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An Ethical Study of the Impact Hedonistic-Utilitarianism

Exerts on the Philosophy and Practice

of Physician-Assisted Suicide

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ABSTRACT

Terminal illness and the prospect of a painful and protracted dying process created new medical realities for Western culture in recent decades. Patients challenged traditional medical canons against medical killing by requesting changes in laws to allow physician assistance with suicide (PAS). This challenge occurred within a broader cultural context where core principles of medical common morality (beneficence, patient autonomy, and justice) were questioned.

A new study of medical killing is warranted because ethical changes are occurring in current issues surrounding doctors and patients (for example, humanism and autonomy, rights, justice, and the morality of medical killing). Furthermore PAS proponents argue that sometimes there is a moral obligation for beneficent medicine to allay suffering; that is, a doctor must kill or assist his patient's suicide. This thesis explores the possible influence that John Stuart Mill's hedonistic-utilitarianism (HU) exerts on one aspect of medical killing, the philosophy and practice of PAS.

This study clarifies certain features of the PAS debate and demonstrates weaknesses inherent in HU that impact adversely on medical canons and doctor-patient relationships (DPR). Six features within the PAS debate are examined for HU influence. Chapter 1 delineates how Mill's key utilitarian pleasure-is-happiness (PH) theme interacts with the topic of PAS in contemporary medico-cultural discussions. Chapter 2 surveys some epochal events in the development of rights, justice, and medical killing, while chapter 3 surveys similarly autonomy, physician paternalism, and sanctity of life (SL)--all in relationship to PAS. The final chapter isolates key HU weaknesses found in PAS arguments and offers moral concerns regarding the utilisation of HU claims to justify changing traditional medical canons to endorse PAS. The thesis contributes to the ongoing medical-ethical dialogue about medical killing by exploring the historical and ethical points crucial to future discussions of medical killing.

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ABBREVIATIONS

AMA	American Medical Association
BMA	British Medical Association
DPR	Doctor-Patient Relationship
GHP	Greatest Happiness Principle
GMC	General Medical Council
HMO	Health Maintenance Organisation
HU	Hedonistic-Utilitarianism
NHS	National Health Service (UK)
NM	Principle of Nonmaleficence
N.P.	No Page
<i>OED</i>	<i>Oxford English Dictionary</i> (2d edition)
PAS	Physician-Assisted Suicide
PH	Pleasure-is-Happiness or Pleasure-Happiness
PPO	Preferred Provider Organisation
PSV	Psychological-Social Version
PU	Preference Utilitarianism
QL	Quality of Life
SL	Sanctity of Life
VAE	Voluntary Active Euthanasia

INTRODUCTION

The advent of new medical technologies in the 1960s enabled physicians to extend life well beyond its natural limits. The dying process oftentimes became a painful and protracted event for terminally ill patients with few people in Western culture having been left untouched in some way by this healthcare scenario. As this sort of medical occurrence continued, by the 1990s a new medical reality emerged. Some patients, in an attempt to escape the harsh possibility of this sort of dying process, began to request a change in laws to allow medical assistance with suicide.¹ The request for physician-assisted suicide (PAS) itself, along with other forms of physician-aid-in-dying, presented a challenge to traditional medical canons against medical killing.² The challenge of PAS occurred within a much broader cultural context where traditional core principles of medical common morality (like beneficence, patient autonomy, and justice) began to be questioned.³ Overall, the medical community faced questions on several fronts that challenged the foundation of established medical practice. Even as cultural and ethical concerns with medicine were growing, fresh philosophical concerns surfaced in other quarters.

Philosophers began to examine all facets of the current state of medicine. Indeed, the same decade of the 1960s gave rise to numerous articles, books, and studies on the implications of ethical concerns upon medical practice. Despite this voluminous corpus of material, a new study of medical killing is warranted for two reasons. First, this thesis will present an

¹Daniel Callahan, "Foreword," in *Euthanasia Examined: Ethical, Clinical, and Legal Perspectives*, ed. John Keown, reprint edition (Cambridge: Cambridge University Press, 1998), xiii-xiv.

²Ibid.

³Discussions of beneficence usually include the topic of nonmaleficence; likewise, patient autonomy gives rise to a discussion of physician paternalism. Please see ch. 3 for a discussion of these themes as they relate to PAS.

examination of the ethical changes in current issues surrounding doctors and patients (for example, humanism and autonomy, rights, justice, and the morality of medical killing) from the perspective of selected historical periods where changes related to these basic issues also occurred. The author believes that these previous periods offer excellent background material that can illuminate selected aspects of proposed cultural and philosophical changes in medical canons regarding medical killing. Such an examination of historical links can broaden and inform the current debate that surrounds proposed changes within medicine.

A further reason for a new study includes a current ethical claim that sometimes there is a moral obligation for beneficent medicine to allay suffering. This can result in a doctor killing or assisting a patient's suicide. While much has been written for and against medical killing and physician-assistance-with-suicide, this thesis will examine the subject from a fresh perspective. It explores the possible influence that John Stuart Mill's philosophical approach (hedonistic-utilitarianism [HU]) exerts on one aspect of medical killing. The topic at hand is the philosophy and practice of PAS.

Mill's form of utilitarianism has long been recognised as a useful philosophical framework for social policy aimed toward improving the conditions of human life by the exercise of rational principles.⁴ John Stuart Mill (1806-1873) championed this notion as a catalyst for social change, and his writings, while gaining wide acclaim in his era, have continued to exert broad influence in the more than one hundred years since he penned them.

An example of Mill's current influence includes contemporary philosophers and medical-ethicists who cite portions of his arguments to support claims within the medical-ethical arena.⁵ Mill centred his philosophy on several core issues which figure prominently in

⁴William L. Davidson, *Political Thought in England: The Utilitarians from Bentham to J. S. Mill* (New York: Henry Holt and Co., 1916), 8-9.

⁵Margaret Pabst Battin, *The Least Worst Death: Essays in Bioethics on the End of Life* (New York: Oxford University Press, 1994), 278; 286, footnote 9; Margaret Pabst Battin, *The Death Debate: Ethical Issues in Suicide* (Upper Saddle River, NJ: Prentice Hall, 1996), 169; Sheila McLean and Alison Britton, *The Case for Physician Assisted Suicide* (London: Pandora,

the current medical-ethical climate: PAS, autonomy, rights, and justice. An examination of his philosophy is important in this instance because it leads to a significant research question-- whether HU provides sufficient moral ground to warrant a change in medical canons regarding medical killing.

The research question is unique in that no other study to date deals specifically with Mill's philosophy in relation to PAS. Van Zyl's work approaches the subject of medical killing (euthanasia) from a virtues-orientation.⁶ Battin does write on PAS and makes isolated references to Mill, but she does not address PAS from Mill's hedonistic-utilitarian perspective.⁷ Singer addresses the subject of medical killing in his writings from a preference utilitarian perspective which differs somewhat from Mill's approach.⁸ None of the above discussions includes the pleasure-is-happiness (PH) theme, which is central to Mill's theory and which could influence patient decisions regarding PAS.

Influence of John Stuart Mill

As far back as ancient Greece, moral theories about what an individual ought to do usually contained at least two basic components: a view about what is "good" (a theory of value) and some theory of what constitutes the "right" (a theory of action).⁹ The latter component, a theory of what constitutes "rightness," dictated how individuals ought to act in

1997), 29; and Tom L. Beauchamp and James F. Childress, *Principles of Biomedical Ethics*, 4th ed. (New York: Oxford University Press, 1994), 125, 276-77, 285, 334.

⁶Liezl Van Zyl, *Death and Compassion: A Virtue-Based Approach to Euthanasia* (Aldershot, England: Ashgate, 2000), 7.

⁷Battin, *Least Worst Death*, 26. Battin explores a range of views on suicide, voluntary euthanasia, and suicide, and states that she is "ambivalent" about the issues surrounding these avenues of death. See also Battin, *Death Debate*, 199. Battin writes that views about PAS are in an "extreme state of flux." She does not settle on any one philosophical view related to PAS.

⁸Peter Singer, *Practical Ethics*, 2d ed. (Cambridge: Cambridge University Press, 1995), 94.

⁹Philip Pettit, "Consequentialism," in *A Companion to Ethics*, ed. Peter Singer (Oxford: Blackwell, reprint ed., 1994), 230.

response to what was valued.¹⁰ Like the ancient Greeks, John Stuart Mill's HU contains these two structural components as well. However, Mill further clarified how action should follow value when he added that "all action is for the sake of some end," and that rules of action must take their "whole character" from the end to which they are "subservient."¹¹ In other words, one's actions, according to HU, must have in end view the maximisation of that which is valued; namely, in Mill's theory, pleasure-happiness (PH) for the many. For Mill and the hedonistic-utilitarian, actions are right when actions maximise pleasure-happiness, or, conversely, minimise pain-unhappiness.¹² Mill's theory, as has been stated previously, contains a pervasive moral outlook that has been applied to a broad range of spheres, one of which is the medical-ethical arena.¹³

Conceptually, classical HU draws support from Mill's early reliance upon Ancient Greek philosophy.¹⁴ Mill believed he was providing correction to the ages'-long speculation regarding the *summum bonum* and the controversy surrounding the nature, or the essence, of what constitutes the concept.¹⁵ Mill's venture into the conflict to isolate and define both the supreme good (theory of value) and rules of action to attain that supreme good (theory of action) resulted in the fresh theory of social reform known as Hedonistic-Utilitarianism.¹⁶ In

¹⁰Ibid.

¹¹John Stuart Mill, *Utilitarianism* (Buffalo, NY: Prometheus Books, 1987), 10. This approach to ethics reflected Mill's attempt to correct the social ills of his generation (e.g. women's suffrage). Mill's philosophy, with its antipathy toward deontological ethics, represented something of a watershed for teleological (consequential) theories in moral philosophy.

¹²Ibid., 16-17. It is well-recognised that Mill forwarded the theory that actions are "right" in proportion to the degree that they tend to promote happiness (pleasure) for the many.

¹³ See thesis, 2.

¹⁴See thesis, 10, for a description of the proposed philosophical roots of Mill's philosophy.

¹⁵Mill, *Utilitarianism*, 9.

¹⁶See David Cook, *The Moral Maze: A Way of Exploring Christian Ethics* (London: S.P.C.K., reprint edition, 2001), 32. Arthur F. Holmes, *Ethics: Approaching Moral Decisions*

postulating such a theory, however, Mill moved conceptually beyond ancient Greek philosophy. Mill set himself against the notion of an *a priori* awareness of moral principles. He set the philosophical boundaries clearly in a realm that was outside of intuitionism when he delimited “moral instinct” as a sufficient guide for *moral decision-making by subordinating it to the principle of utility* (author’s italics).¹⁷

Moral decision-making was important to Mill’s enterprise as a means of requiring a person’s decision-making and the subsequent action to derive from the principle of utility.¹⁸ Mill’s bold solution to the ongoing debate about moral decision-making was his claim that his theory (HU) provided a suitable “ultimate moral standard” by which to settle differences of opinion about the best way to make moral decisions.¹⁹ Mill went so far as to state that the greatest happiness theory formed an “indispensable” basis for moral decision-making even for those who “scorned” its principles.²⁰ His boldness extended to the level of claiming that pleasure-happiness was the supreme good and that right actions either maximised pleasure-happiness, or the converse, that right actions minimised pain-unhappiness.²¹ Mill believed that

(Downers Grove, IL: InterVarsity Press, 1984), 41. Anthony Quinton, “Utilitarian Ethics,” in *New Studies in Ethics: Modern Theories*, vol. 2, ed. W. D. Hudson (New York; Saint Martin’s Press, 1970), 1. Mill’s theory is widely recognised as a treatise on social and political reform.

¹⁷Mill, *Utilitarianism*, 11, 13. Mill believed that a moral instinct, itself, was one of the matters in dispute when determining theories of right action. He believed that a person’s moral faculty provided only a general principle of moral judgment. See thesis, 10-11.

¹⁸Mill, *Utilitarianism*, 39-48. Mill names two sanctions that oblige individuals to promote the general happiness: external and internal. External sanctions are the hope of favour and the fear of displeasure from a person’s fellow creatures or from the “Ruler of the Universe” (40). The internal sanction is a sense of conscience or individual duty (41-42). Bentham names four sanctions: physical, political, moral, and religious. See also Jeremy Bentham, *An Introduction to The Principles of Morals and Legislation*, with an introduction by Laurence J. Lafleur (New York: Hafner Publishing Co., 1948), 24.

¹⁹Mill, *Utilitarianism*, 12.

²⁰Ibid., 12-13. This claim concerning the “indispensable” basis of Mill’s GHP was questioned as much then as it is now.

²¹Ibid., 16-17.

individuals always seek their own pleasure or, at least, to minimise their own pain.²² His hybrid philosophy made normative this pleasure concept when he claimed further that individuals *should* act so as to maximise pleasure-happiness *for the many*, or at least minimise pain-unhappiness for the many.²³ Such actions, for Mill, were adjudged as right or wrong based upon the “goodness” (non-moral) or “badness” of the results. “Goodness” or rightness of an action meant that pleasure-happiness for the many was maximised, or that pain-unhappiness was minimised for the many. The “badness” or wrongness of an action would mean that pleasure-happiness for the many was somehow restricted, or that pain-unhappiness for the many was increased. Mill’s theory did not appear suddenly, however, devoid of context. Indeed, his moral conceptualising emerged from within a specific era, characterised in part by a rise in philosophical and scientific empiricism and an exploration of the causes of, and solutions for, the complex social problems of the age. Mill’s writing was an attempt to bring about reform within that specific setting.

Historical Background

Prior to the nineteenth century, Jeremy Bentham (1748-1832) had originated an instrument of *social reform*, utilitarianism, that he and others (including Mill) would use in an attempt to counter the weight of English tradition.²⁴ Excesses connected with the French Revolution had produced a strong political and social reaction in England, which led to an

²²Ibid., 54. This was an empirical fact to Mill and constituted the basis of his shift from psychological hedonism to ethical hedonism.

²³Piers Benn, *Ethics* (Montreal: McGill-Queen’s University Press, 1998), 61. John Finnis, *Fundamentals of Ethics* (Washington D.C.: Georgetown University Press, 1983), 83. Consequentialism is inherent in Mill’s theory and forms the larger umbrella under which HU stands.

²⁴Frederick Copleston, *A History of Philosophy: Modern Philosophy*, vol. 8 (New York: Image Books, 1994), 3. Benthamism, specifically, and utilitarianism, generally, “expressed the attitude of liberal and radical elements in the middle class to the weight of tradition and to the vested interests of what is now often called the Establishment.” Utilitarianism was an instrument used to facilitate social and political reforms. —

emphasis upon, and return to, social stability and tradition.²⁵ Bentham and others provided philosophical challenges to this perceived restrictive status quo. These reformers proved to be influential as British social philosophy in the nineteenth century passed through three successive phases with utilitarianism occupying the first two: Philosophical Radicalism (associated with Bentham); Benthamism modified and developed by John Stuart Mill; and Idealism.²⁶ Jeremy Bentham, one of John Stuart Mill's mentors, is recognised as a bridge between late 18th and 19th century empiricism, but his brand of empiricism varied from the previous classical British empiricism.²⁷ Bentham, like Hume ("Treatise of Human Nature") sought to apply the method of *experimental reasoning* to moral subjects.

Like Bentham, John Stuart Mill's approach adhered to empiricism, which means Mill believed that knowledge is based upon experience through the senses.²⁸ He also held fast to associationism, in that he believed that the mind's workings depend on law-governed associations of ideas with one-another.²⁹ Jeremy Bentham and James Mill (1773-1836, John Stuart Mill's father), provided the influence for John Stuart Mill to adopt, as well as to adapt,

²⁵Ibid., 8:3.

²⁶Ibid. The third, Idealism, was quite different from utilitarianism.

²⁷Ibid., 8:2. The former had been concerned with the "nature, scope and limits of human knowledge," while the utilitarian movement was essentially practical in focus, "oriented towards legal, penal and political reform." The continuity between both was evident in the method of reductive analysis or the reduction of the whole to its simple elements or parts. Bentham carried forward this element of empiricism.

²⁸John Stuart Mill, *Utilitarianism*, edited by Roger Crisp, 8. See also Elizabeth S. Anderson, "John Stuart Mill and Experiments in Living," in *Mill's Utilitarianism: Critical Essays* (Lanham, MD: Rowman & Littlefield Publishers, 1997), 123. Conceptions of the good according to Mill, then, must be tested by "the experiences we have in living them out, not merely by comparing them with ethical intuitions." Mill rejected the view that a person could know about the good singularly through *a priori* intuitions.

²⁹Mill, *Utilitarianism*, edited by Roger Crisp, 8. See also Copleston, 8:29. Associationism figured prominently in Mill's method of linking goods, like virtue or money or fame, to *the* good, happiness. The former goods, in Mill's estimation, cannot properly be described as happiness, but a person can explain them as being sought for their own sake through an *association of ideas*. Ultimately, a good, like virtue for example, comes to be associated with happiness and is seen as a constituent part of it.

these ideas for his own use.³⁰ John Stuart Mill also was influenced by Auguste Comte, who stressed the acquisition of knowledge through accepted methods of science.³¹ Mill, as a result, came to believe that it was possible for a person to apply the methods of physical science to moral and social phenomena. Through the impact of all of these influences, Mill's amalgamated approach, which attempted to blend science with morality, embraced Utilitarianism, a construct which, in turn, supplied him with a critical framework for the conveyance of his ideas. While Mill amplified Bentham's utilitarian *framework* he never deserted entirely Bentham's utilitarianism.³² In fact, Mill states that it became his "creed," "doctrine," and "philosophy."³³

Basis of Mill's Utilitarianism

The purpose of Mill's philosophical thinking was to answer the question "How *should* one live?" To answer such a question would involve answering three further questions: "What is happiness?" "What is the relation between happiness and morality?" and "What is the

³⁰Copleston, 8:29. See also John Stuart Mill, *Autobiography of John Stuart Mill*, with a preface by John Jacob Coss (New York: Columbia University Press, Kessinger's Rare Mystical Reprint edition, 1924), 36-39, 45, and 47. James Mill was a strict Benthamite and the younger Mill was educated in Benthamism. James Mill also held to associationist psychology which he passed on to John Stuart Mill. However, John Stuart Mill, in his work and writings, effectively undermined Bentham's framework with his qualitative move into a "valued pleasure."

³¹Mill, *Autobiography*, 146-47. He was indebted to Comte's "Inverse Deductive Method," whereby a person obtains "generalizations by a collation of specific experience, and verifies them by ascertaining whether they are such as would follow from known general principles." Mill stressed further that Comte had influenced his thinking at the point of the "moral and intellectual ascendancy," an influence formerly exercised by priests, and which Comte envisioned now passing from priests to philosophers. At the same time, Mill did *not* agree with Comte's practical system that a hierarchy of philosophers would possess the same spiritual supremacy that priests in the Catholic Church had once possessed. Mill's emphasis upon elevating and protecting individuality and personal liberties precluded Mill's adoption of Comte's assumptions at this point (149). See also Copleston, 8:16. Mill sought to employ a scientific method in morals and politics. Of course, the feasibility of such a moral approach has been the subject of much debate.

³²Mill, *Utilitarianism*, ed. by Roger Crisp, 8.

³³Mill, *Autobiography*, 47.

morally right way to live or act? Mill sought to address these three central questions in *Utilitarianism*.³⁴ His overall aim was not to write about how the world is, but to explore how it *should* be. In order to establish a basis for this ethical approach, Mill chose, as his foundational principle, the same principle as Bentham did, the *Greatest Happiness Principle* (GHP).

Hedonism, or the view that happiness consists in pleasure, had been given, up to that time, its most sophisticated development by Bentham,³⁵ who reasoned that the happiest life was the one that, simply, consisted in the *greatest amount* of pleasure over pain.³⁶ Bentham had claimed that pleasure was a “kind of sensation, common to all those experiences described as enjoyable or as contributing to the value of a life to the person living it.”³⁷ For Bentham, “pain” referred to all experiences, both physical pain and mental suffering, which people found to be objectionable.³⁸ Bentham’s empirical and quantitative method had led him to postulate that all pleasures and pains are structurally similar sensations, so it would be possible to construct a felicific calculus in order to *measure* the various courses of action one might employ in order to derive the expected utility of any given action.³⁹ This Benthamic approach helped to form the basis for John Stuart Mill’s philosophy.⁴⁰

³⁴Mill, *Utilitarianism*, edited by Roger Crisp, 5.

³⁵Crisp, 10. See also Copleston, 8:8. Hedonism was not a novel doctrine, but Bentham, according to Copleston, gave a “memorable” statement of it.

³⁶Crisp, 10.

³⁷Ibid.

³⁸Ibid.

³⁹Ibid.

⁴⁰Ibid. Mill’s background in empiricism and associationism coloured his understanding of pleasurable physical and mental states. Mill integrated his philosophical and psychological frameworks into a revised utilitarian philosophy. An awareness of Mill’s attempt at a tri-partite blending is important to understand how he aimed to craft a practical, working moral philosophy. See also Henry R. West, *An Introduction to Mill’s Utilitarian Ethics* (New York: Cambridge University Press, 2004), 10. West states, “There can be little question that John Stuart Mill’s moral philosophy cannot be rightly understood without reference to the psychological framework within which he developed it, and from within which he attempted to explain it.”

Following after Bentham, Mill further defined Utilitarianism: “The creed which accepts as the foundation of morals, Utility, or the Greatest Happiness Principle, holds that right actions are right in proportion as they tend to promote happiness, wrong as they tend to produce the reverse of happiness. By happiness is intended pleasure, and the absence of pain; by unhappiness, pain, and the privation of pleasure.”⁴¹ Mill assumed that there must be either a single principle at the root of all morality, or, if there are several, there is to be a determinate order of preference to them.⁴² The GHP answered the need for a unifying principle in Mill’s mind. He also recognised there would be challenges to his claim and he sought to answer them. Mill’s hedonistic-utilitarian theory, together with challenges leveled against it, invites thoughtful exposition and critique.

Exposition and Critique of Mill’s HU

Mill’s HU: Theory of Value

Mill supported the utilitarian view by his defence of the same in his 1863 treatise, *Utilitarianism*.⁴³ In the first chapter he provided a brief critique of alternative *a priori* (intuitive) ethical theories. In so doing, he sought to demonstrate the superior strength of a utilitarian (inductive/empirical) approach. In contrast to an intuitive moral approach, Mill did not believe that there was a “moral sense” that enabled a person to discern what was right and wrong in each particular case,⁴⁴ instead, he believed that a person’s “moral sense” was but an outgrowth of his reason. Observation and experience was sufficient, in his scheme, to supply a

⁴¹Mill, *Utilitarianism*, 16-17; see also Bentham, *Principles*, 2.

⁴²West, 31-32; and Mill, *Utilitarianism*, 1, 3.

⁴³Mill, *Utilitarianism*, 13; and West, 28. The thesis author has chosen to critique Mill’s approach by examining the two basic components of the theory: value and action.

⁴⁴Crisp, 22. Mill was willing, however, to admit a moral sense by which a person can grasp general moral principles. See also West, 170.

person with what was a right action in any particular circumstance.⁴⁵ Mill believed that the GHP played a significant role in shaping moral doctrines—even of those who rejected its authority—because he believed that a person’s feelings could not help but be shaped by what he or she supposed to be the effect of experiences upon his or her happiness.⁴⁶ Mill’s chief claims concerning utility is that *happiness is desirable*, and the *only thing desirable* as an end.⁴⁷

Critical Assumptions

Even in Mill’s polite opening “defence” of utilitarianism he *assumed* several things. One of his assumptions was that morals and legislation are practical arts—meaning that they are derived scientifically, thereby discounting (rejecting) an *a priori* intuitive approach to morals. He also *assumed* a teleological view of morality,⁴⁸ with pleasure-happiness serving as the *summum bonum* as defined by the GHP. His utilitarian theory of morality meant that *actions* were considered to be right or wrong as they tended to produce happiness or unhappiness.

Rather than offering a careful critique of the *a priori* approach, Mill actually offered specific alternatives in order to establish the moral theory he then developed in his remaining chapters of *Utilitarianism*. Mill intended to respond to objections by clarifying his adaptation of the primary tenets of utilitarianism—both within the framework of its theory of value and its theory of action.⁴⁹

Mill’s defence of utilitarianism in chapter one is based on assumptions that presuppose a structure to a moral theory. Mill sought to base his argument on hedonistic principles that he

⁴⁵West, 170.

