for many constitute

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<sup>78</sup> Finnis, “Bland: crossing the Rubicon?” 335.

<sup>79</sup> Gillon, “Persistent vegetative state.”

a paradigm for such treatments that, in the context of scarce resources, should not be funded by the state.<sup>80</sup>

Are natural law theories adequately equipped with the theoretical tools for solving questions of priority setting in health care? I contend that many different theories of priority setting in health care may be largely compatible with the NNL outlook. Finnis's eighth requirement of practical reason, 'foster the common good of your communities', and the third – the golden rule – may be taken as support for the legitimacy of priority setting. The discussion of the ethical arguments in the PVS case have shown many of the arguments to be largely reducible to other, more basic arguments, as facets of those. However, the argument from priority setting seems to be a separate argument that could carry weight on its own; the question of whether it is morally obligatory to spend money on a certain life-sustaining treatment, money that could otherwise be spent on other good purposes, is not the same question as whether the same life-sustaining treatment is morally obligatory because life is an instance of basic human good.

The argument from priority setting against continued treatment in PVS would seem to carry some weight, then; however, the total financial burden to society from caring for PVS patients is surely rather light. Whatever resources can be saved from not providing ANH to PVS patients will most likely not make too much of a difference in the big picture. Thus the argument from priority setting does not seem to be very forceful.

#### 4.5 A summary and appraisal of the arguments

In the ongoing process of reflective equilibrium, a lot of arguments have been considered thus far, many of which have either been *refuted* or have been shown to be mainly facets of other, more basic arguments, to which they are *reducible*. Five main arguments have survived the analysis and are worthy of further consideration. 1) An argument was that life in PVS might involve loss of dignity; when people speak of life in PVS as undignified, they have not misunderstood the concept of dignity, as suggested by some natural law proponents, but instead are applying it precisely in accord with two of the three commonly accepted meanings of the term. 2) There were

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<sup>80</sup> Ibid., 68.



reasons to think that continued provision of ANH in PVS can be contrary to the purpose of medicine. However, this argument should not be taken to be decisive, as it relies on contentious definitions of medicine's purpose. 3) When exploring the morality of actions that lead to the PVS sufferer's death, it was found that the removal of ANH with the intention of removing futile or meaningless (or overly burdensome) treatment may be morally acceptable. 4) One strand of argument is that the PVS sufferer's life is not a good *to* him or her. 5) However, another line of argument suggests the opposite, that continued life in PVS is an instance of the basic good of life and thereby constitutes a benefit to the patient.

#### 4.5.1 Paradoxes in the new natural analysis of the PVS case

In 3.3.1 I argued that the NNL writers are really committed to a view on treatment-limiting decisions in PVS that is rather unpalatable and implausible. There, I opined that:

It seems that NNL proponents are committed to the view that continued ANH is *always* morally obligatory for the PVS patient, unless (1) the patient is in the process of dying; or (2) the financial or practical burdens of care are too high; or, perhaps, (3) the patient has made a prior, autonomous choice to forgo ANH with the charitable motive of sparing relatives of the emotional burdens of care. Because (2) and (3) seldom apply, this view seems to imply that withdrawing ANH would be morally acceptable in *only very few* actual cases.

The view that the NNL position is problematic is corroborated by the above appraisal of the arguments. When confronted with the 'orthodox' NNL theory, the first four of the five arguments above give rise to problems that cannot be resolved by the theory. 1) The indignity of being kept in the PVS condition speaks in favour of limiting treatment. But a decision to that effect, both when made by health care workers/caretakers and the patient in a prior stated wish, is typically ruled out as unacceptable by the NNL approach. 2) There are reasons to think that continued provision of ANH in PVS is not in accordance with the purposes of medicine – a position that sits uneasily with the NNL view that continued treatment *is* meaningful and a benefit. 3) The withdrawal of ANH with the intention of removing futile,

meaningless or overly burdensome treatment is in general morally acceptable – but ANH itself in the setting of PVS cannot be judged to be futile, meaningless or overly burdensome in an NNL framework. 4) The PVS sufferer’s life does not seem to be a good *to* him. But this point cannot be accommodated by the orthodox NNL theory, which instead insists that continued life is a benefit.

#### 4.5.2 How can the problems be resolved?

These, then, are four problems created in the intersection between the arguments and considered judgments about the PVS case, and the normative guidance provided by the moral theory. When arguments point out such problems or inconsistencies, the method of reflective equilibrium incites us to examine whether they can be ironed out. Can the fit between theory and considered judgments be improved? Does NNL theory have the theoretical resources to incorporate the considered judgments that have caused the paradoxes?

The process of reflective equilibrium now calls for the examination of the ‘theoretical wiggle-room’ in NNL theory construction. The crucial role of the seventh requirement of practical reasonableness in the construction of the moral norms salient to the analysis of the PVS case has been noted repeatedly. In Chapter 2, four alternative candidate formulations for the seventh requirement were presented. Can any of the alternatives, when substituted for the direct action thesis, achieve a harmonization of considered judgments, arguments, intuitions, and moral theory? Will this enable us to reach a reflective equilibrium?

Recall the four alternative formulations from Chapter 2:

*Direct action thesis (Finnis):* ‘Do not choose directly against any basic human good’.

*Respect thesis (Chappell):* ‘Respect each basic good in every action’.

*Real aspect thesis (Dubois):* ‘Never act intentionally against a real aspect of a human being’s fulfilment’.

*Combination thesis:* ‘Respect each real aspect of a human being’s fulfilment in every action’.

The task now is to see whether the three latter theses are able to resolve the four problems suffered by the ‘orthodox’ NNL theory equipped with the direct action thesis.

*The respect thesis* was able to respond adequately to both of the two main test cases (see 2.4.2). The gist of Chappell’s respect thesis was that the different goods make different demands on us; intentionally acting against an instance of good, like an on-going game, is not necessarily incompatible with proper respect for the good.

How, then, would the respect thesis consider the basic good of life instantiated by the PVS sufferer? Does proper respect for this good rule out an intentional attack on it, like the cessation of ANH with the explicit intention of ending the patient’s life? Chappell’s formulation seems to give room for prudential judgment and discretion. However, as shown (2.4.1), Chappell himself thinks that proper respect for the good of life does indeed make intentional attacks on it immoral.<sup>81</sup> What constitutes disrespect for a given good varies, but in the case of the basic good of life, Chappell’s own verdict is clear: intentional destruction of a human life constitutes disrespect for the basic good of life. Therefore, intentional attacks on human life are immoral.

This conclusion makes the respect thesis line up exactly with the direct action thesis on the questions of the morality of treatment-limiting decisions in PVS. It seems, therefore, that *the respect thesis fares no better than the direct action thesis* when it comes to accommodating the considered judgments and problems presently under consideration. The respect thesis inherits the same problems that plague the ‘orthodox’ NNL analysis of the PVS case.

*The real aspect thesis* tackled one of the two test cases adequately. This thesis asks us to consider whether the instance of basic good in question is in fact a *real aspect* of the relevant person’s human fulfilment and flourishing. If yes, then an intentional action against this instance of good is ruled out by the seventh requirement’s demand. If no, then the seventh requirement does not outlaw the intentional destruction of the instance of good. The question now is whether the PVS sufferer’s instantiation of the good of life is in fact a real aspect of his fulfilment and flourishing. As with the respect thesis, once again more room for prudential reasoning is introduced. NNL theory contends that whatever participation in human fulfilment the PVS sufferer has, he has due to his biological life (argument 5 above). However,

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<sup>81</sup> Chappell, *Understanding Human Goods*, 87.

contradictory lines of argument have also turned up: that the PVS sufferer is not really *flourishing* at all; rather, his biological life has ceased being a good *to* him (4), and he perhaps suffers indignities (1). The real aspect thesis rejects wholesale ascriptions of basic goods as wholly and always good *to* the person in question. Instead, one must examine the question in each particular instance. *Is this particular instance of basic good a constituent of the person's human fulfilment?* It is not decisive that in the vast majority of cases, biological life is both good in itself, a constituent of flourishing, and a precondition for participation in the other goods, for in the PVS case, common intuition – and strong arguments – instead say that the PVS sufferer's life has ceased being a good to him. It is *no longer a real aspect of the PVS sufferer's fulfilment*. And in that case, the real aspect thesis does not rule out intentional actions against the PVS sufferer's life (however, there may be other moral reasons for not accepting such actions, as will be examined below).

How does the real aspect thesis tackle the four problems or paradoxes listed above? Although the PVS sufferer's life is an instance of basic good, reasons have been given for judging that it is no longer of value *to* him; it is no longer a real aspect of the PVS patient's fulfilment. If the patient's dignity suffers, not through the life-preserving treatment but through continued existence in PVS, then this constitutes a real harm to the PVS patient. However, if the patient's life is no longer of value to him, it no longer constitutes an important reason for action. Therefore, the real aspect thesis does not rule out intentional attacks on the good of life – in particular, the removal of ANH – in order to bring an undignified existence to an end. Furthermore, it now makes more sense to say that continued treatment is contrary to the nature of medicine, because of the non-existent benefits of treatment. And finally, if the preservation of the PVS sufferer's life is no longer a reason for action, continued provision of ANH is indeed futile or meaningless, and can be forgone. *All four problems or paradoxes of PVS, then, are resolved by exchanging the real aspect thesis for the direct action thesis.*

The combination thesis inherits the strengths (and the potential weaknesses) of the respect and the real aspect theses. An analysis of the PVS paradoxes in light of the combination thesis would be similar to the real aspect thesis analysis just presented. The PVS sufferer's life is no longer a real aspect of his fulfilment, and one is thus not obligated to show the same kind of respect commanded by basic goods that *do* constitute real aspects of persons' fulfilment. The real aspect and combination theses

introduce the idea that a basic human good may not always contribute to a person's true flourishing. This idea allows me to drive a wedge between the concepts of basic human good and pre-moral value. The upshot is, arguably, more in line with common sense: even though the basic ingredients of a fulfilled life are valuable and desirable, human life is so diverse that in special circumstances specific instances of such goods may not be valuable and desirable.

The combination thesis has one slight advantage over the real aspect thesis: it deals more adequately with the hacker case (2.4.2). This is due to the emphasis on *proper respect* for goods introduced by the combination thesis, as opposed to the absolute ban on direct attacks on goods that contribute to someone's fulfilment, as enjoined by the real aspect thesis. In other test cases, and in the paradoxes currently examined, the two theses fare equally well. There is, then, one reason to prefer the combination thesis to the real aspect thesis. Furthermore, the superior ability of the combination thesis to resolve problems and paradoxes, compared to the direct action thesis, does not come at the expense of introducing new theoretical weaknesses. No indication that the combination thesis leads to a reduction in theoretical coherence compared to the direct action thesis was found (2.4.1). The combination thesis seems to bring with it several merits, while introducing no new vices.

The upshot of the process of reflective equilibrium, therefore, is that *an NNL theory in which the combination thesis is substituted for the direct action thesis* achieves the greatest harmony between considered judgments and moral theory. The combination thesis emerges as the 'winner' of the contest between the four alternative formulations of the seventh requirement, as adjudged by the logic of reflective equilibrium. It should be incorporated in a revised version of the NNL theory.

It is time to point out some limitations of the approach. I wanted to test the NNL theory against common moral intuitions. I chose the PVS case and its associated moral intuitions because the 'fit' between NNL theory and intuitions here seemed to me to be bad, with significant consequences. The choice of *other* test cases could conceivably have led to other conclusions about the versions of the seventh requirement. However, the combination thesis has both tackled the test cases and improved the fit between intuitions, arguments and moral theory by resolving the PVS paradoxes; it ought to be preferred to the competing formulations of the seventh requirement, until novel arguments indicate otherwise.

Three objections must now be defused. Is my proposed alteration of NNL *easily brushed aside and self-contradictory*, or does it commit me to an *untenable dualism*? Neither, I believe. One might imagine the NNL proponent giving the following response to my overall argument so far: ‘You cannot change the basic tenets of the NNL theory. The moral verdict in the PVS case may appear unappealing to you. But it does follow, inevitably, from the basic premises of the theory – premises that are justified.’ However, in reply I would say that a core part of my argument has been to show that the NNL proponent has *no principled reason* to prefer the ‘orthodox’ version to the revised version of the theory. On the contrary, it has been argued that *all reasons examined* count in favour of switching out the direct action account of the seventh requirement of practical reasonableness with the combination thesis. At the outset, the combination thesis had an equal claim to justification by self-evidence as the direct action thesis. However, the argument thus far has shown reasons to prefer the combination thesis.

My solution drives a wedge between the concept of ‘basic good’ on the one hand, and ‘human fulfilment’, ‘reasons for action’ and ‘benefits’ on the other. The basic human goods are the goods that constitute human fulfilment. However, rare instances of basic human good *do not* contribute to fulfilment. By implication, neither are they benefits. Likewise, instances of basic human goods *typically* give rise to reasons for action, but in the special case where the instance does not contribute to fulfilment, the instance of good does not constitute a reason for action. My solution demanded that the relations between these core concepts must be stated anew. However, I cannot see that the new descriptions involve me in any self-contradictions.

In their book, Lee and George are eager to label opponents as ‘dualists’ (however, often for good reasons).<sup>82</sup> And indeed, they have such a critique in store for proposals such as mine as well:

So, to view one’s whole biological life as merely instrumentally or merely conditionally valuable is indeed, though perhaps only implicitly, to identify oneself with something other than that living bodily entity. Thus, to deny that one’s biological life is intrinsically good is, at least implicitly, to adopt a body-self dualism.<sup>83</sup>

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<sup>82</sup> Lee and George, *Body-Self Dualism*.

<sup>83</sup> *Ibid.*, 161.

What does it mean that participation in the good of life is no longer *good for* the PVS patient? Does this not imply that the identification of the person with his biological life has been severed, and an instrumental relation between the subject and his biological life introduced? No such thing. The person still *is* his biological life. That the PVS patient's life is no longer good for him simply means that existence as such has lost value. In the 'orthodox' NNL theory, this is an impossibility, but the proposal is neither self-contradictory nor dualist. Biological life *is* intrinsically good, whenever it is good; that is, it is good in virtue of nothing outside of itself. It just so happens that it may, in extreme circumstances, *cease* being good.

The revised theory ought to be tested further on a broad range of cases. Indirectly, the discussion of other end-of-life decisions in light of the theory in the following chapter constitutes such tests. For the time being, we are justified in incorporating the combination theory in our secular NNL theory.

#### 4.6 A revised new natural law theory

Let the current and the two previous chapters briefly be recapitulated. Chapter 2 showed how an NNL theory develops moral norms. The requirements of practical rationality were presented and justified as self-evident explications of the function of practical reason. Of particular interest was the seventh requirement, which gives rise to crucial negative moral norms. It was found that three other formulations of this requirement could lay equal claim to apparent self-evidence as Finnis's formulation, the one employed in classical NNL theory. The four competing formulations did not fare equally well when faced with test cases. In Chapter 3, I then embarked on an exposure of some weak points in orthodox NNL theory, where the theory seems to yield moral guidance that runs contrary to strong moral intuitions about the PVS case. The literature on attitudes towards PVS patients and treatment-limiting decisions was reviewed. Moral arguments and premises implicit in these intuitions were derived. In Chapter 4, these arguments were critically examined in light of NNL theory. The arguments entered into a critical dialogue with NNL theory and arguments from other sources – a reflective equilibrium. Some arguments were refuted, some assimilated to more basic arguments, and five remaining arguments were shown to be sound and more or less powerful. These gave rise to four paradoxes in the NNL treatment of the

PVS case, where the moral guidance given by the theory collided severely with the surviving arguments and the moral intuitions on which they are based. The three other formulations of the seventh requirement of practical rationality now again entered the stage, and the real aspect and combination theses were shown to dissolve the paradoxes. To this significant merit was added the fact that these theses outperformed the direct action thesis when confronted with the test cases in Chapter 2. The combination thesis, however, is slightly stronger than the real aspect thesis in that it was able to make sense of one of the test cases (the hacker case) that the real aspect thesis was unable to handle.

Through a process of reflective equilibrium, then, I have argued that the combination thesis is superior to its competitors, and ought to take the place of the direct action thesis in a modified secular NNL theory, which I will from here on call ‘revised NNL theory’ as opposed to (orthodox) NNL theory.

Such a slight modification of the greater theoretical corpus of the NNL theory of ethics could seem like a mostly cosmetic touch. However, it will turn out to have significant consequences. The modification changes NNL’s analysis of the PVS case, as will be detailed below. Dependent on how it is interpreted further, it may have other considerable normative consequences in the final chapter’s discussion of the ethical aspects of other end-of-life issues, as well.

#### **4.7 Moral status and the right to life**

I have argued that a revised version of NNL theory, in which the ‘combination thesis’ is substituted for the ‘direct action thesis’, should be accepted. The combination thesis was formulated as ‘Respect each real aspect of a human being’s fulfilment in every action’.

Furthermore, it was argued that although biological life is in itself a basic human good, there are situations in which biological life is not a real aspect of the person’s human fulfilment. In these situations, the combination thesis does not rule out intentional actions against the person’s life. Therefore, the combination thesis does not rule out intentional killing of the PVS patient in situations in which the patient’s life is rightly judged to not contribute to the patient’s human fulfilment.

However, it would be too quick to accept the conclusion (unpalatable to many) that killing the patient through lethal injection (or even shooting, or other means)



would be morally acceptable. Even though such actions are not ruled out by the combination thesis, there may be *other* moral norms that would forbid the intentional killing of the patient.

One such norm could be the moral prohibition on killing beings that have moral status and a right to life. That is, even though a given person's biological existence does not contribute to his fulfilment, it could be morally wrong to intend the person's death, because the *person* is still there, with his Kantian-sense dignity and moral status intact.

Many writers in the new and classical natural law traditions embrace the account of a person's right to life often called *the substance view*.<sup>84</sup> This account is especially invoked in debates on the moral status of unborn human life, but it also attempts to ground the moral value of humans in general. According to the substance view, a human being is a substance (in the Aristotelian sense of an independently existing thing) from conception until death. This substance partakes in our shared human nature, which is a rational nature. Until death ensues, all change, such as growth, development or degeneration of the nervous system, and aging is *accidental*, not *substantial*. It is the same human substance that subsists through the changes. The moral status of the human being follows from its rational nature. The human being's rational nature makes it a *person* in the moral sense – a being that has certain rights, most fundamentally *the right to life*. The right to life enjoyed by persons is a right not to suffer intentional bodily harm, including death.

Why does moral status spring from rational nature in a natural law view? According to NNL theory, my practical reason grasps the basic human goods as opportunities for fulfilment. However, it is also grasped that the goods do not only fulfil *me* – they fulfil all beings relevantly like me. As Patrick Lee writes,

I do not apprehend merely that *my* life or knowledge is intrinsically good and to be pursued. I apprehend that life and knowledge, whether instantiated in me or in others, are good and worth pursuing ... the basic goods worthy of pursuit are *intelligible*

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<sup>84</sup> See especially Patrick Lee, "The Basis for Being a Subject of Rights: The Natural Law Position," in *Reason, Morality, and Law. The Philosophy of John Finnis*, eds. John Keown and Robert P. George (Oxford: Oxford University Press, 2013); Francis J. Beckwith, *Defending Life. A Moral and Legal Case against Abortion Choice* (Cambridge: Cambridge University Press, 2007); Christopher Kaczor, *The Ethics of Abortion. Women's Rights, Human Life, and the Question of Justice*, (New York: Routledge, 2011); George and Tollefsen, *Embryo*; Lee and George, *Body-Self Dualism*.

*goods*, and so the basic goods of rational beings ... the responsibility toward goods to be pursued extends to the goods, including the being and fulfillment, of all those who can – either now, or potentially – understand these goods as worth pursuing.<sup>85</sup>

Thus, being a rational being entails awareness of the basic goods and a certain responsibility for realizing instantiations of these goods in my own life and in the lives of beings relevantly similar to me.

The case can also be made in terms of human dignity. Intrinsic dignity, writes Daniel P. Sulmasy, is ‘the value that human beings have simply by virtue of the fact that they are human beings’.<sup>86</sup> And furthermore,

‘Intrinsic dignity’ is just the name we give to the special type of intrinsic value that belongs to members of natural kinds that have kind-specific capacities for language, rationality, love, free will, moral agency, creativity, aesthetic sensibility, and an ability to grasp the finite and the infinite.<sup>87</sup>

The PVS patient, being a living human being, shares in the rational human nature. Therefore, he is a person in the moral sense, with a right to life and intrinsic dignity. The patient is a ‘rights-bearer’, a subject of rights, and must be treated accordingly. It does not matter that the patient’s biological existence currently does not contribute to his human fulfillment. This by no means changes the intrinsic *nature* of the patient. He is still an individual with a rational nature.

An obvious challenge to this view is: how can the patient rightly be said to have a rational nature, seeing as how he cannot – neither presently nor in the future – be capable of exercising rationality? This problem is analogous to the case of anencephalic foetuses, a case treated extensively by adherents to the substance view. This is, arguably, the weakest point of the substance view. The usual retort is to explain the concept of substance in more detail. A substance’s nature does not change in accordance with any changes to what it is capable of (its active potentiality). Rather, the substance is what persists through changes – it is the thing to which changes occur. The nature of a substance does not change. Rather, the nature or essence is that which does not change as long as the substance remains what it is.

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<sup>85</sup> Lee, “The Basis for Being a Subject of Rights,” 241-42.

<sup>86</sup> Sulmasy, “Dignity and Bioethics,” 473.

<sup>87</sup> *Ibid.*, 476.

Both for the PVS patient and for the anencephalic foetus, a severe defect in the nervous system blocks the exercise of the radical capacity (i.e., passive potentiality) for rationality. However, this radical capacity for rationality still belongs to what-they-are, to the natures of the kinds of beings they are. As Lee says, ‘Every human being ... [possesses] the basic natural capacity to reason and make deliberate choices, but they may also suffer from some impairment that prevents the actualization of that capacity’.<sup>88</sup>

The PVS patient, then, is a person and possesses human dignity. Therefore, it seems he cannot be intentionally harmed without acting contrary to his right to life.

#### 4.7.1 A dilemma

However, the conclusion above may be too quick, for how is the principle of respect for beings of a rational nature justified? How is the principle connected to the NNL corpus of moral norms? According to Finnis, his own seventh requirement of practical reasonableness plays the crucial role here: ‘The seventh requirement [is] the principle on which alone rests ... the strict inviolability of basic human rights’.<sup>89</sup>

To the revised NNL theory treatment of the PVS case this creates a puzzle. On one hand, the patient is entitled to respect, since he is of a rational nature. On the other hand, the principle of respect for persons is grounded in the seventh requirement’s prohibition on intentional actions against basic human goods. But the seventh requirement of the revised theory does *not* forbid intentional actions against the patient’s life, as his biological existence currently does not contribute to his human fulfilment. Killing the patient, although incompatible with proper respect for persons, does not deprive him of any genuine flourishing.

The proponent of the revised theory here faces a dilemma. *Either* he accepts Finnis’s view of the justification of rights and then concedes that the PVS patient does *not* have inviolable human rights, including the right not to be killed. However, this may seem unattractive in that the patient *is* a being of a rational nature, the kind that has intrinsic dignity and the associated human rights.

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<sup>88</sup> Lee, “The Basis for Being a Subject of Rights,” 243.

<sup>89</sup> Finnis, *Natural Law and Natural Rights*, 121.

*Or* the proponent of the revised theory searches for another justification for human rights in the natural law theory. Can justifications for absolute human rights, justifications that complement Finnis's appeal to the seventh requirement, be found?

My argument bifurcates at this junction. I find the second option just mentioned the most plausible, but my argument for this, as will be supplied presently, appears to me less than fully satisfactory. Therefore, the first option remains a live one.

#### 4.7.2 Revised new natural law theory, first interpretation: respect persons

I shall start with the second horn of the dilemma and attempt to justify by revised NNL reasoning the PVS patient's right not to be intentionally killed. A fundamental tenet of NNL is that all reasons for action, including the second-order reasons for action that together constitute morality, ultimately must spring from considerations of human goods. The proposed justification must therefore remain connected to considerations of the basic human goods, and cannot be 'free-floating'. Thus, it is inadequate to simply state that respect for dignity is owed to all beings of a rational nature, and leave it at that. A deeper explanation invoking basic precepts of NNL must be provided.

Lee seems right in that practical reason's grasp of the basic goods includes the insight that participation in the goods is perfective not only of me, but of beings relevantly like me; namely, of beings for whom the goods are *intelligible goods*; that is, for beings of a rational nature. Lee argued that this insight commands a certain respect for such beings. As was shown above, a parallel argument in terms of *intrinsic dignity* could also be made; beings for whom the basic goods are intelligible and perfective possess intrinsic dignity, implying that they must not be intentionally harmed.

It appears, therefore, that there is a very short step from our grasping that the goods are perfective for beings-like-me, to our grasping that beings-like-me command a certain *respect*. Arguably, the latter insight is also grasped as self-evident for our practical reason. So perhaps there is an additional, an 11th, requirement of practical reasonableness, to the effect that one must 'respect individuals whose flourishing consists in realization of the basic human goods'. All requirements of practical reasonableness must be rooted in consideration of the basic goods. And indeed this

11th requirement is: it is rooted in the grasped significance of being an individual whose flourishing consists in the pursuit of the basic human goods.

The proposal can perhaps be strengthened by pointing to strong moral intuitions that apparently cannot be justified in other ways. Consider the norm of treating dead human bodies with respect. As no basic human goods pertaining to the deceased individual are at stake here, something like the 11th requirement must perhaps be invoked to explain why not showing proper respect for the body is morally wrong. Because the body was an individual whose flourishing consisted in realization of the basic human goods, the body commands respect even when dead.

