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Author(s): Dan W. Brock

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A Critique of Three Objections to Physician-Assisted Suicide

Dan W. Brock

In June 1997 the U.S. Supreme Court reversed decisions in the Ninth and Second Federal Circuit Courts of Appeals that had held that state laws prohibiting physician-assisted suicide (PAS) in Washington and New York, respectively, were unconstitutional.¹ The decisions left states free to craft policy on PAS and to prohibit it, as most states now do, or to permit it under one or another regulatory system, as Oregon now does.² While I believe there is a plausible constitutional argument that can be, and was, made for a constitutionally protected liberty interest in determining “the time and manner of one’s death,” as the Ninth Federal Circuit Court’s opinion put it, the present Supreme Court has made clear that it does not accept any such broad right. Some commentators, as well as more than one of the justices, have interpreted the Court’s decision as leaving open the possibility of accepting a more narrowly framed right to physician-assisted suicide in the future, but for now the principal focus of efforts to secure such a right will return to the states, either through referenda or legislative action, where it had been before the two circuit court opinions.

There are several political and policy advantages to returning the issue to the public and to legislatures at the state level. First, any change in public policy to permit PAS will now occur much more gradually than it would have had the Supreme Court upheld one or both of the two federal circuit court opinions, thereby striking down prohibition of PAS in all states. For what many citizens and health professionals see as a radical and dangerous change in public policy that threatens the well-being and even the lives of many Americans, it is reasonable to use the “laboratory of the states,” introducing the practice into one or a few states at a time. If the practice has as bad consequences and unavoidable abuses as many of its opponents fear, a gradual introduction of the practice will limit their scope and enable the practice to be carefully studied, and its

1. *Compassion in Dying v. Washington*, 79 F.3d 790 (9th Cir. 1996) (en banc); *Quill v. Vacco*, 80 F.3d 716 (2d Cir. 1996); 117 S.Ct. 2258 (1997) and 117 S.Ct. 2293 (1997).

2. *Oregon Death with Dignity Act*, Or. Rev. Stat. 127.800–827 (1995).

abuses and harms identified. Possible changes in regulatory or other mechanisms that would reduce those harms and abuses then can be identified, or, instead, the prohibition of PAS can be restored.

Second, there is often a significant political cost in the Court's forcing a radical change on a highly divisive policy issue like PAS. While judicial review is clearly part of our overall democratic tradition, the Supreme Court is by intent the branch of government least subject to democratic control and accountability. When the Court forces radical change on such an issue, as it did, for example, with *Roe v. Wade* on abortion, its legitimacy to force such change is seriously questioned by many citizens.³ If the issue must be fought through legislative or referenda processes, the result is more likely to be accepted as the will of the majority and, to that extent, legitimate, even by those who oppose the change. Moreover, since public opinion polls have consistently shown that a majority of Americans favor terminally ill patients having access to assistance in dying from their physicians, it should be possible to win these changes over time through democratic processes. This is not to say, of course, that the courts should not protect unpopular or highly controversial constitutional rights of individuals—doing so is one of their central functions. Court review to uphold constitutional rights is intended to place a limit on democratic majorities and that is in part why I believe it should have upheld at least one of the two federal circuit court decisions. My point is only that there can be a heavy political cost in its playing this role, as the continuing deep social and political divisions over abortion make clear. Moving more slowly through more democratic processes can reduce that political and social cost.

Third, had the Court found that outright prohibition of PAS was not constitutionally permissible, it would, without doubt and correctly, still have found that the states have a legitimate interest in regulating the practice. The result would have been litigation extending not just over years, but probably over decades, about what regulation is compatible with individuals' constitutional right to PAS. Now well into the third decade since *Roe v. Wade*, such litigation is one reason why abortion remains such a prominent and divisive force in American politics. We have paid a heavy social and political cost for securing the right of women to safe and legal abortions. I should not be misunderstood on this point—in the case of abortion, that cost was clearly worth paying. In the case of PAS, where the right to refuse life-sustaining treatment effectively secures the right to determine the time and manner of one's death for most patients, the cost of not upholding a right to PAS is much less than the cost to women of not securing the right to abortion would have been. A calculus of the social costs of upholding constitutional rights is not, of course, the proper basis for deciding whether there are such rights—I

3. *Roe v. Wade*, 410 U.S. 113 (1973).

mean only to note the lesser social and political costs of democratic legislation over judicial imposition on a deeply divisive issue of this sort. When the Court imposes a deeply controversial position, even when the position is supported by most citizens, one result can also be to undermine the legitimacy of the Court in the eyes of many citizens.

Fourth, if the right to PAS is a constitutionally protected right, it would be hard to restrict it to the class of persons to which even most of its supporters want to limit it. Most referenda and legislative proposals from supporters of PAS would limit it to terminally ill adults who are competent to make their own health care and other decisions. For decisions about life-sustaining treatment, the courts have consistently held since *Quinlan* that patients do not lose their rights when they become incompetent.⁴ Instead, surrogates, typically close family members, are entitled to decide for them, exercising so-called substituted judgment, that is, making the decision the patient would have made in the circumstances that obtain were the patient competent.⁵ Moreover, many court decisions have also made clear that the right to refuse life support is not restricted to terminally ill patients but is the right of all patients. If a constitutional right to PAS were grounded in the same fundamental rights and principles that ground the right to forgo life support, it would be difficult, if not impossible, to restrict the right to competent, terminally ill patients. Moreover, the reasoning that would ground a constitutional right to PAS, such as that of either the Ninth or Second Federal Circuit Courts, would likely support a right to voluntary-active euthanasia (VAE) as well, on the grounds that restricting the right to patients able to take the last physical action of using a lethal medication or other lethal process would impermissibly discriminate against patients unable to do so for themselves. But extending the right to PAS to patients who are not terminally ill and who are no longer competent, with decisions made either by advance directive or by a surrogate, and to VAE as well as PAS, would greatly enlarge the class of patients who might receive PAS or VAE and increase the risks that PAS or VAE was not what the patient would have wanted. Such a broadened practice would unquestionably have greater potential for abuse and would probably not be supported by a majority of the public. If there is no constitutional right to PAS, however, the states can permissibly extend PAS to some persons, for example, terminally ill and competent adult patients, but not to others, in making reasonable policy judgments about the risks and benefits of different alternative practices and policies.

In the foreseeable future the debate about PAS will be principally a moral and policy, not a constitutional, debate, and referenda or legisla-

4. *In re Quinlan*, 355 A.2d 647 (N.J.), cert. denied 429 U.S. 922 (1976).

5. Allen E. Buchanan and Dan W. Brock, *Deciding for Others: The Ethics of Surrogate Decision Making* (Cambridge: Cambridge University Press, 1989).

tive efforts will be at the state level. Though the Supreme Court's decision was a federal decision on the constitutional issue, it did signal what some of the central issues will continue to be in that debate. I believe the Court's reasoning, as well as that of many opponents of PAS, on several central issues, is either confused or unpersuasive, and I will try to establish that here for three of those issues. The Court had accepted in its *Cruzan* decision, at least for the purpose of addressing Missouri's procedural and evidentiary requirements for surrogate decision making, that there is a constitutionally protected liberty interest in deciding about and forgoing life-sustaining treatment.⁶ Moreover, in the two PAS cases, Rehnquist's majority opinions, as well as some of the concurring opinions, endorsed the treatment of patients' pain even when that would hasten the patient's death; indeed, one commentator has argued that the Court in effect endorsed a constitutional right to palliative care.⁷ The Court's endorsement of palliative care extended to the practice of some hospice programs known as terminal sedation, in which the patient is sedated to the point of unconsciousness when necessary to relieve his pain, and then treatments, including nutrition and hydration, are withheld causing the patient's death.⁸ Given these positions, a central part of the Court's task, as of opponents of PAS generally, was to distinguish PAS from forgoing life support and palliative care that hastens death. Each of these three objections to PAS on which I will concentrate concerns one central aspect of those distinctions. While the Court, of course, ultimately was making a constitutional argument, it appealed to moral distinctions and claims in doing so, and my concern here as well is with the moral issues, though I interpret these as including arguments about what would be morally justified public policy about PAS. Briefly, the objections of the Court and other opponents of PAS on which I will focus are three:

1. Forgoing life support is justified by the right to bodily integrity and against unwanted bodily invasion, whereas this right provides no justification for PAS.
2. PAS is morally wrong because it involves intending the patient's death, whereas, in forgoing life support and palliative care that hastens death, the patient's death is not intended.
3. The potential for abuse and other harmful consequences is much greater with PAS than with forgoing life support and palliative care that hastens death.

