

A moral defense of Oregon's physician-assisted suicide law

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Abstract

Since 1998, physician-assisted suicide has been legal in the American state of Oregon. In this paper, I defend Oregon's physician-assisted suicide (PAS) law against two of the most common objections raised against it. First, I try to show that it is not intrinsically wrong for someone with a terminal disease to kill herself. Second, I try to show that it is not intrinsically wrong for physicians to assist someone with a terminal disease who has reasonable grounds for wanting to kill herself.

Keywords: *Autonomy, Callahan, Double Effect, Kass, Oregon, Pellegrino, Physician-Assisted Suicide*

Introduction

Since 1998, physician-assisted suicide (PAS) has been legal in the state of Oregon. If an Oregon resident has less than six months to live and is mentally competent, she can request that a physician prescribe her drugs that will cause a quick and painless death.

Most of the objections to the Oregon law fall into one of three categories. In the first category is the claim that it is intrinsically wrong for someone to kill herself. In the second category is the claim that it is intrinsically wrong for physicians to assist someone in killing herself. In the third category is the claim that legalizing PAS will lead to very bad consequences for the sick, the elderly and other vulnerable elements of our population.

In this article, I address the first and second categories of objections. In the first part of the article, I try to show that it is not intrinsically wrong for someone with a terminal disease to kill herself. In the second part, I try to show that it is not intrinsically wrong for physicians to assist someone with a terminal disease who has reasonable grounds for wanting to kill herself.

I do not discuss the consequentialist arguments that occupy the third category of objections to the Oregon law. These consequentialist arguments are important, and they need to be addressed. But they fall outside my current purview.

Let me also mention another important aspect of my position. I do not argue that anyone has a constitutionally protected *right* to assisted suicide. Laws prohibiting PAS and laws allowing PAS may both be equally consistent with the US Constitution. I try to give reasons for thinking that we ought to support the Oregon law, but I do not try to show that the Constitution demands that we make PAS available. I try to show that there may be good

moral reasons for implementing a law allowing PAS, even if there is no basis for anyone to claim that she has a constitutionally protected right to assistance in suicide.

Why it is not intrinsically wrong for a terminal patient to commit suicide

Arguments against the autonomy-based justification for allowing suicide

Leon Kass has provided one of the most influential statements of the belief that someone using the Oregon law to kill herself is doing something intrinsically wrong. Kass uses the concept of tragedy to frame his opposition. Something is tragic, Kass tells us, if it is necessarily self-contradictory. “In tragedy the failure is imbedded in the hero’s success, the defeats in his victories, the miseries in his glory” (Kass, 2002a: 48). Kass claims that many of the recent developments in health care are tragic in the way that he defines it, or necessarily self-contradictory. PAS under the Oregon law is one of his prime examples. PAS, Kass argues, inevitably destroys the thing of value that it is intended to promote.

The value the Oregon law is intended to promote is the autonomy of human beings. In the following, I say more about how we ought to conceive of what is valuable about autonomy, but for now we can think of it simply as a person’s ability to make decisions for herself, to decide for herself what will happen to her own body. According to its proponents, the Oregon law promotes autonomy because it expands the range of decisions a person can make. When PAS is legal, a person has the choice of deciding whether or not to end her life by taking a pill. But when PAS is illegal, a person does not have that choice. And a state of affairs that gives a person more choices is, from the standpoint of trying to promote autonomy, better than a state of affairs that offers a person fewer choices.

According to Kass, however, this way of thinking is tragically simplistic, shallow and shortsighted. For in fact the legalization of PAS does not promote autonomy but encourages its destruction. Far from giving people more choices, PAS brings about a state of affairs in which a person has lost the ability to make choices altogether. For the person who engages in PAS will, obviously, be dead, and someone who is dead can no longer exercise her autonomy. It is thus *self-contradictory* to argue for PAS by claiming that it promotes autonomy, as PAS destroys a person’s ability to make decisions. As Kass puts it, there can be “no ground at all” for claiming that “autonomy licenses an act that puts our autonomy permanently out of business” (Kass, 2002a: 217–218).

Opponents of PAS often color in this charge of self-contradiction by contending that the autonomy-based justification of PAS leads to obvious absurdities (Callahan, 2002: 61–63). One such absurdity is the legalization of a certain kind of slavery. It is illegal to sell yourself into slavery. Even if you want to contract with someone to become her slave, you are not allowed to do so. The contract would be null and void. According to PAS opponents, however, the autonomy-based justification of PAS implies that forbidding someone from selling herself into slavery restricts her range of self-determining choices, and that as a result we should give everyone the option of deciding whether or not to become a slave. So the autonomy-based justification of PAS implies that we should legalize self-slavery contracts. But the idea of legalizing slavery of any kind is absurd. And so, PAS opponents conclude, the autonomy-based justification of PAS is fundamentally flawed.

Another absurdity PAS opponents try to foist on the attempted justification of the Oregon law is the legalization of PAS for people who are healthy and non-terminal. Oregon’s law allows PAS only for people who have six months or less to live. But the autonomy-based justification of PAS implies that we ought to expand the range of self-regarding decisions every competent individual can make. The autonomy-based justification implies, then, that

we should give even healthy and non-terminal people the option of deciding whether or not to commit suicide. But, opponents of PAS argue, the idea of legalizing PAS for healthy and non-terminal people is absurd. So we have, once again, a clear reason to reject the autonomy-based justification for PAS.

