

What Makes Killing Wrong? — And Why it Matters

Walter Sinnott-Armstrong

Duke University

A Case

- Abe shoots Betty in the head.
- Abe's shot causes Betty to die.
- Why does he kill her? His motive might be
 - hatred or
 - to get her money or
 - to silence her or....
- Abe's act is morally wrong.
- Why?

What Makes Killing Wrong?

- Harm to the victim (the person killed)
- Harm to the victim's friends and family
- Harm to the community (insecurity & fear)
- Harm to the agent (hardening the heart)

Which Harm to the Victim?

- Pain
- Death or loss of life
- Total loss of consciousness
- Total loss of ability
- Total loss of autonomy
- Violations of rights

A Test Case

- Total disability = universal and irreversible
- Total disability with consciousness and life
- Is death any worse than total disability?
- If so, for whom is it worse?
 - the victim (Betty)
 - the victim's friends and family
 - the community

Lessons for Theory

- Killing a totally disabled patient as such is not morally wrong.
- Killing anyone who is not totally disabled is morally wrong (unless excused or justified).
- So, what makes killing morally wrong is that killing causes a total loss of ability.
- We need a moral rule against disabling anyway.
- We do not need a separate moral rule against killing as such.
- Killing as such is not morally wrong.

Responses

- Competing explanations:
 - loss of consciousness
 - Abe's intention to harm Betty
- Every tradition supports the rule “Don't kill”
 - Total disabling was killing until recently.
 - General rules are pedagogical tools.
 - Killing weeds is not wrong. Why not?
- Inequality and thresholds

Lessons for Practice

- It is not morally wrong to kill totally disabled patients in order to harvest their organs for transplantation.
- Some vital organ donors are
 - “brain dead”
 - not really dead
 - totally disabled
- The dead donor rule should be rejected.

DO
YOU
HAVE
ANY
QUESTIONS
OR
COMMENTS?

What is PVS?

	AWAKE	AWARE	BEHAVIOR
NORMAL	Yes	Yes	Yes
LOCKED-IN	Yes	Yes	No
MCS	Yes	Intermittent	No
VEGETATIVE	Partial	No	No
COMA	No	No	No

Vegetative State \neq Death

	Brain Death	Vegetative State
Eyes opening	No	Often
Breath on own	No	Usually
Regulate body temp.	No	Yes
Body movements	Minimal	Richer variety
Facial expressions	No	Smile, cry
Sounds	No	Grunt, Moan, Scream
Time before Diagnosis	Hours to days	Months (12 for TBI)

A SURPRISE

Detecting Awareness in the Vegetative State

Adrian M. Owen,^{1*} Martin R. Coleman,² Melanie Boly,³ Matthew H. Davis,¹ Steven Laureys,³ John D. Pickard²

Science 313, 8 (Sept. 2006), 1402.

