Solidarity: The Journal of Catholic Social Thought and Secular Ethics

Volume 6
Issue 1 *Bioethics: Multidisciplinary Perspectives on Euthanasia*

Article 3

2016

The Dialectic of Autonomy and Beneficence in the Standard Argument for 'Death with Dignity'

Jeremy Raymond Bell
Campion College, j.bell@campion.edu.au

ISSN: 1839-0366

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Abstract

Philosophers who defend a person's right, under certain circumstances, to end his own life or to have a physician end it for him typically appeal both to respect for patient autonomy and to considerations of beneficence. Neither autonomy alone nor beneficence alone can ground a persuasive case for euthanasia. I argue, however, that the standard argument for euthanasia is unsound. It is not possible to combine the principles of autonomy and beneficence in such a way as to justify euthanasia for those who request it and are either incurably ill, in irremediable pain, or fearful of future incapacity, while excluding both involuntary euthanasia and assisted death for those who request it despite being neither incurably ill, in irremediable pain nor fearful of future incapacity.

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Jeremy Bell

Introduction

Defenders of voluntary passive euthanasia (VPE), physician-assisted suicide (PAS) and voluntary active euthanasia (VAE)[1] usually argue somewhat as follows: under certain conditions, a physician may reasonably comply with a patient's request for assistance in ending his or her life. If, for instance, a patient is incurably ill and in excruciating, irremediable pain, it is understandable that he should not want to go on living. Again, if a patient is in the early stages of Alzheimer's disease and fearful of a slow descent into pitiful senility, it is understandable that she should wish to die before her cognitive faculties become severely impaired. A physician need have no moral qualms about helping such patients to die at their request, provided they are *compos mentis*, properly informed about their situation and not making the request under duress.[2] Moreover, although medical professionals who support PAS often oppose VAE, and although some jurisdictions permit the first but prohibit the second, it is doubtful that there is any significant moral difference between the two. If a physician may assist a patient to commit suicide, why may he not kill her himself, at her request? It can happen, after all, that the second is possible and the first not. (Some gravely ill patients who understandably want to die are physically unable to commit suicide, even with a physician's assistance.)[3] It is not surprising that most ethicists who defend PAS also defend VAE.[4] There may be prudential grounds for opposing the legalization of VAE while supporting the legalization of PAS, but the two seem morally equivalent.[5]

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[1] For the purposes of this paper, "euthanasia" means any action or omission *intended* to end a patient's life. Euthanasia is "active" if it involves an action (e.g. administering a lethal injection) and "passive" if it involves only an omission (e.g. not supplying necessary treatment). The distinction between active and passive euthanasia is not without its problems, but these have no bearing on my argument.

[2] Some would add that physicians must also take into account the likely effects of a patient's death on others, such as the patient's relatives and friends. See, for instance, Jeff McMahan, *The Ethics of Killing*, (Oxford: Oxford University Press, 2002), 462. McMahan believes that cases in which considerations of this kind would rightly outweigh considerations of the patient's own good are 'comparatively rare'.

[3] An anonymous reviewer has pointed out that a physician may supply a patient with the means of painlessly ending her own life, though expecting (and hoping) that she will not in fact use it. The patient may derive comfort simply from knowing that she now has the option of ending her life painlessly, even if she never does so. There is arguably an important moral difference between supplying a suicide pill, confident that it will not be used, and supplying it with the intention that it will be used. However, it would clearly be absurd to pass legislation permitting the first but prohibiting the second.

[4] Some examples: Philippa Foot, "Euthanasia", *Philosophy & Public Affairs*, Vol.6, No.2 (1977), 85-112; John Harris, *The Value of Life* (Routledge, 1985), 77-80; Dan Brock, "Voluntary Active Euthanasia", *The Hastings Center Report*, Vol. 22, No. 2. (1992), 10-22; Gerald Dworkin and R. G. Frey, "Distinctions in Death", in *Euthanasia and Physician-Assisted Suicide*, 17-42; Michael Tooley, "In Defence of Voluntary Active Euthanasia and Assisted Suicide", in *Contemporary Debates in Applied Ethics*, ed. Andrew I. Cohen and Christopher Heath Wellman (Blackwell, 2005), 161-178; Frances Kamm, "Four-Step Arguments for Physician-Assisted Suicide and Euthanasia", in *Bioethical Prescriptions: To Create, End, Choose and Improve Lives* (Oxford: Oxford University Press, 2013), 53-83. One prominent defender of PAS who does not defend VAE is Timothy Quill (perhaps not coincidentally, a physician). See his "Physicians Should "Assist in Suicide" When It Is Appropriate", *Journal of Law, Medicine and Ethics* (Spring, 2012), 57-65.

[5] 'The only reason to favour PAS rather than euthanasia must be based on either political expediency or on safeguards.' Ezekiel J. Emanuel, "What is the Great Benefit of Legalizing Euthanasia or Physician-Assisted Suicide?", *Ethics*, Vol.109, No.3 (1999), 630.

The argument just sketched, which may safely be described as the standard argument for VPE, PAS and VAE, appeals to two principles. The first is often called "autonomy". The second is sometimes called "mercy" or "compassion", but I shall use the broader term "beneficence."[6] The principle of beneficence holds that a doctor must act in the best interests of her patient. The principle of autonomy is less easy to define.[7] Roughly, it holds that every competent adult is rightfully his own master. He has the right, at least within certain limits, to dispose of his own person and property as he sees fit, without interference. The medical ethicist Tom Beauchamp, who is also a proponent of the standard argument for VPE, PAS and VAE, defines autonomy as 'personal rule of the self' that is 'free of controlling interferences by others and free of personal limitations that prevent choice'.[8] He identifies two basic conditions of autonomy: '(1) *liberty* (independence from controlling influences); and (2) *agency* (capacity for intentional action)'. Clearly any human being who has what Beauchamp calls "agency" must, at a minimum, be *compos mentis*. 'Agency' arguably requires more than this, but I shall not enter into this question. In the context of the euthanasia debate, it is usually only the minimal sense of "agency" – legal competence – that is relevant.

It is widely agreed that neither of these principles (autonomy and beneficence) is sufficient on its own to justify a physician's killing a patient or assisting in his or her suicide. If autonomy alone were decisive, there would be no reason why a healthy young man of unimpaired mental capacity should not enlist a physician's aid in ending his life, simply because, like Goethe's Werther, he has been unhappy in love and wants to die. Yet few would contend that it is morally permissible for physicians to assist those in the prime of life and health to commit suicide. Since there is normally good reason to expect that a healthy but heartbroken young man will rally soon enough, most supporters of PAS and VAE would acknowledge that the principle of beneficence should in this case override that of autonomy. On the other hand, if euthanasia were justified solely on grounds of beneficence, there would be no obvious objection to a physician's taking it upon himself to end the life of a competent patient in irremediable pain or in dread of imminent physical/mental deterioration, without her request. But nearly all campaigners for 'death with dignity' emphatically oppose involuntary active euthanasia (IAE), branding it a gross violation of patient autonomy.

The standard argument for VPE, PAS and VAE thus rests on the conjunction of the principles of autonomy and beneficence, not on either alone.[9] As Hallvard Lillehammer says, 'the patient's autonomous request…*and*…the doctor's competent judgement that death would be a benefit to the patient…are *individually necessary*, and *jointly sufficient*, conditions for

[6] One of the more important areas of disagreement among proponents of the standard argument concerns the appropriate scope of this principle. For instance, it is controversial whether a physician may, in the name of beneficence, assist in suicide or perform euthanasia in order to relieve intense mental suffering, unaccompanied by either physical suffering or somatic illness. See Christopher Cowley, "Euthanasia in Psychiatry Can Never Be Justified. A Reply to Wijsbek", *Theoretical Medicine and Bioethics* 34 (2013), 227-238, and Jukka Varelius, "Mental Illness, Lack of Autonomy and Physician-Assisted Death", in *New Directions in the Ethics of Assisted Suicide and Euthanasia*, ed. Michael Cholbi and Jukka Varelius (Springer International Publishing, 2015), 59-77.