6. *Cruzan v. Missouri*, 497 U.S. 251 (1990).

7. Robert Burt, "The Supreme Court Speaks: Not Assisted Suicide but a Constitutional Right to Palliative Care," *New England Journal of Medicine* 337 (1997): 1234-36.

8. Timothy E. Quill, Bernard Lo, and Dan W. Brock, "Palliative Options of Last Resort: A Comparison of Voluntarily Stopping Eating and Drinking, Terminal Sedation, Physician-Assisted Suicide, and Voluntary Euthanasia," *Journal of the American Medical Association* 278 (1997): 2099-2104.

Of course, each of these claims is much more complex than this simple statement of them indicates, and their evaluation is hardly simple. But it is useful to state them initially in this simple unqualified form because that displays most directly their intuitive appeal. To succeed in the public and professional debate about public policy on PAS, supporters of PAS must succeed in undermining the considerable intuitive appeal that these three claims have to many people. That is what I shall attempt to do here.

THE RELATION BETWEEN FORGOING LIFE SUPPORT AND PHYSICIAN-ASSISTED SUICIDE

Most opponents of PAS, and even some of its supporters, consider it very different morally from forgoing life support.⁹ There is little controversy that competent patients are morally and legally entitled to decide about any life-sustaining treatment and to have it withheld or withdrawn if they choose. Surrogates of incompetent patients, likewise, are entitled to give or refuse consent for any life-sustaining treatment, though there is controversy about the scope of their discretion and the proper evidentiary requirements regarding the patient's wishes. When life support is forgone, the patient's imminent death is often as certain as it is from PAS, though, in other cases, whether the patient will survive without the treatment is uncertain. A common account of the underlying moral values that ground the consensus regarding patients' rights to refuse life support is that this right respects patients' self-determination or autonomy and reasonably supports patients' well-being.¹⁰ Here, I understand self-determination to consist in making important decisions about one's life for oneself and according to one's own values or conception of a good life. It is through the exercise of self-determination, and through the respect of it by others, that people take control over and responsibility for their lives. When competent patients make informed and voluntary decisions to refuse life support, those decisions will also typically be in accord with their own well-being. When patients are competent, they will

9. I will not, of course, pursue all the grounds on which commentators have sought to morally distinguish forgoing life support from PAS. Of those grounds that I shall set aside here, the most prominent is that PAS is killing, whereas forgoing life support is allowing to die. I have argued elsewhere both that the killing/allowing to die distinction does not map onto the PAS/forgoing-life-support distinction and that it is problematic whether killing is, in itself, morally worse than allowing to die. See my papers, "Voluntary Active Euthanasia," *Hastings Center Report* 22 (1992): 10–22, "Taking Human Life," *Ethics* 95 (1985): 851–65, "Death and Dying," in *Medical Ethics*, ed R. Veatch, 2d ed. (Boston: Jones & Bartlett, 1996). The literature and debate on this issue is voluminous.

10. President's Commission for the Study of Ethical Problems in Medicine and Biomedical and Behavioral Research, *Deciding to Forgo Life-Sustaining Treatment: A Report on the Ethical, Medical, and Legal Issues in Treatment Decisions* (Washington, D.C.: Government Printing Office, 1983).

have adequate capacities to understand the nature of the decision they face and to make a reasoned choice. When patients are informed, they will have available, typically from their physician, understandable information about the risks and benefits of different treatment alternatives, including the alternative of no treatment. When patients' choices are voluntary, they will be based on patients' own values, not coerced or manipulated to serve someone else's interests or someone else's view of what would be best for the patient. Together, these three standard requirements of informed consent and refusal ensure that the patient's decision regarding treatment reasonably promotes his or her well-being.¹¹

Some would challenge whether a decision to end one's life could ever forward one's well-being. Once a patient dies, the person he once was no longer exists with a well-being of any sort, and there could be no improvement in the patient's well-being from his death. But the consensus that has developed about patients' rights to refuse life support recognizes that patients' quality of life sometimes becomes so poor that they reasonably judge the best life possible for them with treatment to be worse than no further life at all. In those circumstances, although the patient's well-being is not improved by death, the patient's condition is a state worse than death, and, therefore, dying is not contrary to the patient's well-being. When patients' continued life is no longer a benefit to them but has become unwanted and a burden, these same values of patient self-determination and well-being can support PAS when a competent and informed patient freely asks for it. From this patient-centered perspective, the same underlying moral values of patient self-determination and well-being that ground the consensus about patients' rights to refuse life-sustaining treatment also support patients' access to PAS from a physician willing to provide it. From the patient's perspective, forgoing life support and PAS can each be means to the same end of the patient's death. Each is subsumed by the same moral and legal right that the Ninth Circuit Court endorsed, the right to determine the time and manner of one's death. Why, then, do forgoing life support and PAS seem to many people so different morally? There are two perspectives from which this question can be addressed—that of the patient and that of the physician.

In the next section of the article, I will pursue the role of intent in differentiating forgoing life support from PAS from the standpoint of the physician and what he or she does in each case. In this section, I will pursue why, from the perspective of the patient, despite the common, patient-centered values underlying the two practices, the right to refuse life support has seemed to many to be both different and weightier morally than any right to PAS. One central reason many would give is that I

11. Dan W. Brock, "Informed Consent," in *Health Care Ethics*, ed. D. VanDeVeer and T. Regan (Philadelphia: Temple University Press, 1987).

have mischaracterized the fundamental moral basis of the right to refuse treatment. When we formulate that basis correctly, we will see that it does not also lend support to PAS. The right to refuse life support, it is said, like the more general right not to be treated without one's informed consent, derives from the right of bodily integrity, that is, the right to be free from unwanted physical intrusions. It is this more narrow right to bodily integrity, not a broad right to determine the time and manner of one's death, or an even broader right to self-determination, that is the moral and legal basis of the right to refuse life support. This right to bodily integrity would be violated if patients' rights to refuse treatment were not respected and physicians were to impose treatment on patients without their consent. By contrast, if physicians refuse their patients' request for PAS, then, as Frances Kamm has put it, physicians do nothing to the patients; patients are simply left alone and nothing unwanted is imposed on them.¹² Thus, the refusal to respect patients' rights to forgo life support would violate their right to bodily integrity, whereas the refusal to accede to their request for PAS does not violate that right but simply leaves patients as they were; in the former case, the violation of patients' bodily integrity would make them worse off, whereas, in the latter case, physicians' refusal of patients' requests for PAS makes the patients no worse off than if the physicians had never existed.

This first way of putting the appeal to bodily integrity also involves rejecting the appeal to self-determination to ground the right to refuse life support. However, a second version of the bodily integrity appeal grants that a right or interest in self-determination supports forgoing both life support and PAS, but adds that only respecting patients' decisions to forgo life support is supported by a second right to bodily integrity. Thus, forcing unwanted treatment on patients would do two wrongs, violate patients' rights to self-determination and rights to bodily integrity, whereas refusing patients' requests for PAS would do only one wrong, violate patients' rights to self-determination. Thus, even granting that self-determination supports patients' rights both to forgo life support and to PAS, they remain morally distinguishable, and this is reflected in the widely accepted absolute right to refuse life support, whereas even proponents of PAS defend only a more limited right to obtain PAS from a willing physician. This second version of the appeal to bodily integrity serves opponents of PAS less well than the first, since self-determination might be sufficient to ground a right to PAS even without the second appeal to bodily integrity.