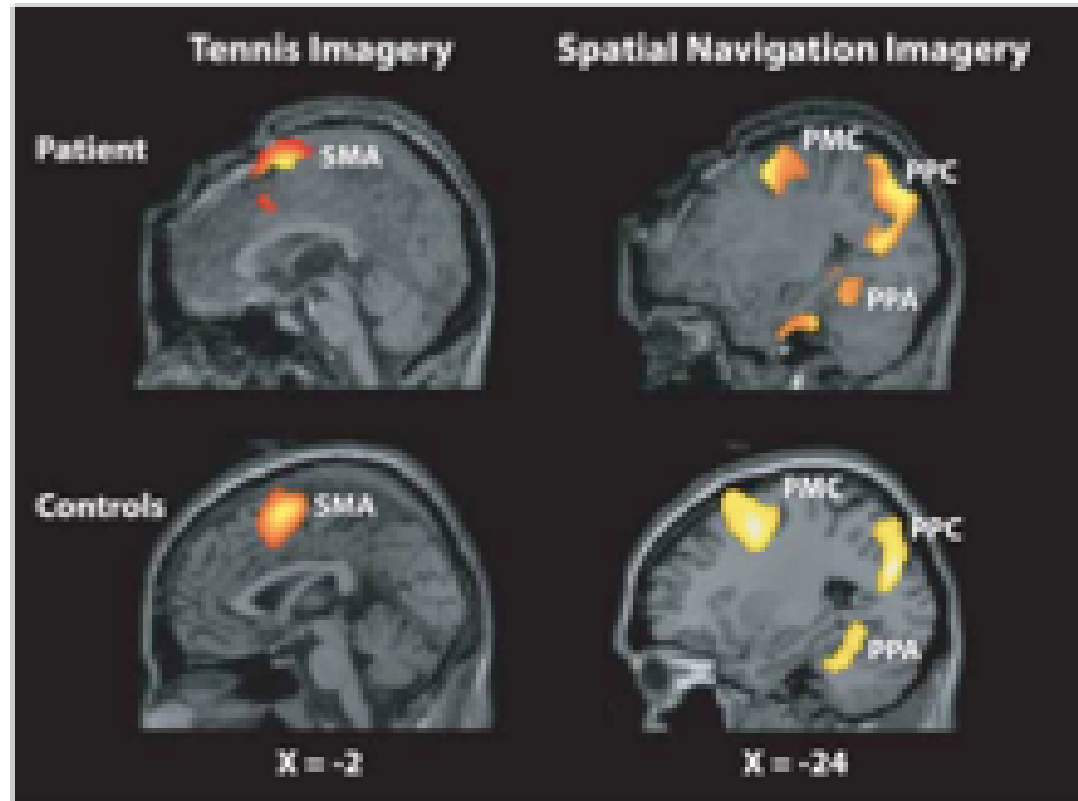


Fig. 1. We observed supplementary motor area (SMA) activity during tennis imagery in the patient and a group of 12 healthy volunteers (controls). We detected parahippocampal gyrus (PPA), posterior parietal-lobe (PPC), and lateral premotor cortex (PMC) activity while the patient and the same group of volunteers imagined moving around a house. All results are thresholded at $P < 0.05$ corrected for multiple comparisons. X values refer to distance in mm from the midline in stereotaxic space (SOM text).

MORE SURPRISES



Monti ... Laureys, *New England Journal of Medicine* 362, 7 (Feb. 18, 2010), 579-89.

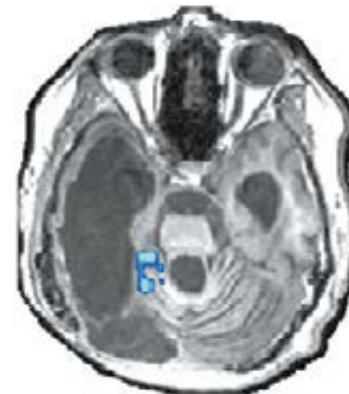
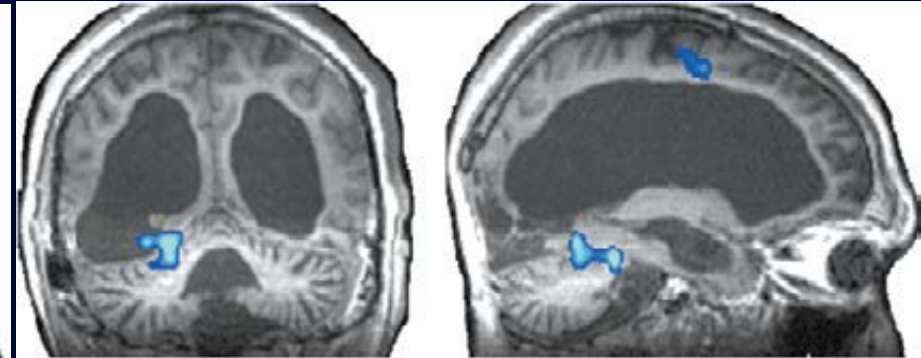
“Of the 54 patients enrolled in the study, 5 were able to willfully modulate their brain activity. In three of these patients, additional bedside testing revealed some sign of awareness, but in the other two patients, no voluntary behavior could be detected by means of clinical assessment.”