Defense of the Oregon law's autonomy-based justification for allowing suicide

Proponents of PAS can respond to these criticisms of their autonomy-based justification in one of two ways. First, they can take the hard-line libertarian route, which consists of biting the bullet and embracing the implications that PAS opponents say are absurd. Hard-line libertarian supporters of PAS will agree that their justification of PAS implies that we should legalize self-slavery and assisted suicide for healthy, non-terminal individuals, but then go on to argue that people *should* be allowed to sell themselves into slavery if they freely choose to do so, and that healthy, non-terminal individuals should be allowed to seek assisted suicide. According to this hard-line libertarian approach, everyone really should be given the legal option to make whatever self-regarding decisions she wants. Whether we think a decision is moral or immoral is legally irrelevant. As long as no one else is harmed, the moral status of a person's justificatory principles is none of the law's business. So even if we come to believe that there is some kind of "self-contradiction" involved in a person's choosing to undertake some course of action, that would not justify using the law to prevent a person from undertaking that course of action, so long as no other person is hurt. This hard-line libertarian position has an internal consistency that shields it from any quick and simple refutation. A full treatment of this position would, however, involve us in a large-scale critique of the American legal system, and would thus take us far afield from the Oregon law, which is in fact in conflict with the hard-line libertarian position. I think, consequently, that we would do best to leave to one side the libertarian defense of assisted suicide. It's a topic for a different discussion.

The reason the Oregon law conflicts with the hard-line libertarian position is that it does not allow healthy, non-terminal individuals to choose PAS. And this feature of the Oregon law points towards the second way in which one can try to defend the autonomy-based justification of PAS against the charge of self-contradiction. Those proposing this second kind of defense will agree that self-slavery and assisted suicide for healthy, non-terminal individuals ought to remain illegal, but then go on to argue that their autonomy-based justification of the Oregon law does not imply that those other things ought to be legal. They will argue, rather, that there is a clear and morally significant difference between what the Oregon law provides for, on the one hand, and self-slavery and assisted suicide for healthy, non-terminal individuals, on the other. So while it would be wrong to legalize self-slavery and assisted suicide for healthy, non-terminal individuals, the autonomy-based defense of the Oregon law does not commit one to holding that those other things should be legal. The self-contradiction that afflicts those other things does not afflict the kind of assisted suicide that the Oregon law allows.

The Oregon law has provisions to ensure that the people who engage in PAS are competent, and that their decision to commit suicide is a result of autonomous decision making. But, crucially, it also has provisions to ensure that the people who engage in PAS have terminal illnesses. Specifically, the Oregon law allows a person to receive lethal drugs only if two doctors have verified that she has six months or less to live. And what defenders of the Oregon law can argue is that the suicide of a person who is about to die does not violate the value of autonomy because the person's decision-making ability is going to disappear whether she commits suicide or not. The person with a terminal disease who

decides to commit suicide is not changing the universe from a place in which she would have been able to exercise her autonomy in the future into a place in which she will not be able to exercise her autonomy in the future. For she will not be able to exercise her autonomy in the future no matter what she does. Hers is not a decision to prevent herself from being able to make future decisions, because future decisions will not be hers to make regardless. The ending of her decision-making ability is a foregone conclusion. She is simply choosing that it end in one way rather than another. The person who commits suicide under the Oregon law should be compared to someone who blows out a candle that has used up all its wax and is now nothing but a sputtering wick that is just about to go out on its own. She should not be compared to someone who snuffs out the bright, strong flame of a new candle.

This autonomy-based defense of the Oregon law gains strength through a consideration of how the final stages of a terminal disease can corrode a person's autonomous nature. Progressive bodily deterioration can limit and ultimately eliminate one's ability to undertake physical action, and mental deterioration can limit and ultimately eliminate one's ability to make any kind of decision at all. In the end, one may be barely conscious and maintained by machines, bereft of the autonomous nature that gives human beings dignity and inestimable moral worth. It is this lingering half-life that persons who use the Oregon law may seek to prevent. And such a decision does not necessarily contradict the value of autonomy because during such a half-life autonomy does not exist anyway. Indeed, defenders of the Oregon law can argue that the decision to commit suicide in the final stages of a terminal illness can proceed from a great respect for autonomy, as such a decision can reveal that what a person values about herself is not simply her physical existence but the ability to decide what happens to her.

The fact that the Oregon law allows only terminal patients to commit suicide also gives PAS proponents the conceptual resources for repelling the absurd consequences PAS opponents try to foist on them. Opponents, recall, claimed that the autonomy-based justification of PAS implied that we should legalize self-slavery and assisted suicide for healthy, non-terminal individuals. But PAS proponents can point to a clear moral difference between the suicides allowed under the Oregon law, on the one hand, and self-slavery and the assisted suicide of healthy, non-terminal individuals, on the other. Someone who makes herself into a slave or commits suicide while healthy is throwing away the capacity for self-determination. If she does not make herself a slave or commit suicide, she will be able to make her own decisions for years to come; but if she does either of those things, she will not be able to make her own future decisions. But a person who is about to die is not going to be able to make decisions for years to come, whether she commits suicide or not. She is not throwing away her ability to determine her future because that ability no longer exists. So the autonomy-based justification of assisted suicide for terminal individuals is completely compatible with the prohibitions on self-slavery and assisted suicide for healthy, non-terminal individuals. PAS proponents can consistently condemn actions that destroy the ability to make future decisions, because the suicide of a terminal individual is not a case of such destruction.

