A Critique of Objections to Physician-Assisted Suicide

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Overview

According to the American Medical Association, physician-assisted suicide is when “a physician provides a patient with the medical means and/or the medical knowledge to commit suicide.”¹ Most typically this involves a physician providing a patient with a lethal dose of narcotics knowing that said patient intends to use the medication for the purpose of ending his or her life. While the term ‘physician-assisted suicide’ is often confused with or exchanged for the terms ‘euthanasia’ or ‘mercy-killing,’ the two diverge in the act-description. In an assisted suicide, as opposed to euthanasia, the final physical act of killing is left to the intended recipient of the death, as opposed to the third-party assister, thus making it a suicide. The moral difference has been subject to debate but for the sake of argument, this paper will assume that the distinction between the two, at least metaphysically, holds.² Due in part to the limited nature of this piece, I will focus my analysis on identifying and attempting to refute two common arguments against the permissibility of physician-assisted suicide. This work is divided as follows:

I. Introduction and Background
II. The Doctrine of Double Effect
III. The Killing Versus Letting Die Distinction
IV. Concluding Remarks

I. Introduction and Background

Physician-assisted suicide is an issue that has received considerable press in the last few decades. Absent from the agenda for the vast majority of the 20th century, it leapt into public spotlight in the United States in June 1990 when Dr. Jack Kevorkian, later nicknamed “Dr. Death”, assisted in the suicide of Janet Atkins.3 Since then the issue has gone to the Supreme Court on multiple occasions and physician-assisted suicide has been legalized in four states: Oregon, Washington, Montana and Vermont.

After failed attempts in Washington State and California, Oregon became the first state to legalize physician-assisted suicide with the Oregon Ballot Measure 16 in 1994, a referendum that established Oregon’s “Death with Dignity Act (ORS 127.800-995). Approved in the November 8, 1994 general election by a mere 1.3% margin, the measure established a patient’s right to physician-assisted suicide with certain restrictions. Potential candidates are required to be 18 years or older and a resident of the state. They must also be diagnosed, by a licensed physician, with a terminal illness resulting in six months to live or fewer. Patients are required to initiate the request, and two witnesses, at least one of whom must be unrelated to the patient, among other stipulations, must confirm it. Additionally, prospective candidates must be able to self-administer the life-ending medication and free of mental health conditions that would impair ability to make health care decisions. 4

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4 “Death With Dignity Act.” Oregon Health Authority.
Oregon’s legalization was followed by a fourteen-year hiatus, during which the issue was hotly contested but no further successes in legalization were achieved. Finally, in 2008 Initiative 1000 established Washington State’s “Death with Dignity Act,” similarly sanctioning restricted physician-assisted suicide. Compared to Oregon’s tiny margin, Washington’s 57.82% in favor represented a resounding victory.\(^5\) Based on Oregon’s Measure 16, Initiative 1000 details nearly identical restrictions.

While both Oregon and Washington legalized physician-assisted suicide through voter referendum, Montana sanctioned the practice in 2009 through the court ruling *Baxter v. Montana* and in May 2013, Vermont achieved legalization with the approval of the bill, *Patient Choice and Control at End of Life Act*, by its House of Representatives.\(^6\)

Just this January, New Mexico became potentially the fifth state in the United States to legalize physician-assisted suicide with the ruling of Judge Nan Nash of the Second Judicial Court. She ruled that the right of a competent, terminally ill patient to choose help in dying is a right fundamental to the “liberty, safety and happiness of a New Mexican.”\(^7\)

Yet despite these advances toward legalization the American Medical Association’s current stance on the issue is that physician-assisted suicide is in its very essence incompatible with the professional role of a physician. Additionally, the Supreme Court rulings in the *Washington v. Gluckberg* and *Vacco v. Quill* cases

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\(^7\) “Judge Rules to Allow Physician Assisted Suicide in New Mexico.” *Steve Siebold.*
established that state laws forbidding physician-assisted suicide were constitutional, denying any universal right to this form of aid. However, I believe the burden of proof should be on those who want to declare this act impermissible, as the right to receive the means to end one's own life in a dignified manner from a willing third party seems to be encompassed by the right of personal autonomy. As established by the 1992 case on abortion Planned Parenthood v. Casey, people have the right to make their own choices about issues “involving the most intimate and personal choices a person may make in a lifetime, choices central to a person's dignity and autonomy,” and this right is protected by the Fourteenth Amendment.\(^8\) As a result this paper will focus on the negative argument, analyzing and raising objections to two of the most common arguments in defense of the impermissibility of physician-assisted suicide: the Doctrine of Double Effect and the killing versus letting die distinction. While I would ideally also address any criticisms of the positive argument regarding autonomy, this must be the topic of a future paper instead, in order for me to properly treat the two negative arguments proposed.