⁴⁶Ibid., 171.

⁴⁷Mill, *Utilitarianism*, 49.

⁴⁸Ibid., 10; and West, 31.

⁴⁹The utilitarian theory as conceived by Bentham had received challenges, the force of which Mill sought to blunt or refute entirely. See Mill, *Utilitarianism*, 14, 15-38.

claims originated in Ancient Greece. He believed that the two schools of thought, inductive and intuitive, were rooted there by reference to Socrates' argument for hedonism in the *Protagoras*.⁵⁰ Essentially, Socrates was believed by Mill to hold to the idea that pleasure and pain were intrinsically good and bad, respectively, and that this principle formed the ultimate standard for moral reasoning.

Mill followed the same approach when seeking to respond to critics of utilitarianism. He believed that his opponents unconsciously used the principle of utility and that without it they had no ultimate standard.⁵¹ Therefore, Mill's assumptions concerning the *a priori* school actually imposed a structural condition upon ethics that makes it difficult to consider eligible alternatives.⁵² While this approach worked for Mill, it actually begged the question against "the most fundamental characteristics of intuitive ethics."⁵³ In Mill's mind, overall "moral obligation depended entirely upon the intrinsic worth of the intended or expected results."⁵⁴

⁵⁰West, 29.

⁵¹Mill, *Utilitarianism*, 11; and West, 30.

⁵²West, 31.

⁵³*Ibid.*, 32. While elements of both the deontological and the teleological can be found in any particular ethical theory, intuitionism was ruled out by Mill when he assumed a teleological classification and a single principle at the root of all morality. Mill's teleological approach did not adhere to the deontological requirement that there were certain duties inherently incumbent upon a person. The concept of intuitionism also allows for a number of possible first principles, a notion that Mill disallowed. See John Rawls, *A Theory of Justice* (Cambridge, MA: Belknap Press, rev. ed., 1999), 34.

⁵⁴In Mill's view, "All action is for the sake of some end, and rules of action, it seems natural to suppose, must take their whole character and color from the end to which they are subservient." Mill, *Utilitarianism*, 10; and West, 32. West states that such a view falls within the realm of "result" theory. Mill, by assuming that rules take their character from the end they serve is to presuppose that a consequentialist theory is the proper one. This thesis, for example, examines the implications of Mill's consequentialist view relative to medical concerns surrounding challenges to proscriptions against medical killing and the determination if, indeed, Mill's presupposition may be supported as a proper foundation for future legal action.

Mill never addressed the fact that the very *nature* of an act sometimes was a determining factor in a person's moral duty to act in a specific way. Mill stood against the "formalist theory" school that held that the "nature" of the act is "sometimes an important fact bearing on whether there is a moral obligation to perform or avoid it"; for example, whether it is a lie or a breach of promise--something about it differs from the inherent worth of actual or

Mill assumed that HU was the best alternative among the many moral theories where moral obligation was based upon the intrinsic worth of the actual or expected results.⁵⁵

Mill claims that the only proof that PH is the *summum bonum* is that people actually desire PH.⁵⁶ This raises a question concerning the elusive quality of *actual* ordinary individual preferences and presents a difficulty when a person might prefer something different if he or she were more fully informed and what he or she might prefer if such a preference actually were to occur.⁵⁷ An uninformed preference may fail to coincide with “what . . . an individual would prefer if he became informed.”⁵⁸ Furthermore, numerous social forces contribute to what a person wants, or is capable of wanting, so it is not *just* a simple matter of a person’s desire.⁵⁹

Mill’s assumption was that there *must* be a single principle at the root of all morality, or that such a principle would be placed first in order of preference among multiple principles. He dismissed intuitive theories because a prominent general feature of these types of theories is the plurality of principles with no set procedure for settling decision-making conflicts between them.⁶⁰

expected consequences. West, 32; see also Richard B. Brandt, *Ethical Theory: The Problems of Normative and Critical Ethics*, Prentice-Hall Philosophy Series, ed. Arthur E. Murphy (Englewood Cliffs, NJ: Prentice-Hall, 1959), 354-55.

⁵⁵West, 33. See G. E. Moore, *Principia Ethica*, rev. ed. (Cambridge: Cambridge University Press, 1993), 135-36, and 145. It is also possible for a consequentialist theory to “give preference to the agent or those who are in special relations to the agent in counting the significance of the results.” Mill’s approach differed from Benthamism’s analysis of the dimensions of pleasures and pains.

⁵⁶Mill, *Utilitarianism*, 50.

⁵⁷J. J. C. Smart and Bernard Williams, *Utilitarianism: For and Against*, repr. ed. (Cambridge: Cambridge University Press, 1995), 147. This sort of difficulty with hedonism holds implications for end-of-life decision-making. A criticism of PAS and VAE is that patients have had limited awareness of end-of-life alternatives to a stated desired preference for medical killing.

⁵⁸Ibid.

⁵⁹Ibid.

⁶⁰West, 34. For Mill to assert that there must be a first principle or an order of preference among principles, assumes that any theory that lacks such features is insufficient as

Another reason for Mill's dismissal of *a priori* moral theories was his belief that they "prevented rational criticism and reform of existing moral and social practices."⁶¹ Mill adhered to the belief that the question of a person's duty was open to discussion like any other question. He believed that changes could be expected not only in a person's opinions on such a subject but also in "progress of intelligence," from "more authentic and enlarged experience," and from "changes in the condition of the human race." Such changes would require "altered rules of conduct."⁶² While Mill defended his theory and further clarified his foundational assumptions, questions also arose that challenged hedonism itself.

Challenges to Mill's Hedonism as a Theory of Value

By 1870, opponents of hedonism were challenging Mill's theory in broad general terms.⁶³ Specifically, however, Mill sought to defend Utilitarianism against the more narrow objection that life had no higher end than pleasure and that utilitarianism was a "pig" philosophy⁶⁴--a specific objection directed toward Bentham's quantitative hedonism. In response to objections that hedonism was a doctrine only worthy of swine, Mill introduced the notion of qualitative differences between pleasures. His reply was that if humans were capable of only those pleasures suitable for swine, then the same rule of life could govern both humans and swine. Instead, Mill states that human beings have more elevated faculties than animal appetites, and once individuals are made aware of their higher faculties, they do not regard

a moral theory. See also Rawls, *Theory of Justice*, 34. Rawls's definition of intuitive theories includes this feature.

⁶¹West, 43.

⁶²Ibid. See also Mill, *Autobiography*, 158-59. Mill held to a progressively developing morality.

⁶³John Grote challenged Mill on the grounds of ambiguity, and Joseph Mayor challenged him on the grounds of false analogies. G. E. Moore questioned Mill's "naturalistic fallacy," and Gorge Sabine exposed what he considered to be Mill's fallacious argumentation. See discussion of these early challenges in West, 119-20.

⁶⁴Mill, *Utilitarianism*, 17.

anything as happiness that does not include the satisfaction of them.⁶⁵ He reasons that it is quite compatible with utility to recognise the fact that some kinds of pleasure are more desirable and valuable than others.⁶⁶ However, in seeking to allay the chief objection that HU was little more than a swine theory, Mill's response only introduced a fresh difficulty to his theory.

The Challenge Related to Quantitative and Qualitative Pleasure

Bentham had proposed specific criteria for measuring the value of any pleasurable experience.⁶⁷ He believed that all pleasures were measurable on a single scale and that the best life for a person would consist in the greatest balance of pleasurable experiences over painful ones. For example, it could be worth undergoing a painful medical operation in the short term in order to produce the greatest balance of pleasure over pain in the long run. According to Bentham, all pleasures and pains were structurally similar sensations and it would be possible to construct a *felicific* calculus in order to measure the value of various courses of action.⁶⁸

In response to people who thought Bentham's calculus could itself lead to unhappiness,⁶⁹ John Stuart Mill explored further the idea that the *very nature of the pleasure* in question was important.⁷⁰ Mill argued that greater quantity alone could not make one pleasure

⁶⁵West, 48-49. Mill includes among the higher faculties the intellect, the feelings and imagination, and the moral sentiments. See also Mill, *Utilitarianism*, 17-18.

⁶⁶Mill, *Utilitarianism*, 18. The more desirable pleasure was the one that, in Mill's scheme, once two pleasures were experienced, was given a decided preference.

⁶⁷Bentham, *Principles*, 29-30. Bentham names seven overall circumstances for a person, or a number of persons, to evaluate pleasures and pains: intensity, duration, certainty or uncertainty, propinquity or remoteness, fecundity, purity, and extent.

⁶⁸*Ibid.*, 29-32.

⁶⁹The prospect of living a life of lower pleasures, because it consists of greater duration when compared to a shorter life of higher pleasures, was distasteful and raised objections to HU. Mill sought to allay the objections by introducing a qualitative dimension to PH. According to Mill, some kinds of pleasure were *both* more desirable and more valuable. Mill names the intellect, the feelings and imagination, and the moral sentiments, as examples of the higher faculties. See West 69-73.

⁷⁰Mill, *Utilitarianism*, 17-18.

higher than another.⁷¹ This claim led people to charge Mill with deserting hedonism. They reasoned that to remain a hedonist Mill must accept that pleasure was the *only* value.

Such a claim against Mill assumed that there was only one variety of hedonism, an assumption Mill would himself deny. Like Bentham, Mill believed that pleasure was the only good-making property but, unlike Bentham, he believed that the value of pleasure was determined *also* by its *nature*.⁷² Mill's distinction, indeed, had stretched his hedonism to its known limits, for now Mill's hedonism would require a more complex calculus in order to evaluate both quantity and quality of pleasure. Notwithstanding the stresses that Mill's qualitative dimension added to hedonism, there were also significant problems raised by his qualitative *method* and application of his *argument* for hedonism.

The Challenge Related to the Structure and Application of Key Argument

Chapter four of *Utilitarianism* contains Mill's key argument, for it is here that he seeks to lay the groundwork for hedonism as the "valuational foundation for all of life and for morality as a part of that."⁷³ The core structure of Mill's system is that happiness is desirable and the only thing that is desirable.⁷⁴ To the claim that happiness is desirable, Mill presents his method in three statements: 1) ". . . The sole evidence it is possible to produce that anything is desirable is that people do actually desire it;" 2) ". . . each person, so far as he believes it to be

⁷¹West, 48-49; and Mill, *Utilitarianism*, 18.

⁷²Mill, *Utilitarianism*, 18.

⁷³West, 119. Even though the chapter in *Utilitarianism* is only twelve paragraphs long, West states that considerable disagreement exists concerning how to interpret Mill's argument.

⁷⁴Mill, *Utilitarianism*, 50.

attainable, desires his own happiness;” and 3) “. . . each person’s *happiness is a good* (desirable⁷⁵) to that person”⁷⁶

The first challenge to Mill’s method derives from his first statement. Mill argues for what is desirable based upon what is desired. Such a claim is common to psychological hedonism, whether it is of a quantitative or qualitative variety. Mill’s premise denied that a person intuits what is intrinsically good in some “directly cognitive way.”⁷⁷ Pleasure is *the* good because it is what *all* people—ultimately—desire or aim toward.⁷⁸ Mill believed it to be a true theory of human nature that pleasure is desired as the end.⁷⁹ Mill seeks to deny an intellectual intuition of the normative ends of conduct. His claim rules out the possibility that a person intuits what is intrinsically good in a directly cognitive way and he also denies that there is an “overarching physical or metaphysical structure on the basis of which normative ends of conduct can be determined.”⁸⁰ A *critique* of Mill’s claim is the counter argument that a person does not desire certain things (knowledge or virtue, for example) *because* such things give him or her pleasure. People choose certain things, for example knowledge or virtue, even if they bring no pleasure at all.⁸¹ Mill would argue that for such a rebuttal to be valid, it must be shown

⁷⁵West, 122. West believes that Mill substitutes “good” in the place of “desirable” simply for stylistic reasons.

⁷⁶Ibid. William K. Frankena, *Ethics*, 2d ed. (Upper Saddle River, NJ: Prentice-Hall, 1973), 85-87. Frankena states the same argument in similar language.

⁷⁷West, 126.

⁷⁸Frankena, 85. See also Epicurus, “Letter to Menoeceus,” in *The Essential Epicurus: Letters, Principal Doctrines, Vatican Sayings, and Fragments*, trans. and with an introduction by Eugene O’Connor (Buffalo, NY: Prometheus, 1993), 64-65.

⁷⁹There is no logical necessity, however, to accept desire as the sole evidence for desirability. See West, 126.

⁸⁰Ibid.

⁸¹Aristotle, *The Ethics of Aristotle: The Nichomachean Ethics*, trans. J. A. K. Thomson, revised with notes and appendices by Hugh Tredennick, and with an introduction and bibliography by Jonathan Barnes (New York: Penguin Books, rev. ed., 1976), 317-18.

that knowledge, or virtue, can be *intuited* to be good as an end.⁸² Mill was attempting to demonstrate that a desire for virtue, for example, was due to a psychological association of virtue with pleasure, thereby accounting for any claim that virtue was intuited to be good as an end. In order to challenge Mill's theory, a person must demonstrate that Mill's claim—that pleasure is what a person desires—*cannot be the normative case* because people often desire things other than pleasure and desire such things without having pleasure as an ultimate goal.⁸³

The second challenge to Mill's method derives from his second statement and assumes a universalisation of psychological hedonism. Utilitarian doctrine reflects upon the basis and nature of a foundational principle of morality—the maximisation of the happiness of the many.⁸⁴ Yet, a challenge to such a view is that there is no clear reason why morality is to be judged solely in terms of the good to be promoted.⁸⁵ It may be reasoned that morality consists in “certain categorical requirements” that “apply regardless of the good.”⁸⁶

The third challenge to Mill's method is an enduring problem concerning the move from individual happiness to aggregate happiness. Mill assumed that the value of “different instances of happiness” can be “summed up to generate a larger good.”⁸⁷ A problem within Mill's theory surfaces when he assumes that happiness can be summed up to find a general or aggregate total of happiness. Mill's assertion was offered simply without explanation or argument. He believed that the “general happiness” was a “mere sum of instances of individual happiness.”⁸⁸

⁸²West, 126-27.

⁸³Aristotle, 318. Aristotle denied that pleasure was *the Good*.

⁸⁴West, 123; and see Mill, *Utilitarianism*, 50.

⁸⁵Crisp, 25.

⁸⁶*Ibid.*

⁸⁷West, 141. Mill reasoned that since “A's” happiness is a good, and “B's” happiness is a good, and “C's” happiness is a good, then the sum of all these goods, even if they are different, must be a good. West cites Mill's letter to Henry Jones from *The Later Letters of John Stuart Mill 1849-1873*.

⁸⁸West, 140.

Mill believed that happiness was the “kind” of thing that constituted intrinsic welfare. He also assumed that the value of different instances of happiness could be thought of “as summed up to generate a larger good.”⁸⁹ By these steps Mill believed it to be *empirically obvious* that happiness may be measured and summed.⁹⁰ For Mill, the promotion of happiness is the test by which to judge all conduct, and from which it follows that happiness must be the criterion of morality. Mill does not make it clear who would be an unbiased judge, or how one would be able to judge, “felt experiences” because such experiences are seldom, if ever, simultaneous.⁹¹

The various difficulties with Mill’s method were not restricted to his theory of value alone, but also included his theory of action. Mill had sought to establish the two—the theory of value and the theory of action—as a working ethical theory, so the following section will now focus attention on the latter, and the challenges to his method.

Mill’s HU: Theory of Action

Development of the Theory of Action

Jeremy Bentham and James Mill influenced J. S. Mill’s position on right and wrong action. Jeremy Bentham is well known for his detailed instructions for determining the “general tendency” of any act “by which the interests of a community are affected.”⁹² He accomplished this by means of his hedonic calculus, which was intended to provide a guide for measuring pleasures and pains produced by “acts.”⁹³ Bentham assessed acts strictly by

⁸⁹Ibid., 141.

⁹⁰Mill, *Utilitarianism*, 81.

⁹¹West, 144.

⁹²Bentham, *Principles*, 30.

⁹³Fred R. Berger, *Happiness, Justice, and Freedom: The Moral and Political Philosophy of John Stuart Mill* (Berkeley, CA: University of California Press, 1984), 74. Where numbers of persons are affected by acts, the calculus calls on one to judge pleasures and pains by a specific criteria: the intensity, duration, certainty and uncertainty, propinquity or remoteness, fecundity, purity, and extent. See also Bentham, *Principles*, 30.

their consequences, even though he allowed for the necessity of useful social rules upon occasion.⁹⁴

Like Bentham, James Mill (John Stuart Mill's father) held that the morality of an act is dependent upon the consequences that the act will produce. The question of the rightness or wrongness of an act is dependent upon its consequences just as judging the morality of an

⁹⁴Berger, 76. See Bentham's discussion of the case of nonpayment of taxes; see also Bentham, *Principles*, 160-63.

In late twentieth-century terminology, it has become common to distinguish between two versions of utilitarianism--act utilitarianism (AU) and rule utilitarianism (RU). Act Utilitarians believe that an act is right only if it produces the best consequences among all possible acts an agent may perform. Rule Utilitarians hold that acts are only right if they are prescribed by rules which are, in turn, justified by the consequences that to which has been adopted or conformed. See Berger, 64. Objections were raised against AU, because it was believed that it would be too difficult to make decisions this way due, for example, to ignorance, bias, or a lack of time. Frankena, 40. RU was offered as a simpler alternative to AU; however, RU has been shown to dissolve into AU in certain circumstances and, therefore, is thought by some to be untenable. See Smart and Williams, 10-11.

Some utilitarians of late, based upon *the difficulty with determining objectively* "what is intrinsically good in any circumstance," offer a variation on Mill's classical HU by naming the good as "that which is subjectively desired or wanted." The goal of such moral actions becomes the satisfaction of desires or wants. This approach is based upon individual *preferences*, and utility is measured in terms of an individual's actual preferences rather than in terms of "intrinsically valuable experiences." Preference utilitarianism (PU), as this approach is termed, is based upon what an individual prefers to obtain. Utility is translated into the satisfaction of individual needs and desires. Tom L. Beauchamp, *Philosophical Ethics: An Introduction to Moral Philosophy* (New York: McGraw-Hill Book Co., 1982), 115. To maximise individual utility, for a preference utilitarian, would be to maximise the satisfaction derived from what has been chosen or what a person would choose from available alternatives. To maximise the preference utility for all persons, who would be affected by a specific action or policy, would be to maximise the preference utility of an aggregate group. Even though these types of individual (or aggregate) preferences are permitted, this does not imply that the pleasure/pain characteristics are totally absent from consideration. Singer, 14. Singer acknowledges the suggestion, for example, that classical utilitarians like Bentham and Mill used "pleasure" and "pain" in a broad sense that allowed them to include achieving what one desired as a "pleasure" and the reverse as a "pain." If this is the case, according to Singer, then the differences between classical utilitarianism and utilitarianism, based on interests, will disappear.

Neither Bentham, James Mill, nor J. S. Mill can rightly be classified under any of the rubrics above, because these writers pre-date the classifications and held ideas that may have conformed to both AU and RU. This thesis applies Mill's usage of the terms and word ideas of "act" and "rule" within Mill's historical context. Current interpretations of Mill often assign expanded meanings, such as those defined above, to these terms, which Mill himself perhaps had not conceived or applied. Settling the ongoing discussion as to whether Mill was an act utilitarian, a rule utilitarian, or a combination of both, as defined by *current theoretical* definitions, need not be the chief focus in examining his moral approach.

act is conducted by calculating the consequences.⁹⁵ James Mill felt that most cases fell under general rules that were universally accepted, “so that a man can act upon them, as pre-established decisions, which he may trust.”⁹⁶ The younger John Stuart Mill learned from both Bentham and his own father, but enlarged upon Bentham’s theory of action.

John Stuart Mill’s HU and Action

John Stuart Mill thought that the views of both Bentham and his father were too narrow, and that their conceptions of human happiness were inadequate.⁹⁷ Mill’s own psychology made it possible for him to believe that people can desire things for their own sakes, and that these things can contribute to a person’s happiness though that person does not explicitly *aim* at happiness in a direct way. Mill also recognised the need for “internal culture” and happiness that would require the balancing of a person’s faculties, including the “emotional sensibilities.”⁹⁸

As discussed earlier, Mill’s psychology was associationistic. He believed that psychology sought to establish general laws of the mind—meaning those laws “according to which one mental state succeeds another.”⁹⁹ Essentially, these laws of association were ascertained by observation and experience. Mill believed that social science could supply a person with information that could form a basis from which he or she could frame moral

⁹⁵Berger, 80. Berger cites James Mill, *A Fragment on Macintosh* (London: Longmans, Green, Reader, and Dyer, 1870), 162-63.

⁹⁶Berger, 80; and Mill, *Fragment*, 163. While James Mill was writing to refute Macintosh’s claim that utilitarianism required too many calculations, it does show that he accepted the view that general rules of thumb were an accepted consideration for daily conduct.

⁹⁷Berger, 82; and see Mill, *Autobiography*, 141-43, and 152-53. Mill believed some of the doctrines of his father and Jeremy Bentham were untenable.

⁹⁸Berger, 83. Mill saw as important the various “instruments of human culture,” like music and poetry, to balance a person’s “faculties,” which is a notion other utilitarians had dismissed. See also Mill, *Autobiography*, 78, 101.

⁹⁹Berger, 87.

guidelines for maximising, in his or her action, the achievement of the ultimate end.¹⁰⁰ Yet, he also believed that rules of conduct were to be considered only as provisional. They were not to supersede, when time permitted, the scientific process for framing a rule from the data of particular cases. Noting the complexity of his views, it may be observed that Mill, like Bentham before him, sought to provide *practical* instruction in how to apply social science to morality.¹⁰¹

Mill's HU: Action Based upon Consequences

The practical content of Mill's utilitarianism states that the "right action in any circumstance" is the one "which produces the greatest overall balance of pleasure over pain."¹⁰² Mill's utilitarian theory concerns what makes actions right.¹⁰³

Criticism of Odd Consequences

Mill's view is one that potentially produces *odd consequences*.¹⁰⁴ Mill considered *what effect his committing an act* in a particular situation would have on the overall balance of good over evil. For example, in the case of truth-telling as a moral rule, an utilitarian might determine that truth-telling is for the greatest general good *or* that telling the truth is not for the greatest general good. A utilitarian would consider breaking a moral rule against lying if that

¹⁰⁰Ibid., 89. "Rules of thumb" are guidelines which may be trusted for daily living, based upon positive consequences of past experience, and which are reliable for everyday rules of conduct. These rules, however, are guides only and may be dropped in favour of calculation whenever time and circumstances permit, or under unusual situations (ibid., 64).

¹⁰¹Ibid., 89. See also Mill, *Utilitarianism*, 35-36. Mills says that ". . . mankind must by this time have acquired positive beliefs as to the effects of some action on their happiness; and the beliefs which have come down are the rules of morality for the multitude, and for the philosopher until he has succeeded in finding better."

¹⁰²Crisp, 14.

¹⁰³Ibid., 18; see also Mill, *Utilitarianism*, 9.

¹⁰⁴Ibid., 14-15.

violation would lead to a greater amount of pleasure-happiness.¹⁰⁵ While Mill attempts to produce right action, his calculus sometimes yields the odd consequence of undoing the benevolence HU aims toward. Telling a lie to a friend may increase the general happiness but it may also undermine a valuable friendship.¹⁰⁶ In the case of telling a lie, it is impossible to assess the bad consequences of shaking human confidence in a person's statements. It is also very difficult to know the effect of a solitary act (e.g., a lie), upon the larger scheme of human action and habit, when compared to the immediate pleasure it would bring.¹⁰⁷ Mill's counterargument was that the bad effect would be small in relation to the happiness of mankind and the pleasure to be gained,¹⁰⁸ but this is not at all a certainty.¹⁰⁹ Actions that maximise utility increase the likelihood of adverse individual effects.

