SPECIAL COMMUNICATION

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Physician-Assisted Suicide and the Doctrine of Double Effect

ABSTRACT: In this paper, I try to show how the clash between two different types of ethical theory—consequentialist and nonconsequentialist—affects moral and legal arguments for physician assisted suicide (PAS) and euthanasia (E). I begin by presenting a three-step argument for the permissibility of PAS and E, and then examine two possible criticisms of this argument. In conclusion, I consider how the possible further consequences of permitting PAS are dealt with by proponents of the two ethical theories.

In their presentations, Drs. Rosner and Nordby have introduced certain key approaches to, and problems with, ethical theory. As they have said, ethics is the theory of right acts, good character, and what is valuable in life. A very general characterization of the ethical or moral point of view is that it is the impartial point of view, for example, the view we would take about the rightness of acts if we were to consider what was right without being biased in favor or against anyone. The discipline employs reasoned arguments for conclusions. Sometimes, the arguments involve deriving conclusions from general principles. Other times, as Dr. Rosner points out, we use our judgments about cases—real life ones or hypothetical cases, like the Transplant Case he mentioned—to criticize the implications of proposed principles or as evidence for new principles. Dr. Rosner has pointed out that an important debate in ethical theory is whether an impartial evaluation of the right acts is only a function of their good consequences impartially considered—the consequentialist theory—or whether something in addition to consequences plays a role in determining the rightness of acts. The latter view is called nonconsequentialism, though I emphasize that it need not deny that consequences can play some role. Theories which locate more than one source for the rightness of acts, e.g., fairness as well as good consequences, are subject to the sort of conflicts that Dr. Nordby emphasizes, for an act that has one right-making property may conflict with an act that has another right-making property. Finally, as has also been pointed out, an ethically permissible act is not necessarily a legally permissible one or vice versa, for it is arguably true that a law can be valid as law even if it is immoral and that not all morally required acts are enforceable by law. Nevertheless, it has been argued by some legal theorists that because the American Constitution in particular emphasizes such ethical notions as justice, equality, and rights, constitutional judicial decision making in our legal system will have to make use of a large amount of ethical reasoning. While some legal theorists, e.g., Yale Kamisar (1) argue that the law is not a syllogism and many distinctions it draws are not logical, other legal theorists e.g., Ronald Dworkin emphasize the importance of consistency in legal reasoning and the search for underlying principles that unify different court decisions.

I will discuss the topics of physician-assisted suicide and euthanasia in a way that illustrates the conflict between consequentialism and nonconsequentialism in ethical theory, and shows how we might resolve conflicts between the ethical duties of physicians to save life and to relieve pain. In addition, I hope to show how current legal reasoning about these matters parallels ethical reasoning by focusing only on philosophical arguments that find their parallel in the legal reasoning in the case of *Compassion in Dying v. Washington,* currently on appeal with the Supreme Court. Finally, I hope to show how what philosophers call the analysis of concepts, or conceptual analysis, while in itself not making moral judgments, plays a role in justifying moral judgments.

Section I

Euthanasia involves a *death that is intended* (not merely foreseen) in order to benefit the person who dies. It differs from physician-assisted suicide undertaken in the interest of the person who dies only in that it involves a final act by the doctor, not by the patient, to end the patient's life. Some, e.g., Leon Kass (2), have argued that the idea of euthanasia makes no sense because it is logically impossible to benefit someone by seeking his death, given that death eliminates the person; we cannot produce a benefit if we eliminate the potential beneficiary, he argues. One of the ways conceptual analysis can be useful in the ethical examination of euthanasia is by making clear how someone can be benefited by death even if it involves his nonexistence, just as someone can be harmed by death even though it involves his nonexistence. To be benefited or harmed, one need not continue on in a state of good experience or bad experience. If one's life would have had important goods in it if it continued, then one of the ways in which one is harmed by death is that it interferes with those important goods; as a result of death, one has had a less good life overall than one would have had and this is a harm. But if one's life would have gone on containing only misery and pain with no compensating goods, then one will be benefited in having had a shorter life containing fewer of such bad things rather than a longer one containing more of such uncompensated-for bad things. In this sense, it is possible for death to benefit a person. Hence, the concept of euthanasia is at least not logically confused. This analysis, however, does not show that it is always morally permissible

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to benefit a person in this way, even when they request it. That is our next question, the one which exhibits a dispute between consequentialists and some nonconsequentialists.