[7] "Autonomy" is a hotly contested term in contemporary political discourse. For the purposes of this paper, I am only concerned with the specific sense attached to it in what I am calling the standard argument for euthanasia, but I recognize that this is not its only possible sense.

[8] Tom Beauchamp, "Who Deserves Autonomy, and Whose Autonomy Deserves Respect?", in *Personal Autonomy: New Essays on Personal Autonomy and its Role in Contemporary Moral Philosophy*, ed. J. Stacey Taylor (Cambridge: Cambridge University Press, 2005), 310.

[9] Margaret Pabst Battin, "Is a Physician Ever Obligated to Help a Patient Die?", in *Ending Life: Ethics and the Way We Die* (New York: Oxford University Press, 2005), 89. See also 92.

permissible [physician-assisted suicide and] voluntary euthanasia'.[10] Yet this raises questions. Firstly, what is a physician to do in situations where he judges that death would be a benefit to a patient whose mental or physical condition has deteriorated to the point that she is *unable* to make autonomous requests of any kind? Assuming she has not given any advance directives, may the physician put her to death on his own initiative? This would be what is called non-voluntary euthanasia (NVE). Since NVE in such a case would not *violate* the patient's autonomy, it is not clear that proponents of the standard argument can consistently object to it, as some of them freely admit.[11] This point has been stressed by two opponents of PAS and euthanasia, John Keown and David Albert Jones.[12]

A further question raised by the standard argument concerns the possibility of conflict between the demands of autonomy and the demands of beneficence. Respect for a patient's wishes and concern for his best interests may pull a physician in opposite directions. It is sometimes necessary to sacrifice one or the other. Although there is a pronounced tendency in contemporary medicine and medical law to regard autonomy as paramount, no responsible health professional will accede to any and every autonomous patient request. To be sure, most physicians would balk at the idea of *coercing* a competent patient to undergo treatment. However, there are cases in which this would arguably be the lesser of two evils. For instance, it occasionally happens that a competent patient rejects potentially life-saving treatment, despite having no religious or other principled objections to it.[13] Involuntary treatment is not *obviously* unethical in this case. Defenders of VPE, PAS and VAE maintain that death is sometimes in a patient's best interests and that intentionally ending a patient's life is not intrinsically wrong. Let us suppose for argument's sake that they are right. It is conceivable that some competent patients for whom death would be a benefit might nonetheless refuse to request assistance in dying. Granted that, in the abstract, the principle of autonomy does not *necessarily* override the principle of beneficence, why is it *never* morally permissible for a physician to take it upon himself to end the life of such patients? Why is IAE *never* justified?

In this paper I shall argue that proponents of the standard argument for VPE, PAS and VAE can give no satisfactory answer to this question.[14] My contention is that, if intentionally ending a patient's life is not intrinsically wrong, and if, nonetheless, IAE is *never* justified, this can only be because the principle of autonomy *does* necessarily override the principle of beneficence, whenever the two conflict. But, in that case, the appeal to the principle of beneficence in the standard argument for VPE, PAS and VAE would be idle. The principle of autonomy alone would justify a physician's assisting in a patient's suicide or killing her himself at her request. Yet to concede this would be to abandon the standard argument.

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[10] Hallvard Lillehammer, "Voluntary Euthanasia and the Logical Slippery Slope Argument", *Cambridge Law Journal*, Vol.61, No.3 (2002), 548 (emphasis in original).

[11] Harris, *Value of Life*, 79; Brock, "Voluntary Active Euthanasia", 20; Peter Singer, *Rethinking Life and Death: The Collapse of Our Traditional Ethics* (New York: St. Martin's Griffin, 1994), 207. See also Peter Singer, *Practical Ethics*, 3rd edition (Cambridge: Cambridge University Press, 2011), 158-169.

[12] See John Keown, *Euthanasia, Ethics and Public Policy: An Argument Against Euthanasia* (Cambridge: Cambridge University Press, 2002), 76-79, and David Albert Jones, "Is There a Logical Slippery Slope from Voluntary to Nonvoluntary Euthanasia?", *Kennedy Institute of Ethics Journal*, Vol.21, No.4 (2011), 379-404. Jones in this paper seeks to defend Keown's argument against the objections raised by Lillehammer in "Voluntary Euthanasia and the Logical Slippery Slope Argument" and by Stephen Smith in "Fallacies of the Logical Slippery Slope in the Debate on Physician-Assisted Suicide and Euthanasia", *Medical Law Review*, Vol.13 No.2 (2005), 224-243.

[13] I discuss two cases of this kind below (p.13).

[14] Keown suggests in passing (*Euthanasia, Ethics and Public Policy*, 77) that campaigners for euthanasia may not be able to rule out IAE, but he does not develop the suggestion.

If autonomy sometimes trumps beneficence and beneficence sometimes trumps autonomy, we need general criteria for distinguishing cases. We therefore need to be clear just why autonomy is important in the first place. As one defender of the standard argument, Emma Bullock, remarks, if we accept that what is in the best interests of a patient need not coincide with what the patient happens to want, 'it is an interesting question…why we should care about patient autonomy at all'.[15] Proponents of the standard argument for VPE, PAS and VAE answer this question in different ways. They disagree chiefly about whether autonomy is intrinsically valuable or only instrumentally valuable. I shall argue in the first three sections that there is no good reason, on either view, to think that IAE could *never* be justified. In section III, I shall briefly consider some of the broader implications of my critique of the standard argument.

I. Autonomy and Utility

The principle of autonomy is the keystone of contemporary liberalism. Generally speaking, a competent adult should, we think, be free to dispose of his own person and property as he sees fit. His autonomy demands respect. But why? What makes autonomy deserving of respect?

Many defenders of VPE, PAS and VAE do not thematically address this question. Probably most ethicists would claim that autonomy is somehow *intrinsically* valuable. A competent individual's freedom to live (and perhaps to die) as he chooses is something good in itself, they would say, even if he uses this freedom unwisely. Utilitarians, however, would disagree. Peter Singer is perhaps the best-known utilitarian writing today, and he is also a proponent of the standard argument for VPE, PAS and VAE.[16] 'Utilitarians,' he observes, 'do not respect autonomy for its own sake'.[17] They respect it only insofar as it tends to promote utility. Leaving every competent adult largely free to dispose of his person and property as he thinks fit, they might argue, will indeed tend to promote utility for all. That is, it will tend to maximise pleasure, or to minimise pain, or to maximise preference-satisfaction, for all. At the same time, we should have no compunction about sometimes violating the autonomy of competent adults, if we have reason to think that this will lead to greater net utility. Autonomy, in short, is only instrumentally valuable. Put differently, the principle of autonomy is necessarily subordinate to the principle of beneficence.

This utilitarian view certainly has its attractions. Whenever a person desires to act in a certain way but is not allowed to do so, she is robbed of an opportunity to increase her utility. Especially in a technologically advanced and prosperous society, in which many different careers and lifestyles are possible, wide-ranging freedom of choice is arguably indispensable if people are to maximise their utility. Freedom helps to foster habits of self-reliance and initiative, which in turn tend to make for a more satisfying life. Grown men and women often resent even well-intentioned curbs on their freedom. The sense of being in control of one's own life – of being an autonomous individual – is itself a source of utility. On the other hand, unrestricted freedom for every competent adult would certainly not tend to promote utility for all. If competent adults were left free to manufacture, sell and buy crystal methamphetamine, for instance, the likely results would be catastrophic. Governments are therefore justified in

[15] Emma Bullock, "Assisted Dying and the Proper Role of Patient Autonomy", in *New Directions in the Ethics of Assisted Suicide and Euthanasia*, ed. Cholbi and Varelius, 20.
[16] I noted earlier (n11) that, as well as defending voluntary euthanasia for competent patients, Singer also defends non-voluntary euthanasia for (some) incompetent patients.
[17] Singer, *Practical Ethics*, 3rd edition, 84.

criminalizing its manufacture and trade, even though this violates the autonomy of would-be drug-dealers and drug-users. Since autonomy is not *intrinsically* valuable, we need have no scruples about such 'paternalism'.