Opponents of PAS will respond, however, by claiming that the suicide of a person with a terminal disease *is* a case of the destruction of the ability to make future decisions. For a person who has six months to live has, after all, six months to live. And while she may be unconscious and unable to make her own decisions for part of that time, she will be conscious and able to make her own decisions for the other part. It might be true that her ability to make decisions will persist for only a few weeks or months. But, according to this way of criticizing the Oregon law, that ability is still of ultimate value, even if its temporal reach is relatively short. Earlier, I compared a terminal individual who commits suicide to

someone who blows out a dying candle. There is a difference, however, between extinguishing a candle that is almost burned out but still providing light, and letting the candle burn itself out. A person who blows out a candle, even one that is almost finished, is undertaking a course of action that extinguishes light. As a result of her action, darkness comes sooner than it otherwise would have. Similarly, allowing a person to kill herself is allowing her to destroy the ability to make decisions, and that remains true even if the person would die of natural causes in a few months time anyway.

Opponents of PAS could try to put the point of the previous paragraph in terms of a nasty dilemma for proponents. If proponents of PAS really do base their position on the value of autonomy, opponents might argue, then they must be opposed both to the killing of a person who is incompetent to make her own decisions (which the Oregon law does in fact prohibit) and to the suicide of someone who will be able to make her own decisions in the future (no matter how short that future may be). But everyone falls into one of those two categories. Everyone is either incompetent to make her own decisions or will be able to make her own decisions in the (immediate) future. So the value of autonomy implies the moral legitimacy of the suicide of no one.

Autonomy as the ability to make “big decisions”

Does this criticism defeat the autonomy-based justification of PAS? Does the fact that even a terminal patient still possesses decision-making ability show that the value of autonomy cannot be used to support the Oregon law? I don't think so. I think, rather, that the goal of promoting autonomy is consistent with PAS in general and the Oregon law in particular, and that the criticism described in the previous two paragraphs is mistaken. In order to explain what is wrong with the criticism, however, we need to say a bit more about the value of autonomy.

Many ethical discussions that invoke the value of autonomy equate autonomy with the ability to make one's own decisions. To this point, I too have accepted this equation. But if we want to be clear about what the value of autonomy in end-of-life issues really involves, we need to draw a distinction between the kinds of decisions a person may make. The distinction I want to draw is between what I will call “big decisions” and “little decisions.”

Big decisions are decisions that shape your destiny and determine the course of your life. Big decisions call on you to make a choice in light of things that matter most to you, in light of the things that give your life whatever meaning it has. Big decisions proceed from your deepest values. Little decisions, by contrast, concern matters that are momentary or insignificant. They do not proceed from your deepest values, but draw only on preferences that rest on the surface of your character. Big decisions are momentous, in that making one big decision rather than another will change in some non-negligible way the course of your life. But little decisions don't matter that much. Regardless of whether you make one little decision or another, your life will continue in much the same way. Little decisions don't shape your destiny. So an example of a big decision would be deciding to get married, while an example of a little decision would be deciding to eat the blue jello instead of the red jello.¹

I maintain that to respect autonomy is, first and foremost, to respect a person's ability to make big decisions. It is to respect a person's ability to determine her own fate, to shape her own life. The capacity to make little decisions matters less. That's not to say that the freedom to make little decisions doesn't matter at all. We should let people make as many of the little decisions that affect them as is possible. But it is the ability to make big decisions

that is of inestimable value. That is where the great moral weight of the value of autonomy lies.

A person who meets the Oregon law's criteria of competence and terminality will probably have the capacity to make little decisions for weeks or months to come. She will, that is, probably be able to continue to make decisions about many of the details of her daily routine. But she may very well not have the same ability to make big decisions. Her ability to determine her own destiny, to shape her own life, may be all but gone. There are two reasons for this. First, the limited amount of time a person with a terminal disease has left to live eliminates many of the options that constitute big decision making. Long-range planning of a life is impossible when the life will end in a few months. Second, the nature of many terminal diseases can preclude big decision making in a manner that is distinct even from the amount of time a person has left to live. Terminal diseases can consume the mind as well as the body. And all too often, the only decisions a person ends up making at the end-stage are those that concern pain management and the most basic of bodily functions. The kinds of concerns that involve big decision making, the kind that call on one's deepest values and create the opportunity to shape a life, are crowded out by the immediacy of disease.

There is, however, one big decision a person who meets Oregon's criteria will still be able to make, one choice about her destiny that will still be open to her. She can still decide how and when to die. She can still choose the shape of the end of her life, the concluding words of her final chapter. This may, in fact, be the only big decision that her limited time left affords her. Thus, giving a person with a terminal disease the option of PAS can promote the thing of value that we have in mind when we talk of respect of autonomy. For the option of PAS can enhance such a person's ability to make a big decision for herself. When, by contrast, we make it more difficult for a person with a terminal disease to commit suicide, we restrict her ability to make a big decision. And this restriction cannot be justified by claiming that we are respecting her autonomy, unless what we mean by autonomy is simply the capacity to make little decisions for a few more weeks or months. For besides the choice of how she wants her life to end, ever littler decisions may be all that such a person has any prospect of making.