Section II

Nonconsequentialists argue that even if different behaviors result in the same consequences, how we bring these consequences about can make a difference to the moral permissibility of acting. For example, they claim that, at least sometimes, it matters morally whether a death occurs because we intended it as a means or whether it was merely foreseen as a side effect; also it matters morally, at least sometimes, whether a death occurs because we let someone die or because we killed him. The first distinction between intention and foresight is different from the killing/letting die distinction. We can show this by combining the two distinctions in four different ways: first, we can kill, intending the death or, second, we can kill merely foresee it (as when we run someone over while speeding); third, we can let die, foreseeing the death, as when we decide to save five people and let one drown because we cannot help everyone, or, fourth, we can let die, intending death, as when we refuse an antibiotic to a patient so that he will die because we think death is better for him.

Let us first consider the possible moral significance of the intention/foresight distinction. It is thought that doctors may, at least with the consent of a terminally ill patient, give morphine for the relief of severe pain otherwise not manageable even if they foresee *with 100 percent certainty* that death would thereby occur sooner than it would without morphine. Why may the doctor do this? One reason given is that in this particular case the *greater good is relief of pain,* and the *lesser evil is the loss of life* given that life would end soon anyway and is not of very good quality. This means the patient is overall benefited by a shorter painful life rather than having a longer, more painful life. Notice that this could be true even if the morphine put the patient in a deep unconscious state when he was alive, from which he never awoke before he died, so that he does not experience conscious pain-free time alive. It would not be true that pain relief is the greater good and death the lesser evil if one could go on to live a long pain-free life after a temporary bout of intense pain. In this case, the patient would not be benefited by a shorter, less painful life. In the *morphine for pain relief case* (MPR), furthermore, the lesser evil of death is only a foreseen side effect. It is not intended. The fact that death will occur with certainty does not mean it is intended. If I have a drink to soothe my nerves and foresee that it will certainly cause a hangover tomorrow, that does not mean that I intend the hangover. Still, in the MPR case, the doctor gives a drug which is causing death, so I see no reason not to call this a case of killing, though the doctor does not intend the death. She only foresees it, and intends pain relief.

Now suppose the morphine has lost its pain-relieving effects on the patient, but it can still be used to kill the patient as a means to ending his pain and the patient requests its use to kill him in order to end his pain. Call this the *morphine for death case* (MD). It is said by some nonconsequentialists that we may not kill in this case, even though relief of pain is still the greater good and death the lesser evil, and so the consequences of killing him are *essentially* the same as in MPR. It is said to be impermissible to *intend the lesser evil* as a means to a greater good, but it is permissible to produce the greater good if the lesser evil is merely foreseen. The nonconsequentialists who say this are supporting what is known as the Doctrine of Double Effect (DDE) (though not all supporters of some version of DDE would rule out killing in MD).

Without denying that sometimes the distinction between intending and foreseeing makes a moral difference, here is an argument to the effect that it is no reason not to perform euthanasia or assist suicide: Doctors on many other occasions already, with the patient's consent, *intend the lesser evil* to a person in order *to produce his own greater good.* For example, a doctor may intentionally amputate a healthy leg (the lesser evil) in order to get at and remove a cancerous tumor, thereby saving the patient's life (the greater good). Or, he may destroy a perfectly healthy nerve in order to remove a benign tumor that is pressing on another nerve and causing great pain. Furthermore, he may intentionally cause someone pain, thereby acting contrary to a duty to relieve suffering, if this is a means to saving the person's life. Here the duty to save life just outweighs other duties. Why then cannot doctors likewise intend death when it is the lesser evil, in order to produce the greater good of no pain, thereby benefiting the patient by giving her a shorter, less painful life rather than a longer, more painful one? Recall that in MPR, it was assumed that death could be the lesser evil and pain relief the greater good. That was one reason we could give the morphine. It is true that in the surgery, where we intend the destruction of the leg or nerve, or when we intend pain, we save the whole person, and in aiming at death, we destroy the whole person. But, as argued above, this may still overall benefit the patient.

To summarize, we have constructed a three-step argument for physician-assisted suicide and euthanasia: (1) We may cause death as a side effect if it relieves pain, because sometimes death is a lesser evil and pain relief a greater good. (2) We may intend other lesser evils to him, for the sake of a patient's greater good. (3) We may sometimes intend death in order to stop pain. Call this the Three-Step Argument (3).