An argument along the lines of the first version above of the appeal to bodily integrity was an important component of Rehnquist's majority opinions in the two PAS cases, and it is common in much thinking on

12. F. M. Kamm, "A Right to Choose Death? A Moral Argument for the Permissibility of Euthanasia and Physician-Assisted Suicide," *Boston Review* 22 (1997): 20–23.

these issues. Rehnquist specifically rejected the Ninth Federal Circuit Court's attempt to ground a right to "determine the time and manner of one's death" in the Supreme Court's earlier decision in *Casey* which endorsed a right of individuals to make their own decisions about matters "involving the most intimate and personal choices a person may make in a lifetime."¹³ Rehnquist argued that the Supreme Court's decision in *Cruzan* did not ground the right to refuse medical treatment in any general right to personal autonomy, which might then be argued to include the Ninth Circuit's right to determine the time and manner of one's death. Instead, the right to refuse life support articulated in *Cruzan* was derived from the narrower right to physical integrity, which implies no general right to determine the time and manner of one's death, nor specific right to PAS. Rehnquist argued that it was a mistake to take the argument in *Casey* as showing that because a number of liberty interests that are constitutionally protected could be brought under a general interest in personal autonomy, then any liberty derivable from personal autonomy is likewise constitutionally protected.

I want to challenge both versions of the appeal to bodily integrity to distinguish a right to refuse life support from a right to secure PAS from a willing physician. The claim that not respecting a refusal of treatment involves forcing an unwanted physical intrusion on the patient, whereas not respecting a supposed right to PAS only leaves the patient alone and forces nothing on the patient, is misleading. If a physician leaves a patient alone who wants life support withdrawn or wants PAS and needs it to end her life, the physician in each case forces the patient to continue to endure an existence that the patient finds intolerable and that the physician could enable the patient to avoid. If the state by law forbids a willing physician to withdraw life support or to provide PAS to a patient who wants it, the state likewise forces the patient to endure an existence the patient finds intolerable. Just as with PAS, in those cases of refusal of life support in which doing so is the patient's means to bring about a wanted death, what the patient wants to avoid, and what would be forced on her if her right to refuse life support were not respected, is also an existence the patient finds intolerable. But there are two deeper reasons for doubting whether the right to refuse life-sustaining treatment can be grounded in either of the two versions distinguished above of the appeal to a right to bodily integrity. First, I suggest there is no independent moral right to bodily integrity; that right is itself grounded in an appeal to self-determination. If this is correct, then the first version of the appeal to bodily integrity will fail because rejecting the appeal to self-determination rejects the very basis of any right to bodily integrity. Moreover, bodily integrity is properly understood not as a second right in addition to a right to self-determination, making two wrongs when refusals

13. *Planned Parenthood v. Casey*, 506 U.S. 833 (1992).

of life support are not respected, but as a consideration bearing on the relative moral importance of the appeal to self-determination in the case of refusals of life support. Second, I argue that the right to bodily integrity cannot be the moral basis for the right to refuse life support because the latter right is just as strong when bodily integrity would not be violated by imposing treatment.

I turn to the first of these two reasons for doubting the appeal to bodily integrity as the basis for the right to refuse life support. It is not obvious on its face and without argument that there is an independent moral, or perhaps even legal, right to bodily integrity and, in particular, to be free from unwanted physical intrusions. How might we explain and justify that right? The most natural explanation is that our morality and laws take seriously the distinction between individual persons and the right of each person to have substantial control over and responsibility for what happens to him or her. Since persons are embodied individuals, and anything that happens to our bodies happens to us, one important component of this personal control concerns what is done to our bodies. If we own anything, it has been said, we own our bodies, though our relationship to our bodies is even closer than that of ownership, which assumes a distinction between the owner and what is owned. Thus, if individuals should have significant control over their lives and what is done to them, this should include what is done to their bodies. The idea is that individuals should have a protected sphere of control or sovereignty in which they cannot be interfered with without their consent, and that control over what is done to one's body is a core of that sphere.

If something like this is the moral basis for a right to bodily integrity, then that right does turn out to be grounded in a broader right of self-determination or personal autonomy. This means that it is inconsistent to appeal to the right to bodily integrity while rejecting its moral basis in self-determination, as the first version of the argument I distinguished above does, and also that other liberties equally well grounded in personal autonomy should have comparable moral importance. This is not to say that every decision that might be subsumed under a right to self-determination or personal autonomy has equal moral importance and equal claim to protection from interference by others. There are at least three bases relevant to forgoing life support and to PAS for according differential moral importance to different exercises of personal autonomy and choices about one's life.

First, we distinguish personal choices generally, just as we distinguish choices regarding medical care in particular, according to whether they are made by a competent or incompetent individual, that is, an individual with or without decision-making capacities.¹⁴ The autonomy of young children to make significant choices is not respected because they

14. Buchanan and Brock, chap. 2.

lack the requisite decision-making capacities that would warrant respecting their choices. Likewise, the effects of disease and other conditions can erode or destroy the decision-making capacities of previously competent adults. The restriction of PAS to competent adults reserves it to the sphere in which we do respect individuals' autonomy, just as decisions by competent patients to forgo life support are commonly thought to be more morally binding than are decisions by surrogates for incompetent patients to do so.

Second, even for competent persons, not every decision about their lives is of equal significance. Some decisions, such as whom to marry, whether to have children, or what career to pursue have deep and far-reaching impact, while others, such as what to have for lunch or whether to drive or walk to work, are of transitory and little significance. The deeper and more far-reaching the impact of a decision on the course and nature of one's life, the stronger its claim to be respected on grounds of personal autonomy. The appeal to bodily integrity can be understood as signaling a significant physical effect of an action on an individual, and hence the relative importance of personal autonomy regarding that action; this is quite different from its signaling a second independent moral right. When and how a person's life ends determines the conclusion to his or her biography, the end to the particular course that the life has taken, and we want the end of our lives to fit, and be fitting to, what has gone before. The common talk of "death with dignity" signals the importance to most people of their lives ending in a manner consistent with how they have sought to live their lives, with the dignity they have brought to the rest of their lives. The assistance of others, either in forgoing life support or in assisting in suicide, can sometimes be necessary to avoid a death that would degrade and stain the life that came before it.

Third, a person's decisions have a weaker claim to being respected and not interfered with on grounds of personal autonomy, the more substantial the impact of those decisions on the legitimate interests and rights of others. Our lives typically are deeply intertwined with those of others, and so our deaths in turn typically deeply affect others. But the deepest impact of people's death on others who love them is usually the loss of the loved one him or herself, and neither prohibiting PAS nor denying patients' control over life support can prevent the ultimate death and loss of loved ones. When loved ones are deeply negatively affected by how someone dies, not just that they died, it is typically because the process of dying is hard and bad for the one who died, an affront to the life it ended. Both forgoing life support and PAS, however, do not create, but are typically sought to avoid, such a death. The effects on loved ones of a patient's decision to forgo life support or to employ assisted suicide are likely to be positive, not negative, bringing a release to the patient from intolerable suffering, though PAS's illegality has made it hard to gather data on this point. In each case, then, these three factors

that give greater or lesser weight to particular exercises of personal autonomy support giving substantial weight to respecting a dying patient's choice either to forgo life support or to employ PAS.

The second reason to doubt whether a person's moral right to refuse life-sustaining treatment is grounded at the deepest level by a right to bodily integrity can be seen by imagining treatments that do not invade bodily integrity, and so whose resulting imposition on patients would not involve forced physical intrusion on the patient. Consider three examples. First, in some cultures with radically different beliefs about the causes of illness than those of modern Western medicine, illness is seen as a sign of bad spiritual forces affecting the ill person. The "treatment" then needs to be a sacrifice or spiritual ritual, performed by the ill person or by others, that need not involve a physical intrusion. Assume that these treatments worked, in the sense that they prevented the deaths of persons with otherwise life-threatening illness, but that they left the ill persons with limitations on the quality of their lives comparable to those from more familiar physically intrusive life-sustaining treatments, like renal dialysis or respirator support. And assume that these spiritual treatments have risks, together with their prospects for extending lives, similar to our physically intrusive life-sustaining treatments. The idea is that these spiritual treatments have benefits and risks, together with impacts on quality of life, comparable to our more familiar physically intrusive life-sustaining treatments. For example, a patient with end-stage renal disease experienced regular periods during which his ability to move about was limited comparably to that of a person undergoing hemodialysis (i.e., for a similar number of hours on a similar number of days, he lacked the energy to move about). We can even imagine that, comparable to typical anxiety about being physically violated from a medical treatment, the patient experiences anxiety about being "spiritually violated" from the spiritual treatment. The only significant difference between our familiar medical treatments and these spiritual treatments is that the medical treatments are physically intrusive; whatever undesirable effects the physical intrusions have on patients' quality of life is matched by comparable undesirable effects from the spiritual treatments.