MORE SURPRISES

Is your Father's name "Alexander"?
"Yes" response with motor imagery



Is your Father's name "Thomas"?
"No" response with spatial imagery



MORE SURPRISES

- Patient 23 answered the first five questions correctly.
- No response was observed to the sixth question, possibly because the patient went to sleep.

One Ethical Issue

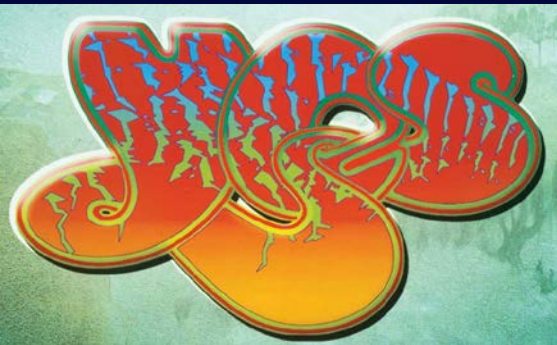
- Should this method be made available to **ALL** patients who have been diagnosed in PVS?
- Should this method be made available to **ALL TBI** patients who have been diagnosed in PVS?
- There are **thousands** of such patients in the US.
- So the costs would **not** be trivial.

Possibilities

- This Laureys method enables us to ask patients diagnosed in PVS whether they want to die.
- IF we detect consciousness and ask what they want, there are several possible responses:

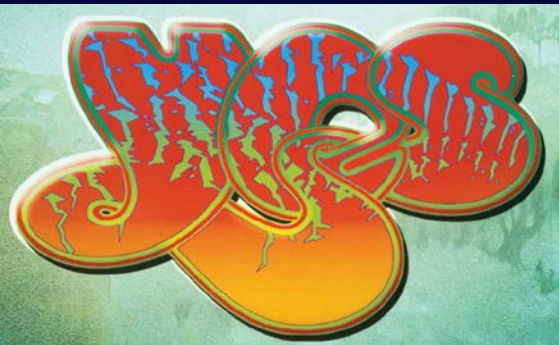
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- (A) The patient indicates s/he **wants** to die.



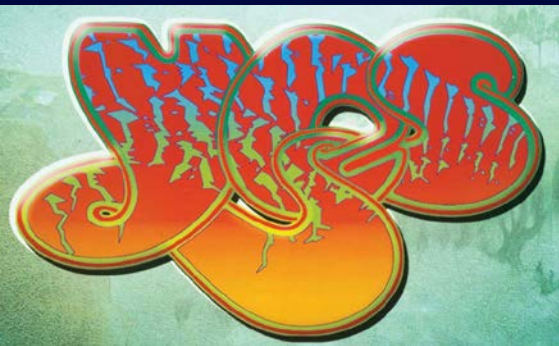
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- This Laureys method enables us to ask patients diagnosed in PVS whether they want to die.
- IF we detect consciousness and ask what they want, there are several possible responses:
 - (A) The patient indicates s/he **wants** to die.
 - (B) The patient indicates s/he does **not want** to die.



Possibilities

- This Laureys method enables us to ask patients diagnosed in PVS whether they want to die.
- IF we detect consciousness and ask what they want, THEN there are several possible responses:
 - (A) The patient indicates s/he **wants** to die.
 - (B) The patient indicates s/he does **not want** to die.
 - (C) The patient does **not answer** this question.



