

*Lars Johan Materstvedt*

## WHAT IS THIS THING CALLED MEDICAL ETHICS? A KANTIAN INTERPRETATION<sup>1</sup>

Among moral philosophers, few have had a greater impact than Immanuel Kant (1724–1804). The liberal societies we now live in, and enjoy the fruits of, are fundamentally shaped by Kant’s thinking, both as regards individual freedom and conceptions of what constitutes right and wrong conduct in very many areas.

Moral philosophy may also be called ›normative ethics‹ (see overview on the next two pages). A sub-specialty within this area is *medical ethics*. In this chapter, I offer a reading of this field which is mainly Kantian; that is, I use Kant to analyse and assess certain issues of principle within medical ethics. The works referenced in this connection are *Grundlegung* [*Grounding for the Metaphysics of Morals*] (1981), *Tugendlehre* [*The Metaphysics of Morals*, second part: Doctrine of Virtue] (1988), and *Anthropologie in pragmatischer Hinsicht* (1907).

So what is medical ethics? I present and discuss two particular conceptions of it. One is known as the ›four principles approach‹ to health care ethics, developed by the Americans Tom Beauchamp and James Childress (1979; 2009). The other has been designated ›philosophical medical ethics‹ (PME for short) by the UK physician and philosopher Raanan Gillon (1985).<sup>2</sup> Since Gillon calls himself the four principles’ ›unpaid European agent‹ (2003a, p. 267), I also identify ways in which his PME may conflict with the four principles approach. Finally, I offer some reflections on the question, ›what is the use of philosophical medical ethics?‹

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<sup>1</sup> Thanks go to Professor Bjørn Myskja, colleague at the Department of Philosophy, NTNU, for comments and disagreements that helped improve the text in several places.

<sup>2</sup> ›Who is Raanan Gillon‹, philosophers who are not very familiar with medical ethics will wonder. He describes himself thus: ›a hybrid medical doctor and philosopher and Chairman of the Institute of Medical Ethics Governing Body ... a retired NHS general practitioner, Emeritus Professor of Medical Ethics at Imperial College London, and a member of the British Medical Association’s Medical Ethics Committee. He was Editor of the *Journal of Medical Ethics* for 20 years until 2001 and has published extensively in the field of medical ethics. His 1985 book *Philosophical Medical Ethics* has had some 13 reprints and a second edition is planned, to be co-authored with his erstwhile colleague Daniel Sokol.‹ Institute of Medical Ethics: [www.instituteofmedicaethics.org/members/rgil](http://www.instituteofmedicaethics.org/members/rgil)

## ETHICS: A DIVISION

Before attempting to identify the area of medical ethics it might be helpful to start with the basics, as it were, and ask ›but what is *ethics*?‹ As philosophers are well aware, there are several approaches to this issue. I see it this way: First, there is the etymological aspect. ›Ethics‹ derives from the Greek *ethos*, which has to do with attitude and character – whereas its sibling, ›morality‹, has at its core the Latin *mos*, which refers to custom and habit. (And so the original meaning of the two is not identical.) Second, I consider it appropriate to make a threefold distinction between metaethics, normative ethics, and descriptive ethics. These represent different areas of investigation:

### METAETHICS

Abstract, technical-philosophical analysis of key concepts and ideas, addressing issues such as:

- What is the meaning of ›moral‹ and ›immoral‹? (Socrates; Kant)
- How are particular conceptions of morality justified? (Aristotle: based on ›human nature‹; Kant: stems from the mind)
- Do moral utterances meet conditions of truth and falsity?
- Is there such a thing as moral knowledge?
- May we deduce ›ought‹ from ›is‹? (›Hume's problem‹)
- Is morality just an expression of feelings? (Ayer's emotivism; noncognitivism)
- Is morality mainly a matter of reason? (rationalism; cognitivism)
- Are we morally responsible? (the problem of free will; ›mad or bad‹)
- Moral scepticism (›morality is meaningless‹)
- Moral realism (Matthew Kramer)

### NORMATIVE ETHICS (MORAL PHILOSOPHY)

Theoretical – cf. *theoria* = ›way of looking at‹ – conceptions of right and wrong, including:

- Deontology/ethics of duties (Kant)
- Consequentialism (classical Utilitarianism: Bentham, J.S. Mill; act and rule Utilitarianism; preference Utilitarianism)
- Intuitionism (Sidgwick; W.D. Ross; Rawls)
- Virtue ethics (Aristotle; Alasdair MacIntyre)
- Discourse ethics (Socrates; Apel; Habermas)
- Moral relativism (the Sophists; Gilbert Harman)
- Moral objectivism (Plato)
- Natural rights theories (Locke)
- Ethical egoism (Ayn Rand)

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- Ethics of care (Carol Gilligan)
- The four principles of health care ethics (beneficence, non-maleficence, autonomy, justice)
- Philosophical medical ethics (Raanan Gillon)
- Doctrine of double effect (medical treatment; just war)

#### DESCRIPTIVE ETHICS (EMPIRICAL ETHICS)

Concerns what particular views exist of right and wrong, both in general and in concrete cases

- a. within cultures (›common morality‹; consensus; moralisation)
- b. at the level of society (e.g. laws – both within and across level a.)
- c. within each social group (military ethics; the ethical codes of various professions; mafia ethics)
- d. at the level of the individual (subjective)

### ON THE RELATIONSHIP BETWEEN METAETHICS AND NORMATIVE ETHICS

The distinguishing characteristics of metaethics and normative ethics are portrayed thus by Mark Schroeder:

Philosophers classify ... questions about the metaphysics and epistemology of morality as belonging to the area of ›metaethics‹, so called because many people believe that the questions of metaethics are not question *within* ethics – that is, they are not themselves moral questions – but are rather questions *about* moral questions – so they are ›meta‹ questions (2010, p. 3).

The ›thickness‹ of the wall between metaethics and normative ethics is, however, a matter of dispute. For example – and as implicitly reported in the above overview – Kant's *Grundlegung* (1785) may be seen as both a work of normative ethics: ›how ought I to live and act?‹; and of metaethics: ›what do people actually mean when they say that something is immoral? How do we account for that?‹

But even though these areas are interconnected in various ways and may also influence each other (i. e. the ›wall‹ is not watertight or impossible to climb), some philosophers believe that you may engage in metaethics without subscribing to any ethical view whatsoever. One famous example of this attitude is found in the writings of philosopher Alfred Jules Ayer (1910–1989), whose work *Language, Truth and Logic* (1936) is considered *the* classic text of Logical Positivism and modern British philosophy, and is accredited with founding both. Put briefly, Ayer's metaethical position is emotivistic, seeing moral utterances within normative and descriptive ethics simply as expressions of feelings of like or dislike. Ayer says

nothing about the moral correctness of any view at those levels; indeed, he thinks that morality can be neither true nor false, and so it evades rational deliberation altogether.<sup>3</sup>

This is not the place for pursuing the difficult issue of moral truth. Suffice it to say that although philosophers have struggled with this issue since David Hume (1711–1776) (see in particular Hume, 1958), a ›solution‹ seems distant at best. The late US philosopher Robert Nozick (1938–2002)<sup>4</sup> puts the problem succinctly:

How can ethical statements be true, if truth consists in correspondence to the facts? Are there special kinds of facts, ethical ones, and if so, by what route do we discover them? Not, apparently, by everyday observation or by scientific experimentation and theorizing. How else can we discover them? The history of philosophy is abundant with unsuccessful attempts to establish a firm basis for ethical rules. Inductively, we infer that this task is unpromising (2001, p. 236).