However, this present line of argument can also be challenged: in the case of the PVS patient, no pursuit of the goods contributing to human fulfilment takes place. Thus the requirement of respect for an individual's pursuit of the goods arguably does not apply to the PVS patient: there is no pursuit-of-the-goods to protect.

This line of argument appears to me to be promising but, due to the challenge just given, inconclusive. If, however, the argument is stipulated to be true, the following can be summed up about the PVS patient: he or she is a human being with a rational nature, a person in the moral sense, possessing intrinsic dignity. From this springs the patient's moral right not to suffer intentional harm. This moral right protects persons and their participation in the good of life. For all other basic goods, however, the revised seventh requirement of practical reasonableness is still decisive: there is no moral norm against intentionally attacking instances of such goods when these instances do not contribute to a person's fulfilment. This last point arguably comports well with a strong intuition: there is something about the good of life that commands a deeper respect compared to the other basic goods. Here this intuition is explained or preserved in the differential treatment of the good of life, to which in all instantiations great respect is always owed, compared to the other basic goods, which can legitimately be intentionally attacked in particular (and rare) circumstances.

Revised NNL theory, on this first interpretation, does not allow intentional killing of the PVS patient. This prohibition is not due to the seventh requirement of practical rationality, but to the norms forbidding intentional harm to persons. In this respect, revised NNL adjudges in line with NNL. However, NNL is committed to considering continued existence in PVS to be a good and a benefit. But for revised NNL, life in PVS, though formally an instance of basic good, does not contribute to the person's human fulfilment. Thus there *is no benefit* resulting from continued life-

prolonging treatment. Such continued treatment, provision of ANH included, is then *futile*. Futile treatment ought not to be provided, and ought therefore to be removed. The intention in removing ANH is not to kill the patient – that would be an immoral intention forbidden by respect for persons – but simply to remove futile treatment. The patient’s death comes as a foreseen but unintended side-effect.

The revised NNL (first interpretation) view of treatment decisions for PVS patients can now be sketched: when a judgment that the diagnosis of PVS is correct, and the condition permanent, can be made with sufficient precision, the PVS patient may rightly be said to not derive any benefit from continued life. The patient still instantiates the basic good of life, but this is no longer a good *to* him, and therefore neither a reason for action. Continued life is no longer an aspect of his human fulfilment. Therefore there is no benefit in continued provision of life-prolonging treatment: ANH, antibiotics for intercurrent infection, and any additional treatment modalities such as dialysis and ventilators. Such treatment is rightly deemed futile, and therefore, in this view, morally not only *can*, but *ought* to be withdrawn. Ordinary nursing care, on the other hand, still achieves its purpose in maintaining basic bodily integrity and promoting dignity, and therefore should be continued. Life-prolonging treatment is withdrawn with a morally upright intention, namely to cease providing futile treatment. The patient dies as a foreseen but unintended consequence.

Remember, this view contrasts with the ‘orthodox’ NNL view in that in the latter account, life-prolonging treatment necessarily provides a benefit, namely continued biological life. Therefore it is morally unacceptable to withdraw it, unless there are special (and, in PVS, quite uncommon) circumstances in which burdens of treatment outweigh the benefits.

#### 4.7.3 Revised NNL theory, second interpretation: accept intentional harm

If the above reasoning is judged unconvincing, the second horn of the dilemma must be accepted instead. One then accepts that revised NNL does *not* exclude the intentional killing of the PVS patient. Even though the patient is a human being with a rational nature, a person possessing intrinsic dignity, his special circumstances – the total inability to pursue goods contributing to human flourishing – means that there is no justification for a moral right not to suffer intentional harm. Such a moral right is meant to protect the pursuit of the goods, and in this case there is no such pursuit to

protect – no basic human goods contributing to fulfilment are at stake. This thesis, then, drives a wedge between those persons with intrinsic dignity who have the right not to suffer intentional harm, and those persons who have not. Having intrinsic dignity no longer implies such a right.

However, even though the PVS patient does not have a moral right not to suffer intentional harm in the strict sense, this does not mean that there are no moral strictures on how the patient can be treated. There are five important ethical considerations that constrain the treatment to which a PVS patient can be subjected.

First, the patient remains a human being, a person with intrinsic dignity. Even though these facts do not in this case imply a right not to suffer any intentional harm, the patient must be treated with a certain, fitting respect. Even though it is judged that the person is no longer capable of pursuing human flourishing, it is not inconsequential how the person is treated.

Second, a blanket ethical approval of any treatment of the patient would have numerous and strong negative consequences in practice, such as distress for the patient's relatives and the health care personnel caring for the patient.

Third, even though killing the PVS patient would not be unethical as such, overt killing of the PVS patient (including poisoning or shooting) could perhaps still be an action with significant negative symbolic value, and could aid the cultivation of harmful attitudes towards the value of human life. It could be thought to fuel the brutalization of culture and individuals. In addition, it could be perceived to introduce actions into medicine that are inimical to its traditional purpose and ethics.

Fourth, there is the practical problem of distinguishing human rights-bearers from the small subset of human *non*-rights-bearers, such as PVS patients. Even though the latter do not have a right to life, it could be pernicious to sort citizens into those who have the right not to be killed, and those who do *not* have the right not to be killed – and to give physicians or external observers the authority to do the sorting. This is especially so considering that in practice, a misdiagnosis of PVS is quite often made for patients who retain some consciousness – and therefore may have a right to life after all (see 3.2.1).

Finally, there is absolutely no *need* for overt violence in the PVS case. When the verdict is reached that continued life-prolonging treatment (including ANH) does not contribute to the patient's fulfilment, then such treatment can be withdrawn. The patient's peaceful death will ensue. A significant difference from the first

interpretation, though, discussed in the section above, is that death in the present case could in principle *rightly be intended* as a main purpose of the treatment withdrawal, and not only considered as an unintended side-effect.

In sum, therefore, there are five reasons for restricting the means of bringing about the PVS patient's death to the withdrawal of treatment. Even though the intentional killing of the patient by all and any means is not ruled out by the seventh requirement of practical reasonableness, there are several other ethically weighty considerations that together give grounds for restricting the options.

#### 4.7.4 Revised NNL theory

This chapter has argued that NNL theory must be revised. Two competing interpretations of the revised theory were outlined. The first interpretation, implying differential treatment of the good of life and the other basic goods, is preferable in my view. However, I have doubts whether it can be established conclusively. Therefore, there was a need to sketch a rival, second interpretation.

Perhaps many readers will balk at the exposition of the PVS case in light of the second interpretation of revised NNL, given above. The charge that this treatment of the case is unacceptable because of its conflict with strong intentions will be put into the context of a more general criticism of my approach in the final section of the concluding chapter (5.8).

Equipped with a revised NNL theory, it is now time to discuss the ethics of some other crucial decisions at the end of life. Because two rival interpretations of the theory remain possible, both will be brought to bear on the topics discussed.



## 5 Euthanasia and other issues at the end of life

Finally, we turn to other medico-ethical dilemmas at the end of life. In this final chapter, euthanasia and physician-assisted suicide, treatment-limiting decisions, palliative sedation, voluntarily stopping eating and drinking, the minimally conscious state, and the locked-in syndrome will all be discussed. Major ethical dilemmas are outlined, then considered in light of the revised NNL theory in its two interpretations.

### 5.1 Euthanasia and physician-assisted suicide<sup>1</sup>

The topics of euthanasia and physician-assisted suicide (PAS) have garnered a lot of attention – scholarly, political, and popular. There is no lack of discussions of the ethics of euthanasia in the academic literature, and so I will here concentrate on the questions that are most pressing in an NNL view. A revised NNL approach must first and foremost attempt to answer two questions: first, whether euthanasia can be squared with ethical norms against killing, and second, whether the institutionalization of euthanasia would promote or damage society's common good. Finally, it will be shown how some important arguments for euthanasia – as voiced by some prominent proponents – can be assessed and countered from NNL premises.

#### 5.1.1 Definitions

For the last decade much of the international scholarly debate has made use of the Dutch definitions of euthanasia and PAS:

*Euthanasia*: A doctor intentionally killing a person by the administration of drugs, at that person's voluntary and competent request.<sup>2</sup>

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<sup>1</sup> My treatment of these topics draws partly on a chapter from my book: *Menneskeverd i klinikk og politikk. Bioetikk i lys av kristen tro* (Oslo: Lunde forlag, 2013), 113-37.

<sup>2</sup> Lars Johan Materstvedt et al., "Euthanasia and physician-assisted suicide: a view from an EAPC Ethics Task Force," *Palliative Medicine* 17 (2003): 98.; cf. John Griffiths, Heleen Weyers, and Maurice Adams, eds., *Euthanasia and Law in Europe* (Oxford: Hart Publishing, 2008), 2.

*Physician-assisted suicide*: A doctor intentionally helping a person to commit suicide by providing drugs for self-administration, at that person's voluntary and competent request.<sup>3</sup>

The ethics of euthanasia and PAS is a complex issue that too often has been made unnecessarily complex and confusing by the application of less well-suited definitions and concepts. In Norwegian, the prime example of the latter is the time-honoured distinction between 'aktiv dødshjelp' ('active aid in dying') and 'passiv dødshjelp' ('passive aid in dying'). The first concept (usually) corresponds to the concepts euthanasia and PAS combined, whereas the latter (usually) is taken to mean treatment-limiting decisions. Many, especially critics of euthanasia and PAS, would argue that it is most unfortunate to assign such similar labels to practices which in reality are clinically and morally fundamentally distinct. The labels invite retorts like, 'Seeing as passive aid in dying is universally accepted, it is a small step to accept active aid in dying as well'. In the eyes of critics of euthanasia and PAS (though not necessarily in the eyes of defenders of these practices), the terms obfuscate vital clinical and ethical distinctions. For instance, in a Norwegian textbook of Christian ethics, the corresponding terms 'passive and active euthanasia' are introduced. The authors then go on to state that 'the borders between these forms of euthanasia are not always easy to draw'.<sup>4</sup> My contention is that it is the reliance on the unhelpful pair of terms that obscure the salient ethical distinctions for the authors. These distinctions will be drawn and defended throughout the chapter.

Some other definitions are also crucial to the ethical analysis of this field. A *medical killing* is *non-voluntary* where the person is unable to consent, and *involuntary* where the person is able to consent but has not consented.<sup>5</sup> Such actions are not *euthanasia* properly speaking, as euthanasia is voluntary only. *Limitation of treatment*, a *treatment-limiting decision* (or *non-treatment decision, NTD*), or *letting die* designate the decision to withdraw or withhold treatment that potentially could have prolonged the life of a seriously ill patient (see 5.2). Finally, *palliative care* or *palliation* is active treatment and nursing care for patients with a disease that cannot be cured and who typically have a short life expectancy. In such situations, the

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<sup>3</sup> Materstvedt et al., "Euthanasia and physician-assisted suicide," 98.

<sup>4</sup> Gunnar Heiene and Svein Olaf Thorbjørnsen, *Kristen etikk – en innføring* (Oslo: Universitetsforlaget, 2011).

<sup>5</sup> Materstvedt et al., "Euthanasia and physician-assisted suicide."

alleviation of the patient’s physical pain and other symptoms becomes the overriding goal, together with measures aimed at psychological, social, and spiritual and existential problems. The goal of palliative care is to improve quality of life in the last stages of life.

### 5.1.2 Laws on euthanasia and PAS

Euthanasia and PAS are discussed vigorously in the public square in many Western countries. Presently, four countries and four American states allow one or both of these practices (see Table 1).

**Table 1.** *Jurisdictions in which euthanasia or physician-assisted suicide are allowed.*<sup>6</sup>

<b>Jurisdiction</b>	<b>Euthanasia and/or PAS</b>	<b>Year legalized</b>
The Netherlands	Both euthanasia and PAS	2002; tolerated since 1973
Belgium	Both euthanasia and PAS	2002
Luxembourg	Both euthanasia and PAS	2009
Switzerland	Assisted suicide	
Oregon (USA)	PAS	1997
Washington (USA)	PAS	2008
Montana (USA)	PAS	2010
Vermont (USA)	PAS	2013

As for Norway, the Norwegian penal code (Straffeloven) forbids killing (§ 233) and assistance with suicide (§ 236). The punishment can be lowered below the standard minimum if the killing or assistance was motivated by ‘compassion (...) for a hopelessly ill’ individual, or performed with the person’s consent (§ 235).

<sup>6</sup> Griffiths, Weyers, and Adams, *Euthanasia and Law in Europe*.

### 5.1.3 Are there ethically relevant differences between euthanasia and physician-assisted suicide?

Many theorists consider the physician's contribution in euthanasia and PAS, respectively, to be on a par ethically. The reason is that both actions – either the *injection* or *writing of a prescription* (or other means of provision) of lethal medication – imply sharing the person's suicidal intention. In addition, each constitutes a central step in the process, and a necessary condition for the accomplishment of the suicide. This is the natural law view also: the intention, which is the moral object chosen and the plan embraced, is the ethically crucial feature of the action (2.5). In typical cases, the ethical evaluation is unaffected by whether the suicidal intention was accomplished through euthanasia or PAS. Directly and in themselves, then, euthanasia and PAS are morally equivalent. In the present discussion I will mainly, for brevity's sake, speak of euthanasia.

However, when the emphasis is not solely on the ethicality of the physician's actions, differences between euthanasia and PAS emerge that may be ethically relevant. Some who accept PAS think it preferable to euthanasia because an external observer can be more certain that the suicide is truly the person's own decision, as the person him- or herself performs the final step of the causal chain leading to death, the ingestion of the lethal drugs. Thus, PAS may be less prone to abuse than euthanasia.<sup>7</sup>

### 5.1.4 Does euthanasia imply the violation of a moral absolute?

Many considerations, empirical and theoretical, are relevant in an NNL evaluation of the question of euthanasia. However, two topics are of particular importance from this perspective, and may be decisive. When phrased as questions, the first is, does euthanasia imply the *violation of a moral absolute*? In that case, euthanasia is unethical, in and of itself and regardless of the further circumstances. The second is, does a practice of euthanasia somehow *promote or damage the common good*, the

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<sup>7</sup> It is worth mentioning here that PAS sometimes fails – due, e.g., to the patient vomiting after ingesting the drugs, or the drugs not having the desired effect. In a 2000 study from The Netherlands, there were problems with completion in 15% of PAS cases. In 21 out of 114 cases in which PAS had been the intention, the physician ended up administering the lethal drugs. PAS was thus converted to euthanasia: Johanna H. Groenewoud et al., “Clinical problems with the performance of euthanasia and physician-assisted suicide in the Netherlands,” *New England Journal of Medicine* 342 (2000). Such ‘conversion’ to euthanasia would be illegal in the four US states that have legalized PAS.

societal conditions for individual and collective pursuit of flourishing? If there are reasons to suspect the latter, as will be argued below, then this is a strong argument against the *institutionalization* of euthanasia, although not necessarily against *every particular act* of euthanasia. These two questions will now be examined in turn.

Most writers on this question from a new or classical natural law perspective maintain that euthanasia does indeed violate the moral absolute against killing innocent human beings, and thus is unethical.<sup>8</sup> For instance, Paterson writes:

Since suicide, assisted suicide and voluntary euthanasia are all species of the genus homicide ... they all fall under the scope of a concrete moral absolute prohibiting the intentional killing of an innocent person, regardless of any further appeal to end or consequences.<sup>9</sup>

According to Finnis, euthanasia is incompatible with respect for the person:

In short, human bodily life is the life of a person and has the dignity of the person. Every human being is equal precisely in having that human life which is also humanity and personhood, and thus that dignity and intrinsic value ... In sustaining human bodily life, in however impaired a condition, one is sustaining the person whose life it is. In refusing to choose to violate it, one respects the person in the most fundamental and indispensable way.<sup>10</sup>

The intentional killing of an innocent human being is always irrational because the damage to the basic good of life intended cannot be outweighed by other practical reasons. This is due to the incommensurability of the basic goods: ‘The basic goods are aspects of the human persons who can participate in them, and their instantiations in particular persons cannot, as reasons for action, be rationally commensurated with one another’.<sup>11</sup>

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<sup>8</sup> What does *innocence* have to do with euthanasia? Not much; however, natural law’s traditional prohibition on killing is formulated to explicitly exclude the killing of the *non*-innocent, as was discussed in 2.6.2. Killing the latter may, arguably, sometimes be acceptable.

<sup>9</sup> Paterson, *Assisted Suicide and Euthanasia*, 104.

<sup>10</sup> Finnis, “A Philosophical Case Against Euthanasia,” 32.

<sup>11</sup> *Ibid.*, 29.

Grisez and Boyle state that ‘suicide which is killing in the strict sense is necessarily immoral simply because it violates the basic good of human life’.<sup>12</sup> Similarly, Lee and George state that euthanasia and suicide are wrong because ‘they are choices contrary to the intrinsic good of a human person. Such acts are contrary to the openness to the fulfillment of oneself and others, which is the standard (...) for morality’.<sup>13</sup> To act against life for the sake of ending pain and other symptoms implies subordinating a basic good (life) to another good (the absence of pain). It thus involves treating what is in fact a basic good as though it was not. This is practically unreasonable, and incompatible with the will towards integral human fulfillment mandated by the first principle of morality.

The writers typically go on to discuss many other aspects of the ethics of euthanasia, but in the end it is made clear that the moral absolute really settles the case. And, in a way, the discussion could have ended with the demonstration that the moral absolute applies. Thus, with these writers one is sometimes left wondering what point there is in the detailed discussion of other aspects of the case of euthanasia if the moral absolute settles the case.

Such invocation of moral absolutes – on this, as on other bioethical issues – sometimes attracts a certain (predictable) kind of criticism. The writer who contends that the absolute settles the case may be charged with dogmatism, with not having attended carefully to the true complexity of the case and the infinite variations offered by particular concrete cases. Furthermore, the theorist may even have an excessively theoretical (and thus inadequate) approach to the matter, thus missing crucial nuances and facts of the case. The theorist may even appear unable to take seriously the human suffering involved, and charges of a lack of empathy may be implicit. The theorist who appeals to a moral absolute may in principle answer these charges along (at least) two lines: firstly, the absolute is not asserted dogmatically or taken from thin air, but rather is rooted in arguments, even deduced logically from first principles. The theorist’s moral theory is a body of propositions that together attempt to *prove* the moral principles, including the absolutes. Secondly, the theorist will attempt to show that yielding to the absolute is really not unreasonable in light of human experience when interpreted soberly and in light of our other (ethical) knowledge.

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<sup>12</sup> Germain Grisez and Joseph M. Boyle, *Life and death with liberty and justice. A contribution to the euthanasia debate* (Indiana: University of Notre Dame Press, 1979), 411.

<sup>13</sup> Lee and George, *Body-Self Dualism*, 155.

Note that the moral absolutes brought forth by NNL and my revised NNL do not make particular reference to killings in a medical context. The scope of the absolutes is wider than that, encompassing all killing of the innocent in any situation. Thus, a consistent NNL theorist must hold that ‘mercy killings’ were wrong 200 years ago as well, before the advent of modern palliative care; that such killings are also wrong today in underdeveloped countries where the scant medical care available bears little resemblance to the advanced palliative care available in Western countries; and that mercy killing is a morally deficient response even in extreme cases such as the following:

You are the co-pilot of a plane that crashes dramatically in an unpopulated mountainous region. The main pilot and yourself are the sole survivors. However, your colleague is stuck in his seat with life-threatening burns, is screaming in agony and is bound for a horrible death within minutes. You have a gun at hand and have the choice to kill him now, to spare him hours of agonized dying, or to watch as he suffers a painful death.<sup>14</sup>

I contend that it is many people’s intuition that shooting and killing the pilot is an acceptable choice in this situation, perhaps even a morally laudable or obligatory choice. My point is that the critic of euthanasia who defends the moral absolute against killing innocents is committed to uphold the absolute in such cases as well.<sup>15</sup> On the other hand, the euthanasia critic who does not rely on the moral absolute can grant that mercy killings in extreme circumstances may be morally acceptable, but that there are decisive reasons for not allowing killing in the medical realm.

As discussed (2.4.1), the NNL theory’s direct action thesis leads to a moral prohibition on the killing of innocents. *Revised* NNL, on the other hand, has substituted the combination thesis for the direct action thesis. The moral prohibition on killing must thus be shaped by this thesis. The principle becomes, ‘Respect human life when it constitutes a real aspect of the person’s fulfilment’. This implies that one

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<sup>14</sup> This is based on a real case from Sweden that was referenced in Lars Johan Materstvedt, Aslak Syse, and Petter C. Borchgrevink, “Straffelovkommisjonen om aktiv dødshjelp [Law committee on active euthanasia],” *Tidsskr nor legeforen* 125 (2005).

<sup>15</sup> Perhaps even in the following case: A mad scientist threatens to blow up the entire world unless you kill an innocent person. Will you comply with the killing and thus avert disaster? Or will you uphold the moral absolute against killing, thus risking, literally, the end of the world?

should not kill innocents whose biological life constitutes a real aspect of their fulfilment as human beings – that is, actually contributes to their flourishing. On the first interpretation of revised NNL, the above principle need not be decisive, for in this interpretation, there is an additional, independent ethical principle ruling out the intentional killing of human beings, regardless of whether their life currently contributes to human fulfilment (4.7.2). It is practically unreasonable to destroy that which characteristically has its fulfilment in the pursuit of the basic human goods.

In the second interpretation of revised NNL, on the other hand, there is no such additional principle: the norms on intentional killing are shaped by the seventh requirement alone. Then the crucial question for the defender of revised NNL becomes: *what characterizes lives in which biological existence has ceased to be a real aspect of the person's fulfilment?*

In The Netherlands, as will be discussed more thoroughly later on, euthanasia is allowed when suffering is 'unbearable' with 'no prospect of improvement'. The law does not differentiate between somatic and psychiatric suffering, and so PAS is an option for patients with psychiatric suffering.<sup>16</sup> Further, the law does not require life-expectancy to be limited, so suffering from chronic conditions is on a par with suffering from terminal disease. Consider the following case:<sup>17</sup>

In a case which has attracted world attention, Belgian doctors have announced that a fortnight before Christmas [in 2012] they euthanased 45-year-old deaf identical twins who were going blind and thought that they had nothing to live for. Marc and Eddy Verbessem were born deaf. They never married and lived together, working as cobblers. When they discovered that they had another congenital disorder, a form of glaucoma, they asked for euthanasia. According to their local doctor, David Dufour, they had other medical problems as well. 'All that together made life unbearable,' he told the London Telegraph. 'I have been very surprised but there is so much interest and debate about this'. He described their final moments: 'They were very happy. It was a relief to see the end of their suffering. They had a cup of coffee in the hall, it went well and [they had] a rich conversation. The separation from their parents and brother was very serene and beautiful. At the last there was a little wave of their hands and then they were gone.' Under Belgian law euthanasia is allowed if 'the

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<sup>16</sup> The Dutch courts accept PAS only, not euthanasia, in the context of psychiatric suffering.

<sup>17</sup> From Cook, M. "Belgian twins euthanased because they 'had nothing to live for,'" [http://www.bioedge.org/index.php/bioethics/bioethics\\_article/10363](http://www.bioedge.org/index.php/bioethics/bioethics_article/10363) (accessed Jun. 25, 2013).



patient is in a medically futile condition of constant and unbearable physical or mental suffering that cannot be alleviated, resulting from a serious and incurable disorder caused by illness or accident'. Critics point out that the Verbessem brothers were not terminally ill nor suffering physical pain. In fact, it took the men two years to find doctors who would agree to help them. A doctor at their local hospital said, 'I do not think this was what the legislation meant by "unbearable suffering"'. Professor Wim Distelmans, a right-to-die activist who was the other doctor involved in the decision to euthanase the men, based his own assessment on their psychological suffering. 'It's the first time in the world that a "double euthanasia" has been performed on brothers. There was certainly unbearable psychological suffering for them. Though [it is of course] always possible to stretch the interpretation of that. One doctor will evaluate differently than the other.'

The case raises a lot of issues, but in focus currently is what can be said about the existence the brothers decided to end. The doctor judged their handicaps to entail 'unbearable psychological suffering'. The brothers judged the cessation of life to be *preferable* to continued living. However, though their handicaps were becoming severe, it seems obvious that they were still able to realize many forms of human flourishing (including, but not limited to, friendship) to a certain extent. The subjective verdict that one is, all things considered, better off dead, does not imply that one is incapable of human flourishing and participation in human goods. It appears, then, that one's wish that life would end does not logically entail that life has ceased being a real aspect of one's fulfilment. Whether one is experiencing 'unbearable suffering' can, arguably, be ascertained by the person herself, as it is of the essence of suffering to be subjectively experienced. On the other hand, whether one's life contributes to human fulfilment cannot only be assessed by the subject, but in principle also by an external observer. The notion of *contribution to human fulfilment* is objective, whereas *suffering* is subjective. This means that a judgment that the life of oneself or another is or is not currently contributing to human fulfilment could, logically, be *mistaken*.

Consider next the case of a patient with terminal cancer of the tonsils. These cancers can in some cases grow so as to involve facial disfigurement, breathing problems, and pain that is difficult to alleviate. Consider a severe case in which palliation has been largely unsuccessful, the patient suffers physically and psychologically, remains cognitively intact and is considered to have only days left to

live. If this patient longed for death to end her suffering, what could be said about the value of her participation in the good of life?

