Part One

Introduction

Gerald Dworkin

WE INTEND TO ARGUE that, under certain circumstances, it is morally permissible, and ought to be legally permissible, for physicians to provide the knowledge and/or means by which a patient can take her own life. This facilitation of suicide is what we shall mean by physician-assisted suicide. When we refer to euthanasia we shall mean cases in which the physician performs the last causal step leading to the death of the patient, and thus can be said to kill the patient.

The reasons for favoring physician-assisted suicide are not difficult to determine. They consist mainly of the interests that dying patients have in the process of dying being as painless and dignified as possible. They also rely on the interest of patients in determining the time and manner of their death. Autonomy and relief of suffering are values that we all can agree to be important. But it has seemed to many people that, important as these values are, there are significant objections to allowing physicians to serve these values either by facilitating suicide or by killing their patients. We believe that these objections are mistaken and that once they are seen to be mistaken, the reasons favoring medically assisted dying lead to our conclusions.

Our basic strategy of argument is essentially ad hominem; that is, we will claim that those who oppose medically assisted dying themselves favor policies that cannot be morally distinguished from the policies we favor and they oppose. Our starting point is the claim, which we are assuming is shared by those who oppose medically assisted dying, that a competent patient has a right to

refuse any proposed medical treatment, or to withdraw from existing medical treatment, even if she knows that this will result in death. The general strategy is to argue that, if one accepts this, then one ought to accept that a patient may request physician-assisted suicide or, in certain conditions, euthanasia, and that under certain conditions it is permissible, and ought not be criminal, for health care providers to give such assistance.[1]

The idea, then, is to consider the various arguments for supposing a normative asymmetry to exist between refusal/withdrawal of treatment and assisted dying, and to argue that such an asymmetry does not hold. The most important arguments for asymmetry are the following.

1. There is a morally relevant difference in intentionality and/or causality that justifies a moral asymmetry. Falling under this heading are various views about the moral significance of distinctions such as killing versus letting die, intention versus foresight (and the associated principle of double effect), act versus omission, and so on. In addition, there are arguments involving causality and its moral significance, for example the argument that in letting die the patient dies from his disease whereas in killing the doctor is the cause of death.

2. There is a morally relevant difference in the likely consequences of the two policies. Here the main arguments are various forms of the slippery slope, the thin edge of the wedge, and the like. The claim is that even if it is true that some instances of medically assisted dying are morally permissible, we either are not able to distinguish in a principled manner or would not be able to stop the progression to instances that we all recognize as abhorrent.

There are also arguments that the distinction between refusal of treatment and medically assisted dying is important when we consider the institutionalization of such a policy. The claim is that even if we thought individual instances morally permissible, it

[1] While the argument as we formulate it only has force for those who accept our assumptions, we believe the assumptions are morally correct (although we do not argue for them) and that therefore the argument is sound.

would be mistaken to have a policy allowing them. Independent of our views about the morality of assisted dying, we ought to enforce the asymmetry by means of legal restrictions, professional norms, and the like. Here we get issues about the pressures on patients to opt for suicide, the difficulties of insuring that the patient is rational, the symbolic significance of not allowing one person to kill another and so forth.

3. Finally, we have arguments from the nature of medicine and of the profession of medicine and its norms. It is claimed that these require one to make and preserve a sharp distinction between allowing patients to die, which doctors do every time they "no-code" a patient or withdraw a patient from a ventilator, and assisting or causing their death.

With respect to each of these claims about moral asymmetry we intend to show that they do not hold in a form that defeats the claims of autonomy and relief of suffering of competent patients who are suffering from a terminal illness or an intractable, incurable medical condition that the patient experiences as incompatible with her fundamental values.

1 The Nature of Medicine

Gerald Dworkin

> It is not decent for society to make a man do this to himself. Probably, this is the last day I will be able to do it to myself.
>
> Percy Bridgman
> Suicide note

Among physicians the most frequently heard argument against physician-assisted suicide is one about the nature of the medical profession. It is argued that the norms of medicine prohibit a physician from ever acting with the intent to kill a patient or to aid him in killing himself. For this reason it is essential, they believe, to maintain a sharp distinction between allowing patients to die, say by the refusal to initiate cardiopulmonary resuscitation (CPR), and acts of assisted suicide.