A recent position not only challenges the traditional way of thinking about the relationship between metaethics and normative ethics (as depicted in the above quotation from Schroeder); it even holds that in the case of moral realism, the distinction between the two collapses: ›Moral realism – the doctrine that morality is indeed objective in the various respects to be elaborated here – is a moral doctrine‹ (Kramer, 2009, p. 1). In other words: here, metaethics *is* normative ethics. But that, too, is a theme for another time.

#### A NOTE ON DESCRIPTIVE ETHICS

Descriptive ethics is, as this author sees it, non-normative by nature. For example, an anthropologist reporting and explaining the ethics of infanticide in some non-modern society would not, *as an anthropologist* (although as a private person he might well, and would perhaps inevitably do so), evaluate that practice in any other way than scientifically – observing, so to speak, Hume’s distinction between ›is‹ and ›ought‹ (1958). Such is also the case in medical research investigating the attitudes and ethical thinking of Dutch doctors who practice infanticide in neonatology. This is legally acceptable in the Netherlands under very strict conditions – notwithstanding the fact that it is, in principle, murder under the Dutch penal code (Griffiths et al., 2008). Although this is something that normally provokes strong moral emotion and outcry in doctors and lay people alike, work has been

<sup>3</sup> Miller (2003) provides a helpful introduction to Ayer’s position and subsequent contemporary metaethics.

<sup>4</sup> For information about Nozick, see my home page: [www.materstvedt.net](http://www.materstvedt.net)

published that displays a neutral attitude to the ethics of this rare phenomenon (Moratti, 2011) – or so I would argue.<sup>5</sup>

This kind of empirical ethics plays a pivotal role in *applied* ethics, a category within which one uses the tools of normative ethics to analyse and assess certain controversial real-world issues. Medical ethics is a case in point, and in the above division, the last four approaches listed under normative ethics all concern this subject. The euthanasia<sup>6</sup> debate provides a good illustration of the need to know the ethical thinking of doctors and patients – which among doctors differs markedly across countries, although some majority views of euthanasia can be seen to exist (Bosshard et al., 2008) – for if your empirical premises are wrong, inappropriate ethical conclusions may follow. This also holds true for detailed knowledge of medical matters (Materstvedt, 2007a).

#### THE FOUR PRINCIPLES APPROACH TO HEALTH CARE ETHICS

The principles are as follows:

1. Beneficence – the obligation to provide benefits and balance benefits against risks
2. Non-maleficence – the obligation to avoid the causation of harm
3. Respect for autonomy – the obligation to respect the decision-making capacities of autonomous persons
4. Justice – obligations of fairness in the distribution of benefits and risks

Gillon notes that ›Although they do not provide ordered rules, these principles can help doctors and other health care workers to make decisions when reflecting on moral issues that arise at work‹ (1994, p. 184). Thus, none of the principles take precedence over the others – although Gillon has later (2003b) argued that the principle of autonomy should be ›first among equals‹. The four principles do not resolve medical-ethical challenges and dilemmas. They cannot be used to calculate an answer. ›Ethics is not mathematics‹, to paraphrase Aristotle's critique of Plato (who did indeed think that it was). We may therefore say that the character of the four principles is to, rather than provide ›the‹ solution, represent a particular way

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<sup>5</sup> That is not to say that I am unaware of the problems associated with the idea of ›pure‹ descriptions. Some would question whether there really is such a thing, arguing that descriptions are inevitably rich with normative content. I do not believe this to be generally true: surely, some descriptions are no more than just that. Others are in a grey area; still, I believe that one can be neutral about them. I therefore find myself in agreement with historians who hold that an entirely non-normative history of the Holocaust is both possible and scientifically desirable.

<sup>6</sup> See definition below.

of thinking; to help structure the medical-ethical field; and to function as a kind of ›check-list‹ for physicians and other healthcare workers.

The principles may conflict both in theory and in practice, due to their *prima facie* nature (Beauchamp & Childress, 2009, p. 33); see examples below. This need not be taken as a sign of a lack of potential, though. On the contrary, some see it as evidence that it is a flexible approach, which is most welcome in the complex world of medicine and medical decision making.

Nonetheless, others reject the four principles as culturally contaminated, claiming that accordingly, their scope is limited (Wulff, 1994).<sup>7</sup> Be that as it may – they are at least useful as a Weberian ideal model for analysing the values and norms of other cultures: for example, I myself have employed them thus in a piece about conceptions of morality in Uganda (Materstvedt, 2006). Additionally, together with an intensive care physician I have used the four principles as a device in a discussion of the ethics of organ donation (Materstvedt & Hegvik, 2004).

UK philosopher and medical ethicist John Harris argues that the four principles are largely unhelpful. He distances himself from them, favouring instead

an unprincipled approach to biomedical ethics ... in the sense that the four principles are neither the start nor the end of the process of ethical reflection. While the four principles constitute a useful ›checklist‹ approach to bioethics for those new to the field, and possibly for ethics committees without substantial ethical expertise approaching new problems, it is an approach which if followed by the bioethics community as a whole would, the author believes, lead to sterility and uniformity of approach of a quite mindbogglingly boring kind (2003, p. 303).

In contrast, Gillon takes a dramatically opposite view, to the extent of holding that the principles will even prove applicable well outside the medical field:

In the long run ... I believe the four principles approach to ethics will be recognised to have far wider moral relevance than its application to health care ethics. Indeed I predict its increasing acceptance as the basis for a global ethics, compatible with and acceptable across the range of the world's moral cultures, sensitively negotiating the delicate path between moral relativism and moral imperialism and helping in the pursuit of morally acceptable world peace. If I am right, one day the pioneering work of Tom Beauchamp and Jim Childress will be recognised for its global importance – if it were in my power I'd put them up for the Nobel Peace Prize today! (2003b, p. 311).

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<sup>7</sup> This has to do with how global the four are, and also whether different religions would agree or converge on them. Gillon's (ed., 1994) huge collection of texts addresses these and many other issues. The work includes the chapters ›The four principles and their use: the possibilities of agreement between different faiths and philosophies‹; ›Theology and the four principles: a Roman Catholic view‹; ›An Anglican view of the four principles‹; ›A Jewish perspective on the four principles‹; ›Islam and the four principles‹; ›Buddhism and the four principles‹; ›African ethical theory and the four principles‹; ›Limitations of the four principles‹; ›The four principles in practice: facilitating international medical ethics‹.

