
Guest editorial

Is medical ethics lost?

R M Hare *University of Florida, USA*

If one talked just with ordinary competent, hard-working and caring doctors, who are in the great majority, one would think that medical ethics is in good shape. They have a fairly secure feel for what they should and should not do to, or for, their patients. They get this feel from colleagues and from their training. On the whole it leads them to look after their patients as they should, and no trouble ensues.

On the other hand, if one looks at the media, here and even more in the US, one gets a different impression. It looks as if nobody knows what the duties of doctors are. A great many people have strong opinions about this, differing wildly from one another; and it would be a bold doctor who thought he could be certain about the rightness of any of them. The position is worse with the more controversial questions: about abortion and euthanasia; about the preservation of life and the definition of death; and about various kinds of experimental procedures. But the trouble can easily spread from these controversial questions and infect the general practice of medicine. The huge rise in malpractice insurance premiums in the US is evidence of this.

How does this contrast come about? Is it just because a lot of interfering non-medical people – clergymen, lawyers, philosophers and politicians – have found business for themselves by raising problems which would not have troubled the doctors if left to themselves? There is some truth in this suggestion, but it is not the whole truth. The truth is that doctors ought, not merely in self-protection against interfering outsiders and busybodies, but because there is a real need for it, to think more seriously about these questions *before* they are confronted with awkward particular cases. Otherwise they may find themselves in the predicament of poor Dr Cox.

It is possible to speculate about Dr Cox's state of mind when he killed his patient at her request, to end her suffering, by injecting potassium chloride (1). Was he, for example, intent on getting himself into court in order to secure an acquittal and so change the law? Doctors and surgeons have sometimes done this sort of thing. This may have happened in the Netherlands; and it is probable that Mr A W Bourne, an obstetric surgeon, who performed an abortion to preserve the life, or at least

the health of a patient in the thirties before the law was liberalised, had this intention (2). But a reading of the press reports suggests that this explanation is unlikely in the case of Dr Cox.

It is even less likely that Dr Cox was of the stamp of Dr Kevorkian in Michigan, who has invented a machine with which patients can easily end their own lives; he seems to be a campaigner who wants to make assisted suicide (which was, until recently legal in Michigan) generally available and convenient, and does not mind the adverse publicity.

A much more probable explanation is that Dr Cox is an ordinary caring physician who is entirely innocent of any knowledge of casuistry, good or bad. It is highly likely that more sophisticated casuistry might have kept him out of trouble. He probably did not know that some people, including some lawyers, attach immense importance to the subtle distinction between killing by injecting potassium chloride, whose only intention must be to kill, and killing by giving increasing doses of morphine or heroin until the doses become lethal. The former course, it is said, must indicate an intention to kill; whereas the latter course can indicate only an intention to relieve suffering, the death of the patient being unintended. It would not be surprising if Dr Cox, who seems to be a good simple man, were unaware of this distinction.

This manoeuvre is an application of one simple version of the so-called law of double effect. One wonders whether Dr Cox had heard of this. It says, in this simple version (there are of course more complex versions and a large literature), that it is morally permissible to do an act which has two effects if the intention is to produce one of them, which is morally permissible (relieving the patient's pain), even if the other is impermissible (killing the patient). Was Dr Cox any the worse morally if he had not heard about this piece of casuistry?

Even in its more complex versions the law of double effect needs to take 'intention' in an extremely narrow sense. Jeremy Bentham made an important distinction between direct and oblique intention (3). To intend directly I have both to know that I am bringing about, or trying to bring about, the intended effect, and to want to bring it about for its own sake. To intend obliquely, I have merely to know that it will be an effect of my action, even if I

do not want to bring it about for its own sake. So, for example, I may obliquely intend to wake up the neighbours when I clean my room with a noisy vacuum cleaner in the early morning, if I merely know that this will wake them up, even if I do not *want*, for its own sake, to wake them up.