Once again, then, we can see the clear difference between PAS for people with terminal diseases, on the one hand, and the suicide of healthy people, on the other. A typical healthy person possesses the ability to make big decisions in the future. Such a person, typically, can control her own destiny and shape her own life for years to come. So by killing herself, a healthy person does violate what is most important about autonomy: she has before her the choice between a future in which she can make big decisions and a future in which she cannot make big decisions, and she opts for the latter. But a person with a terminal disease may not be able to make big decisions in the future, no matter what decision she makes now. So it is not necessarily the case that a person with a terminal disease will be choosing between a future in which she can make big decisions and a future in which she cannot make big decisions. It may be the case, rather, that such a person's ability to make big decisions will be nonexistent in all the futures between which she must choose.

The difference between PAS for people with diseases and self-slavery is even more clear and instructive. A slave may very well be able to make numerous little decisions throughout her life. She may be in control of the details of fulfilling her basic bodily needs, and she could have some degree of choice about how to go about completing her assigned tasks. But even if a slave possesses the capacity to make little decisions, we will still believe that her slavery violates autonomy in a fundamental way. And that is because the slave lacks the ability to make big decisions. She lacks the ability to control her own destiny, to shape her own life. It is the ability to make big decisions that is of profound moral importance. The fact that the slave may be able to make little decisions is, by comparison, morally insignificant. It is the

ability to make big decisions that ought not to be tossed away. But a person with a terminal disease who chooses PAS will not necessarily be tossing away her ability to make big decisions; she may, rather, be exercising it in the only way she can. For the ability of such a person to make big decisions may already be all but gone, the only big decision left to her being that of deciding how her life will end. Now it is true that a person with a terminal disease who chooses PAS will be tossing away a few weeks or months of little decision making. But as the case of the slave illustrates, the ability to make little decisions is relatively unimportant.

Opponents of PAS may object that I have underestimated the extent to which a person with a terminal disease can be able to make big decisions. They may argue that even a person whose physical abilities are severely limited and who will die within a few months may still be able to do many things to affect the shape of her life. Such a person may, for instance, use the time she has left to change her will or to make vital arrangements for the care of her loved ones. She may reconcile with people from whom she has long been estranged. Through the experience of suffering and dying, she may learn profound truths about herself and the human condition. She may forge a new relationship with God. All of these things are of the utmost importance to the shape of a life. None of them is little or insignificant. But by availing herself of PAS, a person destroys her ability to do any of these things.

In response to this objection, let me say first of all that it is true that *some* people may have profound, life-changing experiences at the very end of life. The very end of life may be the time when *some* people achieve a new awareness or forge new relationships that cast all their previous years in an entirely different light. What is crucial to realize, however, is that this may not be true for *all* people. There may also be people who have settled all their worldly and spiritual affairs a month or two before they are expected to die. Some people may have no need to make financial arrangements or pursue any sort of interpersonal reconciliation in the final months of life because they may already have done all the work on their wills and their relationships that they believe they need to do. Some people may not need to experience any more suffering and dying because they may believe that they have learned all the lessons about themselves and the human condition that they are ever going to learn. Some people may have already achieved exactly the relationship with God to which they aspire. So while PAS may be the wrong thing for *some* people, it is not necessarily the wrong thing for *all* people. Proponents of the Oregon law do not claim, of course, that everyone with a terminal disease should commit suicide. They claim, rather, that because suicide may be right for some people, it should be an option. It should be available to all people who are terminal and competent to make their own decisions.

Opponents of PAS seem to believe, however, that it is wrong for *anyone* with a terminal disease to commit suicide. They seem to believe that there are morally significant reasons against suicide in every situation, that everyone should live for as long as she can so that she can learn for herself, and teach others, profound lessons about the meaning of life. Thus, Kass maintains that “what humanity needs most” are people who “continue to live and work and love as much as they can for as long as they can,” and that such people are worthy of admiration in a way that suicides are not (Kass, 2002b: 39). And Callahan implies that people who live for as long as they can in the face of suffering and a lack of control are more “noble and heroic” than those who choose suicide (Callahan, 2002: 57), that the former fulfill the “duty to bear suffering as a form of mutual human support” in a way that the latter do not (Callahan, 2002: 66).

But some people may believe that the very end of their lives will *not* produce any profound and meaningful insights, for them or anyone else, into “the point or purpose or end of human existence” (Callahan, 2002: 58). And this belief of theirs may follow from their own

fundamental values. It may proceed from their own deepest views of what is profound and meaningful about life. To respect autonomy is to promote their ability to act on these fundamental values. Suicide may be an unreasonable end to the lives of some people with terminal diseases. But it may not be an unreasonable end for the lives of others. And everyone should be allowed to decide for herself whether she is the first sort of person or the second. It is a big decision, deciding what sort of ending is for you the fundamentally right one, maybe one of the biggest decisions of all. That is why everyone whose end is imminent should be allowed to make it for herself.