In my view, the case shows that suffering can be so intense, unceasing and pervasive as to preclude any participation in human flourishing. In such a case, there can be no meaningful pursuit of human fulfilment, nor of the goods in which fulfilment consists. Then neither will the patient's biological existence contribute to fulfilment.

However, for *any* meaningful participation in the goods to be unachievable, the condition must be extreme indeed. It is only when the suffering is intense, constant, and cannot be palliated, that one can truly and objectively say that there is *no* meaningful pursuit of the goods. In most terminal phases with severe physical and psychological symptoms, the natural course or palliative treatment allows for intervals of calm and possibility for meaningful experiences, e.g., of friendship. Revised NNL gives no sense to the pangs of existence 'outweighing' participation in the goods. In this view, the patient's participation in the good of life or the other goods *are* real aspects of fulfilment no matter the downsides to continued existence.

What then becomes of the moral absolute against killing? According to the first interpretation of revised NNL (which is the one I favour; 4.7.2), an intentional attack on the good of life in the form of euthanasia or PAS would be contrary to the person's intrinsic dignity and right to life – no matter the person's own wishes, physical or psychological suffering, or degree of human flourishing. The moral absolute against killing encompasses all cases of euthanasia and PAS.

According to the second interpretation, most cases of euthanasia or PAS would be unethical, because they would amount to intentional attacks on the basic good of life so far as this is a real aspect of the person's human fulfilment. However, this interpretation acknowledges that there are extreme situations in which living does *not* contribute to the person's fulfilment, due to intense, constant, unceasing suffering that cannot be palliated. In such extreme cases, intentional actions against the good of life (including killing) are not in themselves unethical.

### 5.1.5 Does the institutionalization of euthanasia damage the common good?

NNL theory points to the fundamental importance of the basic human goods in human lives. The defining feature of the good society is that it is conducive to pursuit of the goods. Societal conditions influence the ways in and the ease with which citizens may pursue the goods. Thus, well-functioning institutions promoting justice and general welfare and a moral climate conducive to the development of individual and collective virtues are the cornerstones of a successful society. In 1.4.11, three senses of ‘common good’ were outlined, and the third sense is the relevant one here: the common good is the set of conditions required for the community to pursue the goods for which it exists. The golden rule demands that one take into account other people’s opportunities for participating in the basic human goods, and the eighth requirement of practical reasonableness, in Finnis’s version, simply states that you should ‘foster the common good of your communities’ (2.2.2). Actions, therefore, also have ethical significance insofar as they promote or impede the common good.

The question now becomes how the institutionalization of euthanasia would change a society in this respect. *Would it damage or promote the conditions that aid human flourishing?* It must be granted for the sake of argument that some instances of euthanasia are in themselves morally acceptable. If this presupposition is not granted then the answer to the question is given: the institutionalization of a procedure that is in itself morally wrong, perhaps gravely so, must clearly damage society’s common good. A full treatment of this question should take into account reasons for thinking that the institutionalization of euthanasia may *promote* the common good; however, because natural lawyers have tended to view such institutionalization as decidedly detrimental, and for the sake of brevity, I will only discuss one side of the question: whether institutionalization damages the common good. However, the discussion will point to premises that would be relevant for the other side of the question as well.<sup>18</sup>

Perhaps the question of how the institutionalization of euthanasia influences the common good is so complex that it cannot be answered decisively. However, at the very least reasons can be given that point in one or the other direction. Cumulatively, justification for holding one or the other conclusion as most well-

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<sup>18</sup> A common good argument *for* the institutionalization of euthanasia could point to the increased space for exercise of autonomy, and perhaps the potential for removing fear of the dying process, thus promoting psychological harmony.

founded can be acquired. Mark well that the present question is both ethical and political. It is the legalization and political institutionalization of euthanasia that is currently pondered. In this perspective, it could turn out that a practice of euthanasia in fact damages the common good and so is problematic (politically and ethically) in an NNL view, whereas a particular act of euthanasia itself nevertheless could be ethically acceptable (as per the presupposition), as the particular act does not imply the institutionalization of euthanasia.

The way I will proceed in trying to answer the question of euthanasia and the common good will be to examine ‘the Dutch experiment’. When The Netherlands legalized euthanasia in 2002, euthanasia had already been institutionalized and commonly accepted for decades. If one wonders how the institutionalization of euthanasia changes a Western society, it is therefore natural to look to the Dutch experiment for answers. Where relevant empirical data is lacking, the discussion will also take into account relevant studies from Belgium and Oregon.

By reviewing the Dutch experiment (particularly through examining empirical data on euthanasia and PAS) I would like to shed light on three main questions that have to do with the common good: 1) Does the institutionalization of euthanasia change attitudes towards human life in general? 2) Does it change attitudes toward society’s vulnerable groups? 3) Is there reason to believe that it damages the professional conduct of the medical profession? The discussion must begin with an account of the development of the practice of euthanasia in the Netherlands.

#### 5.1.5.1 *Euthanasia and physician-assisted suicide in the Netherlands*<sup>19</sup>

Euthanasia has been legally accepted in the Netherlands since the 1970s, beginning with the Postma case in 1973. Dr. Postma was convicted for euthanizing her mother, but the process of outlining criteria for when euthanasia would not lead to prosecution was begun. In the Schoonheim case in 1984, the Supreme Court established that physicians could appeal to the principle of necessity (*force majeure*; article 40 of the penal code) for the legal justification of acts of euthanasia.<sup>20</sup> Detailed criteria for when the principle could be appealed to were put forth by the courts and the Royal

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<sup>19</sup> This section draws on, in particular, Griffiths, Weyers, and Adams, *Euthanasia and Law in Europe*.

<sup>20</sup> J.A. Rietjens et al., “Two Decades of Research on Euthanasia from the Netherlands. What Have We Learnt and What Questions Remain?” *Journal of Bioethical Inquiry* 6 (2009).

Dutch Medical Association, KNMG, and a report system was put in place. However, a considerable under-reporting of cases of euthanasia was discovered. This provided an incentive for more transparent legal regulation of euthanasia. Finally, euthanasia was fully legalized in 2002. The law was considered to be a codification of already (legally, socially and ethically) accepted practices. At the core of the law are the ‘due care criteria’ (see Box 1). Euthanasia must be carried out in accordance with these criteria. Notification is sent to the review committee, which considers whether the criteria are met. If they are not, then the committee can choose to report the physician to the prosecutorial authorities, who can then decide to press charges; between 1999 and 2009, 0.21% of cases were reported to the authorities, but no charges were pressed.<sup>21</sup> Studies indicate that physicians now report to the committee nearly all cases that they themselves consider to be euthanasia.<sup>22</sup> The legalisation of euthanasia does not mean the legal de-regulation of end-of-life practices. On the contrary, legalisation involves tighter control than ever before, through a number of laws and regulations.

1. The patient’s request should be voluntary and well considered.
2. The patient’s suffering should be unbearable and without prospect of improvement.
3. The patient should be informed about their situation and prospects.
4. There are no reasonable alternatives.
5. Another, independent physician should be consulted.
6. The termination of life should be performed with due medical care and attention.

**Box 1.** *Due care criteria of the Dutch euthanasia act.*<sup>23</sup>

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<sup>21</sup> P. Lewis and I. Black, “The Effectiveness of Legal Safeguards in Jurisdictions That Allow Assisted Dying,” (Commission on Assisted Dying, 2012), 14.

<sup>22</sup> Bregje D. Onwuteaka-Philipsen et al., “Trends in end-of-life practices before and after the enactment of the euthanasia law in the Netherlands from 1990 to 2010: a repeated cross-sectional survey,” *The Lancet* (2012).

<sup>23</sup> From H.M. Buiting et al., “Dutch criteria of due care for physician-assisted dying in medical practice: a physician perspective,” *Journal of Medical Ethics* 34 (2008).

Mark well that there is no criterion that the patient be terminally ill. Unbearable suffering caused by a chronic disease suffices. This is in contrast to the Oregon ‘Death with Dignity Act’, in which a necessary condition for PAS is that life expectancy is judged to be six months or less, but where unbearable suffering is not a requirement. Mark also that, in The Netherlands, the patient has no *right* to euthanasia/PAS, and the physician has no corresponding duty to provide it.

In a survey, Buiting et al. examined physicians’ experiences with the due care criteria.<sup>24</sup> Among physicians who had performed euthanasia or PAS, 25% had found the application of the due care criteria to cause problems. Most problems pertained to the evaluation of the patient’s suffering (criterion 2; especially whether the physician herself was convinced that the suffering was unbearable) and whether the request was voluntary and well considered (criterion 1). These findings highlight the problem of demanding an external, objective assertion of a subjective condition (the patient’s suffering).

As for the total number of euthanasia and PAS procedures, the figures (Table 2) vary from year to year, but the trend lately has been for a rather marked increase in the total amount. Some suspect that the increase is even greater than the numbers indicate; confusion about definitions in the 1990s could have resulted in some deaths following treatment-limiting decisions being falsely categorized as euthanasia. This would spuriously inflate the oldest euthanasia numbers, leading to an underestimation of the subsequent increase. PAS constitutes only a small fraction of the total number of procedures. Medical killings without request – often called ‘life ending acts without explicit patient request (LAWER)’ – have been a great concern, but the numbers have decreased substantially (discussed further below).

Note that the figures for 2011 and 2012 cannot be compared directly with the preceding figures (Table 2). The figures for 1990 to 2010 are the researchers’ estimates based on their death certificate study. Here, instances that physicians themselves did not, but the researchers did, consider to be euthanasia/PAS are included (e.g., for 2010, 23% of the total number). 2011-12 numbers, on the other hand, are the official numbers, that is, only the cases reported to the regional committees. The most recent numbers, therefore, strongly indicate a marked rise in true euthanasia cases. If one was to follow the definitions of the researchers in the

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<sup>24</sup> Ibid.

death certificate studies and presuppose a similar non-reporting rate as in 2010, then true 2011-12 numbers would be approximately 23% higher than listed above. Correspondingly, the *official* number of euthanasia and PAS cases for 2010 was 3136.

**Table 2.** *Euthanasia, physician-assisted suicide and medical killings without consent in the Netherlands 1990-2012.* Estimated numbers and percentage of all deaths.<sup>25</sup>

Year	Euthanasia		Physician-assisted suicide		Medical killings without request	
	Number	%	Number	%	Number	%
1990	2300	1.7 %	400	0.2 %	1000	0.8 %
1995	3200	2.4 %	400	0.2 %	900	0.7 %
2001	3500	2.6 %	300	0.2 %	900	0.7 %
2005	2325	1.7 %	100	0.1 %	550	0.4 %
2010	3860	2.8 %	190	0.1 %	*)	0.2 %
2011	3499		196			
2012	4003		185			

\*) Absolute numbers not listed

The results of the 2010 survey are worth studying in some detail.<sup>26</sup> Of all deaths, 2.8% were due to euthanasia, whereas PAS was uncommon (0.1%). Medical killings without request were down to 0.2%, one-fourth of the number in 1990. In all, 45% of requests for euthanasia were granted. Of all deaths, 58% were preceded by an end-of-life decision, most often ‘intensified alleviation of symptoms’ (36%, rising steadily since 1990) or ‘forgoing of life-prolonging treatment’ (18%, steady since 1990). In addition, 12% of deaths were preceded by administration of continuous deep sedation (see 5.3). Furthermore, in 0.4% of cases, death came after the patient voluntarily stopped eating and drinking; almost half of these people had made a euthanasia request that was declined. Euthanasia or PAS were estimated to have shortened the person’s life by a week or more in 58% of cases.<sup>27</sup> Of the cases that the researchers classified as euthanasia or PAS, the physicians agreed with the classification in 77%

<sup>25</sup> 1990-2010 data from Onwuteaka-Philipsen et al., “Trends in end-of-life practices”; this was a death certificate study with similar methodology year for year. 2011-2012 numbers are the cases actually reported to the regional committees (from <http://www.euthanasiecommissie.nl/>, accessed Nov. 18, 2013).

<sup>26</sup> Onwuteaka-Philipsen et al., “Trends in end-of-life practices.”

<sup>27</sup> It is well known that such estimates may be quite inaccurate, sometimes very much so.

of cases, choosing instead the designation ‘ending of life’ in 2%, and ‘palliative or terminal sedation’ in a further 18% (in these latter cases, the traditional ‘euthanatica’, barbiturates and neuromuscular blockers, had not been used).<sup>28</sup> Of the cases that the researchers classified as ‘ending of life without explicit request’, none were classified by physicians as either euthanasia/PAS or ending of life; instead the cases were labelled ‘intensified alleviation of symptoms’ (41%) or ‘palliative or terminal sedation’ (52%). All cases that the physicians labelled as euthanasia or PAS had been reported to the authorities. From 1990 to 2010, the characteristics (age, sex, underlying disease) of patients receiving euthanasia or PAS remained largely unchanged. Euthanasia is most common for people who are younger than the average seriously ill patient, and for cancer patients. It is typically carried out in general practice, rather than in hospitals or (infrequently) nursing homes.

Throughout the years, euthanasia has become legal in an increasing range of situations, mostly through landmark court cases. From 1994, with the Supreme Court ruling in the Chabot case, it has been accepted that *psychiatric diseases* can give rise to unbearable suffering without prospects of improvement, in a manner equal to somatic diseases. Throughout the 2000s, typically two to five patients received PAS for psychiatric diseases annually, rising to 14 patients in 2012.<sup>29</sup> However, *tiredness of life* without any underlying medical condition can arguably also give rise to subjectively experienced unbearable suffering, but the Dutch Supreme Court ruled in the Brongersma case (2002) that tiredness of life cannot justify euthanasia; as the suffering is not caused by medical conditions, the physician has no relevant expertise in such cases. The last word on the matter has not been said, however, and some campaign for an extension of the euthanasia criteria to encompass tiredness of life. The Dutch medical association KNMG’s views will be discussed below.

The 2002 law allowed for euthanasia and PAS for *children over 12 years of age* with parental consent, following from the fact that there was no age limit in the euthanasia law. Furthermore, euthanasia could also be provided in accordance with an *advance directive*, which would be particularly relevant in the case of dementia. This option has not often been made use of, until the last few years when the number of

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<sup>28</sup> The researchers classified cases as euthanasia or PAS if and only if the respondents admitted having ‘administered, supplied, or prescribed drugs with the explicit intention of hastening death’ in conjunction with a patient request: *ibid.*, 910.

<sup>29</sup> <http://www.euthanasiecommissie.nl/overdetoetsingscommissies/jaarverslag/default.asp>, accessed Nov. 18, 2013.



cases has increased, to 42 in 2012.<sup>30</sup> One of several practical problems is the timing – at what point in time are the conditions of the advance directive fulfilled? When exactly should the physician judge that euthanasia is appropriate for the once-autonomous person suffering from dementia (who may even appear content, without signs of suffering)?

The *medical killing of infants* is also accepted in the Netherlands. Mark that this practice is not included in the definition of euthanasia, as infants cannot consent. The so-called Groningen protocol outlines criteria that should be met. The protocol is modelled on the due care criteria for euthanasia. Griffiths et al. (2008) state that approximately 75 infants are killed yearly,<sup>31</sup> but Verhagen (2013) claims that the number subsequently has shrunk to almost zero.<sup>32</sup> According to Verhagen the main reason is that the medical conditions that previously could lead to medical killing in infancy (e.g., spina bifida) now are detected prenatally and aborted selectively. Of more uncertain legal status is the practice of giving neuromuscular blockers (NMBs) to dying infants for whom intensive care (often including ventilator treatment) has been withdrawn. NMBs paralyze the respiratory muscles, quickly leading to death. Verhagen et al. studied deaths in Dutch neonatal intensive care units and found that 95% of deaths before the age of two months followed upon a treatment-limiting decision.<sup>33</sup> Of these 340 infants, NMBs were given to 55. The study included interviews in which clinicians gave three reasons for administering NMBs: first, NMBs were sometimes continued after ventilator treatment was withdrawn, in order to prevent suffering.<sup>34</sup> Second, NMBs were sometimes given to stop the child's gasping. Third, the drugs were sometimes given on parental request or to spare parents of the unpleasant experience of a protracted terminal phase (which could go on for up to or beyond 48 hours) with gasping.<sup>35</sup>

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<sup>30</sup> Ibid.

<sup>31</sup> Griffiths, Weyers, and Adams, *Euthanasia and Law in Europe*.

<sup>32</sup> A.A. Eduard Verhagen, "The Groningen Protocol for newborn euthanasia; which way did the slippery slope tilt?" *Journal of Medical Ethics* 39 (2013).

<sup>33</sup> A.A. Eduard Verhagen et al., "Analgesics, sedatives and neuromuscular blockers as part of end-of-life decisions in Dutch NICUs," *Archives of Disease in Childhood-Fetal and Neonatal Edition* 94 (2009).

<sup>34</sup> NMBs are sometimes given to patients on ventilators in conjunctions with sedatives. In the case where these drugs are continued when the ventilator is withdrawn, death ensues quickly and with complete certainty.

<sup>35</sup> Common practice in Norway is not to use NMBs in this situation. Before ventilator treatment is withdrawn, the parents are thoroughly informed about what to expect in the

The discovery of the 1990 survey that as many as 1000 medical killings without request were performed yearly generated great concern. Since then the number has gone down markedly, and more knowledge has been gathered about this category.<sup>36</sup> There turn out to be four main groups of medical killings without request. First, there are infants who are killed either with or without accordance with the Groningen protocol. Second, a few patients in PVS are killed yearly. Third, there are terminal patients for whom life-sustaining treatment has been withdrawn but where the patient lingers on. In some cases, a physician has administered lethal drugs without a request from the patient, in order to cut short a protracted dying process judged to be undignified or to cause suffering. Fourth, a number of patients, often with cancer, who have short life expectancies (days) but suffer gravely are killed yearly. These medical killings are not euthanasia, for the patient has not given consent – either because the patient is incompetent, or because the physician has not asked. More and more Dutch doctors reject killings without request in principle – the proportion who state that they ‘would never perform’ such killings has risen from 41% in 1990 to 86% in 2005.<sup>37</sup>

As for the future, Griffiths et al., in considering recent development and court cases, speculate that

Dutch law is slowly but steadily moving in the direction of explicit recognition of a doctor’s duty to ensure that his patient dies a ‘humane’ or ‘dignified’ death as a distinct ground for the conflict of duties that lies at the basis of the justification of necessity.<sup>38</sup>

That is, *avoiding a dying process deemed undignified* may become a sufficient justification for medical killings, also in the absence of subjectively experienced suffering and autonomous consent.

Salient features and trends of the Dutch practice of euthanasia and related practices have now been outlined. This provides the backdrop for the examination of three crucial questions about the wider impact of these practices.

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child’s dying hours, including the risk of gasping. The gasping itself is not thought to imply conscious suffering for the child (Trond Markestad, personal communication).

<sup>36</sup> Griffiths, Weyers, and Adams, *Euthanasia and Law in Europe*.

<sup>37</sup> *Ibid.*, 181.

<sup>38</sup> *Ibid.*, 143.

#### 5.1.5.2 *Does the institutionalization of euthanasia change attitudes towards human life and killing?*

One would like to know whether the institutionalization of euthanasia leads to *more* euthanasia procedures, and whether it lowers the threshold for *choosing* (for the patient) or *performing* (for the physician) euthanasia. Furthermore, would people's opinion of what justifies euthanasia change? Will there be more cases of suicide and homicide? These questions are often posed in the particular form of a slippery slope argument. Such arguments are examined towards the end of the section.

#### *The expansion of euthanasia and medical killings*

As shown above, the practice of euthanasia has increased in volume. When evaluating the significance of the increase, it is important to realize that euthanasia will never be a desired alternative for *all* people nearing death. Many die suddenly, or from accidents, or would want to extend their lives as much as possible. A society in which euthanasia has been fully normalized, then, does not have a euthanasia rate of 100%. When this is kept in mind, a euthanasia rate of 2.8% of all deaths – and the recent increase – may be considered very large.<sup>39</sup>

Not only the volume of, but also the *scope of the indications* for euthanasia and medical killings has widened. Regarding this development, euthanasia critic J. Pereira comments:

The boundaries of what constitutes 'good' practices with respect to euthanasia and PAS continue to change, and some of the current practices would just a few decades ago have been considered unacceptable in those jurisdictions that have legalized the practices.<sup>40</sup>

The prevalence of medical killing without request has been taken by many to be the final proof of a slippery slope development. A typical assertion is made by R.J.D. George et al.:

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<sup>39</sup> I owe this point to a discussion with Morten Horn.

<sup>40</sup> J. Pereira, "Legalizing euthanasia or assisted suicide: the illusion of safeguards and controls," *Current Oncology* 18 (2011): e40.

The inevitable accommodation of this shift in the status of assisted suicide and therapeutic killing is seen clearly in the Netherlands. Therapeutic killing is now extended to children, people with psychiatric illness, and those who are mentally incapable. Therapeutic killing without consent has become laudable and morally necessary.<sup>41</sup>

However, the new evidence that has accrued the last few years, and that was discussed above, shows that killings without consent have gone down significantly, and are rejected by more and more physicians. One may speculate that the openness and public debate about euthanasia has contributed to bringing down the reported number of killings without consent through at least three mechanisms: 1) the physician and patient may discuss options openly, and thus reach a decision at an early stage, when the patient is still competent; 2) the attention given to issues at the end of life has educated physicians about vital medico-ethical distinctions. Misclassifications, e.g., of intensive pain control as ‘euthanasia’, may thus have been reduced; and 3) the open debate has convinced a number of physicians of the ethical unacceptability of killings without consent.

It is true that the scope of indications for euthanasia has widened. Both proponents and opponents would see this development as a natural working out, in the course of several decades, of the premises at the core of the initial court decisions that deemed euthanasia acceptable; however, proponents and opponents differ on whether this development is to be praised or deplored. All in all, however, it seems that the widening scope of euthanasia indications in The Netherlands is due to a gradual unpacking of the logical consequences of premises decided on initially, more than a subsequent change in fundamental premises.

Two recent cases from The Netherlands and Belgium shed light on this development. In the first, a Dutch 70-year-old widow born with poor eyesight went blind. After several unsuccessful suicide attempts she was granted euthanasia because the blindness was deemed to cause ‘unbearable suffering’. There were no other medical conditions contributing to suffering.<sup>42</sup>

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<sup>41</sup> R.J.D. George, Ilora G. Finlay, and David Jeffrey, “Legalised euthanasia will violate the rights of vulnerable patients,” *BMJ* 331 (2005): 684.

<sup>42</sup> <http://www.dailymail.co.uk/news/article-2448611/Blind-Dutch-woman-euthanised-loss-sight.html> (accessed Nov. 19, 2013).

In the second case, a Belgian 44-year-old was euthanized after an unsuccessful sex change operation. Six months of counselling did not change the desire to die. Dr. Wim Distelmans, who performed the euthanasia, stated that ‘unbearable suffering for euthanasia can be both physical and psychological. This was a case that clearly met the conditions demanded by the law.’<sup>43</sup>

Together with the case of the Verbessem brothers above, these cases are telling. The lessons are at least three: first, the law’s requirement of ‘unbearable suffering’ defers very much to the patient’s own judgment. The law requires the physician to make up her own mind about the degree and nature of suffering experienced, but as suffering is a subjective phenomenon, this appears somewhat contradictory. Materstvedt and Bosshard note that deference to subjective assessment, as is found in the Dutch law, may lead to a gradual widening of accepted indications for euthanasia and PAS:

If you open up the gates of euthanasia and PAS through legalization in a highly individualistic culture, the two main driving forces will be respect for self-determination and individual suffering. That means giving *subjectivism* the upper hand: because people’s values may differ radically as to what counts as a life worth living, and since all suffering is in a fundamental way something very personal, attempts at gate keeping by setting limits to who should have access to euthanasia and PAS – types of suffering, terminal illness as criterion, etc. – will both be discriminatory and will fail.<sup>44</sup>

Second, with vague criteria there will always appear cases that stretch and challenge the original intended meaning of the wording employed. ‘Unbearable suffering’ surely is a very vague criterion. Is it even possible to construct a euthanasia law that does not incorporate vague terms? Third, it will always be possible to find physicians with ‘extreme’ views who are willing to cede to patients’ requests even in controversial cases like the above. Dr. Distelmans was involved in both of the Belgian cases, and in an interview he reveals that there have been many other ‘borderline

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<sup>43</sup> <http://www.telegraph.co.uk/news/worldnews/europe/belgium/10346616/Belgian-killed-by-euthanasia-after-a-botched-sex-change-operation.html> (accessed Nov. 19, 2013).

<sup>44</sup> Lars Johan Materstvedt and Georg Bosshard, “Euthanasia and physician-assisted suicide,” in *Oxford Textbook of Palliative Medicine*, 4th ed., eds. R. Portenoy et al. (Oxford: Oxford University Press, 2009), 308.

cases'.<sup>45</sup> Together these three factors mean that ever new challenges to the restrictions on euthanasia will appear.

However, these tendencies also mean that in a large country it will always be possible to find extreme examples like the cases above – which can then be put forth as proof of problematic abuse. But it may be problematic to proffer such extreme examples as evidence of more general tendencies.