#1: Patient Requests to Die (and Refuses Treatment)

- Suppose that we detect consciousness, ask personal questions, and receive correct answers.
- Then suppose that we ask whether the patient wants to die or refuses treatment, and then we receive **affirmative** answers.
- Should we let the patient die?
- **TOO QUICK !!!!!**

#1: Patient Requests to Die (and Refuses Treatment)

- Before asking that momentous question, we need to follow a careful procedure:
 - **First**, we should ask what we can do for comfort.
 - **Second**, we should test for mental illness.
 - **Third**, we should inform the patient—
and make sure the patient understands.
 - **Fourth**, we should seek repeated confirmation.
- Then this patient's refusal is valid.
- NOW, what if the patient still wants to die or refuses treatment?

#1: Patient Requests to Die (and Refuses Treatment)

- THEN it would be morally **wrong** to treat without permission and contrary to explicit refusal.
- PVS patients often do not need ventilation or medication in order to stay alive.
- The prohibition on treatment after valid refusal includes forcing food and fluids.
- Withdrawing food and fluids will (reportedly) not be painful to PVS patients.
- So doctors **must** withdraw food and fluids and let the patient die.

#2: Patient Wants NOT to Die

- Suppose we ask the patient whether he wants to die and receive **negative** answers.
- We should still inform the patient of his prognosis and seek occasional confirmation.
- If patient is competent, the question is: **Who pays?**
- If the patient has adequate **private** funds or insurance to pay the real costs of treatment, and if the patient is not depriving others of needed resources, then it would be morally wrong to withdraw food and fluids.
- If a patient needs the **public** to pay large amounts or needs resources other patients need, it is not as clear.
- BUT: Food and fluids as well as EEG are cheap.
- SO: patients who want to live must be kept alive.

#3: Patient Does Not Respond

- Suppose that we detect consciousness, receive correct responses to many questions, ask the patient whether he wants to die and whether he refuses to be treated, and receive **no** answer at all.
- We should try again and again, since consciousness might be intermittent.
- The issue can **sometimes** be settled by:
 - (1) an **advance directive** from the patient or
 - (2) **agreement** among family and friends about what the patient would want.
- BUT what if the issue **cannot** be settled in these ways?