II. The Doctrine of Double Effect

One of the moral arguments that is most commonly called into play as an argument against legalizing physician-assisted suicide is based off of a principle known as the Doctrine of Double Effect (DDE). The Doctrine of Double Effect asserts that it is morally permissible to cause a harm as a side effect, or ‘double effect,’ of an action that would bring about a good result, even if it would not be acceptable to perform that action as a means to the same good end. This principle is often invoked when discussing military action and the permissibility of civilian casualties. In the case of physician-assisted suicide the specific argument can be divided into two parts. First, a physician doing an action with the intention of causing a patient’s death is fundamentally different than a physician doing something knowing that death will be a potential side effect. Secondly, this argument claims that the difference has the following moral significance: the first case is always morally impermissible while the second, in certain circumstances, is morally permissible. ⁹

This argument has been endorsed by the American Medical Association as it claims in CEJA Report 8 – I-93 that palliative treatment prescribed by a physician which the physician is aware may cause the patient’s death, should not be confused with euthanasia or physician-assisted suicide. They claim that intent matters and that as such it is “ethically acceptable for a physician to gradually increase the appropriate medication for a patient, realizing that the medication may depress respiration and cause death,” since the intent of palliative treatment is to relieve

suffering. While the end result, the patient’s death, may be the same in both cases, the organization of means, ends and side effects is distinctly different. In the case of palliative care, which the AMA deems permissible, a classic example is providing morphine as the means to the ends of relieving suffering, with the patient’s death only as a foreseen side effect. In an example of physician-assisted suicide, the means is the same, a drug such as morphine, but the patient’s death is the end itself. While a desire to relieve the patient’s pain and suffering may be the reasoning behind intending their death, the death itself is considered the ends or the intention.

Walter Dellinger, then acting solicitor general, used this argument in his testimony when presenting the Washington v. Glucksberg and Vacco v. Quill cases to the U.S. Supreme Court. In arguing the case against physician-assisted suicide he stated: “We agree that state law may... not only allow withdrawal of medical treatment but also allow physicians to prescribe medication in sufficient doses to relieve pain even when the necessary dose will hasten death.” However, he subsequently clarified that this is allowed only “so long as the physician’s intent is to relieve pain and not cause death.” These sentiments are echoed by Chief Justice William Rehnquist’s decision and his opinion as he adds (in propria persona): “[Just as a State may prohibit assisting suicide while permitting patients to refuse unwanted lifesaving treatment, it may permit palliative care related to that refusal,

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12 Thomson, “Physician Assisted Suicide,” 508.
which may have the foreseen but unintended ‘double effect’ of hastening the patient’s death.”

While this argument is clearly considered effective, especially since it is included in both official AMA policy and the Supreme Court’s landmark decision in the *Glucksberg* and *Quill* cases, it lends itself to criticism in a few areas. One reason why the Doctrine of Double Effect has reached such levels of popularity is that intention seems to explain our intuitions in certain difficult cases. As John Rawls details in his *Theory of Justice*, there are provisional, fixed points which we assume any conception of justice or moral theory must fit. Whether one accepts this or not, it does seem plausible that any moral theory should incorporate as best as possible strong, widely supported intuitions on certain cases.

One of the clearest demonstrations of where consequentialist moral theories and our intuitions diverge is the set of thought experiments proposed initially by Philippa Foot in 1967, broadly called the ‘trolley problems.’ In the general form of the problem there is a runaway trolley with faulty breaks that is hurtling toward five workmen on the main track. While the driver is powerless to stop the trolley, he discovers that he has the option to pull a lever and divert the trolley onto a side set of tracks. Unfortunately, there is one man trapped on this set of tracks as well. All else being equal, such as assuming that none of the people on the tracks are either extremely laudable or contemptible, both basic utilitarian calculus and general

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human intuition seem to support the permissibility of pulling the lever and diverting the trolley.