### *Changing justification for euthanasia*

A 2003 Dutch study by Marquet et al. details changes in the reasons given for euthanasia requests in the last decades.<sup>46</sup> In 1977, fear of pain dominated. However, towards 2001 (the last year recorded in the study), the proportion of requests motivated by fear of pain declined to approximately 25%. At the same time, general deterioration rose to become the predominant motive. Another 2000-02 study found the four most commonly given reasons to be 'pointless suffering' (75%), 'deterioration or loss of dignity' (69%), 'weakness or tiredness' (60%), and pain (30%).<sup>47</sup>

Figures from Oregon complement this picture with newer data. In the latest survey (2012), the predominant end-of-life concerns among recipients of PAS are losing autonomy (94%), losing the ability to engage in activities that make life enjoyable (92%), and loss of dignity (78%).<sup>48</sup> Concern about being a burden on family, friends and caregivers had risen from previous years, to 57%. Concern about inadequate pain control was cited by 30%, losing control of bodily functions by 35%, and 4% cited concerns with the financial implications of treatment. Mark well that these concerns may not necessarily be *reasons* for the choice of PAS. The patients'

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<sup>45</sup> <http://news.nationalpost.com/2013/11/22/death-by-doctor-controversial-physician-has-made-his-name-delivering-euthanasia-when-no-one-else-will/> (accessed Mar. 28, 2014). Dr. Distelmans is also, remarkably, chairman of the Belgian euthanasia review committee.

<sup>46</sup> R.L. Marquet et al., "Twenty five years of requests for euthanasia and physician assisted suicide in Dutch general practice: trend analysis," *BMJ* 327 (2003); mark that all three studies referenced in this and the next paragraph are based on doctors' reports; the patients themselves were not surveyed about their reasons.

<sup>47</sup> Marijke C. Jansen-van der Weide, Bregje D. Onwuteaka-Philipsen, Gerrit van der Wal, "Granted, Undecided, Withdrawn, and Refused Requests for Euthanasia and Physician-Assisted Suicide," *Arch Int Med* 165 (2005).

<sup>48</sup> Oregon Public Health Division, *Oregon's Death with Dignity Act – 2012*. <http://public.health.oregon.gov/ProviderPartnerResources/EvaluationResearch/DeathwithDignityAct/Documents/year15.pdf> (accessed Jul. 9, 2013).

‘end-of-life concerns’ (as perceived by their doctors) have been listed; it could be that a given person judges that she objectively is a burden to her caregivers, but that this does not in fact motivate seeking PAS. However, it does seem likely that for most it is the *sum* of end-of-life concerns that motivates the PAS request.

Dees et al. performed in-depth interviews with Dutch patients who had requested euthanasia or PAS.<sup>49</sup> Physical suffering was not a predominant reason for the request; instead, physical suffering contributed to a process in which emotional, psychological, social and existential themes figured at least as prominently. As long as there was some kind of hope for a worthwhile future, any suffering was not perceived as unbearable, whereas hopelessness led to suffering being perceived as unbearable. These findings are related to the link between depression and euthanasia requests: it has been shown that depression leads to a fourfold increase in euthanasia requests, and hopelessness is a dominant emotion in depression.<sup>50</sup>

It is remarkable that ‘suffering’ in the traditional sense (that is, from physical symptoms) is no longer a prime motivation for requests. This sits well with the claim made by many palliative care physicians that contemporary advanced palliative care nearly always is able to provide considerable relief for physical symptoms.<sup>51</sup> The changes in justification for euthanasia/PAS appear to bespeak a cultural change in which individual autonomy takes the high seat and less discomfort at life’s end is tolerated. A protracted dying process involving suffering is perhaps increasingly seen as in itself meaningless and profoundly undesirable.

### *Changing attitudes towards euthanasia*

There is substantial support for legalised euthanasia in The Netherlands, but this support gathered in large part *before* its institutionalization. As early as 1975, 77% of the general public supported euthanasia in at least some cases. In 2004, this figure had risen to 90%.<sup>52</sup> Euthanasia/PAS for ‘tiredness of life’ has the support of a considerable minority of the general public: in a 2003 study, 45% of the population

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<sup>49</sup> M.K. Dees et al., “‘Unbearable suffering’: a qualitative study on the perspectives of patients who request assistance in dying,” *Journal of Medical Ethics* 37 (2011).

<sup>50</sup> M.L. van der Lee et al., “Euthanasia and depression: a prospective cohort study among terminally ill cancer patients,” *Journal of Clinical Oncology* 23 (2005).

<sup>51</sup> See, e.g., Magelssen, *Menneskeverd i klinikk og politikk*, 127.

<sup>52</sup> Griffiths, Weyers, and Adams, *Euthanasia and Law in Europe*, 25.

agreed ‘that if they ask for it elderly people should be able to receive drugs to end their life’, a proposal that seems close to ‘PAS-on-demand’.<sup>53</sup> In a population-based study, 26% agreed that PAS would be appropriate in a case vignette depicting an 86-year-old man who was tired of life without suffering from any medical conditions, while 58% disagreed.<sup>54</sup> Similarly, a substantial minority of physicians believe euthanasia/PAS to be acceptable for the elderly who express ‘suffering from life’ or being ‘finished with life’, although not experiencing serious suffering from medical conditions: 34% of medical specialists and 25% of GPs gave full or partial assent to this.<sup>55</sup> As for euthanasia in general, 87% of Dutch physicians are in principle willing to accommodate a euthanasia request, and 89% think that euthanasia should be a part of medical practice.<sup>56</sup>

The KNMG 2011 position paper on euthanasia provides interesting information on the evolution of the medical profession’s official stance.<sup>57</sup> First of all, euthanasia is accepted, although as a ‘last resort’. Physicians may opt out of providing euthanasia – in principle, or in a particular situation – but according to the KNMG are morally obligated to refer the patient to a colleague. Furthermore, the concepts of ‘unbearable suffering’ and its ‘medical basis’ are crucial. The document states that interpretations of these terms among physicians, review committees and courts have evolved in a ‘less restrictive’ direction since the Supreme Court’s ruling in the 2002 Brongersma case (which concerned euthanasia for ‘tiredness of life’).<sup>58</sup> Suffering is a subjective phenomenon, the ‘unbearableness’ of which must primarily be assessed by the patient herself. However, the physician must still assess the patient’s overall situation and judge whether suffering can likely be said to be unbearable without prospect of improvement. The document emphasises that several contributing factors that individually may be small, in sum can make suffering unbearable:

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<sup>53</sup> Cited in *Euthanasia and Law in Europe*, 38.

<sup>54</sup> Natasja J.H. Raijmakers et al., “Assistance in dying for older people without a serious medical condition who have a wish to die: a national cross-sectional survey,” *Journal of medical ethics* (2013).

<sup>55</sup> Referenced in KNMG, “Position paper: The role of the physician in the voluntary termination of life” (2011), 16.

<sup>56</sup> <http://www.lifesitenews.com/news/poll-of-dutch-doctors-shows-broad-acceptance-of-euthanasia> (accessed Nov. 19, 2013).

<sup>57</sup> KNMG, “Position paper.”

<sup>58</sup> *Ibid.*, 26.



Vulnerability stems not only from health problems and the ensuing limitations, but also the measure in which people have social skills, financial resources and a social network. Vulnerability has an impact on quality of life and on prospects for recovery, and can lead to unbearable and lasting suffering (...) it is wholly justifiable that vulnerability – extending to such dimensions as loss of function, loneliness and loss of autonomy – should be part of the equation physicians use to assess requests for euthanasia.<sup>59</sup>

This appears to come very close to a principled endorsement of euthanasia for ‘tiredness of life’. However, the position paper demands that the suffering at least in part must stem from medical conditions for euthanasia to be an acceptable option, saying, ‘Suffering that has no medical basis falls outside the domain of medicine and therefore outside the Euthanasia Law’.<sup>60</sup>

The paper also addresses the topic of patients who are denied euthanasia because suffering is either not unbearable or not lasting. Even though criteria for euthanasia are not fulfilled, the physician must counsel patients in the ‘pros and cons’ of other methods of suicide, particularly voluntarily stopping eating and drinking. If the patient makes a choice for suicide, ‘the physician must respect that patient’s decision’.<sup>61</sup> This policy seems to create inconsistencies that the paper does not address. Society, and the health care services in particular, traditionally have had a responsibility to deter people from taking their own lives; suicidal persons are admitted to psychiatric care to prevent suicide, and for treatment of the underlying mental imbalance or condition that gave rise to the suicidal impulses. How – in the KNMG’s view – does this well-established principle comport with the physician’s duty to counsel and respect people who choose suicide?

In sum, the views of the Dutch public appear to be somewhat more radical than those of counterparts in other European countries. The Dutch physicians are much more supportive of euthanasia/PAS than foreign colleagues. To what extent are the permissive changes in attitudes that have taken place due to the institutionalization of euthanasia/PAS itself? This is difficult to judge, but again, it seems like developments may be mainly due to the slow working out of the premises at the core of the Dutch ‘yes’ to euthanasia. In addition, societal changes in the direction of

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<sup>59</sup> Ibid., 22.

<sup>60</sup> Ibid., 25.

<sup>61</sup> Ibid., 36.

political liberalism and greater deference to individual autonomy are likely to have played a role.

In Lars Johan Materstvedt's analysis, euthanasia has undergone a particular process: its *legalization* prepared the ground for its *institutionalization*, which over time has led to its *normalization*.<sup>62</sup> When normalization has occurred, the practice becomes more or less routine, and critical opposition wanes, or becomes more difficult or even frowned upon. According to Materstvedt,

Country-specific research shows a link between legal status and attitudes: legalization raises both the general acceptability of euthanasia among physicians and their overall willingness to perform it. And although physicians had little involvement in the legal process which culminated in the entering into force of a euthanasia law in Belgium in 2002, by 2009 the country's physicians generally endorsed the law. This suggests that normalization is indeed taking place.<sup>63</sup>

#### *Suicide and homicide*

Suicide and homicide rates in The Netherlands gives indirect evidence to evaluate whether the institutionalisation of euthanasia decreases respect for human life. However, suicide rates remain lower than, and homicide rates equal to, the European Union average.<sup>64</sup>

#### *Slippery slope arguments*

The worry that the institutionalization of euthanasia will have unacceptable consequences is often formulated in terms of a *slippery slope argument*. In general, slippery slope arguments claim that A leads to B, and since B is unacceptable we therefore must not do A. The states A and B must be connected in some way (the

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<sup>62</sup> Lars Johan Materstvedt, "Palliative care ethics: The problems of combining palliation and assisted dying," *Progress in Palliative Care* 21 (2013).

<sup>63</sup> *Ibid.*, 161.

<sup>64</sup> Eurostat, "Death due to suicide," <http://epp.eurostat.ec.europa.eu/tgm/refreshTableAction.do?tab=table&plugin=0&pcode=tps00122&language=en>; Eurostat, "Death due to homicide, assault, by sex," <http://epp.eurostat.ec.europa.eu/tgm/table.do?tab=table&init=1&language=en&pcode=tps00146&plugin=0> (accessed Aug. 6, 2013.)

‘slope element’), and B must be perceived as undesirable, and more so than A (the ‘slippery element’).<sup>65</sup>

Slippery slope arguments can take several forms. One is the *logical*. A logical slippery slope argument against the legalization of euthanasia can be formulated thus: the principles implicit in the acceptance of euthanasia (A) would commit us to accept medical killings in situations in which it is definitely unacceptable (B).<sup>66</sup> Granted that euthanasia is acceptable in some cases (A), its legalization would still leave no clear demarcation line to fend off claims for more controversial or even plainly unacceptable medical killings (B). For instance, if it is a good for a severely suffering competent patient to be relieved of further living through being euthanized, then it must also be a good for a severely suffering *incompetent* patient to be euthanized. This seems to be a logically inescapable consequence. This *creates significant pressure* to allow the latter once the former has become legal.

However, this version of the logical slippery slope argument may in practice be rather weak, for two reasons. First, the realization that it is a good for some incompetent patients to be killed does not *logically commit* us to accept the *legalization* of medical killing of the incompetent. It is not *illogical* to demand that only voluntary requests for killing be granted, else the risk of abuse be unacceptable. On the contrary, the latter may be reasonable grounds for discriminating between voluntary and non-voluntary medical killings. Second, if strong safeguards – for instance, second and third opinions by specialists, comprehensive post-procedure review, etc. – are put in place so that only those incompetent patients for whom death is *truly and undoubtedly a good* are killed, principled opposition to such medical killings may wither away. In that case, the logical slippery slope argument will impress a smaller audience.

Another version of a logical slippery slope argument is the following: if euthanasia is acceptable for competent persons who request it and who are terminally ill and suffering unbearably for medical reasons, why is it not acceptable for other competent persons? What principled reasons could there be to restrict euthanasia to the terminally ill, to those whose suffering is unbearable, and to those whose death

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<sup>65</sup> As explained in S.W. Smith, “Evidence for the Practical Slippery Slope in the Debate on Physician-Assisted Suicide and Euthanasia,” *Medical Law Review* 13 (2005): 19.

<sup>66</sup> The slippery slope argument is more effective 1) the more people agree that B is unacceptable, and 2) the more unpalatable B appears to be.

wish is grounded in medical suffering and disease? The logic in this position seems to imply a moral right to euthanasia for competent persons regardless of reason.

Griffiths, Weyers and Adams (GW&A), however, argue that this logical slippery slope arguments fails, because building on

the common if ill-considered notion that for any law there must be one and only one justifying principle. But euthanasia law in the Netherlands, Belgium (and Oregon) is based not only on autonomy but *also* on a second principle: *beneficence*. This second principle is necessary because, unlike the situation of autonomous suicide, not just the person concerned is involved but also another person, the doctor. The behaviour of this second person requires some justification other than the autonomy of the person wanting to die.<sup>67</sup>

GW&A are correct in that current euthanasia legislation is based on both autonomy and beneficence, and that this does indeed offer some protection against further sliding down the slippery slope. However, there is a question of whether the conjunction of the two principles is *stable* or not. The developments of, on the one hand, the Groningen protocol for the medical killing of disabled infants,<sup>68</sup> and on the other hand, the pressure to legalize euthanasia for ‘tiredness of life’ show that some would welcome the legalization of medical killings justified in single principles; here, beneficence or autonomy, respectively. When one has established that an autonomous decision to die should be respected, what reason is there really for not jettisoning the beneficence requirement? Similarly, if death is truly a benefit for a person and this can be assessed and known objectively by outsiders, why must one require autonomous consent? In this sense, the conjunction of the two principles appears to be unstable, and will be challenged from two directions: from the proponents of ‘PAS-on-demand’ based in autonomy, and from the proponents of ‘mercy killing’ based in beneficence. This logical version of the slippery slope argument, then, seems to be powerful.

Then there are *empirical* versions of slippery slope arguments. An empirical slippery slope argument against euthanasia would claim that legalizing A *in practice* will lead to B, regardless of any logical entailment. Since B is unacceptable, we must

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<sup>67</sup> Griffiths, Weyers, and Adams, *Euthanasia and Law in Europe*, 513-14.

<sup>68</sup> And the Belgian proposal to remove all age limits for euthanasia/mercy killings, at the time of writing contemplated by the legislative bodies.

not legalize A. An empirical slippery slope argument could pick up where the above-mentioned logical argument left off. Historical developments in the Netherlands seem to prove true some of the worries of the euthanasia critic. Through landmark court cases, the right to euthanasia has been granted to more and more new groups, with the main justification in each case being that the extension of the practice follows naturally from the principles upon which euthanasia was justified initially. Thus, patients with psychiatric disease may suffer ‘unbearably’ just as those afflicted with somatic disease, and thus must have access to euthanasia. The principles give no principled reason to withhold euthanasia from patients as long as they are competent, and so children down to 12 years of age became eligible for euthanasia (with parental consent for under-16s). The Groningen protocol for medical killing of newborns was also justified by reference to the criteria for euthanasia, as an equivalent for this patient group. Then there is the discussion of extending euthanasia to those ‘tired of life’; as shown above, the KNMG comes very close to endorsing such a development. Thus there will have been ‘slippage’ from somatic to psychiatric to existential suffering.<sup>69</sup>

The proponent of this empirical slippery slope argument must then show either that one or more of these developments is morally unacceptable, or that even further problematic ‘sliding down the slippery slope’ is likely or inevitable. In addition, the Dutch experience must be relevant for the jurisdiction in question – counter-arguments that one’s country should not expect development along Dutch lines must be met.

The empirical slippery slope argument is problematic in that the relation between the decisions to legalize A and B, respectively, becomes obscure. What exactly makes it the case that legalizing A leads to legalizing B? On the one hand, if the relation is one of logical entailment – A commits us to B on pain of inconsistency – then the argument becomes the logical slippery slope argument, treated above. On the other hand, if the relation is not one of logical entailment, what is it? As GW&A state, ‘If (...) the citizens of a given country decide to legalise B as well as A, this [is] not because they have no real choice in the matter but because they exercise that choice in a particular way’.<sup>70</sup>

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<sup>69</sup> Materstvedt and Bosshard, “Euthanasia and physician-assisted suicide,” 307.

<sup>70</sup> Griffiths, Weyers, and Adams, *Euthanasia and Law in Europe*, 519.

Does A darken our moral perception so that, in a future where A is legal, we are no longer able to see what we now perceive clearly: that B is unacceptable? That appears unlikely. It therefore seems that the proponent of the empirical argument owes us a plausible account of *why* A leads to B. Until such an account is brought forth, the logical slippery slope argument has greater rational force than its empirical counterpart.

A prominent proponent of slippery slope arguments against euthanasia is John Keown.<sup>71</sup> His version of the empirical argument involves a slippery slope from euthanasia as a last resort (A) to both the trivialization of euthanasia *and* medical killings without request (B):

The empirical slippery slope argument runs that even if a line can in principle be drawn between [euthanasia] and [medical killings without request], and between [euthanasia] as a last resort and as an earlier resort, a slide will occur in practice because the safeguards to prevent it cannot be made effective. In other words, purely as a *practical* matter, [euthanasia] resists effective regulation.<sup>72</sup>

His main contention is that euthanasia is in principle impossible to regulate closely, because of the privacy of the physician-patient relationship and the physician's ample opportunities to describe unethical lines of action in terms conforming to the due care criteria to the review committee.

However, in my view, this line of argument is unconvincing. First, it is true that no legislation can protect fully against abuse and deception, but this is as true for blanket prohibitions on euthanasia as for permissive laws such as the Dutch. It is not the legalization of euthanasia in itself that opens opportunities for medical killings without request, but rather health care workers' positions of privilege and privacy. As discussed below (5.1.5.3), medical killings without request are widespread in some countries in which euthanasia and other medical killings are strictly forbidden.

Second, the most important kind of abuse that Keown warns of – medical killings without request – has in fact decreased since the Dutch law came into effect, and more and more physicians reject such killings. This illustrates how many lines of

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<sup>71</sup> John Keown, *Euthanasia, Ethics and Public Policy* (Cambridge: Cambridge University Press, 2002).

<sup>72</sup> *Ibid.*, 72.

arguments for or against euthanasia may become outdated based on empirical data, the interpretation of which has subsequently changed, or which have been made obsolete by new findings. This fate has befallen, for instance, much of Keown's influential decade-old critique. This should warrant caution and a suspension of judgment – attitudes that are, regrettably, less prevalent than they ought in discussions on euthanasia. What today appear to be clear trends may appear in a different light a few years hence.

Third, it is not naive to suggest that, were abuses really widespread, at least some cases would surface and become media stories. And although the Dutch review committees report 0.21% of euthanasia cases as not compliant with due care criteria, there have been very few reports of very serious abuses. These, then, are three counter-arguments that reduce the force of Keown's empirical slippery slope argument.

Thus again, in my opinion, the version of slippery slope argument that is most potent is the logical version. Furthermore, in the case of euthanasia and medical killings, it does have significant force, for the principled reasons given above. The actual evolution of practices in the Netherlands corroborates this view.

#### *Changes to deliberation at the end of life*

Will the institutionalization of euthanasia change the way people reason about end-of-life decisions? The institutionalization of euthanasia communicates the viewpoint that sometimes a life is not worth living; sometimes death by suicide (or suicide by proxy) is rational and to be preferred. What is more, this viewpoint comes with official sanction, approved by the state. People's preferences, intuitions and considered judgments are shaped by the surrounding moral milieu. When the concept of a life 'not worth living' becomes 'available', through normalization of euthanasia, then more people will begin to evaluate their own life in light of this concept. In that case, the very availability of euthanasia may drive demand for it by shaping people's assessment of their own life and situation. The availability of euthanasia may then cause some persons to value their lives less.<sup>73</sup> Consider this provocative quote from Emmanuel Hirsch:

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<sup>73</sup> In putting forth this argument I am inspired by Oderberg, *Moral Theory*, 169-71.

In the field of the choice between life and death, therefore, resort to the notion of individual autonomy is in part an illusion. [A] patient [whose physical and mental faculties are deteriorating] may truly want to die, but this desire is not the fruit of his freedom alone. It may be – and most often is – the translation of the attitude of those around him, if not of society as a whole which no longer believes in the value of his life and signals this to him in all sorts of ways. Here we have a supreme paradox: someone is cast out of the land of the living and then thinks that he, personally, wants to die.<sup>74</sup>

This argument is not empirical – there is, I believe, no data to back it up – but rather it is conceptual and speculative. Perhaps it could, however, be assessed by a qualitative research design probing actual end-of-life deliberation processes in different jurisdictions (as also discussed later). Although not corroborated by any empirical findings, it is still a powerful argument. Perhaps it can provide (part of) the account called for in the empirical slippery slope argument treated above, of why A is likely to lead to B.

#### *Assessment*

In sum, what does the evidence say about changes brought forth by the institutionalization of euthanasia? It is important to note that *institutionalization itself* seems to have played a minor causal part. It was the widespread support for euthanasia among the public, health professionals and politicians that came first and that led to the fundamental premises of euthanasia being embraced. The Netherlands, then, seems to have experienced a ‘logical slide’ towards today’s situation of widened indications for euthanasia. The past decades have seen the gradual working out of the consequences of the fundamental premises, more than the introduction of new ethical premises.

However, that the changes have been huge cannot be denied. The Dutch have gone from euthanasia limited to exceptional cases in which the physician feels she has her back against the wall and can only justify mercy killing by the right of necessity – to today’s situation, in which nearly half the populace and a quarter of the physicians condone ‘death-on-demand’, and euthanasia becomes increasingly common. But the

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<sup>74</sup> Hirsch translated and quoted in Nigel Biggar, *Aiming to Kill. The Ethics of Suicide and Euthanasia* (London: Darton, Longman and Todd, 2004), 148.



institutionalization itself played only second fiddle in this process. The primary driving reason appears to have been the public sentiment, which gave rise to a legislative will.

In addition, attitudes towards human life have indeed changed: suffering and a protracted dying process are not tolerated to the same extent they were before. Euthanasia has become a real option, perceived to be morally acceptable by most. The causal role of the institutionalization itself in *these* processes is difficult to assess.

### 5.1.5.3 *Does the institutionalization of euthanasia change attitudes towards vulnerable groups or put them at risk?*

A worry about the institutionalization of euthanasia that is often raised is that it could put vulnerable persons at risk. In particular, the availability of euthanasia as an option could put pressure on people who perceive themselves to be burdening family, caregivers or society. Euthanasia could come to be perceived as the best, easiest or cheapest ‘way out’, in the perspectives of patients themselves, caregivers, health care workers and society at large. Even worse, the normalization of euthanasia could perceivably reduce health care workers’ mental barriers to involuntary and non-voluntary medical killings. The following quote from the British palliative physician Bill Noble voices this concern succinctly:

I see vulnerable patients under pressure. Older people, who are already ejected from our NHS funded and governed care, acquiesce to be nursed in commercial institutions of variable and uncertain quality. Their wish not to be a burden on family is powerful, and I have seen patients reject treatments to shorten survival to make it easier for their family. If assisted dying is legalised, I fear that our society’s neglect of older people, poverty, and the lack of home care services will drive up demand for assisted suicide.<sup>75</sup>

Among potentially vulnerable groups, those often listed include senior citizens, people with physical disabilities, people with mental retardation, people who are poor or lack education, and people suffering from terminal illnesses. For practical reasons,

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<sup>75</sup> B. Noble, “Legalising assisted dying puts vulnerable patients at risk and doctors must speak up,” *BMJ* (2013).

empirical studies compare rates of euthanasia between different groups, but the *individual* vulnerability – which is much more difficult to assess in research designs – is more important, and is shaped by such factors as social network and psychological resilience. As the UK Commission on Assisted Dying states, ‘Anybody subjected to negative assumptions about their quality of life might be considered vulnerable in the context of assisted dying legislation’.<sup>76</sup> Group affiliation is only part of this story.

### *Vulnerable groups*

Battin et al.’s study of PAS and euthanasia practices in Oregon and The Netherlands investigated evidence for the abuse of vulnerable groups.<sup>77</sup> The authors concluded that vulnerable groups – with the exception of AIDS patients – were not overrepresented among persons receiving euthanasia and PAS:

Rates of assisted dying in Oregon and in the Netherlands showed no evidence of heightened risk for the elderly, women, the uninsured (inapplicable in the Netherlands, where all are insured), people with low educational status, the poor, the physically disabled or chronically ill, minors, people with psychiatric illnesses including depression, or racial or ethnic minorities, compared with background populations. The only group with a heightened risk was people with AIDS.<sup>78</sup>

Concerning educational attainment, it was found that in Oregon, higher attainment correlated with a higher usage rate of PAS (comparable data for The Netherlands was unavailable). Another point worth elaborating is the assessment of whether people with disabilities were at a higher risk of euthanasia/PAS; the study used the Dutch research on euthanasia cases in 2005, in which physicians were asked for their assessment of the life-shortening effect of euthanasia in each case. Only 0.2% patients receiving euthanasia or PAS were considered to have had a life-expectancy six months or more at the time of euthanasia/PAS. This indicates that the disabled (who would typically have longer life expectancies) are not at higher risk for euthanasia/PAS. The study also found no increased risk for persons suffering from

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<sup>76</sup> The Commission on Assisted Dying, “Final Report,” (London: Demos, 2012), 162.