Classical or hedonistic (Benthamite) utilitarianism is concerned with pleasure-maximization and pain-minimization. If a patient is in irremediable, excruciating pain,[18] the classical utilitarian would surely say that death would be a benefit for him. He can no longer take significant pleasure in anything and the only thing that will deliver him from his terrible pain is death. Again, if he anticipates with anguish a slow descent into senility or degrading dependence on others, he may likewise find it impossible to take real pleasure in anything. He may nonetheless not request his physician to aid him in dying. Perhaps he is so terrified at the thought of death that he cannot bring himself to do so. Even if the physician offered to kill him, his fear of death would make him instantly refuse the offer. Why, then, should the physician not put him out of his misery, without his consent? Patient autonomy, in this situation, does *not* promote utility. On the contrary, it indirectly promotes disutility. Since utilitarians respect autonomy only insofar as it promotes utility, it is hard to see how a classical utilitarian could object to IAE in cases of this kind.

This does not mean, of course, that a classical utilitarian would necessarily support the legalization of IAE. Quite possibly he would maintain that IAE should be illegal, even though it is sometimes morally unobjectionable. There would be no inconsistency in this position. Nonetheless, since the standard argument for VPE, PAS and VAE is above all a moral argument, it is important to recognize that a classical utilitarian proponent of it should have no *general* moral objection to IAE. Most campaigners for 'death with dignity' denounce IAE under any circumstances, but a classical utilitarian cannot.

Peter Singer himself acknowledges that the classical utilitarian 'might have to accept that in some cases it would be right to kill a person who does not choose to die on the grounds that the person will otherwise lead a miserable life' (84). He argues, however, that this is true only at what, following R. M. Hare, he calls the 'critical level' of moral reasoning. At this level, one considers the moral complexities of individual actual or hypothetical cases. But, again following Hare, he claims that critical moral reasoning cannot guide everyday moral decision-making. For practical purposes, our moral reasoning must remain at the 'intuitive' level. We must be guided by 'broad ethical principles', including those that 'experience has shown, over the centuries, to be generally conducive to producing the best consequences' (79). The principle of autonomy is 'a prime example of such a principle' (84). Consequently, classical utilitarian moral reasoning at the intuitive, everyday level would rule out IAE.

Even if this were true, it would not follow that the classical utilitarian would never condone particular cases of IAE. Singer admits the possibility that 'very occasionally we will find ourselves in circumstances in which it is absolutely plain that departing from the [broad ethical] principles will produce a much better result than we will obtain by sticking to them, *and then we may be justified in making the departure*' (79, emphasis added). A physician who finds himself saddled with an incurably ill patient in chronic, irremediable pain might consider it 'absolutely plain' that he should depart from the broad ethical principles that (allegedly) rule out IAE. If he were a resolute classical utilitarian, he almost certainly would.

[18] Given the resources of contemporary medicine, this situation is in fact unlikely (though not impossible), at least in the more affluent parts of the world. I am grateful to an anonymous reviewer for stressing this point.

Opponents of IAE would therefore take little comfort in Singer's Harean argument, even if it were sound. But the argument is unsound, because it does not take into account the possibility of conflict between the 'broad ethical principles' to which Singer appeals. Precisely because these principles must be rough-and-ready rules of thumb, suitable for daily life, they are bound to conflict from time to time. The principle of autonomy sometimes conflicts with that of beneficence, and one or the other must be sacrificed. The classical utilitarian may well adopt the principle of autonomy to guide him in his 'intuitive' moral reasoning, but we can expect that he will sometimes, perhaps quite often, deem it necessary to sacrifice autonomy for the sake of beneficence. We cannot then assume that his everyday morality will rule out IAE. In fact, we have good reason to think that it will not. A physician who is a classical utilitarian will probably accept the principle of patient autonomy. However, he may also accept the principle that, when death would manifestly benefit a patient (e.g., by delivering her from irremediable pain), her physician should kill her. This principle is simply a classical utilitarian inference from the principle of beneficence. It would override the principle of patient autonomy in *all* cases where patients whom death would (supposedly) benefit nonetheless do not request assistance in dying. It would have to do so, since utilitarians regard autonomy as necessarily subordinate to beneficence. To be sure, it might in turn be overridden by other principles. For instance, if IAE is illegal and the physician thinks there are classical utilitarian grounds for accepting the principle that, in general, one should not break the law, he might refrain from IAE out of deference to *this* principle. But, then again, he might not, if he thinks he can break the law without being caught.

Singer might object that the radically 'paternalistic' mercy-killing principle just described can hardly be said to have stood the test of time. Most physicians throughout history have not made it their rule to kill patients whom they judge death would benefit, without their consent. Experience has not shown, 'over the centuries,' that the paternalistic mercy-killing principle is 'generally conducive to producing the best consequences'. But, after all, Singer does not claim that *all* of the principles guiding everyday moral reasoning must have stood the test of time. The principle of autonomy in medical ethics is itself a mid- or late-20th century development. (In any case, Singer's appeal to the moral experience of centuries is somewhat incongruous, given his bold call elsewhere for a 'Copernican revolution' in ethics.[19])

Singer describes cases in which killing a person without her consent would maximise utility as 'unusual hypothetical cases'.[20] As we saw earlier, he admits that, from a classical utilitarian perspective, such killing might 'very occasionally' be justified. Nonetheless, he gives the impression that the question is academic, a matter of armchair speculation rather than real-world deliberation. But the question clearly is not academic. Physicians *do* have to deal with patients in irremediable, excruciating pain or in dread of a future descent into degrading senility – not every day, indeed, but sometimes. A classical utilitarian, as we have seen, has every reason to contemplate putting such patients out of their misery, without their consent or even in violation of their expressed wishes. It seems that Singer's chief reason for treating as merely academic the question of justifiably killing people without their consent is that it would be necessary, and difficult, to keep such killing secret. From a classical utilitarian perspective, secrecy would be necessary because, if other people found out about the killing, they would 'become fearful of being murdered or gloomy about their prospects of living to a ripe old age'. (No doubt secrecy would also be necessary if the physician wished to avoid incarceration.) It would be difficult, presumably, because keeping murder secret usually is difficult. But it would

[19] Singer, *Practical Ethics*, 2nd edition, 189.
[20] Singer, *Practical Ethics*, 3rd edition, 78.

not always be as difficult as Singer seems to think. If a patient in irremediable agony is also terminally ill, a skilful physician who decides to kill her without her consent may have little trouble in keeping the true cause of death secret. We are all familiar with stories of nurses discreetly administering fatally high doses of medication to bedridden nursing-home residents. Such actions are of course fraught with risk, but, on classical utilitarian premises, the risk will sometimes be worth taking.

Classical utilitarians, then, cannot rule out IAE. Singer, however, is a preference utilitarian, not a classical utilitarian. Preference utilitarianism, in his words, 'judges actions, not by their tendency to maximise pleasure or minimise pain, but by the extent to which they accord with the preferences of any beings affected by the action or its consequences'.[21] Does preference utilitarianism rule out IAE, at least at the level of 'intuitive' moral reasoning?

A patient in irremediable, severe pain or dreading imminent senility may get little or no pleasure out of life, yet still prefer to stay alive. A classical utilitarian would discount this preference, but a preference utilitarian would not. Admittedly, utilitarianism in all its forms seeks to maximise general utility, not the utility of specific individuals. Even if the suffering patient preferred to stay alive, it is conceivable that considerations of general utility (general preference-satisfaction) would dictate killing him against his will. This possibility raises questions I lack space to discuss here. On the assumption that the suffering patient's preferences alone should dictate the appropriate course of action, it may seem evident that IAE would *not* be justified in this case.