Section III

As noted above, nonconsequentialists also claim that the difference between killing and letting die can sometimes make a moral difference even when consequences are the same. When a doctor withholds treatment, she lets a patient die. Sometimes, this is morally permissible and sometimes it would be wrong. Suppose a patient has a right to be treated, but when competent, informed, and not coerced, he waives his right and directs a doctor not to treat him. Then, the doctor has a duty not to treat because the patient has a right against bodily invasion against his will, if there is no overriding state interest present. Furthermore, suppose the patient has no right to demand a particular treatment because it is experimental and scarce. Then, even if the patient wants to be treated, a doctor may permissibly let the patient die, even if the doctor's reasons are that he thinks it is best for the patient to die. In these cases of letting die, the doctor does not cause the death, and the patient dies of the underlying disease or its effects.

What if a patient is already receiving treatment or other assistance and a doctor must actively terminate it by, for example, pulling out tubes? Here we must do a fair amount of conceptual analysis to understand what is going on. Although an act rather than an omission is required to terminate aid, if the doctor is terminating aid he (or the organization of which he is a part) gives, then I think he lets die rather than kills. Consider the following analogy: I am saving someone from drowning and I decide to stop. Even if I must actively push a button on my side to make myself stop, I still let the person die rather than kill him. (It is

not necessarily right of me to let die.) But suppose I perform an act that interferes with some device that is not mine and that someone else is using to provide lifesaving aid to a patient. I do this without the permission of the owner of the machine, the provider of the service, or the patient. Then, even though the patient dies of his disease, a underlying natural process, I believe I will have killed him. Still, even when a doctor pulls a plug on aid he is giving, the fact that he acts makes him, I believe, a partial cause of death, the disease being the other partial cause. So, there is the following difference between not beginning treatment and terminating the aid one provides: only in the latter case does *letting die cause,* in part, *a death.*

The fact that a doctor lets die and an underlying natural process finally causes death does not mean that the letting die is permissible, for if a patient wants treatment continued, a doctor might have a duty to continue it. Nor is killing always wrong. Suppose I kill someone by removing a lifesaving machine that neither I nor a group of which I am part started. This may not be morally wrong because the person I kill deserves to die and I am his legal executioner.

If a patient wants treatment withdrawn, his right not to continue being invaded arguably gives the doctor a *moral duty* to remove treatment. If so, then the doctor is not permitted to refuse to remove it on the grounds that if he removed it, he would *be a partial cause* of the patient's death. In the Cruzan case, it was said that a patient has a constitutional right to have someone who is willing to remove treatment not be interfered with. It also seems clear that Cruzan decided that a patient would have a right to have it removed and so that someone could have a court-mandated duty to remove it. A doctor's *legal duty* to remove the life-saving aid may also stem from the special relationship he has to his patient.

If a doctor gives a patient an injection which is lethal, he kills the patient, whether he intends the death or not. If he provides a lethal medicine and the patient takes it himself, it is more difficult to characterize the doctor's role beyond saying that he is a partial cause of the death. For the doctor might only be giving a patient *the choice* as to whether to kill himself or not, an option he did not have without the medicine. But if the doctor does help a person to kill himself, once he knows the person has formed the intention to die, in order to help him act on that intention, then, it seems, there are two persons who engage in a killing, even if only the patient gives himself the lethal medicine. Is it permissible for a doctor to kill rather than just let die? A patient's right to life includes a right not to be killed, but it has been argued (4) that the right to life is a discretionary right—that is, it gives one a protected option whether to live or die, an option with which others cannot interfere; it does not give one a duty to live. If a patient decides to die, he is waiving his right to live, as someone may waive their right to speak on a given occasion. By waiving his right, he releases others from their duty not to kill him, *insofar as their duty not to kill stemmed from his right to live.* Notice that this waiver seems to be necessary even when the doctor wishes to give a pain killer that will kill as a side effect. This means doctors should get permission for giving the morphine as pain killer as well as giving it to deliberately kill. I do not believe they always do so

To waive one's right to life and transfer a right to another to kill one is not the same as alienating or giving up one's right to life, which is what would occur if slavery were permitted. For then one is forever under another's power to decide whether one lives or dies, having ceded all one's right over one's life to another. In waiving one's right to life, one merely picks someone to do one's bidding in respect to dying. It is true that if one successfully waives one's right to live and is killed, one will never again exercise one's right to live, and this is also a consequence of alienating one's right. But only in the case of alienating can one live on under the control of another person.

If a patient has waived his right, the doctor will not violate the patient's right if he kills, but it may still be impermissible for him to kill because, for example, he would harm the patient because it is not in the patient's best interests to die. That is, the doctor's duty not to kill may stem from other sources than the patient's right not to be killed. But suppose it is in the patient's interest to die, in the sense that no more pain is the greater good and death is the lesser evil, as described above.