<sup>77</sup> Margaret P. Battin et al., “Legal physician-assisted dying in Oregon and the Netherlands: evidence concerning the impact on patients in ‘vulnerable’ groups,” *Journal of Medical Ethics* 33 (2007).

<sup>78</sup> *Ibid.*

dementia or psychiatric disorders, including depression. However, the evidence for this conclusion was found to be weak, especially because not all patients were evaluated by mental health specialists. (This finding is interesting seen in conjunction with other research that indicates that euthanasia *requests* are more common among depressed patients. As mentioned, in one study among Dutch terminal cancer patients there was a fourfold increase in requests among patients with ‘depressed mood’.<sup>79</sup>)

In a commentary article, Finlay & George construe ‘vulnerability’ in quite another way.<sup>80</sup> In their view, vulnerability should rather be sought in diverse factors that ‘apply across the social spectrum’, such as ‘emotional state, reactions to loss, personality type and situation and possibly to PAS contagion’. The empirical data relied upon by Battin et al. cannot assess the influence of such factors.

Materstvedt points out that a mere comparison of the numbers or persons who undergo euthanasia/PAS in different socioeconomic categories does not tell us anything about any experienced pressure.<sup>81</sup> For instance, it could be that some elderly experience heavy pressure in the direction of euthanasia, but that their more traditional or conservative moral views make them resist the pressure. Materstvedt points out that a research study with a qualitative interview design would be best suited to explore any experiences of pressure.

In sum, there is no empirical evidence indicating that vulnerable groups are euthanized more often. However, there are concerns that available research has to some extent been looking in the wrong place. Qualitative research designs have the potential to provide more in-depth knowledge about any experienced pressure.

### *Legal safeguards*

A thorough report for the UK Commission on Assisted Dying evaluated the effectiveness of legal safeguards in jurisdictions that allow euthanasia and/or PAS.<sup>82</sup> The report details the relevant legal frameworks and the empirical evidence on end-of-life practices. The report concludes that, by and large, the legal safeguards are

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<sup>79</sup> M.L. van der Lee et al., “Euthanasia and depression.”

<sup>80</sup> Ilora G. Finlay and R. George, “Legal physician-assisted suicide in Oregon and The Netherlands: evidence concerning the impact on patients in vulnerable groups – another perspective on Oregon’s data,” *Journal of Medical Ethics* 37 (2011).

<sup>81</sup> Lars Johan Materstvedt, “Inappropriate conclusions in research on assisted dying,” *Journal of Medical Ethics* 35 (2009).

<sup>82</sup> Lewis and Black, “The Effectiveness of Legal Safeguards.”

observed and are reasonably effective in regulating physician behaviour in this field. However, a weakness in the report, stemming from the empirical studies relied upon, is that case evaluations necessarily rely on the physicians' written reports. For instance, if the physician attests in writing that the patient is competent and suffering unbearably, then the control authorities are in no position to question this contention.<sup>83</sup> Relying on physician reports, then, can in principle never rule out abuse. It could also be the case that medical killings that physicians know do not meet the due care criteria are simply not reported to the review committees.

### *Social pressure*

The report of the British Commission on Assisted Dying contains some interesting quotes from experts from the jurisdictions that allow euthanasia or PAS. For instance, Dutch professor de Beaufort contended that in practice, friends and family are much more likely to *oppose* a person's wish for euthanasia than to promote it.<sup>84</sup> Further, Oregon professor Ganzini stated that 'the idea that disabled people might experience increased social pressure to request an assisted suicide was "completely untrue", as "people are not offered assisted dying. They come out of the woodwork and insist on it"' .<sup>85</sup>

However, such requests do not arise in a moral vacuum. As discussed above, the options perceived by individuals to be available to them are shaped by both laws and societal mores. One could imagine people with chronic illnesses or disabilities internalizing expressed societal attitudes that lives such as theirs are not worth living.

A 2011 poll among people with disabilities in the UK found 53% being 'very' or 'slightly' concerned about a law allowing assisted suicide.<sup>86</sup> Of respondents, 70% would be concerned about 'pressure being placed on other disabled people to end their lives prematurely', whereas 56% thought such a law could change the way people with disabilities are viewed by society in a negative way.

Some euthanasia opponents are even willing to grant that the option of euthanasia would be a good to a select few – the strongly autonomous who are certain that death is preferable to life in their situation – but all in all should not be allowed

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<sup>83</sup> Apart from the physician providing the second opinion.

<sup>84</sup> The Commission on Assisted Dying, "Final Report," 290.

<sup>85</sup> *Ibid.*, 187.

<sup>86</sup> *Ibid.*, 179.

because the potential good is outweighed by the risks for society's numerous vulnerable individuals. Iona Heath put it thus:

Most of the discussion of and support for assisted dying revolves around exceptional individuals who are intelligent, articulate, and facing the prospect of intolerable suffering and who clearly understand their situation and predicament. Yet legislation has to protect everyone, including those who struggle to express or even fully understand what is happening to them. It seems to me to be impossible to ensure that an apparently voluntary request for assisted dying is not in some small way coerced. It is all too easy for sick and disabled people to believe that they are becoming an intolerable burden to those closest to them, and indeed they often are a burden. In such circumstances a request for assisted dying can become a sort of sacrifice on the part of the dying person, with complicit, self interested support from relatives, professionals, or carers.<sup>87</sup>

In this perspective, the legalization of euthanasia would provide options that for a select few are truly beneficial (*ex hypothesi*) – but that for many others would be detrimental in subtle ways, through altering their perception of themselves and their value in a negative way. Seen this way, the common good is best served by a prohibition on euthanasia.

Indeed, some euthanasia critics, such as Paterson, argue that legalization would imply the rejection of the equality of all citizens, as the intentional killing of some citizens (although with their request) due to their *attributes* would be sanctioned by the state:

The state, in sanctioning such killing, permits a wrong directed against the structural fabric of civil society. Actions that intentionally kill the innocent are being granted *official public standing and recognition* in the name of the political common good. All members of a society, whether or not they realize it, are being objectively harmed with regard to their interests by the very *incivility* of such an enactment.<sup>88</sup>

However, Paterson's argument arguably presupposes the ethical unacceptability of euthanasia, and therefore does not have independent force against euthanasia.

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<sup>87</sup> Iona Heath, "What's wrong with assisted dying," *BMJ* (2012).

<sup>88</sup> Paterson, *Assisted Suicide and Euthanasia*, 168.

### *Medical killings without request*

In the EURELD study, end-of-life practices in six European countries (Belgium, The Netherlands, Switzerland, Italy, Denmark and Sweden) were studied.<sup>89</sup> Data were collected in 2001-02. Whereas euthanasia and PAS constituted 2.8% of all deaths in the Netherlands and ending of life (medical killings) without an explicit request a further 0.6%, the situation was rather different in Italy, Denmark and Sweden (see Table 3). In short, in these three countries that do not allow euthanasia and PAS, the practices were either very rare or not occurring. However, an important exception is that in Denmark, the ending of life without explicit request was as prevalent as in The Netherlands; in Sweden this also occurred sometimes, although at only one tenth of the Dutch rate.

**Table 3.** *Intentional medical killings in six European countries.* Percentage of all deaths.<sup>90</sup>

	The Netherlands	Belgium	Switzerland	Denmark	Sweden	Italy
Euthanasia	2.6%	0.30%	0.27%	0.06%	0	0.04%
PAS	0.21%	0.01%	0.36%	0.06%	0	0
Ending of life without request	0.60%	1.5%	0.42%	0.67%	0.23%	0.06%

In another study, from the UK, using similar questions, the proportions of all deaths due to euthanasia, PAS, and ending life without request were found to be 0.21%, 0 and 0.30% respectively (sampled in 2007-8; results were similar in a 2004 study using the same questions).<sup>91</sup>

A study from Belgium showed that in 2007, 1.8% of deaths were medical killings without an explicit patient request, down from 3.2% in 1998.<sup>92</sup> The patients

<sup>89</sup> Agnes Van der Heide et al., "End-of-life decision-making in six European countries: descriptive study," *The Lancet* 362 (2003).

<sup>90</sup> Adapted from *ibid.*

<sup>91</sup> C. Seale, "End-of-life decisions in the UK involving medical practitioners," *Palliative Medicine* 23 (2009).

<sup>92</sup> K. Chambaere et al., "Physician-assisted deaths under the euthanasia law in Belgium: a population-based survey," *CMAJ* 182 (2010).

involved were, compared to euthanasia patients, more likely to be above 80 years of age, to die in hospital, and to have diseases other than cancer. (The last observation can perhaps be explained by the fact that incurable cancer tends to have a more or less predictable course, allowing for planning of the terminal phase, including planning for euthanasia. Non-cancer illnesses are less predictable and sudden deteriorations more often occur. This can preclude terminal-phase planning.) In 22% of cases of killing without an explicit request, the physician had discussed euthanasia with the patient. Reasons given for not discussing were coma (70%) or dementia (21%), or the judgment that discussion itself would have harmed the patient (8.2%). In 79% of cases, the decision was discussed with the patient's family, whereas in only 6.5% of cases the physician did not discuss with anyone. The estimated shortening of life was significantly less than is common for euthanasia: in 48% of cases, estimated shortening was less than 24 hours, and in only 14% more than one week. The authors note that the practice of medical killing without explicit request was most often carried out in groups that are deemed vulnerable: patients >80 years of age, and patients in coma or with dementia. Opioids, not muscle relaxants and barbiturates, were used to cause death. The authors note that

although physicians specified an intention to hasten death, opioids were often given in doses that were not higher than needed to relieve the patient's pain. This suggests that the practice of using life-ending drugs without an explicit patient request in reality resembles more intensified pain alleviation with a 'double effect,' and death was in many cases not hastened.<sup>93</sup>

This observation is, in my view, both crucial and surprising: the physicians stated the intention of bringing about the patients' death, but they did not cause death by the most efficient measure (the injection of sedatives and muscle relaxants). Indeed, it seems likely that in many of these cases *they did not cause death at all*, as the drugs given and the dosages used were incapable of killing. This must lead one to question whether (some of) the physicians have been confused – either about the concept of intention or about the death-causing properties of opioids. In sum, as the authors state, the study indicates that euthanasia and killing without explicit request are 'distinct

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<sup>93</sup> Ibid., 900.

types of end-of-life decisions that occurred in different patient groups and under different circumstances’.<sup>94</sup>

As the incidence of medical killings without request has gone down in The Netherlands (and in Belgium) in the last decades, it seems clear that the institutionalization of euthanasia cannot be a *cause* of such killings.

#### *Palliative care and euthanasia*

There have been concerns that where euthanasia is an option, this may appear as a ‘simpler’ and cheaper response to suffering at the end of life than the implementation of a sophisticated and costly program of palliative care. However, a report on the state and development of palliative care in six European countries concluded that ‘Palliative care is well developed in countries with legalised euthanasia/assisted suicide, or at least no less well developed than in other European countries’.<sup>95</sup> Furthermore, ‘The idea that legalisation of euthanasia and/or assisted suicide might obstruct or halt palliative care development thus seems unwarranted and is only expressed in commentaries rather than demonstrated by empirical evidence.’ In the Netherlands and Belgium, euthanasia is most often carried out for cancer patients, which is the group that has the best access to palliative care. In Belgium, it is the palliative care units that have the highest incidence of euthanasia.

#### *Assessment*

In sum, there is no empirical evidence that the institutionalization of euthanasia decreases respect for vulnerable groups or places them at particular risk of medical killings. However, as noted above, the available empirical studies seem to be unable to answer the most compelling question: how does the institutionalization change the *perceived pressure* to choose euthanasia? Materstvedt is right that an exploration of this question should involve qualitative methods, such as interview studies.<sup>96</sup>

I would propose a study design along the following lines: similar qualitative studies should be performed in jurisdictions that have legalised euthanasia/PAS and in

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<sup>94</sup> Ibid.

<sup>95</sup> European Association for Palliative Care, “Palliative Care Development in Countries with a Euthanasia Law,” (2011).

<sup>96</sup> Materstvedt, “Inappropriate conclusions.”



‘control’ countries that have not, and in which medical killings are very rare (Norway would be a good example). The studies should interview different groups of people – senior citizens, the seriously ill, and the physically disabled. Their thoughts on end-of-life choices and the factors that influence such decision-making processes should be elucidated. When compared, the studies will indicate differences in decision-making processes between the countries; for instance, will worries about being an ‘unproductive’ citizen ‘burdening’ society loom large in The Netherlands, but not in Norway? Although methodologically challenging, such studies could perceivably provide some of the answers needed to see how a society is impacted by the institutionalization of euthanasia.

#### 5.1.5.4 *Does the institutionalization of euthanasia damage the ethics of the medical profession?*

There are concerns that physicians as a profession cannot be granted the right to euthanize without this causing unhealthy changes to the profession’s ethical standards and conduct.

However, the empirical data discussed above hardly corroborate this fear. The number of medical killings without request have gone down, and more and more physicians agree that such killings are unacceptable. There are no reports that Dutch physicians are perceived to be less conscientious or ethical in general than their colleagues in other countries, aside from the controversial practices currently under discussion.

A few studies merit discussion, however. A 1995-96 study found that among 110 Dutch physicians who had performed euthanasia, 75% had ‘feelings of discomfort’ after their recent case.<sup>97</sup> 5% stated doubts, although not regrets, about performing euthanasia. 95% would be willing to perform euthanasia or PAS again. This shows that performing euthanasia has an emotional impact.

A 2007 qualitative interview study probed GP’s experiences with the performance of euthanasia. The emotions and thoughts expressed were varied, and generalization is difficult. Still, a subset of physicians expressed serious misgivings

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<sup>97</sup> Ilinka Haverkate et al., “The emotional impact on physicians of hastening the death of a patient,” *The Medical Journal of Australia* 175 (2001).

about their participation in euthanasia. One stated, ‘Nevertheless, I still always have a sense of guilt. I feel as if I’m an executioner. Who am I to have the right to do this?’<sup>98</sup>

The authors state that ‘Euthanasia is a drastic, and sometimes even traumatic event for the [GPs] involved’.<sup>99</sup> Many described the task of performing euthanasia as a burden put on them by society. One informant stated:

We were crazy to do it, looking back. Who am I to do this? Euthanasia was put on my plate. It’s a rotten job. I apparently felt, thought, that it was normal that [GPs] did this. How did we let ourselves into it in this way? I wanted to be important as well. I wish they would no longer ask me, but I’m scared to say so. Perhaps I will have the courage to say so in a few years time. I feel very close to people, but I also feel angry: ‘what do you think you can ask of me?’<sup>100</sup>

Many informants had become more reluctant to perform euthanasia; as one stated,

I now say clearly to everyone: I don’t perform euthanasia any more. To my surprise a number of people say: ‘Doctor, you are so right, I understand completely.’ Then I thought to myself: how deep do these requests really go? I found that disconcerting to notice.<sup>101</sup>

Another study showed that some physicians feel that the euthanasia law itself has made patients think that they have a *right* to euthanasia, and that this threatens the autonomy of the physician.<sup>102</sup> Finlay and van Dijk conclude,

Perhaps the greatest lesson to be learned from the situation in Holland is that the law is a blunt instrument and that every human is infinitely complex. When the doctor, trained to respect the right to life, is asked to end life, an unforeseeable and subtle series of changes occur in the way the doctor practises and in society’s expectations.<sup>103</sup>

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<sup>98</sup> H. van Marwijk, I. Haverkate, and P. van Royen, “Impact of Euthanasia on Primary Care Physicians in the Netherlands,” *Palliative Medicine* 21 (2007): 611.

<sup>99</sup> *Ibid.*, 612.

<sup>100</sup> *Ibid.*, 613.

<sup>101</sup> *Ibid.*

<sup>102</sup> Ilora G. Finlay and Bertus van Dijk, “Euthanasia: the Dutch experience and what it entails in practice,” *The Lancet Oncology* 3 (2002).

<sup>103</sup> *Ibid.*

In a similar vein, a 2008 qualitative interview study reports that dealing with euthanasia requests was considered by many GPs to be very emotionally and ethically demanding; nearly half of the GPs in the study wanted to avoid euthanasia/PAS because it went against their moral views or was emotionally burdening.<sup>104</sup>

In a natural law perspective, such reports are not surprising. If the killing of another human being is a breach with principles of practical reason and cultural taboos, it is no wonder that many physicians experience processes of euthanasia as emotionally difficult, and that guilty conscience and regret may ensue.

#### 5.1.5.5 *The common good argument assessed*

The common good argument against euthanasia states that the institutionalization of euthanasia will damage the common good, that is, the societal conditions for collective and individual pursuit of human fulfilment through the basic human goods. To avoid begging the question, the arguments must not presuppose that the act of euthanasia is intrinsically morally wrong.

The examination of ‘the Dutch experiment’ showed that euthanasia is becoming more common, that indications have widened and that there is pressure for a further widening. Attitudes towards the last stages of life, including suffering and the dying process, have changed. No changes to attitudes towards non-medical killing have been demonstrated. There are hypotheses that the normalization of euthanasia changes the way people reason and value their lives at the end of life, but such arguments remain speculative. Indeed, empirical evidence remains unhelpful in answering some of the core questions; we lack evidence about how people for whom euthanasia could be an alternative view themselves, value their lives, and conduct their decision processes.

Further, there are strong speculative arguments that the institutionalization of euthanasia will create subtle kinds of pressure for vulnerable groups. However, empirical studies do not back up this claim. As noted, this could be because the studies may not have looked in the right places. Finally, the number of medical

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<sup>104</sup> J.J. Georges, Bregje D. Onwuteaka-Philipsen, and G. van der Wal, “Dealing with requests for euthanasia: a qualitative study investigating the experience of general practitioners,” *Journal of Medical Ethics* 34 (2008).

killings without request have gone down, and there was no evidence that the ethics of the medical profession in general had deteriorated.

It was emphasized that assessing the causal importance of legalization and subsequent institutionalization in the changes that have taken place is difficult. A common good argument approach may criticize the legalization-institutionalization-normalization process, but may just as well target the attitudes and views that justified medical killings and then led to legalization in the first place. It is striking to what a limited an extent some of the common good arguments can be supported by empirical data. This does not mean that the arguments fail, but that more relevant empirical studies are sorely needed, and arguably that ethical arguments can be sound and relevant even in the relative absence of empirical backing. Table 4 summarizes the four main premises from which potent common good arguments can be constructed.

**Table 4.** *Premises for common good arguments against euthanasia.*

No.	Observation/hypothesis	Empirical backing
1	Euthanasia expanding in numbers and indications	Ample
2	Changing attitudes to suffering and dying process	Yes, directly and indirectly
3	Changed deliberation at end of life	No
4	Vulnerable groups subjected to pressure	No

Which basic goods may be at stake with the legalization of euthanasia? The proponent of the common good argument fears for *health* and *security* (aspects of the good of life), and *friendship* and *human solidarity* (an aspect of the good of friendship). In addition, *justice* (as an aspect of practical reasonableness) may be at stake.

In my view the common good arguments that can be constructed from the two latter premises are the strongest, even though there are no empirical findings to corroborate these premises. There is reason to believe that widespread euthanasia practices can damage the common good through relativizing human worth according to the person's contribution to society. When the dying process in itself loses human significance and is considered more and more an undignified ending to life's story,

then reasons for seeking an earlier death may appear decisive. In particular, the fear is that patients will perceive themselves to be burdening family, caregivers and society, and that this perception will weigh heavily on the scales, motivating choices for death. A prohibition on euthanasia, on the other hand, would act as a bulwark against attacks on the dignity and moral worth of persons with disabilities or in the last stages of life: it is a way of society's saying to such persons that they are valuable and wanted. A similar argument that legalization could lead to a harmful, perceived 'duty to die' is often made.

What difference does it make that the natural lawyer makes her argument in terms of *the common good*? First, this way of putting the argument highlights that consequences, both intended and unintended, of social policies matter ethically. Second, it highlights the great importance of the argument – the requirement to promote, not damage, the common good springs from a fundamental requirement of practical reasonableness itself. Third, speaking of the common good shows that we are ethically responsible for other persons and thus for our shared society. This puts legitimate restraints on individual freedom – which is exactly what the proponent of the argument advocates: in order to protect the vulnerable, we must restrain the few, strongly autonomous who are not prone to abuse and who could (*ex hypothesi*) have benefited from euthanasia.

In summary, I have argued that rather strong common good arguments with a basis in four premises can be made. However, such arguments can only partly rely on empirical data. Some of the most vital questions have not been enlightened by empirical studies.

#### 5.1.5.6 *Digression: A critique of the Dutch national studies on end-of-life practices*

The studies of Dutch end-of-life practices that are conducted roughly every five years are comprehensive and commendable.<sup>105</sup> However, several methodological choices could be criticized. Here I will point to one that has to do with the concept of intention.

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<sup>105</sup> The latest, from 2010, is published as Onwuteaka-Philipsen et al., "Trends in end-of-life practices."

The Dutch national studies rely on the physician's report of her subjective intention when classifying the medical actions and decisions preceding death. From an NNL standpoint, this makes sense in that the action's intention is a crucial feature in the ethical assessment of the action (see 2.5). However, this creates space for *confusion* and even *deception*.

*Confusion*, because it is well known that physicians are sometimes confused by the concept of intention. For instance, if providing aggressive symptom relief is performed as medically indicated, the physician believes that the medication provided may shorten life, and the physician hopes that death will ensue shortly so that the patient will be spared suffering – then some physicians will say that they *intended death*. However, in line with the concept of intention I have defended (2.5) one should rather say that the intention was to relieve suffering, and that any shortening of life, however unlikely, would come as an unintended side-effect.

*Deception*, because it is of course possible for a physician who has performed a medical killing to simply report her intention as being symptom relief. Alternatively, the studies could have asked what medication was actually provided and in what doses – what the physician *actually did* – and whether this was medically indicated.<sup>106</sup> If you inject large doses of euthanatica, then your intention must be to kill. In general, the physician's intention can often be gathered from a description of the patient's condition and what actions were actually performed.

#### 5.1.6 Some important arguments for euthanasia

It is now time to discuss some other important arguments from the literature. This discussion will be succinct, with brief retorts indicating how the arguments will be countered from NNL premises.

A vocal critic of 'traditional ethics', Peter Singer analyzes end-of-life decisions in light of his particular brand of preference utilitarianism.<sup>107</sup> As a consequentialist, he rejects any version of a moral absolute against killing innocents. According to Singer, for the person receiving euthanasia, death may very well be a benefit, in that it involves the satisfaction of the patient's preferences for death and for

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<sup>106</sup> As also suggested in Griffiths, Weyers, and Adams, *Euthanasia and Law in Europe*, 150-52.

<sup>107</sup> Peter Singer, *Practical Ethics*, 2nd ed. (Cambridge University Press, 1993); Singer, *Rethinking Life and Death*.

freedom from physical and mental distress. Indeed, as he summarizes, ‘The strength of the case for voluntary euthanasia lies in this combination of respect for the preferences, or autonomy, of those who decide for euthanasia; and the clear rational basis of the decision itself’.<sup>108</sup>

Singer advocates the substitution of the ‘traditional sanctity of life ethic’ with a ‘quality of life ethic’ of his own devising. ‘The traditional ethic’, writes Singer, ‘will be unable to accommodate the present demand for control over how we die’.<sup>109</sup> His ‘Copernican revolution’ in ethics involves five new ‘commandments’, of which two in particular have special bearing on euthanasia and medical killings. First, ‘Recognise that the worth of human life varies’. Singer writes,

The best argument for the new commandment is the sheer absurdity of the old one [that all human life has equal worth]. If we were to take seriously the idea that all human life, irrespective of its capacity for consciousness, is equally worthy of our care and support, we would have to root out of medicine not only open quality of life judgments, but also the disguised ones. We would then be left trying to do our best to prolong indefinitely the lives of anencephalics, cortically dead infants, and patients in a persistent vegetative state.<sup>110</sup>

The third new commandment is, ‘Respect a person’s desire to live or die’.<sup>111</sup> Killing a person against her will is seriously wrong, because it goes against her autonomous will, and ‘render[s] fruitless much of her past striving’. Killing a human non-person, on the other hand, is without such significance, and may be morally acceptable in certain circumstances.

However, in my view, the ‘traditional sanctity of life ethic’ may very well concede that quality of life varies. This ethic presses the point that all human beings have the same *right to life*, that is, the right not to be intentionally killed. This does not commit one to the view that all human beings have the same *quality of life*, that is, the same degree of opportunities for pursuit of the basic human goods. This point will be expanded upon in the section on treatment-limiting decisions (5.2).

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<sup>108</sup> Singer, *Practical Ethics*, 200.

<sup>109</sup> Singer, *Rethinking Life and Death*, 148.

<sup>110</sup> *Ibid.*, 191.

<sup>111</sup> *Ibid.*, 197-98.

According to John Harris, not all human beings are persons. A person, crucially, has the ability to value her existence. Whereas persons must be respected, and killing them would harm them in depriving them of a life they can value, the same respect is not due to non-persons; their death could hardly constitute a harm to them if they are unable to value life. However, when persons of sound mind no longer value their lives and request euthanasia or assisted suicide, proper respect for persons requires that we heed the request:

If the harm of ending a life is principally a harm to the individual whose life it is and if this harm must in turn be understood principally as the harm of depriving that individual of something that they value and want, then voluntary euthanasia will not be wrong on this account. Such a view prioritising the individual's autonomy and her liberty to pursue it in her own way may be termed the liberal view of euthanasia.<sup>112</sup>

Indeed, according to Ronald Dworkin, prohibiting the person from arranging for death in accordance with her values would be profoundly illiberal and wrong: 'Making someone die in a way that others approve, but he believes a horrifying contradiction of his life, is a devastating, odious form of tyranny'.<sup>113</sup> The prohibition on euthanasia fails to exhibit proper respect for persons and their autonomy.