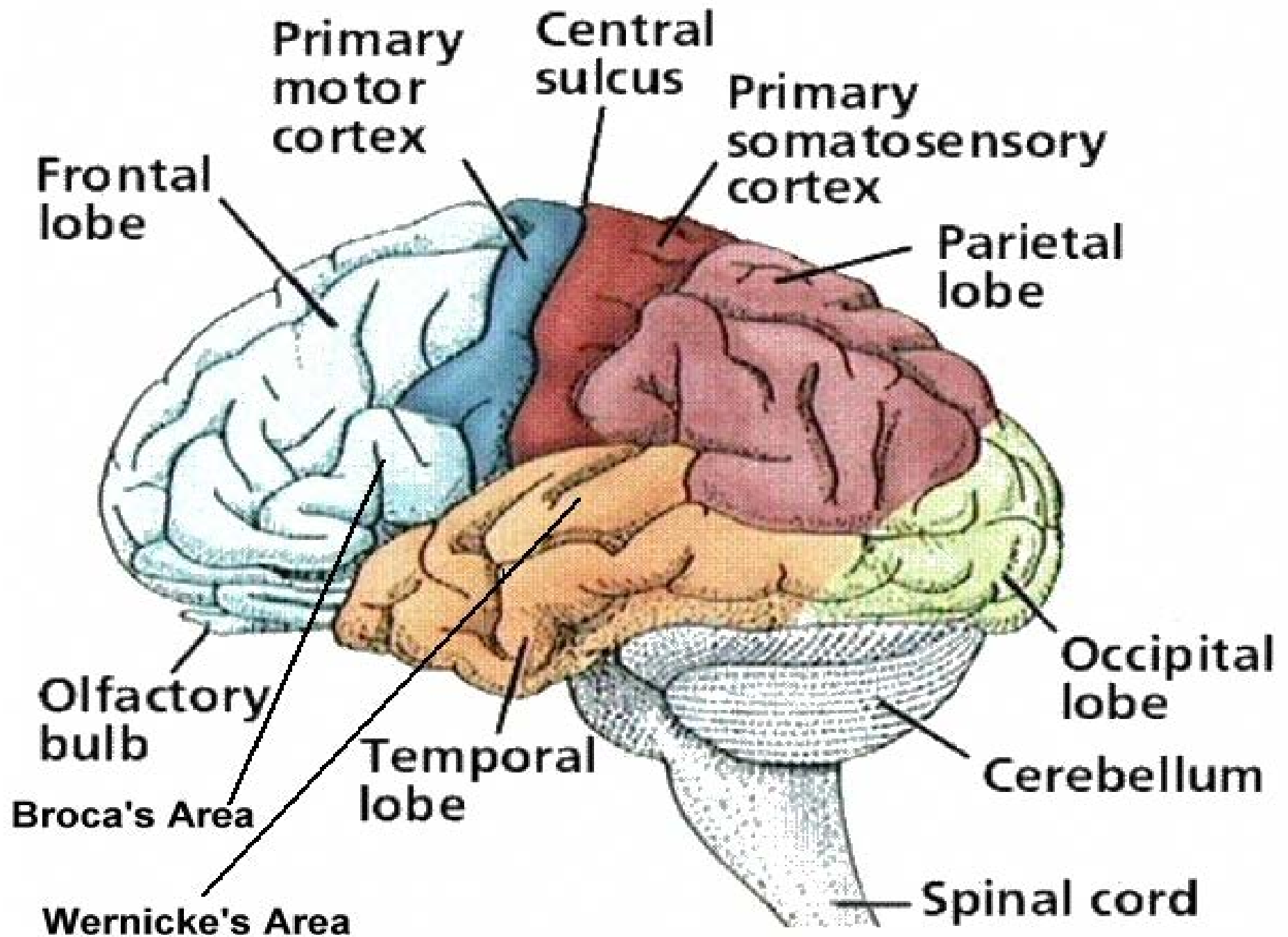
#3: Patient Does Not Respond

- With no response, advance directive, or agreement, then the question is: Where is the **presumption** or **burden of proof**?
- Two Issues:
 - (a) **Descriptive Issue**: Do most patients in these cases ask to die?
 - (b) **Evaluative Issue**: Is it worse to let someone die who does not want to die or instead to not let someone die who wants to die?

DO
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That's all, folks.





The Family

- What if the family wants the patient to be kept alive?
- Compare: A patient validly refuses to give permission for a surgery it is rational to refuse, but the family requests the surgery. In this case, it would be serious assault, criminal, and morally wrong to perform the surgery.
- A patient in PVS who can communicate only by brain scans has the same legal or moral rights, including the right to refuse treatment.
- So, even if the family disagrees, it would be morally wrong to treat a PVS patient who validly refuses treatment.

PROBLEMS FOR fMRI

- Many facilities have no scanner.
- Scanners are not portable.
- The test costs a lot.
- The test takes time to administer and the data takes time to analyze.
- Patients must stay still.
- fMRI cannot be used if the patient has any metal implant.

EEG

- What **EEG** is: electrodes on the scalp
- **Advantages**: available, portable, cheap, quick, not affected by motion or metal
- **Method** (Cruse et al., *Lancet* 11/10/2011):
“Every time you hear a beep, try to imagine that you are squeezing your right hand into a fist and then relaxing it/wiggling all of the toes on both of your feet and then relaxing them.”
- **Subjects**: 16 subjects diagnosed by experts compared to 12 controls