However, the addition of a thought experiment, identical by utilitarian standards, complicates matters. In this example, a doctor at a small local hospital is faced with a difficult situation. She has five patients, all in critical condition, who require different organ transplants in order to survive. As she contemplates the futility of the situation, a man walks in to the emergency room who requires treatment for some minor ailment, say a sprained ankle. The thought occurs to the doctor that if she killed this man and harvested his organs, she would be able to save all five of her other patients. Assuming that she could complete this transaction in secrecy and without legal or social consequences, any theory based on maximizing the good or pleasure and minimizing the bad or pain would claim that this action is morally permissible. Yet the general consensus is that this would be reprehensible. Our intuitions rebel against the very idea. This is where proponents of the Doctrine of Double Effect propose that intent comes into play in a morally significant manner. In the case of the trolley driver the death of the one man on the side track can be seen as a foreseen but acceptable side effect of pulling the lever, which in itself was the means to avoiding the deaths of five. In the case of the doctor, on the other hand, the death of the one man is a means to saving the lives of the other five.

In these two cases the Doctrine of Double Effect seems to be a plausible explanation of our intuitions and the separation between what our intuitions tell us and what a consequentialist moral theory would presumably require. While this kind of thought experiment is frequently touted as support for the Doctrine of Double Effect, Philippa Foot’s purpose in conceiving of the experiment was to support another explanation, the distinction between killing and letting die. This theory has its own limitations, which I will address in the next section, but on first glance it does seem to shed doubt on the idea that the Doctrine of Double Effect is the only viable explanation for our intuitions.

Regarding the case at hand, there are a few sources of concern about the supposed moral difference between intending and foreseeing as a side effect. For one, the entire argument is based off of the intentions of the agent, in this case the physician, and it seems reasonable to question these assumptions about the doctors’ intentions. If physician-assisted suicide were legalized it is plausible that some physicians would provide the means to commit suicide to their patients, such as prescription drugs, with the intention to provide their patients with a semblance of control over their own lives, yet hoping that these patients will not choose to use the means that they’ve been given to end their own lives. In this case, the intention of the physician would be to give the patient a sense of control, and the death of the patient would be only a foreseen potential side effect.\textsuperscript{18} If so, it follows that this should also be permissible under the Doctrine of Double Effect. While some may claim that in this case the intention is too hard to determine, this argument could

\textsuperscript{18} Judith Jarvis Thomson, “Physician-Assisted Suicide,” 510.
then also be applied to specific examples of palliative care, weakening the argument that the Doctrine of Double Effect is what determines the moral difference.

Another objection is one eloquently outlined by Judith Thomson in her 1999 treatise on the matter. She explains that using the Doctrine of Double Effect to argue against the permissibility of physician-assisted suicide means that there must be a good effect and a bad effect of the physician's action. Here, the bad effect is assumed to be the death of the patient. But why is this necessarily a bad effect of the action? What is good or bad for a person is dependent on his condition and it is believable that a person's life could be in such a painful state that prolonging that life would not actually be good for that person. Some have replied that determining that an effect of an action would be good for a person does not translate into it being a good event. The underlying idea here is that there is a property, separate from being good or bad for a person, which determines the value of the event. Said property is usually referred to as intrinsic goodness or badness. The existence of such a property is under debate, and the domain of a different paper, but the idea that death should not necessarily be considered a bad effect can certainly be proposed as a possible counter to this objection against physician-assisted suicide.

In her work, Judith Thomson divides related situations into four cases: disconnecting cases, nonconnecting cases, drug-providing cases and drug-injecting cases. Applying the Doctrine of Double Effect to currently legal cases, such as

disconnecting cases, helps to illustrate the absurdity of this approach. A disconnecting case is where the patient requests that life-saving treating which is currently in progress be stopped. In these cases the acting physician positively intervenes, by removing the patient from the mechanisms that are sustaining him. These “disconnecting cases” are currently legal and largely considered to be morally permissible. However, the Doctrine of Double Effect can be applied here as well. The patient’s doctor could just as easily in this case be intending the patient’s death as means or an ends, as in the case of physician-assisted suicide. Would the hospital administrator thus be required to evaluate the intentions of the attending physician and then inform the patient that they must search for another doctor if the current physician sees the patient’s death as a means or an ends? This seems highly implausible.