Despite the above disagreements, it is nevertheless a fact that the approach has gained remarkable acceptance since its introduction in 1979 – not least within medical schools in many countries, together with an increased interest in, and realisation of the importance of, medical ethics as part of medical education (Doyal & Gillon, 1998; Singer, 2003; Hegstad, Materstvedt & Kaasa, 2004).

Furthermore, the so-called ›ethical matrix‹ developed by Ben Mepham and colleagues in the early 1990s springs to a large extent from the four principles approach (see also Mepham, 2005). Its application is not confined to the area of medicine:

One well-known assessment tool in agricultural and food ethics is the ethical matrix method. This tool stands in an intuitionist tradition from Ross via Beauchamp and Childress' principle based ethics. Both Ross and Beauchamp and Childress advocate a fundamental pluralism of moral principles and argue that no substantial ethical theory has the same certainty as general ethical principles. Therefore, one cannot identify a hierarchy of principles or an overarching principle that will be able to decide in cases where principles conflict. In the matrix, this pluralism of principles is expressed through three general principles structuring the ethical concerns: care for well-being, respect for dignity, and justice (Forsberg, 2007, p. 456).

### BENEFICENCE – ›DO GOOD‹

Beneficence is the principle that one should ›do good‹. This is a *positive* principle, meaning that it requires physicians and other healthcare workers to actively promote the well-being of patients. In this interpretation, the physician acts as the patient's ›attorney‹.

But sometimes it can be hard to tell exactly what would benefit a particular patient. Take, for instance, the case of radical surgery for advanced metastatic cancer. Is such potentially life-prolonging treatment always ›worth it‹? What is the more beneficial approach: to offer the treatment, or to offer only palliative care (although the importance of the latter cannot be overestimated)? The key issue underlying such assessments is the question of what would count as the best possible quality of life for someone whose life is coming to an end. In this case, the danger is that aggressive and unnecessary, futile treatment – i. e. overtreatment – ruins the final phase. In the words of the Council of Europe:

Professionals should recognise the limits of medicine and refrain from overtreatment ... The core principles underpinning all palliative care services are focused on achieving the best possible quality of life for each patient and their family (2003, explanatory memorandum, §§ 60 and 56).

But does not, then, the non-maleficence principle (dealt with in the next section) offer a better picture of this scenario: after all, doctors and others would cause harm

through overtreatment. Nevertheless, they would not intentionally be inflicting harm in such cases: unfortunately, they *end up* harming, but their actions do not have harming *as* an end. And so these actions carry the hallmark of beneficence: do good. The harm that is caused is, accordingly, an adverse effect.

Beneficence can be traced back to the thinking of the Greek physician Hippocrates (ca. 460 BC–ca. 370 BC), whose oath<sup>8</sup> states that,

I will use those dietary regimens which will benefit my patients according to my greatest ability and judgement. . . . Into whatever homes I go, I will enter them for the benefit of the sick.

One may frame beneficence in the language of Kant's ethics (1988) too: it is an imperfect duty, since it is practically impossible to ensure that everyone in need of medical assistance receives it in every case. And even attempting to do so would, as a minimum, drain any health care budget, or it would cause it to expand to extreme proportions, so as to stand in the way of other necessary tasks that must be carried out in society. To contribute to the happiness of others, then, is an imperfect duty because such a duty is ›wide‹, meaning that ›it determines nothing about the kind and extent of actions themselves but allows a latitude for free choice‹ (1988, §20, p. 446: AA).<sup>9</sup> Kant's *Tugendlehre* even has a section entitled ›On the Duty of Beneficence‹. Beneficence is defined thus:

To be beneficent, that is, to promote according to one's means [*Vermögen*] the happiness of others in need, without hoping for something in return, is every man's duty (1988, §30, p. 453: AA).

The realisation of the next principle, non-maleficence, amounts to a Kantian perfect duty upon us: it is fully feasible to avoid intentionally inflicting harm upon anyone, and therefore to abide by it unconditionally.

### NON-MALEFICENCE – ›DO NOT HARM‹

Non-maleficence, in contradistinction to beneficence, may be coined the ›do not harm‹ principle. Avoiding ›harm‹ (itself a problematic concept) does not entail that one should not harm *per se*. Doctors harm patients every day: a heart surgeon who cuts open your chest harms you in a very profound way. Two important qualifications to the ›do not harm‹ principle make such harming legitimate, in my view. First, that the harming must be clinically necessary or required (not contra-indicated); and, second, that it must not be done against the patient's will, be it explicit or presumed (as in the cases of those who lack decisional competence, such as newborns and the severely demented). Non-maleficence is a *negative* or

<sup>8</sup> [www.nlm.nih.gov/hmd/greek/greek\\_oath.html](http://www.nlm.nih.gov/hmd/greek/greek_oath.html)

<sup>9</sup> AA = Akademie-Ausgabe; i. e. the pagination refers to the German original.



›hands off‹ principle. It states that physicians and other healthcare workers must abstain from acting in ways that are harmful to patients – subject to the above qualifications.

Hippocrates wrote: ›I will do no harm ... to [my patients]‹. Thus the ›do not harm‹ principle is part of the early history of medicine. But I would propose that we can also understand it in a more modern way. By this I mean that it is equally feasible to see it as based on the idea that individuals have absolute, inalienable rights. While Kant (1981; 1988) is a very important name in this connection – in particular with the second formula of the categorical imperative (quoted below) – the idea can be traced back to Locke's (1988) political philosophy, which was ›transplanted‹ into the US Declaration of Independence of July 4<sup>th</sup> 1776.<sup>10</sup> The idea comes to the forefront in the following statement of the Declaration:

We hold these truths to be self-evident, that all men are created equal, that they are endowed by their Creator with certain unalienable Rights, that among these are Life, Liberty and the pursuit of Happiness.

The ›all men are created equal‹ formulation is not meant to be taken literally, since from an empirical point of view it is a false statement; however, the normative meaning is that all men are created with equal *worth* (before God and one another), and accordingly have equal (natural) rights. The Frenchmen who fought on the American side in the colonial war against the British brought back with them this ideology – which was later to permeate the French Constitution of 1789, or the Declaration on Human Rights, as it is also called. This ideology then spread to other parts of Europe. For example, the Norwegian Constitution of 17 May 1814 contains a prohibition on torture during police interrogation<sup>11</sup> – a norm which is strongly rights based, or in contemporary language: *human* rights based.

Since this negative rights perspective entails that an individual's rights are absolute, it follows that these must never be disrespected or overridden. You may not violate the rights of any one individual no matter what, or how great, the advantages – real or potential – to other individuals. In the modern setting, this way of thinking is seen in the World Medical Association's (WMA) Declaration of Helsinki, which regulates medical research. It is particularly prominent in Article no. 6:

In medical research involving human subjects, the well-being of the individual research subject must take precedence over all other interests (WMA, 2008).