Criticism of Extensive Calculations

Mill's theory of action also produces *unusual requirements*. If Mill expected a person to calculate the full consequences of every act he or she would voluntarily perform, then these calculations could potentially be endless. Mill agreed that rules can guide daily conduct, based upon past experience and the sufficient reliability of such rules for ordinary matters.¹¹⁰

¹⁰⁵Compare Beauchamp, *Philosophical Ethics*, 118. See Crisp, 15. Yet, in order to produce a workable morality, most utilitarians currently do not express their view in terms of *actual* but *expected* outcomes of actions. An expected outcome of an action would be "calculated by multiplying the value of an outcome by the probability of its occurring."

¹⁰⁶Crisp, 21.

¹⁰⁷Berger, 92.

¹⁰⁸Ibid. Mill reasoned that the bad effect, the telling of a lie in this case, would be small in relation to the happiness of all mankind. An individual's rights, however, may be adversely affected by such action to maximize the happiness of mankind (ibid., 124).

¹⁰⁹Ibid, 124. This concern raises questions concerning duties of justice. These duties, however, appear to have "bases in considerations other than consequences." Furthermore, *duties* of justice may have bases in considerations (moral) other than whether, or not, a maximisation of good consequences has occurred. In this case a lie, even when localized among a few people, may be harmful to an individual or to a group of people.

¹¹⁰Berger, 64.

One of the criticisms levelled against Mill is that an individual should not rely upon rules or generalizations from past experience. While rules and principles may be useful as guides, HU requires one to calculate anew the *effects of all possible actions* open to a decision-maker every time a decision is to be made.¹¹¹ This has been criticised as being simply impractical, if not impossible, to implement.

A counter response, of course, would be that such a course of action would generate still another difficulty, because it is conceivable that in a certain situation, two acts, once all calculations of good and evil are tallied, may result in the same hedonic score. However, it might be that the first of the two acts involves breaking a promise or telling a lie or being unjust, for example, while the second act includes none of these things. In this case, the consistent utilitarian must say that both acts are equally right, because the consequence is the same.¹¹²

Even when employing general rules of thumb, utilitarians face challenges. A challenge is that applying moral rules themselves often produces conflict in moral life. There are circumstances, for example, that call for telling a lie to protect a confidence, or stealing in order to protect a life. In such cases, utilitarians must decide which kind of action, or rule, is to have priority; however the most relevant consideration for the utilitarian method is what kind of action will lead to the maximisation of pleasure, not necessarily the observance of a moral rule.

Summary

John Stuart Mill, indeed, followed his own father and Jeremy Bentham in further crafting and refining a theory introduced to bring about social and political reform. While not

¹¹¹Frankena, 35-36; cf. Beauchamp, *Philosophical Ethics*, 117. Similarly, Beauchamp believes that past experience can provide general guidelines or “summary rules of thumb,” but these past experiences are not to be considered “unmodifiable prescriptions.”

¹¹²Compare Frankena, 36.

specifically tailored, originally, to be a personal moral theory, it was only a matter of time until HU's social and political constructs were applied to the individual realm and even to areas well beyond Mill's initial focus. One of those areas, as already noted, is that of medicine and medical ethics.

The challenges to Mill's brand of Hedonistic Utilitarianism, its assumptions, its theory of value, and resulting action, remained problematic not only during Mill's lifetime, but across the next century, even to the present. The unresolved challenges continued to seek reasoned cohesion and integrity of method, if not solutions.

The specific challenge to hedonism itself as a "pig" philosophy, and the burden imposed upon Mill's theory of HU to quantify and qualify the nature of PH, remained unresolved. Another unsettled challenge for Mill concerned what he considered to be an empirical fact—that pleasure is *the* good because it is what *all* people ultimately desire, or aim toward.

These tensions, compounded by the constructs of those who would further modify Mill's concepts, accompanied Mill's HU as it moved through the Enlightenment and modern eras. Notwithstanding the core unresolved tensions in Mill's theory, HU has been applied throughout medical ethics in a number of key areas, not the least of which are circumstances related to medical end-of-life decision-making, which sometimes include PAS.

This study will answer the research question by clarifying certain features of the PAS debate and demonstrating weaknesses inherent in HU that impact adversely on medical canons and the doctor-patient relationship (DPR). Six features of the PAS debate, each used by PAS proponents, will be isolated and evaluated for HU influence. First, however, chapter 1 will address the research question by defining the terms of the current medical-ethical dialogue, delineating the philosophical background to Mill's key utilitarian PH theme,¹¹³ including his

¹¹³The thesis covers other supporting themes in greater detail in chs. 2 and 3.

links with ancient Greek philosophy and introducing how Mill's HU theme interacts with the occurrence of PAS in contemporary medico-cultural debate.

The following chapter will examine three core features in the PAS debate by defining each one and by conducting an historical examination of the growth and development of each. The three features to be examined include rights, justice, and medical killing. These three features will be linked together because Mill believed rights and justice were intimately associated with one another and with the principle of utility. PAS advocates, as well, link the notions of rights and justice together as support for their claims to medical killing.

The historical development of autonomy, physician paternalism, and sanctity of life (SL), and examining the relationship of each of these areas to the debate within PAS, are the subjects of chapter 3. The final chapter will isolate key HU weaknesses found in claims or arguments in each of the six PAS debate features, will offer several moral concerns regarding the use of employing HU claims to justify changing medical canons to endorse PAS, will evaluate the impact HU exerts on the philosophy and practice of PAS, and will draw conclusions based on the research conducted in the first three chapters. The thesis, upon completion, will contribute to the wider ongoing medical-ethical dialogue about medical killing by exploring the broader historical and ethical views and providing points crucial to ethical considerations that will supplement future discussions of medical killing.

CHAPTER 1

HEDONISTIC-UTILITARIANISM

Before one can enter into the PAS ethical debate, one must understand the backdrop and evolution of the terms involved, the influence of Mill upon the topic, and the impact of his work upon the current medical-ethical ethos. The following definitions and core concepts comprise a foundational understanding of utilitarianism, particularly Mill's HU, and provide a framework for the PAS discussion.

Utilitarianism: Definitions and Terms

Dictionary Terminology

Utilitarianism, as defined by the *Oxford English Dictionary (OED)*, means “the doctrine that the greatest happiness of the greatest number should be the guiding principle of conduct.”¹ It also means “Utilitarian doctrine, principles, theories or practices. . . .”² The root concept is *utility* which the *OED* defines as “the ability, capacity, or power of a person, action, or thing to satisfy the needs or gratify the desires of the majority, or of the human race as a whole.”³ In philosophical usage there are four general categories of utilitarianism.

Distinguishing Utilitarianism in Its Varied Forms

Each of the four general divisions of utilitarianism may be distinguished by its political or moral approach.⁴ *Economic* utilitarianism is usually applied to the governmental realm

¹*Oxford English Dictionary*, 2d ed., s.v. “utilitarianism.” Henceforth, the *Oxford English Dictionary* will be referred to as the *OED*.

²*Ibid.*

³*Ibid.*, s.v. “utility.”

⁴Robin Barrow, *Utilitarianism: A Contemporary Statement* (Brookfield, VT: Edward Elgar Publishing Co., 1991), 40. See also Anthony Quinton, “Utilitarian Ethics,” in *New Studies in Ethics: Modern Theories*, vol. 2, ed. W. D. Hudson (New York: Saint Martin's

wherein any given policy might be evaluated by its usefulness.⁵ In *ideal* utilitarianism actions are right insofar as they serve various moral ends.⁶ This form of utilitarianism allows moral ends other than pleasure to be valued intrinsically.⁷ Another more recent variety of utilitarianism is the *preference* type. This approach differs from other forms, as Singer states, in that “best consequences” are understood as meaning essentially that which furthers the interest of those affected rather than merely what increases pleasure and reduces pain.⁸ Human good, in this case, would be viewed as constituting whatever satisfies a person’s preferences or desires. A fourth variety, and the subject of this thesis, is *hedonistic* utilitarianism, which claims that happiness or pleasure is the only ultimate end and that the rightness of any given action is to be determined by its tendency to produce or contribute to that end.⁹

Press, 1970), 3. Quinton also states that utilitarianism can be understood in three ways. It can be viewed as (1) a legal, political, and social reform movement of the early nineteenth century, (2) as the ideology of that reform movement, or (3) as an ethical theory. It is the ethical theory that is in view in this thesis.

⁵Barrow, 39-40. Barrow describes *economic utilitarianism* as being derived from government policies. The utility of a product or an activity is based upon its usefulness. This approach is not intended to be a moral one because its focus is an effective means to an end rather than a moral means to an end (*ibid.*, 39).

⁶G. E. Moore was a leading proponent of this approach. Moore included beauty and friendship in the list of moral ends. Cf. G. E. Moore, *Principia Ethica* (Cambridge, Cambridge University Press, revised edition, 1993); Barrow, 40; and Quinton, 4. Basically this variant of utilitarianism holds that pleasure is intrinsically valuable, but it is only one thing among others that are intrinsically valuable. Beauty and friendship are examples of other such moral ends. Beauchamp terms this as “pluralistic” utilitarianism. See Tom Beauchamp, *Philosophical Ethics: An Introduction to Moral Philosophy* (New York: McGraw-Hill Book Co., 1982), 83.

⁷Barrow, 40. See also Quinton, 6. Examples of other possible intrinsically valued ends would be: virtue, knowledge, and beauty. See also Beauchamp, *Philosophical Ethics*, 81. An intrinsic value is one that a person wishes to own and enjoy for its own sake and not for “something to which it leads.”

⁸Singer, 14. See also Beauchamp, *Philosophical Ethics*, 84.

⁹Barrow, 40. See also Jan Narveson, *Morality and Utility* (Baltimore, MD: Johns Hopkins Press, 1967), 51. Narveson states that utilitarianism is usually described as a “species” of hedonism.

The *OED* does not list the compound term “Hedonistic-Utilitarianism.” It does contain listings of various individual parts of the compound term, however. *Hedonistic* means “pertaining to hedonists, or of the nature of hedonism.”¹⁰ *Hedonism*, in turn, means “the doctrine or theory of ethics in which pleasure is regarded as the chief good, or the proper end of action.”¹¹ The resulting compound word, hedonistic-utilitarianism, denotes an idea of pleasure and happiness for the greatest number of persons, but there is more to the meaning of the term.

Ethical Implications of Hedonistic-Utilitarianism

The ethical theory classified as Hedonistic-Utilitarianism rests upon two core principles: consequentialism and hedonism.¹² The consequentialist principle determines the rightness or wrongness of an action by the goodness or badness of the results that follow from the action.¹³ Measuring the worth of actions by their ends¹⁴ is not new or unique to utilitarianism, but the theory is the most influential of several ethical theories that gauge the value of actions in this way.¹⁵ A consequentialist approach to utilitarian ethical decision-making would require that a right action be distinguished from a wrong action solely on the

¹⁰*OED*, 2d ed., s.v. “hedonistic.”

¹¹*Ibid.*, s.v. “hedonism.”

¹²Quinton, 3.

¹³*Ibid.* See John Stuart Mill, *Utilitarianism* (Buffalo, NY: Prometheus Books, 1987), 16-17. See also Jeremy Bentham, *An Introduction to the Principles of Morals and Legislation*, with an introduction by Laurence J. Lafluer (New York: Hafner Press, Macmillan Publishing Co., 1948), 2.

¹⁴Beauchamp, *Philosophical Ethics*, 73. The Greek is *telos*, meaning “end,” and such a theoretical approach is termed teleological or “consequentialist.”

¹⁵*Ibid.* See also Alan Donagan, *The Theory of Morality* (Chicago: University of Chicago Press, 1st paperback ed., 1979), 52. In contrast, an anticonsequentialist affirmation would be that principles of morality are to be observed whatever the consequences. See also Joseph J. Fins and Matthew D. Bacchetta, “Framing the Physician-Assisted Suicide and Voluntary Active Euthanasia Debate: The Role Of Deontology, Consequentialism, and Clinical Pragmatism,” *Journal of American Geriatrics Society* 43, no. 5 (May 1995): 564-65. “Proponents of this view judge the moral acceptability of an action or rule based upon its net balance of good and bad consequences.”

ground that its consequences are better than any other consequences produced for the general well-being of all who are affected by the action of the agent.¹⁶ The second element, hedonism, states that the only thing that is good in itself is pleasure and the only thing bad in itself is pain.¹⁷ While classical HU theory regards pleasure as the good, later species of utilitarianism broaden the scope of what was considered to be good.¹⁸ Hedonistic-utilitarianism, however, claims specifically that an action is right based upon its ability to contribute to happiness (pleasure).¹⁹

Some authors designate the philosophy of Jeremy Bentham and John Stuart Mill as “hedonistic-utilitarianism,” even though neither Bentham nor Mill used the term as a rubric for their ethical theories.²⁰ Even though John Stuart Mill did not use the term “hedonistic-utilitarianism” specifically, he alluded to the ideas contained within the compound concept when writing to rebut criticisms of his philosophy.²¹ His philosophical statement, *Utilitarianism*, is an elaboration of HU. His definition and subsequent exegesis of the concept “utilitarianism” indicates his belief that the philosophy rested upon consequential and hedonistic principles.²² Henry Sidgwick added later insight into the composition of HU with his

¹⁶Donagan, 189. Donagan notes that any acceptable moral system “exalts” benevolence. See also Beauchamp, *Philosophical Ethics*, 73.

¹⁷Quinton, 3.

¹⁸See ch. 1, fns. 5-8.

¹⁹Barrow, 40. Hedonistic utilitarians may accept that beauty, for example, is good but not that it is a moral good (*ibid.*, 41). See also Bentham, 70. Bentham equates happiness with pleasure and absence of pain. See also Mill, 16-17. Mill states that by happiness he intends to mean pleasure and absence of pain.

²⁰E. F. Carritt, *Ethical and Political Thinking* (Westport, CT: Greenwood Press, Publishers, 1973), 59. See also Barrow, 40; and Beauchamp, *Philosophical Ethics*, 81.

²¹Mill, 15, called attention to critics of “utility” who denounced the theory of utility as being “impracticably dry” when the word utility preceded the word pleasure, and “too practicably voluptuous” when the word pleasure preceded the word utility.

²²*Ibid.* Mill’s words include the core statement that “. . . actions are right in proportion as they tend to promote happiness, wrong as they tend to promote the reverse of happiness” (*ibid.*, 16). He also writes that by happiness he intends pleasure and the absence of pain (*ibid.*,

clarifying remarks on utilitarianism. He equated the meaning of utilitarianism with “Benthamite hedonism” or “universalistic hedonism.”²³ Sidgwick employed the term “universalistic-hedonism” to distinguish between egoistic hedonism (Epicurean) and the more universal variety of hedonism as postulated by Jeremy Bentham.²⁴ A precise clarification of HU is difficult to isolate. Arriving at a clear evaluation of Mill’s usage is equally difficult. Mill has been characterised as a hedonistic-utilitarian²⁵ and a quasi-ideal utilitarian,²⁶ but Mill thought himself to be a utilitarian in the Epicurean tradition.²⁷

Mill’s Self-Definition of Hedonistic-Utilitarianism

Mill’s own statements about his theory help to establish his working definition out of which considerations of the ethical implications may be broached. Hedonistic-Utilitarianism (HU) was termed “utility” by Mill, and he equated it with the “greatest happiness principle” (GHP).²⁸ The GHP (utility) meant simply that actions are right in proportion to which they tend to promote happiness—that is pleasure and the absence of pain for the many. By the same token, actions are wrong in proportion to which they tend to produce the opposite of happiness-

16-17).

²³Henry Sidgwick, *The Methods of Ethics*, 7th ed. (Indianapolis: Hackett Publishing Co., 1981), 84.

²⁴*Ibid.*, also *ibid.*, 87-88, footnote. He gives Jeremy Bentham the credit for this form of hedonism because Bentham was the one who chiefly taught it. See discussion of the background and development of Epicurean hedonism in the following section of this chapter, 14-25.

²⁵Carritt, 59.

²⁶J. J. C. Smart and Bernard Williams, *Utilitarianism: For and Against*, reprint edition (Cambridge: Cambridge University Press, 1995), 13. Smart states that Mill’s position was somewhere between hedonistic and ideal utilitarianism. Sidgwick, 85, states that Mill’s utilitarianism was an attempt to establish a logical connection between the psychological and ethical varieties of hedonism.

²⁷W. D. Hudson, *A Century of Moral Philosophy* (Guildford: Lutterworth Press, 1980), 10. Mill claimed that there had been utilitarians down through the ages.

²⁸Mill, 16.

-that is pain or the privation of pleasure for the many.²⁹ Whether the term used is “utility” or “hedonistic-utilitarianism” or “greatest happiness principle,” the ethical theory derived from the use of the term is the same.³⁰ Mill claimed that utilitarian theory was rooted in Ancient Greece.³¹ Since his model is the one used in this study, it is important to examine those proposed roots in order to trace his development of HU and its meaning.

Proposed Philosophical Roots of Hedonistic-Utilitarianism

Copleston writes of the splendid achievement of Greek thought that was “cradled” in Ionia, the home of the early Greek philosophers who were exploring the meaning of life events: the “fact of change, of birth and growth, decay and death.”³² These early thinkers believed that life events were evidence of the “inescapable facts of the universe.”³³ While it is true that the early Ionians held to a belief in the divine governance of the world, the difference between them and the older civilisations of Homer and Hesiod was that the Ionians began to examine the world through the lense of independent thought without relying on the perceived whims of the gods.³⁴ Rational reflection and argument had surely been used before, but the difference at

²⁹Ibid., 16-17, 22. See also Sidgwick, 414-16.

³⁰The term hedonistic-utilitarianism (HU) will be used throughout the thesis. This is not to imply, however, that the use of the term means that Bentham’s and Mill’s approach (combining hedonism and utilitarianism) is free from philosophical difficulty and debate.

³¹Mill, 15-16.

³²Richard D. McKirahan Jr., *Philosophy Before Socrates: An Introduction with Texts and Commentary* (Indianapolis: Hackett Publishing Co., 1994), 20. The timeframe was the sixth century B.C. Philosophers and representatives of this era and area included Thales of Miletus, Anaximander, and Anaximenes. Others who had Ionian roots, though not from Miletus, included Democritus and Anaxagoras, and other philosophers. Frederick Copleston, *A History of Philosophy: Greece and Rome*, vol. 1 (New York: Image Books, 1993), 13, 17.

³³Copleston, 1:17. Examples might include the changing seasons or a person’s lifespan from birth to death.

³⁴McKirahan, 73. See also G. E. R. Lloyd, *Science and Morality in Greco-Roman Antiquity* (New York: Cambridge University Press, 1979), 11; and G. E. R. Lloyd, *Magic, Reason and Experience: Studies in the Origin and Development of Greek Science* (New York: Cambridge University Press, 1979), 32. See also Anthony Harrison-Barbet, *Mastering Philosophy* (London: Macmillan, 1990), 9. The early Greek philosophers (Milesians) “were the

this time was that the Ionian philosophers turned their rational minds toward finding meaning in cosmology and theology with the confidence that the rational mind was sufficient for the task.³⁵

The Ionians were also conscious of the dark side of existence on earth, noting well the certainty of death and the darkness of the future.³⁶ Their perception of the cycles from life to death to life again led to a beginning of philosophy as these thinkers grappled also with the “why” of life and death. Even though change and uncertainty were an obvious part of life, the Ionians believed in, and sought after, something permanent.³⁷ They believed that in order for change to occur there must be something primary “which persists” that was not simply the result of cyclical events. These early philosophers desired to discover the essential element of this “Unity.”³⁸ The Ionians held this essential element of the universe to be material in nature and matter as the principle of unity. Soon Greek philosophers turned their foci to the manner in which they lived.³⁹

first thinkers to begin to disengage themselves from a mythological framework and to show a determination to enquire into the nature of things, freely and without regard for religious dogma or prejudiced opinion.”

³⁵McKirahan, 73.

³⁶Copleston, 1:17.

³⁷Ibid., 19-20.

³⁸Ibid., 20. The German word *Urstoff* was used by Copleston to describe the primitive unifying element. It helped to explain the notion of “primitive element or substrate or ‘stuff’” of the universe. See also S. E. Frost Jr., *Basic Teachings of the Great Philosophers: A Survey of Their Basic Ideas*, revised edition (New York: Anchor Books, 1989), 6-10. Frost writes that the earliest philosophers were greatly interested in the nature of the universe and desired to break it open in their minds in order to discover the “stuff” from which all things come. See also Harrison-Barbet, 9, who writes that the earliest Greek philosophers were concerned with finding a unifying principle for the world. They sought to look beyond the appearances of the sensory world to penetrate and postulate “unchanging and underlying reality.” See also R. D. Hicks, *Stoic and Epicurean* (New York: Russell & Russell, 1962), 204. The early Greeks were in search of some “permanent and primary element which by its transformations would account for the variety of nature.”

³⁹Copleston, 1:78.

At first the focus was placed on the object, the external world, but eventually it was shifted to man in the world and his interaction with man as a moral, willing, and acting subject.⁴⁰ Man was believed to be an inseparable part of the world and society and had a moral relationship with other members of the world. Ethics, being concerned primarily about goodness, was employed to guide man in living a good life. Man's every activity whether artistic or scientific, for example, was believed to have for its object the attainment of some good. The Ancient Greeks held to this view of life and they sought to discover the end which moral agents sought for its own sake, terming this end "the absolute good."⁴¹ This good, it was generally agreed, was identified with "happiness" or well-being (*eudaimonia*).⁴² Even though the end or absolute good to which all men aimed might be equated generally with happiness, it was not easily determined of what that happiness consisted.⁴³

A happy person, therefore, was believed to possess that which he or she thought to be desirable, which might be believed to include, for example, wealth, a fine family, or power.⁴⁴ From its inception individual happiness was linked to the fulfilment of that person's desire or need. *Eudaimonia* remained a woolly term, yet it encompassed a significant portion of Ancient

⁴⁰Ibid.

⁴¹Harrison-Barbet, 60; and Christopher Rowe, *An Introduction to Greek Ethics* (London: Hutchison & Co., 1976), 9.

⁴²Harrison-Barbet, 60; and Rowe, 9. It is fair to state that the Ancients were not at all certain about the composition of *eudaimonia*.

⁴³There were a variety of responses to the question of what happiness consisted. See Aristotle, 66. Aristotle, for example, wrote that *eudaimonia* meant "living well" or "doing well" but this is ambiguous. Aristotle stated that the word had been variously defined as consisting of pleasure or money or eminence and that often the person giving his view changed his opinion. Plato, as another example, believed the highest good to be "reason." See Frost, 84. Epicurus, it is well known, believed the supreme good to reside in pleasure. See Frost, 86. See also *The Cambridge Dictionary of Philosophy*, s.v. "eudaimonism." The word is translated "happiness" or "flourishing" and refers to the ethical doctrine that happiness is "the ultimate justification for morality."

⁴⁴Christopher Rowe, "Ethics in Ancient Greece," in *A Companion to Ethics*, ed. Peter Singer, reprint edition (Cambridge, MA: Basil Blackwell, 1994), 122.

Greek philosophical discussion and speculation. It does seem clear from the discussion of what constituted personal happiness that the philosophical roots of hedonism were planted within a milieu of philosophical exploration and speculation.

Indeed, in the age before scientific examination, individual philosophers offered their varying appraisals of happiness. One such philosopher, Epicurus (341-271 B.C.),⁴⁵ was unique in that he advanced the notion that pleasure was the supreme good and that pleasure alone constituted happiness.⁴⁶ His bold assertion drew attention because his theory that an individual's desire determined personal happiness held ethical implications. Although Epicurus developed a different approach to happiness, his ideas were not formed in a moral vacuum. He incorporated earlier ethical systems into his own, drawing from several preceding centuries before his own time. Several early Greek philosophers who shared similar cosmological views as Epicurus had focussed previously on pleasure.

Hedonism in Early Greek Thought

Life's Aim is Pleasure

Aristippus of Cyrene (435-350 B.C.)⁴⁷ was noted early on for his interest in developing an ethical theory which was based on the underlying assumption that things are ultimately to be evaluated by a supreme goal or good of life. To him the "supreme goal" or "good"⁴⁸ was

⁴⁵Eugene O'Connor, trans., *The Essential Epicurus: Letters, Principal Doctrines, Vatican Sayings, and Fragments* (Buffalo, NY: Prometheus Books, 1993), 9, 11.