Despite these inconsistencies the Doctrine of Double Effect remains a popular argument against legalization of physician-assisted suicide. Philosophers have debated the persistence of this theory and Thomson has proposed two main causes for its continued relevance. First is the problem that the difference between what is morally permissible for a person to do, and whether or not doing it would make someone a bad person is underemphasized. The relevant example that Thomson provides is the doctor who injects the patient, according to their wishes, with a lethal dose out of hate or malice. This doctor is clearly a bad person, but the action itself could still be morally permissible. Secondly, there is the common assumption that if intention is disregarded in determining permissibility than the

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only alternative is consequentialism. This viewpoint can be seen from the first introduction of the Doctrine of Double Effect into secular philosophy by G. E. M. Anscombe.\(^23\) However, this is unimaginative as action may infringe on a right depending on the circumstances, and not just the agent's intention, allowing rights-based normative theories to be a possibility, as well as consequentialist ones.\(^24\)

While Judith Thomson criticizes this argument against physician-assisted suicide mainly on the basis that intent does not have the moral weight that proponents of the Doctrine of Double Effect suggest, Dan Brock takes a different approach. He claims that even if one accepts that intent has moral importance, it does not necessarily follow that it can be used to separate physician-assisted suicide from other acceptable actions in medicine that accelerate death.\(^25\) This can be looked at either from the perspective of the patient who requests the action, or the physician who carries it out. In the first instance it is easy to imagine a patient who intends to die and her means to that end is to have her life support withdrawn. Yet here the intent to die seems to have little bearing on either the legal position in the United States, or what is generally considered morally permissible. Whether the patient intends her own death or not, upon request life support must be removed.\(^26\)

Since the debate surround physician-assisted suicide generally focuses on the role of the physician and the permissibility of their action, however, it is this second perspective that holds more weight. The physician’s intent often cannot be

\(^{24}\) Judith Jarvis Thomson, “Physician-Assisted Suicide,” 517.
\(^{26}\) Dan W. Brock, “A Critique,” 532.
differentiated in cases that are considered morally permissible, such as terminal sedation in end-of-life care, and those that are argued not to be, namely the case at hand, physician-assisted suicide. Terminal sedation is a practice used in hospice care when a patient’s pain has proved resistant to the typical means of pain control. In terminal sedation the patient is sedated until they are unconscious in order to relieve their pain and then other treatments such as nutrition and hydration are withheld from the patient until they die. This practice, while generally considered permissible by those who use the Doctrine of Double Effect to argue against the permissibility of physician-assisted suicide, presents a consistency problem for that argument. It is not possible to claim that the patient’s death is not the intention in terminal sedation. One might be able to argue that about the initial sedation but withholding liquids and nutrients as well can serve no purpose other than to cause the patient’s death.27

Additionally, the intention of the physician in physician-assisted suicide is under question, as raised earlier with the example of the physician who simply wants to provide his patient with a feeling of control. While death may be the patient’s intention, and even this is debatable, it does not follow that the death of the patient must be the physician’s intention as well. It is certainly possible that the physician intends for the patient to use the assistance provided to end his life; nevertheless this is not always the case. Knowing that there is a significant chance

that the patient will use the assistance to end his life is not enough to prove that this is what the physician intends it to be used for.  

Finally the Doctrine of Double Effect, by focusing entirely on intent, fails to take into consideration other important factors, namely the consent of the patient. As both Thomson and Brock noted, death itself may not a bad effect and even acting with the intention to bring about the patient's death may thus be permissible. Brock proposes that the moral status of death hinges on the consent of the patient. This autonomy-based argument is entirely ignored by the Doctrine of Double of Effect.

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29 Dan W. Brock, “A Critique,” 537.
III. The Killing Versus Letting Die Distinction

A second argument that is often raised to help establish the moral impermissibility of physician-assisted suicide is one Philippa Foot thought to be established by our intuitions in the now famous Trolley Cases: the killing versus letting die distinction. The basic structure of this argument within the realm of medical ethics has two parts. First, that a physician killing his patient is different from him letting the patient die and secondly that this distinction makes a moral difference, in fact determining the very permissibility of the act.

