INTRODUCTION

In Western medical ethics, the centre has not held and things are fast falling apart. Some practices long recognized as barbarous in themselves and opposed to the nature and aims of medicine are now routine; others are fast winning acceptance, and even those still beyond the pale have an air of inevitability. Abortion is now one of the most common medical procedures; assisted suicide enjoys broad public support and has won some contests in legislatures and popular referenda; infanticide and passive euthanasia are widespread practices for which some demand legalization and moral legitimation. Flood tides of social change erode our long-held conception of medicine and its associated restraints and pull us into a sea of medical homicide. A new ethic, really a reinvigorated ethic from the Enlightenment, has emerged to grant its moral and intellectual imprimatur to medicine’s lethal new agenda. In it, medical technology is to proceed largely unconstrained by any fear that we degrade humanity when we consider the sick and dying merely as providers of recyclable organs, or when we treat people as objects of manufacture and their parts as commercial goods, or when we experiment on embryos in utero or in test-tubes or on the terminally ill. Indeed, in the emerging ethic, modern medicine’s technological imperative increasingly meets its match only when it runs afoul of the new agenda of death and dehumanization. For these ‘ethicists’ technology systematically loses out only to the fear that it might be used to preserve life our elites deem unworthy, nonautonomous, or undignified, especially the lives of those relegated to their new, Orwellian category of human ‘unpersons’: the brain-damaged, the irreversibly comatose, the unborn, and so on.

The Hippocratic tradition famously deplored several of these now accepted, even fashionable, practices, most notably euthanasia and abortion. However, it acknowledged that some medical procedures it deemed legitimate could sometimes go wrong, prematurely ending a patient’s life or pregnancy, while others were known to cause pain or loss of function as side-effects of measures taken to restore health or preserve life. The medical code came to limit its condemnation to the ‘intentional termination of life’, a formulation still sometimes employed. One reason
for this is straightforward. Medicine is, as we say today, a part of health care. Its primary goal, and that of its practitioners, is the patient's health, understood as the integrated functioning of her systems as an organism. Dying is the comprehensive breakdown and dissolution of this functioning. You do not get any less healthy, any worse off as an organism, than by dying. So, as the tradition recognized, it perverts medical skills to turn them to the pursuit of death, whether as means or end, as happens when physicians become executioners, suicide assistants, or — assuming the unborn are human beings — abortionists.¹ Those 'ethicists' who celebrate the emerging medical order have made this restriction their preferred target, identifying the traditional claim that life is sacred with endorsement of just such a moral principle against the intentional termination of human life.² Thus, Helga Kuhse labels 'the [Q]ualified Sanctity-of-Life Principle' the thesis that 'it is absolutely prohibited either intentionally to kill a patient or intentionally to let a patient die, and to base decisions relating to the prolongation and shortening of human life on consideration of its quality or kind; it is, however, sometimes permissible to refrain from preventing death'.³ She directs her book's arguments chiefly against this thesis. The self-declared enemies of life's sanctity insist the stricture against medical personnel acting with the intent that a patient's life end stems from religious faith and lacks all justification outside that context.⁴

In my view, these hostile critics of this element of traditional medical ethics deeply misunderstand or ignore reasons supporting it. In other essays, I have tried to defend traditional moral absolutism against general philosophical attacks, especially its emphasis on the crucial moral role of the agent's intentions. Here I wish to rebut some of the criticisms salient in the medical ethics literature, concentrating on Kuhse's discussion, which is, as far as I know, the most detailed and sophisticated attack on the moral importance of intentions in medical ethics. I will defend what we can call 'intention-sensitivity' in medical ethics. More specifically, I will try to show: (i) that there is a genuine psychological difference between intending something to result from one's behaviour and merely expecting it to; (ii) how it can matter to whether a health-care worker acts in ways morally permissible that she intends (and does not merely foresee) certain aspects or results of her behaviour; and (iii) that we can often have reasonable beliefs about whether an agent acted with an intention that should disqualify a course of action. I will also sketch the beginnings of an approach to medical ethics in which the reasons for the critical importance of intentions become clearer. My approach here will be secular in James Rachels's sense: I will not treat morality simply 'as a matter of faithfulness to abstract rules or divine laws', but rather will treat 'the