I interpret this as a basically deontological ethics that runs counter to classical Utilitarianism in its crudest form, since by logical implication it rejects that ›the

<sup>10</sup> [www.ushistory.org/declaration/document/](http://www.ushistory.org/declaration/document/)

<sup>11</sup> The original Norwegian (or, rather, Danish) text reads: ›Pinligt Forhør maa ikke finde Sted.‹ Text of The Constitution in its entirety may be downloaded at [www.stortinget.no/no/Stortinget-og-demokratiet/Grunnloven/utgaver/](http://www.stortinget.no/no/Stortinget-og-demokratiet/Grunnloven/utgaver/)

greatest happiness of the greatest number‹ should be the guiding principle of any policy. It is easy to imagine situations in which this Utilitarian formula is fulfilled as a result of violating the rights of one or more individuals.

One of the most extreme examples of violation against the principle of non-maleficence in the history of medicine is provided by the ›terminal experiments‹ conducted by Nazi doctors, in which innocent people were tortured to death in the name of medical research. The experiments included the immersion of prisoners in tanks of ice water until they died at 28 degrees Celsius, and experimentation involving parachutes, in which the prisoner's neck was broken. In the light of Kant's second formula, I would term these experiments ›ultra-Utilitarian‹. In my view, Kant's second formula is the strongest existing anti-Utilitarian moral axiom within normative ethics:

Act in such a way that you treat humanity, whether in your own person or in the person of another, always at the same time as an end and never simply as a means (1981, p. 429: AA).

The Nazis did indeed treat the prisoners as mere means. In this context, I consider as most apt Nozick's general description in his political philosophy – which at this point is mainly Kantian rather than marked by the usual Lockean strain (see Materstvedt, 2006, pp. 83–97) – of what it means to ›use‹ someone:

Using one of these people for the benefit of others, uses him and benefits the others. Nothing more. What happens is that something is done to him for the sake of others. Talk of an overall social good covers this up. (Intentionally?) To use a person in this way does not sufficiently respect and take account of the fact that he is a separate person, that his is the only life he has. *He* does not get some overbalancing good from his sacrifice, and no one is entitled to force this upon him (1974, p. 33).

A more recent, albeit rather less dramatic, example of medical practice that violates Kant's formula of humanity is the case of the South African professor of oncology and haematology Werner Bezwoda. In 2000 Bezwoda was fired for falsifying data in published work on the treatment of metastatic breast cancer (Bezwoda, Seymour & Dansey, 1995; Horton 2000; Grady, 2000). At the 1999 annual meeting of the American Society of Clinical Oncology (ASCO; [www.asco.org](http://www.asco.org)) he claimed to have demonstrated that high-dose chemotherapy (HD-CNVp) was superior to standard-dose (CAF) chemotherapy for high risk, surgically treated, primary breast cancer in that it resulted in higher survival rates (Bezwoda, 1999; Skavlid, 2004). (›Survival‹ does not here mean survival as such, but in the form of an extended lifespan over a particular number of years.) No one knows how many desperate women underwent this extreme and painful treatment in vain – a treatment which also involves hospital isolation to protect against dangerous bacteria and viruses – and whose life quality was therefore destroyed during their final weeks and months of life, when they could have received palliative care

instead. As Bezwoda must have known that this would happen, he intentionally harmed those women by giving them false hopes.

Even today, physicians participate in executions in the USA. The American Medical Association (AMA) bars them from doing so, however, and censures those who participate in capital punishment – although some 27 US states require the presence of doctors at executions (Josefson, 1998). The AMA has guidelines on what constitutes ›participation‹ (and what does not) in this respect (2010), as exemplified by the following excerpt:

An individual's opinion on capital punishment is the personal moral decision of the individual. A physician, as a member of a profession dedicated to preserving life when there is hope of doing so, should not be a participant in a legally authorized execution. Physician participation in execution is defined generally as actions which would fall into one or more of the following categories: (1) an action which would directly cause the death of the condemned; (2) an action which would assist, supervise, or contribute to the ability of another individual to directly cause the death of the condemned; (3) an action which could automatically cause an execution to be carried out on a condemned prisoner.

Furthermore, physicians are involved in torture in many parts of the world. They may invent new sophisticated types of torture, carry out punitive amputations, or abuse psychiatry (Rasmussen, 1991). They tell torturers whether prisoners are able to tolerate more torture, and, if so, to what extent they can be exposed to such torture without infliction of permanent or visible bodily damage.

In the terminology of the four principles, one could say that the physician thus contributes to *less* harm being done; that he helps reduce the amount of maleficence. This is not to say that he respects the principle of non-maleficence as such, however; quite the opposite: he participates in a practice which in itself entails the infliction of harm – the subsequent reduction of harm is a side effect of the doctor's involvement, if you will. It follows that it is likewise incomprehensible that he should be respecting the principle of beneficence by partaking in such practices: if anything is not to ›do good‹ this must be it.

But why would physicians engage in executions? To prevent harm to the condemned. US surgeon Atul Gawande (<http://gawande.com>) has written a most interesting paper on this issue in *The New England Journal of Medicine*, where he describes how anaesthesiologists, in particular, think they can stop the following from happening:<sup>12</sup>

Evidence from execution logs showed that six of the last eight prisoners executed in California had not stopped breathing before technicians gave the paralytic agent, raising a serious possibility that prisoners experienced suffocation from the paralytic,

<sup>12</sup> See also this video at the NEJM website: Physicians and Execution – Highlights from a Discussion of Lethal Injection: [www.nejm.org/doi/full/10.1056/NEJMp0800378](http://www.nejm.org/doi/full/10.1056/NEJMp0800378)

a feeling much like being buried alive, and felt intense pain from the potassium bolus. This experience would be unacceptable under the Constitution's Eighth Amendment protections against cruel and unusual punishment (Gawande, 2006, p. 1221).

In contradistinction to torture, capital punishment is not about harming someone intentionally but accidentally at times; hence the doctor's participation to help avoid such. Unless, that is, one is prepared to say that death can be harmful. To the inmate's next of kin and friends, his death is obviously harmful, but – as far as we can tell – it is not harmful to the deceased, since he is no longer around.<sup>13</sup>

### TRUTH-TELLING, HARMING AND DISRESPECT FOR AUTONOMY

Physicians may, accidentally and unintentionally, happen to inflict physical harm upon patients who voluntarily participate in research projects. It is for committees of medical research ethics to judge whether the risk of this occurring is acceptable, and such committees typically act on the basis of the Declaration of Helsinki (WMA, 2008). Also, patients can be harmed psychologically/mentally, and one might consider ›truth dumping‹ vis-à-vis the seriously ill – that is, informing patients fully and matter-of-factly about their condition in one consultation – an example of such potentially harmful practice.

