

Euthanasia

Should individuals, especially terminally ill people in excruciating pain, be able to end their lives? If so, may they hasten their deaths only by refusing medical treatment designed to sustain their lives, or may they take active measures to kill themselves? If they can take measures to kill themselves, can they ask others to assist them? Who can they ask: their spouses? close friends? their doctors? Should the law support their decisions?

Many people think that (at least) terminally ill people have the moral authority to decide whether and how to end their lives. If people have the freedom to choose how to live, they ask, why should they not also have the freedom to choose how to die? Many authors in this section think people should have that choice. If we respect individuals then we should give them this control over their lives. That view reflects the general public's. Most people now acknowledge that it is sometimes acceptable for an individual to act (or refuse to act) in ways that hasten her death.

Here the broad consensus ends. There is still considerable disagreement about when, where, and how a person may do so. Some claim only the terminally ill have the moral authority to end their lives, while others claim that anyone who finds her life no longer worth living may kill herself. Some claim an individual can hasten her death only by refusing medical treatments that sustain her life, while others claim that an individual can legitimately take active measures to end her life. In short, many people disagree about the conditions under which a person may legitimately seek death, and about what such a person can legitimately do, or entice others to do, to achieve that end.

Even this broad consensus is fairly recent. Historically many people thought it was immoral for anyone to hasten her death, either by actively killing herself or by failing to take heroic measures to keep herself alive. They believed one must preserve her life, even if it were, in some important sense, no longer worth living. Although few people now embrace this view in its strongest form, a significant number of people, like Velleman, have serious misgivings about the claim that people have a right to end their own lives, even if they are terminally ill and in considerable pain.

Velleman critiques the claim common to three of these essays: that we can justify the right to die by appealing to individual autonomy. Having options, he argues, is not an unadulterated good. Options may make us vulnerable to unwanted pressure from others. For example, having the option of working for less than minimum wage increases the chances that employers will offer people less than the minimum wage. Options also close off the possibility that we can maintain the status quo (in this case, continuing to live) without having to choose it. Autonomy is not the only good nor is it invariably desirable.

Nonetheless, most people, Velleman included, believe autonomy is a significant element of morality that the law must respect. They disagree profoundly, however, about the scope of autonomy, about the specific role it plays in a proper understanding of morality and the law. For instance, should law always respect our explicit wishes, even when we wish to act in a way that would normally be considered harmful – as killing oneself would be?

Should we have autonomy to do only those things that society considers to be in our own best interests?

Concern for autonomy is also critical for many moral issues, especially, questions about PATERNALISM AND RISK. Should an individual be able to choose how she wants to live, even if others think her those choices are detrimental to her? Suppose the action is likely detrimental, for example, through the use of mind-altering drugs. Does that justify the state's making such use illegal? Wilson thinks so; Husak does not (PATERNALISM AND RISK).

Just as virtually everyone recognizes that autonomy is morally significant, most also acknowledge that it is not the only relevant moral consideration. Among other things, the single-minded attention on autonomy may mask the ways in which our choices (or lack of them) are shaped by our legal, political, social, and economic environments. For instance, an individual may decide that her life is no longer worth living, because she is suffering from an extremely painful and debilitating disease. However, as Cohen and Lynn argue, the disease may be especially painful and debilitating only because she cannot afford first-rate medical care. Under these circumstances, death may be her best option. However, death may be the best option only because of the reigning political and economic structures. In a different economic and political world other options might be preferable.

The emphasis on autonomy may also lead us to overlook the ways that our dying – or continuing to live – profoundly affects our families. Suppose I decide to have doctors use every conceivable means to keep me alive. That choice does not affect only me. Family and friends must inevitably bear the emotional trauma of seeing me debilitated and in pain. Likely they must also bear substantial financial costs. Often they must make considerable personal sacrifices since they likely would be expected – at least in our society – to care for me. In short, my decision to live or die substantially affects the interests of friends and family. Should they therefore, as Hardwig argues, be centrally involved in making the decision about my death? Or should they, as Hooker argues, be explicitly excluded from making such decisions since they are likely biased precisely because their interests are so heavily affected?

This disagreement between Hooker and Hardwig hints at a deep divide in ethical perspectives between individualists, who hold that personal autonomy is one of the, and likely the highest, moral good, and communitarians, who

stress our relationships with others. Put differently, individualists focus on our separateness from (and often conflicts with) others, while communitarians focus on our relationships with, dependence on, and responsibilities to, others. This fundamental difference in moral outlook weaves through many issues discussed in this volume.

Despite these differences, virtually all ethicists acknowledge that in addition to determining whether it would be moral to end one's life, we must also ask whether these choices should be legally protected. For instance, Beauchamp, Hooker, and Cohen/Lynn argue (for different reasons) that we must be concerned about the broader effects of legalizing assisted suicide. What are the likely consequences of legally permitting physician-assisted suicide? Beauchamp is worried that it would damage the doctor-patient relationship; in particular, he fears it would make doctors less committed to saving life and less sensitive to their patients' pain. Cohen and Lynn think this consequence is likely if one speaks, as Hardwig does, about a duty to die. If this were a consequence of legalizing the practice, it would be a powerful reason to oppose its legalization, even if we might think individuals have the right to take their own lives.

The issue of euthanasia is further complicated by the injection of the act/omission (or doing/allowing) distinction. Most people think there is a significant moral difference between things we do, and things we permit: it is worse to kill Robert than (merely) to let him die. Some people employ that distinction to explain why passive euthanasia (removing medical measures sustaining a person's life) is morally acceptable, while active euthanasia, (an individual's – or some person acting for the individual – taking active steps to hasten her death) is morally objectionable. Most people who oppose active euthanasia rest their case on the purported moral significance of the act/omission distinction.

We will see this distinction at work in several moral issues. For example most people think that while killing Bengali children would be morally heinous, refusing to provide these same children with food, medical, and economic assistance is not immoral (WORLD HUNGER). And LaFollette explains how either adherence to – or rejection of – this distinction creates problems for standard justifications of ANIMAL experimentation.

This distinction is often associated with a deep theoretical divide between deontological and consequentialist moral theories. Consequentialists, being more concerned with the outcome or consequences of actions, will

tend to see no strong reason to think that acts are morally more significant than omissions. As Beauchamp argues, although it sometimes appears that acts are morally more significant than omissions, that is usually because this distinction is conjoined with morally relevant differences that explain the different moral evaluations.

Deontologists, on the other hand, are more likely to think the act/omission distinction is fundamentally important. Since they think the consequences of our actions are, at most, only a portion of the moral story, they are prone to put moral emphasis on what we explicitly do rather than on what we permit.

Further Reading

- Arras, J. D. (1999) "Physician-Assisted Suicide: A Tragic View." In J. D. Arras and B. Steinbock (eds.) *Ethical Issues in Modern Medicine*, 5th edn. Palo Alto, CA: Mayfield, pp. 274–280.
- Battin, M. P. (2000) "Euthanasia and Physician-Assisted Suicide." In H. LaFollette (ed.) *Oxford Handbook of Practical Ethics*. Oxford: Oxford University Press, pp. 673–704.
- Beauchamp, T. (ed.) (1996) *Intending Death: The Ethics of Assisted Suicide and Euthanasia*. Englewood Cliffs, NJ: Prentice-Hall.
- Beauchamp, T. and Childress, J. (1983) *Principles of Biomedical Ethics*, 2nd edn. Oxford: Oxford University Press.
- Beauchamp, T. and Walters, L. (eds.) (1994) *Contemporary Issues in Biomedical Ethics*. Belmont, CA: Wadsworth.

- Pence, G. (1995) *Classic Cases in Medical Ethics*, Chapter 1: "Comas: Karen Quinlan and Nancy Cruzan." New York: McGraw-Hill.
- Quill, T. (1991) "Death and Dignity: A Case of Individualized Decision Making." *New England Journal of Medicine* 324, 691–694.
- Quill, T. and Cassell, C. (1995) "Nonabandonment: A Central Obligation for Physicians." *Annals of Internal Medicine* 122, 368–374.
- Steinbock, B. (1980) *Killing and Letting Die*. Englewood Cliffs, NJ: Prentice-Hall.
- Veatch, R. (ed.) (1989) *Medical Ethics*. Boston, MA: Jones and Bartlett.

Rule-Utilitarianism and Euthanasia

Brad Hooker

I Introduction

As scientific and technological advances enable the medical profession to keep people alive longer, the question arises whether this is always a good thing. Should those who could prolong life step back under certain conditions and allow a very ill person to die? And if allowing to die is sometimes right, then what about actively killing patients when this would be better for the patients than allowing them to die more slowly and painfully?

Such questions are debated under the heading of euthanasia. The term "euthanasia" derives from the Greek term for an easy, painless death. However, we often now hear the term "passive euthanasia," which refers to passing up opportunities to save an individual from death, out of concern for that individual. If passive euthanasia is indeed one kind of euthanasia, then "euthanasia" cannot mean "killing painlessly"; for to pass up an opportunity to save someone, that is, passive euthanasia, is arguably not *killing*. Furthermore, the death involved in passive euthanasia is often *painful*. So let us take the term "euthanasia" to mean "either killing or passing up opportunities to save someone, out of concern for that person." (Note that, on this definition, what the Nazis called "euthanasia" was not euthanasia, because it was not done out of concern for the patients.)

Different moral theories will of course approach questions about the moral status of euthanasia in different ways, though some of these theories will end up with the same conclusions. This essay considers euthanasia from the perspective of just one moral theory.

The theory is rule-utilitarianism. Rule-utilitarianism assesses possible rules in terms of their expected utility. It then tells us to follow the rules with the greatest expected utility. (Expected utility is calculated by multiplying the utility of each possible outcome by the probability that it will occur.)

In the next section, I explain what the term "utility" means. Then I outline another utilitarian theory – act-utilitarianism. I do this in order to contrast rule-utilitarianism with this perhaps more familiar theory. I then outline the distinctions between different kinds of euthanasia. The final sections of the essay consider the various factors that would go into a rule-utilitarian decision about euthanasia.

II Utility

A moral theory is utilitarian if and only if it assesses acts and/or rules in terms of nothing but their utility. Classical utilitarianism took "utility" to refer to the well-being of sentient creatures. And classical utilitarianism took the well-being of sentient creatures to consist in pleasure and the absence of pain (Bentham, 1823; Mill, 1863; Sidgwick, 1877). On this view, people's level of well-being is determined *solely* by how much pleasure and pain they experience.

If anything is desirable for its own sake, pleasure is. But most utilitarians now think that pleasure, even if construed as widely as possible, is not the *only* thing desirable in itself, and pain not the *only* thing undesirable

in itself (Moore, 1903, ch. 6; Hare, 1981, pp. 101ff; Parfit, 1984, appendix I; Griffin, 1986, Part One; Goodin, 1991, p. 244; Harsanyi, 1993). Utilitarians can think that things that are desirable for their own sake include not only pleasure but also important knowledge, friendship, autonomy, achievement, and so on. Indeed, many utilitarians now construe utility just as the fulfillment of desire or the satisfaction of preferences, with relatively few restrictions on what the desires or preferences are for.

One reason most utilitarians have moved away from a version of utilitarianism that focuses exclusively on pleasure has to do with knowledge. Many of us care about certain things over and above the pleasure they typically bring, and one of these things is knowing the important truths (e.g., about the nature of the universe and about oneself), even if not knowing the truth would be more pleasant for us. Bliss isn't everything – for example, if purchased at the cost of ignorance. To be sure, knowledge does not always constitute a more significant addition to well-being than does pleasure. But sometimes it does.