NNL rejects the distinction between human persons and human non-persons (see 4.7). NNL also rejects the notion, essential to Harris's view, that in order for something to be valuable, it must be valued by someone. On the contrary, a person's life may be valuable even though the person currently does not value it (because of depression, transient or permanent disorders of cognition, etc.). To NNL, Harris's account of value involves an untenable subjectivism, where the pre-moral order is turned on its head – for we do not accord (e.g.) our life with value; rather, we grasp that *it is valuable*. Against Singer, Harris and Dworkin, NNL does not accept that a line of action otherwise immoral becomes acceptable through being willed autonomously by the agent (1.4.8).

Brad Hooker's sophisticated version of rule-consequentialism is considered promising by many. According to Hooker, 'An act is wrong if it is forbidden by the

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<sup>112</sup> John Harris, "Euthanasia and the Value of Life," in *Euthanasia Examined. Ethical, Clinical and Legal Perspectives*, ed. John Keown (Cambridge: Cambridge University Press, 1995), 10.

<sup>113</sup> Dworkin, *Life's Dominion*, 217.



code of rules whose internalization by everyone everywhere in each new generation has maximum expected value in terms of well-being (with some priority for the worst off).<sup>114</sup> The crucial question then becomes ‘whether a new code allowing euthanasia under some conditions must have lower expected value than a moral code forbidding euthanasia’.<sup>115</sup> Hooker’s own discussion of this question is sketchy; however, as ‘expected value’ is cashed out in terms of ‘well-being’, the fundamental premises of other consequentialists, that death may sometimes be preferable to life and that intentional killing is not wrong in itself, are carried over to Hooker’s theory. Hooker’s tentative conclusion is that euthanasia is ethically acceptable with necessary safeguards. However, I suggest that a more thorough investigation might entail the opposite conclusion; in particular, the considerations discussed under the heading of the common good argument (5.1.5) would be relevant for Hooker’s question as well.

Writing from an explicitly theological standpoint, Nigel Biggar finds that the special value of humans springs from their calling by God ‘to play an inimitable part in the maintaining and promotion of the welfare of the world’.<sup>116</sup> Human life is usually very valuable; however, when the above-stated goal is irreversibly beyond pursuit for an individual, her life has lost its instrumental and intrinsic value. This happens when the person is afflicted by unbearable suffering that cannot be remedied, or has suffered severe brain injury or disease so as to be incapable of consciousness. Biggar therefore distinguishes between the ‘biographical’ and the ‘biological’ qualities of life; only the former, not the latter, is intrinsically valuable. However, Biggar’s notion of biographically meaningful existence is broader than that of, for instance, Harris and Dworkin: for Biggar, even when rationality and autonomy are severely threatened, life may be biographically meaningful, in that the person may still answer God’s call by having retained the ability for ‘showing due appreciation for what is good and bearing prophetic witness to what is true’.<sup>117</sup>

In Biggar’s view, the prohibition on killing means that one may never intentionally kill ‘without proportionate reason, unfairly, or unfaithfully’.<sup>118</sup> When biographical life has been irreversibly lost, there may be such proportionate reason to kill. However, he finds that slippery slope arguments and other considerations of

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<sup>114</sup> Brad Hooker, *Ideal Code, Real World* (Oxford: Oxford University Press, 2000), 32.

<sup>115</sup> *Ibid.*, 187.

<sup>116</sup> Biggar, *Aiming to Kill*, 166.

<sup>117</sup> *Ibid.*, 167.

<sup>118</sup> *Ibid.*, 165.

society's common good make it the case that euthanasia and physician-assisted suicide should remain prohibited.

Biggar's view closely resembles the revised NNL view. However, the revised NNL would be wary of the appeal to 'proportionate reason' to justify intentional killings. In the revised NNL view, reasons for killing can never be 'proportionate' as to outweigh the value of life. Instead, intentional killing is (per the second interpretation of revised NNL) only acceptable when life *has ceased to be valuable*, so that there is no value to 'outweigh'. Appeals to 'proportionate reason' can, in the NNL view, never override moral absolutes. This line of reasoning is at home in consequentialism or its theological cousin, proportionalism, but it is inimical to NNL.

Beauchamp and Childress (B&C) discuss euthanasia in the context of nonmaleficence, one of the four principles foundational to their ethical approach of 'principlism' (see 1.7.4).<sup>119</sup> They argue that there is an unacceptable inconsistency between patients' rights to refuse treatment 'so as to bring about their deaths' on the one hand, and 'the denial of a similar autonomy right to arrange for death by mutual agreement between patient and physician under equally grim circumstances' on the other.<sup>120</sup> What makes killing wrong in typical cases is that the person is deprived of goods and opportunities. However, in the special case of a suffering patient who autonomously requests assistance in suicide, death may be a benefit, and such assistance would not harm or wrong her. A decisive background assumption here is the authors' rejection of the intention-foresight distinction.<sup>121</sup> This move allows them to portray all patient or physician decisions to limit treatment as instances of intentionally causing death. An NNL approach, on the other hand, would distinguish any treatment-limiting decisions that intentionally cause death from those that cause death as a foreseen but unintended consequence (5.2). Even though the former are legally accepted, they are ethically unsound. Therefore, the allegation, even if true, that physicians sometimes bring about death intentionally through a treatment-limiting decision, should not count in favour of allowing euthanasia or assisted suicide.

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<sup>119</sup> Beauchamp and Childress, *Principles of Biomedical Ethics*, 178-86.

<sup>120</sup> *Ibid.*, 182.

<sup>121</sup> *Ibid.*, 166-68.

B&C acknowledge slippery slope arguments against the legalization of euthanasia and physician-assisted suicide, but maintain that it should be possible to construct acceptable laws allowing these practices under certain conditions.

Jeff McMahan argues that the typical killing is wrong because it deprives the victim of goods and is contrary to her autonomous will.<sup>122</sup> However, in particular circumstances, euthanasia and suicide can be justified: when the person's life is no longer worth living, and the person prefers death to continued life, concern for the person's intrinsic worth should lead us to respect the person's will. The person's intrinsic worth cannot demand that we refrain from assisting in killing. This worth is not affirmed by demanding that the person suffers through continued existence.

McMahan's argumentative strategy is to dispel the possible justifications for a moral absolute against killing that covers euthanasia and suicide. He discusses and rejects the Kantian view that suicide is wrong because it involves 'sacrificing the person's rational nature for the sake of his good', something that implies treating rational nature as instrumentally, not intrinsically, valuable.<sup>123</sup> In McMahan's view, respect for the person's autonomous choice for suicide is compatible with respect for her rational nature.

McMahan also, quoting Finnis, discusses the natural law view that respect for human life enjoins that it may never be intentionally targeted. However, McMahan does not interact with the specifics of the natural law view; in NNL, the moral absolute against killing is justified by deduction from self-evident first principles. McMahan's arguments, on the other hand, are intuition-driven and attack only the natural law conclusion without challenging the reasoning behind it.

In total, McMahan's discussion lends credence to the view that it takes *either* a natural law *or* a Kantian-style approach to provide a secular justification for a moral absolute against euthanasia and suicide; these two approaches are, arguably, the only targets of McMahan's criticism that retain some plausibility, not having been conclusively refuted in the course of his discussion.

This brief tour of arguments for euthanasia also shows that arguments on this issue, both for and against, typically rely on more fundamental premises. Philosophical discussion on euthanasia will therefore, in large part, consist in

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<sup>122</sup> McMahan, *The Ethics of Killing*, 455-85.

<sup>123</sup> *Ibid.*, 478.

uncovering and critiquing such fundamental assumptions. Arguments that at first may seem intuitively right may thus be shown to rely on untenable presuppositions.

#### 5.1.7 A revised new natural law view of euthanasia

When discussing euthanasia, NNL theory would give particular attention to the two questions emphasized here: whether euthanasia breaks the ethical prohibition on killing, and whether its institutionalization damages the common good.

It was argued that, in the first interpretation of revised NNL theory, euthanasia does indeed run afoul of the ethical prohibition on killing innocents. In the second interpretation of revised NNL, most cases of euthanasia/PAS are unacceptable for their involvement of intentional attacks on basic goods (life) that are real aspects of fulfilment. However, in a few extreme cases, continued living does *not* contribute to fulfilment because suffering is intense, constant and cannot be alleviated sufficiently. Here, intentional attacks on life, including euthanasia, are morally acceptable.

However, examination of ‘the Dutch experiment’ showed four premises about unsound consequences of institutionalizing euthanasia. From these premises, strong common-good arguments against the legalization of euthanasia could be constructed – arguments that are equally strong in the first and second interpretations of revised NNL. This comports well with the first interpretation’s principled rejection of euthanasia in all instances. With the second interpretation’s exception for extreme cases, however, it leads to the following constellation of views: a principled *rejection of legalization* of euthanasia due to the profound negative societal consequences (impeding the common good), while maintaining that *morally*, euthanasia may be acceptable in extreme and exceptional cases. Interestingly, this view fits well with what – in my experience – is commonly heard among doctors: euthanasia is generally wrong and ought not to be legalized – but there are some extreme situations in which it is nevertheless an acceptable, necessary, or at least excusable thing to do. For instance, Norwegian physician Stein Husebø – who did perform euthanasia once, for which he was given what in Norwegian law amounts to a ‘formal reprimand’ – gave voice to this view when he stated that ‘there are situations where euthanasia is right,

but in the interests of 99% of the population we cannot equip doctors with a licence that makes killing the patient an alternative'.<sup>124</sup>

## 5.2 Treatment-limiting decisions

Many express concern that the medically advanced health care services of Western countries have been unable to strike the proper balance between treating aggressively when indicated, and allowing a natural and dignified death when appropriate. The following statement, made in the context of a report on British cardiopulmonary resuscitation practices, is typical of some European sentiments:

[T]oday we stand at a crossroads. To the left lies a destiny familiar from America where 60% of us will die in an [intensive care unit] and we will spend 50% of [National Health Service] expenditure in the last six months of life, much of it seeking to postpone the inevitable. This will happen, not because the patient has asked for it or because someone has taken a calculated decision that it is in the patient's interest to make the attempt, but because the doctors think that they have a duty to do everything that they can to prolong the process of dying.

To the right lies an acceptance of the limits of what is practical and a recognition that the armamentarium of medicine should be deployed only where it is likely to benefit the patient. In an age of unprecedented respect for the patient's autonomy, wherever possible a contract should be formed.<sup>125</sup>

When I practiced as a clinician, this was a recurring topic. End-of-life decision making – choosing the right course of action at the right time – is an art that requires practice and good communication. Ethical principles are very helpful, but because of their generality must be supplemented with the virtue of practical reasonableness. I am sorry to say that not infrequently when I reconsidered a patient's disease course after the patient had met her end, I would have to admit that the optimal balance had not been achieved.

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<sup>124</sup> Interview in nationwide newspaper *Morgenbladet*, May 29, 2009.

<sup>125</sup> National Confidential Enquiry into Patient Outcome and Death, "Time to Intervene? A review of patients who underwent cardiopulmonary resuscitation as a result of an in-hospital cardiorespiratory arrest," (2012), 6-7.

Natural law has a well-developed framework for evaluating treatment-limiting decisions. Some principles have already been discussed in Chapter 4. At some point in the course of progression of a patient's disease, the time may come to consider switching from a *healing* approach, to a *life-prolonging* approach, to a *palliating* approach – notwithstanding the fact that the divide between the three is not always watertight. A treatment-limiting decision involves withdrawing or withholding potentially life-prolonging treatment such as dialysis, ventilator, cardiopulmonary resuscitation, chemotherapy, antibiotics, and ANH. The most crucial natural law principle is that such decisions must be carried out with morally upright intentions; specifically, the physician's or patient's (or other decision-maker's) intention must not be to *hasten death*, or to *end* or *shorten life*. Instead, the intention must be to reject interventions that are no longer effective, or for which the burdens outweigh the benefits. Morally sound intentions respect the good of life through not attacking it intentionally. However, according to the second interpretation of revised NNL, an exception should be made for extreme cases in which life does not contribute to the patient's fulfilment – here, the intention may legitimately be to end or shorten life.

When weighing burdens and benefits, what kinds of burdens and benefits are relevant? Some think that quality of life judgments should never be taken into account when weighing burdens and benefits. However, I think such judgments are both ubiquitous and morally relevant in such cases. How great is the benefit from prolonging a patient's life in a given situation? Something more or less objective can be said about this: what kinds of participation in human goods, what kinds of human flourishing will the life-prolonging treatment allow? This is the *benefit* or the *quality of life* derived from the treatment. Rational comparisons can be made between such benefits and the corresponding burdens, even though participation in basic human goods cannot be quantified with a numerical value. Indirectly, then, judgments of quality of life play a role in morally upright decisions about limiting treatment, through influencing evaluation of the potential benefits that treatment can bring.

Sometimes clinicians take treatment-limiting decisions to imply the intention to hasten the patient's death. For instance, as part of the EURELD study, researchers found that physicians in six European countries (Belgium, Denmark, Italy, The Netherlands, Sweden and Switzerland) stated an intention to hasten death in 45% of cases in which treatment was withdrawn or withheld (range: 36% (Denmark) to 52%

(Switzerland)).<sup>126</sup> Deaths were categorized according to which treatment was forgone; however, there was no association between intention to hasten death and objective features of the treatment, such as ‘the likelihood and extent of a death-hastening effect, the immediacy of death, or the expected burden of any potential life-sustaining measure’.<sup>127</sup>

Similarly, a study among German palliative physicians found that as many as 27% of deaths were preceded by an end-of-life decision in which shortening of life was intended.<sup>128</sup> Physicians who were certified in palliative care stated this intention significantly less often.

Now, if such practices are indeed widespread, then in an NNL perspective this is cause for grave concern. Intentional shortening of life is morally unacceptable. However, crucial wording in the questionnaires is problematic: respondents were asked whether the action was done ‘with the explicit intention of *not prolonging life* or hastening the end of life’ (my italics). Intending to not prolong life is not necessarily problematic, in the way that intentional hastening of death is. This wording could have led to an overestimation of problematic intentions. There is also another problem: respondents were asked whether they chose to intensify treatment for the alleviation of pain, ‘taking into account that this would probably or certainly hasten the end of the patient’s life’.<sup>129</sup> This formulation trades on the common and resilient prejudice that aggressive symptom control (with opioids and benzodiazepines) at the end of life hastens death. But Sykes and Thorns found in their review that ‘there is no evidence that initiation of treatment, or increases in dose of opioids or sedatives, is associated with precipitation of death’.<sup>130</sup>

Thus, as Forbes and Huxtable state, ‘The problem with some questionnaires used in studies of end of life decisions is thus that the questions are based on the

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<sup>126</sup> Georg Bosshard et al., “Intentionally hastening death by withholding or withdrawing treatment,” *Wiener Klinische Wochenschrift* 118 (2006); however, in a UK survey where the EURELD questionnaire had been modified, less than one-fifth of treatment-limiting decisions involved the physician intending the patient’s death: Seale, “End-of-life decisions in the UK.”

<sup>127</sup> *Ibid.*, 326.

<sup>128</sup> J. Schildmann et al., “End-of-life practices in palliative care: a cross sectional survey of physician members of the German Society for Palliative Medicine,” *Palliat Med* 24 (2010).

<sup>129</sup> Bosshard et al., “Intentionally hastening death,” 324.

<sup>130</sup> Nigel Sykes and Andrew Thorns, “The use of opioids and sedatives at the end of life,” *The Lancet Oncology* 4 (2003): 312.

assumption that alleviation of symptoms may hasten death and are asked of doctors who believe it does.’<sup>131</sup>

How, then, could the findings that up to half of treatment-limiting decisions involve an intention to shorten life be interpreted? One interpretation is that the physicians were misguided about the concept of intention. Physicians could have *wished for* the patient’s death to come sooner rather than later, to the patient’s relief, and could have thought that their decision to limit treatment *would lead to* an earlier death. Further, they could have been under the false belief that such thoughts necessarily imply the *intention* to shorten life/hasten death. In the NNL view, of course, wishes do not imply intentions. Intentions are mental states that result in particular acts. From a wish, on the other hand, no action follows.<sup>132</sup>

A question I would have liked to ask the respondents who stated an intention to hasten death is, if you intended the patient’s death, why did you not choose a quicker, more effective method that avoids the suffering of the patient’s remaining days – i.e., a lethal injection? I would have expected some respondents to answer that they feel such an act to be of a wholly different character than withdrawal or withholding of treatment. Then, might this difference consist mainly in that the lethal injection is *for the sake of killing*, whereas the treatment-limiting decision, after all, is not? I speculate that some cases of confusion about what intention – the plan embraced in a choice, resulting in action – really is, and what it is not, could thereby be exposed.

Furthermore, the distinction between *intended* and *foreseen but unintended* consequences is also vital in the NNL view (2.5). What do physicians think of this distinction? Is it consciously rejected? Does it play any part in their reasoning when end-of-life decisions are made?

Still, some would grab the other horn of the dilemma, and say that the European doctors’ report of their intentions were most likely correct: one *does* (sometimes) intend death when limiting treatment at the end of life. A proponent of this view could then go on to criticize the NNL view of intention, with its required distinctions, as a *moral fiction*.

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<sup>131</sup> Karen Forbes and Richard Huxtable, “Clarifying the data on double effect,” *Palliative Medicine* 20 (2006): 395.

<sup>132</sup> Materstvedt and Bosshard, “Euthanasia and physician-assisted suicide,” 311.



This is the path taken by Miller, Truog and Brock in a thought-provoking article.<sup>133</sup> Although they do not address natural law theory specifically, and although several other theorists have made similar claims, their critique of traditional medical ethics is trenchant and clear, and therefore is here singled out as representative of an important strand of critique. However, the lucidity of Miller et al.'s arguments also makes it simpler to identify where their critique goes wrong, and what an NNL response should be.

The article starts with a case description:

John and Sam are motorcycle enthusiasts. At age 50 both of them have serious accidents that leave them quadriplegic and dependent on a ventilator to breathe. Two years after the accident John remains ventilator-dependent, whereas Sam has regained the capacity to breathe spontaneously and has been weaned off his ventilator. During the third year after their accidents, both John and Sam find their lives intolerable; they don't want to go on living because of their complete dependence on others for the activities of daily life and the associated absence of privacy. John requests to be admitted to the hospital where he was treated after the accident, in order to have his home ventilator withdrawn and receive the palliative care he needs to die peacefully. Hospital clinicians are initially reluctant to honor John's request but agree to do so after being persuaded that he is a competent decisionmaker who has thought carefully about his situation. Sam requests his physician to administer a lethal dose of medication so that he can die a swift and dignified death. Although Sam's physician is sympathetic to his request, he refuses to comply with it because active euthanasia, even with consent, is contrary to the law and medical ethics.<sup>134</sup>

Miller et al. use this case in an attempt to show that traditional medical ethics cannot explain why withdrawal of life-prolonging treatment is morally acceptable whereas euthanasia is not, without relying on moral fictions. 'Moral fictions', they explain, 'are false statements endorsed to uphold cherished or entrenched moral positions in the face of conduct that is in tension with these established moral positions'. And furthermore,

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<sup>133</sup> Franklin G. Miller, Robert D. Truog, and Dan W. Brock, "Moral fictions and medical ethics," *Bioethics* 24 (2010).

<sup>134</sup> *Ibid.*, 453.

The moral fictions relating to end-of-life decisions are motivated to make morally challenging medical practices, such as withdrawing life-sustaining treatment and providing pain-relieving medication at the risk of hastening death, consistent with the norm that doctors must not kill, or assist in killing, patients.<sup>135</sup>

It is these alleged moral fictions that they then go on to expose, by analyzing what they take to be traditional medical ethics' response to the case of John. Traditional medical ethics, the authors think, would reject (1) that the doctor causes John's death, (2) that the doctor's intervention is active, (3) that the doctor intends John's death, (4) that the doctor kills John, (5) that John's death could be termed suicide, and (6) that the doctor is morally responsible for John's death. Miller et al. think that, regarding (3), the doctor may or may not intend to hasten death; they point to the EURELD study discussed above to argue that physicians in fact often do intend death in such situations. As for the other five verdicts of traditional ethics, they should all be exposed as moral fictions. In short, the doctor *does* cause death, she does so actively, she does so intentionally, she does kill the patient, the action is one of suicide and assisted suicide, and the doctor is morally responsible for the death. Not surprisingly, Miller et al. go on to argue that such actions usually are morally acceptable, which is what they think of euthanasia.

A revised NNL analysis of John's case could go along the following lines: as it is described, John's intention in requesting that ventilator treatment be withdrawn could be suicidal, or not. Is John's intention to get rid of the ventilator treatment because it is so intolerable and burdensome that the benefits cannot make up for it? Or is it simply a decision to end life as such because it is not worth living? The first intention is morally upright, whereas the second is morally unacceptable because it is suicidal. The authors acknowledge that John's intention may be to end burdensome treatment, but they stipulate that it is the second intention that should be attributed to John in their subsequent discussion of the case.

If John's intention is suicidal, what then about the physician's intention in helping him? The physician may be sharing John's intention, but not necessarily. The physician can make up her own mind about John's case, and judge that ventilator treatment might reasonably be thought too burdensome to justify continued treatment, or she may intend simply that the patient's request for the cessation of treatment be

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<sup>135</sup> Ibid., 454.

honoured. Remember that the intention is the moral object chosen, the description under which an action (or a sequence of actions) is carried out. The physician may describe what takes place in different terms than John, without any self-deception being involved. So I contend that fulfilling John's wish *need not* involve the physician's intending death, even when *John's* intention is for hastening death. Therefore, even though John's intention may be suicidal, the physician's intention need not necessarily be. Therefore, the physician's contribution is not necessarily morally equivalent to euthanasia.

Would it be right to say that the doctor *causes* John's death? Miller et al. believe so, arguing that if someone turned off the ventilator without John's consent, they would be guilty of homicide. The difference between homicide and legitimate treatment withdrawal hinges on John's consent, 'But this ethical and legal difference has nothing to do with the cause of the patient's death, which is the same in both cases'.<sup>136</sup>

Norwegian official guidelines state to the contrary that 'not to initiate or to terminate life-prolonging treatment for a seriously ill patient leads to death because of the patient's disease, whereas in euthanasia and assisted suicide it is [these acts] that shorten life'.<sup>137</sup> It seems that the Norwegian guidelines depend upon a causal analysis that is not morally neutral, but rather *already moralized*: it is only because limiting treatment is deemed to be morally acceptable that it is said *not* to be a cause contributing to death.

Beauchamp & Childress attempt to show how 'letting die' and 'killing' cannot be defined so that they do not overlap. They write, 'Conventional definitions are unsatisfactory for drawing a sharp distinction between killing and letting die. They allow many acts of letting die to count as killing, thereby defeating the very point of the distinction'.<sup>138</sup> For instance, if a patient, Alicia, can be cured easily by the administration of a drug, her physician has a duty to treat. If the physician intentionally refrains from administering the drug with the intention that Alicia should die, and she does die, then the physician has both *let her die*, and *killed her*. If the distinction between killing and letting die cannot be cogently made, the distinction cannot perform the required moral work.

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<sup>136</sup> Ibid., 456.

<sup>137</sup> Helsedirektoratet, "Beslutningsprosesser," 10.

<sup>138</sup> Beauchamp and Childress, *Principles of Biomedical Ethics*, 175.

Lars Johan Materstvedt provides a set of clinical distinctions and definitions that evade this criticism. On his analysis, Alicia's physician has not at all 'let her die'; rather, the physician has killed her through an omission, because treatment was not contraindicated.<sup>139</sup> Furthermore, Materstvedt says of withdrawal of ventilator treatment for ALS patients, 'This is not tantamount to a hastening of death; quite the opposite, it allows death to take its natural course. Alternatively, it can be described as not delaying death or not artificially prolonging life. In other words, the patient is allowed to die.'<sup>140</sup> Materstvedt contends that there is a fundamental difference 'between intentionally producing hastened death by drugs [i.e., euthanasia and PAS], and intentionally producing non-hastened death by omission'.<sup>141</sup> It is his view that although in both instances life is shortened (as compared to continued treatment), only in the former is death also *hastened* (artificially through injection or ingestion of drugs that speed up the dying process), whereas this process is natural, 'left alone', when continued life-prolonging treatment is clinically contraindicated. The physician's intentional act is labelled (1) 'killing' in the case of euthanasia/PAS; (2) 'killing by omission' when life-prolonging treatment is clinically indicated but is nevertheless withheld/withdrawn with the intention that the patient should die; and (3) 'letting die' where life-prolonging treatment is clinically contraindicated and accordingly withheld/withdrawn.

In Materstvedt's analysis, therefore, no action which is a 'killing' is also a 'letting die'. Thus he has disproved B&C's contention that 'killing' and 'letting die' cannot be defined so that they do not overlap. However, in my view this feat and the tidy set of definitions come at a price, as his analysis entails a denial of what I take to be commonsensical statements about causation. For instance, Alicia's physician would rightly be condemned for *letting her die*, as her life could easily have been saved; the physician has killed Alicia through letting her die. The example could also be changed so that the physician did not intend Alicia's death: perhaps the physician was unaware of the life-saving treatment option. In this case also, one might very well say that the physician has let the patient die, and thereby killed her (through culpable negligence). In addition, whereas removing the ALS patient's ventilator does allow the disease to take its natural course, the action also *hastens death* (and not only

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<sup>139</sup> Lars Johan Materstvedt, "Euthanasia and letting die," *Palliative Medicine* 20 (2006).