Why it is not intrinsically wrong for a physician to participate in PAS

Physicians and the decision of whether life is worth living

Let us now turn to the second objection to PAS as it occurs under the Oregon law. This objection is based on the role of a physician. Even if it is in some cases morally acceptable for a person to commit suicide, PAS opponents maintain, it still will always be wrong for a physician to assist her. Those who defend PAS “misunderstand the moral foundations of medical practice,” failing to appreciate 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” (Kass, 2002b: 19).

Now it is worth noting, first, that even if physicians’ special moral position makes it wrong for them to assist in suicide, that does not mean that it is wrong for *anyone* to assist in suicide.² Perhaps we should allow members of some other profession—such as lawyers—to provide lethal drugs to competent people with terminal diseases (see Sade & Marshall, 1996). Indeed, the more the argument against PAS depends upon principles that are special to the medical profession, the less applicable it will be to other professions’ assistance in suicide.

But of course the Oregon law does allow physicians to prescribe lethal drugs. So in the interests of defending the Oregon law, let me now address the charge that assisting in suicide violates the essential moral duty of the medical profession.

Opponents of the Oregon law contend that, in requesting PAS, a person is asking her physician to make a decision that is inappropriate for a physician to make. This is because a physician who must decide whether to assist in a person’s suicide is forced to make a judgment about moral and spiritual matters that have nothing to do with medicine. Thus Kass contends that to comply with a request for PAS, “the physician must, willy-nilly, play the part of judge, and his judgments will be decidedly nonmedical and nonprofessional, based on personal standards” (Kass, 2002b: 29–30). And Pellegrino maintains that in prescribing a lethal dose a physician is making the non-medical judgment that her patient’s “life is unworthy of living” (Pellegrino, 2002: 51). Callahan makes the same point when he writes, “The purpose of medicine is not to relieve all the problems of human mortality, the most central and difficult of which is why we have to die at all or die in ways that seem pointless to us . . . This is not the role of medicine because it has no competence to manage the meaning of life and death, only the physical and psychological manifestations of those problems. Medicine’s role must be limited to what it can appropriately do, and it has neither the expertise nor the wisdom necessary to respond to the deepest and oldest human questions” (Callahan, 2002: 59).

This criticism seems to me to miss entirely the provisions of the Oregon law. For the Oregon law makes very clear the role physicians are to play in requests for PAS. It says that physicians are to determine if the patient requesting PAS has a terminal disease and if the

patient is competent. These are both medical judgments. In order to make them, a physician does not need to make any judgments about “fundamental philosophical and religious matters” pertaining to the meaning of life. The physician is not asked to decide for the patient whether or not life is worth living. The patient makes that decision for herself. Indeed, it is Kass, Pellegrino and Callahan who would take the decision about whether life is worth living out of the hands of the patient. For they are the ones who contend that suicide is always the morally inferior option. It is their view that passes a substantive “philosophical and religious” judgment on how one should cope with terminal disease. The Oregon law, by contrast, asks physicians to make two medical judgments, and then (if the patient meets the relevant criteria) to assist the patient in doing whatever the patient herself has decided about how best to cope with suffering and loss of control at the end of life.³

Of course, there may be some physicians who are personally morally opposed to all forms of suicide (just as there are some physicians who are personally morally opposed to abortion), and such physicians should have the option of refusing to participate in any requests for PAS. But there may also be some physicians who believe that an individual should be allowed to make up her own mind about how she wants her life to end, and those physicians’ participation in requests for PAS will consist entirely of their making medical judgments about individuals’ mental competence and life expectancy, and then facilitating the patient’s own decision.

The duty to promote health and the duty to reduce suffering

Kass, Pellegrino and Callahan go on to argue, however, that so long as the physician is knowingly involved in a process that leads to suicide, she is doing something wrong. For, according to Kass, Pellegrino and Callahan, to participate in such a process is to violate the essential moral duty of the medical profession: it is to violate the medical duty to promote health (Callahan, 2002: 58; Kass, 2002b: 20–21).

Kass, Pellegrino and Callahan are certainly correct in saying that physicians have a moral duty to promote health. But there is an obvious problem with claiming that trying to make patients healthy is a physician’s *only* moral duty. The problem is that people with terminal diseases cannot be made healthy. A physician cannot heal someone whose disease is lethal and untreatable. So if trying to make patients healthy were their *only* duty, physicians would have no role to play in the care of dying patients. It is clear, however, that physicians do have a role to play in the care of the dying. No one advocates that physicians are obligated by their professional ethic to abandon their patients upon making a terminal diagnosis. On the contrary, it is well recognized that physicians have especially pressing obligations to such patients’ care.

In caring for dying patients, one of a physician’s principal roles is to reduce suffering. When healing is no longer possible, the reduction of suffering takes center stage.

This duty to reduce the suffering of dying patients is limited in at least one crucial respect. If the dying patient is competent, then physicians should reduce her suffering only in ways to which the patient consents. This limitation on the duty to reduce suffering also applies to the physician’s duty to promote health. It is just as wrong for a physician to try to cure a competent patient by undertaking a course of action to which the patient does not agree as it is for a physician to try to reduce the suffering of a competent patient by undertaking a course of action to which the patient does not agree.