⁴⁶Rowe, "Ancient Greece," 123. See also *The Cambridge Dictionary of Philosophy*, s.v. "eudaimonism." Epicureans, unlike others that made virtue or virtuous activity a "constituent" of the happy life, ". . . construe happiness in terms of pleasure, and treat virtue as a means to the end of pleasant living."

⁴⁷Diogenes Laertius, *Lives of Eminent Philosophers*, vol. 1, trans. R. D. Hicks (Cambridge, MA: Harvard University Press, 1972), 195.

⁴⁸J. C. B. Gosling and C. C. W. Taylor, *The Greeks on Pleasure*, reprint edition (Oxford: Clarendon Press, 1984), 35.

pleasure, and he and his adherents⁴⁹ advocated a lifestyle which pursued that pleasure.

Aristippus' notion of pleasure was different from that of Epicurus in that he did not focus on the removal of pain or freedom from discomfort.⁵⁰ Cyrenaics pursued pleasure as the "end," and happiness was viewed as the sum total of the particular pleasures: the more sensual pleasure the better, which contained a quantitative element.⁵¹

Another significant element to Aristippus' ethical system was the view that, since the past no longer existed and the future was uncertain, the present was the only thing with which the wise man was to be concerned.⁵² Unrestrained pursuit of immediate sensual pleasure was the path the Cyrenaics chose. This basic position was radical hedonism wherein the specific goal was to maximise the pleasure of the moment, especially bodily pleasure.⁵³ This view of pleasure demonstrated a quantitative measurement and the consequential result could lead to sensual excesses.⁵⁴

⁴⁹Laertius, 1:195, 215, 217. Laertius writes that Aristippus was from Cyrene and refers to him and his school as "Cyrenaic."

⁵⁰Ibid., 217.

⁵¹Ibid. Aristippus believed pleasure as the end was proved by the fact that from youth onward people were instinctively attracted to it and once it was obtained they sought nothing more and shunned nothing more than its opposite, pain. Gosling and Taylor, 41. The view that pleasure was the supreme good was based upon an observation that all living things pursue pleasure and avoid pain, but it must be stated that not everyone held the same view. There were then, as now, differing views of the supreme good and Aristippus' view can be contrasted with Aristotle who argued that there were some pleasures that were not good with some even being open to censure. Aristotle, 250. Aristotle also argued against the view that pleasure is an end. See also Plato, *The Republic of Plato*, trans. with introduction and notes by Francis MacDonald Cornford (England, 1941; reprint New York: Oxford University Press, 1968), 215. Plato states that most people viewed the good as pleasure, but that the enlightened thought it was knowledge. Plato, as well, did not view pleasure as the supreme good, viewing instead knowledge as being in that position.

⁵²Gosling and Taylor, 41.

⁵³Ibid., 41. Cf. Copleston, 1:122.

⁵⁴See Copleston, 1:122.

Aristippus' PH view engendered ethical implications. Since he had advanced the idea that the future was inconsequential, he purported that pleasure was to be the supreme goal and, therefore, made the individual the deciding influence in the pleasure equation. It followed that one need not fear the moral retribution of the gods.⁵⁵ Even though his concept of pleasure was somewhat nondiscriminatory and perhaps unsophisticated, his view on individual pleasure served as a precursor to future development of the "PH" theme. Another philosopher, Democritus, built upon his ideas.

Democritus (460-357 B. C.)⁵⁶ carried forward a variation of the PH theme with the development of his ethical system. He laid down a test to be applied in deciding questions of conduct. His criterion was the consideration of the ultimate aim or purpose in human life.⁵⁷ He moved beyond the sensual bodily pleasures of Aristippus' views and advanced the notion that what made life worthwhile was neither possessions nor any other external thing, but one's state of mind.⁵⁸ In Democritus' belief "tranquility" was the ultimate aim, and achievement of that aim was the supreme good.⁵⁹ He differed from Aristippus in that his notion of pleasure rested upon mental states of mind. Further, Democritus did not advocate pursuit of the pleasure of the moment as did Aristippus. Instead, he advanced the notion that the individual, by calculation, measured pleasure against the aim of his life's span.⁶⁰ He had unintentionally introduced an

⁵⁵Later Cyrenaics did not believe in the gods.—See also *ibid*; and Laertius, 1:227.

⁵⁶Diogenes Laertius, *Lives Of Eminent Philosophers*, vol. 2, trans. R. D. Hicks, reprint edition (Cambridge, MA: Harvard University Press, 2000), 443.

⁵⁷Gosling and Taylor, 29.

⁵⁸*Ibid.*, 30.

⁵⁹*Ibid.*, 29. Laertius, however, distinguishes Democritus' *euthumia* from pleasure and does not equate the two. Democritus' "tranquility" meant a state where the soul was continually calm and strong, "undisturbed by any fear or superstition or any other emotion." Laertius states that Democritus called this state "well-being" among many other names. Laertius, 2:455.

⁶⁰Gosling and Taylor, 32.

individual qualitative characteristic to the pursuit of PH.⁶¹ Democritus' views set the stage for Epicurus who followed and carried forward the idea of pleasure as the supreme good.

Epicurus developed not only a moral viewpoint but a comprehensive worldview that provided a philosophical justification for human decisions.⁶² Epicurus equated pleasure with tranquility (*ataraxia*),⁶³ and the highest pleasure or the "supreme good" he attributed to living without pain or disturbance. Epicurus believed this to be the condition to which all living things should aim.⁶⁴ His ethical system had its roots in the systems of his predecessors. Pragmatically, he followed Democritus in the sense that Epicurus did not advocate a life of the pursuit of dissipation⁶⁵ because it did not produce a pleasant life. Further, like Democritus, he advocated mental pleasure throughout the span of one's life.⁶⁶ Finally, in an era which had yet to realise a full awareness of the individual, the philosophical systems of all three, Aristippus, Democritus, and Epicurus, were moving unknowingly toward positioning the individual as the moral decision-maker in the pursuit of what would later constitute PH.

⁶¹Laertius, 2:455. This idea will be developed further within the framework of the section on atomism. Unknowingly, his belief that all things happen by necessity actually undermined rather than strengthened his notion of individual choice.

⁶²John Newport, *Life's Ultimate Questions: A Contemporary Philosophy of Religion* (Dallas, TX: Word Publishing, 1989), 461.

⁶³Peter Preuss, *Epicurean Ethics: Katastematic Hedonism*, vol. 35, *Studies in the History of Philosophy* (Lewiston, NY: Edwin Mellen Press, 1994), 169-70.

⁶⁴Gosling and Taylor, 365. Epicurus believed pleasure was the good and this meant *ataraxia/aponia*.

⁶⁵Preuss, 99. Epicurus, "Letter to Menoeceus," in *The Essential Epicurus: Letters, Principal Doctrines, Vatican Sayings, and Fragments*, trans. and with an intro. by Eugene O'Connor (Buffalo, NY: Prometheus, 1993), 66.

⁶⁶Newport, 461. See also Laertius, 10:136. Laertius states that Epicureans advocate the katastematic type of pleasure, not the kinetic.

Epicurean Pleasure

For Epicurus there were two types of pleasure: the *kinetic* and the *katastematic*. Either of these could take place in the mind or in the body.⁶⁷ Kinetic pleasure was defined as satisfying bodily desires,⁶⁸ the experience of active stimulation of enjoyable bodily feelings, such as the alleviation of hunger or thirst,⁶⁹ or states of mind. A characteristic of this type of pleasure was that it lasted only as long as the activity that gave rise to it.⁷⁰ Kinetic pleasures included all the things that ordinary people would call pleasures.⁷¹ Epicurus defined katastematic pleasure as the lack of disturbance of mind (*ataraxia*) and of pain (*aponia*). This aspect of pleasure defended against the charge that he was advocating a life of debauchery.⁷² The essence of katastematic pleasure was “the organism itself, without any additional external

⁶⁷Philip Merlan, *Studies in Epicurus and Aristotle* (Wiesbaden: Otto Harrasowitz, 1960), 6.

⁶⁸Preuss, 162-63. Kinetic pleasures come and go and in this way are discontinuous. They are dependent upon their object. It is a matter of individual choice whether or not to continue a life of kinetic pleasure. Gosling and Taylor, 365. The authors add also the possibility of some mental pleasures such as learning. See also A. A. Long and D. N. Sedley, *The Hellenistic Philosophers*, vol. 1, *Translations of the Principal Sources with Philosophical Commentary* (Cambridge: Cambridge University Press, 1987), 123. Kinetic pleasure included all experience that “consists in active stimulation of enjoyable bodily feelings or states of mind.” Gisela Striker, *Essays on Hellenistic Epistemology and Ethics* (New York: Cambridge University Press, 1996), 196.

⁶⁹Preuss, 123. Compare also Phillip Mitsis, *Epicurus' Ethical Theory: The Pleasures of Invulnerability*, vol. 48, *Cornell Studies in Classical Philology* (Ithaca, New York: Cornell University Press, 1988), 45. He states that kinetic pleasure is equivalent to motion, meaning the satisfying of a desire. Katastematic pleasure is equivalent to being stable or having satisfied a desire.

⁷⁰Long and Sedley, 123. See also Preuss, 90. Preuss states that kinetic pleasure is essentially discontinuous, meaning it comes and goes.

⁷¹Striker, 196.

⁷²Epicurus, 66. Gosling and Taylor, 366. See also Joseph M. Bryant, *Moral Codes and Social Structure in Ancient Greece: A Sociology of Greek Ethics from Homer to the Epicureans and Stoics* (Albany, NY: State University of New York Press, 1996), 412. See also Cyril Bailey, *The Greek Atomists and Epicurus* (New York: Russell & Russell, 1964), 524.

stimulus. . .”⁷³ His theories of pleasure furthered the qualitative/quantitative dimension of pleasure. The potential for individual rationality in decision-making was inherent in Epicurus’ system where a person determined what would sustain personal katastematic pleasure.

The ethical significance of kinetic and katastematic pleasure rested in this context of individual choice; that is, with the morally discerning individual who made a choice. Epicurus argued that a person’s “final good,” or pleasure, must lie completely within that person’s control.⁷⁴ Although not universally accepted, Epicurus’ view was uniquely empowering for the individual.⁷⁵ A difficulty with empowering the individual with the capacity for moral choice, and the responsibility to determine his own pleasure or “supreme good” by those choices, was the question of how specific moral action could originate from atomistic (exclusively material), or nonmoral origins. As unique as the Ionian departure was from mythological constructs to the advent of unhampered individual choice, a parallel advance was embodied in the development of atomistic thought.

⁷³Merlan, 7. The author believes that this type of pleasure was “static,” meaning the person reached some state of equilibrium. The pleasure is not caused by an external stimulus. Preuss, 121. While katastematic pleasure could be of both body and mind, Epicurus believed that the pleasure of the mind was the more important (*ibid.*, 123). The Epicurean would learn to sustain the katastematic pleasure during bouts of kinetic pain.

⁷⁴Mitsis, 49.

⁷⁵This viewpoint was not without its detractors. See Mitsis, 49, and Preuss, 97-98. Among the critics were Clement of Alexandria, Cicero, and Plutarch. See also Roger J. Sullivan, *An Introduction to Kant’s Ethics*, reprint edition (New York: Cambridge University Press, 1995), 124. Learning what people do does not necessarily give instruction into what they ought to do. Even though Kant advanced later another form of individual moral autonomy, he would express also that such a moral view (hedonism) was false because a person based his or her analysis of morality on experience. Carritt, 91. Another significant aspect was the individual determination of whether or not the life being lived was filled with a greater balance of pleasure over pain. A problem with this approach was that not all pleasures could be stated as being of supreme importance and not all pain as being something to be avoided.

Early Greek Atomism

Atomism is the path along which certain philosophers carried the notion that the material worldview gave rise to moral responsibility.⁷⁶ Atomism⁷⁷ emerged from within this same early cultural milieu of rational consideration, originated with Leucippus⁷⁸ and Democritus,⁷⁹ and rested upon two core features: cosmology and determinism.

Democritus articulated the completely material cosmological view⁸⁰ that supported the natural origins of an eternal and unchanging material universe.⁸¹ For Democritus, nothing was created out of the nonexistent, nor was anything destroyed into the nonexistent.⁸² His view, it is

⁷⁶These early philosophers did not seek to explain how the amoral material cosmos could give rise to moral considerations.

⁷⁷Compare Hicks, 205. Hicks states that the path of progress resembles a “spiral” and that whatever the reason the mechanical (in this case, atomism) explanation of nature was discarded by Plato and Aristotle. Compare also Andrew G. Van Melsen, *From Atomos to Atom: The History of the Concept ‘Atom’*, vol. 1, Duquesne Studies *Philosophical Series*, trans. Henry J. Koren (Pittsburgh: Duquesne University Press, 1952), 77-78, 81. Van Melsen writes that the seventeenth century was the century which saw a revival of philosophic atomism. Van Melsen, 77, notes that while there had been those in the Middle Ages and the Renaissance that appeared to be adherents of atomism, there was “no question of any steady traditional atomism.” Van Melsen gives two reasons for the limited following of Democritus’ atomism as an “infection” of “anti-Christian materialism” and as far as a physical explanation was needed in the Middle Ages, Aristotle’s minima theory “offered at least as many possibilities as atomism.” Ancient Greek atomism represented a separate root of Greek thought that grew for a period of time and then lay dormant until centuries later where it was cultivated once again.

⁷⁸Hicks, 205. Hicks terms Leucippus “the earliest of the Atomists.” Cf. Laertius, 2:441. Laertius states that Leucippus was the “first to set up atoms as first principles.”

⁷⁹Bailey, 116. Bailey says that Democritus learned the atomic theory from his master Leucippus. See also Laertius, 2:445, who writes that Democritus met Leucippus but does not say that he learned the atomic theory from him. Laertius, 2:453, does write that Democritus’ first principles of the universe were atoms and empty space. See also Hicks, 207. Hicks writes that the writings of both Leucippus and Democritus have perished with the exception of a few fragments. Almost all that is known of their theories is derived from Epicurus and from the Roman Lucretius in his poem *On the Nature of Things*.

⁸⁰Copleston, 1:74. The Atomists believed that all that existed in the beginning were atoms in the void. They reasoned that “. . . no external Power or moving Force was assumed as a necessary cause for the primal motion.”

⁸¹Bailey, 119.

⁸²Laertius, 2:453, 455.

believed, contains early roots of the laws of the universality of “cause and effect” and the “permanence of matter,”⁸³ since the world was the “undesigned” result of “inevitable natural processes.”⁸⁴ Democritus, unconsciously, had introduced the possibility of an entirely scientific view of the world.⁸⁵ In his mind there was neither purpose in the creation of the world, nor was it ruled by design. None of its parts, organic or inorganic, was the result of any purpose.⁸⁶ Creation was, therefore, the result of “inevitable natural processes.”⁸⁷ This cosmological view constituted the first of the atomistic core features.

The second feature was the early seed thought that became determinism. In Democritus’ system “Necessity” (the “Whirl”) ordered all things which were predetermined from all eternity.⁸⁸ At the same time, he believed that the “Whirl” was produced automatically

⁸³Ibid., 455; and Bailey, 120. The world did not need semi-religious external forces as the efficient causes of the world. The World is a wholly physical existence, “purely mechanical,” and “controlled by the law of its own being and nothing more.” Bailey, 120-21. The universe was eternal and not created by anyone, Democritus believed, and had existed for all time.

⁸⁴Bailey, 121-22.

⁸⁵Ibid., 122.

⁸⁶Ibid., 121-22. Bailey, writes that atomism was “an untrammelled system of natural physics” (ibid., 122). Religion had attached itself to philosophy from its conception, but in Democritean atomism it was absent totally. There was, for Democritus, no need for the mysterious, semi-religious external forces that formed a part of the systems of other philosophers. “Soul” was thought to be formed in the same sense as any other part of the body and would cease to exist when physical life ended. Compare also Walter Charleton, *Natural History of the Passions* (London: T. N., 1674), n. p. Charleton states also that the soul was not considered to be immortal in atomism.

⁸⁷Bailey, 121-22.

⁸⁸Ibid., 121. Necessity, according to Democritus, was equal to natural law and was the foundation stone of his system (ibid., 122). Necessity was the governing cause of everything in the universe and not only did every effect have a cause, but there was an effect (motion) for which there was no cause except universal “necessity” (ibid., 133). Bailey believes that he might have employed “necessity” as a random means to explain what could not be explained. The eternal atomic motion was, in Democritus’ view, beyond all causes. He did not conceive, though, of the moral difficulty this created between free will and determinism.

and by chance,⁸⁹ an outcome of natural causes, and was undetermined entirely either by purpose or design.⁹⁰

Atomism relates to Epicurean philosophy at this significant point. Atomism formed the core of Epicurus' thought concerning the principles of causality and permanence as these relate to the natural world.⁹¹ Essentially, Epicurus believed also that every material thing had a material cause.⁹² Even though Epicurus claimed independence from any other philosopher, it is believed that elements of his system came from Democritus.⁹³ Epicurus, then, was the link through which this concept of a material world transferred to later philosophers. Epicurean atomism lay virtually dormant until a convergence of ideas in the mid-sixteenth century revived a newfound interest in the underlying nature of matter.⁹⁴ If matter was indeed purposeless, then mankind must evaluate his role in light of his advancements in the new "scientific" age.

A noticeable shift in philosophical moorings took place about the time when Galileo Galilei was forging new roads in science. The shift moved from an Aristotelian-Thomistic view, with its Christian presuppositions, to a new "natural philosophy." This new philosophy was similar to the classical forms in that it took "its bearing from nature," but it proved to be much different in its leanings.⁹⁵ The old philosophy had understood nature in a teleological

⁸⁹Ibid., 139.

⁹⁰Ibid., 141.

⁹¹Ibid., 275.

⁹²Ibid., 276.

⁹³Ibid., 226. Epicurus' disciples admitted that he owed credit to Democritus, but Epicurus seemed unwilling to acknowledge this dependence.

⁹⁴Marie Boas, "The Establishment of Mechanical Philosophy," *Osiris* 10 (1952): 452-53.

⁹⁵Frederick Vaughan, *The Tradition of Political Hedonism from Hobbes to J. S. Mill* (New York: Fordham University Press, 1982), 6.

sense, with all things being ordered to their proper end, and that, in Aristotelian cosmology, “man’s proper end . . . [was] found in moral virtue--in justice and magnanimity.”⁹⁶

The new natural philosophy, however, rejected the teleological view of nature “and affirmed that nature could be properly understood only in terms of its physical properties—those properties which could be weighed and measured.”⁹⁷ The new philosophy was grounded in the atomism of Democritus and, as a result, the only ancient philosopher who was himself an atomist and “provided an alternative to the Aristotelian-Thomistic view of nature and morality,” was Epicurus.⁹⁸ Seventeenth-century philosophers, like the Frenchman Pierre Gassendi, articulated the fresh nuance. Nature before had established the norm in the old system. Now, “. . . man ascribed the norm in a world which was viewed as fundamentally purposeless and even hostile.”⁹⁹ When man judged the world to be “hostile,” his perspective introduced an ethical evaluation.

⁹⁶Ibid.

⁹⁷Ibid.

⁹⁸Ibid., 23.

⁹⁹Epicurus, 14. Cf. G. B. Stones, “The Atomic View of Matter in the XVth, XVIth, and XVIIth Centuries,” *ISIS* 10, no. 2 (1928): 462. Gassendi’s works form a catalyst for the thought and writing of others. His system is the basis of the English work by Walter Charleton (1619-1707), physician to King Charles II. Stones, 461. Boas, 452-53. Pierre Gassendi, the seventeenth-century French philosopher, is credited with reviving Epicurean philosophy and atomism with it. Gassendi developed the fundamental properties of atoms along the same lines as Epicurus believing that they could not be created or destroyed, that they were solid, and that they could not be divided into smaller parts. This revival of sorts was spawned initially, at least in part, by a general anti-Aristotelian attitude that had been engendered by Renaissance humanists.

The Move from Atomism to Ethics

Democritus had not connected atomism with ethics intentionally.¹⁰⁰ Indeed, he had asserted that the physical world was controlled by “Necessity,” eliminating the governance of the world by either chance or theological conception.¹⁰¹ However, his philosophical approach created an ethical dilemma because this “Necessity,” when extended to the realm of ethics, would result in determinism and hinder the possibility of free or autonomous human choice.¹⁰² Epicurus used this foundational quandary of determinism versus individual choice to bring ethical dimensions of decision-making into philosophical discussions.

Epicurus held as a first condition of a moral life the belief that the gods had no part in the government of the world.¹⁰³ It is not as though the gods did not exist, but that belief in mythology required no necessity to participate in prayer and worship as an attempt to influence

¹⁰⁰Gosling and Taylor, 27. The authors write that the Democritean collection contains nothing that connects directly the physical theory with the ethical maxims. Cf. Bailey, 188. Bailey offers a viewpoint that Democritus’ ethics are largely independent of his physics. McKirahan contributes an important consideration when he notes that much of Democritus’ writings have been lost and one cannot really know. “In general, atomic theory provides a variety of viewpoints from which to approach epistemological issues, and our severely limited sources may simply not add up to a coherent theory just because their contexts may have been lost.” McKirahan, 334.

¹⁰¹Bailey, 186.

¹⁰²Philip Wheelwright, ed., *The Presocratics* (New York: Macmillan Publishing Co., 1966, 18th printing 1988), 182. This “unqualified determinism” does not appear to leave room for moral choice. Wheelwright notes that Democritus’ philosophy held fast to “human values and human assumptions” even though it was costly to logical consistency. See also Bailey, 186-87, and McKirahan, 338-39. There is not much that remains of Democritus’ writings, and the authenticity of many of the ethical fragments is itself in question according to McKirahan. Democritus seems to have believed that the atomic theory provided a physical basis for ethics. Gosling and Taylor, 29-30. The tranquility Democritus wrote about could not be achieved externally (for example, by obtaining possessions) but by one’s state of mind. See also McKirahan, 339. Cheerfulness was the goal of life and Democritus did not identify this as being the same as pleasure. He calls this state, “well-being” along with many other names. He linked this with the movement of atoms and identified a particular physical condition of the soul (which was corporeal) as the goal of life. Cheerfulness was the condition that helped a person recognise whether he or she was in this state. Not all pleasures, according to Democritus, were to be pursued.

¹⁰³Bailey, 438.

divine beings to alter the course of temporal events.¹⁰⁴ Epicurus did not believe the world could have been created by the gods because, in his mind, a perfect and all-powerful being could not create a world that had been made so poorly, an attitude consistent with his mechanical view of cosmology. Together, Democritus and Epicurus helped to pave the platform where man, unhindered by any outside authority, would take the centre place in moral decision-making. Hedonism as a philosophy was the bridge to the individual making moral decisions. Hedonists believed that an individual's moral decisions then, would be prompted by internal pleasure feelings rather than the external forces like the gods.

Basics of Epicurean Hedonism

The hedonist believed that most human actions could be explained directly by reference to pleasure. Hedonists used pleasure to mean the kind of "feeling" that stimulated a person's will to act in a manner tending to sustain or produce it. The volitional stimulus for pleasure was termed "desire."¹⁰⁵ Other actions could be explained by referring to pleasant consequences a person might desire, or to unpleasant consequences a person might wish to avoid.¹⁰⁶ Herein lies a connection between Epicurean hedonism and the PAS debate. While detractors might argue the rationality of sustaining life at any or all costs, proponents might argue that it would sometimes be rational to kill if it helped to fulfill a person's desire to eliminate pain. The basic hedonist position rested, then, upon the foundational principle that if an action were chosen, then the final reason for choosing it would have reference to pleasure or avoidance of pain.¹⁰⁷

¹⁰⁴Ibid.

¹⁰⁵Sidgwick, 42-43. See also Epicurus, 64-65.

¹⁰⁶J. C. B. Gosling, *Pleasure and Desire: The Case For Hedonism Reviewed* (Oxford: Clarendon Press, 1969), 1. Cf. also Sidgwick, 41. Sidgwick agreed with Bentham that "... on the occasion of every act he exercises, every human being is' inevitably 'led to pursue that line of conduct which, according to his view of the case, taken by him at the moment, will be in the highest degree contributory to his own greatest happiness. . . .'"