People also care about autonomy, by which I mean control over one's own life. Many of us would be willing to trade away some pleasure for the sake of an increase in autonomy. Again, this is not to say that even a tiny increase in autonomy is more important than a great deal of pleasure; rather, the point is that pleasure is not always more important to our well-being than autonomy. Neither value is always more important than the other.

I agree with such convictions. Knowledge, autonomy, and other things can be beneficial to us, can increase our well-being, over and beyond whatever pleasure they directly or indirectly bring us. I shall presuppose this in what follows.

I shall also follow conventional philosophical opinion in supposing that it is possible to be in such a bad condition that death would be a welcome release. Severe pain can be unrelenting, and indeed so overpowering that the person experiencing it can think of nothing else. If the rest of my life would consist of nothing but excruciating physical pain, then I might be better off dead. Indeed, if the rest of my life would consist wholly of intense psychological suffering, I'd be better off dead. Of course, we may argue about where to draw the line between being better off dead and being better off alive (Mitchell, 1995). But it seems deeply unreasonable to insist that there are never any instances of patients who would be better off dead.

Now, what about *divinely bestowed* benefits and harms? Most utilitarians, and all utilitarian writers of our era, have written as if there were no rewards or punishments granted by a god or gods. This is not to say that all utilitarians have been atheists. In fact, many have been religious believers (perhaps most notably, Bishop Berkeley, 1712). Nor would *any* utilitarians – theistic or agnostic or atheistic – hold that a person's religious beliefs are completely irrelevant to the morality of how he or she is treated. For any utilitarian would recognize that people's religious beliefs can have an effect on what brings them pleasure and on what preferences they form. So utilitarianism will favor, for example, freedom of religion and even the neutrality of the state with respect to religion.¹ But while utilitarians can think that people's religious beliefs are often relevant to moral argument about how these people should be treated, modern utilitarians eschew basing any moral argument on the *truth* of any religious belief. And this prohibition on assuming the truth of any religious belief applies to the belief that there are divinely bestowed benefits and harms.

That said, we must also note that utilitarianism is also often said to assume a god's-eye point of view. The main respect in which this is true is that the utilitarian approach prescribes a totally impartial calculation of well-being. To be more specific, in the calculation of utility, benefits or harms to any one person are to count for just as much as the same amount of benefit or harm to anyone else – that is, count the same without regard to race, religion, gender, social class, or the like.

It is a mistake to think that utilitarians hold that what benefits more people is *necessarily* better than what benefits fewer. Utilitarians focus on the greatest aggregate good. What results in the greatest aggregate good is sometimes not what benefits the majority. This is because the benefits to each of the smaller number may be large and the benefits to each of the greater number small. And large benefits to each of a minority can add up to more than small benefits to each of a majority. Thus, utilitarians will favor what benefits the minority if (but only if) what benefits the minority results in the greatest good overall.

On the other hand, many philosophers have pointed out that utilitarianism gives no intrinsic weight to how equally or fairly benefits are distributed. I myself accept that this is an important potential problem with utilitarianism. But because I don't think these worries about distribution are relevant to euthanasia, I shall ignore them in this essay.

III Act-Utilitarianism

The most direct and most discussed form of utilitarianism is act-utilitarianism. There are different versions of this theory. One version holds that an act is right if and only if its *actual consequences* would contain at least as much utility as those of any other act open to the agent. Another version claims that an act is right if and only if its *expected* utility is at least as great as that of any alternative.

But there are many familiar counter-examples to both versions of act-utilitarianism. Some of these counter-examples have to do with moral prohibitions. For example, both versions of act-utilitarianism imply that killing an innocent person, or stealing, or breaking a promise would be morally right if the expected and actual utility of the act would be greater, even if just slightly greater, than that of any alternative act. We might think that normally prohibited acts could be right in very rare circumstances in which doing such acts is the only way to prevent something much worse. But we don't think such acts are permissible when the expected and actual utility of such an act would be only slightly greater than that of complying with the prohibition.

Another problem with act-utilitarianism is that it seems unreasonably demanding, requiring acts of self-sacrifice that seem beyond the call of duty. Think how much a middle-class individual in a relatively affluent country would have to give to CARE or Oxfam before further sacrifices on her part would constitute a larger loss to her than the benefit to the starving that CARE or Oxfam would produce with that contribution. Making sacrifices for strangers up to the point that act-utilitarianism requires would be saintly. But morality, most of us think, does not *require* sainthood.

IV Rule-Utilitarianism

Rule-utilitarianism differs from act-utilitarianism in that rule-utilitarianism does *not* assess each act solely by its utility. Rather, rule-utilitarianism assesses acts in terms of rules, and rules in terms of their utility. Rule-utilitarianism holds that an act is morally permissible if and only if the rules with the greatest expected utility would allow it. The expected utility of rules is a matter of the utility of their "general" internalization, that is, internalization by the overwhelming majority. For a code of rules to be

internalized is for people to believe these rules justified and to be disposed to act and react in accordance with them. Assume I have internalized a rule against killing people against their will. If this assumption is correct, I will (a) think this kind of act wrong, (b) be disposed not to do this kind of act, and (c) be disposed to react negatively to those who I think have done it.

To say that rule-utilitarians focus on the consequences of the general internalization of rules does not mean that they consider only rules that existing people *already* accept. Rather, the question rule-utilitarians ask about each possible code is what the effects on utility would be of the code's being successfully inculcated in people who had no prior moral beliefs or attitudes. At least in principle, the code of rules best from a utilitarian point of view might be very different from those now accepted in any given society. (For developments of this sort of theory, see Brandt, 1963, 1967, 1979 part two, 1988; Harsanyi, 1982; Johnson, 1991; Barrow, 1991; Hooker, 1995, 2000.)

The intuitive attractions of rule-utilitarianism become clear as we notice the ways in which this theory seems superior to act-utilitarianism. For unlike act-utilitarianism, rule-utilitarianism agrees with common conviction that individual acts of murder, torture, promise-breaking, and so on can be wrong even when they produce somewhat more good than their omission would produce. For the general internalization of rules prohibiting murder, torture, promise-breaking, and the like would clearly result in more good than the general internalization of rules that did not prohibit such acts. Thus, on the rule-utilitarian criterion of moral permissibility, acts of murder, torture, and so on, can be impermissible even in rare cases where they really would produce better consequences than any alternative act.

Likewise, rule-utilitarianism will not require the level of self-sacrifice act-utilitarianism requires. For, crudely, rule-utilitarianism approaches this problem by asking how much each relatively well-off person would have to contribute in order for there to be enough to overcome world hunger and severe poverty. If *the overwhelming majority of the world's relatively well-off* made regular contributions to the most efficient famine relief organizations, no one would have to make severe self-sacrifices. Thus, rule-utilitarianism is not excessively demanding (Hooker, 1991, 2000; cf. Carson, 1991).

The advantages of rule-utilitarianism over act-utilitarianism are often construed as utilitarian advantages. In other words, some philosophers have argued that

rule-utilitarianism will in fact produce more utility than act-utilitarianism (Brandt, 1979, pp. 271–7; Harsanyi, 1982, pp. 56–61; Johnson, 1991, especially chs. 3, 4, 9; Haslett, 1994, p. 21; but compare Hooker, 1995, section III). I am *not* running that argument. Instead, I am merely pointing out that rule-utilitarianism seems to have implications that are more intuitively acceptable than those of act-utilitarianism (Brandt, 1963, 1967).

V Kinds of Euthanasia

We need to distinguish three different kinds of euthanasia, or rather three different ways euthanasia can be related to the will of the person killed. Suppose I ask you to either kill me or let me die should my medical condition get so bad that I am delirious and won't recover. If you then comply with my request, we have what is commonly called *voluntary euthanasia*. It is voluntary because the person killed asked that this be done.

Now suppose that I slip into an irreversible coma without ever telling anyone whether I wanted to be killed in such circumstances. If I am then killed or let die, we have what is commonly called *non-voluntary euthanasia*. The distinguishing characteristic of non-voluntary euthanasia is that it is euthanasia on someone who did not express a desire on the matter.

But what if I do express a desire not to be killed no matter how bad my condition gets? Then killing me would constitute what is called *involuntary euthanasia*. Quite apart from its moral status, involuntary euthanasia can seem puzzling. To be euthanasia, it must be done for the good of the person killed. Yet if the person concerned expresses a desire that it not be done, how can it be done for this person's own good? Well, involuntary euthanasia may be morally wrong (we will discuss why in a moment), but we must start by acknowledging that people are *not always* in the best position to know what is best for themselves. Someone could be mistaken even about whether he or she would be better off dead than alive in a certain state. And other people could think that the person in front of them had made just this kind of mistake. If they not only thought this but also were motivated to do what was best for this person, they might contemplate euthanasia. What they would then be contemplating would be involuntary euthanasia.

Another important distinction is the distinction between active and passive euthanasia. Active euthanasia involves actively killing some one out of a concern

for that person's own good. Passive euthanasia involves passing up opportunities to prevent the death of someone out of concern for that person's own good.

The distinction between active and passive euthanasia cuts across the distinction between voluntary, non-voluntary, and involuntary euthanasia. In other words, either with my consent, or without knowing what my wishes are or were, or against my wishes, you might kill me. Likewise, either with my consent, or without knowing what my wishes are or were, or against my wishes, you might pass up an opportunity to keep me from dying. Thus we have:

Active Voluntary Euthanasia
Active Non-voluntary Euthanasia
Active Involuntary Euthanasia
Passive Voluntary Euthanasia
Passive Non-voluntary Euthanasia
Passive Involuntary Euthanasia

VI Law and Morality

We also need to distinguish between questions about law and questions about moral rightness, permissibility, and wrongness. Utilitarians, as well as moral philosophers of many other stripes, can think that there may be some moral requirements that the law should not try to enforce. A relatively uncontroversial example concerns the moral requirement forbidding breaking verbal promises to your spouse. There may be good utilitarian reasons for not bothering the law with such matters – to police the give and take of such relationships might be too difficult and too invasive. This isn't to deny that breaking verbal promises to spouses is usually morally wrong, only that the law shouldn't poke its nose into this matter.

So, initially at least, there is the potential for divergence in what the rule-utilitarian says about the law and about morality. There is less scope for this on rule-utilitarianism, however, than there is on some other theories. For both in the case of law and in the case of morality, the first thing rule-utilitarianism considers is the consequences of our *collective* compliance with rules. (See Mill, 1863, ch. 5.)

With respect to euthanasia, rule-utilitarianism is especially likely to take the same line on law as it does on morality. That is, if rule-utilitarians think that people's being allowed in certain circumstances to kill or let

die would have generally good consequences, then they will think such acts are *morally* allowed in the specified circumstances. They will also think the *law* should allow them in the specified conditions. And if they think the consequences would be generally bad, then they will think morality does, and the law should, prohibit the acts in question.

Thus, in the following discussion of the rule-utilitarian approach to euthanasia, I will focus on just one realm and assume that the other follows suit. The realm on which I shall focus is the law. The question, then, is: What kinds of euthanasia (if any) should the law allow?

VII The Potential Benefits of Euthanasia

Perhaps the most obvious potential benefit of permitting euthanasia is that it could be used to prevent the unnecessary elongation of the suffering experienced by many terminally ill people and their families. What about painkilling drugs? Some kinds of pain cannot be eliminated with drugs, or at least not with drugs that leave the patient conscious and mentally coherent. And in addition to physical agony, there is often overwhelming emotional suffering for the patient, and derivatively for friends and family in attendance. All this could be shortened if euthanasia were allowed.