Second, sometimes treatment of a patient's condition involves no physical intrusions or ingestions of any substances but, instead, only a restriction on activities, for example, a condition requiring protracted bed rest. Such treatment involves no intrusion or violation of bodily integrity but instead restricts the patient's freedom to move about and to engage in his or her usual activities. For example, suppose a life-threatening heart condition required the patient to give up any activities that involved significant physical exertions; this is the treatment, or a part of the treatment, for the patient's heart condition that keeps it from threatening his or her life.

Third, suppose a treatment, whether curative or preventive, requires changes in the patient's environment instead of physically intrusive changes to the patient's body; instead of surgery or medications, the patient must be protected from contact with organisms or substances present in the normal environment. A real-world example was the so-called bubble boy in Texas some years ago with a severely compromised immune system who had to remain in a protective chamber that isolated him from the normal environment. The restrictions of his treatment were comparable to those imposed by many life-sustaining treatments, although they were not physically intrusive. We can even imagine less restrictive environmental interventions (e.g., a portable bubble) where the patient's disease still leaves him or her with an extremely poor quality of life, comparable to that of many patients who refuse more familiar physically intrusive life-sustaining treatments.¹⁵

It might be objected that all of these treatments are physically intrusive. To take the example of spiritual treatments, if those treatments work and have risks and burdens, they must affect the diseases and physical conditions of patients. But if they affect the internal physical condition of the human body, they must be physically intrusive and, therefore, must violate bodily integrity. Now it is correct, of course, that these spiritual treatments must have physical effects on the body, but their doing so is not sufficient to violate bodily integrity except on an implausibly broad notion of bodily integrity. If I speak to you or move across your field of vision, I create physical changes in your brain, but I do not violate or even affect your bodily integrity. Even if hearing me speak or seeing me risks so upsetting you as to cause you physical harm, I do not violate your bodily integrity. The notion of physical or bodily integrity is not a precise one—open-heart surgery affects it; radiation treatment to reduce a tumor affects it, although it does not “break the skin”; merely taking an x-ray probably does not affect bodily integrity (although it may violate privacy if done without consent); but passing across someone's field of vision does not affect bodily integrity. The mere fact that a spiritual treatment, such as offering a sacrifice or performing a ritual for an ill person, must have physical effects to be effective or might carry risks or burdens for the ill person, is no reason to believe that it affects or violates bodily integrity.

Is there any reason to believe that patients would not have a right to decide about and to refuse any of these three non-physically intrusive life-sustaining treatments? Is there any reason to believe that patients would not have just as strong a right to decide about these life-sustaining

15. Jerry Dworkin has suggested to me the example of a person who would die from exposure to the sun's rays and is protected by an electromagnetic shield that has no effect on the person. Withdrawing the protective shield or treatment, not imposing it, would result in a harmful physical intrusion on the patient of the sun's rays.

treatments as about physically intrusive medical life-sustaining treatments? Finally, is there any reason to believe that the ground of each right is not essentially the same—that individuals' personal autonomy or self-determination entitles them to decide about undertaking a treatment with particular benefits and risks, and about whether the best life possible for them with the treatment is sufficiently poor to be worse than no further life at all? I believe the answer to each of these three questions is no. The fundamental moral ground of the right to decide about and to refuse life-sustaining treatment is not physical integrity but, rather, personal autonomy or self-determination, specifically regarding how and when one either dies or has one's life sustained. And this ground typically applies equally to PAS as to forgoing life-sustaining treatment.

DOES INTENT MORALLY DISTINGUISH FORGOING LIFE SUPPORT FROM PAS?

Many opponents of PAS, including many medical and health professionals, cite the difference in intent as the fundamental moral difference between forgoing life support and PAS. In withholding or withdrawing life support, the physician's intent, it is said, is to respect the patient's wishes and the patient's right to give or refuse consent to treatment; the physician does not intend the patient's death. Whereas, in PAS, opponents argue, the physician intends the patient's death, and that is held to be morally impermissible, or at least incompatible with the norms and goals of the medical profession. It is controversial whether intent has the moral weight supposed by this line of reasoning, and I shall briefly suggest at the end of this section an alternative account of the moral permissibility of, and responsibility for, taking life that does not rely on intent.¹⁶ But first I want to assume that opponents of PAS are correct in stating that intent has the moral importance they suppose and then pursue whether it can be used to distinguish PAS from other morally acceptable actions that hasten death in medicine.

Even most supporters of the moral importance of intent grant that no fully adequate theoretical account of the distinction has been offered; I rely on cases in which what is or is not intended is not controversial, although it will not always be possible to do so.¹⁷ Nevertheless, a few brief points about the nature of intent are needed. Proponents of the moral importance of intent, for example, as it functions in the doctrine of double effect, typically distinguish the end that an agent seeks to bring about and the means taken to that end, from the foreseen but unin-

16. Timothy E. Quill, Rebecca Dresser, and Dan W. Brock, "The Rule of Double Effect: A Critique of Its Role in End of Life Decision Making," *New England Journal of Medicine* 337 (1997): 1768–71.

17. Charles Fried, *Right and Wrong* (Cambridge, Mass.: Harvard University Press, 1978); Thomas Nagel, *The View from Nowhere* (New York: Oxford University Press, 1986).

tended consequences of the particular means taken to reach a particular end.¹⁸ The end and the means together are what an agent intends, and these are both distinguished from the foreseen but unintended consequences of what the agent does. Very roughly, an agent's end can be determined by a counterfactual test—it is what the agent aims at, seeks in acting to bring about, and would be disposed, other things being equal, to take further steps to bring about if it were not attained. The means are what an agent does because he believes them to be causally necessary or sufficient on the particular causal path taken to achieve his end. The foreseen but unintended consequences are those consequences that the agent foresees will (are likely to/might) occur as a result of what he does to achieve his end but that do not causally contribute to achieving the end. Much unresolved complexity lurks in these distinctions, both theoretical complexity in the analysis of the distinctions, together with practical complexity and uncertainty about how to apply them in particular cases. However, as already noted, I hope to restrict my discussion largely to applications of the distinctions which are not controversial. Can intent morally distinguish forgoing life support from PAS?

First, consider decisions by patients, carried out by their physicians, to withhold or withdraw life support. In some cases, the patient's intent may be only to avoid an unacceptably burdensome treatment, hoping that she will be able to continue to live without it; she does not intend her death. But in other cases, the patient's intent may be to die because her suffering and life have become intolerable to her. The means she takes to this end is to have her life support withdrawn. Some patients are quite explicit about their intent to die—they want life support withdrawn because they are ready and want to die. But, interestingly, few people who hold that it is impermissible to intend death argue that the patient's decision is morally wrong in this latter kind of case, or that, consequently, it need not be respected. Public policy is clear that patients are entitled to refuse life support, whether or not they intend their own death in doing so.

The debate about PAS and intending death, however, usually focuses on the permissibility of the physician's intending the patient's death. What is the physician's intent who respects her patient's decision to forgo life support? Whether or not the patient intends her own death, the physician's intended end may be only to respect her patient's wishes and her patient's right to decide about treatment; withholding or with-

18. Joseph M. Boyle, "Toward Understanding the Principle of Double Effect," *Ethics* 90 (1980): 527–38; Philippa Foot, "The Problem of Abortion and the Doctrine of Double Effect," in her *Virtues and Vices* (Berkeley: University of California Press, 1978), pp. 19–32; Warren S. Quinn, "Actions, Intentions, and Consequences: The Doctrine of Double Effect," *Philosophy and Public Affairs* 18 (1989): 334–51; also see the issue of the *Journal of Medicine and Philosophy*, vol. 16, no. 5 (October 1991), devoted entirely to papers on double effect.

drawing treatment is her means to that end. Her patient's death is not intended but is only the foreseen and unintended consequence of respecting her patient's wishes by removing treatment. But, in other cases of forgoing life support, physicians sometimes do intend their patients' death. Intentions are often complex, and people can have multiple intentions in performing a particular action. For example, you might offer to give a friend a ride home after work with the intent of paying back a favor you owe her, having some company for the trip, and getting some information from her about a mutual acquaintance; all three aims are part of your intended end in offering the ride.