Kass, Pellegrino and Callahan acknowledge this role of the physician. They agree that a physician has a moral duty to help to reduce the suffering of a patient with a terminal disease. I presume they would also agree with the limitation on the duty to reduce pain that I

have described—that is, that they would agree that physicians should undertake courses of action to reduce the suffering of competent patients with terminal diseases only if the patients have consented to those courses of action. But Kass, Pellegrino and Callahan place another limitation on this duty as well. They argue that a physician’s duty to reduce the suffering of patients with terminal diseases can never include assistance in suicide.

So while the Oregon law implies that a physician’s duty to reduce the pain of competent patients with terminal diseases should be limited by the patient’s own wishes, Kass, Pellegrino and Callahan believe that this duty should also be limited by a prohibition on assisting in suicide. But why do they believe the additional limitation is warranted? Why do they believe that if a patient is competent and dying, her physician should not be allowed to help her reduce her suffering by suicide, if that is what she requests?

Kass argues that the second limitation on the duty to reduce suffering is warranted because it is impossible to benefit a patient by helping to bring about her death. Thus, the idea that we can make a patient better off by helping to kill must be morally incoherent. As Kass puts it, “‘Better off dead’ is logical nonsense—unless, of course, death is not death indeed but instead a gateway to a new and better life beyond. Despite loose talk to the contrary, it is in fact impossible to compare the goodness or badness of one’s existence with the goodness or badness of one’s ‘nonexistence,’ because it nonsensically requires treating ‘nonexistence’ as a condition one is nonetheless able to experience and enjoy . . . [T]o intend and to act for someone’s good requires that person’s continued existence for the benefit to be received . . . This must be the starting point in discussing all medical benefits: no benefit without a beneficiary” (Kass, 2002b: 34).

Kass claims, then, that it is logically impossible and morally incoherent to try to justify assisted suicide by saying that a person may be better off dead than alive. And perhaps there is some peculiarly literal reading of the words “person” and “better off” that makes Kass’s claim true. But there is nothing at all incoherent about a person’s preferring a state of affairs in which she is dead to a state of affairs in which she is alive. Throughout human history, many people have believed death is preferable to life under intolerable conditions. And some of the people who have acted on those preferences—people who have sacrificed their lives—have been deemed morally heroic. Even if we refrain from saying that these people are “better off” dead, we can still make perfect sense of the idea that they had morally impeccable reasons for their actions. But what of others who assisted those who sacrificed their lives? What should we say about those who have helped another person undertake a course of action that leads to her death? Again, we might refrain from saying that these others made the person who sacrificed her life “better off.” But that does not mean that what those others did is morally incoherent. If a person has morally impeccable reasons to sacrifice her life, then a person who helps her may have reasons that are equally morally impeccable. Just as assisting someone in carrying out the ultimate sacrifice can be morally coherent, so too may helping a dying patient carry out suicide be morally coherent. There is no logical barrier to justifying these courses of action in terms of the wishes and suffering of the person who will die as a result of them. A person who is dying may reasonably prefer to be dead rather than alive. Helping that person take a course of action that leads to her death can accord with the duty to respect the person’s autonomy and to reduce her suffering. The fact that the person will not be able to “experience and enjoy” the results of this course of action does not vitiate any attempted justification to help her. Indeed, Kass’s own attitude towards certain kinds of care at the end of life reveals that he himself believes that it may be right to help someone undertake a course of action even if she will not be able to “experience and enjoy” the results of it. For Kass believes that a physician may be right to undertake courses of action that will increase the likelihood of death (Kass, 2002b: 22 and 37).

But perhaps what Kass means to argue is that participating in PAS violates physicians' first duty of promoting health. It is not clear, however, that that duty *can* be violated when a patient has an incurable, terminal disease. If it is impossible to heal someone, it is difficult to see how the duty to heal her even applies. Physicians have the duty to try to heal patients who can be healed (and who want to be healed). But when a patient cannot be healed, the duty to reduce suffering (in concert with the patient's wishes) takes center stage. The duty to heal no longer seems to be in the picture.

The principle of double effect

Kass, Pellegrino and Callahan would probably object at this point that my conception of the duty to heal is illegitimately attenuated and isolated. That duty, Kass, Pellegrino and Callahan might say, stems from an even more fundamental duty—the duty to life itself. It is life itself to which physicians must always remain devoted. And this devotion must take precedence over all other considerations, even the attempt to reduce pain or accede to patients' requests.

The idea that physicians must always place morally conclusive value on life itself fits well with Kass, Pellegrino and Callahan's suggestion that all people ought "to live . . . for as long as they can." But this devotion to life seems *not* to fit with a practice that is common to the medical profession today—the practice of participating in the withdrawal of life-sustaining treatment, including food and water, which Kass, Pellegrino and Callahan all explicitly endorse (Kass, 2002b: 22; Pellegrino, 2002: 50–51; Callahan, 2002: 54). A physician who participates in the withdrawal of life-sustaining treatment undertakes a course of action that does not promote life itself. Such a physician is participating in a course of action that will lead to less life rather than more. So how do Kass, Pellegrino and Callahan justify physician participation in the withdrawal of life-sustaining treatment without committing themselves to the justifiability of assisted suicide? How do they fit the withdrawal of life-sustaining treatment into their conception of the moral role of physicians while at the same time keeping PAS out? They do so by deploying the principle of double effect. As Kass explains, "The well-established rule of medical ethics that governs this practice is known as the principle of double effect . . . It is morally licit to embrace a course of action that intends and serves a worthy goal (like relieving suffering), employing means that may have, as an unintended and undesired consequences, some harm or evil for the patient. Such cases are distinguished from the morally illicit efforts that indirectly 'relieve suffering' by deliberately providing a lethal dose of a drug and thus eliminating the sufferer" (Kass, 2002b: 37).