To the extent that the point is speedy termination of physical and emotional suffering, active rather than passive euthanasia can seem desirable. For passive euthanasia would often involve a slow and painful death, whereas active euthanasia could end the patient's suffering immediately. There may, however, be especially large costs associated with allowing active euthanasia. I shall consider these later.

Another advantage of permitting euthanasia – and again the advantage is even more pronounced in the case of permitting active euthanasia – concerns resource allocation. The resources, both economic and human, that are now devoted to keeping alive people who have incurable and debilitating diseases could often more cost-effectively be devoted to curing people of curable diseases, or to funding preventive medicine, or even just to feeding the starving. What I mean by saying that the change in resource allocation would be more cost effective is that this would increase average life-expectancy and quality of life.

For utilitarians who count personal autonomy as a value over and above whatever feelings of satisfaction it brings and frustration it prevents, there is an additional consideration. It is that *voluntary* euthanasia must increase personal autonomy, in that it gives people some control over *when* their lives end. And if active voluntary euthanasia were allowed, this would give people some control over *how* their lives end. Concern for people's autonomy obviously counts only in favor of *voluntary* euthanasia. It is irrelevant to the discussion of non-voluntary euthanasia of any kind, and opposes involuntary euthanasia of any kind.

VIII The Potential Harms of Allowing Involuntary Euthanasia

A law permitting active *involuntary* euthanasia is likely to be strongly opposed by rule-utilitarians for other reasons as well. One such reason is that many people would be scared away from hospitals and doctors if they thought that they might be killed against their wishes. I cannot imagine how allowing involuntary euthanasia could generate benefits large enough even to begin to offset this loss. The last thing a public policy should do is scare people away from trained medical experts. A related point is that allowing involuntary euthanasia would terrify many people taken to a hospital while unconscious. Imagine waking up to find that you had been taken to a hospital where people can, *against your wishes*, kill you, as long as they (claim to) think this would be best for you.

Furthermore, to allow the killing of innocent people against their wishes would be difficult to square with other moral prohibitions of supreme importance. In particular, the general feeling of abhorrence for the killing of innocent people against their wishes is, as Hobbes (1651) insisted, the bedrock of social existence. Without communal acceptance of that prohibition, life would be precarious and insecure. No law should be passed which genuinely threatens to undermine people's commitment to the general prohibition on killing the innocent against their wishes.

At this point someone might say, "Ah, but we can distinguish between killing innocent people against their wishes but *for their own good*, and killing them *for some other reason*." True, we can make that distinction. But is it a distinction whose enshrinement in law would be felicitous? No, again because people would not feel

IX The Potential Harms of Allowing Voluntary and Non-Voluntary Euthanasia

Turn now to the harms that voluntary and non-voluntary euthanasia might involve. Suppose the doctors tell Jones he has disease X. This disease almost immediately produces excruciating pain, dementia, and then death. Jones asks to be killed, or at least allowed to die, before the pain gets too severe. The doctors comply with Jones's wishes. Later, however, a post-mortem reveals that he didn't have disease X at all, but instead some curable condition. As this story illustrates, euthanasia can inappropriately take a life after a mistaken diagnosis.

And yet how often do medical experts misdiagnose a condition as a terminal illness when it isn't? And how wise is it now to go against expert medical opinion? And are there ways of minimizing the risk of doctors acting on misdiagnoses? Euthanasia could be restricted to cases where three independent medical experts – and I mean *real* experts – make the same diagnosis. With such a restriction, the worry about misdiagnoses seems overblown.

But closely associated with the point that doctors sometimes misdiagnose someone's condition is the point that doctors are sometimes wrong about what will happen to someone whose condition is correctly diagnosed. Suppose the doctors rightly believe that there is now no treatment known to prevent the disease some people have from bringing acute pain followed by a painful death. But a cure or more effective pain block might soon be discovered. If people are killed or allowed to die today and the medical breakthrough comes tomorrow, euthanasia will have amounted to giving up on those people too soon – with obviously tragic results.

However, again restrictions could be put in place to prevent the losses envisaged. One restriction could specify that euthanasia is completely out of the question until someone is fairly near the final stages of a disease, where new cures or treatments are very unlikely to be able to change the fatal path of the disease. (And one way of approximating this restriction would be to allow *passive* but not *active* euthanasia. But this seems an unnecessarily crude way of ensuring that people aren't killed before they could be cured.) Another restriction could specify that euthanasia be out of the question until after a thorough and disinterested investigation into the state of research on cures and treatments. When this

secure in a society where they might be, against their wishes, killed for their own good.

These points about insecurity add up to a very persuasive rule-utilitarian argument against permitting *active* involuntary euthanasia. But do they count against *passive* involuntary euthanasia? In the case of passive euthanasia, there isn't such a risk that people will stay away from doctors and hospitals for fear of being made worse off than they are already. Suppose you had a serious illness and found yourself in a society where active involuntary euthanasia was neither permitted nor practiced, but passive involuntary euthanasia was permitted and practiced. Then, you would not need fear that going to the hospital would get you killed against your wishes. But you might worry that the doctors or hospital would, against your wishes, pass up opportunities to prolong your life. Yet you probably wouldn't live longer if you stayed out of the hospital. Indeed, if you were under the care of a doctor, you would probably suffer less. Thus, you have less to lose by going into the hospital in a society where passive involuntary euthanasia is permitted than you do in a society where active involuntary euthanasia is permitted. If passive involuntary euthanasia only were legally and morally permitted, the consequence would not be that everyone who thought they had or might have a fatal disease would avoid doctors. So the disadvantages of allowing passive involuntary euthanasia are clearly less than the disadvantages of allowing active involuntary euthanasia.

The disadvantages of allowing passive involuntary euthanasia may nevertheless be enough to convince rule-utilitarians to oppose it. Utilitarians have long argued that their doctrine is generally anti-paternalistic (Mill, 1859). Grown-up human beings are generally the ones who know which of the ways their lives might unfold would be best for themselves, because they are generally the ones who know best their own aspirations, tastes, talents, sensitivities, vulnerabilities, and so on. Of course there are general exceptions – for example, people with permanent or temporary mental impairments. But, by and large, people are the best guardians of their own well-being.

As noted at the very end of the previous section, rule-utilitarians can have another reason for opposing involuntary euthanasia, passive just as much as active. This reason comes from the idea that autonomy is an important component of well-being. Indeed, this seems to be the strongest rule-utilitarian reason for disallowing passive involuntary euthanasia.

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of euthanasia

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investigation shows that the development of a cure or new treatment is a *realistic* possibility during the life of the patient, euthanasia would again be prohibited.

From a rule-utilitarian perspective, the points about mistaken diagnoses and future cures seem to mandate restrictions on when euthanasia would be considered, but they don't preclude euthanasia altogether – even active euthanasia. Something else, however, does threaten to add up to a conclusive case against allowing any kind of euthanasia, especially active euthanasia. This is the danger of intentional abuse.

Think of the people who might be in a hurry for some ill person's death. Some of these might be people who have to care for the ill person, or pay for the care and medicine the person receives. Another group, often overlapping with the first, is made up of the person's heirs. The heirs might even include the hospital in which the person lies. With so much to gain from an early death of the ill person, these people might easily convince themselves that the ill person would be better off dead. If it were left up to these people, many ill people might unnecessarily be killed or allowed to die. A system which allowed this would both result in unnecessary deaths and terrify the ill.

Even without these points about intentional abuse, rule-utilitarians have enough reason to disallow *involuntary* euthanasia. But do the points about intentional abuse add up to a compelling rule-utilitarian argument against *voluntary* euthanasia? Certainly they necessitate severe restrictions at the very least.

One sensible restriction would be that, with a single exception, the people given authority in the decision about euthanasia must be people with nothing to gain directly or indirectly from their decision. The single exception is of course the patient himself or herself. But heirs and those who stand to benefit from heirs could be denied any authoritative say in the matter. Thus if a hospital is itself an heir, its doctors could be precluded from having any role, including that of making or confirming the diagnosis. The law could be designed to ensure that the decision to perform euthanasia on a patient is made by people focusing on the wishes and best interests of the patient. Of course the patient may ask loved and trusted others, including heirs, what they think. But the law could insist that doctors with nothing to gain certify that the patient really would be, at the time of the euthanasia, better off dead. And the law could insist that the patient be asked on a number of occasions whether he or she really does

want euthanasia. Patients will need the law to protect them against coercive pressures by family and other heirs (not that the law can ever entirely protect us from our families).

Focus now on *non-voluntary* euthanasia – euthanasia performed on people who have not indicated whether or not they want their lives to be prolonged. Some patients have never been in a position to give or withhold consent. This is true of individuals who never developed sufficient rationality to be capable of consenting. Any euthanasia performed on such people will be non-voluntary euthanasia. Rule-utilitarians might well think that a cost-benefit analysis of this sort of euthanasia would end up supporting it – given that the law is designed so as to ensure that the people making the final decision are experts with nothing but the best interests of the patient in mind.

But what about patients who were once rational enough to consent or withhold consent but never made their wishes known and now are incapable of prolonged rationality? Rule-utilitarians can think that to allow euthanasia would be best here too. A more important question, however, might be whether the law should require adults now in possession of their faculties to indicate formally whether they want euthanasia if they become terminally ill and are plagued by acute pain which can be mollified only by severely mind-altering drugs. It might actually increase autonomy to get people to decide whether they would want euthanasia for themselves before they are unable to make such decisions. Obviously, the system for doing this would have to involve informing people what they were being asked to decide about. It would also need to be designed so as to make sure people's decisions are their own, that is, not the result of some sort of coercion. Furthermore, ideally the system would annually ask for confirmation that people haven't changed their minds (there could be a box to check on annual tax returns).

Some people will think that, no matter how clever rule-utilitarians are in adding safeguards to a law allowing euthanasia, there will be at least a few people who manage to subvert it, and so abuses will occur. Rule-utilitarians may grant this, but then ask how many such abuses there would be. Would there be so many abuses as to terrify the general population? These questions are ones of sociology and social psychology. If the answers to them are that the abuses would be extremely rare and the general population would not become paranoid over them, then a rule-utilitarian might be willing to accept

that, if some abuse is inevitable, this cost of a few abuses would be worth the benefits of allowing euthanasia.

There is one more potential harm associated with allowing voluntary and non-voluntary *active* euthanasia. To allow them might seem to be a step onto a slippery slope to a very undesirable position. As I have already noted, the prohibition on killing the innocent against their will is an immensely valuable, indeed essential, prohibition. Would people slide away from a firm commitment to that prohibition if they came to accept the permissibility of voluntary and non-voluntary active euthanasia?

This question, like the question of whether the level of intentional abuse would be unacceptably high, is really one for social scientists. Any answers to such questions have to be partly speculative. We ought to know by now that large social, economic, or legal changes often have unexpected results. We cannot be *certain* what the results of allowing voluntary and non-voluntary active euthana-

sia would be. Rule-utilitarians have to make a judgment based on what they think the probabilities are. And with respect to the sorts of changes under discussion here, reasonable people can disagree about the probabilities. Thus, reasonable rule-utilitarians can come down on different sides about the permissibility of voluntary and non-voluntary active euthanasia.

But even where there is reasonable disagreement, there can be a right answer. The success of voluntary active euthanasia in Holland suggests that the worries about abuse and slippery slopes can be answered. Of course any law allowing euthanasia (especially, active euthanasia) would need to be very carefully drafted. And the law would have to be rigorously policed, to prevent abuse. Though not certain, I am confident these things could be done. And, undeniably, the benefits, mainly in terms of the decrease of suffering and the increase in autonomy, are potentially enormous.