When Philippa Foot introduces this argument, she frames it in terms of the distinction between doing something and allowing something to happen. She sees this as fundamentally separate from the distinction between an act of omission and an act of commission, a distinction that is often conflated with that of killing and letting die. This subtle difference can be shown by a case such as the actor who fails to turn up for a play that he is starring in. While this is an act of omission, it can still be said that he ‘does’ ruin the play, instead of simply ‘allowing’ it to be ruined. Instead, the moral relevance lies in the difference between positive rights and negative rights. A positive right can be defined as the right to aid, while a negative right is the right not to be harmed. Killing would be the violation of a negative right and letting die the violation of a positive one.

When this framework is taken into consideration regarding the Trolley Cases, the results initially line up with those produced by the Doctrine of Double Effect, as discussed previously. In the case of the trolley driver who faces either

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running over five people, or switching tracks and running over one, it is a conflict of negative duties. He is not able to avoid both and must either ‘kill’ one or ‘kill’ five and as such he must choose to do the least harm he can and kill only the one. This is consistent with both our intuitions and what the Doctrine of Double Effect would mandate. Similarly both our intuitions and the explanation of the Doctrine of Double Effect concur with the conclusion reached using the killing and letting die distinction in the case of the doctor who has five patients who will all die without organ transplants and one man whose organs could save them all if she sacrifices him. In this case the physician faces a positive duty, the duty to aid the five, versus a negative duty, the duty not to harm the one. Since violating a negative right is considered less morally permissible than violating a positive one, it follows that the physician should not kill the one and harvest his organs to save the five.\footnote{Philippa Foot, “The Problem of Abortion and the Doctrine of the Double Effect,” 4.}

Where Foot, correctly, thinks this theory is superior to the Doctrine of Double Effect is in other cases where the killing versus letting die distinction produces conclusions that mimic our intuitions while those produced by the Doctrine of Double Effect do not. One such case is as follows. Five terminally ill patients in a hospital could be saved by the manufacturing of a certain gas, however, the production of this gas would release toxic fumes into another room, killing the one patient residing there. In this situation the death of the one patient would clearly be an unintended, yet foreseen, side effect and thus under the Doctrine of Double Effect this act could be considered permissible, despite our intuitions to the contrary. Conversely, if the case is seen from the standpoint of letting the five who
would need the gas die versus killing the one patient in the other room, the act would not be permissible.\textsuperscript{32}

Although the basic argument that the difference between killing and letting die makes a moral difference in terms of an act’s permissibility seems to be a more plausible approach than the Doctrine of Double Effect, it is also flawed in its attempt to justify why physician-assisted suicide is morally impermissible. Not only is the question of whether the distinction is truly morally relevant open to criticism, it is also possible to argue that even if it is, it does not lead to the conclusions that those who use it to oppose physician-assisted suicide claim.

Philosopher James Rachels argues through a series of cases and thought experiments that the distinction between killing and letting die is not as morally relevant as Foot, among others, has suggested. The first example he gives is that of babies born with Down’s syndrome and current medical policy toward these children. Most children born with Down’s syndrome are born otherwise healthy but some are born with other congenital defects, such as gastrointestinal blockage. These blockages often mean that the child will die without surgery and sometimes parents and physicians decide not to operate and to allow the child to die of the defect. In these cases surgery could easily be performed thus the decision not to operate is essentially a value judgment on the life of the child. This situation is possible because when there is an intestinal obstruction those involved can let the baby die, conventionally judged as morally permissible, while without the defect nothing can be done because that would be ‘killing’ the baby. This appears to be an

almost arbitrary distinction here as the judgment about the worth of the life of the child is made separately from the easily curable defect, which supposedly allows this judgment to occur in the first place. That this theory leads to decisions about life and death being made on such irrelevant grounds is reason in itself to question the validity of it. Furthermore, based on this killing and letting die distinction, such babies marked for death are forced to wither away painfully over the course of hours and even days, as a quick and painless injection that would have produced the same result, the death of the child, is considered killing and not simply letting die.  