Now we come to a crucial point: Is the fact that the doctor gives a lethal injection and so will be the sole cause of the destruction of a life—the sole killer—a reason for its being impermissible for doctor to perform euthanasia? But the doctor does this when he gives morphine as a painkiller (even though he doesn't intend the death), as I explained above. So this alone cannot be the reason why the doctor may not do what the patient wants. Furthermore, it seems that the fact that the doctor would be the sole cause of destruction cannot serve as a reason for him not to perform one of his medical duties, to relieve suffering by killing, if his being the sole cause of destruction does not serve as a justification for not giving morphine when it works as a painkiller but has predicted lethal side effects.

So if the fact that he will be a killer does not override the doctor's duty to relieve suffering when morphine is a painkiller, then the fact that he will be a killer does not alone override his duty to relieve suffering by intentionally ending a life. This argument suggests that, contrary to what many have said, the doctor may well have a duty, not only a permission, to assist suicide or perform euthanasia in order to relieve suffering.

More specifically, I said that doctors have a duty not to treat and a duty to end treatment because patients have a right not to be physically invaded against their will when they are competent, informed, and not coerced and there are no interests of the state (e.g., apprehension of criminals or threat to public safety) that countervail. But the case in which morphine is a painkiller shows that patients also have some right *to be* physically *invaded,* for example, with pain medication when they request it for pain relief. This gives a doctor a duty, not a merely a permission, to treat them even if he will then kill. The three-step argument (above) claimed to show that there was also no objection to killing based on its involving intending death, and even a duty to do so because death can be a lesser evil and other lesser evils are intended. Now, we claim to have shown that there is no objection based on killing. The combination of the two arguments may result in doctors having a duty to kill simply as a means of ending pain. That is, we have a *new,* combination argument: (1) There is a *duty* to treat pain even if it foreseeably makes one a killer. (2) There is a duty to intend the lesser evil for a patient's own greater good. (3) There is a duty to kill the patient intending his death when this is the lesser evil and pain relief the greater good. (Call this the Combined Argument.)

There may, of course, be some other reason to which a doctor could point besides or in addition to being sole causal agent of destruction and intending a lesser evil as a justification for not having a duty to kill to end pain at the request of a patient. It is possible that this reason would not rule out the *permissibility* of killing if the patient wanted it. But it might.

Section IV

What other reason could a doctor have for not intentionally killing a patient to end his pain, or even for his being prohibited from doing so, if he is willing to provide or even must provide the morphine as painkiller, though this will kill? That he does not want to or must not intend death? This brings us back to our original three-step argument. We asked why it is wrong to intend the lesser evil of death when it is all right to foresee it, and also all right to intend other lesser evils. (Notice that if it is wrong to intend death, then it will also be wrong for a doctor to let someone die with the intention that he died even if this is what he wants. But in all cases where the patient wants no treatment because *he* intends his own death, the doctor need not remove the treatment with the same *intention,* though she might. This is because the doctor's ever-present intention will be not to invade a patient against his wishes. In general, it will be important to remember to distinguish between the patient's intention and the doctor's.)

It is time to try to rebut the three-step argument. To do so, I must consider one proposal for supporting the DDE and distinguishing morally between intending and foreseeing *overall harm* to people. Warren Quinn distinguished (5) between (1) not treating people as ends, and (2) treating them as mere means. We do the former, he said, when we pursue our projects without constraining our behavior in the light of the foreseen harm to others. We do the latter when we treat people as there merely for our purposes, something we can take charge of and use to meet our goals. He thinks the latter is a worse attitude.

What does this imply about our taking someone's life as a means to stopping their own pain because they direct us to? It implies that we think it is permissible for them and, hence, all people, to take control of and destroy their persons for their own purposes; the whole of their being is not off limits to be used to stop their pain. If morality has a special interest in insisting that people not see themselves as under their control to be used for their purposes in this way, this would be consistent with its not having as much interest in their making attempts to preserve their life when death is merely foreseen. Arguably, taking control of one's life can only be done actively; if one intends a death but only omits to stop a deadly natural event that one hasn't set in motion, the element of control is less. If so, then the *combination* of killing and intending is more significant than the combination of omitting and intending.

The three-step argument asked why we may not intend death if it is a lesser evil and we intend other lesser evils. The answer suggested here is because acting with the intention to bring about the lesser evil of death in particular requires us to have a further intention, namely to treat ourselves, rational beings, as eligible to be used for our purposes when these purposes require the termination of a person. We do not have this further intention when we intend such other lesser evils as destruction of a leg. [One of the things that seems odd about killing only someone who is capable of voluntarily deciding in a reasonable way to end his life is that one is making sure that one is destroying a being of great worth—a reasoning, thinking being. This will not be so if the person is unconscious or vegetative or otherwise no longer functioning as a rational being.]