So the argument that the Oregon law conflicts with physicians' moral duty presupposes the principle of double effect. Indeed, the principle of double effects seems to be doing more work in this argument than the duty to heal or promote life. For Kass, Pellegrino and Callahan's endorsement of the withdrawal of life-sustaining treatment shows that they accept physician participation in courses of action that are intended neither to heal nor to promote life, which seems to imply (in contrast to some of their other comments) that they do not take the duty to heal or promote life to be always applicable to medical practice.

Now the principle of double effect is a general moral principle. It is not unique to the world of medical ethics. This is worth noting because opponents of the Oregon law sometimes contend that their arguments against PAS are based on the special moral status of physicians. Callahan, for instance, often relies on claims about the "purpose of medicine" or "medicine's role" (Callahan, 2002: 59) and Kass maintains that his "argument rests on understanding the special moral character of the medical profession

and the ethical obligations it entails” (Kass, 2002b: 17). If a person really understands the intrinsic moral character of medicine, opponents of the Oregon law suggest, she will never accept PAS. We now find, however, that their arguments against PAS depend on the principle of double effect. And a defense of that principle cannot be grounded in the “special moral character of the medical profession.” The anti-PAS position is based, in other words, not on the unique moral role of medicine but on a contentious non-medical moral principle.

This raises the question of whether there are in fact decisive grounds for accepting the principle of double effect. I myself think that the principle is extremely problematic. It relies on the drawing of a very sharp distinction between, on the one hand, the intentions and goals of all the physicians who engage in terminal sedation or withdraw food and water and, on the other hand, the intentions and goals of all the physicians who would prescribe a lethal dose of drugs. It seems to me, however, that there is no principled way of distinguishing the morally relevant features of the intentions and goals of these two groups of physicians, no non-question-begging reason to think that there is some feature of the actions of all those who would prescribe lethal doses that is inconsistent with the practice of medicine but is also absent from the actions of all those who engage in terminal sedation or withdraw food and water. Unfortunately, an extensive treatment of the principle of double effect is beyond the scope of this article. Note, however, that even if the principle is generally defensible, that on its own will not vindicate Kass, Pellegrino and Callahan’s argument against the Oregon law. For not all defensible moral principles ought to be enforced by law. Some moral questions are so difficult, profound or personal that the law rightly allows each person the opportunity to answer them for herself. If reasonable people can disagree about the soundness of a moral principle, the best public policy might be one that is neutral between a person’s living in accord with it or not. And it seems that the principle of double effect is something with which reasonable people can disagree. Indeed, the traditionally most influential defenses of the principle are based on religio-theological commitments. But such religio-theological commitments are not shared by every reasonable person, and they are not typically thought of as the basis for public policy in a secular society. At the very least, the opponents of PAS must give us reasons for believing not merely that the principle of double effect is philosophically defensible but also that it ought to shape our legislation concerning end-of-life decisions.

Kass’s claim that the principle of double effect is a “well-established rule of medical ethics” does not help to make the case. For not all medical ethicists or physicians agree that the essential moral duty of physicians implies that the principle of double effect should be used to forbid PAS. Miller, Brody and Quill, for instance, have argued that assisting in suicide can be entirely consistent with the integrity of the medical profession (see Quill, 1991; Miller & Brody, 1995; Quill *et al.*, 1997).

Moreover, when the principle of double effect is invoked in medical ethics, it is usually done so in the context of explaining the prohibition on PAS. To say that the principle of double effect is a “well-established rule of medical ethics” is to say little more than that physicians have traditionally been prohibited from assisting in suicide. But the pressing question is whether physicians *should* be prohibited from assisting in suicide. The fact that PAS has been prohibited in the past does not constitute an argument for continuing to prohibit it in the future.

But the greatest weakness of the attempt to use the principle of double effect to defeat the Oregon law is that the principle will imply the wrongness of PAS only on the assumption that it is bad that a person with a terminal disease die sooner rather than later. The only business the principle of double effect is in is telling us when it is permissible to perform an

action that has foreseeable bad consequences and when it is impermissible. If an action's consequences are not bad, the principle is completely inapplicable. Now the opponents of PAS believe that it is bad if a terminal patient dies sooner rather than later, and it is on the basis of the badness of such a death that they deploy the principle of double effect. But many proponents of PAS disagree, holding that in certain circumstances it is not bad if a terminal patient dies sooner rather than later. Of course, there is a great deal of dispute about which side is correct—about whether it is necessarily bad that a terminal patient dies sooner rather than later (this was one of the topics of the first part of this article). But unless that issue is resolved in their favor, opponents of PAS cannot use the principle of double effect to argue against the Oregon law. Even if the principle is generally philosophically defensible, and even if it should be enshrined in law (two big ifs), we still will not have reason to prohibit PAS unless there are also independent grounds for thinking that it is always bad for a terminal, competent patient to die sooner rather than later. The principle of double effect is downstream of the central justificatory question of whether it is bad that a terminal, competent patient commits suicide.