However, matters are not so simple. If we say that the patient 'prefers' to stay alive, we may mean different things. The preference utilitarian John Harsanyi distinguishes between what he calls 'manifest' and 'true' preferences.[22] A person's 'manifest' preferences are those he observably manifests in some way, and these may well be irrational. The lovesick youth who begs to be killed has a patently irrational 'manifest' preference for death. A person's 'true' preferences, on the other hand, are 'the preferences he *would* have if he had all the relevant factual information, always reasoned with the greatest possible care, and were in a state of mind most conducive to rational choice' (emphasis in original). It is only a person's 'true' preferences that Harsanyi believes the preference utilitarian should take into account.[23] A patient in agonizing pain or in dread of his imminent mental decline who is also terrified of dying is presumably not in 'a state of mind most conducive to rational choice' and probably is not 'reasoning with the greatest possible care'. If his physician is a Harsanyian preference utilitarian, she might well think that his manifest preference to stay alive does not reflect his 'true' preferences, and put him out of his misery without his consent.

Even if we shrink from the rather sinister move of describing a person's 'true' preferences as those he *would* have if were thinking clearly, Harsanyi is surely right to say that '[a]ny sensible ethical theory must make a distinction between…rational preferences and irrational preferences' (645-646). The physician who is also a preference utilitarian could certainly reason that her patient's preference not to suffer is rational, while his preference to

[21] I am here quoting the definition of preference utilitarianism that Singer gives in the second (1993) edition of *Practical Ethics* (94), which is longer and more exact than the definition given in the corresponding passage of the third (2011) edition (80).
[22] John C. Harsanyi, "Morality and the Theory of Rational Behaviour", *Social Research*, Vol.44, No.4 (1977), 646.
[23] He adds the qualification that 'antisocial' (true) preferences, such as 'sadism, envy, resentment and malice', should be discounted (647).

stay alive is not, and act accordingly. She might reason that her patient desires incompatible things and that it is her job to satisfy what she takes to be his more rational desire.

Singer acknowledges that a person may desire incompatible things.[24] At one point he moots the suggestion that a utilitarian should take a person's 'interests' to be 'what, on balance and after reflection on all the relevant facts a person desires' (94). But suppose a person reflects on all the relevant facts and then decides that, on balance, he desires something whose irrationality is obvious to all but himself. (Think again of the despairing young lover.) Singer would surely not deny that this is possible. If he were to say that even patently irrational desires deserve respect if they appear to be the fruit of reflection on all the relevant facts, this would be tantamount to claiming that utilitarians *should*, after all, 'respect autonomy for its own sake'. Assuming that he would *not* wish to claim this, he would have to concede that, sometimes, it is appropriate to disregard a person's expressed preferences. Why, then, should our utilitarian physician not disregard her suffering patient's expressed preference to stay alive?

Singer indeed goes so far as to admit that '[i]t might be possible' to imagine a case in which killing a person against his will, to spare him 'extreme agony', would be justified.[25] However, he is sceptical. To make this decision, he says, 'one would have to be confident that one can judge when a person's life is so bad as to be not worth living – and that one is in a better position to make that judgement than the person herself'. But, he argues, the other person's wish to go on living is itself 'good evidence that her life is worth living'. 'What better evidence,' he rhetorically asks, 'could there be?'[26]

In the second edition of *Practical Ethics*, though not in the third, he goes further and says that '[i]t is not clear that we are ever justified in having much confidence in our judgement about whether the life of another person is, to that person, worth living'.[27] Is this true? I am inclined to agree with Philippa Foot that, on the contrary, the judgement 'that life is or is not a good to someone' is 'often fairly easy to make'.[28] More precisely, it is often fairly easy to judge that a person does not value his or her own life, without their formally expressing any desire to die (or to be killed). Many of us have seen elderly relatives slowly decline to a point where they no longer desire to go on living. Foot boldly declares that 'someone may cling to life where we would say confidently that it would be better for him if he died, and he may admit it too' (89-90). The suffering patient who dreads death might indeed be said to 'cling to life', despite not truly valuing it. His fear of death need not reflect a love of life. What Singer would call his 'wish to go on living' may not, in truth, be 'good evidence' that his life *is* 'worth living', in the sense of according with his rational preferences. If he has a perceptive physician who knows him well, she may be able to judge with confidence that 'it would be better for him if he died', at least if her understanding of the value of life is that of a preference utilitarian. And what reason would she have not to act on this judgement, if she thought she could do so secretly and safely?

[24] Singer, *Practical Ethics*, 2nd edition, 13. This acknowledgement does not appear in the corresponding passage of the third (2011) edition (11-12).
[25] Singer, *Practical Ethics*, 3rd edition, 177.
[26] In *Rethinking Life and Death*, Singer similarly remarks: 'It is, after all, the patient's life, and as long as the patient is capable of reaching an informed decision, then who better to decide whether life is worth living?' (132).
[27] Singer, *Practical Ethics*, 2nd edition, 201.
[28] Foot, "Euthanasia", 88.

Neither the classical utilitarian nor the preference utilitarian can consistently object to IAE *per se*. The reason is, at bottom, very simple. Utilitarians treat autonomy as merely instrumentally valuable, and therefore subordinate the principle of autonomy to that of beneficence. Utilitarian proponents of the standard argument for VPE, PAS and VAE accept that the principle of beneficence sometimes dictates intentionally ending a patient's life. The moral permissibility of at least some instances of IAE follows necessarily from these premises.

II. Rights and Self-Sovereignty

Let us now examine whether proponents of the standard argument who treat autonomy as *intrinsically* valuable can avoid the same conclusion. We may usefully begin by considering Philippa Foot's presentation of the argument. As we have seen, Foot accepts that it is sometimes possible to judge with confidence that a person does not truly value his life, despite clinging to it. She even thinks that, in such a case, it may be possible to judge with confidence that 'it would be better for him if he died'. She nonetheless maintains that 'so long as he wants to live this does not justify us in killing him' (100). This is because he has a *right* to life, which he has not freely waived. Since he has this right, it would be *unjust* to kill him, even for his own benefit. 'A man may have the right,' she says, 'to something which he himself would be better off without.' A utilitarian would be unlikely to agree with this. Though Foot does not here use the word "autonomy", she does say that 'where rights exist it is a man's will that counts, not his or anyone else's estimate of benefit or harm'. A man's exercise of his rights may in no way benefit him, but other people are nonetheless obliged to respect his choices. We may say, then, that Foot regards autonomy as intrinsically valuable.

The intrinsic value of autonomy, for Foot, is apparently a consequence of the intrinsic inviolability of human rights, or at least of some human rights. Why should we agree with her that (some) human rights are inviolable, or even that our ontology should include human rights? She does not attempt to defend the claim that all human beings have a right to life, presumably because it is relatively uncontroversial. Nor does she adumbrate any general account of the nature and foundation of human rights, since meta-ethics is not her immediate concern. Nonetheless, a striking general consequence of her argument is that a person's rights are in a way independent of his interests. She admits that 'men have the right only to the kind of thing that is, in general, a good' (100). All the same, 'there is…no direct connection between that to which a man has a right and that which is for his good'. For this reason, '[j]ustice as such is not directly linked to the good of another, and may require that something be rendered to him even where it will do him harm' (97).

Foot does not go so far as to say that human rights exist *in virtue of* human goods (human interests), but this seems a reasonable extrapolation from her remark that 'men have the right only to the kind of thing that is, in general, a good'. If human rights exist at all, it is surely plausible to suppose that they are in some sense founded on human goods (interests). The human rights theorist James Griffin, who is also a proponent of the standard argument, declares that human rights are 'derived from' human interests'.[29] If, as Foot claims, human rights are nonetheless in one way *independent* of human interests, it is natural to ask why they should necessarily be inviolable. If human interests are the foundation of human rights, and if we can occasionally serve a certain individual's interests better by overriding his rights than by respecting them, why should we not do so? Griffin himself acknowledges that 'a human right can be outweighed' (222).