Results

	Sex	Age at assessment (years)	Interval postictus (months)	Cause (TBI/non-TBI)	CRS-R	Number of tasks contributing to analyses	EEG classification accuracy (%)	p value for EEG command following
Patient 1	Male	35	9	Anoxia	7	202	61.38%	<0.01
Patient 2	Male	63	39	Anoxia	5	113	61.90%	NS
Patient 3	Male	55	21	Anoxia	4	160	47.50%	NS
Patient 4	Male	35	32	Anoxia	6	69	43.47%	NS
Patient 5	Male	30	24	Anoxia	6	102	51.96%	NS
Patient 6	Female	41	56	Anoxia	5	132	53.78%	NS
Patient 7	Male	63	32	Anoxia	7	76	56.58%	NS
Patient 8	Female	44	1	Anoxia	3	86	48.83%	NS
Patient 9	Male	48	94	Anoxia	6	116	58.62%	NS
Patient 10	Female	36	77	Stroke	3	114	39.47%	NS
Patient 11	Male	62	1	Stroke	6	142	48.59%	NS
Patient 12	Male	45	23	Trauma	6	146	71.23%	<0.001
Patient 13	Male	29	3	Trauma	6	96	78.13%	<0.001
Patient 14	Male	29	16	Trauma	6	150	40.70%	NS
Patient 15	Male	14	18	Trauma	6	60	41.66%	NS
Patient 16	Male	21	7	Trauma	7	98	47.95%	NS

TBI=traumatic brain injury. CRS-R=coma recovery scale-revised. EEG=electroencephalogram. NS=non-significant.

Table: Patient demographics and EEG classification accuracies

False Negatives?