¹⁰⁷Gosling, 9. And the converse would be true, namely, that if no pleasure is found in the end result of the action then the action was unreasonable. The hedonist does recognise that there are many things that are done not because they give pleasure but in spite of the fact that

This hedonist principle formed the base of Mill's HU, that if an action was chosen, then the final reason for choosing it would also have reference to pleasure or avoidance of pain. Mill, though, added that the action would be for the greatest pleasure (or avoidance of pain) of the many.¹⁰⁸ Mill, like Epicurus before him, believed that "tranquillity" was a key constituent of a satisfied life.¹⁰⁹ He also believed that tranquillity enabled a person to be content with very little pleasure.¹¹⁰ Mill also centred moral decision-making within the individual who would judge "whether a particular pleasure was worth purchasing at the cost of a particular pain."¹¹¹ These core elements contained within Mill's theory establish a core historical and philosophical framework for examining HU. Having defined the terms associated with utilitarianism, particularly HU, and the influence of John Stuart Mill upon the application of those terms, it is necessary to consider the terminology and ethical considerations of the PAS side of the dialogue.

Physician-Assisted Suicide

Introduction

In recent years a trend has developed which has allowed greater flexibility for a patient to choose death, including physicians even aiding those who are terminally ill toward that

they give none: for example, having a tooth extracted, going to war, or climbing Mount Everest. Sidgwick, 120. See also Mill, 16-17. Happiness, according to Mill, meant pleasure and the absence of pain. Plato, 212. In contrast, Plato believed the good was "knowledge of the Good," an understanding of the moral and physical order of the entire universe. John Rawls, "Classical Utilitarianism" in *Consequentialism and Its Critics*, ed. Samuel Scheffler (New York: Oxford University Press, 1988), 16-17. Rawls adds that if the good is defined as pleasure, then we have hedonism. If the good is defined as happiness, then we have eudaimonism. Aristotle, in contrast, held a different conception of the good. His conception of the good included the "realization of human excellence in the various forms of culture." Plato, 212. Socrates, himself, declined even to define the supreme good.

¹⁰⁸Mill, 28.

¹⁰⁹Ibid., 24.

¹¹⁰Ibid.

¹¹¹Ibid., 21.

end.¹¹² It is the latter feature of the trend that is in view in this thesis. Efforts to legalise PAS span the globe--from Australia to the United Kingdom to the Netherlands to the United States.¹¹³ Central to the debate for and against helping patients die are the philosophical and ethical claims used to support these efforts or arguments.

Many historians have noted the long history of voluntary active euthanasia (VAE) and PAS, with both practices dating back to Ancient Greece.¹¹⁴ Through current efforts of grass roots groups, media, and internet exposure, and a growing body of literature relevant to the subject,¹¹⁵ PAS issues and concerns, inclusive of ethical, legal, political, and practical facets,

¹¹²Tom L. Beauchamp, ed., *Intending Death: The Ethics of Assisted Suicide and Euthanasia* (Upper Saddle River, NJ: Prentice Hall, 1995), 1.

¹¹³David C. Thomasma, "An Analysis of Arguments for and Against Euthanasia and Assisted Suicide: Part One," in *Cambridge Quarterly of Healthcare Ethics* 5 (1996): 62-76. Thomasma offers general information of the specific pieces of legislation in the United States, The Netherlands, and Australia's Northern Territory. See especially p. 63. Donald W. Cox, *Hemlock's Cup: The Struggle for Death with Dignity* (Buffalo, NY: Prometheus Books, 1993), 149-57, 169-79. Cox offers a chronological account of PAS legal initiatives in Washington, California, and Australia's Northern Territory. Wesley J. Smith, *Forced Exit: The Slippery Slope from Assisted Suicide to Legalized Murder* (New York: Random House, 1997), 66. Smith quotes and gives a brief explanation of the controversial PAS ruling of the New York State Ninth Circuit Court of Appeals.

¹¹⁴Committee on Medical Ethics Episcopal Diocese of Washington D.C., *Assisted Suicide and Euthanasia: Christian Moral Perspectives, The Washington Report* (Harrisburg, PA: Morehouse Publishing, 1997), 60. Ronald Dworkin, *Life's Dominion: An Argument About Abortion, Euthanasia, and Individual Freedom* (New York: Vintage Books, 1994), 3.

¹¹⁵The following representative list of sources demonstrates the crucial importance of PAS in biomedical ethics. Representative sources that make a claim for legalising PAS are: Howard Brody, "Assisted Death--A Compassionate Response to a Medical Failure," in *New England Journal of Medicine* 327, no. 19 (November 1992): 1384-88; Derek Humphry, *Final Exit: The Practicalities of Self-Deliverance and Assisted Suicide for the Dying* (New York: Dell Publishing, 1991); Sheila McLean and Alison Britton, *The Case for Physician-Assisted Suicide* (London: Pandora, 1997); and Timothy E. Quill and Margaret P. Battin, eds., *Physician-Assisted Dying: The Case for Palliative Care & Patient Choice* (Baltimore: Johns Hopkins Press, 2004), 1-8.

Representative sources that make a claim against legalising PAS are: Kathleen Foley and Herbert Hendin, eds., *The Case Against Assisted Suicide* (Baltimore, MD: Johns Hopkins University Press, 2002), 1; Yale Kamisar, "Physician-Assisted Suicide: The Last Bridge to Active Voluntary Euthanasia," in *Euthanasia Examined: Ethical, Clinical and Legal Perspectives*, ed. John Keown (Cambridge: Cambridge University Press, rev. paperback ed., 1995), 225-60; Leon Kass, "Physician-Assisted Suicide Should Not Be Legalized," *Commentary* 89, no. 2 (February 1990): 33-43; and John Keown, *Euthanasia, Ethics and*

have increasingly clamoured for public attention and evaluation. The 1990s indeed was a decade when PAS began to be distinguished from VAE¹¹⁶ and was moved by right-to-die advocates in the United States to the forefront as a leading issue of importance in the right-to-die movement. Evidence of this fact may be adduced from the progressive development of sophisticated legislation that sought to canonise PAS into law. PAS legislation emerged in the early 1990s, but became re-focused following the success of the Oregon Death with Dignity Act in 1994 and its final passage into law in 1997.¹¹⁷

Initially, voter initiatives to legalise “aid-in-dying” were introduced in Washington State in 1991 (“Death with Dignity Act” or Initiative 119) and California in 1992 (“Death with Dignity Act” or Proposition 161).¹¹⁸ Both voter initiatives failed. Advocates of the initiative believed these propositions failed due to public aversion to the concept of doctors actively killing patients. Measure 16, Oregon’s “Death With Dignity Act,” was a physician assisted suicide bill *only* and this measure passed and went into effect in 1997.¹¹⁹ Overall, PAS legislation has developed in three phases: (1) legislation that did not differentiate between PAS

Public Policy: An Argument Against Legalisation (Cambridge: Cambridge University Press, reprint ed., 2004), 31-36.

Representative sources on the overall issue of PAS include: Robert F. Wier, ed., *Physician-Assisted Suicide* (Bloomington, IN: Indiana University Press, 1997); and Gerald Dworkin, R. G. Frey, and Sissela Bok, eds., *Physician-Assisted Suicide: For and Against*, ed. (New York: Cambridge University Press, 1998).

¹¹⁶See BMA, “End of Life Decisions--Views of the BMA”; internet, available at <http://www.bma.org/ap.nsf/Content/Endoflife~Physicianassistedsuicide#7>; accessed 13 July 2006.

¹¹⁷See Valerie J. Volmar’s “Physician-Assisted Suicide” website at <http://www.willamette.edu/wucl/pas/index.html>. Volmar provides detailed development of national and international legislation related to PAS from 1997 forward. See also the U.S. Center for Clinical Ethics and Humanities in Health Care website on PAS legislation: <http://wings.buffalo.edu/faculty/research/bioethics/court.html>; and the State of Oregon’s website on PAS legislation at <http://egov.oregon.gov/DHS/ph/pas/ors.shtml>.

¹¹⁸Rita L. Marker, “Assisted Suicide: The Continuing Debate,” ed. International Task Force on Euthanasia and Assisted Suicide; internet; available at <http://www.iaetf.org/>; accessed 19 August, 2006.

¹¹⁹*Ibid.*

and euthanasia; (2) Oregon's "PAS" legislation; and (3) legislation combined with carefully-orchestrated political tactics that was reflective of Oregon's law.¹²⁰ PAS was initially subsumed within Voluntary Active Euthanasia, but by the 1990s it began to be viewed separately from VAE and legislation related directly to PAS began to emerge.¹²¹ A reason for this could be that advocates for changing laws related to medical killing viewed PAS as a middle way between a proscription of medical killing and VAE.¹²²

The early legislation to permit medical killing had included both euthanasia and PAS language as in the cases of Washington and California.¹²³ Following the losses of both campaigns, the Oregon Death With Dignity Act (1994) included "prescribing only" legal

¹²⁰Eli D. Stutsman, "Political Strategy and Legal Change," in *Physician-Assisted Dying: The Case for Palliative Care and Patient Choice*, ed. Timothy E. Quill and Margaret P. Battin (Baltimore: Johns Hopkins University Press, 2004), 254-55. Compare the International Task Force on Euthanasia and Assisted Suicide website for a detailed discussion of PAS and euthanasia legislation. See <http://www.internationaltaskforce.org/cd.htm>.

¹²¹Keown, *Public Policy*, 31. A significant indication of this was the introduction of "PAS" in separation from euthanasia legislation in the courts. Keown mentions the legislation to decriminalise PAS in the states of Washington, California, and Oregon. See also the recognition of PAS in the Netherlands' 2002 euthanasia law: "The Termination of Life on Request and Assisted Suicide (Review Procedure) Act," accessed at http://www.minbuza.nl/default.asp?CMS_TCP=tcpAsset&id=CA83D9494B444D268938017F2330E54E; 16 July 2006.

¹²²Jean Davies, "The Case for Legalising Voluntary Euthanasia," in *Euthanasia Examined: Ethical, Clinical and Legal Perspectives*, ed. John Keown (Cambridge: Cambridge University Press, reprint ed. 1998), 89. Davies writes that legalising assistance with suicide in Britain might be "more acceptable" to those within the medical profession. She indicates that this approach might be more suitable than participating "directly in the action" that causes a patient's death. There is, of course, the contrasting view that PAS is linked directly to the action. Keown, more recently, views a reason for distinguishing between VAE and PAS as a matter of political "tactics." He suggests that "right-to-die" campaigners believe PAS can be sold more easily as an exercise of patient autonomy. Keown, *Public Policy*, 35. The reasons for a focus on PAS may actually centre on the belief that PAS offers a more palatable political strategy to all as a way to safeguard patient "rights" and "autonomy." See Stutsman, 247. The desire to protect individual "rights" and to limit medical or governmental control over a person's dying process, seem to be significant issues in PAS legislation. PAS, in theory, gives a patient more control over his or her dying process. The belief that PAS and laws to permit it, among other things, will give patients more control over the dying process, as the thesis intends to demonstrate, does not necessarily make it so. In any case, PAS has assumed centre stage in legislation in the United States.

¹²³Stutsman, 254.

language,¹²⁴ which terminology has become a standard for “Oregon-style” legislation that followed.¹²⁵ This indicates some move toward a “centrist” (PAS) position regarding right-to-die advocacy. Advocates for PAS, like McLean and Britton, believe that respect for a patient’s autonomy and a physician’s obligation to respect a patient’s liberty are compelling reasons to legalise PAS.¹²⁶ Quill and Battin articulate a similar argument to call for the legalisation of PAS when they list patient autonomy and mercy as twin claims to support a change in laws concerning PAS.¹²⁷

Opponents like Hendin and Foley, however, present a counter view of patients when they describe dying patients as vulnerable, and state the need for doctors to treat their patients “humanely,” “compassionately,” and “appropriately.”¹²⁸ For them, PAS cannot fit these criteria for care. Whether agreeing or disagreeing with PAS, that PAS is of central import in end-of-life considerations is recognised by both its advocates and opponents. PAS also has been claimed to be of crucial political and legal significance, as it relates to the issue of the sanctity of human life¹²⁹ and as a strategic political instrument to advance right-to-die issues.¹³⁰ Yet, even with the

¹²⁴Ibid.

¹²⁵Ibid., 252-54. Michigan, Maine, and Hawaii legislative initiatives all included Oregon-style elements, but these initiatives failed. Part of the appeal of Oregon’s legislation, apart from the fact that Oregon’s law has withstood legal challenges, is its PAS-only emphasis. There is indication that the law provides for some balance between the two perceived extremes of either no such law at all and VAE.

¹²⁶McLean and Britton, 23, 25, and 29.

¹²⁷Quill and Battin, eds., 6.

¹²⁸Foley and Hendin, eds., 1.

¹²⁹Peter Singer, *Rethinking Life and Death: The Collapse of Our Traditional Ethics* (New York: St. Martin’s Press), 132-33, 158. Singer states that “politically, it is here that the most vigorous battle against the sanctity of life ethic is now being fought.” Singer presents several human “stories” of assisted suicide to illustrate the “ways in which pressure is building for a change” in the traditional sanctity-of-life ethic (133-37). He believes the Dutch model will not be the most suitable approach for all countries to adopt. He believes that PAS will likely be the area where a change in United States law against medical killing will occur (158). While the thesis will also demonstrate the importance of PAS, the dissertation will draw different conclusions from Singer relative to life’s sanctity and a need for changes in medical

abundance of information, a considerable amount of philosophical and ethical ambiguity remains about PAS. This section, therefore, will distinguish PAS from other forms of physician-aid-in-dying, define terms and explore key historical features of the PAS debate that affect the DPR, and note the emerging shifting patterns of acceptance regarding the practice. This understanding will clarify the philosophical and ethical ambiguities and lay the groundwork for the discussions in the following chapters regarding the influences of HU upon PAS.

What Is “Physician-Assisted Suicide?”

Distinguishing Concepts

PAS has been grouped under a broader heading of “physician-assisted death” or “physician-aid-in dying,” an association that can confuse the meaning of both PAS and euthanasia.¹³¹ The umbrella term “physician-assisted dying” is used because PAS advocates believe it “carries with it no misleading connotations,” although it is recognised that

canons related to medical killing. Singer’s views, then, are not the only perspective on the issue of the sanctity of life, its meaning and application, and medical killing. See Keown, *Public Policy*, 39-51; and David Cook, *Patients’ Choice: A Consumer’s Guide to Medical Practice* (London: Spire, 1993), 161-62. See also chapter 3 of the thesis for a discussion of the sanctity of life.

¹³⁰Keown, *Public Policy*, 35. Good evidence exists that PAS has surpassed VAE as the focus for legal initiatives. See Kathleen Foley and Herbert Hendin, “The Oregon Experiment,” in *The Case Against Assisted Suicide: For the Right to End-of-Life Care*, edited by Kathleen Foley and Herbert Hendin (Baltimore: Johns Hopkins University Press, 2002), 172. As such, the focus on PAS in the thesis is warranted, and its importance cannot be understated.

¹³¹Beauchamp and Childress, 228. The authors say that assisted death and physician-assisted death, though now widely used, are ambiguous since both assisted suicide and VAE involve assistance with bringing about death. See also Beauchamp, *Intending Death*, 4. Beauchamp writes that the term incorporates several forms of assistance under one general heading. See also Charles F. McKhann, *A Time to Die: The Place for Physician Assistance* (New Haven, CT: Yale University Press, 1999), 6. McKhann uses the term “physician-aid-in-dying” instead of suicide because he believes “dying” is a more appropriate term than “suicide” for people who are already terminally ill.

“physician-assisted suicide” is “technically accurate.”¹³² Quill and Battin, however, seek to eliminate the perception sometimes present in American writing that suicide may be “conflated with mental illness” and considered to be “self-destructive” and, therefore, an irrational act.¹³³ The latter term, *euthanasia*, has itself experienced an historical evolution in meaning and may be subdivided into several applications.¹³⁴ The word *euthanasia* is a Greek word originally meaning nothing more than “gentle and easy death.”¹³⁵ Originally, there was no implication of a physician, for example, causing a patient’s death. The term was used instead to describe the nature of the “dying process” that an individual or an institution might undergo.¹³⁶ During the nineteenth century, the meaning of the term shifted.¹³⁷

Today the word commonly means the *act* of painlessly putting to death a person suffering from a terminal illness, or is used as a metaphor by pro-life and pro-choice

¹³²See also Quill and Battin, eds., *Physician-Assisted Dying*, 1-2. The thesis writer takes a different position of the term. Subsuming PAS under the overall rubric “physician-aid-in-dying” could lead a person to believe that PAS is a form of end-of-life *care* and potentially eclipses the view that PAS *remains* a form of medical killing. See the distinction at BMA, “End of Life Decisions,” Internet. Although the BMA had taken a neutral position on endorsing PAS, the BMA presently neither endorses PAS, nor does it view PAS as end-of-life care. See also Keown, *Public Policy*, 31-35. See Netherlands’ 2002 Euthanasia Law, “Termination of Life on Request,” Internet. The Dutch euthanasia and PAS law, “Termination of Life on Request and Assisted Suicide (Review Procedure) Act,” now includes a requirement of “due care” so as to include both as forms of “medical treatment.”

¹³³See also Quill and Battin, eds., *Physician-Assisted Dying*, 1-2.

¹³⁴Beauchamp, *Intending Death*, 3. Beauchamp distinguishes between voluntary passive euthanasia, nonvoluntary passive euthanasia, VAE, nonvoluntary active euthanasia, and involuntary euthanasia.

¹³⁵John Keown, ed., “Extracts from the Report of the House of Lords Select Committee on Medical Ethics,” in *Euthanasia Examined: Ethical, Clinical and Legal Perspectives*, rev. paperback ed. (Cambridge: Cambridge University Press, 1997), 99. Cf. also Beauchamp, *Intending Death*, 2-3; and C. Everett Koop, “The Challenge of Definition,” *Hastings Center Report Special Supplement* 19, no. 1 (January/February 1989): 2. See also Van Zyl, 2. The term was coined from the Greek in the seventeenth century and meant literally “a good death.”

¹³⁶Van Zyl, 2.

¹³⁷*Ibid.* Ch. 2 of the thesis examines some of the cultural background to this change in meaning and application. See thesis, ch. 2, 123-25, 130-32.

individuals to express right-to-die concepts.¹³⁸ Euthanasia as an umbrella term is actually subdivided into several more specific areas: it can be *voluntary* (active or passive), *nonvoluntary* (active or passive), or *involuntary*.¹³⁹ VAE takes place when a patient requests a doctor's aid to die. *PAS* is still another term which is commonly subsumed within the kindred term *VAE*.¹⁴⁰ In all forms of VAE and PAS a patient desires to commit suicide, yet there remains a difference in meaning and intent in the usage of the terms.¹⁴¹

A technical difference between VAE and PAS lies in the agent who directly *causes* a death. This technical distinction, however, must be coupled with the awareness that a doctor's assistance involves both the cause--the writing of a prescription and explaining how to use the drugs--and the intent to bring about the patient's death.¹⁴² The difference between intentionally ending a patient's life (VAE) and intentionally helping a patient end his or her life is negligible.¹⁴³ An awareness of circumstances that surround a withdrawal of treatment can also have a bearing on PAS. Competent adult patients have a right to refuse medical treatment, but this right has its ethical and legal limits. A doctor is *neither* ethically nor legally bound to assist a refusal of treatment that is suicidal. Suicidal withdrawal of treatment is intended to *hasten*

¹³⁸Thomasma, 67. Thomasma claims euthanasia has become the ultimate "patient's rights metaphor" or "the way out."

¹³⁹Beauchamp, *Intending Death*, 2-3. There are two main subtypes to euthanasia: active or passive and voluntary and nonvoluntary. Voluntary means the patient requests the action, and assisted suicide is a subclass of this area. Nonvoluntary involves cases where the patient is not mentally competent to make an informed choice. Involuntary euthanasia "involves a person capable of making an informed request but who has not done so." See also Keown, 100.

¹⁴⁰Beauchamp, *Intending Death*, 4.

¹⁴¹There are philosophical considerations as well. One aim of the thesis will be to explore possible links and influences between HU and PAS relative to a philosophical blurring (and possible elimination) of distinctions between killing and allowing to die. See thesis, ch. 2, 119-22, 134-36.

¹⁴²Keown, *Public Policy*, 33.

¹⁴³*Ibid.*

*death*¹⁴⁴ and hastening death in this manner is unlawful.¹⁴⁵ The withdrawal of treatment when further treatment would be futile or burdensome is to be distinguished from hastening death, or assistance with suicide, for other reasons. Therefore, while there remains a primary technical distinction between VAE and PAS, there also remains a critical difference of opinion between *causation* and *intention* and “conditions under which killing would be beneficent.”¹⁴⁶ In the former, a doctor causes death; in the latter, a patient causes his own death.¹⁴⁷ There is a primary distinction between VAE and PAS.¹⁴⁸ It is important to clarify the meaning in the common usage of the terms.

Defining Terminology

In common use, euthanasia has now come to mean “deliberate intervention undertaken with the express intention of ending a life to relieve intractable suffering.”¹⁴⁹ Specific

¹⁴⁴Ibid., 253.

¹⁴⁵Ibid., 254. A court order would be required.

¹⁴⁶Edmund Pellegrino, “The False Promise of Beneficent Killing,” in *Regulating How We Die: The Ethical, Medical, and Legal Issues Surrounding Physician-Assisted Suicide*, ed. by Linda L. Emanuel (Cambridge, Massachusetts: Harvard University Press, 1998), 72. The focus of discussion surrounding PAS and VAE has shifted away from intrinsic evil and the rule about the wrongness of killing to utilitarian arguments that focus on motive and results.

¹⁴⁷Beauchamp, *Intending Death*, 3.

¹⁴⁸The writer has chosen to address the ethical issue of competent patients who make requests of a doctor for assistance in killing themselves. This places the matter of patients who do not have the capacity to understand the meaning of euthanasia or PAS outside the scope of this thesis.

¹⁴⁹Ibid. Cf. also Beauchamp, *Intending Death*, 2-3. Beauchamp notes “that technological advances in medicine, which have made it possible to prolong the lives of patients who have no hope of recovery,” have led to the introduction of the term *negative* or *passive* euthanasia to indicate withdrawal of extraordinary means used to preserve life. The Select Committee (Keown, 99) felt the term *passive euthanasia* to be misleading. They felt that there was scope for argument over ethical equivalence of “killing and letting die.” See also Koop, 2. Koop understands *active euthanasia* to mean that someone plays an active role to bring about the “good death” of another. He understands *passive euthanasia* to be someone taking no action to prevent death from occurring.

definitions of “VAE” vary slightly, but for the thesis¹⁵⁰ the core definition will include the following ingredients: the killing of an incurably ill patient at his or her own request, the use of a lethal dose of medication, the express intentionality of the one doing the killing (other than the one dying), and the aim of painlessly and mercifully ending the suffering and life of the patient.¹⁵¹

In contrast, definitions of PAS vary as well, but its definitions indicate a middle-ground position that emphasises a patient’s choice to die and a resulting action which ends his life.¹⁵²

Even though death from VAE or PAS is often considered to be the same, a key point of

¹⁵⁰Diane E. Meier, Carol-Ann Emmons, Sylvan Wallenstein, Timothy Quill, R. Sean Morrison, and Christine Cassel, “A National Survey,” *New England Journal of Medicine*, vol. 338, no. 17 (April 1998): 1194. The survey defines VAE from the perspective of the physician who kills. It is understood that in the case of VAE someone other than a doctor at times does the killing, but for the sake of equal comparison with PAS, the thesis will define the term with the physician serving as the one who kills.

¹⁵¹Keown, 99. Cf. also Beauchamp, *Intending Death*, 2-4; and Meier et al., 1194. See also Beauchamp, *Intending Death*, 3-4. Beauchamp defines the parent term *euthanasia* (of any type) as requiring the following exact conditions: “. . . (1) the death is intended by at least one other person whose action is a contributing cause of death; (2) the person who dies is either acutely suffering or irreversibly comatose (or soon will be), and this condition alone is the primary reason for intending the person’s death; and (3) the means chosen to produce the death must be as painless as possible, or a sufficient moral justification must exist for a more painful method.”