Acknowledgments

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Notes

- 1 Though utilitarians may also favor some restrictions on this. I remember that in Tennessee in the 1960s there was a Christian sect using rattlesnakes in church services. As I remember, the government stopped the practice after it led

to a few deaths, and the courts upheld that freedom of religion did not extend to persuading people to submit to lethal dangers during worship. These decisions could well be supported on utilitarian grounds.

References

- Barrow, R. (1991) *Utilitarianism*. London: Edward Elgar.
- Bentham, J. (1823) *An Introduction to the Principles of Morals and Legislation*.
- Berkeley, G. (1712) *Passive Obedience, or the Christian Doctrine of Not Resisting the Supreme Power, Proved and Vindicated upon the Principles of the Law of Nature*.
- Brandt, R. B. (1963) "Toward a Credible Form of Utilitarianism," *Morality and the Language of Conduct*, ed. H.-N. Castañeda and G. Nakhnikian. Detroit: Wayne State University Press, pp. 107-43.
- (1967) "Some Merits of One Form of Rule-Utilitarianism," *University of Colorado Studies in Philosophy* pp. 39-65. Reprinted in Brandt, 1992, pp. 111-36.
- (1979) *A Theory of the Good and the Right*. Oxford: Clarendon Press.
- (1988) "Fairness to Indirect Optimific Theories in Ethics," *Ethics* 98: 341-60. Reprinted in Brandt, 1992, pp. 137-57.
- (1992) *Morality, Utilitarianism, and Rights*. New York: Cambridge University Press.
- Carson, T. (1991) "A Note on Hooker's 'Rule Consequentialism'" *Mind* 100: 117-21.
- Goodin, R. (1991) "Utility and the Good," *A Companion to Ethics*, ed. P. Singer. Oxford: Blackwell, pp. 241-8.
- Griffin, J. (1986) *Well-Being: Its Meaning, Measurement and Moral Importance*. Oxford: Clarendon Press.
- Hare, R. M. (1981) *Moral Thinking*. Oxford: Clarendon Press.
- Harsanyi, J. (1982) "Morality and the Theory of Rational Behaviour," *Utilitarianism and Beyond*, ed. A. Sen and B. Williams. Cambridge: Cambridge University Press, pp. 39-62.

- (1993) "Expectation Effects, Individual Utilities, and Rational Desires," *Rationality, Rules, and Utility: New Essays on the Moral Philosophy of Richard Brandt*. Boulder, CO: Westview Press, ed. B. Hooker, pp. 115–26.
- Haslett, D. W. (1994) *Capitalism with Morality*. Oxford: Clarendon Press.
- Hobbes, T. (1651) *Leviathan*
- Hooker, B. (1991) "Rule-Consequentialism and Demandingness: Reply to Carson," *Mind* 100: 270–6.
- (ed.), (1993) *Rationality, Rules, and Utility: New Essays on the Moral Philosophy of Richard Brandt*. Boulder, CO: Westview Press.
- (1995) "Rule-Consequentialism, Incoherence, Fairness," *Proceedings of the Aristotelian Society* 95: 19–35.
- (2000) *Ideal Code, Real World: A Rule-Consequentialist Theory of Morality*. Oxford: Oxford University Press.
- Johnson, C. (1991) *Moral Legislation*. New York: Cambridge University Press.
- Mill, J. S. (1859) *On Liberty*.
- (1863) *Utilitarianism*
- Mitchell, D. (1995) "The Importance of Being Important: Euthanasia and Critical Interests in Dworkin's *Life's Dominion*," *Utilitas* 7: 301–14.
- Moore, G. E. (1903) *Principia Ethica*. Cambridge: Cambridge University Press.
- Parfit, D. (1984) *Reasons and Persons*. Oxford: Clarendon Press.
- Sidgwick, H. (1877) *The Methods of Ethics*. London: Macmillan, 1874.

Justifying Physician-Assisted Deaths

Tom L. Beauchamp

Some recent developments in law encourage more discretion in the ways physicians are permitted to help patients die, despite traditional prohibitions in medicine against assisting in suicide and causing the death of patients. Among the most striking developments was the Canadian Supreme Court's decision in the case of Sue Rodriguez. She attempted to strike down section 241 of the Criminal code of Canada, which prohibits physician-assisted suicide. The court did not find in her favor, but several justices delivered opinions that give strong support to the moral justifiability of Rodriguez's goal of dying with a physician's direct assistance.¹ A few legal developments in the United States have likewise suggested that prohibitions of assisted suicide are unconstitutional,² that certain acts of assistance in dying do not constitute manslaughter,³ and that a physician's writing of a prescription is acceptable.⁴

These legal developments encourage us to think of the primary moral questions about euthanasia as questions of legalization. The morality of what physicians do in particular cases is thereby demoted in importance, and it is left unclear whether the fundamental moral issue is the justification of *individual acts* of killing and letting-die or the justification of institutional rules and public laws – *policies* – that permit or prohibit such acts. In due course, I will argue that certain acts by physicians in assisting persons to die are justified. This argument will not, however, be sufficient to support conclusions about the legitimization of physician-assisted suicide or voluntary active euthanasia.

The Troubled Distinction between Killing and Letting-Die

Those who claim that physician-assisted suicide is fundamentally wrong typically assume that there is a basic distinction between acts of killing and acts of merely letting-die. This distinction is troubled. The problem is illustrated by the many cases in which parents, surrogates, and physicians evaluate their intentional omissions of treatment as justifiable acts of letting-die, whereas their critics charge that they have unjustifiably killed by intentionally allowing to die. For example, in one recent case, Dr Gregory Messenger was charged with manslaughter after he terminated his own premature infant son's life support system by disconnecting the ventilator. In his view, he merely allowed his son to die.

Ordinary language, law, and traditional medical ethics afford no clear answer whether such cases should be described as "allowing to die" or "letting die," rather than "killing." Moreover, in neither ordinary language nor law does the word "killing" entail a wrongful act or a crime or an intentional action. For example, we can say that persons are killed in accidental shootings and automobile collisions. In ordinary language, *killing* represents a set of related ideas whose central condition is causal intervention to bring about another's death, whereas *allowing to die* represents another family of ideas whose central condition is intentional avoidance of causal intervention so that disease, system failure, or injury causes death.

But if we are to retain this distinction between killing and letting-die, we need clearer, more precise meanings for these notions. For example, the term "killing" could be restricted entirely to circumstances in which one person *intentionally and unjustifiably* causes the death of another human being – a usage that limits and reconstructs the ordinary meaning of the term. "Killing" would then be morally loaded, so that justified acts of arranging for death in medicine logically could not be instances of killing, they would always be cases of allowing to die. Under this stipulative meaning of "killing," physicians logically cannot kill when they justifiably remove a life-sustaining treatment in accordance with a patient's refusal of treatment, and patients cannot kill themselves when they justifiably forgo treatment.

I want to resist this simple move to redefine "killing" – or at least to refine its meaning. It is little more than stipulation that evades the moral and conceptual problems. Although I am skeptical that there is or can be a morally neutral analysis of either "killing" or "letting-die," I prefer to start with a neutral assumption that the term "killing" refers only to certain ways in which death is caused.

When Does a Role in Bringing about Death Constitute Killing?

Under this assumption, which captures more or less the ordinary sense of "killing," the justifiability of any particular type of killing is an open question and we cannot assert without looking at a particular case that killing is morally worse than allowing to die. That is, to apply the label "killing" or the label "letting-die" correctly (as morally neutral terms) to a set of events acceptable or unacceptable.⁵ Of course, killing may in most cases be worse than allowing to die, but this is not because of the meaning of the words. Some particular act of killing (a callous murder, say) may be morally worse than some particular act of allowing to die (forgoing treatment for a dying and comatose patient, say); but some act of letting-die (not resuscitating a patient who could easily be saved, but who has refused treatment because of a series of mistaken assumptions, say) also may be morally worse than some particular act of killing (mercy killing at the request of a seriously ill and suffering patient, say).

The point is this: Nothing about either killing or allowing to die, construed as morally neutral, entails

judgments about the wrongness or rightness of either type of action, or about the acceptability of the intentions of the actor in performing the act. Rightness and wrongness depend exclusively on the merit of the justification underlying the action, not on the type of action it is. A judgment that an act of either killing or letting-die is justified or unjustified therefore entails that something else be known about the act besides its being an instance of killing or an instance of allowing to die. The actor's intention or motive (whether benevolent or malicious, for example), the patient's refusal of treatment or request of assistance, the balance of benefits over burdens to the patient, and the consequences of the act are all relevant to questions of justification, and some such additional factor is required to make a normative judgment.

Some writers who apparently accept the morally neutral character of "killing" have attempted to reach conclusions about the moral acceptability of letting-die, as follows:⁶ They construe omission of treatment as letting-die rather than killing whenever an underlying disease or injury is the cause of death. By contrast, they argue, killings require that acts of persons be the causes of death. Accordingly, a natural death occurs when a respirator is removed, because natural conditions simply do what they would have done without the respirator. They conclude that one acts appropriately in many cases of intentionally allowing persons to die (one is no cause of death at all), but inappropriately in intentionally killing.

This argument does not support the moral conclusions that many draw from it. To make the argument plausible, one must add that the omission of treatment that allows a person to die is a *justified* omission. But what justifies an omission of treatment? The mere fact that a natural cause brings about death is not sufficient to justify not treating someone. To see why merely citing natural causes (of disease, etc.) is unsatisfactory without an additional justification, consider the following example: Mr. Mafia comes into a hospital and maliciously detaches a patient, Mr. Policeman, from a respirator. This act of detaching the patient from the respirator is causally no different from the acts physicians perform all the time in allowing patients to die. Some features in the circumstance other than omitting treatment, disconnecting the respirator, and the presence of disease or injury must be considered, to arrive at moral conclusions.

If Mr. Mafia killed Mr. Policeman – and he did – then physicians who do the same thing with their patients likewise kill their patients, unless we introduce a condition

about the justifiability of the one omission of treatment and the unjustifiability of the other omission. Without some feature in the circumstances that renders their omissions of treatment justified, doctors cannot justifiably say "We do not kill our patients, only the underlying diseases and injuries do," any more than Mr. Mafia can say, "It was the disease, not me, that killed him." An account of killing and letting-die restricted to omitting treatment, disconnecting machines, and disease-caused death leads to the absurd conclusion either that Mr. Mafia did not kill the patient or that doctors always kill their patients when the patients die from such omissions of treatment. To solve this problem we must provide a more plausible account of justified omissions and justified actions.

Valid Refusal as the Basis of Letting-Die

What justifies a physician's omission of treatment and disconnection of the respirator that does not justify Mr. Mafia's "omission" of treatment and disconnection? Typically what validates the physician's omission is an *authoritative refusal of treatment* by a patient or authorized surrogate. It would be both immoral and illegal of the physician not to omit treatment in the face of a competent, authoritative refusal. It therefore seems attractive to say that what sorts the physician's act into the category of allowing to die rather than killing, and makes Mr. Mafia's act one of killing rather than allowing to die, is nothing but the competent authoritative refusal of treatment present when the physician acts and absent when Mr. Mafia and others act.

This claim has been defended by James L. Bernat, Bernard Gert, and R. Peter Moggelnicki.⁷ They apparently believe that the type of action – killing or letting-die – depends on whether there is a valid refusal warranting an omission of treatment, rather than the validity of an omission of treatment (disconnection of the respirator, etc.) depending on the type of action it is. This clarification is insightful. Traditionally we have thought that the distinction between killing and letting-die is to be accounted for in terms of either the *intention* of persons (whether they intend someone's death) or the *causation* of persons (whether they cause someone's death). But the patient-refusal hypothesis provides a third way and demotes causation and intention in importance, giving the pivotal role to *valid refusal*.