	Significant	Non-significant	Total
Controls	9	3	12
TBI	2	3	5
Non-TBI	1	10	11

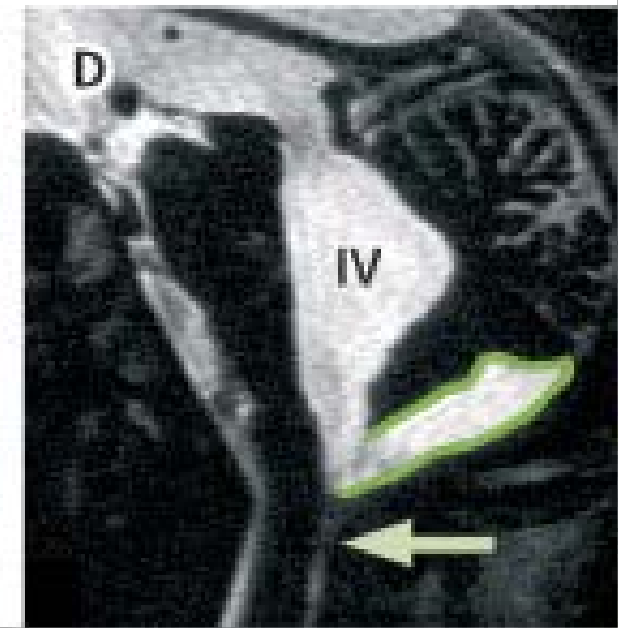
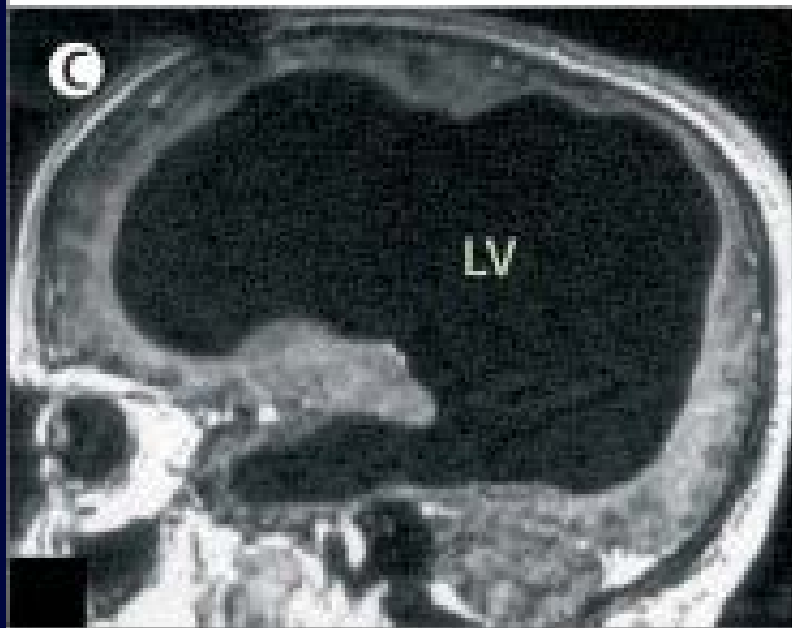
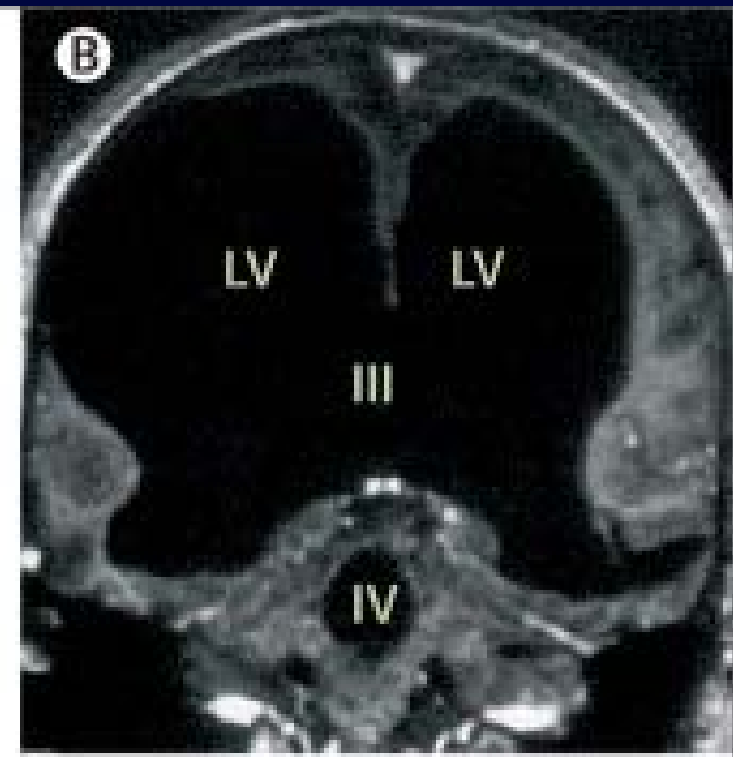
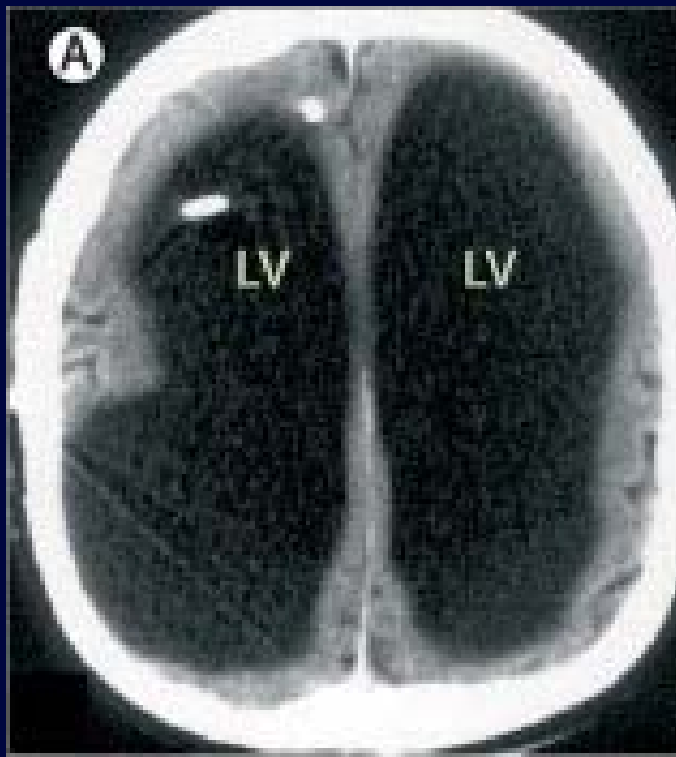
Massive ventricular enlargement, in a patient with **normal social functioning**

(A) CT;

(B,C) T1-weighted MRI, gadolinium contrast;

(D) T2-weighted MRI

LV=lateral ventricle
III=third ventricle
IV=fourth ventricle
Arrow= Magendie's foramen



WHICH KIND OF CONSCIOUSNESS?