A more basic question is whether telling the patient that he has a terminal illness is tantamount to harming him. What is best, ›To know or not to know?‹ There are huge cultural differences across the world with regard to disclosure or not of diagnosis and prognosis in the terminally ill, even within Europe (Dein & Thomas, 2002). For example:

The Spanish palliative care movement has championed the revision of the long-held assumption that diagnosis disclosure and open information are always in the best interest of the patient. Colleagues from other countries are often surprised to learn that in Spain – and in other nations similar in culture – a cancer diagnosis is not always transmitted to our patients . . . The word *cancer* or its semantic equivalents are frequently omitted when the patient is present. The patient does not ask whether it is cancer, and the physician does not specify the exact nature of the illness (Núñez Olarte & Gracia Guillen, 2001, p. 51).

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<sup>13</sup> No one can be in a position to tell whether the dead have any (transcendental) experiences of our empirical world since one cannot rule out the possibility of such experiences *a priori*: who knows – and perhaps literally ›only God knows‹. Otherwise, it could even be that a particular deceased person is better off than the living; see Olver's thought-provoking book *Is Death Ever Preferable to Life?* (2002).

Yet the Council of Europe states, contrary to such practices, that,

Patients with advanced disease and dying patients have ... a right to be informed, but also a right to decline information and/or diagnostic procedures and/or treatment (2003, explanatory memorandum, § 65).

Obviously, you cannot say ›no‹ to medical interventions if you are unaware that there is something to be rejected.

From a Kantian perspective, concealing vital facts from, or lying to, a patient would be tantamount to disrespecting him as an end in himself. He is treated like an object without a free will, unable to make up his own mind, and this violates his dignity and worth (*Würde*) as a human being (Kant, 1981). Basically, keeping a patient in the dark about his condition is a matter of disrespecting someone's autonomy.

#### AUTONOMY: ETHICAL AND EMPIRICAL

›Autonomy‹ stems from the Greek *auto* = self, and *nomos* = law. Thus it means self legislation: one gives oneself the ›laws‹ by which one chooses to live. It seems safe to conclude that Kant is the ›father‹ of autonomy in the sense of being the originator of the way that autonomy is thought of and spoken of in contemporary Western society.

As noted, the principle of autonomy states that one ought to respect the decision-making capacities of autonomous persons. It is essential in this connection to distinguish between what I would call ethical versus empirical autonomy. The second concept concerns to what extent a person has actual competence; the former has been explained thus:

To say that a person is autonomous, in this view, is not to *describe* the person (e. g., as mature, reflective, or independent); it is to *grant* the person a *right* to control certain matters for himself or herself. The operative analogy here is with autonomous nations. They may not be especially wise or well governed, but they have a right to determine their internal affairs without outside interference of various sorts (Hill, 1991, p. 48).

To speak of a person's empirical autonomy, by contrast, is precisely to describe the person. Although under normal circumstances, adults can be expected to have fully-fledged autonomous faculties from an empirical point of view, in the seriously ill, the autonomous faculties may be impaired – sometimes severely so – due to several factors. These include clinical depression; hopelessness (Beck scale); pain; dyspnoea; nausea; delirium; fatigue; cachexia; the experience of meaninglessness; and existential crisis/suffering. So, while a person has the moral *right* to decide for himself, it is sometimes the case that he will not have sufficient empirical *capacity* to do so.

Interestingly, taking as its point of departure the four principles approach, the Council of Europe gives fundamental weight to respect for autonomy within palliative care – or more precisely, to respect for ethical autonomy:

Following the four principles determined by Beauchamp and Childress ... (respect for autonomy, beneficence, non-maleficence, and justice) as in all other areas of medical care, physicians and other caregivers should demonstrate respect for the patient's autonomy by agreeing about priorities and goals of care with the patients and carers, by not withholding information desired by the patient and by respecting the patient's wish not to receive treatment (2003, explanatory memorandum, § 61).

Concerning empirical autonomy, the Council makes a strong factual claim about any patient's abilities, describing

... the fact that the incurable and/or terminally ill patient is ... a person and, as such, capable to the very end, if integrated into a relationship, of making life an experience of growth and achievement (2003, explanatory memorandum § 59).

But as pointed out, to what extent a particular patient is really capable of acting in such ways is sometimes a question with no clear answers. Also, it does not follow from the mere statement that a patient is a *person* that he is thus capable – whatever we take personhood to mean; and the Council does not provide a definition. For example, although according to particular conceptions a patient undergoing deep and continuous palliative sedation (terminal sedation) (DCPS) in the last days of life is still a person, this treatment – which involves permanent<sup>14</sup> loss of consciousness – renders him ›socially dead‹ and thus incapable of doing any of those things mentioned in the quotation (Materstvedt & Bosshard, 2009).

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<sup>14</sup> Not permanent by nature, but by decision – a decision that may be reversed at any time; however, in most cases regained consciousness will probably result in renewed intolerable suffering and so waking up the patient will not be feasible. The loss of consciousness will therefore often *turn out* to be permanent. On this issue, see Guidelines of the Norwegian Medical Association on Palliative Sedation (NMA, 2009), no. 9: ›Although sedation of some patients is most likely to be continued until death occurs, raising the level of the patient's consciousness must be considered and attempted. If it becomes clear during the waking process that the patient's situation is still intolerable, it is justifiable to increase sedation without the patient regaining consciousness.‹ These guidelines are also printed in Førde, Materstvedt & Syse, 2008. In a paper on this issue, I and co-author, physician and professor of medical ethics Reidun Førde ([www.med.uio.no/helsam/english/people/aca/forde/index.html](http://www.med.uio.no/helsam/english/people/aca/forde/index.html)), criticise the absoluteness of the wording and requirement ›*must* be attempted‹, arguing that the NMA should change this formulation (including also a suggestion for a less strict wording); see Materstvedt & Førde, 2009.

## ON PATERNALISM

The other side of the coin of (ethical) autonomy is often held to be paternalism, from the Latin *pater* = father, fatherly. *The Blackwell Encyclopaedia of Political Thought* notes the following:

Paternalism runs against the main currents of liberal thinking, for typically liberals insist that each person is the best judge of his or her own welfare (Miller, ed. 1991, p. 368).

Within philosophical ethics, there is much debate over the exact meaning of paternalism, as well as over whether there is such a thing as legitimate paternalism – which I argue elsewhere that there may be (Materstvedt & Landmark, 2009).

›By paternalism‹, writes Gerald Dworkin, ›I ... understand roughly the interference with a person's liberty of action justified by reasons referring exclusively to the welfare, good, happiness, needs, interests or values of the person being coerced‹ (1972, p. 65). Nozick speaks of ›Paternalistic aggression‹, which he identifies as ›using or threatening force for the benefit of the person against whom it is wielded‹ (1974, p. 34). (Yet someone may freely choose to live under any paternalistic arrangement. This is why Nozick's position is non-paternalistic, not anti-paternalistic: there is nothing wrong with a paternalism that is not forced upon a person – indeed, a liberalism that is anti-paternalistic would *itself* be paternalistic. – See my extensive discussion of this issue in Materstvedt 2006, chap. III, pp. 113–170.) As Derek Parfit sees it, ›We are paternalists when we make someone act in his own interests‹ (1984, p. 321).