A refusal is valid when the patient, who has rightful authority, autonomously refuses the proposed treatment (or an authorized surrogate does so). This account of the validity of a refusal is intimately tied to a larger account of the limits of professional authority and duty. The physician has a duty to follow an appropriate refusal and is required by society to do so; a bystander or someone like Mr. Mafia has no comparable duty or social recognition. This duty and the corresponding limits of physician authority give us a reason for saying that the physician's actions *do not cause death*, whereas Mr. Mafia's actions do cause death.

This theory shapes the meaning of the pivotal terms "killing" and "letting-die" in a way that protects the conventional moral thesis in law and medicine that it is justifiable to allow to die and unjustifiable to kill. This is exactly what Bernat, Gert, and Mogielnicki argue. But do they beg a central moral question by assuming that only letting-die, not killing, is justified? My own preference is to avoid this conclusion by independently looking at acts of killing to see if they can be justified on grounds other than a valid refusal. I believe we cannot decide the critical moral questions about physician-assisted suicide and euthanasia entirely by appeals to valid refusals and the letting-die-killing distinction. The critical question is whether there is an adequate justification for the action taken, whatever *type* of action it is and whether or not there has been a refusal of treatment.

I do agree with Bernat, Gert, and Mogielnicki that justification turns on having a valid *authorization*, but I would not limit the notion of a valid authorization to a valid refusal, and I would not make the account turn in any significant way on the distinction between killing and letting-die. I will now explain why.

Valid Refusals and Valid Requests

The problem with the analysis of Bernat, Gert, and Mogielnicki is not with their views about valid refusals, but with what they say about valid requests. They are correct in saying that a valid refusal of treatment always justifies a corresponding omission of the treatment, even if it is a refusal of hydration and nutrition that will result in death by starvation. Whenever valid refusals occur, how death occurs is not decisive, and it is never a moral offense to comply with a valid refusal. My disagreement with their analysis comes when they insist that a *request*

for help by a competent patient has no legitimate role to play in the justification of an action of physician-assisted suicide or voluntary active euthanasia. They believe the moral and legal requirement to honor a refusal does not extend to honoring a request. My view, by contrast, is the following: (1) Physicians are both morally and legally required to honor refusals; (2) they are not legally required to honor requests; and (3) whether they are either morally required or morally permitted to honor requests depends on the nature of the request and the nature of the patient-physician relationship.

In some of the clearest cases of justified compliance with requests, the patient and the physician discuss what is in the patient's best interest, under the assumption that the physician will not abandon the patient or resist what they jointly decide to be in the patient's best interests. A physician with these professional commitments has made a moral commitment to help patients that differs from the commitment made by a physician who rigidly draws the line in opposition to any form of euthanasia or assistance in suicide.⁸ In some cases, a patient both refuses to start or continue a possible treatment and requests help in dying in order that the death be less painful; refusal and request are combined as parts of a single plan, and, in many of these cases, the physician agrees with the plan. In this way assisted suicide or active euthanasia grows naturally out of a close patient-physician relationship.

In cases in which patients make reasonable requests for assistance in dying, it is a misconception to suppose that doctors can escape responsibility for their decisions if they refrain from helping their patients die. No physician can say, "I am not responsible for outcomes when I choose not to act on a patient's request." There has long been a vague sense in the physician and legal community that if only the doctor lets nature take its course, then one is not responsible for the outcome of death. But a physician is always responsible for any decision taken and the consequent action or inaction. The physician who complies with a patient's request is therefore responsible in exactly the way physicians who refuse to comply with the request are responsible.

Physicians who refuse to comply with a request cannot magically pass responsibility to the patient's condition of disease. The only relevant matter is whether the path the physician chooses, including what is rejected and omitted, has an adequate justification. Doctors cannot evade responsibility for acting in the best interests of the patient, and they cannot turn their backs on

what the patient believes to be in his or her best interests. Of course, doctors often reject courses of action requested by patients and have good and sufficient reasons for doing so. That is not in dispute. The question is whether the physician who conscientiously believes that the patient's request for assistance in dying is reasonable and justified and assumes responsibility for any assistance undertaken does wrong in complying with the request.

Bernat, Gert, and Mogielnicki will object that I am confusing moral obligations and (non-required) moral ideals. They regard the physicians I just described as moving beyond professional obligations of providing medical care, into the domain of optional moral ideals of assistance in dying. In important respects, I do not want to resist this classification of the physician's commitment as a moral ideal, but the distinction can be misleading without further qualification. As Gert himself has argued, moral ideals sometimes legitimately override moral obligations in cases of contingent conflict. This position will do well enough for our purposes. If a physician *justifiably* believes that his or her moral ideals of patient-assistance override all other moral obligations (to avoid killing, to not violate laws, etc.), this conclusion is all I need to support the argument in this section.

The Wrongness in Causing or Assisting in Death

But is the act the physician believes to be justified really justified? Could assistance in someone's self-requested death be wrong, even if the physician conscientiously believes it is right?

The only way to decide whether killing is wrong and letting-die not wrong in some cases, though wrong in others, is to determine what *makes* them wrong when they are wrong. By longstanding convention, a person is not guilty of a crime or a wrongful act merely because he or she killed someone. Legitimate defenses for killing (excusable homicide) include killing in self-defense and killing by misadventure (accidental and non-negligent killing while engaged in a lawful act). From a moral point of view, causing a person's death is wrong *when it is wrong* not because the death is *intended* or because it is *caused*, but because an unjustified harm or loss to the person occurs. Therefore, what makes a physician's act

of killing or "assisting" in causing a death wrong, when it is wrong, is that a person is unjustifiably harmed – that is, unjustifiably suffers a setback to interests that the person otherwise would not have experienced.

The critical question for acts both of killing and of letting-die in medicine is whether an act of assisting persons in bringing about their deaths causes them a loss or, rather, provides a benefit. If a person chooses death and sees that event as a personal benefit, then helping that person bring about death neither harms nor wrongs the person and may provide a benefit or at least fulfill the person's last important goal.

This helping might harm society by setting back its interests, and therefore might be a reason against *legalization*, but this form of harm does not alter conclusions about the justifiability of the *act* of helping. Not helping persons of this description in their dying, on the analysis I have presented, can interrupt or frustrate their goals and, from their perspective, cause them harm, indignity, or despair – even if, at the same time, it protects society's interests.

The Key Argument in Defense of Euthanasia and Assisted Suicide

These conclusions can now be joined with the previous reflections on valid refusals and requests. If passive letting-die based on valid refusals does not harm or wrong persons or violate their rights, then how can assisted suicide and voluntary active euthanasia harm or wrong the person who dies? In both cases – active killing and passive letting-die – the person is, in effect, refusing to go on and is seeking the best means to the end of quitting life. The judgment is that the best obtainable information about the future indicates that continuing life is, on balance, worse than not continuing it. The person who attempts suicide, the person who seeks active euthanasia, and the person who forgoes life-sustaining treatment are identically situated except that they select different means to bring about the end of life. Each intends to quit life because of its bleak possibilities.⁹ Therefore, those who believe it is morally acceptable to let people die when they refuse treatment, but not to take active steps to help them die when they request assistance, must give a different account of the wrongfulness of killing and letting-die than I have offered.

To insist on continued treatment (or even palliation, in many cases) while refusing to comply with a patient's

request for assistance in dying is to burden rather than help the patient and, of course, to reject their autonomous wishes. As the autonomy interests in this choice increase on the scale of interests, denial of help to the patient increasingly burdens the patient; and to increase the burden is to increase the harm done to the person.

The core of the argument in favor of the moral justifiability of acts of physician-assisted suicide and voluntary active euthanasia is that relief from suffering and a voluntary request justify our doing what we otherwise would not do: implement a plan to end a human life. This action has its strongest defense when: (1) A condition is extremely burdensome and the burden outweighs any benefits; (2) pain management cannot be made adequate; (3) only a physician is capable of bringing relief; and (4) the patient makes an informed request.

Medicine and law seem now to say to many patients, "If you were on life-sustaining treatment, you could withdraw the treatment and we could let you die. But since you are not, we can only give you palliative care until you die a natural death." This position condemns the patient to live out a life he or she does not want – a form of cruelty that violates the patient's rights and prevents discharge of the fiduciary obligations of the physician. To use this argument is not to claim that physicians face large numbers of desperately ill patients. Pain management has made circumstances at least bearable for most of today's patients, but some patients still cannot be satisfactorily relieved, and, even if they could, questions would remain about the autonomy rights of patients: If there is a right to stop a medical treatment that sustains life, why is there not a right to stop one's life by arrangement with a physician?

Dr Kevorkian's "patients" raise profound questions about the lack of a support system in medicine or elsewhere for handling their problems. Having thought for over a year about her future, Adkins decided that her suffering would exceed the benefits of continuing to live. She apparently had firm views about what she wanted, and she carefully calculated both the costs and the benefits. She faced a bleak future from her perspective as a person who had lived an unusually vigorous life. She believed that her brain would be slowly destroyed, with progressive and devastating cognitive loss and confusion, fading memory, immense frustration, and lack of all capacity to take care of herself. She also believed that her family would have to assume the full burden of responsibility for her care. From her perspective, what Kevorkian offered was better than other physicians offered, which, to her, was no help at all.

Current social institutions, including the medical system, have not proved adequate for patients like Adkins. Dying persons often face inadequate counseling, emotional support, pain information, or pain control. Their condition is intolerable from their perspective, and without any avenue of hope. To maintain that these persons act immorally by arranging for death is a harsh judgment that needs to be backed by a more persuasive argument than I have seen.

If this argument is sound, then the burden of justification for prescriptions of acts of voluntary active euthanasia and physician-assisted suicide rests on those who refuse or hinder assistance to patients who express a competent and rational wish to die, rather than on those who would help them die. Associations of medical professionals in the US have, I believe, reversed the proper burden of justification by placing it on physicians who want to help patients.¹⁰

Justifying Policies and Justifying Acts

The argument thus far leads to the conclusion that physicians' acts of honoring valid refusals and complying with valid requests can both be justified under specifiable circumstances. However, I said at the beginning that my argument is not strong enough to show that *policies*, such as the law passed in Oregon, are justified. I want now to explain how one can consistently hold strong views about the justifiability of some acts of physician-assisted suicide and voluntary active euthanasia, while simultaneously having deep-seated reservations about revising public policies that prohibit these acts. The point is that one can consistently judge acts morally acceptable that one cannot support legalizing.

The backbone of the resistance to physician-assisted euthanasia and voluntary active euthanasia has long been an argument referred to as the wedge argument or "slippery slope" argument. It proceeds roughly as follows:¹¹ Although particular acts of assistance in dying might be morally justified on some occasions, the social consequences of sanctioning practices of killing would involve serious risks of abuse and misuse and, on balance, would cause more harm than benefit to society. Attitudes, not merely guidelines, can be eroded by shifts in public policy. Prohibitions are often symbolically important, and their removal could weaken the fabric of restraints and beneficial attitudes. The argument is not that these negative consequences will occur

immediately after legalization, but that they will grow incrementally over time. Society might start with innocent beginnings by developing policies that carefully restrict the number of patients who qualify for assistance in suicide or euthanasia. Whatever restrictions are initially built into our policies will be revised and expanded over time, with ever-increasing possibilities in the system for unjustified killing. Unscrupulous persons will learn how to abuse the system, just as they do with methods of tax evasion that operate on the margins of the system of legitimate tax avoidance.