The final point I want to make about the principle of double effect is that it cannot be used to bolster another significant criticism of PAS that Kass, Pellegrino and Callahan present. This other criticism is that although it may seem as though the Oregon law leaves the decision of whether or not to request PAS entirely up to the patient, in fact the law leads her physician to make that decision for her. In theory, the Oregon law restricts the physician's role simply to medical judgments. But in practice (according to Kass, Pellegrino and Callahan's criticism), the physician's own values will pressure the patient into whatever decision finally gets made. The patient's thinking will be "easily and subtly manipulated" by the physician (Kass, 2002b: 24). The physician will exercise "subtle coercion" that will undermine "the patient autonomy that assisted suicide and euthanasia presume to protect" (Pellegrino, 2002: 48).

Now in claiming that the legalization of PAS will increase the chance of manipulation and coercion, Kass, Pellegrino and Callahan are making an essentially consequentialist argument.⁴ They are contending not that PAS is intrinsically morally wrong but that it will lead to morally unacceptable consequences. This consequentialist argument against PAS has to be taken very seriously. If it turns out that the Oregon law increases manipulation and coercion, then there will be at least one consequentialist but still extremely important reason to reject the law.

It seems to me, however, that the fact that physicians can ethically participate in the withdrawal of life-sustaining treatment gives us at least some reason for doubting that the legalization of PAS will necessarily lead to increased manipulation and coercion. For if allowing physicians to participate in the withdrawal of food and water does not necessarily increase manipulation and coercion, why think that allowing physicians to participate in PAS will do so? If it is possible for the option of withdrawing life-sustaining treatment to exist without an increase in manipulation and coercion, why should it not also be possible for the option of PAS to exist with an increase in manipulation and coercion?

We have seen, of course, that opponents of the Oregon law believe that there is an intrinsic moral difference between assisting in suicide and withdrawing life-support, a difference explained by the principle of double effect. But they cannot rely on that putative intrinsic difference when they are making the consequentialist argument that the Oregon law will lead physicians to manipulate and coerce patients into choosing PAS. For this consequentialist argument is based on claims about the real-world effects of the Oregon law. And we cannot determine what those effects will be simply through an examination of the morally contentious principle of double effect.

Conclusion

I have presented reasons for thinking that there is nothing intrinsically morally wrong with PAS as it is currently practiced in Oregon. In the first part of this article, I have tried to show that there are morally reasonable grounds to restrict PAS to individuals who are competent and have less than six months to live. In the second part, I have tried to show that participation in PAS does not necessarily violate physicians' professional integrity. The value of autonomy and physicians' duty to reduce the suffering of dying patients together imply that PAS can sometimes be a morally acceptable option.

Endnotes

- 1 Of course this distinction is far from sharp. For one thing, the combination of all of your little decisions does affect in a non-negligible way the shape of your overall life. For another thing, there are many decisions that fall somewhere between the big and the little, decisions that are not as momentous as deciding to get married but are nonetheless more important than deciding to eat the blue jello. There is a continuum between big decisions and little ones, not an absolute cut-off. Still, some decisions are clearly closer to one end of the continuum rather than the other, and we often find it natural and easy enough to draw such a distinction.
- 2 Showing that it might be morally acceptable for a person to commit suicide does not on its own show that it might be morally acceptable for someone else to assist in the suicide. There can be goals that are morally acceptable for me to pursue but that nonetheless it would be morally unacceptable for others to help me pursue. It is, for instance, morally acceptable for me to try to win a competitive sporting event but it is morally unacceptable for a referee to try to help me win. I believe, however, that the burden of proof lies with those who would argue that assistance is morally unacceptable. If a course of action is morally acceptable for me to pursue, then generally there will be no absolute moral reasons forbidding anyone else from helping me to pursue it (which is not to say that I necessarily have the *right* to demand assistance in the pursuit of my morally acceptable goal). Those who contend that it is morally unacceptable to assist someone in performing a morally acceptable act will need to explain the added moral feature that makes assistance unacceptable in that particular circumstance. In the case of a competitive sporting event, it is morally unacceptable for a referee to try to help me win because (as competitive sporting events are zero-sum games) it is unfair to the side against which I am competing.
- 3 So I disagree with Callahan in that I hold that allowing PAS is "socially neutral" on the question of whether "some suffering is meaningless and unnecessary" (Callahan, 2002: 57). A society that allows PAS, it seems to me, does not take a position on whether it is better or worse for a dying, competent person to commit suicide; such a society facilitates each person's making that decision for herself. Callahan, in contrast, bases his opposition to society's allowing PAS on a non-neutral view of the positive value of suffering (Callahan, 2002: 58–59).
- 4 Perhaps Kass, Pellegrino and Callahan would argue that it is misleading to say that worries about physician manipulation and coercion are entirely "consequentialist." For they may contend that the role physicians play in patient decision making would make it impossible for them *not* to exert undue pressure on patients for whom PAS is an option. But the claim that it would be impossible for physicians not to exert undue pressure depends upon a certain view of what is essential to the role of physicians, a view others

might not share (see, for example, Miller & Brody, 1995). That claim also seems to me to be contradicted by the fact that the possibility of the withdrawal of life-sustaining treatment does not necessarily produce undue pressure on patients.

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