¹⁵²Lawrence E. Holst, “Do We Need More Help in Managing Our Death? A Look at Physician-Assisted Suicide,” *Journal of Pastoral Care*, 47, no. 4 (Winter 1993): 337. Holst writes that assisted suicide involves someone helping a person to plan and carry out a “chain of events” intended to cause “self-inflicted death.” Beauchamp, *Intending Death*, 4. Beauchamp writes from the view of the decedent and states that a person whose death is “brought about” must be the “final cause” of that death. In Meier et al., 1194, the authors define PAS as “the practice of providing a competent patient with a prescription for medication for the patient to use with the primary intention of ending his or her own life.” Harold G. Koenig, “Legalizing Physician-Assisted Suicide: Some Thoughts and Concerns,” *Journal of Family Practice* 37, no. 2 (1993): 171. Koenig’s definition is more specific about physician involvement. A physician, by his definition, would be intentionally and willfully involved by taking actions that help a suicidal patient to end his or her life. This assistance may involve providing information on ways to commit suicide, supplying a prescription for lethal medication, providing a syringe filled with a lethal dose of medication, inserting an intravenous line so that a patient can inject a lethal dose of medication, or providing a “suicide” device that the patient is able to operate. See also Keown, 100. Assisted suicide is defined as occurring when “. . . a competent patient has formed a desire to end his or her life but requires help to perform the act, perhaps because of physical disability.” When a doctor helps the patient it is termed “physician-assisted suicide.”

distinction between the two is that in PAS, the patient commits the action; that is, he is *assisted* by a physician, but administers his own lethal dose of medication.¹⁵³ The choice is left, ideally, to the patient whether to end his or her life; therefore, the physician's involvement in a case of PAS is purported to be less direct than it would be with VAE. Physician assistance with suicide can take two forms: actually giving a patient the means to commit suicide or giving advice about methods, for example, the most effective methods.¹⁵⁴ Notwithstanding the moral questions surrounding PAS, advocates believe that PAS helps to buttress a patient's autonomy, his right to self-determination, and allows him to remain in control of his dying process.¹⁵⁵ PAS advocates also believe that the process of following through with PAS itself allows time for the patient to change his or her mind. The most effective method¹⁵⁶ for PAS has been determined to be ineffective in a significant number of cases, however, which raises questions concerning whether patients are actually able to exercise control over the dying process with PAS after all. PAS may be defined as: the act of a physician who prescribes the necessary medication to commit suicide and supervises the process, when a competent patient makes a request to

¹⁵³Yale Kamisar, "Physician-assisted Suicide: The Last Bridge to Active Voluntary Euthanasia," in *Euthanasia Examined: Ethical, Clinical and Legal Perspectives*, ed. John Keown (Cambridge: Cambridge University Press, 1995; reprint edition 1998), 230. Kamisar, while observing campaigns in the state of Washington and California, noted that the general public and the media *either* did not understand the distinction between VAE and PAS or they did not accept it. He states that examination of the literature on the law and morality of assisted dying reveals a blurring (and sometimes an obliteration) of the line between PAS and VAE.

¹⁵⁴Keown, 31.

¹⁵⁵*Ibid.*, 32-33.

¹⁵⁶Foley and Hendin, "Oregon Experiment," 166. The Dutch typically use 9 grams of barbiturates, because that dosage is considered to be lethal. Studies reveal, however, that 20 percent of patients who received this dosage lived for more than three hours following ingestion. Reports also indicate that in 18 percent of the latter category of cases, such delays caused doctors to intervene with a lethal injection.

terminate his or her own life.¹⁵⁷ This approach to the end stages of a terminal illness has not evolved without question or debate.

What PAS Is: Intentional Medical Killing

The current focus on PAS provides a unique platform for cultural, medical, philosophical/theological, and moral examinations of end-of-life treatment options and care. An examination of the *nature* of PAS, however, has been eclipsed somewhat by the focus on the preferable consequences that may be considered to result from such legalised implementation (for example, giving patients who face “intractable pain and suffering” a way to gain better control of their dying process). The aim to provide consequences that are favourable to patients, physicians, families, and medicine as a whole has clouded the reality that PAS still remains a form of medical killing, a reality that calls for careful examination of the impact its routine legalisation would elicit within medicine and culture.¹⁵⁸ The definition of PAS, as it relates to a *doctor’s involvement* (acts of prescribing and supervising), suggests that PAS is not a “middle-ground” position between a patient’s choice to die and active euthanasia.¹⁵⁹ Indeed, PAS remains clearly a form of medical killing, because a doctor participates both causally and with intent throughout the process.

The emphasis upon consequential reasoning when making end-of-life decisions has introduced an ethical application that runs contrary to traditional medical canons and law.

¹⁵⁷Meier et al., 1194. See also Keown, 100. See also Smith, *Forced Exit*, xxv. See also Margaret Otlowski, *Voluntary Euthanasia and the Common Law* (New York: Oxford University Press, 1997), 57. While the Oregon law restricts PAS to the *terminally ill* this is not the case in The Netherlands.

¹⁵⁸Keown, *Public Policy*, 31-36. Keown notes the “negligible” difference between a doctor “intentionally ending a patient’s life” (VAE) and a doctor “intentionally helping a patient to end his or her own life” (33). He makes a case that little difference exists between the various forms of medical killing.

¹⁵⁹See also Kamisar, “Physician-Assisted Suicide,” 230-33, 244-45. Kamisar is arguing that the blurring of the lines between PAS and VAE indicates a deeper agenda on the part of advocates of PAS and VAE; namely, to gain legalisation of both (244-45).

Medicine has historically placed great emphasis upon a physician's intent with regard to patient treatment. When utilitarianism is used as a basis for justifying and implementing medical killing, the radical paradigm shifts that such a view would, of necessity, bring to end-of-life medical care call for careful analysis and thorough critique.¹⁶⁰ The implications of such a paradigm-shift to legalise PAS are as significant if included under the rubric of overall end-of-life patient care.¹⁶¹

What PAS Is Not: End-of-Life Care

Some PAS advocates include PAS under a larger umbrella of end-of-life care options;¹⁶² however, to those who see PAS as a form of medical killing, this view raises

¹⁶⁰Edmund D. Pellegrino and David C. Thomasma, *A Philosophical Basis of Medical Practice: Toward a Philosophy and Ethic of the Healing Professions* (New York: Oxford University Press, 1981). See Edmund D. Pellegrino, *For the Patient's Good: The Restoration of Beneficence in Health Care* (New York: Oxford University Press, 1988); Edmund D. Pellegrino, "Doctors Must Not Kill," *Journal of Clinical Ethics* 3, no. 2 (Summer 1992): 95-102. Pellegrino presents a case that medicine has traditionally aimed toward providing benefit to a patient or, at least, doing no harm to a patient. The law until recently remained consistent throughout history; medical killing was unlawful. See thesis, 116-40, for an examination of the historical and traditional understanding of medical killing with comparison to HU.

See also the impact of utilitarian and consequentialist reasoning on medical decision-making; Luke Gormally, ed. *Euthanasia Clinical Practice and the Law*; Book One: *Euthanasia and Clinical Practice: Trends, Principles and Alternatives*; Book Two: *Euthanasia and the Law: The Case Against Legalization* (London: Linacre Centre, reprint ed., 1995), 28-29, 184-85. Gormally discusses the utilitarian/consequentialist reasoning that no significant moral distinction exists between "hastening death as a foreseeable consequence of the administration of drugs aimed at controlling pain, and bringing about death as a result of administering a lethal dose of drugs aimed precisely at bringing about death." He argues for maintaining the traditional medical understanding of intention by differentiating these distinctions within the definition of intention, even though a typical utilitarian argument would argue for the converse.

For an example of the shift in reasoning regarding end-of-life decision-making, see Charles H. Baron, "Hastening Death: The Seven Deadly Sins of the Status Quo," in *Physician-Assisted Dying: The Case for Palliative Care & Patient Choice*, ed. Timothy E. Quill and Margaret P. Battin (Baltimore: Johns Hopkins Press, 2004), 309-21. Baron reverses the usual utilitarian argument that the death of a person who is less than happy might be well-received by reasoning that keeping patients alive in support of the status quo essentially means "You must continue to suffer because it is good for us." In either view, Baron's approach illustrates one facet of concern; namely, the focus in consequential reasoning is often on the desired consequences and not the means (a doctor killing) to the consequences.

¹⁶¹Quill and Battin, eds., *Physician-Assisted Dying*, 1-2.

¹⁶²*Ibid.*, 1.

questions about the moral meaning and nature of including PAS under a rubric of “care” at all. Even when noting the medical and technical distinctions between VAE and PAS, there remain valid questions concerning whether a significant *moral* difference exists between VAE and PAS and whether such action *equals* care. Regardless of the technical or semantic differences between VAE and PAS, *a physician exercises intention in bringing about the death* of a patient¹⁶³ which, historically, has been deemed an unsuitable action in the exercise of beneficent medicine. For example, even though PAS advocates claim that a patient gains a greater degree of control with PAS,¹⁶⁴ the patient is still required to receive assistance in his dying process from a doctor.¹⁶⁵ A doctor is significantly—indeed morally—involved in both instances of VAE and PAS when he *intentionally* exercises some measure of control over the patient’s dying process.¹⁶⁶ A physician’s action towards a patient, to aid the bringing about of the death of that patient, is a moral action.¹⁶⁷

¹⁶³Keown, *Public Policy*, 33.

¹⁶⁴The DPR is a place where a focus upon favourable outcomes (HU consequences) holds implications for patient autonomy. See thesis, chapter 3 for an examination of autonomy. This is also of crucial concern to an historic ethic of physician care, because the historic nature of the DPR is altered when a physician acts to aid a patient with his or her suicide. See thesis, chapter 4, for an examination of a medical ethic of care.

¹⁶⁵Keown, *Public Policy*, 33. The doctor still exercises a “decisive” amount of medical control in PAS. A patient cannot require a doctor to assist with PAS. Further, a doctor will not assist a patient, unless he or she determines that suicide is appropriate in the patient’s case. Finally, a doctor will not agree to help a patient commit suicide, unless he or she forms a judgment that the patient’s life is no longer worth living and that death is the best alternative. The patient does not have as much control in the PAS equation as advocates promote.

¹⁶⁶A question remains as to why a patient’s autonomous request for PAS carries more weight than the same sort of request for VAE.

¹⁶⁷*Ibid.*, 33. See also Kamisar, “Physician-Assisted Suicide,” 230-33. Even though PAS is considered to protect patient autonomy and to provide a beneficent response to end-of-life terminal illness and suffering, genuine moral concerns exist that surround physician assistance with a patient’s suicide. Felicia Cohn and Joanne Lynn, “Vulnerable People: Practical Rejoinders to Claims in Favor of Assisted Suicide,” in *The Case Against Assisted Suicide: For the Right-to End-of-Life Care*, ed. Kathleen Foley and Herbert Hendin (Baltimore: Johns Hopkins University Press, paperback edition, 2004), 240. The authors note the abuses of PAS in The Netherlands of significant numbers of unreported PAS cases without patient request or consent.

A further question, however, addresses whether PAS is truly an end-of-life palliative care option. Even though there are those who believe that PAS is one such option,¹⁶⁸ promoting legalised PAS as a parallel treatment equal to hospice and palliative care is not an accurate assessment of “care.” PAS advocates proffer this treatment as an option when “nothing more” can be done to provide end-of-life care; however, medicine can--and often does--offer much care to a patient until the very end of a terminal illness.¹⁶⁹ PAS opponents state that *much more can be done* to help allay the pain that patients experience.¹⁷⁰ While advocates for medical killing promote VAE (and PAS) for “unbearable and unrelievable pain,” the reality is that pain symptoms can “almost always be relieved” with the help of good nursing and/or palliative care.¹⁷¹ Doctors not only need to inform patients about palliative care options, but they also need to help patients to gain easy access to such alternative care. Even when pain relief drugs are not working--noting the fact that 95 percent of patients receive pain relief and that 100 percent can be helped--there are, for example, other non-drug methods such as a TENS (“Transcutaneous Nerve Stimulation”) machine.¹⁷² Under the surface, then, the arguments for the legalising of PAS are sometimes not actually as much about the *presence or lack of possibilities* at end-of-life as they are more directly related to a *failure to provide adequate arrangements* for patients at the end of life.¹⁷³

¹⁶⁸Quill and Battin, eds., *Physician-Assisted Dying*, 1.

¹⁶⁹Cohn and Lynn, “Vulnerable People,” 243-44.

¹⁷⁰Alison Davis, “Submission to the Voluntary Euthanasia Select Committee, House of Keys, Isle of Man”; internet; available at <http://www.spuc.org.uk/about/no-less-human/10Meuthanasia.pdf#search=%22%22Robert%20Twyrcross%22%20%22pain%20relief%22%20%22article%22%22>; accessed 20 August 2006.

¹⁷¹*Ibid.*

¹⁷²*Ibid.*

¹⁷³Cohn and Lynn, “Vulnerable People,” 243-44.

The failure to provide adequately for end-of-life circumstances is indeed related to another issue that surrounds PAS; namely, the withholding and/or withdrawing of treatment and the fear that surrounds such decisions.¹⁷⁴ The situation in The Netherlands, for example, where significant numbers of patients were euthanised by their doctors without having requested such action, holds implications for families that will be treated by the same physician.¹⁷⁵ This sort of circumstance is compounded by a lack of knowledge and training in medical personnel to alleviate suffering through palliative care¹⁷⁶ which results, in some

¹⁷⁴In a significant number of documented cases in The Netherlands, physicians did not explain treatment options with their patients. Patients were killed without requesting such action by their physicians. John Keown, "Euthanasia in The Netherlands: Sliding Down the Slippery Slope?" in *Euthanasia Examined: Ethical, Clinical and Legal Perspectives*, ed. John Keown (Cambridge: Cambridge University Press, reprint edition, 1998), 261-96.; and Keown, *Public Policy*, 215. Keown addresses the concern with English law and professional ethics that permits passive euthanasia, especially as it regards withholding/withdrawing treatment (or tube-delivered food and fluids) by a doctor with the intent to kill. He claims that this action on the part of doctors has important implications for the United States, among other jurisdictions, where some courts have moved from "inviolability" of life toward "quality" of life--thus moving incrementally closer toward sanctioned medical killing.

¹⁷⁵Zbigniew Zylicz, "Palliative Care and Euthanasia in the Netherlands," in *The Case Against Assisted Suicide*, ed. Kathleen Foley and Herbert Hendin (Baltimore: Johns Hopkins University Press, 2002), 122-43. Zylicz states that the majority of patients with end-stage cancer desire to be cared for at home by a general practitioner (124) who will continue to offer care for the rest of the family (128). He states that, "Mistakes and near-mistakes may have an impact on decades of care afterward" (128). See also Foley and Hendin, "Oregon Experiment," 166. Doctors administered lethal injections to a number of patients, whose attempts to die failed through PAS.

¹⁷⁶Palliative care, as defined by the World Health Organization (2002) is: "... an approach that improves the quality of life of patients and their families facing the problem associated with life-threatening illness, through the prevention and relief of suffering by means of early identification and impeccable assessment and treatment of pain and other problems, physical, psychosocial and spiritual." See <http://www.euro.who.int/document/E82931.pdf>; internet; accessed 23 August 2006. Palliative care provides pain relief, offers care for other distressing symptoms, affirms life, and regards dying as a normal process. See thesis also, at Pellegrino and "ethic of care," 289-93.

instances, in euthanasia of a patient.¹⁷⁷ Patient fears concerning end-of-life treatment are often allayed when doctors discuss clearly end-of-life treatment and palliative care options.¹⁷⁸

Ethical Implications of Physician-Assisted Suicide

The contemporary moral and ethical debate about PAS centres upon the treatment of a terminally ill patient.¹⁷⁹ Proponents cast PAS as a beneficent model to care for patients who often endure emotional and physical pain and suffering in the end stages of a terminal illness.¹⁸⁰

¹⁷⁷Zylicz, "Palliative Care," 124-29.

¹⁷⁸Anthony L. Back, "Doctor-Patient Communication About Physician-Assisted Suicide," in *Physician-Assisted Dying: The Case for Palliative Care & Patient Choice* (Baltimore: Johns Hopkins University Press), 105-8. Back states that patients often do not receive clear answers to questions about their terminal illnesses, especially as it relates to palliative care and withholding treatment. Back states that it is important for clinicians to have the ability "to describe the natural history of illness and palliative care options in the last days of life." Maria Silveria, as cited in Back's discussion, found a substantial degree of misunderstanding among patients about withholding life-sustaining treatment and hastening death. Back, "Doctor-Patient Communication," 105-8. See also Maria J. Silveria, Albert DiPiero, Martha S. Gerrity, and Chris Feudtner, "Patients' Knowledge of Options at the End of Life: Ignorance in the Face of Death," *Journal of the American Medical Association* 284, no. 19 (November 15, 2000): 2483-88. For example, patients did not know that they could refuse life-sustaining medical care, did not know that life support could be withdrawn once it was started, did not know that pain can be managed aggressively "by increasing medication dosages into the realm of a double effect," and did not know enough to differentiate between PAS and VAE.

See also Dieter Giesen, "Dilemmas at Life's End: A Comparative Legal Perspective," in *Euthanasia Examined: Ethical, Clinical and Legal Perspectives*, ed. John Keown (Cambridge: Cambridge University Press, rev. paperback ed., 1995), 200-13, esp. 205-7. Giesen examines the legal issues that surround palliative care and withholding and withdrawing treatment, both within the context of life-sustaining treatment.

¹⁷⁹Bernard Baumrin, "Physician Stay Thy Hand!" in *Physician Assisted Suicide: Expanding the Debate*, ed. Margaret Pabst Battin, Rosamond Rhodes, and Anita Silvers (New York: Routledge, 1998), 181. Cf. also *The Oregon Death With Dignity Act* at http://www.rights.org/deathnet/ergo_orlaw.html; accessed 16 June 2000. Under section 1, "General Provisions," item (12) defines "terminal disease" as ". . . an incurable and irreversible disease that has been medically confirmed and will, within reasonable medical judgment, produce death within six (6) months."

¹⁸⁰Marcia Angell, "Helping Desperately Ill People to Die," *Regulating How We Die: The Ethical, Medical and Legal Issues Surrounding Physician-Assisted Suicide*, ed. Linda L. Emanuel (Cambridge: Harvard University Press, 1998), 17. Angell writes that the "problem of aiding people who face prolonged dying is so great that we cannot ignore it."

Noting both the difficult circumstances surrounding a terminal illness and the physician safeguards noted above in the definition of PAS, it might seem reasonable to conclude that PAS is warranted in some instances and that there would be a minimal amount of disagreement with or about such action on the part of doctors and patients. Further, PAS has been viewed as a middle ground position between VAE and no physician-aid-in-dying that would offer a choice between a natural or an accelerated death to each individual.¹⁸¹ An extensive body of literature examines various facets of debate, using the pillar arguments of mercy or beneficence, and/or respect for patient autonomy and authority to inform proposals for or against cultural perceptions and changes in medical policies and legal canon.¹⁸²

¹⁸¹Lonny Shavelson, *A Chosen Death: The Dying Confront Assisted Suicide* (Simon & Schuster: New York, 1995), 222. Holst, 339. Holst states that a reason for this view is that PAS provides a balance of power that is more nearly equal between a physician and a patient.

¹⁸²The general moral facets of the debate reflect roughly religious perspectives alone, religious and secular perspectives, and secular perspectives alone, but each facet (perspective) often deals with a central feature—the issue of who ultimately controls life and death whether it be governmental, institutional, or individual. There are religious moral concerns as noted by Cassel. Christine Cassel, “Physician-assisted Suicide: Are We Asking the Right Questions?” *Second Opinion* 18, no. 2 (October 1992): 96. She states that most of the world’s great religions believe suicide is an immoral act, an act against God. Cf. also Committee on Medical Ethics Episcopal Diocese of Washington D.C., *Assisted Suicide and Euthanasia*. Then there are those that de-emphasise such religious concerns and seek to approach the debate from a predominantly secular perspective. McLean and Britton, xii. While the authors state that religious reasons represent a portion of resistance to individuals managing their own deaths, they also believe fears that self-control will become public control are reasons for strong resistance to people securing a right to managing their own deaths (meaning, for example, using PAS as a means of managing death). The law, in their view, sees itself as the upholder of traditional values such as the sanctity of all life. Dan W. Brock, “Physician-Assisted Suicide Is Sometimes Morally Justified,” in *Physician-Assisted Suicide*, ed. Robert F. Weir (Bloomington, IN: Indiana University Press, 1997), 88. Brock writes from a strictly secular perspective with the belief that religion should not play a role in the discussion of PAS based in part that we live in a pluralistic society where religious views are rejected by a “substantial portion of society.”

Beneficence (Mercy) for a Dying Patient

One primary pillar used to support a claim for physician-assistance-with-suicide has been the argument from mercy.¹⁸³ Few persons, if any, would dispute the fact that a terminal illness poses deep difficulties for a patient, his family, and his friends. It is reasoned that the avoidance of such misery is beneficial to all involved and, when an action (in this case, for example, PAS) would decrease the misery, then the reduction of misery is the strongest reason in favour of PAS.¹⁸⁴ Advocates for physician-aid-in-dying believe that the medical community responds beneficently when a physician offers assistance with a patient's request for aid in dying.

Another application of the principle of beneficence is that which refers to a *moral* obligation for a physician to act for the benefit of others,¹⁸⁵ that is, that a physician has a moral obligation to further the "important and legitimate interests" of a patient.¹⁸⁶ PAS advocates would claim that aid in dying is sometimes a legitimate interest. This raises questions about the historical meaning of physician beneficence. Historically, beneficence meant that a benevolent physician would act from merciful, kind, and charitable motives. Such a principle directed a

¹⁸³Paul J. van der Maas and Linda L. Emanuel, "Factual Findings," in *Regulating How We Die: The Ethical, Medical, and Legal Issues Surrounding Physician-Assisted Suicide*, ed. Linda L Emanuel (Cambridge, MA: Harvard University Press, 1998), 155. See also British Medical Association, "Arguments and Counter-arguments for Active Termination of Life," in *Euthanasia: Report of the Working Party to Review the British Medical Association's Guidance on Euthanasia* (London: British Medical Association, 1988), 39. The BMA does not endorse VAE or PAS but it does recognise the need for mercy in the face of terminal illness. "There is a strong case, based on common sense and compassion, for granting the wish of terminal patients for a merciful release from prolonged and useless suffering." See also Margaret P. Battin, "Is a Physician Ever Obligated to Help a Patient Die?" in *Regulating How We Die: The Ethical, Medical, and Legal Issues Surrounding Physician-Assisted Suicide*, ed. Linda L Emanuel (Cambridge, MA: Harvard University Press, 1998), 32. Battin states that self-determination and mercy jointly support a moral right to physician assistance in suicide.

¹⁸⁴James Rachels, *The End of Life: Euthanasia and Morality* (Oxford: Oxford University Press, 1986), 156.

¹⁸⁵Beauchamp and Childress, 260.

¹⁸⁶*Ibid.*

physician to secure more good than harm for a patient.¹⁸⁷ These historical concepts of physician beneficence are built, in part, upon various philosophical approaches to the subject of aid in dying. Proponents who use this argument from mercy often buttress it by the use of both utilitarian and non-utilitarian arguments.

The utilitarian GHP, for example, calls for calculations that increase happiness (pleasure) and reduce pain. According to this principle, an action to end a life should be judged as either right or wrong based upon whether it increased happiness or reduced misery. Either euthanasia or PAS could be adjudged morally acceptable from this perspective.¹⁸⁸ It could be further reasoned that the death of a person who is less than happy could be well-received, unless that person's death produced new unhappiness for surviving individuals.¹⁸⁹ Utilitarians are aware that such calculations carry the potential for negative results for the patient but, in a case where the balance of benefits over injury would accumulate to others from the suicide of an individual, it might appear that suicide ought to be encouraged.¹⁹⁰

A typical non-utilitarian argument from mercy reasons also that there are some situations where pain and suffering may become so intense that it would be morally

¹⁸⁷Allan S. Brett and Laurence B. McCullough, "When Patients Request Specific Interventions: Defining the Limits of the Physician's Obligation," *New England Journal of Medicine* 315, no. 21 (November 1986): 1347-51.

¹⁸⁸Rachels, 154-55.