<sup>140</sup> Materstvedt, "Palliative care ethics," 159.

<sup>141</sup> *Ibid.*, 160.

*shortens life*) relative to life with continued ventilator treatment. Indeed, may not ‘hasten death’ and ‘shorten life’ be thought to be near-synonymous?

Another problem is that, in my view, Materstvedt’s analysis is implicitly normative, by relying on judgments of whether the life-prolonging treatment in question is clinically indicated. His terms therefore do not map the causal structure of the acts directly.

A fully appropriate analysis requires, in my view, that we treat questions of causality, responsibility, intentionality, and culpability independently.<sup>142</sup> Consider the cases of John and Alicia. The physician’s removing the ventilator is a cause of death. For John, the underlying disease and the removal of the ventilator are *both* causes of death, causes that are *individually necessary* and *jointly sufficient* for death to occur. It would seem that the Norwegian guidelines attempt to smuggle in a moral judgment: because removing the ventilator is morally acceptable, it cannot be a cause of death. In fact, however, it is more true to the realities to say that the doctor’s removal of the ventilator, together with the underlying disease, causes death. Similarly, the physician’s decision not to treat Alicia is a cause of Alicia’s death, as is her underlying disease. In both cases, death and the diseases have taken their natural course. On this descriptive, morally neutral assessment of the causal structures of the acts, it becomes clear that treatment-limiting decisions imply actions that may *cause* death, and may *hasten* death, relative to the longer life that treatment could have provided.

Do the physicians kill John and Alicia, respectively? This question is trickier, as ‘killing’ may have both morally neutral and moralized senses. Take the following example: an experienced surgeon performs a life-saving operation on a patient, but unfortunately during a challenging procedure to remove a tumor she accidentally cuts open a main artery and the team is unsuccessful in stopping the bleeding. Here the surgeon can be said to have killed the patient, even though there is no intent nor negligence on her part. This is so because in the morally neutral sense, ‘killing’ just means causing death. It follows that John’s and Alicia’s physicians do kill in the technical sense of causing death. In the moralized sense, however, Alicia is killed by her physician, whereas John is not. Whether the morally neutral or the moralized sense is reflected in common language varies between situations. For instance, if I

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<sup>142</sup> Biggar, *Aiming to Kill*, 66.

decide to stop my monthly money transfer to a charity that provides emergency relief, I may thereby cause death at the other end. In the morally neutral sense I thereby also kill, but in ordinary language use, this way of putting it appears strained indeed.

John's physician is *responsible* for causing John's death, just as Alicia's physician is responsible for causing her death. Because both deaths were known to ensue as consequences of the physicians' actions, there is no doubt that the physicians are responsible. However, whether the physicians *intended* death or are *culpable*, are separate questions. Miller et al. rightly point out that 'We are morally responsible for what we intend to do, or do knowingly, or do negligently', but that 'Moral responsibility for causing death does not equate to culpability for wrong-doing'.<sup>143</sup> The physician, then, is *responsible* for her actions. But if performed with a morally acceptable intention, then she is *not culpable*.

John's physician did not (necessarily) intend death. Instead, the physician could have intended that burdensome treatment should cease. In this case, the physician is not culpable. Alicia's physician did intend death, and is culpable.

A NNL analysis would not rely on the acts-omissions distinction (see 4.4.1). The NNL advocate would be happy to concede that removal of the ventilator is an active intervention.

To sum up, NNL should be happy to concede that there are dubious or downright erroneous dogmas in some kinds of traditional medical ethics. However, because it relies on a refined account of intention, NNL is able to analyze John's case in a way that preserves the central intuitions and maintains the core distinctions. NNL would press that in some instances of treatment limitation sanctioned by law, namely when suicidal intentions are acted upon, the patient or the physician or both are still morally culpable.

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<sup>143</sup> Miller, Truog, and Brock, "Moral fictions and medical ethics," 458.

**Table 5.** *A comparison of three analyses of the ventilator case.* Adapted from Miller et al.

	<b>‘Status quo’ (according to Miller et al.)</b>	<b>Revised NNL</b>	<b>Miller et al.’s proposal (‘without moral fictions’)</b>
Is the doctor causing death?	No	<b>Yes</b>	Yes
Is it an active intervention?	No	<b>Yes</b>	Yes
Is the doctor intending death?	No	<b>Sometimes yes, sometimes no</b>	Sometimes yes, sometimes no
Does the doctor kill the patient?	No	<b>Yes, in the non-moral sense or when death is intended</b>	Yes
Is it suicide?	No	<b>Depending on the intention</b>	Yes
Is it assisted suicide?	No	<b>Depending on the intention</b>	Yes
Is the doctor morally responsible for death?	No	<b>Yes, but not culpable when unintended</b>	Yes

So the patient’s intention in demanding limitation of treatment may be suicidal, yet legally sanctioned. How should such suicidal intentions be considered? First of all, they are clearly immoral from an NNL standpoint (as long as life is thought to be a real aspect of fulfilment). However, the patient’s intentions are not readily available for external assessment by physicians or others. As a practical policy, it must be up to patients to decide when the burdens of treatment outweigh the benefits; society and the health care services must, it seems, then tolerate that a proportion of such decisions are made from morally problematic premises. Arguably, no alternative to such a policy of toleration would be feasible. However, if the physician judges that the patient’s decision is unwise, ill-informed and suicidally motivated, she should of

course discuss the matter thoroughly with the patient – and, if the need is sufficient, exercise her right to conscientious objection, transferring responsibility for the patient to a colleague.<sup>144</sup> An NNL analysis would not rely on ‘moral fictions’, but would, as shown, point to well-founded differences between judgments in the moral and legal/practical domains.

Peter Singer’s influential critique of the traditional view of the ethics of treatment-limiting decisions attacks the reliance on the intention-foresight distinction. Singer writes:

But the distinction between directly intended effect and side-effect is a contrived one. We cannot avoid responsibility simply by directing our intention to one effect rather than another. If we foresee both effects, we must take responsibility for the foreseen effects of what we do.<sup>145</sup>

The second of Singer’s five ‘new commandments’ mentioned above is given as ‘Take responsibility for the consequences of your decisions’, by which is meant that we have the same degree of responsibility for foreseen and unintended consequences of our actions as for intended consequences.<sup>146</sup> If you decide that the patient should die, then by ensuring that death comes as a side-effect, and not as directly intended, you do not make a moral difference.

Singer’s criticism of the concept of intention is a core ingredient in the consequentialism he defends. However, in my view, his criticism depends on an impoverished understanding of the concept. As explained (2.5), intentions are mental states that culminate in action. Contrary to Singer’s assertion that intention can be ‘directed’ away from the unwanted effect and towards the wanted effect, the intention is *precisely what is chosen*, and thus is something objective. It is the plan for action that is embraced. It is the goal that practical reason proposes for deliberation and then decides on. If I choose to withdraw ventilator treatment to spare the patient of the burdens of treatment, then this is exactly what I do. If, on the other hand, I withdraw treatment *for the sake of* ending the patient’s life, then *this* is what I do; bringing

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<sup>144</sup> In my experience, the moral right to conscientious objection is very seldom exercised in such cases in Norway; I have yet to hear of a single instance. However, in other countries it is known to occur.

<sup>145</sup> Singer, *Practical Ethics*, 210.

<sup>146</sup> Singer, *Rethinking Life and Death*, 195-96.



about the patient's death becomes an essential part of what I have chosen and what I do. In the first case, the patient's death being a foreseen rather than an intended consequence does not absolve me of moral responsibility. But it may absolve me of moral *culpability*, because death was not chosen.

Singer's critique continues. He thinks that a consequentialist judgment lies behind the analysis and is implicitly relied upon. If I decide to limit potentially life-prolonging treatment this must necessarily be because I judge the patient's future quality of life to be unacceptably poor. This, according to Singer, is 'not a decision based on acceptance of the sanctity of human life, but a decision based on a disguised quality of life judgment'.<sup>147</sup>

However, as discussed above, quality of life judgments should not be anathema in NNL. A morally upright decision to limit treatment must be based on a comparison of the burdens and benefits of treatment – where the benefits of treatment are constituted by the patient's capacity for participating in the basic human goods. This *capacity for flourishing* is closely linked to the concept of *quality of life*. This conceptual link enables NNL to explain our practices and intuitions better than other theories underpinning a traditional medical ethics.

The dilemma portrayed by Singer is, therefore, a false one: the new natural lawyer must not *either* honour the sanctity of human life *or* take quality of life into account. The intention-foresight distinction is sound and performs the moral work here; the physician foresees death but does not intend it. Indeed, as Oderberg writes, 'Consequentialists who see no point in the intention/foresight distinction invariably portray such an assessment as a "covert quality of life judgment"'.<sup>148</sup>

The official Norwegian guidelines for treatment-limiting decisions are, in my view, marked by ethical and clinical wisdom, and the normative recommendations are mostly in line with an NNL view on treatment-limiting decisions. In particular, the balance between burdens and benefits is a prominent condition when limitation of treatment is contemplated, and the physician must not intend death. One critique, however, is the reliance on some of the 'moral fictions' discussed above; another is the unnecessarily restricted scope: the guidelines speak only of 'seriously ill patients with a bad prognosis, who without such life-prolonging treatment would die shortly,

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<sup>147</sup> Singer, *Practical Ethics*, 210.

<sup>148</sup> Oderberg, *Applied Ethics*, 78.

that is, within days or weeks'.<sup>149</sup> However, there is no principled reason why the same ethical and medical principles may not be applied for patients with a longer life expectancy. For instance, a patient with incurable cancer and a one-year life expectancy may decide to forgo a proposed round of chemotherapy, from a consideration of expected burdens and benefits. The same ethical principles apply in this situation as when the patient's death is more imminent.

The same restricted time frame turns out to cause problems for The Norwegian Health Directorate's proposed regulations on advance directives/living wills. In their proposal, they have defined a living will 'as a patient's declaration about a treatment preference in a situation where the patient is dying and incapable of communicating a treatment preference ... by "dying" is meant that the patient will die shortly, that is within days or a few weeks'.<sup>150</sup> The problem with this restricted scope is, first, that it unnecessarily excludes situations where life expectancy is greater; second, that some situations – e.g., PVS – wherein the patient is not dying but a living will surely could be appropriate, are excluded.

Finally, I provide two short cases to illustrate NNL reasoning in greater depth. Consider the case of a patient with a heart condition (complete sino-atrial block, say) that makes her dependent on a permanent pacemaker, which has been fitted surgically. She now demands to have the pacemaker removed. Such an operation would cause her heart to stop immediately, thus leading to death. Now technically her pacemaker constitutes life-prolonging treatment, and so in some jurisdictions the patient may have a legal right to have the request for withdrawal honoured. However, in an NNL framework, the patient's intention is suicidal and thus morally unacceptable, for a permanent pacemaker (usually) does not cause discomfort or burdens, and if the withdrawal is requested because of burdens from living, then again the intention is plainly suicidal.

So a decision to limit life-prolonging treatment may be justified in a comparison of burdens and benefits – but the burdens that are relevant in this comparison are those that stem from treatment itself; not the 'burdens' of living as

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<sup>149</sup> Helsedirektoratet, "Beslutningsprosesser," 4.

<sup>150</sup> Helsedirektoratet, "Forslag om ordning med livssynsøytralt livstestamente" (letter), June 5, 2013; 4.

such.<sup>151</sup> NNL principles might therefore be critical of quite a few actual treatment-limiting decisions taken by clinicians. For instance, an elderly patient with several chronic disorders and low self-reported quality of life develops pneumonia. In this case, some physicians would recommend forgoing antibiotics, not because the *treatment itself* is burdensome, but because life is approaching an end and the pneumonia, as it were, offers a way out of a protracted dying process. ‘Pneumonia is the old person’s friend’, as the saying goes – it is perceived as a natural and gentle way for life to come to an end. Some clinicians would defend this line of reasoning, but from a revised NNL point of view, it would be morally deficient when it involves acting intentionally against a real aspect of the basic human good of life. (Life is still a real aspect of fulfilment for this patient.)

Decision-making in light of revised NNL principles can be complex and fraught with uncertainty. Should the patient with pneumonia be admitted to hospital for treatment with intravenous antibiotics? In favour of admission counts, of course, the prospect of a cure and prolongation of life. However, several potential factors count against, and may loom very significant: although intravenous treatment in itself is most often a negligible burden, hospitalization involves removing the frail patient from a familiar environment; there is the possibility of serious complications to treatment, such as delirium (confusion); intensive care and invasive procedures may become necessary, and be perceived as burdensome; and the recovery phase may be prolonged and involve low quality of life. Most significantly, prognosis for frail, elderly patients who contract pneumonia is poor. In a US study, 41% of over-65s admitted for pneumonia died within one year (in contrast to 29% age-matched control patients with other conditions).<sup>152</sup> Prognosis worsened with increasing age and number of concurrent illnesses. In a given case, therefore, there may be significant reasons not to hospitalize the patient for treatment with antibiotics. The factors listed are among the ones that must be considered when forming an opinion of what benefits can realistically be derived from treatment – and what burdens will accompany them. When the decision-maker (physician, patient or relative) is convinced that, all in all, burdens loom larger than benefits, she is morally justified in deciding or

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<sup>151</sup> The burdens of living are only indirectly relevant, in that they reduce the quality of life and thus the benefit that can be derived from further treatment.

<sup>152</sup> V. Kaplan et al., “Pneumonia: Still the old man’s friend?” *Archives of Internal Medicine* 163 (2003).

recommending against treatment. Death is not intended, but foreseen as an unintended side-effect of the decision.

### 5.3 Palliative sedation

Palliative sedation (PS) is defined as, ‘The use of specific sedative medications to relieve intolerable suffering from refractory symptoms by a reduction in patient consciousness, using appropriate drugs carefully titrated to the cessation of symptoms’.<sup>153</sup> The treatment is considered to be a last resort when more conventional means of palliation have been exhausted and found to be inadequate. PS can be categorized as to depth of sedation – with mild sedation, ‘the patient is awake, but the level of consciousness is lowered’; with intermediate depth, ‘the patient is asleep but can be woken to communicate briefly’; whereas deep sedation induces coma and unconsciousness.<sup>154</sup> When deep sedation is instigated and there is no intention of waking the patient later, this is termed ‘deep and continuous palliative sedation’ (DCPS).<sup>155</sup> DCPS is the most controversial variety of PS. There is no evidence that PS in itself leads to an earlier death.

In an NNL view, there are six particularly morally relevant features of PS. First, with what intention is PS undertaken? The intention with PS should be to relieve suffering, as opposed to killing the patient, which is the intention with euthanasia. The European Association for Palliative Care (EAPC) Ethics Task Force on Palliative Care and Euthanasia succinctly summarizes the salient differences between PS and euthanasia:

‘Terminal’ or ‘palliative’ sedation in those imminently dying must be distinguished from euthanasia. In terminal sedation the *intention* is to relieve intolerable suffering, the *procedure* is to use a sedating drug for symptom control and the successful *outcome* is the alleviation of distress. In euthanasia the *intention* is to kill the patient,

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<sup>153</sup> A. de Graeff and M. Dean, “Palliative sedation therapy in the last weeks of life: a literature review and recommendations for standards,” *J Palliat Med* 10 (2007).

<sup>154</sup> *Ibid.*, 73-74.

<sup>155</sup> A term coined by Materstvedt and Georg Bosshard Materstvedt: “Deep and continuous palliative sedation (terminal sedation): clinical-ethical and philosophical aspects,” *The Lancet Oncology* 10 (2009).

the *procedure* is to administer a lethal drug and the successful *outcome* is immediate death.<sup>156</sup>

Second, what is the *medical justification* for PS? Because PS is a radical measure, reducing consciousness and thus the ability to participate in human goods (such as friendship, knowledge, etc.), there should be a proportionately grave reason for it: namely, strong and refractory physical symptoms. Other, less drastic means should be considered or attempted first. The question has been raised whether mental, social and existential suffering could sometimes justify palliative sedation. According to critics of such proposals, this would imply a problematic medicalization of death.<sup>157</sup> Arguably, such suffering could and should be handled by humane caring, not by the pharmacological reduction of consciousness.

Third, there should be adequate *medical monitoring*. When consciousness is reduced, there are risks; in particular, there are risks of airway obstruction. In addition, dosages will have to be adjusted to achieve the adequate degree of sedation. Therefore, many physicians would argue that PS should always be provided in hospital. In The Netherlands, however, 12% of deaths are preceded by PS, which is often provided in the patient's home.<sup>158</sup> Too little is known about these deaths and whether the procedures followed are medically and ethically acceptable. Some fear that some of these cases amount to a kind of 'slow euthanasia'.

Fourth, the patient's *life expectancy* matters. The Norwegian guidelines state that PS 'may only be given to patients with a life expectancy of a few days'.<sup>159</sup> Others think the limit should be two weeks. The reason for such restrictions is, mainly, the fear of a life-shortening effect if PS was administered to patients with longer life expectancies. However, there are at least three good reasons not to restrict PS to the last two weeks of life. First, as Materstvedt and Førde argue, if suffering is indeed unbearable and cannot be relieved in any other way, then the patient who is more than two weeks away from death has a *greater* claim on PS than the patient who is closer

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<sup>156</sup> Materstvedt et al., "Euthanasia and physician-assisted suicide," 99.

<sup>157</sup> Lars Johan Materstvedt and Reidun Førde, "Retningslinjene for lindrende sedering bør revideres," *Tidsskr nor legeforen* 129 (2009).

<sup>158</sup> Onwuteaka-Philipsen et al., "Trends in end-of-life practices."

<sup>159</sup> Guidelines of the Norwegian Medical Association on Palliative Sedation (2001). <http://legeforeningen.no/PageFiles/42360/Guidelines%20of%20the%20Norwegian%20Medical%20Association%20on%20Palliative%20Sedation.docx>; in the upcoming revision, this criterion is no longer absolute.

to death. The reason is that the first patient is facing a greater amount of suffering in total.<sup>160</sup> Second, a life-shortening effect of PS has not been proven empirically.<sup>161</sup> Third, it may be possible to provide ANH in such cases, thus securing that the patient for whom long-term PS is planned does not die from starvation or dehydration.

This brings up the fifth morally relevant feature, namely *whether ANH is provided* to the sedated patient. When it is withheld, the patient usually dies within two weeks. There are differing views on when nutrition and hydration should be provided, and medical arguments both for and against;<sup>162</sup> however, in a more narrowly ethical view, the crucial feature is the intention in sedating and in withdrawing ANH. The principle of double effect enjoins us to choose the least drastic measure that is capable of producing the good effect. Therefore, if there are no good medical reasons not to (which there often are), ANH should be provided. If ANH is not provided, and there is no medical justification for not providing it, then there is reason to suspect that the hastening of death was intended after all. For, if death was not intended, why choose to withhold ANH?

This is illustrated by the case of Kelly Taylor. In 2007, Taylor, suffering from several medical conditions and experiencing severe symptoms, and being given a life expectancy of one year, requested palliative sedation with the withdrawal of ANH.<sup>163</sup> Death was the explicit intention. The request was denied, on the grounds that the proposal would blur the lines between palliative sedation and euthanasia. Ethically, it would seem to have been a form of assisted suicide. DCPS in the setting of longer life expectancies (e.g., more than one week), then, starts to resemble a medical killing if ANH is withheld for no good reason.<sup>164</sup>

Sixth, the *depth of sedation* should be tailored to the need. The dose of sedatives should be titrated so that consciousness is preserved as much as possible, while still providing adequate symptom relief. The Norwegian guidelines require that

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<sup>160</sup> Materstvedt and Førde, “Retningslinjene for lindrende sedering bør revideres.”

<sup>161</sup> de Graeff and Dean, “Palliative sedation therapy.”

<sup>162</sup> *Ibid.*, 74-75.

<sup>163</sup> “‘Right to die’ fight abandoned.” *The Telegraph*, Apr. 19, 2007. <http://www.telegraph.co.uk/news/uknews/1549067/Right-to-die-fight-abandoned.html>; Taylor went on to live for a further five years, eventually dying in 2012. This highlights the difficulty in making accurate predictions of life expectancy.

<sup>164</sup> Søren Holm, “Terminal sedation and euthanasia: the virtue in calling a spade what it is,” in *Continuous Sedation at the End of Life: Ethical, Clinical and Legal Perspectives*, eds. S. Sterckx, K. Raus, and F. Mortier (Cambridge: Cambridge University Press, 2013).

raising the patient's level of consciousness be attempted or at least considered.<sup>165</sup> When DCPS is provided and awakening is not intended, one can, as Materstvedt explains, rightly speak of 'terminal sedation' (as palliative sedation as a whole is often, less aptly, referred to).<sup>166</sup> A kind of 'social death' ensues, and this practice may appear to some to border on euthanasia. However, as explained, the intention in DCPS is different from euthanasia, and even though DCPS causes a 'social death' from which the plan is that the patient will never be revived, it does not kill. Biological life continues.

This, then, is the outline of an NNL (both revised and 'orthodox') treatment of the ethics of palliative sedation.

## 5.4 Voluntarily stopping eating and drinking

Nurse and writer Marc Newhouse has written of his experiences with the practice of voluntarily stopping eating and drinking:

In April of 2010, my mother made a hard, but unquestionably good decision. She was 89, frail, almost blind, and thought she might have Alzheimer's. The idea of a slow, relentless deterioration – especially in a nursing home – was intolerable to her. A fine poet, she had combined wit with reason all of her life (...)

Finally, we saw that there was only one alternative – one way for my mother to sidestep the nursing home and achieve a good end. VSED. That's voluntarily stopping eating and drinking. Which, initially, I thought cruel. I had been a nurse for a decade, and the traditional wisdom is that a death by dehydration is agonizing. I did the research – there were reports that it had been done, and that it was not as uncomfortable as I had assumed. It took a few days of scrambling, but at last we found a doctor who would support my mother's decision. The doctor handed me a box of Kleenex as my mother matter-of-factly said, 'I know that I might have a few more years, that this could be depression and not Alzheimer's. But so what? I'd still be blind, not able to move, not able to read or write. Most of my old friends are gone, and my younger ones are busy' (...) I had read that the body might produce

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<sup>165</sup> Guidelines of the Norwegian Medical Association on Palliative Sedation; again, in the revised version this requirement will be relaxed somewhat. See also Materstvedt and Førde, "Retningslinjene for lindrende sedering bør revideres."

<sup>166</sup> Lars Johan Materstvedt, "Intention, procedure, outcome and personhood in palliative sedation and euthanasia," *BMJ Supportive & Palliative Care* 2 (2012): 10; Materstvedt and Bosshard, "Deep and continuous palliative sedation".

endorphins after the third day of the fast. I had also read that the sensation of thirst and hunger fade and perhaps disappear after the third or fourth day. My mother disputed that. But she also said, ‘it hasn’t been too bad,’ when someone asked her what it was like, to be five days without food or drink. The last week of her life had a serenity and depth that affected everybody (...) She said farewell to her friends, she resolved three unfinished pieces of business, and then, on the eighth day of her fast, she fell into a coma. And died three days later.<sup>167</sup>

In the course of a natural dying process there comes a stage where the patient no longer has much appetite for food and fluids, and later also becomes unable to eat and drink. However, stopping eating and drinking can also be chosen intentionally at an earlier stage, for the sake of hastening death. This particular practice is called ‘voluntarily stopping eating and drinking’ (VSED). Jansen & Sulmasy define it as ‘a practice in which 1) the patient has no underlying condition that interferes with normal appetite, digestion, or absorption of water and essential nutrients and 2) the patient nevertheless intends to end his or her own life by not eating or drinking’.<sup>168</sup> With VSED, death typically ensues within 1-3 weeks. The discomfort during these last weeks is reported typically to be tolerable, with usual complaints being dry mouth and thirst, hunger, and sometimes delirium (confusion).<sup>169</sup> In what follows, VSED for patients with limited life expectancy only will be considered.

When the patient intentionally stops eating and drinking, three different intentions can be involved in the decision. First, the intention can be to hasten death. This intention is suicidal and thus morally problematic in a revised NNL view.<sup>170</sup> Second, eating and drinking itself can bring discomfort for a frail person nearing death. It can therefore be intentionally forgone as a significant burden that is not outweighed by benefits. Even though eating and drinking in the regular way is not a medical treatment, the same moral principle applies, deeming this intention morally

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<sup>167</sup> Reprinted on the bioethics.net blog: <http://www.bioethics.net/2013/01/sons-perspective-on-using-vsed-to-hasten-death/> (accessed Aug. 30, 2013).

<sup>168</sup> Lynn A. Jansen and Daniel P. Sulmasy, “Sedation, alimentation, hydration, and equivocation: careful conversation about care at the end of life,” *Annals of Internal Medicine* 136 (2002): 845-46.

<sup>169</sup> J. Schwarz, “Exploring the option of voluntarily stopping eating and drinking within the context of a suffering patient's request for a hastened death,” *J Palliat Med* 10 (2007): 1291-92.

<sup>170</sup> For a competent person who contemplates VSED, life most likely still is, objectively, an aspect of human fulfilment. In that case the suicidal intention is morally unacceptable on both interpretations of revised NNL.



sound, depending on the circumstances. Third, eating and drinking can be forgone to relieve the suffering brought on by continued living. However, giving up food and drink does nothing in itself to relieve suffering in this case; rather, death is here sought as a means to end suffering. In this case, as in the first, death is intended. Again, this is unethical on the NNL conception.