The question can also be raised of whether killing is actually worse than letting die or if the assumed moral difference is instead the result of overexposure to clearly morally reprehensible cases of killing, and few potentially morally reprehensible cases of letting die. Rachels attempts to answer this with a thought experiment involving two cases that are identical barring one clear exception, one case involves killing while the other involves letting die. In the first hypothetical, an adult man named Smith will inherit a large sum of money if his six-year-old cousin dies. He decides to drown the child in the bath and does so. In the second case, a man named Jones in the identical situation also plans to drown the child in the bath, but as he walks in to the bathroom to do so the child slips and hits his head, falling face down into the water. Here Jones watches and does nothing as the child drowns on his own, accomplishing the task for him. Technically, Smith 'killed' the child while Jones simply 'let him die' but the second case seems equally morally reprehensible.

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and impermissible. As a result, Rachels claims that the bare difference between killing and letting die fails to make a moral difference.  

Proponents of the killing and letting die distinction have attempted to defend the theory from Rachels’ objections, with relatively little success. Winston Nesbitt, for one, rejects Rachels’ claim based on the fact that in the example that Rachels uses both cases are morally reprehensible, not morally permissible. As a result, the example cannot be used to show the inverse, that because letting die is morally acceptable, then so is killing. However, it is not clear that establishing such a claim would be necessary. While Nesbitt points out that Rachels has not definitively shown that the distinction between killing and letting die is morally irrelevant in all applicable circumstances, Rachels has at the very least called in to question the inherent moral importance of the distinction.

David Callahan also attempts to refute the claim that the distinction between killing and letting die is morally irrelevant. Unlike Foot he believes that the killing versus letting die distinction is the same as the distinction between commission and omission and that these distinctions make a difference in the moral permissibility of an action. Callahan claims that those who think there is no difference confuse causality, the direct physical causes of death, with moral culpability, the moral responsibility attributed to human actions. In the case of a physician discontinuing treatment, the physician is not causing the death of the patient, as omission can only bring about death if the disease would kill in the absence of treatment. If the

omission is in fact wrongful omission then culpability would come in to play but regardless the causal status of this act is different than that of one which directly kills. An act such a lethal injection is the cause of death as it would result in death for both healthy and sick people and as a result it is an act of killing. Callahan then says that cases of unauthorized omissions, or stopping of treatment, could be classified as killings by going a step further and including culpability. While the difference between causality and culpability is an important distinction, Callahan's treatment of the matter does not seem to adequately resolve whatever proposed confusion that led to Rachels' claim that the killing and letting die distinction is not morally relevant.

Callahan continues his argument in favor of using the killing and letting die distinction to oppose physician-assisted suicide and euthanasia by outlining the risks apparently involved in disregarding this distinction. He first suggests that if the distinction is not maintained then physicians will believe they are morally and physically responsible when patients die or when they stop treatment because it is futile. This wrongly burdens physicians and attributes to them the powers of a god. While consideration for the mental status of physicians is important, it is not reason enough to deprive patients of an important option. Also, since doctors save and lose patients regardless of the existence of physician-assisted suicide, they already bear this burden. Secondly, he claims that general acceptance of the killing and letting die distinction as morally irrelevant would lead to the quick and direct

38 Daniel Callahan, “When Self-Determination Runs Amok,” 599.
killing of patients whenever the available medical treatment is judged as no longer effective in prolonging their life.\textsuperscript{39} While certainly a frightening prospect this is not an inevitable next step and could easily be avoided by taking into consideration the patient’s wishes and how they value the quality of the life that they have left.

Despite the flaws in the enumerated objections to the moral irrelevance of the killing and letting die distinction, they are still important to consider and the possibility that the distinction does have moral relevance in the specific medical cases at hand should be addressed. Judith Thomson proposes that even if the distinction does have moral relevance it does not distinguish those cases, such as nonconnecting and disconnecting cases, which are supposedly permissible, from those that proponents of the argument would say are not permissible.

While it seems clear that a nonconnecting case, in which a patient requests not to receive life sustaining treatment, is a case of letting die, it is significantly less clear than a disconnecting case would also fall under that classification. Proponents of this argument claim that in disconnecting cases, like in nonconnecting cases, the physician is simply letting “nature take its course” and allowing the underlying illness to cause the patient’s death whereas in drug-providing and drug-injecting cases it is the drug that causes the death, not the underlying illness.\textsuperscript{40} However, the physician who intervenes in the disconnecting case actually removes what is preventing nature from taking its course and as such could be plausibly be seen as causing nature to take its course, instead of merely allowing it to. In her typical