Now, people obviously take control of their lives and devote themselves to the pursuit of certain goals within the living of their life; but when this is appropriate, it is claimed, they do not interfere with personhood but set it in one direction or another.

This view that there are limits on what we may do to ourselves is Kantian. Kant thought that rational humanity in ourselves and in others was an end in itself, and not a mere means to happiness or other goals. Even if bads outnumber what in our life is good for us, the fact that one is a rational agent in life—judging, aiming, evaluating—has worth in itself. This means that whether our life is a benefit to us (or instead death would benefit us) is a different question from whether our life has worth (or whether death would end something of worth). This worth it may have is not measured by its worth to us in providing us with some satisfaction of our desires. Rather, it is what gives us rational beings worth in ourselves. It is more like an honor to us to have this value as rational beings than a benefit that satisfies some interest of ours. Further, it is because we have worth in ourselves that it is especially important that our lives also be good *for us.*

Section V

Having laid out an argument for the impermissibility of giving a lethal injection, we must consider how good it is. I believe that sometimes the honor of being a rational agent can be accompanied by concomitant burdens when, for example, life involves unbearable pain so that one's whole life is focused on that pain. I do not think this is always a matter of the deterioration or humiliation of rational nature or the absence of dignity, just the burden of living. In such circumstances, one could, I believe, decline the honor of being a rational being, and even intend passively or actively to get rid of it. Furthermore, doing this *need not* involve our treating our life as mere means to a balance of good over evil. But, of course, much argument would be needed to show this. My aim in this paper is not to reach a bottom line, but only to give some idea of how philosophers discuss this issue (7).

As I have said, the legal arguments in the current court case on this issue mimic the philosophical ones I have considered so far. Finally, I wish to consider one additional respect in which the legal debate can be seen as a contest between consequentialism and nonconsequentialism. After deciding whether a person has some sort of liberty interest or right to physician-assisted suicide, the Court engages in a balancing test to see whether the consequences of permitting action on the basis of this liberty interest would be so bad that the liberty interest is overridden. The U.S. government's Amicus Brief asks the Supreme Court to consider the people who might be incorrectly pressured into asking for suicide and *their rights to life* that would be violated in these mistaken deaths. Some philosophers who downplay this bad effect in their opposing amicus brief (6) have two particular *nonconsequentialist reasons* for doing so. First, they believe the liberty interest to physician-assisted suicide to be so important that it is in effect a fundamental right and, they argue, fundamental moral and legal rights cannot, in general, be overridden simply because bad consequences come from exercising those rights. Second, they make use of the intention/foresight distinction. They argue that if we deny a fundamental right to physician-assisted suicide, we are intending to deprive some people of their rights as a means of preventing bad consequences, and this we may not do, even to minimize violation rights overall. If some people's rights are violated because we grant the right for physician-assisted suicide, this will be a foreseen side effect and not intended.

To summarize, in this presentation I have offered examples of conceptual analyses, arguments from principles and cases, a justification for a principle (the Doctrine of Double Effect), and attempted to show the similarity between legal reasoning in the framework of the U.S. Constitution and ethical reasoning.

Endnotes

1. In: Are laws against assisted suicide unconstitutional? Hastings Center Report 1993; May–June: 32–41.
2. In: Neither for love nor money: why doctors must not kill. The Public Interest 1989; Winter; 94: 25–46.
3. I first presented this argument in Creation and Abortion (New York: Oxford University Press, 1992), and then again in Mortality, Mortality, Vol. II (New York: Oxford University Press, 1996), 193–198.
4. Most clearly by Philippa Foot in Euthanasia, and Joel Feinberg in Voluntary Euthanasia and the Inalienable Right to Life, both reprinted in Medicine and Moral Philosophy, ed. M. Cohen et. al. (Princeton: Princeton University Press, 1981), pp. 245–303, on whose discussions mine draws while extending.
5. In Actions, intentions, and consequences: the doctrine of double effect. Philosophy and Public Affairs 1989 Fall; 18: 334–351.
6. The amici curiae brief for Ronald Dworkin, Thomas Nagel, Robert Nozick, John Rawls, Thomas Scanlon, and Judith Jarvis Thomson. Reprinted in the New York Review of Books, 1997; March 27.
7. I try to complete the argument in "A Right to Death?" *The Boston Review*, Summer 1997, pp. 20–23.

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