[29] James Griffin, *On Human Rights* (Oxford: Oxford University Press, 2008), 124.

As we have seen, Foot speaks sometimes of 'rights' and sometimes of 'justice'. Although she apparently thinks that an act of injustice will necessarily be a violation of a right, and vice versa, we should be mindful of the subtle rhetorical difference between speaking of rights and speaking of justice. We are likely to be less discomfited by talk of a right being violated (or 'overridden', or 'outweighed') than by talk of *injustice*. For the same reason, Foot's claim that justice is 'not directly linked to the good of another' at least *sounds* less plausible than her claim that there is 'no direct connection between that to which a man has a right and that which is for his good', even though she treats the two claims as equivalent. In this context she cites with approval a passage in Book III, Part II, Section I of Hume's *Treatise of Human Nature*. Hume is discussing whether justice is a 'natural' or an 'artificial' virtue and he mentions in passing the example of a debt owed to a profligate debauchee who 'would rather receive harm than benefit from large possessions'.[30] Foot claims that, according to Hume, the debt 'must be paid',[31] though this is not precisely what Hume says.[32] It is not obvious that we should agree with Foot's Hume (and Foot herself) on this point. It is not even obvious that, whether or not the debt must be paid, not paying it would be an act of injustice. In a well-known passage in Book I of the *Republic*, Socrates suggests that it could not be just to return a borrowed weapon when its owner has in the meantime gone insane.[33] An armed madman is a danger not only to others but also, sometimes, to himself. It follows that it can sometimes be just *not* to pay a debt. It might be objected that the mentally incompetent do not have the same rights as competent adults, and that Foot's argument concerns only the rights of competent adults. I think Socrates would respond that, quite generally, it cannot be just to respect the property rights of those who are manifestly intent on abusing their possessions.[34] If, for instance, a mentally competent but despondent and self-indulgent adult is in the habit of seeking oblivion in reckless binge-drinking, would a friend of his not act *justly* in confiscating as much of his stock of alcohol as possible? On this Socratic view, considerations of justice cannot be independent of considerations of beneficence in the way that Foot supposes.

Even if Foot is right that justice sometimes demands rendering something to a person, despite its being bad for him, we may think that this only shows the limitations of justice. Perhaps it is not always *good* to act justly, odd as this sounds. As we have seen, from Foot's perspective this is equivalent to saying that it is perhaps not always good to respect people's rights, which certainly sounds less odd. It may sometimes be necessary, for a person's own sake, to override his rights. This would be, in Foot's language, a case of mercy trumping justice, or, as I prefer to say, of beneficence trumping autonomy. We can interpret the friendly action of confiscating a reckless drinker's alcohol in this way. If a physician is justifiably confident that one of her patients would be better off dead, even though he is determined not to ask for assistance in dying, why should she not kill him?

One possible answer would be that the right to life, unlike the right to external property, is strictly inviolable. It may sometimes be morally licit to violate a person's property rights, but it can never be morally licit to violate his right to life, even for his own good. Yet this distinction among rights may seem arbitrary. If it is true, as Foot believes, that there are

[30] David Hume, *Treatise on Human Nature*, ed. Ernest C. Mossner (Penguin Classics, 1985), 534.
[31] Foot, "Euthanasia", 97.
[32] He merely observes that, since paying the debt would harm the creditor, the motive for doing so cannot be 'private benevolence'. His general point is that the motive for acting justly cannot be benevolence. (It is worth noting that, in Hume's view, rules of justice are entirely a matter of convention. This is certainly not Foot's view.)
[33] Plato, *Republic*, trans. Allan Bloom (Basic Books, 1991), 7 (331c1-d1).
[34] I suspect Socrates would also question whether there is really a categorical distinction between the 'insane', on the one hand, and those who do not know what is truly good for them, on the other.

situations in which we can benefit a person by killing him without his consent, why is it never licit to do so, even though it sometimes *is* licit to benefit him by confiscating his property? Why is the right to life radically different from any right in external property?

We might want to say that a person's right over *himself* is necessarily absolute, while his right over external possessions is not. This is an intelligible position. 'Over himself, over his own body and mind,' John Stuart Mill famously wrote, 'the individual is sovereign'.[35] Taken literally, this epigram would indeed imply that killing a person without his consent can *never* be justified, even if confiscating his property sometimes can be. The problem with this response is that it threatens to render idle the appeal to beneficence in the standard argument for VPE, PAS and VAE. If a person has *absolute sovereignty* over his own person, he surely has at least a defeasible right to kill himself, or to request others to kill him, at will. The lovesick youth, no less than the suffering terminal patient, has this right. Admittedly, a physician may have no *obligation* to comply with the youth's request, whereas some euthanasia campaigners argue that he *does* have an obligation to comply with the terminal patient's request.[36] Most proponents of the standard argument, however, would wish to make the stronger claim that a physician has no *right* to comply with the youth's request. Yet it is not clear what basis there could be for this stronger claim, on the assumption that the youth is indeed 'sovereign' over himself. If he freely decides to do away with himself, why should he not request help in doing so, and why should there be any necessary moral objection to a physician's complying with his request? As one proponent of the standard argument, Jeff McMahan, says, 'when it is *permissible* for a person to do a certain act, it should also be permissible for a third party to do that act for him, at his request'.[37] By appealing to 'self-sovereignty' in order to avoid justifying IAE, we seemingly commit ourselves to the unwelcome corollary that autonomy *always* trumps beneficence.

It might be argued that a physician has no right to comply with a healthy young man's euthanasia request, *in his capacity as a physician*. The task of a physician is to benefit his patients, and killing a healthy young man (even at his request) cannot be said to benefit him. Robert Young makes this argument, claiming that 'advocates of voluntary medically assisted dying have always maintained that it should be regarded as a component of appropriate *medical* care'.[38] For this reason, they have no reason to accept that PAS or euthanasia 'would have to be made available' in 'morally fraught cases' such as that of the disappointed lover. The claim that defenders of assisted death have 'always' maintained that it should be a component of medical care seems to me an exaggeration.[39] In any case, Young's argument implicitly concedes that there would be nothing wrong with someone who is *not* a physician complying with the request. Indeed, if the youth made the request of a friend who happened to be a physician (though not *his* physician), there would seemingly be nothing wrong with this physician complying with it, as a friend. No proponent of the standard argument would accept this conclusion.

[35] John Stuart Mill, *On Liberty* (Harmondsworth; Baltimore: Penguin, 1974), 69. Mill hastens to add that this is true 'only of human beings in the maturity of their faculties'.
[36] Frances Kamm, "A Right to Choose Death?", *APA Newsletter*, 97:1 (1997), 92.
[37] McMahan, *The Ethics of Killing*, 463. McMahan adds a qualification ('provided that in doing the act the third party would not be unfairly favouring the one person over another') that is not relevant in the present context.
[38] Robert Young, "'Existential Suffering' and Voluntary Medically Assisted Dying", *Journal of Medical Ethics*, Vol.40 (2014), 108.
[39] Many defences of euthanasia do *not* explicitly treat it as a medical question, though some of these no doubt presuppose that it is.

A different strategy for ruling out IAE without rendering the principle of beneficence idle would be to adopt a less literal and more moderate interpretation of Millian 'self-sovereignty', according to which it amounts to no more than a right of non-interference. Certainly, a mere right of non-interference is not equivalent to a right to dispose of one's person in any way one wishes, with or without the assistance of others. Frances Kamm argues that autonomy is 'essentially a negative right not to be interfered with'.[40] This negative right should not be violated even for the person's own good. 'We think the right of a mentally competent patient not to be physically invaded against his will is typically stronger than our interest in the patient's well-being' (232). It follows that 'it would be morally wrong to kill [a] patient if he did not want to die, even if it were in his best interest to die'. However, it does not follow that a physician should accede to any competent person's request for assistance in dying. On the contrary, 'if…a patient asks for assistance in killing himself when it is not in his medical interest to be killed, it might well be morally *im*permissible to assist in killing him' (232-233).