Likewise, a physician's intentions may be complex when she complies with her patient's decision to stop life support—she may not only intend to respect her patient's wishes but also intend her patient's death because she believes that removal of life support will provide an easier and more dignified death than her patient would otherwise have and so is in her patient's interest. In one survey of physicians, 39 percent said that the patient's death was one of their intentions in sedating patients while withholding or withdrawing life support.¹⁹ Notice that the physician who withholds or withdraws life support can intend her patient's death, believing, for example, that this will provide her patient with a better death than the patient would otherwise have, whether or not the patient herself also intends her own death. Thus, if it is always morally impermissible for physicians to intend their patients' death, then physicians withholding or withdrawing patients' life support is often morally impermissible. Yet there is little controversy, moral or legal, that physicians may, indeed must, respect and carry out their patients' decisions to forgo treatment. There should be equally little controversy that it cannot always be morally impermissible for physicians to intend their patients' death.

In assessing the moral permissibility of physicians intending their patients' death, we need to consider another form of hastening death in which intent is commonly thought to play a crucial role—giving medications, usually morphine, to relieve patients' pain in doses that also risk hastening their death. It is here that the doctrine of double effect has had its most prominent application in end-of-life care. Sometimes, the dosages of pain medications necessary to relieve adequately a patient's pain, especially patients in the end stages of some forms of cancer, must be raised to levels increasingly likely to cause respiratory depression resulting in the patient's death. Supporters of double effect argue that the physician's intention is only to relieve the patient's pain by administering necessary dosages of pain medications, foreseeing but not intending that

19. W. C. Wilson, N. G. Smedira, C. Fink, et al., "Ordering and Administration of Sedatives and Analgesics during the Withholding and Withdrawal of Life Support from Critically Ill Patients," *Journal of the American Medical Association* 267 (1992): 949–53.

this may hasten the patient's death. Likewise, the patient who requests these pain medications intends only the relief of his pain, not an earlier death. Both the physician and the patient, however, are prepared to assume the risk of an earlier death, if necessary to relieve the patient's pain, if the earlier death is seen as a lesser evil than the untreated pain.

But here, too, just as with decisions to forgo life-sustaining treatment, matters are not always so simple. When increasingly large doses of morphine are administered to relieve the pain of dying patients, neither the physician nor the patient need view the earlier death as an evil; one or both may and sometimes do view it as in the patient's interest and hope that it occurs. Do they then intend the earlier death as well as the pain relief? An argument that they do not relies on the connection between what one intends and what one is committed to bringing about. If an earlier death was also an intended end of the administration of morphine, physicians would, if necessary, continue increasing the dosage even after pain had been adequately relieved until respiratory depression and death occurred. Since they generally do not do this, so the argument goes, earlier death is not one of their intentions. But this objection is indecisive. The physician may hope and intend that the patient dies from the administration of morphine necessary to relieve the patient's pain but be unwilling to increase the dosage beyond that level if death does not occur, because the law does not permit doing so, and because he is unwilling to risk civil or criminal legal sanctions to achieve his end of the patient's death. The patient, too, may hope and intend to die from the administration of the morphine but not want more than is necessary to relieve his pain because he does not want to put his physician at legal risk in order to achieve his death. Both the physician and patient may aim at and intend the patient's death, as well as the relief of the patient's pain, when morphine is administered at levels necessary to relieve the patient's pain. Thus, when medications used to relieve pain also hasten death, a context in which the doctrine of double effect has traditionally been thought to have its most secure home in the care of dying patients, and if intending death is never morally permissible, then in those cases in which physicians intend both relief of pain and death, their actions must be condemned. As with forgoing life support, the widespread consensus that, with the patient's consent, administering adequate pain medication is always morally permissible, even when it risks hastening death, is incompatible with the view that intending the patient's death is never morally permissible. Before turning to the question of intentions and PAS, it is worth briefly taking up one other form of end-of-life care.

Terminal sedation is the practice used in some hospice care programs for patients whose pain has proved recalcitrant to standard measures of pain control. Here, the patient is sedated to the point of unconsciousness when necessary to relieve pain, and then other medications

and treatments, usually including nutrition and hydration, are withheld until the patient dies. This practice is generally considered legally permissible since each of its two components, the administration of medications necessary to relieve pain together with the withholding or withdrawing of life-sustaining treatments, are widely agreed to be, with the patient's consent, morally permissible. Yet it is not plausible to claim that the patient's death is not intended in terminal sedation. Perhaps death is not intended when the patient is sedated to unconsciousness, but once that has been done it is hard to see why all treatments, including nutrition and hydration, are withdrawn, unless the intent is to produce death. Once the patient is unconscious, neither treatment nor the patient's condition can result in suffering or burdens to the patient any longer. The only reason for withdrawing treatment at that point appears to be to cause the patient's death. Once again, intending the patient's death is within the accepted practice of medicine and the care of dying patients.

Finally, I turn to the role of intentions in PAS. When patients use means provided by their physician to end their lives, for example, lethal doses of barbiturates or other medications, they do intend their own deaths. Whether death is their intended end because further life has become unwanted, or death is the means taken to avoid intolerable suffering, death is intended by the patient. Studies have shown that patients who seek PAS have a variety of motives for doing so, most commonly a desire not to be a burden to others, fears of loss of independence, and poor quality of life, but, in all these cases, their own death is intended.²⁰ I exclude here "suicidal gestures" in which the intent is thought not to be to end one's life but to seek help for one's condition; these are likely to be much less frequent in PAS than in other suicide attempts.

What are the intentions of physicians who furnish patients who request them with the means to end their lives? Do they always intend their patients' deaths? This question is more difficult than it first may appear. Without question, often physicians may provide means for PAS to their patients, intending that they be used by their patients to end their own lives because they believe that their patients' desires to die should be respected and/or that an earlier death by this means is in their patients' interests. I have already noted that people may have multiple intentions in performing an action and that, in particular, physicians may have multiple intentions in caring for their dying patients. When physicians provide their patients with the means to commit PAS, they may have other intentions besides the patients' death: they may intend to relieve patients' anxieties about having to suffer intolerable pain at the end of life;

20. Anthony L. Bach, Jeffrey I. Wallace, Helene E. Starks, and Robert A. Pearlman, "Physician-Assisted Suicide and Euthanasia in Washington State," *Journal of the American Medical Association* 275 (1996): 919–25.

to give patients choice and a greater feeling of control about when and how they will die; to prevent premature forgoing of life support by patients fearful they will later lose control over their dying, and so forth.²¹

Do physicians, nevertheless, always also intend their patients' deaths when they give them the means to commit PAS? Contrary to what might at first be thought, I believe the answer is no. Suppose a physician gives a prescription for enough sleeping pills to be lethal to a patient who has requested them to commit PAS. The physician may firmly hope and believe that the patient will not fill the prescription and use it to end her life but, instead, will only have her anxiety relieved about losing control over her dying by having the prescription or pills in her possession. Whether or not the physician's belief is correct about whether the patient will use the means, should we say that the physician intends them to be used to end the patient's life? The fact that the physician acknowledges that there is a chance that the patient will use them to end her life seems insufficient to establish that the physician intends that they be so used.

To see this, suppose an adolescent asks his parents for money that he can use to take a very dangerous trip that he knows they oppose because of the dangers. His parents know it is very important to him that they show him that they believe he has sufficient maturity to make this decision for himself and that they will support his decision. They hope and believe, however, that if they do so, he will in the end decide on his own that the trip is too dangerous and not take it. They give him a check as a sign of their support but urge him not to go, hoping and believing that he will decide not to go. Do they intend that he take the trip? They do intend to show him that they respect his maturity and will support his decision, but, whether or not he decides to go, they do not intend that he take the trip, despite having provided him the means to do so. They recognize that there is a chance that he will use the means they have given him—the check—to take the trip, but they do not intend that he do so. Or consider a physician who releases a patient who has been involuntarily hospitalized for suicidal depression, believing that the patient now is no longer at serious risk for suicide, though recognizing that there is still some chance that the patient will commit suicide after being released. If the physician turns out to be mistaken in her judgment and the patient does commit suicide once released from the hospital, no one would then claim that the physician intended that the patient commit suicide, despite the fact that she gave the patient the means—release from the hospital—to do so. So there will be some cases in which a physician may provide a patient with the requested means for PAS, but still not intend that they be used and not intend the patient's death, whether or not the patient in fact uses them to commit suicide.