- Wakefulness vs. Awareness
- Phenomenal vs. Access (controlled)
- Synchronic vs. Diachronic (memory)
- Of Environment vs. of Self

Don't Get Too Excited!

- Some people leap to the conclusion that we should NEVER give up.

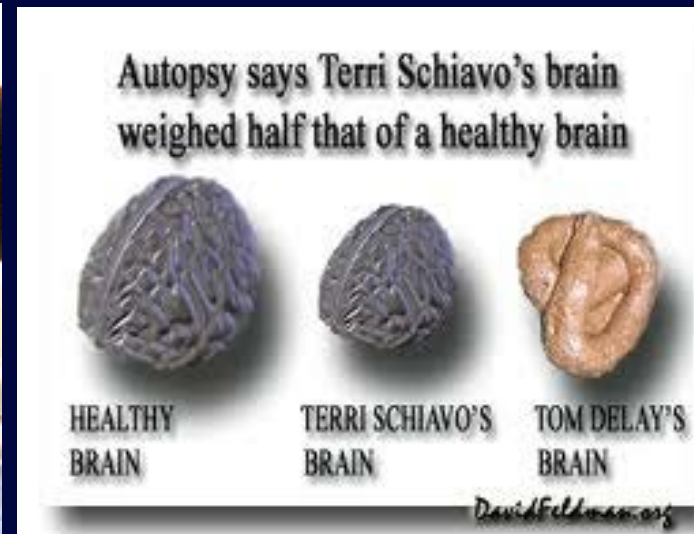
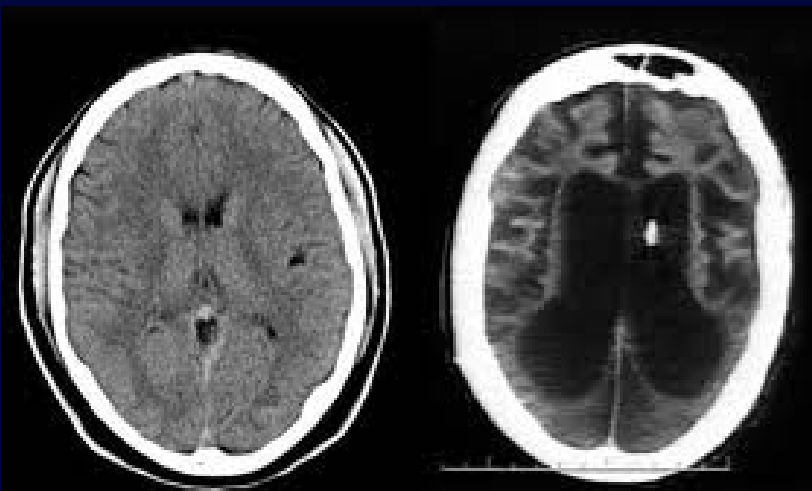
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- Then they claim that it was a mistake to let Terri Schiavo die.



Don't Get Too Excited!

- Some people leap to the conclusion that we should NEVER give up.
- Then they claim that it was a mistake to let Terri Schiavo die.
- But that case is VERY different.



MISDIAGNOSIS

One problem: Up to 43% of patients who had been diagnosed as being in a PVS were reclassified as at least minimally conscious when rediagnosed by expert teams.

Another problem: Among those who are diagnosed by experts, there still might be some patients who are conscious at least to some degree.