Slippery slope arguments depend on speculative predictions of a progressive erosion of moral restraints. If the dire and unmanageable consequences that they predict actually will flow from the legal legitimization of assisted suicide or voluntary active euthanasia, then slippery slope arguments do convincingly show that practices should be legally prohibited. But how good is the evidence that dire consequences will occur? Is there a sufficient reason to think that we cannot maintain control over and even improve public policy? Every reasonable person would agree that these difficult empirical questions are among the primary questions in the current moral controversy about euthanasia.

All that needs to be said here, I believe, is that even if slippery slope arguments provide solid reasons against legalization, they provide no moral basis for the conclusion that acts of euthanasia and physician-assisted suicide are morally wrong (unless one's only moral basis is identical to one's basis for opposing legalization). I will now explain why.

Slippery slope arguments conclude that patients such as Sue Rodriguez and the patrons of Jack Kevorkian cannot be justifiably helped by physicians because to help them, even if they deserve our help, would open the floodgates to killing persons who should not be killed. All patients should be denied help not because of anything they have done or because of any demerit in their cases or in their wishes, but because acts of assistance in dying would hurt others if legalized and therefore should not be tolerated under any circumstances.

There is something that seems both very right and very wrong about this slippery slope argument – right because the argument points to dangers of the most profound sort, wrong because at least some patients deserve to be helped and their physicians do nothing morally wrong in helping them. It may therefore be necessary to prohibit these acts of assistance in our public policies while acknowledging that there is nothing morally wrong with the acts other than their

potentially far-reaching social consequences. They are truly "innocent beginnings."

In conclusion, I want to throw a final wrinkle into this already wrinkled picture. Despite my concerns about slippery slopes, I believe the legislation in Oregon is a promising development (which is not to say it is good legislation as it was passed), and I think that we should welcome some version of it. This suggestion may seem to contradict what I just argued about legalization, but concerns about slippery slopes ought not to be so paralyzing that we are not open to social experi-

ments that will help us see whether empirical predictions are correct and which system works best.¹² The Oregon legislation could be viewed as a social experiment that gives us a good perspective on both risks and benefits – a trial that may or may not succeed. I would hope that research will be carried out to evaluate our experimental programs in upcoming years and that we will learn about the benefits and risks in a comprehensive, timely, and objective manner. Perhaps then we can be positioned to decide from evidence whether the slippery slope is as slippery as some fear it could be.

Notes

- 1 Supreme Court of Canada, *Sue Rodriguez v. Attorney General of Canada*, September 30, 1993, File No. 23476; on appeal from British Columbia Court of Appeal, *Rodriguez v. British Columbia (Attorney General)* [1993], B.C.J. No. 641 (Q.L.) (B.C.C.A.). In early 1994, with broad public support, Sue Rodriguez killed herself with the assistance of an anonymous physician.
- 2 *Compassion in Dying v. State of Washington*, 850 F. Supp. 1454 (W.D. Wash. 1994); overturned March 9, 1995, by the United States Court of Appeals for the Ninth Circuit in an opinion written by Judge John T. Noonan. *Compassion in Dying v. Washington*, No. 94-35534 (US App. March 9, 1995) (available March 1995, on LEXIS).
- 3 State of Michigan in the Circuit Court for the County of Oakland, *People of the State of Michigan v. Jack Kevorkian*, Case No. CR-92-115190-FC (July 21, 1992); Court of Appeals of Michigan, *Hobbins v. Attorney General and People of the State of Michigan v. Jack Kevorkian*, 518 N.W.2d 487 (Mich. App. 1994).
- 4 See *Oregon Death with Dignity Act* (1994). Under this Act, terminally ill adults are allowed to obtain lethal drugs from physicians in order to hasten death and escape unbearable suffering. This initiative, when scheduled to become law, faced legal challenges.
- 5 In effect, this proposal is made in James Rachels, "Active and Passive Euthanasia," *New England Journal of Medicine* 292\2 (January 9, 1975): 78-80; and Dan Brock, "Voluntary Active Euthanasia," *Hastings Center Report* 22\2 (March/April 1992): 10-22.
- 6 See: In the Matter of *Claire C. Conroy*, 190 N.J. Sup. 453, 464 A.2d 303 (App. Div. 1983); In the Matter of *Claire C. Conroy*, 486 A.2d 1209 (New Jersey Supreme Court, 1985), at 1222-3, 1236; In re *Estate of Greenspan*, 558 N.E.2d 1194, at 1203 (Ill. 1990); Daniel Callahan, "Vital Distinctions, Mortal Questions," *Commonweal*, 115 (July 15, 1988): 399-402; and several articles in Joanne Lynn (ed.), *By No Extraordinary Means* (Bloomington, IN: Indiana University Press, 1986), pp. 227-66.
- 7 James L. Bernat, Bernard Gert, and R. Peter Mogielnicki, "Patient Refusal of Hydration and Nutrition," *Archives of Internal Medicine* 153 (1993): 2723-8; Bernard Gert, *Morality: A New Justification of the Moral Rules* (New York: Oxford University Press, 1988), pp. 294-300.
- 8 Cf. Sidney H. Wanzer, Daniel D. Federman, S. James Adelstein et al., "The Physician's Responsibility toward Hopelessly Ill Patients: A Second Look," *New England Journal of Medicine* 320 (March 30, 1989): 844-9.
- 9 For the extension to suicide, see Dan Brock, "Death and Dying," in *Medical Ethics*, ed. Robert M. Veatch (Boston: Jones and Bartlett, 1989), p. 345.
- 10 American Medical Association, Council on Ethical and Judicial Affairs, *Euthanasia: Report C*, in *Proceedings of the House of Delegates* (Chicago: American Medical Association, June 1988): 258-60 (and see *Current Opinions*, § 2.20, p. 13, 1989); "Decisions Near the End of Life," *Report B*, adopted by the House of Delegates (1991), pp. 11-15; and see the abridged version in "Decisions Near the End of Life," *Journal of the American Medical Association* 267 (April 22\29, 1992): 2229-33.
- 11 Cf. Alan J. Weisbard and Mark Siegler, "On Killing Patients with Kindness: An Appeal for Caution," in J. Arras and N. Rhoden, *Ethical Issues in Modern Medicine*, 3rd edn. (Mountain View, CA: Mayfield, 1989), esp. p. 218; Douglas Walton, *Slippery Slope: Arguments* (Oxford: Clarendon Press, 1992); Trudy Govier, "What's Wrong with Slippery Slope Arguments?," *Canadian Journal of Philosophy* 12 (June 1982): 303-16; Frederick Schauer, "Slippery Slopes," *Harvard Law Review* 99 (1985): 361-83; and James Rachels, *The End of Life: Euthanasia and Morality* (Oxford: Oxford University Press, 1986), ch. 10.
- 12 Cf. Franklin G. Miller, Timothy Quill, Howard Brody, John C. Fletcher, Lawrence O. Gostin, and D. E. Meier, "Regulating Physician-Assisted Death," *New England Journal of Medicine* 331 (1994): 119-23.

Against the Right to Die

J. David Velleman

In this essay I offer an argument against establishing an institutional right to die, but I do not consider how my argument fares against countervailing considerations, and so I do not draw any final conclusion on the subject. The argument laid out in this essay has certainly inhibited me from favoring a right to die, and it has also led me to recoil from many of the arguments offered for such a right. But I am very far from an all-things-considered judgment.

My argument is addressed to a question of public policy – namely, whether the law or the canons of medical practice should include a rule requiring, under specified circumstances, that caregivers honor a patient's request to be allowed or perhaps even helped to die. This question is distinct from the question whether anyone is ever morally entitled to be allowed or helped to die. I believe that the answer to the latter question is yes, but I doubt whether our moral obligation to facilitate some people's deaths is best discharged through the establishment of an institutional right to die.

I

Although I believe in our obligation to facilitate some deaths, I want to dissociate myself from some of the arguments that are frequently offered for such an obligation. These arguments, like many arguments in medical ethics, rely on terms borrowed from Kantian moral theory – terms such as “dignity” and “autonomy.” Various kinds

of life-preserving treatment are said to violate a patient's dignity or to detain him in an undignified state; and the patient's right of autonomy is said to require that we respect his competent and considered wishes, including a wish to die. There may or may not be some truth in each of these claims. Yet when we evaluate such claims, we must take care not to assume that terms like “dignity” and “autonomy” always express the same concepts, or carry the same normative force, as they do in a particular moral theory.

When Kant speaks, for example, of the dignity that belongs to persons by virtue of their rational nature, and that places them beyond all price (Kant, 1964, p. 102), he is not invoking anything that requires the ability to walk unaided, to feed oneself, or to control one's bowels. Hence the dignity invoked in discussions of medical ethics – a status supposedly threatened by physical deterioration and dependency – cannot be the status whose claim on our moral concern is so fundamental to Kantian thought. We must therefore ask whether this other sort of dignity, whatever it may be, embodies a value that's equally worthy of protection.

My worry, in particular, is that the word “dignity” is sometimes used to dignify, so to speak, our culture's obsession with independence, physical strength, and youth. To my mind, the dignity defined by these values – a dignity that is ultimately incompatible with *being cared for* at all – is a dignity not worth having.¹

I have similar worries about the values expressed by the phrase “patient autonomy”; for there are two very different senses in which a person's autonomy can

become a value for us. On the one hand, we can obey the categorical imperative, by declining to act for reasons that we could not rationally propose as valid for all rational beings, including those who are affected by our action, such as the patient. What we value in that case is the patient's *capacity* for self-determination, and we value it in a particular way – namely, by according it *respect*. We respect the patient's autonomy by regarding the necessity of sharing our reasons with him, among others, as a constraint on what decisions we permit ourselves to reach.

On the other hand, we can value the patient's autonomy by making it our goal to maximize his effective options. What we value, in that case, is not the patient's capacity but his *opportunities* for self-determination – his having choices to make and the means with which to implement them; and we value these opportunities for self-determination by regarding them as *goods* – as objects of desire and pursuit rather than respect.

These two ways of valuing autonomy are fundamentally different. Respecting people's autonomy, in the Kantian sense, is not just a matter of giving them effective options. To make our own decisions only for reasons that we could rationally share with others is not necessarily to give *them* decisions to make, nor is it to give them the means to implement their actual decisions.²

As with the term "dignity," then, we must not assume that the term "autonomy" is always being used in the sense made familiar by Kantian moral theory; and we must therefore ask ourselves what sort of autonomy is being invoked, and whether it is indeed something worthy of our moral concern. I believe that, as with the term "dignity," the answer to the latter question may be "no" in some cases, including the case of the right to die.

II

Despite my qualms about the use of Kantian language to justify euthanasia, I do believe that euthanasia can be justified, and on Kantian grounds. In particular, I believe that respect for a person's dignity, properly conceived, can require us to facilitate his death when that dignity is being irremediably compromised. I also believe, however, that a person's dignity can be so compromised only by circumstances that are likely to compromise his capacity for fully rational and autonomous decision making.

So although I do not favor euthanizing people against their wills, of course, neither do I favor a policy of euthanizing people for the sake of deferring to their wills, since I think that people's wills are usually impaired in the circumstances required to make euthanasia permissible. The sense in which I oppose a right to die, then, is that I oppose treating euthanasia as a protected option for the patient.