Let it be remarked that *utterances* would not be included: your expressing how you think others should live their lives falls within your freedom of speech. Only if utterances are accompanied by the use of ›coercion‹ or ›force‹ (difficult concepts), or ›interference‹ (pending an interpretation); or if you literally ›make‹ someone do something, or abstain from doing it, in line with your own idea of the good life, e.g. through enforcing a law to that effect, is it a matter of paternalism. This, however, depends on a somewhat problematic way of thinking, according to which there is a clear-cut or watertight distinction between speaking and acting – a distinction which J.L. Austin has effectively shown may not exist, in the classic *How to Do Things with Words* (1962): sometimes speaking *is* acting.

With these conceptions of paternalism in mind, we can see why many authors place such emphasis on the principle of autonomy. To illustrate, not informing a terminally ill patient of his diagnosis and prognosis appears to be a practice that flies in the face of this principle since it will seriously curtail the patient's ability to act autonomously during his illness. (For example, he will not be able to choose optimal treatment; and he is not in a position to make plans for (what is left of) his life.) Conversely, this practice is paternalistic in nature, since it entails that one keeps the patient in the dark so that he can *thereby* ›act in his own interest‹ (avoid losing hope, etc.) – or, rather, in line with what healthcare workers and/or the next of kin conceive of as *actually* his best interest.

Yet, some argue that such secrecy can occasionally be justified – precisely in order to respect the principles of beneficence and non-maleficence – thus downplaying or even setting aside the autonomy principle (Núñez Olarte & Gracia Guillen, 2001). In our Northern European individualistic-liberal culture, I think we tend to reject almost automatically such thinking and acting. But no one who has not experienced it themselves can know for sure how they would react were they to become seriously ill.<sup>15</sup> Perhaps not knowing too much in such a situation *would*, all in all, ensure better quality of life? To be sure, there is a right not to know, but in order to exercise this right, you must be aware that there exists some knowledge about your condition that you would rather not hear about. And so, the cat has already been let out of the bag.

### JUSTICE: ONE CONCEPT, MANY DEFINITIONS

The principle of justice is often thought of, and perhaps even intuitively so, as the principle ›that equal cases be treated equally‹ – and, as a corollary, and as Aristotle put it, ›that unequal cases be treated unequally‹ in order to achieve equality. This is so because ›what is just ... is what is proportionate‹ (Aristotle, 1985, 1131b16). (Book Five of the *Nicomachean Ethics* is devoted in its entirety to the various aspects of justice.)

In the medical setting, I believe that this translates such that it would, for example, prohibit favouring the rich when it comes to treatment. It would also require equal access to health care, and it would prohibit disproportionately risky medical research in the poor; those who cannot afford any other medicines than the potentially dangerous ones provided by researchers.

Nonetheless, there are other and competing conceptions of what constitutes justice. We need to keep in mind that the principle of justice is formal, in that it

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<sup>15</sup> I have written about my own experiences of having a life-threatening disease and narrowly escaping death, and how these impacted on my thinking in Materstvedt, 2007b. I hold a PhD on the political philosophy of Robert Nozick (Materstvedt, 1996), who died of cancer at the age of 63, in 2002. About his own reaction, Nozick writes: ›In late 1994 ... when stomach cancer led to serious surgery followed by months of chemotherapy and radiation treatments, along with dire statistics ... I found, even as I took vigorous steps to avoid what most probably would occur, that I had no complaints and felt no distress. My fifty-five-year lifespan already had been longer than that of most people in human history ... And I had no urge to transform my life in whatever time remained. I harbored no hidden desire to run off to Tahiti, or to become an opera singer, or a racing car driver or a Dean. I wanted to continue loving my wife and my children, having fun with them, and doing exactly the things I had been: thinking, teaching, and writing. Only now I needed to do them better. And sooner. It has been simple to accept my own situation calmly; a danger to those I love, however, would prompt all-out warfare‹ (Nozick, 1997, p. 11). It is well worth comparing this with what he wrote about dying before he fell ill (Nozick, 1989).



pleads for ›fairness in the distribution of benefits and risks‹. Everything hinges, then, on what one takes ›fairness‹ to mean. Here you have theories as different as those proposed by John Rawls (1971) and Robert Nozick (1974; Materstvedt, 1996), authors of some of the classic works on political philosophy in the 20<sup>th</sup> century. Neither philosopher defends a theory of justice that values equality as something intrinsically good. Rawls allows for (and, in particular instances, even prefers) moderate inequality, whereas Nozick thinks that justice may be compatible with vast inequalities in both income and property. Each theory will generate hugely disparate models of distribution of health care resources and treatments, to the extent that the adoption of one rather than the other would in some cases mean a difference of life and death.

In summary, of the four principles, the principle of justice is the least obvious one in terms of content: several and conflicting interpretations are possible. One could say, therefore, that while justice is but one concept, there are many definitions of it.

#### THE PRINCIPLES IN CONFLICT – SOME EXAMPLES

As noted, due to the *prima facie* nature of the four principles, they must sometimes be weighed against each other. In the next paragraphs I present some cases in which it seems very difficult, if at all possible, to strike a balance between three of them, or to give priority to one over the other two.

In the USA, surgeons have amputated perfectly healthy limbs for individuals who, paradoxically, do not ›feel whole‹ unless their body is incomplete, such as if they lack a leg – the name for this condition being Body Identity Integrity Disorder (BIID) (Smith & Fisher, 2003). These patients threaten to shoot off the limb with a shotgun unless the surgeon is willing to help, and have in some cases carried out the threat. Presuming that the patient has empirical autonomy – and that is contested; see the discussion in First, 2005<sup>16</sup> – was he harmed by the operation? At face value, the answer appears to be ›yes, absolutely‹. But compared to the shotgun ›solution‹, there is less damage. Did the surgeon do good, then? Perhaps, but not without doing harm. On the other hand, surgeons might have saved lives in such cases, since persons with BIID have bled to death after attempting self-amputation. (In one instance a woman found her neighbour lying helplessly in the grass, bleeding heavily from the main artery of his left leg, which he had tried to remove by firing at it, certain death only minutes away. She called 911

<sup>16</sup> For example, as regards empirical autonomy First writes the following about his findings: ›Despite the bizarre nature of the desire for amputation, none of the individuals evaluated as part of this study were delusional‹ (2005, p. 188).

and his life was saved.) How one negotiates between the conflicting principles of non-maleficence, beneficence, and autonomy in this case is far from obvious.