Certainly the most important and influential article defending this view is one by Leon Kass.[1] It is almost impossible to find an article opposing medically assisted dying in any of the major medical journals, such as the *New England Journal of Medicine* and the *Journal of the American Medical Association*, that does not cite this article as establishing the view that physicians must not aid

[1] Leon Kass, "Neither for Love nor Money: Why Doctors Must Not Kill," *The Public Interest*, no. 94, Winter 1989. Some of Kass's arguments are directed against the moral right of patients to be killed, and some against the moral duty of doctors to kill. Others raise the issue of whether such rights or duties ought to be incorporated into public policy, either via the law or through the codes and rules of the medical profession. In this chapter we are confining ourselves to the former issues. We will consider the latter in Chapter 4.

patients in dying. We propose, therefore, to critically examine Kass's arguments.

Kass begins by considering "the question about physicians killing (as) a special case of – but not thereby identical to – this general question: May or ought one kill people who ask to be killed."[2] Note the phrase "may or ought," which will assume some importance as Kass develops his argument. They represent two distinct positions: that it is morally permissible for doctors to kill upon request and that doctors are required to do so. The former position is weaker than the latter. It is consistent with the view that doctors would not be acting wrongly to kill that they also would not be acting wrongly if they refused to kill. It is the latter that is ruled out by the stronger position that doctors are obliged to kill.[3]

Kass considers two kinds of reasons that are given in support of the view that doctors may or ought to kill under certain circumstances – reasons that he believes reflect the two leading approaches to medical ethics. The first kind of reason is that of *freedom or autonomy.*

> On this view, physicians (or others) are bound to acquiesce in demands not only for termination of treatment but also for intentional killing through poison, because the right to choose – freedom – must be respected, even more than life itself, and even when the physician would never recommend or concur in the choices made. When persons exercise their right to choose against their continuance as embodied beings, doctors must not only cease their ministrations to the body; as keepers of the vials of life and death, they are also morally bound actively to dispatch the embodied person. . . .[4]

> The second reason for killing the patient who asks for death has little to do with choice. Instead, death is to be directly and

[2] *Ibid.*, p. 26.

[3] There is some room for ambiguity as to whether "ought" is to be read as equivalent to "must" (which is sometimes how moral requirements are phrased). But when somebody says, "You ought to keep your promise," this is usually intended as equivalent to "You must keep your promise."

[4] *Ibid.*, p. 27.

> swiftly given because the patient's life is deemed no longer worth living, according to some substantive or "objective" measure. Unusually great pain or a terminal condition or an irreversible coma or advanced senility or extreme degradation is the disqualifying quality of life that pleads – choice or no choice – for merciful termination. . . . It is not his autonomy but rather the miserable and pitiable condition of his body or mind that justifies doing the patient in. Absent such substantial degradations, requests for assisted death would not be honored. . . . Not the autonomous will of the patient, but the doctor's benevolent and compassionate love for suffering humanity justifies the humane act of mercy killing.[5]

These are the reasons Kass believes are inadequate to justify doctors' killing. Why does he think so? The first claim is that these two views are

> united in their opposition to the belief that medicine is intrinsically a moral profession, with its own immanent principles and standards of conduct that set limits on what physicians may properly do. Each seeks to remedy the ethical defect of a profession seen to be in itself amoral, technically competent but morally neutral.[6]

But how does this follow? It is clearly open to those who support these views to believe that respecting the wishes of patients and seeking to relieve suffering are built into the practice of medicine. They could be built into the ideals of medicine, they could be defining of the role of physician, they could be part of the moral code that physicians are required to abide by, and of the oath they take when initiated into the profession. Of course, it is *possible* to hold that these values are external to the profession of medicine, that they are grafted onto a morally neutral technique, but nothing in the views themselves requires them to be so viewed.

But perhaps this is not the core of Kass's argument. For he goes on to claim that these reasons lead to morally repugnant views:

[5] *Ibid.*, p. 27.

[6] *Ibid.*, p. 28.

> For the first ethical school . . . the implicit (and sometimes explicit) model of the doctor–patient relationship is one of *contract:* the physician . . . sells his services on demand. . . . If a patient wants to fix her nose or change his gender, determine the sex of his unborn children or take euphoriant drugs just for kicks, the physician can and will go to work. . . .
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> For the second ethical school . . . not the will of the patient, but the humane and compassionate motive of the physician – not as physician but as *human being* – makes the doctor's actions ethical. . . . All acts – including killing the patient – done lovingly are licit, even praiseworthy. Good and humane intentions can sanctify any deed.
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> In my opinion, each of these approaches should be rejected as a basis for medical ethics. For one thing, neither can make sense of some specific duties and restraints long thought absolutely inviolate under the traditional medical ethics – e.g. the proscription against having sex with patients. Must we now say that sex with patients is permissible if the patient wants it and the price is right, or, alternatively, if the doctor is gentle and loving and has a good bedside manner?[7]

Now if the views in questions had these implications, for example that all acts done lovingly are licit or that doctors may have sex with patients, this would surely be an important, perhaps decisive, objection to such views. But no such conclusions follow.