One reason for my opposition is the associated belief (also Kantian) that so long as patients would be fully competent to exercise an option of being euthanized, their doing so would be immoral, in the majority of cases, because their dignity as persons would still be intact. I discuss this argument elsewhere, but I do not return to it in the present essay.³ In this essay I discuss a second reason for opposing euthanasia as a protected option for the patient. This reason, unlike the first, is consequentialist.

What consequentialist arguments could there be against giving the option of euthanasia to patients? One argument, of course, would be that giving this option to patients, even under carefully defined conditions, would entail providing euthanasia to some patients for whom it would be a harm rather than a benefit (Kamisar, 1970). But the argument that interests me does not depend on this strategy. My consequentialist worry about the right to die is not that some patients might mistakenly choose to die when they would be better off living.

In order to demonstrate that I am not primarily worried about mistaken request to die, I shall assume, from this point forward, that patients are infallible, and that euthanasia would therefore be chosen only by those for whom it would be a benefit. Even so, I believe, the establishment of a right to die would harm many patients, by increasing their autonomy in a sense that is not only un-Kantian but also very undesirable.

This belief is sometimes expressed in public debate, although it is rarely developed in any detail. Here, for example, is Yale Kamisar's argument against "euthanasia legislation":

Is this the kind of choice . . . that we want to offer a gravely ill person? Will we not sweep up, in the process, some who are not really tired of life, but think others are tired of them; some who do not really want to die, but who feel they should not live on, because to do so when there looms the legal alternative of euthanasia is to do a selfish or a cowardly act? Will not some feel an obligation to have themselves "eliminated" . . . ? (Kamisar, 1970)

Note that these considerations do not, strictly speaking, militate against euthanasia itself. Rather, they militate against a particular decision procedure for euthanasia – namely, the procedure of placing the choice of euthanasia in the patient's hands. What Kamisar is questioning in this particular passage is not the practice of helping some patients to die, but rather the practice of asking them to choose whether to die. The feature of legalized euthanasia that troubles him is precisely its being an option offered to patients – the very feature for which it's touted, by its proponents, as an enhancement of the patients' autonomy. Kamisar's remarks thus betray the suspicion that this particular enhancement of one's autonomy is not to be welcomed.

But what exactly is the point of Kamisar's rhetorical questions? The whole purpose of giving people choices, surely, is to allow those choices to be determined by their reasons and preferences rather than ours. Kamisar may think that finding one's life tiresome is a good reason for dying whereas thinking that others find one tiresome is not. But if others honestly think otherwise, why should we stand in their way? Whose life is it anyway?

IV

A theoretical framework for addressing this question can be found in Thomas Schelling's book *The Strategy of Conflict* (1960), and in Gerald Dworkin's paper "Is More Choice Better than Less?" (1982). These authors have shown that our intuitions about the value of options are often mistaken, and their work can help us to understand the point of arguments like Kamisar's.

We are inclined to think that, unless we are likely to make mistakes about whether to exercise an option (as I am assuming we are not), the value of having the option is as high as the value of exercising it and no lower than zero. Exercising an option can of course be worse than nothing, if it causes harm. But if we are not prone to mistakes, then we will not exercise a harmful option; and we tend to think that simply *having* the unexercised option cannot be harmful. And insofar as exercising an option would make us better off than we are, having the option must have made us better off than we were before we had it – or so we tend to think.

What Schelling showed, however, is that having an option can be harmful even if we do not exercise it and – more surprisingly – even if we exercise it and gain

by doing so. Schelling's examples of this phenomenon were drawn primarily from the world of negotiation, where the only way to induce one's opponent to settle for less may be by proving that one doesn't have the option of giving him more. Schelling pointed out that in such circumstances, a lack of options can be an advantage. The union leader who cannot persuade his membership to approve a pay-cut, or the ambassador who cannot contact his head of state for a change of brief, negotiates from a position of strength; whereas the negotiator for whom all concessions are possible deals from weakness. If the rank-and-file give their leader the option of offering a pay-cut, then management may not settle for anything less, whereas they might have settled for less if he hadn't had the option of making the offer. The union leader will then have to decide whether to take the option and reach an agreement or to leave the option and call a strike. But no matter which of these outcomes would make him better off, choosing it will still leave him worse off than he would have been if he had never had the option at all.

Dworkin has expanded on Schelling's point by exploring other respects in which options can be undesirable. Just as options can subject one to pressure from an opponent in negotiation, for example, they can subject one to pressure from other sources as well. The night cashier in a convenience store doesn't want the option of opening the safe – and not because he fears that he'd make mistakes about when to open it. It is precisely because the cashier would know when he'd better open the safe that his having the option would make him an attractive target for robbers; and it's because having the option would make him a target for robbers that he'd be better off without it. The cashier who finds himself opening the safe at gunpoint can consistently think that he's doing what's best while wishing that he'd never been given the option of doing it.

Options can be undesirable, then, because they subject one to various kinds of pressure; but they can be undesirable for other reasons, too. Offering someone an alternative to the status quo makes two outcomes possible for him, but neither of them is the outcome that was possible before. He can now choose the status quo or choose the alternative, but he can no longer *have* the status quo without *choosing* it. And having the status quo by default may have been what was best for him, even though choosing the status quo is now worst. If I invite you to a dinner party, I leave you the possibilities

bles of this phenomenon in the world of negotiation, one's opponent to settle at one doesn't have the Schelling pointed out that options can be an who cannot persuade his -cut, or the ambassador of state for a change of on of strength; whereas concessions are possible rank-and-file give their pay-cut, then manage- ing less, whereas they hadn't had the option of eader will then have to on and reach an agree- all a strike. But no mat- dld make him better off, orse off than he would e option at all.

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en, because they sub- sure; but they can be . Offering someone an es two outcomes pos- n is the outcome that choose the status quo an no longer *have* the nd having the status hat was best for him, quo is now worst. If I e you the possibilities

of choosing to come or choosing to stay away; but I deprive you of something that you otherwise would have had – namely, the possibility of being absent from my table by default, as you are on all other occasions. Surely, preferring to accept an invitation is consistent with wishing you had never received it. These attitudes are consistent because refusing to attend a party is a different outcome from *not* attending without having to refuse; and even if the former of these outcomes is worse than attending, the latter may still have been better. Having choices can thus deprive one of desirable outcomes whose desirability depends on their being unchosen.

The offer of an option can also be undesirable because of what it expresses. To offer a student the option of receiving remedial instruction after class is to imply that he is not keeping up. If the student needs help but doesn't know it, the offer may clue him in. But even if the student does not need any help, to begin with, the offer may so undermine his confidence that he will need help before long. In the latter case, the student may ultimately benefit from accepting the offer, even though he would have been better off not receiving it at all.

Note that in each of these cases, a person can be harmed by having a choice, even if he chooses what's best for him. Once the option of offering a concession has undermined one's bargaining position, once the option of opening the safe has made one the target of a robbery, once the invitation to a party has eliminated the possibility of absence by default, once the offer of remedial instruction has implied that one needs it – in short, once one has been offered a problematic choice – one's situation has already been altered for the worse, and choosing what's best cannot remedy the harm that one has already suffered. Choosing what's best in these cases is simply a way of cutting one's losses.

Note, finally, that we cannot always avoid burdening people with options by offering them a second-order option as to which options they are to be offered. If issuing you an invitation to dinner would put you in an awkward position, then asking you whether you want to be invited would usually do so as well; if offering you the option of remedial instruction would send you a message, then so would asking you whether you'd like that option. In order to avoid doing harm, then, we are sometimes required not only to withhold options, but also to take the initiative for withholding them.

V

Of course, the options that I have discussed can also be unproblematic for many people in many circumstances. Sometimes one has good reason to welcome a dinner invitation or an offer of remedial instruction. Similarly, some patients will welcome the option of euthanasia, and rightly so. The problem is how to offer the option only to those patients who will have reason to welcome it. Arguments like Kamisar's are best understood, I think, as warning that the option of euthanasia may unavoidably be offered to some who will be harmed simply by having the option, even if they go on to choose what is best.

I think that the option of euthanasia may harm some patients in all of the ways canvassed above; but I will focus my attention on only a few of those ways. The most important way in which the option of euthanasia may harm patients, I think, is that it will deny them the possibility of staying alive by default.

Now, the idea of surviving by default will be anathema to existentialists, who will insist that the choice between life and death is a choice that we have to make every day, perhaps every moment.⁴ Yet even if there is a deep, philosophical sense in which we do continually choose to go on living, it is not reflected in our ordinary self-understanding. That is, we do not ordinarily think of ourselves or others as continually rejecting the option of suicide and staying alive by choice. Thus, even if the option of euthanasia won't alter a patient's existential situation, it will certainly alter the way in which his situation is generally perceived. And changes in the perception of a patient's situation will be sufficient to produce many of the problems that Schelling and Dworkin have described, since those problems are often created not just by *having* options but by *being seen* to have them.

Once a person is given the choice between life and death, he will rightly be perceived as the agent of his own survival. Whereas his existence is ordinarily viewed as a given for him – as a fixed condition with which he must cope – formally offering him the option of euthanasia will cause his existence thereafter to be viewed as his doing.

The problem with this perception is that if others regard you as choosing a state of affairs, they will hold you responsible for it; and if they hold you responsible for a state of affairs, they can ask you to justify it. Hence

if people ever come to regard you as existing by choice, they may expect you to justify your continued existence. If your daily arrival in the office is interpreted as meaning that you have once again declined to kill yourself, you may feel obliged to arrive with an answer to the question, "Why not?"

I think that our perception of one another's existence as a given is so deeply ingrained that we can hardly imagine what life would be like without it. When someone shows impatience or displeasure with us, we jokingly say, "Well, excuse me for living!" But imagine that it were no joke; imagine that living were something for which one might reasonably be thought to need an excuse. The burden of justifying one's existence might make existence unbearable – and hence unjustifiable.

VI

I assume that people care, and are right to care, about whether they can justify their choices to others. Of course, this concern can easily seem like slavishness or neurotic insecurity; but it should not be dismissed too lightly. Our ability to justify our choices to the people around us is what enables us to sustain the role of rational agent in our dealings with them; and it is therefore essential to our remaining, in their eyes, an eligible partner in cooperation and conversation, or an appropriate object of respect.

Retaining one's status as a person among others is especially important to those who are ill or infirm. I imagine that when illness or infirmity denies one the rewards of independent activity, then the rewards of personal intercourse may be all that make life worth living. To the ill or infirm, then, the ability to sustain the role of rational person may rightly seem essential to retaining what remains of value in life. Being unable to account for one's choices may seem to entail the risk of being perceived as unreasonable – as not worth reasoning with – and consequently being cut off from meaningful intercourse with others, which is life's only remaining consolation.

Forcing a patient to take responsibility for his continued existence may therefore be tantamount to confronting him with the following prospect: Unless he can explain, to the satisfaction of others, why he chooses to exist, his only remaining reasons for existence may vanish.

VII

Unfortunately, our culture is extremely hostile to any attempt at justifying an existence of passivity and dependence. The burden of proof will lie heavily on the patient who thinks that his terminal illness or chronic disability is not a sufficient reason for dying.

What is worse, the people with whom a patient wants to maintain intercourse, and to whom he therefore wants to justify his choices, are often in a position to incur several financial and emotional costs from any prolongation of his life. Many of the reasons in favor of his death are therefore likely to be exquisitely salient in their minds. I believe that some of these people may actively pressure the patient to exercise the option of dying. (Students who hear me say this usually object that no one would ever do such a thing. My reply is that no one would ever do such a thing as abuse his own children or parents – except that many people do.)