Nor is it clear in a case from a few years ago involving a woman in Britain suffering from cystic fibrosis (about the disease, see [www.cff.org](http://www.cff.org)). To survive she needed a new pair of lungs, and her brother and sister offered to give her one each. However, no transplant surgeon was willing to operate. The surgeons argued that there was no indication for removing the healthy lungs; indeed, that it would be mutilation and thus a paradigmatic example of maleficence. Finally, one surgeon agreed to perform the operation. Not unexpectedly, the woman died a few years after the transplant which gave her the new lungs, but she still enjoyed extra time that was highly valued by all parties compared to her prospects had the operation not taken place. It would seem everyone's autonomy was respected here, although the siblings were severely damaged, having to spend the rest of their lives with significantly reduced breathing capacity.<sup>17</sup>

One last example is euthanasia – which, in line with Dutch usage, may be defined as ›A doctor intentionally killing a person by the administration of drugs, at that person's voluntary and competent request‹ (Materstvedt et al., 2003; Materstvedt, 2003; see also Materstvedt & Bosshard, 2010 and Bosshard & Materstvedt, 2011). In this understanding, the patient is by definition autonomous. Nonetheless, all kinds of questions may be asked as to the empirical autonomy of a severely ill and/or dying patient, and also as to whether the destruction of autonomy – through the use of the very same autonomy – that takes place when someone is injected with lethal medicines is, or is not, in violation of the probably most influential ethics of our culture, namely Kant's.<sup>18</sup> And what is more: is it possible to take someone's life without thereby harming him according to certain senses of ›harming‹? (This also harks back to the discussion above about legal executions; do these harm the one whose life is taken?) Or is euthanasia the ultimate good one can do to a patient?

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<sup>17</sup> Some claim that living organ donation is a parallel case. If a kidney is removed from a healthy person, this harms him; in addition, any elective operational procedure is potentially dangerous, even to life. However, the parallel is not perfect. One has been unable to document long-term damage to donors: people manage very well with only one kidney, as the capacity of our kidneys far surpasses what is actually used by the body.

<sup>18</sup> In the *Oxford Textbook of Palliative Medicine* (Materstvedt & Bosshard, 2010), I discuss these and related questions in a chapter co-authored with Swiss physician and clinical ethicist Georg Bosshard ([www.georgbosshard.ch](http://www.georgbosshard.ch)) – see this text for further detail.

### PHILOSOPHICAL MEDICAL ETHICS (PME)

In defending what he calls ›*philosophical* medical ethics‹ (PME), Gillon quotes his former teacher at Birkbeck College, the British moral philosopher Professor David Raphael, stating that philosophy has to do with ›the critical evaluation of assumptions and arguments‹. To Gillon, then, PME is the

analytical activity in which the concepts, assumptions, beliefs, attitudes, emotions, reasons, and arguments underlying medicomoral decision making are examined critically (1985, p. 2).

In this conception, medical ethics is

- not the enterprise of quoting or drawing up professional codes of conduct (›traditional‹ medical ethics from Hippocrates onwards)
- not an account of legal constraints on doctors' behaviour (laws may also be immoral)
- not medical declarations and codes like the World Medical Association's declarations of Geneva, London, Helsinki, Tokyo, and so on.

PME is *additional* and *complementary* to these, Gillon holds (1985, p. 2). While that might generally be true, it need not be so in every case. Since this sort of medical ethics is fundamentally other-critical as well as self-critical – such is the nature of philosophy – it has the potential to conflict with whichever medical-ethical norm one comes up with. I therefore disagree with Gillon's subsequent view that PME ›ultimately can be expected to reinforce traditional medical ethics‹ (1985, p. 2).

Take the Declaration of Helsinki, for instance. It prescribes very strict rules concerning the infliction of harm upon individuals. But a philosopher with more Utilitarian leanings could question these rules. Suppose one could somehow ›solve‹ the so-called cancer riddle through experiments involving some amount of torture-like pain in innocent patients; would implementing these experiments always be wrong, given that millions of people would benefit greatly from the results?<sup>19</sup>

Another issue is the prominence given to autonomy in recent medical codes and health legislation. As far as the latter is concerned, this constitutes a ›legal constraint on doctors' behaviour‹ (cf. above), as it curtails the clinician's autonomy

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<sup>19</sup> A parallel in the age of terrorism is whether it would always be wrong to torture suspects – including, by accident, innocent ones – of a planned attack with nuclear weapons on a large city in order to try to prevent the loss of millions of lives. It is unclear whether the recent liquidation of Osama bin Laden by US special forces was preceded by torturous interrogation techniques, e.g. ›waterboarding‹, being applied to prisoners forcing them to disclose information on bin Laden's whereabouts. If so, was this wrong or does the end justify the means?

in relation to his patients (whose autonomy is strengthened at the expense of his). An example is the Norwegian Patients' Rights Act (1999):

Under the ... Act, a competent and fully informed patient may, except in emergency situations, refuse life saving treatment. In emergency situations, however, it is the duty of health care personnel to provide the necessary treatment. There are three exceptions to this rule: even in an emergency, a doctor may not override a refusal if it is connected with a hunger strike for some reason of conscience, if it concerns refusal of blood transfusion on the same ground (Jehovah's Witnesses would be the usual case), or if the patient is dying. The Patients' Rights Act §4-9 specifically describes these three situations (Førde, Materstvedt & Syse, 2008, p. 427).

PME would challenge this law and the thinking behind it, posing questions such as: Why does conscientious objection enjoy a privileged status, and how can this be justified, if at all? Why should apparently irrational behaviour be condoned by legislators? Additionally, is this not a grave intrusion into the doctor's autonomy; how can one demand of him that he simply stand by and watch members of Jehovah's Witnesses die in front of him in the hospital ward? Given his training to save lives, a doctor may find this clinically, ethically and emotionally unacceptable; yet he is forced by law not to intervene. Can anyone who is very sick really know what is best for him; would he not be so ›disturbed‹ by his illness, and sometimes also due to the adverse effects of his medication, that treating him as if he were attending some sort of philosophical seminar about rationality would be intrinsically wrong? In other words, how autonomous is he actually? The latter issue relates to what I suggest we call the ›autonomy reducing‹ factors identified in connection with the discussion of empirical autonomy above.

Furthermore, there is the fundamental question of whether we are indeed free – cf. the above scheme, Metaethics: the problem of free will. If we are not free, it also seems to make no sense to speak of *moral* autonomy. Kant held the freedom of the will to be unattainable for science: all science necessarily paints a deterministic picture of the observable world and hence of our actions. He therefore ›put‹ free will beyond this world, as it were; and perhaps he thought it to reside within the realm of the *Ding an Sich* – transcending three-dimensional space, time, and causality (i.e. the field of science). As is well known, it is his theoretical philosophy that generates the (to Kant) most unwelcome conclusion that we are unfree. To tackle this problem, Kant argues in his practical philosophy that we must nonetheless *perceive* ourselves and others as free; if not, morality becomes meaningless because no one would be responsible for their actions – ›ought‹ implies ›can‹.