However, a case can be made for treating these three cases equally in a juridical perspective. First, an external observer will have difficulty judging which of the three intentions comes into play in a given case. Second, if VSED is chosen with a morally bad intention, what should be the state's response? Force-feeding patients is a grave attack on personal integrity. Arguably, these considerations indicate that VSED must be a legally available alternative, in parallel with the right to forgo medical treatment. It seems, then, that VSED may often be unethical, but still ought to be permitted. However, it could and should be discouraged, and those who contemplate it counselled about alternative courses of action, such as palliative care.

Julian Savulescu argues for a moral and legal right to VSED, and notes that a patient who chooses VSED still has a right to palliation of any symptoms in the remaining days.<sup>171</sup> Palliation could even involve palliative sedation, if symptoms are sufficiently severe. The combination of VSED and aggressive symptom control Savulescu terms 'voluntary palliated starvation'.<sup>172</sup> A question, then, is whether health care workers' participation in palliation constitutes morally illicit cooperation in the patient's suicide. The question will not be treated fully here, but some salient points will be made. First, palliation in the course of VSED need not imply the health care worker's sharing the patient's suicidal intention. Rather, the health care worker can respect the patient's lawful right to forgo food and drink, and can simply intend to provide good symptom relief. The cooperation is therefore not *formal* (i.e., sharing the immoral intention), but *material*. The moral acceptability of material cooperation in wrongdoing depends on a host of factors that will not be reviewed in full here.<sup>173</sup> However, of particular interest is the following: will there be patients who would not

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<sup>171</sup> Julian Savulescu, "A simple solution to the puzzles of end of life? Voluntary palliated starvation," *Journal of Medical Ethics* (2013).

<sup>172</sup> Mercifully, he forgoes the opportunity to introduce yet another TLA (three-letter acronym).

<sup>173</sup> The morality of material cooperation in any particular instance may be assessed, for instance, with the help of Sulmasy's seven questions: Daniel P. Sulmasy, "What is conscience and why is respect for it so important?" *Theoretical Medicine and Bioethics* 29 (2008): 141-42.

choose VSED if it were not for the knowledge that palliation of symptoms due to dehydration and starvation would be readily at hand? If so, the offer of palliation would itself increase the incidence of this kind of suicide. This is surely problematic. The institutionalization of – and routine information about – voluntary palliated starvation may thus appear as an official endorsement of suicide, which would be quite problematic in an NNL view.

## 5.5 The minimally conscious state

Recall (from 3.2) that the *minimally conscious state* (MCS) resembles PVS, but is distinguished from PVS in that in MCS, there is a limited degree of conscious awareness.<sup>174</sup> The ethics of treatment-limiting decisions in PVS has been discussed extensively in Chapter 4. However, what difference should the presence of a limited degree of consciousness make to an NNL ethical assessment?

In 2011, an English court ruled against the withdrawal of ANH from a female patient, M, who had been in the minimally conscious state for 8 years. The court found that, as there was no advance directive refusing treatment and no intolerable suffering, life had to be preserved.<sup>175</sup>

However, to her family M certainly did appear to suffer, and they were clear that M would not have wanted continued treatment. Her sister stated, ‘What can she possibly get out of life? No pleasure. The daily routine of being got out of bed, put back, dressed, doubly incontinent. It’s not a life, it’s an existence and I know she wouldn’t want it.’<sup>176</sup> Commenting on the case, Emily Jackson voices an opinion that is likely to be shared by many:

Imagining myself in M’s shoes, I would regard a life in which I was totally dependent on others for all aspects of daily care; immobile; doubly incontinent; moved by a hoist; being played songs that made me cry and uttering occasional words like ‘where am I’ and ‘bloody hell’ as, to put it bluntly, a living hell.<sup>177</sup>

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<sup>174</sup> Giacino et al., “The minimally conscious state.”

<sup>175</sup> Sheather, “Withdrawing and withholding artificial nutrition and hydration from patients in a minimally conscious state.”

<sup>176</sup> *Ibid.*, 545.

<sup>177</sup> E. Jackson, “The minimally conscious state and treatment withdrawal: *W v M*,” *Journal of Medical Ethics* 39 (2013): 559.; consider also David F. Kelly: ‘Most of us would far more dread an existence where we are aware of being unable to communicate in any human way

To some, then, MCS appears *even worse* than PVS: what good is a limited degree of consciousness if unpleasant experiences dominate?

Wilkinson and Savulescu point to several reasons why MCS could be considered differently from PVS.<sup>178</sup> First, prognosis in MCS is better than in PVS, although only slightly so. Even among patients who recover from MCS, most remain severely disabled. Second, the patient may benefit from even limited interaction with the environment. However, as the authors point out, with a limited consciousness comes also the potential for unpleasant experiences and pain. Considerable discomfort could stem from awareness of the grave disability, inability to communicate, and physical pain from, e.g., spasticity and uncomfortable positioning. An imaging study showed that MCS subjects, unlike PVS patients, have a similar brain activation pattern in response to pain as healthy controls.<sup>179</sup> MCS patients, therefore, seem capable of experiencing significant pain, but they are unable to communicate this.<sup>180</sup> On these grounds, Wilkinson and Savulescu claim that MCS may indeed be *worse* than PVS – severe disability plus negative experiences outweighing positive experiences in MCS, versus severe disability and unawareness in PVS.

Whereas Wilkinson & Savulescu speak of the balance between pleasure and pain, NNL would focus on the conditions for participation in human flourishing. Arguably, it seems fair to say that mental and physical functioning in MCS, as in PVS, is on such a minimal level that biological life does not truly contribute to the person's human fulfilment. In that case, revised NNL's ethical principles are the same in the case of MCS as in the case of PVS: ANH can be withdrawn because no true benefit results (first interpretation); or the patient's life may, in addition, be ended intentionally, because the patient's life is not a real aspect of human fulfilment (second interpretation).

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with our environment, to leave our beds, to move our bodies voluntarily, and to escape the technology that was keeping us “alive” than we would dread an existence where we were aware of nothing at all’: David F. Kelly, Gerard Magill, and Henk ten Have, *Contemporary Catholic health care ethics* (Georgetown University Press, 2013), 187.

<sup>178</sup> Dominic Wilkinson and Julian Savulescu, “Is it better to be minimally conscious than vegetative?” *Journal of Medical Ethics* 39 (2013).

<sup>179</sup> Mélanie Boly et al., “Perception of pain in the minimally conscious state with PET activation: an observational study,” *The Lancet Neurology* 7 (2008).

<sup>180</sup> D.J. Wilkinson et al., “Functional neuroimaging and withdrawal of life-sustaining treatment from vegetative patients,” *Journal of Medical Ethics* 35 (2009).

This discussion highlights a more general point in the revised NNL approach: if a continuum of somatic and mental functioning is considered, then PVS and MCS are at the lowest end. In such states, life is not a real aspect of fulfilment. However, as one moves upward on the continuum, one reaches levels of functioning where life must be said to contribute to fulfilment. In between these stages, there must be conditions where no uncontroversial verdict on life's contribution to fulfilment is possible. In practical, clinical-ethical decisions for such patients, prudence must be exerted; revised NNL does not give definitive guidance.

## 5.6 Locked-in syndrome

*Locked-in syndrome* (LIS) is a rare condition in which the patient becomes 'trapped inside her body', with consciousness intact but without ability to execute voluntary movement. Outwardly, locked-in syndrome may resemble PVS. However, whereas in PVS there is widespread damage to the cerebral cortex and no consciousness, in locked-in syndrome, higher brain functions, including consciousness, may be preserved. Classical locked-in syndrome is usually caused by a brainstem lesion (typically of vascular origin), but locked-in syndrome is also an end stage for neurodegenerative disorders such as amyotrophic lateral sclerosis (ALS).

The prospect of life in locked-in syndrome would appear horrendous to many, perhaps, seemingly, a 'fate worse than death'. In an interview study with 97 health care workers, two-thirds thought that 'being [in] LIS is worse than being in a vegetative or minimally conscious state'.<sup>181</sup> Nick Chisholm, who suffers from LIS, stated, 'Words can't describe the situation I have been left in – but this is as close as I can get it: an extremely horrific experience that I wouldn't wish on my worst enemy'.<sup>182</sup> However, for Chisholm, thoughts of meaninglessness and suicide were not constant. As Grant Gillett, who commented on Chisholm's story, states,

One might concur with Nick when he says that his life in the state to which he has been reduced is not worth living and that at times he just wants to be left to die but also be overwhelmed by the courage and determination he shows by going on living.

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<sup>181</sup> D. Lulé et al., "Life can be worth living in locked-in syndrome," 177 (2009): 347.

<sup>182</sup> Nick Chisholm and Grant Gillett, "The patient's journey: Living with locked-in syndrome," *BMJ* 331 (2005): 94.

In fact his determination to go on living is congruent with the majority response of patients in this condition.<sup>183</sup>

Indeed, empirical data on LIS patients exhibit the ‘disability paradox’ in that ‘people with serious and persistent disability report that they experience a good [quality of life],’<sup>184</sup> whereas family and caregivers systematically underestimate the subjective quality of life experienced by the patients. Some patients are able to interact socially in meaningful and substantial ways. Some are able to, e.g., write books, act as legal consultants, or teach math.<sup>185</sup> Even such an extreme physical disability as experienced in LIS, then, need not preclude meaningful participation in human goods. However, caregivers are needed to facilitate the patient’s flourishing, by providing care, attention, and the means for communication. It becomes a moral duty for health professionals and society to provide the means for LIS patients to lead a meaningful existence.

With the advent of brain-computer interfaces, in which a patient can communicate through conscious thoughts read by a computer, interaction with the world becomes possible even for patients with ‘total LIS’. In ‘total LIS’, even eye mobility is lacking.<sup>186</sup>

All in all, one must avoid painting a too-bleak (or for that matter, a too-rosy) picture of life in LIS, an existence of severe physical disability that can hardly be imagined by most of us. Even in LIS, biological life constitutes a real aspect of human fulfilment, and so suicidal intentions are, in an NNL view, unacceptable.

In the much-publicized case of LIS patient Tony Nicklinson, the English High Court dismissed Nicklinson’s plea that any aid in his suicide must be lawful on the ground of necessity.<sup>187</sup> Nicklinson then chose to stop eating and drinking (VSED) and died six days later, allegedly of pneumonia. Nicklinson’s plight is heart-rending and elicits sympathy. However, in an NNL view, the VSED decision was morally unacceptable if the intention was, as it seemed to have been, suicidal.

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<sup>183</sup> Ibid., 96.

<sup>184</sup> Lulé et al., “Life can be worth living in locked-in syndrome,” 342.

<sup>185</sup> Steven Laureys et al., “The locked-in syndrome: what is it like to be conscious but paralyzed and voiceless?” *Progress in Brain Research* 150 (2005): 505.

<sup>186</sup> Lulé et al., “Life can be worth living in locked-in syndrome,” 346.

<sup>187</sup> “Tony Nicklinson dies after losing ‘right to die’ legal battle.” *The Guardian*, Aug. 22, 2012. <http://www.theguardian.com/uk/2012/aug/22/tony-nicklinson-dies-right-to-die>

There is much debate as to whether, and in what conditions, permanent ventilator treatment should be provided to ALS patients when their respiratory function deteriorates. However, if such treatment is decided against by patient or physician, the intention is (most likely) not suicidal, but to avoid particularly intrusive and burdensome treatment with sparse benefits.

## 5.7 A revised new natural law theory view of end-of-life decisions

To sum up, I will highlight some of the revised NNL theory's virtues, and, in the next section, its potential vices. Revised NNL's considerable complexity enables it to give nuanced ethical guidance. The theory's basic teleology demands specification of the abstract principles so that they are sensitive to what really matters to human beings. Thus ethics becomes the guidance of the rational pursuit of the human goods that are *constitutive of human flourishing*. The emphasis on the pre-moral, basic human goods justifies a greater sensitivity to *the consequences of action* than is typical of deontological theories. This was illustrated in the common good argument regarding euthanasia. The core question of common good arguments is whether the practice under consideration promotes or demotes the basic requirements for citizens' pursuit of the basic goods. Consequences of concrete proposals for these basic conditions are of the utmost ethical relevance.

In a common good argument, data from empirical sciences (natural, social) also become highly relevant, as was seen in the discussion of euthanasia. Thus natural law is not an ethics remote from real life, where highly abstract principles can be 'applied' to a stylized rendition of a highly complex case without consideration of the particular circumstances. The theory's small set of moral absolutes are well-justified in that they forbid actions that are incompatible with a will toward integral human fulfilment, actions that thus counteract human flourishing.

Revised NNL differs from 'orthodox' NNL in taking seriously the fact that, in rare cases, an instance of basic human good does *not* contribute to human fulfilment. Reasons for action spring from the basic human goods, but are ultimately grounded in their promotion of human fulfilment. Thus, instances of basic good that do not contribute to fulfilment do not command our respect – it is not irrational to act

intentionally against them. As has been argued, this move enables revised NNL to make better sense of some important intuitions in the ethics of end-of-life decision making. For even life may – although, fortunately, very uncommonly – cease to be an aspect of human fulfilment.

Revised NNL does not make away with the need for prudent judgment. The morally virtuous health professional appreciates the salient details of complex situations. She understands which moral principles are of particular import in the case at hand. However,

Principles are necessary as benchmarks, but they are not sufficient, since every moral act is a particular act embedded in time, space, place, and persons. A moral decision is not a decision about a principle, but about the relationship of circumstances, intentions, and ends to a principle.<sup>188</sup>

The virtue of prudence is particularly important in the field of medicine, as situations are often extremely complex, medically, humanly, and ethically. Among the fields examined in this chapter, this goes in particular for treatment-limiting decisions. The revision of NNL can be said to slightly widen the space for prudential judgments, thus nudging the theory in the direction of the classical natural law theories.

Revised NNL is a system of ethics that grounds and gives meaning to essential ethical distinctions and concepts. It therefore mounts a robust defence of vital principles in traditional medical ethics. The theory is able to make sense of core intuitions. Because it is, at the fundamental level, justified in a general and plausible theory of practical reason, it constitutes a rationally appealing alternative to the kind of unreflected rule-following and moral relativism that may threaten to erode the professional ethics of health care workers.

## 5.8 Concluding remarks: potential weaknesses in the revised theory

In the preface to *Anarchy, State, and Utopia*, Robert Nozick complains how some works of philosophy are too eager to hide the weak points that are inherent in almost

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<sup>188</sup> Pellegrino and Thomasma, *The virtues in medical practice*, 23.

any complex chain of arguments. He compares such works to trying to fit materials of diverse shapes and sizes into a preordained shape – then:

*Quickly*, you find an angle from which it looks like an exact fit and take a snapshot; at a fast shutter speed before something else bulges out too noticeably. Then, back to the darkroom to touch up the rents, rips, and tears in the fabric of the perimeter. All that remains is to publish the photograph as a representation of exactly how things are, and to note how nothing fits properly into any other shape.<sup>189</sup>

As the author and the readers should be in the shared business of searching for the truth, openness about weaknesses and potential counter-arguments must be a virtue. Therefore, I will close by briefly mentioning twelve potential sources of scepticism towards NNL theory in general and my approach in particular.

*Is it really self-evident?* Chapters 1 & 2 showed how NNL invokes self-evidence to justify crucial theses. The problem of the underdeterminacy of self-evidence was that there may be entire families of propositions that can make equal claim to justification by self-evidence. The problem arises in its most pernicious form if two or more of these propositions are mutually contradictory (1.5). In that case, they cannot all be true, and *a fortiori* they cannot all be *self-evidently* true. In a worst case, such a finding would constitute a *reductio ad absurdum* of the entire endeavour of invoking self-evidence in the NNL context. And in that case, NNL as a whole is refuted.

*Self-evidence as Pandora's box.* A related worry is that my method of choosing the most plausible among a family of competing, putatively self-evident propositions (i.e., the combination thesis: Chapters 2 & 4) can be taken to extremes. For instance, why may one not go even further than the combination thesis, embracing for instance ‘Respect each instance of basic human good as long it is not outweighed by other instances of other goods’, or even ‘Respect each instance of basic good as long as it is the best way to promote flourishing, all things considered’? The worry may be compounded by the relative ease with which a new, 11th requirement of practical reasonableness was conjured (4.7.2). However, there are theoretical reasons why NNL would not allow precepts such as the two first mentioned. Such precepts look dangerously akin to consequentialism. In particular,

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<sup>189</sup> Nozick, *Anarchy, State, and Utopia*, xiii.



there is the incommensurability thesis, which demands that no instance of good is ever acted against *for the sake of* any other instance of good, and which rules out the weighing of instances of good as such. In addition, the precept must be strictly pre-moral at this stage, or else it would imply illicitly importing moral prejudices, thus begging the question. The combination thesis is strictly pre-moral: it is rooted merely in consideration of the basic goods as such – in particular, in practical reason's grasp that instances of basic good may not *always* contribute to flourishing.

*Does the reliance on intuitions imply ad hoc justification?* Does the method of reflective equilibrium wherein intuitions are accorded weight constitute begging the question and deferring to any preferred intuition? May one now pick and choose among NNL's moral verdicts, discarding those that do not fit one's fancy? Not at all. It is very important to realize the specific function of appeal to intuitions in my approach. Here, strong and prevalent intuitions were accorded weight not on the level where concrete moral verdicts are evaluated, but on a more abstract and general level of theory construction. Intuitions were only lent weight because there were no other principled reasons for choosing among the four candidate formulations of the seventh requirement of practical reasonableness. The intuitions that were used were the ones about PVS (Chapter 3), and about intuition-driven test cases (Chapter 2). Some may object that the second interpretation's implication that the PVS patient does not have a moral right to life is counterintuitive and unacceptable, and furthermore, that this flatly contradicts my intention of relying on *plausible* intuitions in the construction of the theory. But this objection fails, for the reasons given above: in my approach, intuitions were lent weight at a general level of theory construction, and justifiably so. This move does not commit me to take seriously *any* intuition-driven objection to concrete moral verdicts.

*The status of the basic goods.* In NNL, the basic goods have an elevated status that may appear quaint and implausible. One may not act intentionally against them (although, according to revised NNL, there are some rare exceptions), and all reasons for action must spring from the goods. However, the new natural lawyers have not simply posited this, but *argued* in favour of it. Their line of reasoning is transparent and counter-arguments are thus welcome. Timothy Chappell is among those who are unconvinced by the NNL thesis that all action is for the sake of the goods:

[NNL] apparently assumes that all action has the shape of *pursuit of some objective*. But that's simply untrue: reasons can be future-based, past-based, present-based, and other things (...) Behind this, it seems, lurks an instrumental conception of action as being always and only about nothing but taking the means to some antecedently given end. What object am I representing as Q-able, what object am I Q-ing, when I play the violin, greet a friend on a railway platform, say the Mass, dance at my brother's wedding, award a Nobel prize, sit down to read Homer for the evening, pause to watch a bee cleaning its legs, laugh in an oppressor's face?<sup>190</sup>

I see the contours of an NNL analysis in terms of the basic goods for each of the actions Chappell mentions. However, such analyses may arguably be strained, and NNL's insistence that all meaningful action can be traced back to the motivating power of the basic goods may fail to convince.

*Challenges to the incommensurability thesis.* The incommensurability thesis has been presented and some difficult challenges outlined (1.4.10). If these cannot be met convincingly, the entire NNL edifice will come crumbling down. The reason for this is that the central role of the thesis in the NNL architecture. It is the incommensurability of basic goods that ensures that a loss of a good cannot be 'outweighed' by any corresponding gain, and thus that intentional actions against any instance of basic goods must be irrational.

*An alternative view of the relationship between goods and norms.* Scepticism towards the elevated status of the basic goods coupled with the problem of the underdeterminacy of self-evidence may lead to another objection: orthodox NNL infers moral norms, some of which are absolute, from the basic human goods and the self-evident requirements of practical reasons. However, is it not equally or more 'self-evident' that the goods, in sum constituting flourishing, are considerations *that we take into account* when deliberating – without elevating them to a semi-sacred status where they cannot be intentionally acted against? This intuition or objection is to some extent met by the revised NNL, in acknowledging that the goods do not always contribute to flourishing and thus do not always give rise to overriding moral reasons for action.

*The artificiality of NNL.* This leads to the related objection that NNL's portrait of practical reasoning may appear artificial and strained. This objection may take

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<sup>190</sup> Chappell, "On not saying more than we know," (2013).

many shapes – for instance, that NNL’s picture does not look much like what goes on when people actually deliberate. However, a retort could be that NNL gives a theoretical reconstruction of *normative principles* for deliberation, not necessarily an account of how deliberation takes place in practice. The reliance on deduction and the invocation of highly general and abstract rules may be off-putting. But then again, many of the theory’s precepts are such as to provide merely mild guidance, and defer much to the person’s exercise of judgment.

*Cumulative doubt about the NNL system.* The above objections to self-evidence, the elevated status of the goods, and the artificiality of the system coalesce in a powerful objection from *cumulative doubt*. The basis for the revision of NNL was that basic precepts were open to doubt, and revisable. Basic precepts were altered, and the upshot is a changed set of moral norms. Dare we trust, and live by, these revised norms? The pliability of the basic principles may appear suspect. This is especially so if concrete moral verdicts appear counterintuitive and unpalatable. The question, then, is what do we trust the most – our considered moral verdicts and strong intuitions, or verdicts derived from abstract foundational premises about practical reason, premises that themselves may appear to be built on shaky foundations? If the foundational premises are in doubt, then on the way towards concrete moral verdicts, the doubt becomes cumulative, threatening the integrity and plausibility of the system as a whole.

*Revised NNL’s moral verdicts as reductio?* It is no secret that NNL theory appeals to many for its apparent ability to codify, explain and defend a corpus of classical Christian ethical verdicts without recourse to religious premises. To such readers, as to those who have strong normative commitments on other bases, revised NNL may appear unpalatable. This is particularly so, perhaps, if the first interpretation is found to be indefensible, and the second interpretation with its defence of a moral right to euthanasia in some cases wins the day. For readers with such strong normative preconceptions that they would be unwilling to shed, revised NNL’s moral verdicts may appear as a *reductio ad absurdum*, either of revised NNL, or, if my reasoning is taken to be sound, of the entire project of NNL. Such a reader would perhaps want to turn to other secular ethical theories such as certain versions of classical natural law theory, or to explicitly religious ethics.

*A huge number of contentious issues.* In choosing the approach followed, I have not made it easy on myself (nor on the reader, perhaps!). The scope and method

necessitated touching on a large number of contentious issues. For many of these issues, the deeper one digs, the more puzzles, questions and doubts are uncovered. Therefore, it is relatively easy to criticize my overall line of argument, as most of the numerous premises on which it depends can be attacked, and from a number of standpoints. Still, when I have chosen to defend the thesis presented herein, it is because I believe that I have chosen – after consideration and argument – the most plausible path in each intersection of the argument. Even with this presupposition, the resulting theoretical edifice may appear shaky to some readers due to the accumulated doubt and counter-arguments amassed. Pointed criticism is most welcome.

*The ‘run out of gas’ argument.* High moral theories, such as NNL, start from very general precepts. It has been argued that such theories typically do not contain the theoretical resources to produce unequivocal fine-grained moral verdicts on their own, without extraneous normative premises. John Arras claims:

whichever theory we happen to embrace – whether it be any flavor of utilitarianism, contractarianism, or natural law – will eventually run out of gas before it reaches the level of concrete decision making required by practical ethics. In most cases, the theorist will have to reluctantly conclude that several policy options are sufficiently just according to their preferred theory, and then rely on a procedural-political solution afforded by some variant of so-called deliberative democracy.<sup>191</sup>

I would speculate that NNL is somewhat stronger than most other theories in this respect, because it relies on a rich conception of basic human goods and thereby also human nature. Nevertheless, the need for extra premises that are not contained in the NNL theory itself has been illustrated a few times throughout the present work. For instance, competing notions of dignity, and the difference it makes which one is relied upon in the application of the theory, were discussed (4.1.8). Another instance is the metaphysical apparatus needed to defend the substance view of the foetus, in order to arrive at the ethical critique of abortion typically favoured by NNL proponents (4.7). A third example is the metaphysical view of the self – body-self monism and the rejection of alternative accounts (4.1.3). A fourth is the specific account of intention and the reliance on the intention/foresight distinction (2.5). While arguably plausible, these concepts do not stem from NNL itself. Thus it seems that on many ethical

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<sup>191</sup> Arras, “Theory and Bioethics.”

issues, *there is no unique NNL view*, but instead a wide range of views that are compatible with basic NNL precepts, for the moral verdict stems not only from the theory's general precepts, but also from the additional premises relied upon in their application.

*Critique of ethical theories.* An important critique of high moral theories is that a moral theory's promise to deduce 'everything' relevant for ethics, including accounts of motivation, deliberation and action, from a small selection of abstract premises, is wildly ambitious.<sup>192</sup> Must such analyses become strained and implausibly reductionist in the attempt to accommodate every fact of human action? Such a critique of ethical theories in general will also affect NNL. However – and arguably – NNL may fare better than many competitors here, thanks to its rich account of practical reason and the basic goods. Indeed, the overarching argument throughout this work has been that NNL theory – particularly in its revised version – is a plausible ethical theory. No ethical theory is without tough objections that must be tackled. However, the claim here has been that revised NNL theory's portrayal of the principles of morality is at least as plausible as that of any other ethical theory.

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<sup>192</sup> Chappell, *Ethics and Experience*, 202-13.



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