¹⁸⁹Margaret Pabst Battin, *Ethical Issues In Suicide* (Englewood Cliffs, NJ: Prentice Hall, 1982), 109. While it might be supposed that the death of a loved one usually produces unhappiness in the life of survivors, the cessation of the patient's pain is thought to outweigh this experience of unhappiness.

¹⁹⁰Battin, *Ethical Issues in Suicide*, 107. She states that "... harm to the deceased would be nil." There would be, in her view, no consequences for the individual who commits suicide. Battin estimates that this would not matter ultimately to a terminally ill patient because he or she would be deceased. See also Rachels, 154. Rachels reasons, too, that killing a hopelessly ill patient who is suffering great pain, at the person's request, would decrease the amount of misery in the world.

permissible for another person either to kill the sufferer or to assist the sufferer in committing suicide. A Christian argument, for example, might reason that a merciful and compassionate God would not allow such an excruciating death for a person;¹⁹¹ thereby, the taking of a life in an extraordinary case might be justified when it prevents “intolerable and uncontrollable suffering near death.” Advocates of mercy killing call for strict safeguards for such action, and for VAE and PAS to be used only in a rare, extreme, and catastrophic case.¹⁹² While patient misery draws merciful concern from others, a second pillar argument used in support of PAS forms the important catalyst in initiating and completing a request for physician-assistance-with-suicide in which a patient makes an “autonomous” request for physician-aid-in-dying.

Respect for Patient Autonomy

A central tenet of current medical ethics is the principle of respect for patient autonomy.¹⁹³ PAS occurs following a patient’s voluntary (autonomous) and repeated request for assistance with suicide.¹⁹⁴ Inherent in the patient’s autonomy argument are three angles: an individual has a fundamental right to direct the course of his life, that respect for this individual

¹⁹¹Committee on Medical Ethics Episcopal Diocese of Washington D.C., *Assisted Suicide and Euthanasia*, 63.

¹⁹²Ibid., 64.

¹⁹³Beauchamp and Childress, ch. 3. Autonomy forms one principle of a cluster of four principles of common morality found in medical morality.

¹⁹⁴*Oregon Death With Dignity Act*. Section 3.06 “Written and oral requests” outlines the procedure the patient must follow. The patient is to make an oral request followed by a written request and then a second oral request within fifteen (15) days of the first oral request.

self-determination mandates legalisation of PAS,¹⁹⁵ and a person has the right to be free of governmental interference when he chooses to end his life.¹⁹⁶

The argument for PAS from patient autonomy raises implications that proponents of legalising PAS and VAE question, such as, whether laws meant to promote patient autonomy might instead give rise to new “extrajudicial” authority to physicians that might result in resurgent paternalism.¹⁹⁷ For example, a physician might be given powers to deny assistance for suicide to legally competent persons by “declaring them decisionally incapable.”¹⁹⁸ Another question is whether the value of human life outweighs an autonomy claim.¹⁹⁹ Another issue is that autonomy safeguards in PAS and VAE legal proposals could impact personal autonomy: for example, the authenticity of a patient’s request (“carefully considered, informed, rational, and mature”), and ability (the patient must be able to demonstrate the ability to self-administer the lethal substance).²⁰⁰ Finally, it is also believed that seeking to end one’s life intrinsically

¹⁹⁵New York State Task Force, 86-87. Proponents believe that legalising PAS would grant individuals further control over their dying process. It is stated further that a tolerant, pluralistic society should support such a decision on the part of a patient. Proponents of patient autonomy and PAS believe that legalising PAS would demonstrate respect for individual beliefs about the meaning of life and the significance of death.

¹⁹⁶New York State Task Force on Life and the Law, *When Death Is Sought: Assisted Suicide and Euthanasia in the Medical Context* (Albany, NY: Health Education Services, 1994), 87. See also Brock, 89. He states that people ought to be able to make the important decisions about their lives for themselves according to “their own values or conceptions of a good life and in being left free to act on those decisions.”

¹⁹⁷Stephen Miles, Demetra M. Pappas, and Robert Koepp, “Considerations of Safeguards in Laws And Guidelines to Legalize Assisted Suicide,” in *Physician-Assisted Suicide*, ed. Robert F. Weir (Bloomington, IN: Indiana University Press, 1997), 217. Autonomy and physician paternalism will be examined in detail in the third chapter of the thesis.

¹⁹⁸*Ibid.*

¹⁹⁹New York State Task Force, 87.

²⁰⁰Miles, Pappas, and Koepp, 212-13. The authors believe that some restrictions on responses to PAS and VAE rather than promote respect for autonomy could, in fact, undermine the rights of persons “whose autonomy should be promoted and are inadequate to protect those whose capacity for an authentic choice is impaired.”

contradicts the value of autonomy²⁰¹ and also makes the action a communal one when a second party becomes involved in PAS.²⁰² The point is that patient autonomy argument is fraught with cultural, legal, and ethical implications that still must be addressed.

The one place where patient autonomy advocates converge is in asserting that a patient has a moral right to physician-assisted death, based upon an underlying affirmation of patient rights.²⁰³ This alleged right functions as “the crucial unquestioned premise in the argument for PAS. . . .”²⁰⁴ This premise, however, raises fundamental concerns about what limits, if any, there are to personal rights, what communal responsibilities a patient has, and how appropriate suicide is.²⁰⁵ Regardless of the limits some might place upon individual autonomy, there are those who would claim that an individual should have the right to control his or her physical being, even to the point of physician-aid-in-dying.²⁰⁶ This argument for autonomy over one’s own death conflicts most often with three authoritative entities: religion, the government, and the medical establishment.²⁰⁷

²⁰¹New York State Task Force, 88.

²⁰²Ibid.

²⁰³While there is agreement that there is a broad continuum that encompasses discussion and debate about a “right-to-die”—one that covers, for example, everything from a right to know the truth about one’s condition to involuntary euthanasia of the incompetent incurably ill—there is much disagreement about the far end of the continuum, legalising physician-assistance-with-suicide. Patient autonomy is embraced on the end of the continuum that includes treatment decisions (i.e., a right to refuse treatment) and is restricted on the opposite end of the continuum where decisions about suicide and euthanasia fall. See New York State Task Force, 49. See also Derek Humphry and Mary Clement, *Freedom to Die: People, Politics, and the Right-to-Die Movement* (New York: Saint Martin’s Press, 1998), 81. The New York State Task Force and Humphry/Clement represent differing conclusions about suicide and euthanasia, but both sides understand autonomy to be a central cog in the entire debate.

²⁰⁴David J. Baggett, “On The Legality and Morality of Physician-Assisted Suicide,” *Asbury Theological Journal* 50, no. 1 (Spring 1995): 57.

²⁰⁵Ibid. See also New York State Task Force, 49. New York law prohibits assisted suicide and euthanasia for the individual’s own benefit and for the sake of the common good. Ch. 2 of the thesis will examine the subject of a “right-to-die.”

²⁰⁶Humphry and Clement, 81.

²⁰⁷Ibid., 167.

Patient Autonomy, Authority, and Physician-Assisted Suicide

Religious perspectives on suicide, VAE, and PAS have drawn considerable attention in the PAS debate.²⁰⁸ The issue is not directly related to a person's belief or disbelief in a deity. Indeed, in the broader dialogue surrounding PAS there seems to be little antagonism toward those who might worship a deity or approach ethical decision-making from a religious perspective.²⁰⁹ Rather, the debate centres upon *the basis for* ultimate authority in decision-making. In the view of some advocates of PAS, a religious authority that limits an individual's autonomous decision to request and receive physician-assistance-with-suicide is to be

²⁰⁸Ibid., 167-85. Richard Doerflinger, "Assisted Suicide: Pro-Choice or Anti-Life?" *Hastings Center Report*, Special Supplement 19 (January-February 1989): 16. In discussing assisted suicide, Doerflinger notes that the intrinsic wrongness of directly killing is "all but axiomatic" in Jewish and Christian worldviews. These views helped shape the laws and mores of Western culture and the self-concept of its medical practitioners. He notes also that the secularisation of Western culture has led to a cutting of the religious roots. See also Eike-Henner W. Kluge, *The Practice of Death* (New Haven: Yale University Press, 1975), 133-40. Kluge outlines in some detail the religious arguments against euthanasia. Eduardo Rodriguez, "The Arguments for Euthanasia and Physician-Assisted Suicide: Ethical Reflection," *Linacre Quarterly* 68, no. 3 (August 2001): 258. In Rodriguez's argument against euthanasia and PAS he notes the religious prohibition in practically all religious traditions. McLean and Britton, xii. While the authors do not believe the religious argument is a main key, they still note religion as an influence against the legalisation of PAS.

²⁰⁹Ch. 3 of the thesis will examine thoroughly the area of autonomy. Indeed, religious authority over an individual, whether the matter was suicide or not, has been challenged by some from the Renaissance forward. See also Gary B. Ferngren, "The Ethics of Suicide in the Renaissance and Reformation," in *Suicide and Euthanasia: Historical and Contemporary Themes*, ed. Baruch Brody, vol. 35 in *Philosophy and Medicine*, ed. H. Tristram Engelhardt Jr. and Stuart F. Spicker (Dordrecht, The Netherlands: Kluwer Academic Publishers, 1989), 155-62. Ferngren writes that it was during the sixteenth and seventeenth centuries that the traditional Christian view related to suicide began to receive challenges; "obliquely" at first, then with "increasing boldness." Suicide, by the end of the seventeenth century, according to Ferngren, was considered to be merely a matter of personal choice that was unencumbered by theological or dogmatic considerations. See, for example, Mill, 33. Mill was not antagonistic toward religion, but he did believe that any religious ethic must "fulfil [*sic*] the requirements of utility in a supreme degree." See also Timothy N. Gorski, "No: Should Spirituality Play a Bigger Role in American Healthcare?"; internet, available at http://umm.drkoop.com/news/focus/January/spirituality_no.html; accessed 16 July 2001. Gorski asserts that religious and spiritual concerns have traditionally been in the background of American healthcare, but the "subordination" of these concerns does not give licence to healthcare professionals to belittle or ignore religious beliefs and practices. He believes that these beliefs and practices are an integral part of a person's sense of well-being.

resisted.²¹⁰ Authority for decision-making is considered to belong to the individual alone and that individual is to be free of all external control. Therefore, religious authority is viewed by some as an impediment to an individual's choice to develop the framework of his or her life autonomously.²¹¹

A second authoritative entity impacting autonomous decision-making is government.²¹² Again, the issue for PAS proponents is the patient's loss of control over his freedom to make an autonomous decision about the framework of his or her life free from governmental interference--in this case to choose and receive physician-assistance-with-dying. As of April 2004, the only jurisdictions granting the patient the legal right to terminate his own life with the assistance of a physician are the state of Oregon in the United States, the Netherlands, and Belgium.²¹³ Legal jurisdiction does in fact inform, and sometimes control, the patient's options for end-of-life decisions. The same holds true for medical canons.

Depending upon a variety of factors a patient has little opportunity to exercise the autonomous choice with supervision unless a physician is either morally willing and/or legally able to assist him. Longstanding medical practice, pledged to sustain life, militates strongly against pressure to accept a patient's final control over his or her own life.²¹⁴

²¹⁰Humphry and Clement, 167.

²¹¹Ibid. Yet, see also Committee on Medical Ethics Episcopal Diocese of Washington, D. C., *Assisted Suicide and Euthanasia*, 67-68. There are those within religious circles who support VAE and PAS under the belief that God's dominion over a person's life does not require a person to continue to live in pain and suffering.

²¹²Humphry and Clement, 167.

²¹³Rita L. Marker and Kathi Hamlon, "Euthanasia and Assisted Suicide: Frequently Asked Questions," ed. International Task Force on Euthanasia and Assisted Suicide; internet, available at <http://www.internationaltaskforce.org/faq.htm>; accessed 23 April 2004. PAS is not yet legal in Switzerland, but it is practised. See also "Medical Body Breaks Euthanasia Taboo"; internet, available at <http://www.nzz.ch/2004/102/105/english/page-synd4696720>; accessed 23 April 2004.

²¹⁴See ch. 3, 179-83, for a fuller discussion of this topic.

Patient control raises questions about the limits of autonomy. Currently, a patient is only free to do whatever he or she desires within certain limits.²¹⁵ PAS advocates claim that a patient may lack the knowledge and means necessary to take his own life and that a physician's aid is needed, which case represents a technical inability. In other cases a patient might not have the mental or physical capability of committing suicide, representing a physical limitation or mental competency inability. These technical and physical restrictions in the case of PAS only add to those limits already imposed by authoritative entities, the latter of which have struggled to maintain a consistency of policy in the face of the onslaught of the rhetoric of both public and private sectors. The tension between these above mentioned authoritative bodies, technical and physical restrictions in the instance of PAS, and heightened patient desire for control over the dying process has created a shifting current within culture.

Evidence of Cultural Shift

Cultural Indications

Heightened Awareness and Public Fear

One of the strongest voices in the debate surrounding PAS is the message delivered by an ever-widening phenomenon of euthanasia societies.²¹⁶ These groups have increased public awareness of right-to-die issues, helped people to prepare for death and its inevitability, and advocated the legalisation of both VAE and PAS.²¹⁷ Derek Humphry, one of the original founders of the *Hemlock Society*, an aggressive proponent of VAE and PAS, has written: "The phrase most often heard by euthanasia societies is: 'I have a dreadful fear of being trapped and

²¹⁵See David Cook, *Freedom and Authority* (London: Scripture Union, 1988), 30-32.

²¹⁶Information on the World Association of Euthanasia Societies can be accessed at "Euthanasia Research and Guidance Organization (ERGO)"; internet, available at http://www.finalexit.org/worldfed_frame.html; accessed 19 May 2004.

²¹⁷Battin, *Least Worst Death*, 7. See also Cox, 59-60; and Samuel I. Greenberg, *Euthanasia and Assisted Suicide: Psychosocial Issues*, with a foreword by Ralph Slovenko (Springfield, IL: Charles C. Thomas Publisher, 1997), 107.

out of self-control like my mother/father was.”²¹⁸ Humphry also writes that “fear of dying in the cold clutches of modern technology has given a major boost to public acceptance of voluntary euthanasia.”²¹⁹

Battin cites the sales success of Humphry’s how-to book on self-deliverance, *Final Exit*, as a clear message of public ferment sent to the medical establishment.²²⁰ She also suggests that these vocal advocates for legal change have aroused the public into wresting the control of dying from both physicians, in whom authority has traditionally rested, and medical institutions, in order to hand that control to the patient.²²¹ The seminal influence in the euthanasia movement in the United Kingdom was the Voluntary Euthanasia Society²²² established in 1931,²²³ the founding group in the United States (1938) was named the Euthanasia Society of America, later to become the United States Society for the Right to Die.²²⁴ Both groups advocated an energetic approach to active euthanasia, but this is not to

²¹⁸Derek Humphry and Ann Wickett, *The Right to Die: Understanding Euthanasia* (New York: Harper & Row Publishers, 1986): 189.

²¹⁹*Ibid.*, 188. Humphry and Hemlock did not begin actively pushing PAS until some years later when a Hemlock Society-supported euthanasia initiative failed in Washington State. Humphry is not alone in recognising the fear many people have of a long and painful illness. See also David Lamb, *Therapy Abatement, Autonomy and Futility: Ethical Decisions at the Edge of Life* (Aldershot: Avebury, 1995): 38. Lamb also cites Robert F. Weir’s 1990 appraisal of therapy options for the terminally ill. He says “fears of medical technology out of control are well expressed . . .” in Weir’s work.

²²⁰Battin, *Least Worst Death*, 7. Battin states that *Final Exit* sold more than 540,000 copies within a year and a half of publication and “hit the top of the *New York Times* how-to bestseller list.”

²²¹*Ibid.*

²²²*Ibid.* The Scottish affiliate of VES is now named EXIT.

²²³Robert G. Twycross, “Voluntary Euthanasia,” in *Suicide and Euthanasia*, ed. Samuel E. Wallace and Albin Eser (Knoxville, TN: University of Tennessee Press, 1981), 88.

²²⁴David C. Thomasma and Glenn C. Graber, *Euthanasia: Toward an Ethical Social Policy* (New York: Continuum, 1990), 185.

imply that all pro-euthanasia groups are the same. Since that decade other societies emerged worldwide and now take varied positions on the matter of euthanasia and PAS.²²⁵

A recent type of society which advocates a more conservative approach to the subject of euthanasia and PAS concentrates its energies on disseminating information, holding legal and medical seminars, winning court cases, and passing legislation to assist in passive death.²²⁶ While no less energetic than the active euthanasia groups, these societies seek to use information and action to help patients “to maintain some control over their dying process, based upon their respect for autonomy born out of patient rights.”²²⁷ The success of these societies hinges on several factors: the public fear of a protracted and painful death, an aggressive agenda to popularise euthanasia and PAS, and efforts to legalise PAS. The public’s fear of a painful, protracted death is a reality both detractors and proponents in the PAS debate must take into account.

A second reason for the heightened public interest is the aggressive agenda of euthanasia societies to popularise euthanasia and PAS. Smith notes the “indomitable spirit” of these societies in the United States by naming them “death fundamentalists.”²²⁸ Britain’s EXIT has been providing drug dosage information to its members for years, “sometimes directly, sometimes through its Scottish affiliate.”²²⁹ With the uniting of individual euthanasia societies

²²⁵Cox, 54. Cox writes of thirty-one different societies in nineteen nations that were formed in the late 1980s. The umbrella organisation for this world network of euthanasia groups is named the World Federation of Right to Die Societies (WFRDS).

²²⁶Ibid., 60. The conservative National Council on Death and Dying was the result of a merger in 1990 between Concern for Dying and Society for the Right-to-Die (formerly the Euthanasia Society). “Conservative” means they do not advocate going beyond the removal of tubes and respirators for the terminally ill. They do push for the legalisation of living wills and powers of attorney. Cf. also Battin, *Least Worst Death*, 7.

²²⁷Thomasma and Graber, 185. See also Battin, *Least Worst Death*, 7.

²²⁸Smith, *Forced Exit*, 116. Smith also notes that euthanasia advocates are undaunted in their efforts even though they suffer legal or political setbacks.

²²⁹Battin, *Least Worst Death*, 7. This action led to legal challenges.

into a world federation,²³⁰ the movement now has a global forum for collecting and disseminating information, lobbying legislation, and advancing the stated agenda of the organisation.²³¹ Derek Humphry, editor of the *World Right-to-Die-Newsletter*, used a 1993 edition to call for legal reform with regard to euthanasia and PAS for the terminally ill. He suggested that the President of the United States appoint a special "President's Commission" to make recommendations on "how to solve the impasse on both the state and federal levels."²³² The fact of a worldwide developing organisation of right-to-die activists was not enough to garner public focus; something else was required to galvanise concern. Several watershed events occurred within the medical community at large that helped to draw the public's attention to the subject of physician-aid-in-dying.

Medical Community

An HU Interface with Medicine

The concept of the moral permissibility of PAS, as well as suicide and assisted suicide, has been discussed for centuries. Both ancient and contemporary societies have presented strongly divided viewpoints, offered ethical and medical perspectives, crafted and, in some instances, passed laws allowing for PAS. Even though the concept of physician-aided death has a long history, only within the last several decades--with the advent of life-sustaining technology and the qualitative considerations of pain measured against the prospect of future happiness--have the cultural, medical, legal, and ethical discussions captured such broad attention and considered the possibility of legalisation. Several watershed cases where medicine applied life-sustaining technology--for example, Quinlan (1976), Cruzan (1990), and Bland (1993)--captured global attention as they related to the appropriateness of the removal,

²³⁰See thesis, 39, footnote 169.

²³¹Cox, 225. The *World Right-to-Die Newsletter* is the chief organ of the global euthanasia organisations.

²³²*Ibid.*

or the refusal, of such life-sustaining medical treatment. Of key and critical importance in these, and other cases to follow, was the growing discussion of *actively shortening lives no longer considered to be worth living*.²³³ Such qualitative discussions of life's value in culture, medicine, and law have evolved over these many centuries of philosophical, ethical, and moral consideration surrounding the basis and nature of life itself--even to the point of establishing life's sanctity. Of key concern to this thesis is the utilitarian and consequential reasoning that has contributed to some of the advocacy for a change in medicine and law that would allow for a form of medical killing, based upon a determination that a life is no longer worth living.²³⁴

A widespread "residue of philosophical utilitarianism" in the broader culture has been an object of focus²³⁵ in this thesis' discussion because such an awareness acknowledges the

²³³Loretta M. Kopelman and Kenneth A. De Ville, eds., *Physician-Assisted Suicide: What Are the Issues? Philosophy and Medicine*, ed. H. Tristram Engelhardt, no. 67 (Boston: Kluwer Academic Publishers, 2001). This is also a focus in this thesis, because PAS has emerged as an option for patients in order to shorten actively lives no longer considered to be worth living.

²³⁴See Peter Singer's utilitarian and consequentialist perspectives on end-of-life decision-making in Peter Singer, *Rethinking Life and Death: The Collapse of Our Traditional Ethics* (New York: St. Martin's Griffin, 1994), 1-6. Singer argues from a utilitarian perspective and his book seeks to establish this form of ethic to replace a traditional sanctity of life ethic. Of course, Singer's intent does not make it so, but Singer's use of Mill's "harm principle" as one leg of support for his overall utilitarian ethical approach is illustrative of utilitarian reasoning. See also Sheila McLean and Alison Britton, *The Case for Physician-Assisted Suicide* (San Francisco, CA: Pandora, 1997), 29. The authors refer to Mill's harm principle and utilise a collective "happiness" argument (GHP) as twin utilitarian supports for their belief that *prohibiting* physician-assisted suicide is *immoral*. See Baron, "Seven Deadly Sins," 312-14. Baron's perspective illustrates the pervasive application of utilitarian reasoning. Again, the focus is on consequences and not on the motive and intent behind the physician's action--the doctor who helps to kill his patient.

²³⁵Gormally, ed. *Euthanasia Clinical Practice and the Law*, 28-29, 184-85. Values must be attached to outcomes in this line of reasoning. For example, it is assumed that a common measure (commensurable) can be placed upon the value of a child's life and the "burdens" associated with the medical treatment needed by that child. The value of a severely handicapped child's life would be calculated, for example, alongside the burdens (financial, physical, and psychological) of treating the child. Alongside both of these calculations, a person would measure the value of alternative possibilities if the child were not kept alive. The assumption is that the value of a child's life can be computed on some sort of calculus applicable to all of the other values. The value of a child's life can be reckoned, according to Gormally, as a positive or negative contribution to greater "happiness."

impact philosophical utilitarianism and consequential reasoning make on *medical decision-making*. Gormally notes, for example, that the discussion surrounding the concept and practice and legalisation related to euthanasia is consequential in nature. Gormally states that there is a widespread inclination to frame medical-ethical questions in terms of outcomes: “What course of action will have the best outcome?” As such, utilitarian and consequential reasoning offers significant implications for medical-ethical decision-making especially at the *end of life*.²³⁶ That application of utilitarian reasoning to support end-of-life PAS medical killing introduces a divergent philosophical framework that is contrary to established medical canons and law.

HU also has provided a philosophical basis for arguments aimed toward *legalising* PAS. James Rachels characterises his utilitarian approach “not as a matter of faithfulness to abstract rules or divine laws, but as a matter of doing what is best for those who are affected by our conduct.”²³⁷ Through utilitarian reasoning, he deems killing “beneficial” in the case of people with subnormal lives. Such reasoning can be applied well beyond the limits of end-of-life terminal illness—a fact of which Rachels is aware. He is willing to run the risk of a slide toward greater killing to gain the benefits of hastened death for those with “subnormal lives.”²³⁸ McLean and Britton cite utilitarian arguments as influential supports for the legalisation of PAS. They believe, like Bentham and Mill, that the essence of morality is not as much “the service of God” or “obedience to abstract rules,” but rather the promotion of the greatest possible happiness for creatures on earth and that the only reason for interfering with a person’s actions would be if those actions have a negative effect on others.²³⁹ They believe that

²³⁶See also Singer, *Rethinking Life and Death*, 57-80. Singer presents a detailed argument for a change in the traditional “sanctity of life” ethic and cites the landmark medical and legal cases of Quinlan, Cruzan, and Bland as support for his view—that a quality-of-life ethic, based on utilitarian and consequential reasoning, is needed to supplant the former sanctity-of-life ethic.