Additionally, Kant says, we *experience* ourselves as free. Despite various sorts of pressure impacting on us from outside (social/cultural) and inside (physiological/psychological) our body, we do experience that we can relate to these pressures and say ›no‹ to the driving forces they represent, no matter how strong. (Save for

situations in which a person has ›lost contact‹ with the moral law due to some mental illness or disorder.<sup>20</sup>) John Searle formulates this Kantian point thus:

We presuppose that there is a gap between the ›causes‹ of the action in the form of beliefs and desires and the ›effect‹ in the form of the action. This gap has a traditional name. It is called ›the freedom of the will‹. In order to engage in rational decision making we have to presuppose free will (2001, p. 13).

This ›gap occurs‹, he continues, ›when the beliefs, desires, and other reasons are not experienced as causally sufficient conditions for a decision‹ (Searle, 2001, p. 62). Still, Searle remarks that this is not the final word:

Even if we are free psychologically, this freedom might be epiphenomenal. The underlying neurobiology might determine all of our actions. There are, after all, no gaps in the brain (2001, p. 63).

It could be, then, that freedom of the will is an illusion.<sup>21</sup> Be that as it may, both Kant and Searle maintain that whatever the metaphysical truth of the matter, we *have to* perceive our actions as free.

## WHY DO PME?

The title of Chapter 5 of Gillon's book *Philosophical Medical Ethics* is put as a fundamental question: ›Conscience, good character, integrity, and to hell with philosophical medical ethics?‹ PME is rejected on the basis of at least three different strategies, Gillon thinks.

You have what he calls ›The pontificators‹, people who ›think they don't need critical medical ethics because, whether they are reactionary or radical, religious or atheistic, left wing or right wing, they *know* the answers‹. Then there are ›The abstainers‹, who think that ›ours is not to reason why, ours is but to do and sigh‹, and who ›find it all too difficult‹. Finally, ›The sceptics think it is either impossible in principle, useless or irrelevant in practice, or a private matter for the individual and his conscience‹ (1985, p. vii).

<sup>20</sup> Kant discusses this issue in *Anthropologie in pragmatischer Hinsicht* (1907), thereby paving the way for the juridical conception of ›the insanity defence‹, according to which a person cannot be held accountable for crimes he commits while suffering from insanity.

<sup>21</sup> Hobbes (1968), for one, thought this to be the case. So why put people in jail when they cannot help being criminals? Because, Hobbes held in accordance with his mechanical-deterministic Renaissance worldview, very severe punishment would alter the direction of the ›social atom‹ – the individual human – and thus the criminal would change his ways – much in the same way that when a dog is hit hard on its head for some unwanted behaviour, it will not repeat that particular behaviour.

We can do without PME, many believe according to Gillon, because all that is needed in a doctor is that he or she has a well-developed conscience, has integrity, and displays good character. But as Gillon rightly brings to attention, there are prominent problems associated with this view. What character is the correct or ›good‹ one; why not a paternalistic one? (Cf. the points made above about Spanish palliative care physicians.) Conscience is not an objective phenomenon; it is subjective and therefore relative to the individualistic view. As for integrity, A and B may both be doctors of great integrity, yet they could genuinely disagree. A telling example of the latter is the issue of euthanasia, as described above. What physician has more integrity: he who performs euthanasia or he who refuses to do so?

But does PME work; is it of any use? Will it result in decisions that are ethically more correct and clinically better? Well, it depends what one means by those descriptions – and research into whether PME is actually useful cannot get off the ground without a sense of their meaning. The first one presupposes some normative theory or other; cf. the above overview. So, which one do we pick?

In the run-up to World War II one witnessed the establishing of the German so-called ›euthanasia clinics‹ – which were in fact not what the name suggests: what took place in these clinics was not euthanasia (as depicted in this chapter), but the murder of innocent people. (See my discussion in Materstvedt, 2003.) An oncologist I know has been treating children with cancer for many years. At a conference, she once met another female physician who had been employed at one of those clinics. The old woman told her that the first week of killing children whose lives were considered physically and/or psychologically unacceptably painful and therefore ›not worth living‹, was the worst; subsequently, such ›compassionate murder‹ quickly became quite normalised. When asked what she now thought of this practice, she said very clearly that it was indefensible. Why did she not think so back then? Would a dosage of PME have helped? We would probably respond that intuitively, she must have known that this was wrong. But intuitions about this topic in those days appear to have been different from our intuitions today.

The way I see it, but without here explaining why, moral intuitions are a shaky foundation upon which to build ethical judgment. While intuitionism has prominent contemporary defenders (e.g. Rawls, 1971; see also overview at the start of the present chapter), the philosopher Peter Singer rejects this approach to ethics (2005). I do not subscribe to his point of view, still I acknowledge much of his criticism – but shall say nothing more about that.

It seems appropriate to conclude this chapter by noting that medical ethics can be challenging, and that introducing it into their education may lead to physicians starting to question views, attitudes and procedures that they earlier took for granted – something that will not be universally welcomed. In this sense Gillon scores a bull's-eye with this remark: ›Philosophical medical ethics is often unpleasant medicine.‹

One should also be aware that the philosophy part of PME may be quite foreign to physicians. About his own training in philosophy, Gillon says the following:<sup>22</sup>

Studying [philosophy] at Birkbeck totally transformed my approach to ethical issues in medicine. The ways of thinking in Philosophy are in some ways very different from those required for medicine. I think my studies at Birkbeck added an important new dimension to the ways in which I understood the world.

PME can have diametrically opposite implications: you either see things in a somewhat or entirely new way; or critical analysis makes you confident, perhaps more than ever, about the points of view you already held. PME may also help you detect problems and issues you had no idea existed (and perhaps are glad you came to see). And you could become significantly more confused than before, albeit at a much higher level – and that is something! PME is also a tool for unmasking two phenomena that philosophers in particular are familiar with: the hindrances to rational argument known as *apparent* agreement/disagreement according to the logic of the Norwegian philosopher Arne Næss. It is not uncommon for discussions to suffer from such apparent concord or discord, and being able to uncover it may help you identify what is actually being said. In any event, and regardless of the outcome of engaging with PME, it will help clear our heads.

#### CONCLUDING REMARK

Naturally, a clinician must, at the end of the day and sometimes immediately (such as in the emergency room), act or not act towards his patients – e. g. by performing, withdrawing, or withholding treatment. (Only philosophers can stay indefinitely in the seminar room, doing armchair philosophy.) There is no escaping medical realities, no matter what amount of ethical theorising has taken place beforehand. But if this reflection has resulted in a certain portion of doubt entering into the mind of the physician, thus adding complexity to the clinical setting, it may not be such a bad thing.

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<sup>22</sup> [www.bbk.ac.uk/news/birkbeck-briefings/elq-briefing/case-studies/raanan-gillon](http://www.bbk.ac.uk/news/birkbeck-briefings/elq-briefing/case-studies/raanan-gillon)

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