21. Timothy E. Quill, "The Ambiguity of Clinical Intentions," *New England Journal of Medicine* 329 (1993): 1039–40.

What can we conclude about physicians intending their patients' death in end-of-life care? First, even if it is always wrong for physicians to intend their patients' death, it does not follow that their giving patients the means to end their lives is always wrong, since physicians need not always intend the patient's death when they do so. Second, if it is always morally wrong for physicians to intend their patients' death, then we have seen that some cases of forgoing life support and of relieving pain when it risks hastening death, as well as probably all cases of terminal sedation, are morally wrong. But I do not believe that most opponents of PAS will accept that conclusion, nor do I believe they should. While I cannot pursue the general question in any detail here, the view that intending death is always wrong, while foreseeing but not intending it can be morally permissible, constitutes a problematic and, in my view, mistaken account of the morality of taking life and of the responsibility for doing so. As in other areas of medicine, physicians are morally responsible for both the intended and the foreseen but unintended consequences of what they do. Death is not always an evil for dying patients and intending it is not always morally impermissible. Instead, on the alternative view I favor, intending death is wrong when it violates a patient's right not to be killed; this view gives central importance to the patient's consent, which the doctrine of double effect that focuses on the physician's intentions ignores. In each of the kinds of cases of intending the patient's death by physicians that I have considered in this section, it is the competent patient's assessment of the benefits and burdens of alternatives which grounds his or her free and informed consent to what the physician does that makes the physician's action not a violation of the patient's right not to be killed and, therefore, morally permissible, not whether the death is intended.

DOES THE POTENTIAL FOR ABUSE MORALLY DISTINGUISH FORGOING LIFE SUPPORT FROM PAS?

The potential for abuse of a legally permitted practice of PAS is probably the most serious concern of many, if not most, opponents of PAS, and it certainly played a significant role in the reasoning of the majority opinion, as well as some of the concurring opinions, in the Supreme Court decisions about PAS. Some versions of this concern invoke the familiar slippery slope argument that proposals for legalizing PAS are only the first step in what would be an ever-expanding practice of killing patients, a practice that would move far beyond justifiable bounds. There are both empirical and moral issues in the assessment of this argument against PAS. One empirical issue is the degree to which safeguards surrounding a practice of PAS would limit unjustified use of it. A second empirical issue is the likelihood that the practice would be unjustifiably expanded over time, for example, as a result of a weakening of respect for human life, to permit PAS in circumstances in which we now believe it would be

wrong. A third empirical issue is whether or not the practice of PAS would be more likely to be abused than the currently accepted practice permitting forgoing of life support.

There are two central moral issues in the assessment of the potential for abuse. The first asks which cases of PAS would be morally justified and which would be morally wrong and count as abuses. The second is the degree of importance or seriousness of both the good and bad consequences of different public policies regarding PAS. All policy options regarding PAS and other forms of end-of-life decision making and care have both good and bad consequences, and the evaluation of any policy option requires assessing the relative moral importance of both.

These empirical and moral issues with bearing on the potential for abuse of different policy options regarding PAS are uncertain and controversial. There are no direct data on the first two empirical issues and the only related case from which inferences are often drawn regarding likely experience in the United States—the experience over the last decade or so in the Netherlands, where PAS and VAE, though not strictly legal, are legally tolerated under certain conditions—is itself highly controversial.²² The third empirical issue is difficult as well, despite the fact that a legally permissible practice of forgoing life support exists in the United States, since there are no systematic studies of which I am aware that focus on abuses in decisions to forgo life support; abuses would be difficult to study in any event, since they would generally be illegal behaviors which there would be strong incentives to hide, although anonymous surveys could avoid this difficulty to some extent. Regarding the two moral issues, plainly there is widespread and deep moral disagreement both about which cases, if any, would be justified and which would constitute abuses, and even more disagreement about the relative moral importance or seriousness of the various good and bad consequences of different policy options. All this means that the objection to permitting PAS because of its potential for abuse cannot be decisively settled, but I believe there are nevertheless strong reasons to be skeptical about it and in particular, to be skeptical that PAS would be more easily and seriously abused than forgoing life support.

Consider first the fundamental, though rarely articulated, assumption underlying the potential-for-abuse objection to PAS. That assumption is that the practices with limited potential for abuse are the forgoing of life support, pain relief that hastens death, and, perhaps, terminal sedation, whether the decisions are made by competent patients or the surrogates of incompetent patients; whereas the potential for abuse is

22. Paul F. VanDerMaas, Gerrit VanDerWal, Ilinka Haverkate, et al., "Euthanasia, Physician-Assisted Suicide, and Other Medical Practices Involving the End of Life in the Netherlands, 1990–95," *New England Journal of Medicine* 335 (1996): 1699–1705.

much greater with PAS and even greater with VAE. As already noted, determining which cases to count as abuses is itself controversial, but the importance widely accorded to informed consent and advance directives, at least in the case of forgoing life support, pain relief that hastens death, and terminal sedation, suggests wide agreement that decisions should follow the patient's wishes; decisions which conflict with what patients do or would want are abuses. The same standard is implicit in the potential abuses typically cited by opponents of PAS, which are subtle or unsubtle pressures for PAS that the patient does not or would not want. If this is roughly the correct standard for what constitutes abuses, then even in the absence of data there is strong reason to believe that the common assumption about which practices are most subject to abuse is mistaken. Instead, the important distinction for the potential for abuse is between those practices in which the competent patient makes the decision for him or herself and other practices in which the patient is incompetent and someone else must decide for the patient. A number of studies have documented that neither physicians nor family members can reliably predict patients' preferences regarding end-of-life care in the absence of explicit and specific discussion with the patient.²³ Even when surrogate decision makers attempt only to determine what the patient would have wanted, they will often fail to do so correctly. Moreover, when surrogate decision makers have conflicts between their own interests or desires, or the interests or desires of others about whom they care, and those of the patient, we can expect further conflicts between their decisions and what the patients for whom they are acting would have wanted. This supports a strong presumption that the point at which the potential for abuse increases substantially in end-of-life care decisions is when surrogate decision makers must decide for incompetent patients instead of competent patients deciding for themselves. And, of course, this means, in turn, that PAS (and even VAE) are among the end-of-life decisions and practices less subject to abuse than are decisions by surrogates for incompetent patients to forgo life support, use pain relief that may hasten death, or employ terminal sedation. But are there other reasons for thinking that, despite this presumption, overall, PAS would be more subject to abuse than these other widely accepted practices of surrogate decision making in end-of-life care?

One very important factor affecting the potential for abuse of any practice is what safeguards are erected to guard against the abuses most

23. Richard F. Uhlmann, Robert A. Pearlman, and K. C. Cain, "Physicians' and Spouses' Predictions of Elderly Patients' Treatment Preferences," *Journal of Gerontology* 43 (1988): 115–21; Tom Tomlinson et al., "An Empirical Study of Proxy Consent for Elderly Persons," *Gerontologist* 30 (1990): 54–61; Robert A. Pearlman, Richard F. Uhlmann, and Nancy S. Jecker, "Spousal Understanding of Patient Quality of Life: Implications for Surrogate Decisions," *Journal of Clinical Ethics* 3 (1992): 114–21.

feared and likely. Proposals for model legislation to permit PAS, as well as the proposal that was adopted by referendum in the state of Oregon, typically have substantial safeguards.²⁴ They include that the patient be:

- an adult;
- diagnosed to be terminally ill (i.e., likely to die within six months, even with treatment);
- suffering from an unbearable and irreversible physical illness or condition;
- informed about his or her diagnosis, prognosis without treatment, possible treatment alternatives that might improve that prognosis, along with their risks and benefits (typically with a required evaluation of the patient by a second physician to confirm the diagnosis and prognosis, and documentation and witnessing of the discussion with the patient);
- offered other available alternatives, in particular, hospice care and other palliative services that might improve the patient's condition and change the desire for PAS;
- evaluated for competence by a qualified mental health professional, in particular, to ensure that the patient's decision for PAS is not the result of treatable clinical depression;
- making an enduring (e.g., with a waiting period of one or two weeks from the first request until the means for PAS are made available to the patient) and voluntary (free from undue influence) request for PAS;
- reported to regulatory authorities, in a manner that protects patient confidentiality while permitting oversight of the practice, as having requested and received PAS.