We should note that, though Kamm speaks of a broad 'right not to be interfered with', she seemingly has in mind a narrower right not to be 'physically invaded' against one's will. It is possible to 'interfere' with a person without 'physically invading' him or her, as when a government prohibits individuals to manufacture, sell or buy crystal methamphetamine. Since few would contend that every competent adult has an *unrestricted* right of non-interference (provided of course that he or she respects this right in others), it is charitable to interpret Kamm as positing only an unrestricted right of competent adults not to be physically invaded against their will. Put differently, it is charitable to interpret her as being concerned with what is sometimes called 'bodily autonomy'. Her construal of (bodily) autonomy as no more than a competent adult's right not to be 'physically invaded' against her will reflects the prevailing views of contemporary health professionals. While all health professionals would admit that it is sometimes right to reject patient requests, many would never so much as consider *coercing* a competent patient to undergo treatment she had not requested, let alone treatment she had expressly refused. However, we must press the question: what is the basis for ascribing to competent adults this *inviolable* right of non-invasion? If rights are grounded in interests, whence the inviolability of this right, even when physical invasion would serve one's interests? I remarked earlier that there are cases in which coercing a competent patient to undergo unrequested treatment would arguably be the lesser of two evils. To appreciate the force of the question about the basis for regarding patient consent as strictly inviolable, it is here worth considering two real-life instances in which doctors have chosen to override it.

(1) Shimon Glick reports a case in which a competent man suffering from bacterial pneumonia refused intubation and mechanical respiration, despite physicians' efforts to persuade him otherwise. After he had fallen unconscious, the physicians intubated him and attached him to a respirator, thereby (most likely) saving his life. His first words on regaining consciousness were "Thank you".[41]

(2) In a landmark 2010 ruling, a British judge gave doctors permission to use force against a 55-year-old woman suffering from uterine cancer. She was not in any usual sense

[40] Frances Kamm, "Ronald Dworkin on Abortion and Assisted Suicide", *Journal of Ethics*, Vol.5, No.3 (1997), 233.

[41] Shimon Glick, "The Morality of Coercion", *Journal of Medical Ethics*, Vol.26, No.5 (2000), 394. Glick believes that the physicians' action was justified. He also notes, with approval, that one liberal democracy (Israel) has patient rights legislation that includes a provision for involuntary treatment under certain circumstances (393).

deranged, but her phobia of hospitals and needles had led her to refuse potentially life-saving treatment.[42]

What is important about these cases is not that the physicians' violations of patient autonomy were obviously justified – the ruling in the second case was highly controversial – but that they were *not obviously unjustified*. Unless we assume that autonomy *always* trumps beneficence, we must acknowledge that there was a *prima facie* justification for the physicians' actions in both cases. If the physicians did indeed act rightly in one or both cases, it would follow that involuntary treatment – physical 'invasion' against a patient's wishes but in her own interests – is sometimes justified. If involuntary treatment is sometimes justified, and if death is sometimes in the best interests of a patient who nonetheless does not ask for it, why should involuntary euthanasia not sometimes be justified? It might be objected that the only situations in which involuntary treatment could be justified are those in which physicians are seeking to *save* life, as in the cases just described. But why should we accept this? Why should preserving a patient's life on the presumption that she still values it be deemed a graver reason for overriding autonomy than delivering a patient from a miserable life that one is confident she does *not* still value?

Since there is a *prima facie* justification for at least some kinds of involuntary treatment, the onus is on defenders of the strict inviolability of a competent adult's right of non-invasion to explain exactly why involuntary treatment can *never* be justified. We have already seen that it will not do to ground an inviolable right of non-invasion in a broader right of 'self-sovereignty'. Certainly, the idea that we all 'own' ourselves or in any case have *absolute rights* over our own persons can seem appealing, or even self-evident. The slogan "Whose life is it anyway?" derives its rhetorical power from the thought that, after all, our lives (and certainly our bodies) *are* our own, which can seem to entail that we may do with them as we choose. But, on this view, it is unclear why there should be any moral objection to others killing us at our request, no matter what our reason for making the request.

If proponents of the standard argument for VPE, PAS and VAE seek to ground the intrinsic, yet not absolute, value of autonomy simply in the existence of waivable rights, as does Foot, it will be difficult for them to explain why a person should not be able to waive his right to life at will. On the other hand, if they also make the plausible move of deriving rights from human interests, it will be difficult for them to explain why there should be anything wrong with occasionally overriding a right – even the right to life – in the name of beneficence. They clearly need a different, or at least fuller, account of the intrinsic (non-absolute) value of autonomy.

III. Dignity

Many supporters of euthanasia connect the value of autonomy with the intrinsic *dignity* of the human being *qua* rational agent. Robin Gibson, for instance, claims that '[pa]rt of the dignity of the person is that person's responsibility for his or her decisions'.[43] Michael Tooley states that 'autonomy is a right that persons possess by virtue of their nature as beings capable

[42] Martin Beckford and Stephen Adams, "Cancer Patient Forced by Judge to Have Surgery", *The Telegraph*, 26 May 2010, www.telegraph.co.uk/news/health/7769243/Cancer-patient-forced-by-judge-to-have-surgery.html, accessed 9/10/2016.
[43] Robin Gibson, "The Case for Euthanasia and Physician-Assisted Suicide", *ISAA Review*, Vol.11, Issue 1 (2012), 12.

of conscious experience, thought, and rational choice'[44]. Roughly speaking, then, autonomy – 'personal rule of the self' free from external constraint – is intrinsically valuable because human beings possess an inherent dignity in virtue of their rationality, and it is an affront to this dignity to interfere with their rational decision-making. Even if human rights are in some way derived from human interests, overriding human rights precisely to further the interests from which they are derived may still be wrong, because incompatible with respect for the inherent dignity of the human person.

We should immediately note that this quasi-Kantian account of the intrinsic value of autonomy could easily be deployed by *opponents* of euthanasia. By killing a human being at her request, a physician destroys a rational agent with the capacity for rational choice. In destroying her, he of course destroys her rationality and her capacity for rational choice. Yet these are supposed to be what endow her with the intrinsic dignity, respect for which is a necessary condition of his complying with her request. The patient may believe that her life has lost all value, but it seems that the physician cannot (on this view) agree. David Velleman succinctly articulates the problem when he says that a person 'cannot claim…that out of respect for his autonomy we should defer to his judgement that he possesses nothing worthy of our respect'.[45] Some proponents of the standard argument acknowledge the problem and seek to show that it is only apparent.[46] However, I shall not pursue the issue here. Let us suppose, for argument's sake, that a competent adult's autonomy deserves respect because her dignity as a rational being deserves respect and that, nonetheless, destroying her at her request can be compatible with respect for this same dignity. Proponents of the standard argument clearly cannot claim that a rational agent's autonomy has an *absolute* value or deserves *unconditional* respect, since this would mean that the principle of autonomy *necessarily* trumps that of beneficence. If killing a person is not necessarily incompatible with respect for her dignity as a rational agent, and if autonomy does not deserve unconditional respect, is killing a person for her own good, without her consent, occasionally justified? Can proponents of the standard argument who ground the intrinsic value of autonomy in the inherent dignity of rational agents rule out IAE?

In order to answer this question, let us firstly consider a broader question. Does the inherent dignity of a rational agent ground a *general* and *inviolable* right of non-interference? Here it is important to bear in mind the distinction between 'interference' and physical *invasion*. Offhand, the idea of an inviolable right of non-interference is quite implausible. Governments are surely within their rights in banning the manufacture, sale and purchase of methamphetamine, for instance, even though this certainly interferes with the activities of would-be drug-dealers and drug-users. With reference to Kamm, I noted that the idea of an inviolable right of non-*invasion* ('bodily autonomy') is intuitively much more plausible. Yet it is unclear why bodily invasion should be *especially* objectionable, if the value of autonomy in general is supposed to be connected with the inherent dignity of a rational agent. The freedom of a would-be drug-user to pursue his goals is restricted more severely by his being forbidden to manufacture or buy crystal methamphetamine than by his being given medical treatment that he needs but, in a moment of irrational squeamishness, refuses.