\textsuperscript{39} Daniel Callahan, “When Self-Determination Runs Amok,” 598.
\textsuperscript{40} Judith Jarvis Thomson, “Physician-Assisted Suicide,” 501.
creative fashion, Thomson invokes a rather absurd analogy to illustrate this point. She compares disconnecting cases to a case where an agent knocks out the main beam of a house, which is holding the roof up. In this case it seems logical to claim that this is not merely letting gravity take its course and is instead actively causing it to. Applying this logic to the disconnecting cases means that these cases are not necessarily simple cases of letting die. This is a significant problem for proponents of the killing versus letting die argument as they use the distinction as the basis for the permissibility of disconnecting cases.41

A plausible response to this objection is that while it is necessary for the patient to die of the underlying condition in order for it to be a case of letting die, this is not sufficient. Instead, other factors, such as culpability per Callahan’s suggestion, must be taken into consideration. For example, if a rival wants to kill his counterpart who is currently in the hospital and he breaks in to the hospital at night and disconnects the patient’s life sustaining treatment in order to do so it is seems appropriate to say that the rival has killed the patient. Based on this two additional necessary conditions can be proposed: (i) that the patient loses what he would have had with the aid of the agent and (ii) that the patient requests the action (or inaction) thus giving the physician the ‘liberty-right’ to carry out the act.42 However, if the requirements for an act of letting die must be refined in such a way then the killing versus letting die distinction is not a non-moral distinction that makes a moral difference. It in itself incorporates a moral difference, the existence of a

'liberty-right'. Additionally, all of this calls into question what the difference between killing and letting die actually is and if this difference is unclear then any proposal that it should make the fundamental moral difference is suspicious at best.

Not only does the distinction “fail to hit all of its target” as it does not definitively incorporate disconnecting cases under letting die, it also “hits what it should not hit” in the latter two cases of drug-providing and drug-injecting. In the case of drug-providing, the classical example of physician-assisted suicide, the premise that a physician ‘killing’ a patient is always morally impermissible may fail to apply. Even if the patient does take the drug provided, which is certainly not a foregone conclusion, it is the patient who actually does the act of killing, not the physician. Some would argue that even if the physician doesn’t kill the patient himself, he is involved in and enables the killing, which is bad. However, if this killing and death is bad, then by this logic suicide itself could be considered morally impermissible. Though this is a view held by some, largely based on religious reasons, it is no longer generally accepted and not supported by modern law. Thus if the cases in question are truly willful suicides, the fact that it is a killing may not mean that it is fundamentally impermissible.

Furthermore, in drug-injecting cases it is clear that the physician does kill the patient so if the classification as a killing means that it is morally impermissible,

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then all drug-injecting cases should be morally impermissible. Interestingly this actually goes against current legal principles and the viewpoint of the American Medical Association, among other entities who consider the killing versus letting die distinction to be an argument against the permissibility of physician-assisted suicide. Incorporating the Doctrine of Double Effect, opponents of physician-assisted suicide sometimes do support drug-injecting cases, specifically those where the death is considered to be a possible side effect, such as the administration of morphine to relieve pain, knowing that death may be a side effect of the dose. Yet this case is still clearly a case of killing, although the intention is different.

Evaluating this example of killing as permissible while deeming others impermissible seems to call in to question the basic premise that the distinction determines the moral permissibility of the action.\(^{48}\)

Despite all the flaws outlined above, this argument has been used to justify state laws that declare physician-assisted suicide illegal. Its use is discussed briefly in the Philosopher’s Brief, the first official intervention by moral philosophers in Supreme Court legislation. In 1997 physician Dr. Harold Glucksberg, supported by three terminally ill patients, four other physicians and a non-profit organization that provides counseling for those considering assisted suicide, Compassion in Dying, challenged Washington State in a case that went all the way to the United States Supreme Court. They challenged Washington’s Natural Death Act of 1979, which banned all assisted suicide, on the grounds that it violated the Due Process Clause of the Fourteenth Amendment to the United States Constitution. Around the same

time, a similar suit was filed in the state of New York by a group of physicians, protesting the state’s prohibition against physician-assisted suicide on the same grounds that it violated the Fourteenth Amendment, although in this case they cited the Equal Protection Clause of the amendment as their justification. These two cases, *Washington v. Glucksberg* and *Vacco v. Quill* led to this now so-called “Philosopher's Brief,” written by six of the most eminent American philosophers at the time: Ronald Dworkin, Thomas Nagel, Robert Nozick, John Rawls and Judith Jarvis Thomson.