In practice, however, friends and relatives of a patient will not have to utter a word of encouragement, much less exert any overt pressure, once the option of euthanasia is offered. For in the discussion of a subject so hedged by taboos and inhibitions, the patient will have to make some assumptions about what they think and how they feel, irrespective of what they say (see Schelling, 1984). And the rational assumption for him to make will be that they are especially sensible of the considerations in favor of his exercising the option.

Thus, even if a patient antecedently believes that his life is worth living, he may have good reason to assume that many of the people around him do not, and that his efforts to convince them will be frustrated by prevailing opinions about lives like his, or by the biases inherent in their perspective. Indeed, he can reasonably assume that the offer of euthanasia is itself an expression of attitudes that are likely to frustrate his efforts to justify declining it. He can therefore assume that his refusal to take the option of euthanasia will threaten his standing as a rational person in the eyes of friends and family, thereby threatening the very things that make his life worthwhile. This patient may rationally judge that he's better off taking the option of euthanasia, even though he would have been best off not having the option at all.

Establishing a right to die in our culture may thus be like establishing a right to duel in a culture obsessed with personal honor.⁵ If someone defended the right to duel by arguing that a duel is a private transaction

between consenting adults, he would have missed the point of laws against dueling. What makes it rational for someone to throw down or pick up a gauntlet may be the social costs of choosing not to, costs that result from failing to duel only if one fails to duel by choice. Such costs disappear if the choice of dueling can be removed. By eliminating the option of dueling (if we can), we eliminate the reasons that make it rational for people to duel in most cases. To restore the option of dueling would be to give people reasons for dueling that they didn't previously have. Similarly, I believe, to offer the option of dying may be to give people new reasons for dying.

VIII

Do not attempt to refute this argument against the right to die by labeling it paternalistic. The argument is not paternalistic – at last, not in any derogatory sense of the word. Paternalism, in the derogatory sense, is the policy of saving people from self-inflicted harms, by denying them options that they might exercise unwisely. Such a policy is distasteful because it expresses a lack of respect for others' ability to make their own decisions.

But my argument is not paternalistic in this sense. My reason for withholding the option of euthanasia is not that others cannot be trusted to exercise it wisely. On the contrary, I have assumed from the outset that patients will be infallible in their deliberations. What I have argued is, not that people to whom we offer the option of euthanasia might harm themselves, but rather that in offering them this option, *we* will do them harm. My argument is therefore based on a simple policy of non-maleficence rather than on the policy of paternalism. I am arguing that we must not harm others by giving them choices – not that we must withhold the choices from them lest they harm themselves.

Of course, harming some people by giving them choices may be unavoidable if we could not withhold those choices from them without unjustly withholding the same choices from others. If a significant number of patients were both competent and morally entitled to choose euthanasia, then we might be obligated to make that option available even if, in doing so, we would inevitably give it to some who would be harmed by having it. Consider here a closely related option.⁶ People are morally entitled to refuse treatment, because they are morally entitled not to be drugged, punctured, or irradiated

against their wills – in short, not to be assaulted. Protecting the right not to be assaulted entails giving some patients what amounts to the option of ending their lives. And for some subset of these patients, having the option of ending their lives by refusing treatment may be just as harmful as having the option of electing active euthanasia. Nevertheless, these harms must be tolerated as an inevitable byproduct of protecting the right not to be assaulted.

Similarly, if I believed that people had a moral right to end their lives, I would not entertain consequentialist arguments against protecting that right. But I don't believe in such a moral right, for reasons to which I have briefly alluded but cannot fully expound in this essay. My willingness to entertain the arguments expounded here thus depends on reasons that are explained elsewhere.⁷

IX

I have been assuming, in deference to existentialists, that a right to die would not alter the options available to a patient but would, at most, alter the social perception of his options. What would follow, however, if we assumed that death was not ordinarily a genuine option? In that case, offering someone the choice of euthanasia would not only cause his existence to be perceived as his responsibility; it would actually cause his existence to become his responsibility for the first time. And this new responsibility might entail new and potentially burdensome obligations.

That options can be undesirable because they entail obligations is a familiar principle in one area of everyday life – namely, the practice of offering, accepting, and declining gifts and favors. When we decline a gift or a favor that someone has spontaneously offered, we deny him an option, the option of providing us with a particular benefit. And our reason for declining is often that he could not have the option of providing the benefit without being obligated to exercise that option. Indeed, we sometimes feel obligated, on our part, to decline a benefit precisely in order to prevent someone from being obligated, on his part, to provide it.⁸ We thus recognize that giving or leaving someone the option of providing a benefit to us may be a way of harming him, by burdening him with an obligation.

When we decline a gift or favor, our would-be benefactor sometimes protests in language similar to that

used by proponents of the right to die. "I know what I'm doing," he says, "and no one is twisting my arm. It's my money, and I want you to have it." If he's unaware of the lurking allusion, he might even put it like this: "Whose money is it, anyway?"

Well, it is his money (or whatever); and we do believe that he's entitled to dispose of his money as he likes. Yet his right of personal autonomy in disposing of his money doesn't always require that we let him dispose of it on us. We are entitled – and, as I have suggested, sometimes obligated – to restrict his freedom in spending his money for our benefit, insofar as that freedom may entail burdensome obligations.

The language in which favors are declined is equally as interesting as that in which they are offered. What we often say when declining a favor is, "I can't let you do that for me: it would be too much to ask." The phrase "too much to ask" is interesting because it is used only when we haven't in fact asked for anything. Precisely because the favor in question would be too much to ask, we haven't asked for it, and now our prospective benefactor is offering it spontaneously. Why, then, do we give our reason for not having solicited the favor as a reason for declining when it's offered unsolicited?

The answer, I think, is that we recognize how little distance there is between permitting someone to do us a favor and asking him to do it. Because leaving someone the option of doing us a favor can place him under an obligation to do it, it has all the consequences of asking for the favor. To say, "I'm leaving you the option of helping me but I'm not asking you to help," is to draw a distinction without a difference, since options can be just as burdensome as requests.

X

Clearly, a patient's decision to die will sometimes be a gift or a favor bestowed on loved ones whose financial or emotional resources are being drained by his condition. And clearly, death is the sort of gift that one might well want to decline, by denying others the option of giving it. Yet protections for the option of euthanasia would in effect protect the option of giving this gift, and they would thereby prevent the prospective beneficiaries from declining it. Establishing a right to die would thus be tantamount to adopting the public policy that death is never too much to ask.

I don't pretend to understand fully the ethics of gifts and favors. It's one of those subjects that gets neglected

in philosophical ethics, perhaps because it has more to do with the supererogatory than the obligatory. One question that puzzles me is whether we are permitted to restrict people's freedom to benefit us in ways that require no active participation on our part. Someone cannot successfully give us a gift, in most cases, unless we cooperate by taking it into our possession; and denying someone the option of giving us a gift usually consists of refusing to do our part in the transaction. But what about cases in which someone can do us a good turn without any cooperation from us? To what extent are we entitled to decline the favor by means of restrictions on his behavior rather than omissions in ours?

Another question, of course, is whether we wouldn't, in fact, play some part in the deaths of patients who received socially sanctioned euthanasia. Would a medically assisted or supervised death be a gift that we truly took no part in accepting? What if "we" – the intended beneficiary of the gift – were society as a whole, the body that established the right to die and trained physicians in its implementation? Surely, establishing the right to die is tantamount to saying, to those who might contemplate dying for the social good, that such favors will never be refused.

These considerations, inconclusive though they are, show how the theoretical framework developed by Schelling and Dworkin might support remarks like Kamisar's about patients' "obligation to have themselves eliminated." The worry that a right to die would become an obligation to die is of a piece with other worries about euthanasia, not in itself, but as a problematic option for the patient.

XI

As I have said, I favor euthanasia in some cases. And, of course, I believe that euthanasia must not be administered to competent patients without their consent. To that extent, I think that the option of dying will have to be presented to some patients, so that they can receive the benefit of a good death.

On the basis of the foregoing arguments, however, I doubt whether policy makers can formulate a general definition that distinguishes the circumstances in which the option of dying would be beneficial from those in which it would be harmful. The factors that make an option problematic are too subtle and too various to be defined in a statute or regulation. How will the option of euthanasia be perceived by the patient and his loved ones? How will it affect the relations among them? Is he

likely to fear being spurned for declining the option? Would he exercise the option merely as a favor to them? And are they genuinely willing to accept that favor? Sensitivity to these and related questions could never be incorporated into an institutional rule defining conditions under which the option must be offered.

Insofar as I am swayed by the foregoing arguments, then, I am inclined to think that society should at most permit, and never require, health professionals to offer the option of euthanasia or to grant patients' requests for it. We can probably define some conditions under which the option should never be offered; but we are not in a position to define conditions under which it should always be offered; and so we can at most define a legal permission rather than a legal requirement to offer it. The resulting rule would leave caregivers free to withhold the option whenever they see fit, even if it is explicitly and spontaneously requested. And so long as caregivers are permitted to withhold the option of euthanasia, patients will not have a right to die.

XII

The foregoing arguments make me worry even about an explicitly formulated permission for the practice of euthanasia, since an explicit law or regulation to this effect would

already invite patients, and hence potentially pressure them, to request that the permission be exercised in their case. I feel most comfortable with a policy of permitting euthanasia by default – that is, by a tacit failure to enforce the institutional rules that currently serve as barriers to justified euthanasia, or a gradual elimination of those rules without fanfare. The best public policy of euthanasia, I sometimes think, is no policy at all.

This suggestion will surely strike some readers as scandalous, because of the trust that it would place in the individual judgment of physicians and patients. But I suspect that to place one's life in the hands of another person, in the way that one does today when placing oneself in the care of a physician, may simply be to enter a relationship in which such trust is essential, because it cannot be replaced or even underwritten by institutional guarantees. Although I do not share the conventional view that advances in medical technology have outrun our moral understanding of how they should be applied, I am indeed tempted to think they have outrun the capacity of institutional rules to regulate their application. I am therefore tempted to think that public policy regulating the relation between physician and patient should be weak and vague by design; and that insofar as the aim of medical ethics is to strengthen or sharpen such policy, medical ethics itself is a bad idea.

Acknowledgments

This is a revised version of a paper that was originally published in *The Journal of Medicine and Philosophy* (1992). That paper began as a comment on a paper by Dan Brock, presented at the Central Division of the APA in 1991. See his "Voluntary Active Euthanasia" (Brock,

1992). I received help in writing that paper from: Dan Brock, Elizabeth Anderson, David Hills, Yale Kamisar, and Patricia White. The present version of the paper replaces sections II and III of the original paper with a new and substantially different section II.

Notes

- 1 Here I echo some excellent remarks on the subject by Felicia Ackerman (Ackerman, 1990). I discuss the issue of "dying with dignity" in Velleman (1999a).
- 2 I discuss this issue further in Velleman (1999b, pp. 356–8, esp. nn. 69, 72).
- 3 See Velleman (1999a).
- 4 The *locus classicus* for this point is of course Camus's essay, "The Myth of Sisyphus" (Camus, 1956).
- 5 For this analogy, see Stell (1979). Stell argues – implausibly, in my view – that one has the right to die for the same reason that one has a right to duel.

- 6 The analogy is suggested, in the form of an objection to my arguments, by Dan Brock in Brock (1992).
- 7 See my paper, "A Right of Self-Termination?" (1999a).
- 8 Of course, there are many other reasons for declining gifts and favors, such as pride, embarrassment, or a desire not to be in someone else's debt. My point is simply that there are cases in which these reasons are absent and a very different reason is present – namely, our desire not to burden someone else with obligations.