If the law of double effect were interpreted strictly, as relating only to direct and not to oblique intentions, it would have the consequence that I could, in this situation, say that, because I did not directly intend to wake up my neighbours, I was blameless for doing so. But most of us think that oblique intentions can also be blameworthy: even if I did not want to wake up my neighbours for its own sake, they could justly reproach me for doing so if I knew that that was what I was doing. Applying this to Dr Cox's case, one might say that, even if he had used increasing and in the end lethal doses of morphine, the fact that he would then have known that death would be the result means that he would have been as much to blame, if he were to blame, as if he had used potassium chloride. For although, on that assumption, he would not have been wanting for its own sake to kill his patient, he would have known that it would be the effect of the action of relieving her suffering. He would not have intended her death directly, but he would have intended it obliquely, and that can also be blameworthy, unless we interpret the law of double effect so narrowly as to exclude oblique intentions from blame. Common opinion would hardly support this.

Common opinion is far from being a reliable guide in morals; and no doubt the casuists will have up their sleeve a lot of refinements to their principle. But this is not the place to pursue them. What the case shows is that Dr Cox and other caring doctors like him will be defenceless against bad casuistry unless they do, or somebody does, some better thinking about sound methods of moral reasoning. It would not be difficult to think about this better than, for example, some ecclesiastics and lawyers (4), who simply make the old casuistical moves without any attempt to justify them. A better method of moral reasoning would be one founded on the principle: 'Therefore all things whatsoever ye would that men should do to you, do ye even so to them: for this is the law and the prophets' (5). The Christian (and indeed pre-Christian) doctrine of love affords a direct solution to Dr Cox's dilemma, and one that is in accord with what he actually did (6). Which of us, if we had been in Dr Cox's predicament, and had asked ourselves what we wished that our doctor

should do to us if we were the patient, would answer that a lethal injection at the patient's request should be ruled out?

This principle, the Golden Rule, can, with much further elaboration, be made the basis for sound reasoning about this and other moral questions about our treatment of other people (7). If medical ethics has lost its way, this would be a way of finding it again. The principle can be used to provide justification for having and following more particular principles such as the four advocated by Beauchamp and Childress and Gillon (8). 'The law and the prophets' have produced not just four, but a whole corpus of such principles. But in difficult cases like those of Dr Cox it may be necessary to have recourse to the root of it all, the Golden Rule. Thinking otherwise can be the source of some very un-Christian decisions.

Professor R M Hare is Professor of Moral Philosophy, University of Florida, Gainesville, USA.

References

- (1) *The Times* 1992 Sept 22: 5 (col 1).
- (2) See R V Bourne (1939) 1 KB 687, summarised in *Report of the inter-departmental committee on abortion*. London: Her Majesty's Stationery Office: 30f, 70f, 73. See also discussion in: Williams G. *The sanctity of life and the criminal law*. London: Faber, 1958: 151.
- (3) Bentham J. *Principles of morals and legislation*. London: Payne. 1789: ch. 8, sec. 6; cf Hart L A. Intention and punishment. *Oxford review* 1967; 4: reprinted in his *Punishment and responsibility: essays in the philosophy of law*. Oxford: OUP, 1968: 120.
- (4) See, for example, Harries R. *The Times* 1992 Nov 21: 6.
- (5) St Matthew 7, 12; cf St Luke 6, 31; St Matthew 22, 39.
- (6) Hare R M. Euthanasia: a Christian view. *Philosophic exchange* 1975; 2: reprinted in his *Essays on religion and education*. Oxford: OUP, 1992: 72; and cf *On dying well*. Report of Church of England working party on euthanasia: chairman, Melinsky M A H. London: Church Information Office, 1975: 23.
- (7) Hare R M. *Moral thinking*. Oxford: OUP, 1981 and *Essays on bioethics*. Oxford: OUP, forthcoming 1993.
- (8) Beauchamp T L, Childress J F. *Principles of biomedical ethics* (2nd ed). Oxford: OUP, 1983; Gillon R. *Philosophical medical ethics*. London: *British medical journal*, 1985, reprinted Chichester, Wiley, 1990. Cf also Bishop Joseph Butler, *Sermon 12 and Dissertation on virtue*, 1786, selections in Raphael, D. *British moralists* (vol 1). Oxford: OUP, 1969.