First, a minor point. Note that in the presentation of the views Kass slips from the "may or ought" formulation to the stronger thesis. "Physicians (or others) are bound to acquiesce in demands not only for termination of treatment but also for intentional killing." "Doctors must not only cease their ministrations to the body; as keepers of the vials of life and death, they are also morally bound actively to dispatch the embodied person." So even were his arguments good ones, at most they would show that the strong thesis is mistaken.

But the arguments are not good ones for two reasons. First, the arguments switch targets in midstream. Second, the arguments assume that the positions are exclusive, each providing a suffi-

[7] *Ibid.*, p. 28.

cient reason for euthanasia, whereas they are most naturally and plausibly understood as providing necessary conditions that, in suitable circumstances, may be together sufficient for making it permissible.

First, the switching of targets. When Kass initially presents what he calls the "second reason," it is in terms of what has usually been called "quality of life" considerations. It is because the patient's life is by some "objective" measure not worth living that mercy is called for. But when he considers the "counterexample" of consensual sex he has dropped this condition and switched to the motives or intentions (he is never clear about the difference between these two) of the doctor. It is good intentions or benevolent motives that justify the doctor's conduct. Hence the supposed implication that if the doctor is gentle and loving then sex is permissible. But this is simply to switch to a very different position than the one originally set out. What counts in the original view is whether the patient is in great pain, advanced senility, or the like. Of course, if the doctor acts on the basis of these conditions he will be acting benevolently but it is the condition that justifies, not the motive. Indeed it would be a bizarre view to suppose that good intentions can justify any deed – but that is not the view that Kass originally presents.

Second, and crucially, Kass sets up a straw man. He considers a view that counts either "choice" or "life not worth living" *but not both* as the relevant considerations. And, indeed, if either of these views is considered by themselves they do have unwanted implications. But the most plausible view that it is both choice *and* condition that make a doctor's killing permissible. That is why the view is called voluntary euthanasia – voluntary to indicate choice of the patient, euthanasia to indicate that death is "good."[8] When Kass says "Unusually great pain or a terminal

[8] Cf. this passage from Glanville Williams's classic treatment of the subject: "Whatever opinion may be taken on the general subject of suicide, it has long seemed to some people that euthanasia, the merciful extinction of life, is morally permissible and indeed mandatory where it is performed upon (1) a dying patient (2) with his consent and (3) where it is the only way of relieving

condition or . . . is the disqualifying quality of life that pleads – *choice or no choice* – for merciful termination" (italics added), he is considering a position that few, if any, hold – at least with respect to competent adults. And when he says that the position he is considering holds that "it is not his autonomy but rather the miserable and pitiable condition of his body or mind that justifies doing the patient in. Absent such substantial degradations, requests for assisted death would not be honored," the second sentence indicates only that the condition of the patient is a necessary condition for justified physician-assisted suicide. It does not support the first sentence, which expresses the view that the condition of the patient is a sufficient condition for justified PAS.[9]

Thus every claim that Kass makes is mistaken. It is not the case that the views in question must regard medicine as a morally neutral profession. He introduces the position to be evaluated as the view that doctors "may or ought" to kill patients, but then considers only the stronger view. He introduces one of the two views as concerned with the quality of life of the patient, but then switches to a view concerned with the physician's motives or intentions. And finally, and most egregiously, he considers the views as operating independently of each other as opposed to op-

his suffering" (*The Sanctity of Life and the Criminal Law* [New York: Knopf, 1957], p. 311).

[9] Exactly the same error is made by Daniel Callahan in the following passage from "When Self-Determination Runs Amok," Hasting Center Report, March–April 1992, p. 54: "The two standard motives for euthanasia and assisted suicide are said to be our right of self-determination, and our claim upon the mercy of others, especially doctors, to relieve our suffering. These two motives are typically spliced together and presented as a single justification. Yet if they are considered independently – and there is no inherent reason why they must be linked – they reveal serious problems." Of course they are not "inherently" linked; it is just that they are both required to make the moral case. Compare someone arguing against the position that it is legitimate for you to destroy my painting only if (1) I give you permission and (2) it is not a great work of art on the grounds that when these "reasons are considered independently – and there is no inherent reason why they must be linked – they reveal serious problems," e.g., you can destroy any of my paintings as long as they are not great works of art or you can destroy the only surviving Rembrandt because it is mine and I give you permission to do so.