In the Philosopher’s Brief, it is noted that petitioners were trying to distinguish the landmark *Cruzan v. Director, Missouri Department of Health* case from the cases at hand using the killing versus letting die distinction and its claim of moral relevance. Said petitioners argued that physicians who remove life support, as was deemed permissible in the *Cruzan* case ruling, are merely letting die, while prescribing lethal drugs is intervening to cause death. The six philosophers behind the brief instead claim, like Thomson and Rachels, that the case of removing life support is much more than just letting die. They claim that both the *Cruzan* case and physician-assisted suicide instead hinge on the desires of the patient, or their proxy. In both cases, the act would help the patient to die, and as such further their wishes. While they acknowledge that there are other differences between the two cases, they too suggest that the killing versus letting die distinction does not seem to be sufficient or effective. 49

49 Ronald Dworkin et. al., "Asissted Suicide: The Philosopher’s Brief."
IV. Concluding Remarks

In this paper I have chosen to focus mainly on the theoretical objections to the legalization and permissibility of physician-assisted suicide. However, a few practical arguments are worth briefly addressing. The first, and weakest, of such objections is the argument that legalization of physician-assisted suicide would lead to an increase in teenage suicides, as teenagers might interpret legalization as the state condoning suicide as a solution to one's problems. This is not supported by empirical evidence, as youth suicide rates in Oregon were actually highest in the early 1990s, prior to Oregon Ballot Measure 16, and have been decreasing since.50 Additionally, even if this claim could not be refuted by empirical evidence, it seems logical that the concern could simply be remedied by changing the terminology used to describe the act, from physician-assisted suicide to one without the word 'suicide', such as physician-assisted death.

Another common practical objection to legalization is the claim that proper pain relief and better palliative care can remove the patient's desire for physician-assisted suicide. Yet, there are a small number of cases in which even those involved in palliative care admit that pain cannot be adequately relieved, resulting in practices such as terminal sedation.51 This objection is also flawed in that even if better palliative care could generally reduce patient desire for physician-assisted suicide; this does not mean that the option should be unilaterally unavailable to them.

50 “Oregon Youth Suicide Facts.” Oregon Health Authority
51 Peter Singer, “Voluntary Euthanasia,” 610.
A final concern, independent of the theoretical objections addressed, is the worry that legalization may have a negative effect on vulnerable populations, such as the disabled, elderly or any people who may be considered a burden. This concern has three potential subdivisions. The first is a slippery slope objection, the worry that legalization will lead to such objectionable practices as involuntary euthanasia. This causal slippery slope argument can be refuted by the results of the legal practice of voluntary euthanasia in the Netherlands, and of physician-assisted suicide in Oregon. There are currently no recorded instances of the Oregon “Death With Dignity Act” being used to coerce patients to commit suicide against their will. Furthermore, in the Netherlands, where not only physician-assisted suicide but also voluntary euthanasia are legal, studies have shown that rates of involuntary euthanasia have not increased following euthanasia and the rate of involuntary euthanasia in the Netherlands is actually lower than those in similar countries, such as Belgium and Australia.

The other two subcategories are concerns that the disabled will feel pressure to opt for physician-assisted suicide so as not to be a burden and that the message suggested by the legalization of physician-assisted suicide is that being unable to care for oneself is a good reason to want to not live. However, this can be resolved by stipulations in the law itself, such as requiring potential candidates to be evaluated as terminal, with six months to live or less, and for the candidate’s request to be verified repeatedly, including by those unrelated to the patient and with

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53 Peter Singer, “Voluntary Euthanasia,” 611.
nothing to gain by their demise. Additionally, even if these concerns could not be
fully spoken to, it is possible to conclude that the risks are outweighed by the right
to autonomy over one of the most significant, if not the most significant, life events,
one's own death.

In conclusion, two of the strongest arguments against the permissibility and
corresponding legalization of physician-assisted suicide, the Doctrine of Double
Effect and the killing versus letting die distinction, are inherently flawed and
unconvincing objections. Additionally, a brief review of popular practical arguments
against legalization has failed to produce any insurmountable objections. As such, I
find the right to physician-assisted suicide able to withstand the most prevalent
arguments against it.
Works Cited