[44] Tooley, "In Defence of Voluntary Active Euthanasia and Assisted Suicide", 165.
[45] David Velleman, "A Right of Self-Termination?", *Ethics*, Vol.109, No.3 (1999), 612. Velleman does not necessarily oppose PAS and euthanasia, but he does believe that 'self-termination' is 'immoral when committed on the grounds that life isn't worth living' (614).
[46] See, e.g., McMahan, *The Ethics of Killing*, 473-485, Griffin, *On Human Rights*, 217-221, and Frances Kamm, "Some Arguments by Velleman Concerning Suicide and Assisted Suicide", in *Bioethical Prescriptions*, 84-98.

If the intrinsic value of autonomy in general derives from the inherent dignity of human beings *qua* rational agents, and if this value is nonetheless not absolute, there is no obvious reason why the intrinsic value of *bodily* autonomy in particular should be absolute. I sought to show above that, though intuitively plausible, the claim that competent adults have a *strictly inviolable* right not to be 'physically invaded' is questionable, to say the least. Since each of the two instances I described of involuntary treatment had a clear *prima facie* justification, the onus is on those who deny that either was in fact justified to explain why not.

It could be argued that the inherent dignity of human beings means that the intrinsic value of autonomy *with regards to certain kinds of decision* (including the decision for or against 'death with dignity') is absolute, even though neither the value of autonomy in general nor the value of bodily autonomy in particular is so. This was the strategy pursued by Ronald Dworkin, Thomas Nagel, John Rawls, Robert Nozick, Judith Jarvis Thompson and Thomas Scanlon in their 1997 amicus curiae "Philosophers' Brief" to the U.S. Supreme Court on assisted suicide. In his introduction to the "Brief", Dworkin stated that 'every competent person has the right to make momentous personal decisions which invoke fundamental religious or philosophical convictions about life's value for himself'.[47] Clearly the decision to hasten death (or not) is one such. The "Brief" argued that people have a 'liberty interest', protected by the U.S. Constitution, in being able to hasten their own deaths. Citing the Court's own majority opinion in *Planned Parenthood v Casey* (1993), the authors claimed that this interest 'flows from the right of people to make their own decisions about matters "involving the most intimate and personal choices a person may make in a lifetime, choices central to personal dignity and autonomy"'.

Taken at face value, these statements seem to imply that *any* competent adult, including one who is neither terminally ill nor in irremediable pain, should have the right to request physician assistance in dying. The lovesick youth's decision to do away with himself is surely one of the most 'intimate and personal choices' he could ever make. It is clear, however, that the authors of the "Brief" did not wish to subordinate the principle of beneficence entirely to that of autonomy. 'It may be legitimate,' they say, 'for a state to deny an opportunity for assisted suicide when it acts in what it reasonably judges to be the best interests of the potential suicide, and when its judgment on that issue does not rest on contested judgments about "matters involving the most intimate and personal choices a person may make in a lifetime, choices central to personal dignity and autonomy"'. One problem with this response lies in the expression "contested judgements". If the despairing young lover is not actually deranged, do we have any reason for simply *discounting* his judgement that death would be preferable to staying alive? The state may prevent him from seeking assistance in suicide on the grounds that he is mistaken, but in doing so it is surely relying on a 'contested judgement'. The youth 'contests' the state's judgement as to what is in his best interest. The "Brief's" authors would likely respond that the youth himself would soon come to see things differently. They argue that a state may reasonably take the view that 'people who are not terminally ill, but who have formed a desire to die, are, as a group, very likely later to be grateful if they are prevented from taking their own lives'. Consequently, it might legitimately 'deny any of them a doctor's assistance [in taking their own lives]', for their own sake. The implication is that it is *enduring* judgements, rather than passing desires, that the state must respect. In his introduction to the "Brief", Ronald Dworkin indeed states that 'people may make…momentous decisions impulsively or out of emotional depression, when their act does not reflect their enduring

[47] Ronald Dworkin, Thomas Nagel, John Rawls, Robert Nozick, Judith Jarvis Thompson & Thomas Scanlon, "Philosopher's Brief on Assisted Suicide" (1997), http://www.nybooks.com/articles/1997/03/27/assisted-suicide-the-philosophers-brief/, accessed 20/03/2016.

convictions'. In such cases, the state may (sometimes) legitimately override would-be suicides' autonomy.

If it is only enduring convictions bearing on 'intimate and personal choices' that the government and physicians are *always* obliged to respect, some unpalatable consequences follow. Firstly, it follows that a healthy young adult who acquires a firm conviction that hastening death would be in his immediate interests may rightfully receive assistance in dying. Take, for example, the members of the Californian religious group Heaven's Gate who in 1997 committed suicide in the belief that the earth was shortly to be destroyed and that the only way to escape was to kill themselves and thereby proceed to the 'Next Level'. They would have had every right to request and receive physician assistance in dying. Secondly, it follows that involuntary euthanasia would not always be wrong. Suppose a certain terminally ill patient in irremediable pain were to refuse to ask for assistance in dying, despite having been for many years an outspoken supporter of 'death with dignity'. Her physician might reasonably think that her refusal does not reflect an abrupt change of fundamental conviction, but is due simply to (understandable) irrational dread at the prospect of imminent death. To borrow a phrase from Dworkin himself, the physician might judge that, when it comes to it, the patient is just 'too…squeamish to sign a document requesting death'.[48] The physician, however, is *not* too squeamish to respect the patient's 'enduring convictions' and give her a quick exit, without her request. It is not clear how Dworkin and his co-authors could consistently fault him for doing so.

We should also bear in mind the obvious fact that large numbers of people simply do not have 'enduring convictions' about life's value. Suppose that a human being who has never given death much thought (or who has perhaps studiously *avoided* giving death much thought) is diagnosed with a terminal illness and before long starts to experience terrible pain, for which medicine offers little relief. His reactions are, on the one hand, horror at the thought of death and, on the other, terror at the thought of ongoing pain. He refuses to countenance the idea of seeking assistance in dying, yet he has no principled objection to the idea of 'death with dignity'. What should his physician do, on the principles limned in the "Philosopher's Brief"? There would seem to be no objection to his taking it upon himself to put the unfortunate man out of his misery.

Like other proponents of the standard argument for PVE, PAS and VAE, Dworkin and his colleagues assumed that, if a suffering patient has an 'enduring conviction' which leads him to refuse assistance in dying, involuntary euthanasia would represent a violation of his right 'to live and die in the light of his own religious and ethical beliefs, his own convictions about why his life is valuable and where its value lies'.[49] This assumption may seem self-evident. Yet it is arguably *false*. Consider the following imaginary case: an elderly woman of devout Catholic faith is suffering from the same form of rheumatoid arthritis that afflicted the Englishwoman Lillian Boyes, who died in 1991. Boyes' arthritis caused her pain so severe that she would scream when touched. At her request, her doctor, Nigel Cox, injected her with potassium chloride to stop her heart, an act for which one of her sons later publicly thanked him.[50] Unlike Boyes, our imaginary devout Catholic considers it a mortal sin to take one's own life or to

[48] Ronald Dworkin, *Life's Dominion: An Argument about Abortion, Euthanasia, and Individual Freedom* (New York: Vintage Books 1994), 180.
[49] Dworkin et al., "Philosopher's Brief".
[50] Patrick Boyes, 'My mother's dying wish', *The Independent*, 10 December 1995, http://www.independent.co.uk/life-style/women-and-men-testimony-my-mothers-dying-wish-1525030.html, accessed 04/04/2016. Cox was nonetheless later found guilty of attempted murder.

request assistance in dying. Nonetheless, like Boyes, her irremediable suffering makes her long to die as soon as possible. Indeed, she prays to die as soon as possible. Let us also imagine that, again like Cox, she has a son who cannot bear to see her suffer. He has long since ceased to share her Catholic faith and does not believe that PAS or euthanasia is necessarily wrong. He finally proposes to her physician that he discreetly substitute potassium chloride for her usual biologics when he next gives her an injection, and the physician agrees. Have the son and the physician violated the woman's right to live and die in the light of her own religious and ethical beliefs, or her own convictions about the value of her life? At least in one sense, clearly not. The woman acted to the end in the light of her religious and ethical beliefs. Her son and physician in no way forced her to act against her Catholic faith. Nor, on the other hand, was death unwelcome to her. She did not want to keep on living and her determination not to ask for assistance in dying did not reflect a conviction that her life was still worth living, only a conviction that she would be punished in the next life if she took any steps to hasten the end of this one. To be sure, according to her creed, her physician acted sinfully in ending her life. But the fact that it was *her* life is here incidental; she would have considered it no less sinful of him to end anyone else's life, consent or no consent. Why, then, should her convictions tie his hands in her case, any more than in any other?