Safeguards like these would not eliminate all potential for abuse of PAS—no set of safeguards could do that, and no practices in the real world are guaranteed to be free of all possible abuse. But the status quo (in which PAS is generally illegal) is not free of abuse either. One abuse of current public policy is that in all the states, except Oregon, that prohibit PAS, PAS still occurs, but not openly and without any safeguards, such as those above, to control its practice. And if we compare the practices of forgoing life support, using pain medications that may hasten death, and terminal sedation, whether decisions are made by a competent patient or by a surrogate for an incompetent patient—in no state are any of the formal safeguards listed above in use, although all of these other practices, like PAS, also result in the death of the patient. This is further reason to believe that PAS would be less, not more, subject to abuse than these other widely accepted practices. Opponents of PAS, nevertheless, often point to the Netherlands, where there are a signifi-

24. Charles H. Baron, Clyde Bergstrasser, Dan W. Brock, et al., "A Model State Statute to Authorize and Regulate Physician-Assisted Suicide," *Harvard Journal of Legislation* 331 (1996): 1–34.

cant number of cases in which somewhat less restrictive safeguards are not fully adhered to, as evidence that these safeguards would be ineffective in the United States.²⁵ The opponents are correct in stating that the safeguards would not be fully effective, but it is difficult to see why they would not at least reduce the potential for abuse with PAS to a level below current levels for other practices that also result in death but lack any comparable safeguards.

Opponents also argue that the potential for abuse would be greater with PAS than with forgoing life support and pain relief that may hasten death because many more people would be at risk of receiving PAS since it would not be restricted to patients receiving some form of life support. But this is mistaken for at least two reasons. First, if PAS is restricted to the terminally ill, as it is in Oregon and in most of the proposals to legalize it, this would substantially limit those eligible for it and limit as well the amount of life that would be lost by any patient who did it; by contrast, patients can and do refuse life-sustaining treatment who are not terminally ill and who sometimes give up many years of possible life. It is difficult to know whether the potential pool of persons eligible for PAS would be larger or smaller than the pool of patients eligible to refuse life support. Second, and more important, we do know that in the Netherlands, where PAS and VAE have been permitted for more than a decade, many times the number of patients die from withholding or withdrawing life-sustaining treatment and pain relief that hastens death than from PAS and VAE. In the 1995 update of the original Rummelink study of 1990, it was estimated that 2.6 percent of all deaths were the result of PAS and VAE (and another 0.7 percent were from ending life without the patient's explicit request at the time at which life was ended), but 20.2 percent were from a decision to forgo treatment and another 19.1 percent were from the use of opioids in large doses.²⁶

Are there, nevertheless, features of PAS that would make it more likely to be abused than decisions to forgo treatment or pain relief that hastens death? Opponents of PAS who focus on the potential for abuse typically cite several possible illegitimate motivations and incentives for PAS. First, with over 40 million Americans now without health insurance, many persons might choose PAS only because they cannot obtain adequate health care at the end of life. Second, even for patients with health insurance, there are well-documented and widespread inadequacies in end-of-life care that could lead patients to choose PAS who would not do so if they had access to higher quality end-of-life care; the widespread failure to provide dying patients with adequate pain management and

25. Daniel Callahan and Margot White, "The Legalization of Physician-Assisted Suicide: Creating a Regulatory Potemkin Village," *University of Richmond Law Review* 30 (1996): 1–83.

26. VanDerMaas et al.

control is a special concern.²⁷ Moreover, the availability of the “easier out” of PAS might undermine society’s and physicians’ motivations to improve the care of dying patients. Third, dying patients are often difficult and demanding to care for, are seen as the failures of medicine by many health-care professionals, and are emotionally draining on family members. Moreover, many dying patients are frail, frightened, vulnerable, and in a poor position to assert their needs and interests. If PAS is legalized, these factors could combine to lead to subtle manipulation or pressuring of some patients to choose PAS who would not really want it. Fourth, in an era of rapid growth of managed care in which cost containment dominates the health-policy agenda, PAS may be seen as a money-saving alternative to very expensive care of critically ill and dying patients, further pressuring such patients to choose PAS. Each of these concerns makes empirical claims for which data are scanty at best, yet the scope and probability of the feared effects are crucial to the weight they should be accorded; empirical research is at least as important as philosophical analysis in responding to them. Nevertheless, we can at least consider briefly whether they are more serious concerns about PAS than about forgoing of life support and pain relief that may hasten death.

The first two concerns, that patients without, and even with, health insurance will only seek PAS because they cannot obtain adequate end-of-life health care, are related. The safeguards proposed for PAS will provide some assurance that patients are informed about treatment and other alternatives, such as hospice care, but they will not always assure that those alternatives will be available and affordable. Some commentators have argued that the threat of PAS being permitted will lead, or already is leading, to strengthened efforts to improve end-of-life care, so as to reduce the pressure to permit PAS and to ensure that if it is permitted, few patients will choose it. However, we do know that even if PAS is permitted only a very small proportion of dying patients will choose it; consequently, we will still have to care for the vast majority of dying patients who do not choose it. All the reasons and motivations for professional and public concern to improve the care of dying patients, which have generated a host of important initiatives now underway, will remain in place. But there undoubtedly would be some patients who choose PAS who would not do so if better end-of-life care were available to them, just as there are now patients who forgo life support who would not do so if better end-of-life care were available to them. This is clearly a strong reason to improve the care of such patients, but is it also a strong reason to oppose permitting PAS, as many opponents suppose? I believe it is not.

27. The SUPPORT Principal Investigators for the SUPPORT Project, “A Controlled Trial to Improve Care for Seriously Ill Hospitalized Patients: The Study to Understand Prognoses and Preferences for Outcomes and Risks of Treatment,” *Journal of the American Medical Association* 274 (1995): 1591–98.

Our failure to provide high quality end-of-life care for all dying patients creates a cruel dilemma for public policy which should be recognized and acknowledged for what it is. Even if the many efforts now under way to improve the care of dying patients all prove immensely successful, there are two kinds of patients who will still prefer PAS. The first are patients who, even with optimal end-of-life care, will still prefer PAS because it best fits their view of a humane and dignified death; for these patients PAS is genuinely the best alternative mode of dying, and they constitute no policy reason for opposing PAS. The second kind of patient would not prefer PAS if they could get better end-of-life care, but since they cannot, they want PAS. What is the cruel dilemma that these patients pose for public policy? On the one hand, policy makers' or individual physicians' reluctance to provide these patients with PAS is quite understandable, knowing that they would not want it if they could get better end-of-life care. On the other hand, we should be equally reluctant to deny them the PAS they want and to make them endure a dying process they find worse than an earlier death by PAS, on the grounds that they would not want PAS if they could get better end-of-life care. To those patients, the prohibition of PAS in effect says this: "You cannot have the PAS that, in your circumstances, you quite reasonably want, but instead must endure a dying process that you find worse than an earlier death by PAS. Why? Because you would not want PAS if your care was further improved, although it will not be." To those patients, that is indeed a cruel death sentence. The resolution of this dilemma is not simply to prohibit PAS, but both to galvanize efforts to improve the care of all dying patients and to make PAS available to those patients for whom PAS remains preferable to the best care available to them.

So the response to the first two concerns about abuse of PAS based on limits in access to health care generally, or to adequate end-of-life care in particular, is, first, that these may as easily lead patients to forgo life support when they would not if better end-of-life care were available and, second, that this concern regarding PAS does not support prohibiting it but, rather, both improving end-of-life care together with permitting PAS for those patients for whom it remains the better and preferred alternative.

The third and fourth concerns above are also related—they focus on the medical, emotional, and financial burdensomeness of critically ill and dying patients to their caretakers, families, and insurance plans, and the incentives these others may consequently have subtly, or even overtly, to manipulate or pressure them to accept PAS. Part of the answer to this concern lies in the safeguards noted above that are designed to ensure that requests for PAS are made without undue influence or pressure from others. Since these go well beyond any current safeguards for decisions to forgo treatment, it is hard to see why the burdens created by dying patients should not, if anything, more easily and frequently lead to

undue influence or pressure on patients or surrogates of incompetent patients to forgo treatment than to choose PAS. And yet there are no data to my knowledge to support that involuntary choices to forgo life support are at all common, although they no doubt do sometimes occur. There is little anecdotal evidence, much less any well-documented problem, of frail, fearful, and vulnerable patients now being pressured to accept earlier deaths than they wish, nor is there good reason to believe that this would occur with PAS if it were permitted.

Finally, the financial concern that PAS would be a cost-saving alternative to high-quality care of dying patients is not well founded. A recent paper, coauthored by a strong opponent and a strong proponent of PAS, estimates the potential cost savings possible from the introduction of PAS and concludes that the savings would be negligible and insufficient to create strong incentives, within managed care plans, for example, to pressure patients to accept PAS.²⁸

There is one last aspect of the fear-of-abuse objection to PAS that I want to pursue briefly. This is a specifically slippery-slope worry that, although PAS would initially be restricted, for example, to competent terminally ill adults with safeguards like those noted above, the practice would soon be expanded and loosened beyond control, to VAE as well as PAS, and to patients who are not terminally ill, to children and the mentally ill, to incompetent patients, either on the basis of their advance directives or of surrogates choosing for them, and ending, finally, with persons for whom there is no longer any pretense that PAS or VAE serve their wishes, imitating the Nazi euthanasia program to rid society of "useless eaters and burdens." Slippery-slope worries of this sort represent different kinds of worries about abuse than those I have been considering above because they do not claim the specific practices of PAS being proposed would be seriously abused. Instead, they are commonly grounded in two sorts of claims: first, that the logic of the arguments offered in support of the restricted practice of PAS now proposed extends as well, and so would be applied over time, to a much broader practice of killing; second, that introducing even a restricted practice of PAS would erode over time society's respect for human life so that we would come to tolerate or accept an ever-expanding practice of killing.

Consider the first sort of claim, that the logic of the arguments of supporters of PAS extends, for example, to nonterminally ill and incompetent patients, and to VAE as well as PAS. Moreover, opponents of PAS point out, in the case of rights of competent terminally ill patients to refuse life support, those rights have in fact been extended in this way to nonterminally ill patients and to decisions based on advance directives

28. Ezekiel J. Emanuel and Margaret Battin, "What Are the Potential Cost Savings from Legalizing Physician-Assisted Suicide?" *New England Journal of Medicine* 339 (1998): 167-72.

or made by surrogates for incompetent patients, in each case in important part because the logic of the initial arguments did apply more broadly. I noted in the introduction to the article that had the Supreme Court upheld a constitutional right of terminally ill patients to PAS, that right might well have been vulnerable to challenges seeking to extend it in exactly these ways. But left as public policy decisions for the states to determine to whom and when, if at all, to make PAS available, states are free to make their own reasonable assessments of the benefits and risks of various extensions of PAS to broader classes of persons and/or to VAE. Nevertheless, it is correct in my view that the fundamental moral principles and values that justify a restricted practice of PAS for competent, terminally ill adults do apply more broadly, though not so far as some opponents claim, and it is either a mistake or dishonest for supporters of PAS to deny that in the hopes of avoiding the broader controversies.

But it need be neither a mistake nor dishonest to limit the argument now, as I have done here, to the more restricted practice. Initially permitting only the more restricted practice would be quite reasonable social policy in order to gain evidence about the degree to which it can be adequately safeguarded and controlled. That evidence would be of fundamental importance in making any later policy judgments about the wisdom of extending the practice more broadly. There is a moral cost in restricting a practice of PAS to competent and terminally ill patients and to permitting only PAS and not VAE. There are equally compelling moral reasons for some nonterminally ill patients undergoing intolerable suffering, for some patients who have lost the capacity to make their own decisions but who clearly would have wanted actively to end their lives, and for some patients unable to perform the last physical action of ending of their own lives, all to have access to a broader practice of PAS and to VAE. The restricted practice of PAS that I have been concerned with in this section of the paper would deny PAS and/or VAE to some persons when, considering only the individual cases, there are compelling moral reasons to permit PAS and/or VAE. But if PAS is extended to nonterminally ill patients, the seriousness and costs of abuses or mistakes increase, and if VAE is permitted for incompetent patients based on their advance directives or on their surrogates' decisions, the risks of decisions that do not reflect the true wishes of the patient increase substantially. The potential risks of increased seriousness and frequency of abuse from these extensions or expansions of PAS may or may not be too great to warrant doing so. But even if the logic of the argument for the restricted practice of PAS does extend more broadly, it is not unreasonable caution to wait until we have experience with the more restricted practice before we decide which, if any, additional steps we wish to take on the slope.

The other version of the slippery-slope worry is that any practice of actively taking life, such as PAS, will inevitably erode respect for human life and set us on a path toward ever wider killing. Only time and expe-

rience with a practice of PAS could decisively refute this concern, but the fundamental role of individual self-determination or autonomy in the broad social movement over the last several decades in the United States to secure for patients control over their dying, a movement driven principally by patients and potential patients—that is, the public—is a formidable bulwark against heading down that feared path. Respecting the self-determination of individual human beings in no way supports practices that would take the lives of persons against their wishes or because doing so might serve the interests of others.

As I stated at the outset of this section, there is no denying the presence of widespread concern that PAS would be subject to much greater abuse than are the currently accepted practices of forgoing life support, pain relief that can hasten death, and terminal sedation. I have suggested a number of reasons, however, why I believe that concern is not well founded. Indeed, I would reiterate that abuse and mistake are more likely in practices in which surrogates make decisions for incompetent patients; concern to prevent abuse by erecting safeguards to protect patients might better focus there than on PAS.

CONCLUSION

I have not attempted in this paper to develop what I see as the main positive moral argument in support of PAS; I have done that elsewhere and have only alluded to it here in my discussion of the moral grounds underlying the consensus about patients' rights to forgo life support, grounds which I believe extend to the support of PAS as well.²⁹ Many, perhaps even most, opponents of PAS do not deny that these moral grounds can support PAS in at least some cases. Nor have I pursued the fundamental moral issues in a general account of why and when taking human life is morally wrong, except indirectly when I addressed the specific position that PAS is morally impermissible because it intends the death of patients, although these issues certainly account for some of the disagreement about PAS.

Instead, I have focused on what I believe are three of the most common and influential arguments against PAS. The first argument addressed one of the central reasons typically offered to differentiate a right to forgo life support from a right to obtain PAS from a willing physician—that the former, but not the latter, follows from people's right to bodily integrity. I have tried to show that patient self-determination is the more fundamental ground of the right to forgo treatment, not bodily integrity, and it equally supports both practices. The second argument addresses one of the most prominent moral objections, particularly from physicians, against ever performing PAS—that it involves intending the patient's death, which is always morally impermissible. Here, my princi-

29. Brock, "Voluntary Active Euthanasia," and "Death and Dying."

pal response has been to show that this cannot differentiate PAS from the other main forms of end-of-life decisions and care—including forgoing life support, use of pain medications that risk hastening death, and terminal sedation—whose permissibility is quite correctly not significantly controversial; all sometimes involve intending the patient's death. Moreover, some instances of PAS do not involve the physician's intending the patient's death. It is the patient's free and informed consent, in circumstances in which death is not an evil for the patient, that justifies actions by physicians that cause or risk causing death, not whether death is intended. The third argument is probably the most prominent objection to changing public policy to permit PAS, an argument made by many who grant that some individual cases of PAS are morally justified—a legalized practice of PAS would be subject to intolerable abuse. I have argued that it is when someone else must make end-of-life decisions for incompetent patients, as compared with decisions made by competent patients themselves, that the potential for abuse increases substantially, and this suggests that PAS (and VAE) is less, not more, subject to abuse than surrogate decisions for incompetent patients to forgo life support, to employ pain medications that risk hastening death, or to employ terminal sedation. Yet virtually no one argues that these forms of surrogate decision making are being intolerably abused. Moreover, I offered several additional reasons to believe that PAS has less potential for abuse than other forms of end-of-life decisions and care.

Each of these three arguments against PAS has been widely influential in the moral, legal, and policy debates about PAS, yet each is, in my view, unpersuasive. Progress in changing public policy to permit PAS depends, at this point in time, at least as much on undermining these, and other, common objections to PAS as it does on reiterating the familiar moral case in support of it.