I argued in the preceding section that supporters of PAS and euthanasia who ground the intrinsic, yet not absolute, value of autonomy on the existence of (waivable) human rights will not be able to rule out IAE. Any plausible theory of human rights will treat them as in some way derivative from human interests, and since supporters of PAS and voluntary euthanasia maintain that a hastened death can sometimes be in a person's best interests, they have no principled reason to claim that violating a person's right to life is *necessarily* wrong. In this section, I have considered the alternative strategy of invoking the dignity of rational agents to explain the intrinsic, yet not absolute, value of autonomy. The fundamental problem with this strategy is that, by effectively denying any connection between the value of autonomy and the promotion of human interests, it leaves us more or less in the dark about the proper limits of respect for autonomy. Hence this strategy too leaves the door open to IAE.

IV. Alternatives to the standard argument

The standard argument for VPE, PAS and VAE is supposed to establish the right to 'death with dignity' for those, and *only* those, who have good reason to consider a hastened death a blessing, while excluding IAE under any circumstances. I have sought to show that the argument fails, because the principles of autonomy and beneficence cannot be combined in the way that the argument requires. As the unfolding of my critique has illustrated, the ineliminable tension between the two principles puts constant pressure on the argument's proponents to concede either that *any* competent adult who wishes to enlist a physician's aid in dying has the right to do so, or that IAE *is* sometimes justified.

If my critique is sound, what conclusion should we draw regarding the morality of euthanasia? One option would be to accept that IAE is indeed sometimes justified, even if legalizing it would be imprudent. However, involuntary euthanasia is anathema to virtually all parties to the euthanasia debate, so we may disregard this option. Erstwhile proponents of the standard argument are much likelier to jettison the principle of beneficence and accept that any competent adult, for any reason whatever, may rightfully enlist a physician's aid in dying. This

position is not unheard of either in the academic literature[51] or in the public sphere. The well-known euthanasia campaigner Philip Nitschke has publicly stated that 'every adult of sound mind' should have automatic access to a 'peaceful pill' such as Nembutal.[52] I cannot discuss the merits of this position in any detail in the present paper. However, it is worth considering some of its implications. It rests on a literal construal of the Millian principle of 'self-sovereignty', according to which, in the words of Robert Nozick, 'someone may choose (or permit another) to do to himself *anything*, unless he has acquired an obligation to some third party not to do or allow it'.[53] If every adult of sound mind may rightfully dispose of himself in any way he wishes, then duelling, for instance, should not be illegal.[54] In fact, there should be no law against torturing, mutilating or killing, when the victim freely consents. If, say, a religious cult should arise in which (as in Aztec religion) human sacrifice was demanded, there should be no law against people freely offering themselves as sacrificial victims. Again, if a man or woman is sexually aroused at the idea of being tortured or mutilated and willingly submits to such treatment, his or her torturer should not be subject to legal sanctions. In 2001, the German Bernd Jürgen Armando Brandes allowed Armin Meiwes to amputate his penis and later kill him, on the understanding that Meiwes would eat his carcass. Should such activities be legal? The philosopher J. Jeremy Wisnewski has argued that, because 'a violation of autonomy is a constitutive part of the wrongfulness of murder', Brandes' consent to his own death meant that Meiwes' action should not be classified as murder – and, presumably, that Meiwes should not have been prosecuted.[55] Absolutism about autonomy comes at a high price.

Another possible conclusion to draw from the failure of the standard argument is that the violation of patient autonomy is *not* what is morally objectionable about IAE. More generally, and *pace* Wisnewski, a violation of autonomy is not 'a constitutive part of the wrongfulness of murder'. What then does constitute the wrongfulness of IAE and of murder generally? Here different answers could be given. One would be that the intentional killing of the innocent is always wrong, even if the victim consents. It would follow, of course, that euthanasia as such is wrong. I believe this would be the correct conclusion to draw. Certainly, it raises a host of further questions (about the meaning of 'innocence', about the distinction between killing and 'letting die', about the nature and moral relevance of intention etc.). These questions are the subjects of prolonged and sometimes fierce debates, into which I cannot begin to enter here. I shall only venture the suggestion that the repugnance most of us feel both at IAE and at the idea of an unrestricted right of all competent adults to have others kill them at

[51] Felicia Ackerman argues that PAS should be available either to *all* competent adults or to no one. 'True privacy and autonomy,' she claims, 'would allow each person to determine for himself what conditions would justify suicide.' Felicia Ackerman, "Assisted Suicide, Terminal Illness, Severe Disability and the Double Standard", in *Physician-Assisted Suicide: Expanding the Debate*, ed. Margaret Pabst Battin, Rosamond Rhodes and Anita Silbers (Routledge, 1998), 151.

[52] Margaret Simons, "Between Life and Death", *The Age*, 31 August 2013, http://www.theage.com.au/lifestyle/between-life-and-death-20130825-2skl0, accessed 02/04/2016. This is not, however, the official position of Exit International, the pro-euthanasia advocacy organisation founded by Nitschke.

[53] Robert Nozick, *Anarchy, State and Utopia* (Basic Books, 1974), 58.

[54] Daniel Callahan points this out in "A Case Against Euthanasia", in Cohen and Wellman, *Contemporary Debates*, 182.

[55] J. Jeremy Wisnewski, "Murder, Cannibalism and Indirect Suicide: A Philosophical Study of a Recent Case", *Philosophy in the Contemporary World*, Vol.14, No1 (2007), 13. Wisnewski mentions, but does not discuss, the mutilation that preceded the killing. Since Brandes consented to this as well, Wisnewski would no doubt see it as morally unproblematic. (More precisely, he would see it as morally unproblematic, given that Meiwes had no dependents, a fact he mentions in n10 (15). Presumably a married man normally has a moral obligation to his wife not to allow his penis to be amputated for non-medical reasons.) Wisnewski anticipates and rebuts the objection that Brandes was not *compos mentis* at the time he consented to being mutilated and killed (16-17).

their request reflects our (perhaps inchoate) recognition of the intrinsic wrongness of intentionally killing the innocent, even with their consent. This would explain why proponents of the standard argument strive to avoid both of the extremes, to one or the other of which their principles nonetheless tend to drive them.

Conclusion

The standard argument for 'death with dignity' seeks to combine the principles of beneficence and autonomy in a way that is ultimately incoherent. We cannot consistently condone some, but not all, instances of voluntary euthanasia in the name of beneficence, while condemning all instances of involuntary euthanasia in the name of autonomy. If we do not wish either to condone some instances of involuntary euthanasia or to follow Philip Nitschke in holding that any competent adult may, for any reason, enlist a physician's aid in dying, we seem compelled to accept that euthanasia as such is morally illicit. I have suggested that the reason for this is that the intentional killing of the innocent is always wrong, even when done at their own request and with their own interests at heart. To develop and defend this suggestion, however, would be a task for another day.