²³⁷See Rachels’s argument in Pellegrino, “False Promise,” 72.

²³⁸*Ibid.*

²³⁹McLean and Britton, *Case for Physician-Assisted Suicide*, 29.

one individual test of moral validity is the “cumulative effect of individual decisions.” As a result, the authors focus on utilitarian outcomes as they call for a change of laws to allow for PAS.

HU, by its focus on good outcomes, neglects important *moral* consideration of the entire scope of an end-of-life decision, which includes a doctor’s intention with PAS. PAS and VAE, when viewed simply as actions or avenues that leads toward desired outcomes, hold serious implications for both traditional medical-ethical decision-making and for law.

Watershed Events

When PAS actually took place, physicians themselves became the focus in the ever-growing PAS debate. Physicians in the Netherlands had been practising VAE and PAS for some years prior to the first public instances in the United States which drew close observation by advocacy groups, philosophers, and the world medical community.²⁴⁰ Dr. Nigel Cox in the UK was tried and convicted after having aided a patient’s death by a lethal injection.²⁴¹ The names in the United States associated most commonly with PAS are Timothy Quill and Jack Kevorkian. Interestingly, both physicians²⁴² first assisted patients with suicide within one

²⁴⁰See “Laws on Assisted Suicide Come with Strict Conditions”; internet, available at http://icwales.icnetwork.co.uk/printable_version.cfm?objectid=13216038&siteid=50082; accessed 5 August 2003. Doctors had practised helping patients to die for decades before the law was changed in 2002. See also International Task Force on Euthanasia and Assisted Suicide, “Holland’s Euthanasia Law”; internet, available at <http://www.internationaltaskforce.org/hollaw.htm>; accessed 4 August 2003. The Dutch law was approved April 10, 2001 and went into effect April 1, 2002.

²⁴¹Keown, 97. Dr. Nigel Cox was tried and convicted in court for attempted murder after he administered a lethal dose to a suffering patient. His conviction prompted great controversy.

²⁴²Quill was a hospice physician at the University of Rochester and Jack Kevorkian was a licensed but retired pathologist at the time he first assisted a patient with suicide. See Fred Rosner, et al., “Physician-Assisted Suicide,” *New York State Journal of Medicine* 92, no. 9 (September 1992): 388-89.

month of each another.²⁴³ Similarities exist between each of these separate, but chronologically related, events. Physician compassion for a “suffering” patient generally led the doctors to take steps to demonstrate mercy. In addition, Quill and Kevorkian also attested to their respect for the autonomous decision of their patients. Such watershed events occurred internationally.

In the Netherlands

The Netherlands views legal PAS and VAE comparatively.²⁴⁴ Formerly, any doctor assisting in the suicide of a patient including providing the means for any person to take another person’s life, was guilty of a crime.²⁴⁵ Article 294 of the Penal Code also included physicians acting upon the request of a patient. However, a number of court cases in the 1980s and 1990s allowed physicians to provide such help under certain conditions.²⁴⁶ PAS emerged in a different light when cases began including psychiatric patients who did not fit the usual profile of euthanasia patients.

In one celebrated case, the psychiatrist assisted a woman to commit suicide who was not terminally ill.²⁴⁷ She was depressed over the break-up of her marriage and the deaths of her two sons. She wanted to join them in death and turned down all forms of therapy suggested by her psychiatrist.²⁴⁸ Two lower courts acquitted the psychiatrist but the Supreme Court found

²⁴³Quill assisted his “patient” Diane in May 1990 and Kevorkian assisted his “patient” Janet Adkins in June of the same year. Rosner et al., 387-89.

²⁴⁴Sjef Gevers, “Physician Assisted Suicide: New Developments in the Netherlands,” *Bioethics* 9, no. 3-4 (1995): 309.

²⁴⁵Ibid.

²⁴⁶Ibid.

²⁴⁷Herbert Hendin, *Seduced By Death: Doctors, Patients and the Dutch Cure* (New York: W. W. Norton & Co., 1997), 60-69. Cf. also Smith, *Forced Exit*, 104-6.

²⁴⁸Gevers, “New Developments in the Netherlands,” 310. Cf. also Smith, *Forced Exit*, 104-6; and Hendin, 60-69.

him guilty although he was not punished.²⁴⁹ He was found guilty because he had not consulted two other psychiatrists who had also examined the woman. Two points apply to this section of the thesis. PAS gained separate notoriety from VAE, and media coverage helped to spread PAS information to the public.²⁵⁰

Another celebrated court case involved a doctor “who euthanized an infant.”²⁵¹ The child, a three-day old girl, was born with spina bifida, hydrocephaly, and leg deformities. The child was killed with her parents’ permission because of a poor prognosis and because the baby screamed in pain when touched. Some controversy was aroused for medical reasons²⁵² and also because of the subsequent trial.²⁵³ The court refused to punish the doctor, and the prosecutor in the case appealed to the Supreme Court to establish a precedent to govern euthanasia for people who cannot consent.²⁵⁴

In the United Kingdom

Two celebrated cases occurred in the United Kingdom, and, while neither case directly involved PAS, both demonstrated basic arguments used to support physician-aid-in-dying—an argument from mercy and an argument from respect for patient autonomy. As stated before, Dr. Nigel Cox administered a lethal dose to a suffering patient. He, after a later public admission, was charged with attempted murder, handed a suspended sentence, and given an

²⁴⁹Hendin, 67-69.

²⁵⁰Gevers, “New Developments in the Netherlands,” 311. Gevers notes that public reaction to the case of PAS was favourable. Cf. also Hendin, 60. Hendin, writing of the Chabot case, states that it aroused “controversy and international interest.”

²⁵¹Smith, *Forced Exit*, 106.

²⁵²Smith notes the child was in pain because she was neglected medically. *Ibid.*

²⁵³Smith responds negatively to the case which is contrary to the Dutch judicial response. Both the negative and the positive responses indicate the tension involved in the overall matter.

²⁵⁴*Ibid.*

admonishment by the General Medical Council (GMC).²⁵⁵ The debate centred on whether the physician should have been prosecuted at all since he had acted in accordance with the wishes of the patient and her family and with a merciful motive.²⁵⁶ Others were concerned that having broken the law and breached the ethical code of his profession, the physician only received a suspended sentence.²⁵⁷

The second UK case involved a patient by the name of Tony Bland who was severely injured in a stadium accident in 1989 and survived several years in a persistent vegetative state. The local health authority with the support of his family sought and received permission to discontinue artificial feeding.²⁵⁸ Some, indicating a merciful response to Bland's situation, welcomed the decision because they felt that all the functions that had made Bland an "individual" had been "irretrievably lost."²⁵⁹ Others felt that nutrition and hydration are such basic elements of care that they should only be withdrawn "when the patient is in the final stages of the dying process."²⁶⁰ They felt that their discontinuance led to an act of deliberate killing. Even though this case was not a case directly about euthanasia or PAS, it did give rise to much press comment and public debate.²⁶¹

In the United States

²⁵⁵Keown, 97.

²⁵⁶Anthony Fisher, "Theological Aspects of Euthanasia," in *Euthanasia Examined: Ethical, Clinical and Legal Perspectives*, ed. John Keown, reprint edition (Cambridge: Cambridge University Press, 1998), 317-18.

²⁵⁷Ibid.

²⁵⁸Ibid.

²⁵⁹Keown, 97.

²⁶⁰Ibid.

²⁶¹Ibid. Bryan Jennett, "Letting Vegetative Patients Die," in *Euthanasia Examined: Ethical, Clinical and Legal Perspectives*, reprint edition (Cambridge: Cambridge University Press, 1998), 170. It has been noted, too, that the issue has some relation to respect for patient autonomy in that it touches upon patient-centred medical ethics. This also has been a central concern in the United States for years. See thesis, ch. 2, 137-38, for Diane Pretty's recent case.

In the United States several celebrated cases have led to increased focus on PAS and great public debate over the phenomenon. On June 4, 1990, Dr. Jack Kevorkian, a retired pathologist, used his "suicide machine" to assist in the death of Janet Adkins, a middle-aged woman diagnosed with Alzheimers.²⁶² Though diagnosed with the disease, Adkins was not yet terminally ill or hospitalised at the time.²⁶³ Kevorkian's method of death through his "suicide machine" aroused "enormous controversy."²⁶⁴ At the other end of the spectrum, Dr. Timothy Quill, a physician in active practice, revealed his participation in the suicide of a woman diagnosed with acute leukaemia. The patient, Diane, decided not to undergo the recommended course of chemotherapy and instead discussed suicide as an option with Dr. Quill.²⁶⁵ Rosner's Committee on Bioethical Issues noted that Dr. Quill's article ". . . was met with considerable understanding and even praise for his courage and forthrightness" and that Quill's case "reopened the debate of physician-assisted suicide."²⁶⁶ Quill based his argument for assisting his patient with her suicide on compassion (mercy).²⁶⁷ Then, in the summer of 1997, the United States Supreme Court voted 9-0 against legalising PAS.²⁶⁸

²⁶²Battin, *Least Worst Death*, 5. Yeates Conwell and Eric D. Caine, "Rational Suicide and the Right to Die: Reality and Myth," *New England Journal of Medicine* 325, no. 15 (October 1991): 1100-1103. Rosner et al., 388.

²⁶³Nancy S. Jecker, "Giving Death a Hand: When the Dying and the Doctor Stand in a Special Relationship," *Journal of American Geriatric Society* 39, no. 8 (August 1991): 831.

²⁶⁴*Ibid.*

²⁶⁵Conwell and Caine, 1100. Cf. also Timothy E. Quill, "Death and Dignity--A Case of Individualized Decision Making," *New England Journal of Medicine* 324 (1991): 691-94. Cf. also Rosner et al., 388-89.

²⁶⁶Rosner et al., 389.

²⁶⁷Beauchamp, *Intending Death*, 17.

²⁶⁸M. Cathleen Kaveny, "Assisted Suicide, the Supreme Court, and the Constitutive Function of the Law," *Hastings Center Report* 27, no. 5 (September-October 1997): 29. Cf. also John Leo, "On Society: Good Sense on 'Right to Die,'" *U. S. News and World Report* 123, no. 1 (July 1997): 14.

Australia's Northern Territory

On May 25, 1995, the parliament of Australia's Northern Territory legalised VAE when it passed the Northern Territory Rights of the Terminally Ill Act.²⁶⁹ Within six months, two letters written in the *New England Journal of Medicine* disputed the initial praise given to the Act.²⁷⁰ The statute was the result of a "personal crusade" of the generally conservative Liberal Party's leader and Chief Minister of the Northern Territory of Australia.²⁷¹ The man had watched his mother die an agonizing death that he said "... he did not want others to have to repeat."²⁷² The initiative permitted both euthanasia and assisted suicide and formally legalised the process.²⁷³

Critical points of similarity exist between these cases of euthanasia and assisted suicide. Doctors were often moved by compassion for suffering individuals and assisted in patient death because of merciful intentions. Patients often wanted to be freed from undignified death and sought the freedom to end their lives in the manner they chose. There were legal and medical challenges in each of these instances. These challenges often gave rise to patient concerns in the PAS debate.²⁷⁴ These patient concerns, added to the cultural indicators such as public fear

²⁶⁹Christopher James Ryan and Miranda Kaye, "Sounding Board: Euthanasia in Australia--The Northern Territory Rights of the Terminally Ill Act," *New England Journal of Medicine* 334, no. 5 (February 1996): 326-28.

²⁷⁰Paul Andrew Glare and Bernadette Tobin, "Correspondence: Euthanasia in Australia," *New England Journal of Medicine* 334, no. 25 (June 1996): 1668-69.

²⁷¹Robert L. Schwartz, "Rights of the Terminally Ill Act of the Australian Northern Territory," *Cambridge Quarterly of Healthcare Ethics* 5, no. 1 (Winter 1996): 157.

²⁷²*Ibid.*

²⁷³The "Rights of the Terminally Ill Act" was overturned in 1996, 8 months after it was legalised. Four patients had died under the terms of the Act before this court action. See "Laws on assisted suicide come with strict conditions"; internet, available at http://icwales.icnetwork.co.uk/printable_version.cfm?objectid=13216038&siteid=50082; accessed 5 August 2003.

²⁷⁴These foundational issues of rights, justice, and patient autonomy are the subjects of chs. 2 and 3.

and heightened awareness of PAS, combined with the medical community's watershed PAS events, produced a complex matrix which expressed several cultural trends.

Core Cultural Concerns

PAS as a cultural phenomenon has been well-chronicled in the media and through various advocacy groups.²⁷⁵ Several cultural concerns surface which interact with the thesis, intersecting both philosophical and medical-ethical areas under examination. One issue gaining societal attention is that of *individual control over the process of dying*.²⁷⁶ Polls indicate that society has consistent concern over maintaining bodily control and individual dignity through the dying process. This cultural attitude has implications for individual autonomy and physician paternalism.²⁷⁷

²⁷⁵A representative sample follows: see also Marrijoy J. Kelner and Ivy L. Bourgeault, "Patient Control Over Dying: Responses of Health Care Professionals," *Social Science Medicine* 36, no. 6 (1993): 757. Robert J. Blendon, Ulrike S. Szalay, and Richard A. Knox, "Should Physicians Aid Their Patients in Dying?: The Public Perspective," *Journal of American Medical Association* 267, no. 19 (May 1992): 2659. Melinda A. Lee, Heidi D. Nelson, Virginia P. Tilden, Linda Ganzine, Terri A. Schmidt, and Susan W. Tolle, "Legalizing Assisted Suicide—Views of Physicians in Oregon," *New England Journal of Medicine* 334, no. 5 (February 1996): 310-15. Jerald G. Bachman, Kirsten H. Alcsér, David J. Doukas, Richard Liechtenstein, Amy D. Corning, and Howard Brody, "Special Articles: Attitudes of Michigan Physicians and the Public Toward Legalizing Physician-Assisted Suicide and Voluntary Active Euthanasia," *New England Journal of Medicine* 334, no. 5 (February 1996): 303-9. Larry R. Churchill and Nancy M. P. King, "Physician-Assisted Suicide, Euthanasia, or Withdrawal of Treatment: Distinguishing Between Them Clarifies Moral, Legal, and Practical Positions," *British Medical Journal* 315, no. 7101 (July 1997): 137-38. Meier et al., 1193. Ezekiel J. Emanuel, "Euthanasia and Physician-Assisted Suicide: A Review of the Empirical Data from the United States," *Archives of Internal Medicine* 162, no. 2 (January 2002): 143.

²⁷⁶Charnicia E. Huggins, "Oregon Patients Request Suicide to Take Control"; internet, available at http://www.nlm.nih.gov/medlineplus/news/fullstory_9042.html; accessed 16 September 2002. A study of terminally ill patients in Oregon suggested that dying patients requested suicide assistance not because they were depressed or lacked family support but because they wanted to "take control of their end-of-life experience." See also Kelner and Bourgeault, 757. The authors claim that a patient desire for more control over healthcare and ultimate destiny reflects the "... pervasive trend in Western society toward individual autonomy." Robert J. Blendon, Ulrike S. Szalay, and Richard A. Knox, "Should Physicians Aid Their Patients in Dying?: The Public Perspective," in *Journal of American Medical Association*, 267, no. 19 (May 20, 1992): 2659.

²⁷⁷Blendon, Szalay, and Knox, 2659. Kelner and Bourgeault, 757.

Another cultural concern relates to the *nature of beneficence and nonmaleficence*. There seems to be a desire on the part of a cross-section of individuals to receive relief from perceived medical intrusion when faced with the prospect of a protracted and painful terminal illness. This has implications for the DPR, the subject of philosophical writings, and--of key concern to this thesis--specific utilitarian writings.

A further cultural concern relates to the subject of *rights* and, more recently, the *right-to-die*. The subject is broad-ranging and includes everything from a belief that government is obligated to provide a minimum of healthcare to citizens, to the belief that the government and medicine are obligated to provide the knowledge and means necessary to end the life of a person who is suffering from a terminal illness. A final cultural concern reflected in opinion polls has been the subject of *justice*. Relating to the subject of rights and the receipt of healthcare are those who deem distributive justice to be a significant issue in PAS discussions.²⁷⁸ For example, in the current medical environment, where there is an ever-growing demand for healthcare and skyrocketing medical costs, some form of rationing is often thought to be necessary. How and in what manner limited resources are distributed have become a key societal concern. It is also of concern to society which has input into how these scarce resources are distributed.

All of these cultural concerns pinpoint potential areas of conflict between HU and PAS that open the way for examination. It is important to explore these difficult and complex areas in order to demonstrate whether HU provides sufficient moral ground for the changes in the medical canons regarding medical killing. Further, this chapter has established a basis for the following chapters by defining terms of the PAS dialogue, delineating the philosophical background to Mill's key utilitarian PH theme, and introducing how the HU theme interacts with PAS in the contemporary medico-cultural debate.

²⁷⁸The subject of ch. 2.

The following chapter will examine three core features in the PAS debate by defining each one and by conducting an historical examination of the growth and development of each. The three features to be examined include rights, justice, and medical killing. These three features will be linked together because Mill believed rights and justice were intimately associated with one another and with the principle of utility. PAS advocates, as well, link the notions of rights and justice together as support for their claims to medical killing. The discussion will now turn to the examination of these three features.

CHAPTER 2

RIGHTS, JUSTICE, AND MEDICAL KILLING IN RELATION TO HEDONISTIC-UTILITARIANISM AND PHYSICIAN- ASSISTED SUICIDE

Introduction

Across the years, advocates of PAS have advanced claims upon which consideration of PAS arguments have been constructed. These foundational claims, taken together, provide the platform which calls for the legal relaxation, if not wholesale legalisation, of PAS. PAS advocates, in part, buttress their claims by citing John Stuart Mill's views on rights, justice, and autonomy. Therefore, an elaboration of Mill's views in the claims that follow provides an opportunity to examine whether such claims may be valid. First, PAS advocates claim that a person has a moral right to exercise his life preferences according to his own personal desires and that this right is binding upon medicine, even to the point of obliging doctors to assist with those preferences. According to Mill, justice was believed to be closely associated with an individual's rights. Whether this was truly the case will be examined.

In similar fashion, PAS advocates also claim that justice obliges a physician to honour the preferences of a patient, which, in some cases, includes assisting a patient with suicide. The third, the "mercy killing" claim, asserts that medical killing is sometimes permissible, indeed, even morally obligatory for the physician, especially when the twin principles of autonomy and mercy are present in selected circumstances. Mill believed that an individual's moral right to shape freely the course of his or her own life according to individual desire carried with it a powerful claim upon others not to interfere with such freedom. To do so would be a violation of a person's right to freedom and would be an injustice.¹ This chapter as a whole deals with

¹This chapter addresses each of the above-stated claims. Mill, *Utilitarianism*, 78. See also Mill, *Utilitarianism, On Liberty, and Essay On Bentham*, 135. These sources provide

the HU and PAS claim that, in certain circumstances, an individual patient is justified not only to *request to die*, but actually to receive physician-assistance-with-suicide.

Rights, Hedonistic-Utilitarianism, and Physician-Assisted Suicide

History records numerous social and political movements that could be termed human rights' movements.² Moral considerations in each movement were important, and the manner in which they were applied was both "delicate" and "complex."³ The same is true of the moral considerations that surround the "right-to-die" movement. It is not unusual in democratic societies for complex moral debate to emerge from the life issues related to human rights, but a debate whether to recognise a right to die is especially significant because the human rights' debate has characteristically been about preserving and enhancing life. To designate a right to die as a basic human right bears far-reaching moral and ethical implications for society and is deserving of closer examination.⁴ Each rights' movement sought to promote or protect some

Mill's classic statements on rights, justice, and freedom from external interference with a person's autonomous preferences. The use of these sources is not to suggest that there is a philosophical agreement on the part of this writer with Mill's claims in part or in whole.

²This chapter will be devoted to the specific subject of human rights. The term "rights" will be used throughout to refer to human rights. Warren Lee Holleman, *The Human Rights Movement: Western Values and Theological Perspectives* (New York: Praeger, 1987), 1. Holleman offers, as examples of human rights' movements, the democratic "urge" in ancient Greece, the democratic revolutions in France and America, various nineteenth- and twentieth-century Third World revolts against colonialism, the abolitionist movement, and the gay rights' movement today.

³*Ibid.*, vii. Holleman writes of the difficulty of applying an ideologically oriented morality that is capable of simple rights and wrongs. He points to the fact that persons on opposite sides of an argument will often defend their position by invoking the "sacrosanct" name of human rights.

⁴Battin, *Death Debate*, 166, 195. Battin claims that suicide is a basic human right on par with other rights like the right to worship, freedom of speech, and liberty. She does not distinguish, however, between rights that promote and enhance life and rights that end life.

aspect of what is termed today “human rights” but, for all of its history, the theory of human rights has never gone unchallenged.⁵ The same is true of the proposed “right” to die.

Holleman suggests that a reason for the challenges to human rights is the tendency Westerners have to define these too narrowly. He believes Westerners focus on the rights of the individual and ignore the rights of the community (and the responsibilities of the individual to the community).⁶ “Human rights,” however, is necessarily a multi-faceted concept that runs far deeper than the more narrow focus on individual rights. There are rights of individuals in relation to their governments, communal rights, and rights to material necessities, as well as rights that “accrue to persons as members of a particular nation or culture.”⁷ Even though it is common knowledge that the citizens of ancient Greece had rights, some of which were similar to those listed above, they were not individual rights in the same sense as today. A broad historical examination of rights adds clarity and perspective to a current understanding of rights. The subject of rights in this section of the chapter will be examined first from several broad, but pivotal, historical perspectives: natural rights’ heritage, events surrounding and leading to the secularisation of both legal and modern human rights. Human rights will also be examined for the possible implications that changes in rights may have, or any potential influence that an HU rights’ and justice perspective might exert, on the DPR.

What are Rights?

Rights Defined

The *OED* defines a “right” as “the standard of permitted and forbidden action within a certain sphere; law; a rule or canon.”⁸ A right, according to the *OED*, is also “a legal, equitable,

⁵Maurice Cranston, *What are Human Rights?* (London: Bodley Head, 1973), 3.

⁶Holleman, 6.

⁷*Ibid.*

⁸*OED*, 2d ed., s.v. “right.”

or moral title or claim to the possession of property or authority, the enjoyment of privileges or immunities, . . .”⁹ The *OED* also states that a right is “a justifiable claim, on legal or moral grounds, to have or obtain something, or to act in a certain way.”¹⁰ The dictionary definitions indicate a wide range of meaning to the word that implies a wide range of possible interpretation and application. The definitions indicate, however, that a “right” includes boundaries (permitted and forbidden action), and suggests that a right may permit the holder to lay a justifiable claim to something.

Other sources sharpen the focus of the term “right.” A right may be termed a “positive right,” meaning it is a right that someone actually possesses by means of having been conferred and enforced by the system of municipal law that prevails in any country. “Legal” rights fall into this category.¹¹ This type of right is one that “men actually have”¹² by law, in contrast to those men “ought” to have,¹³ which are often termed “Moral” rights. In contrast, a “negative”

⁹Ibid.

¹⁰Ibid.

¹¹Holleman, 88, 95. Holleman writes that positive rights are guaranteed by “actual” law. Cf. Maurice Cranston, 4-5. Positive rights are actual laws of actual states. Yet, cf. Beauchamp and Childress, 72-73. They define a positive right as “a right to be provided with a particular good or service by another,” but they make no mention of a law that supports the right. Elsewhere, they write of legal rights that are justified by legal principles and rules, and moral rights that are supported by moral principles and rules (71-72). The context implies that positive rights and negative rights are those that may be supported legally or morally. They write further “A person’s positive right entails another’s obligation to do something for that person.” For example, while the Supreme Court in the United States recognises a woman’s negative right (right to privacy) to abortion, it has not yet recognised a positive right (governmental obligation) for her to receive government funds for a nontherapeutic abortion. Yet, for the purpose of the thesis, a positive right will be considered as one that is guaranteed by actual law.

¹²Cranston, 4-5. He likens the idea of justice or deserts to the concept of “moral” rights. The difference between a positive right and a moral right is that the former is enforceable by law, and the latter is not necessarily enforceable (6). Cf. Holleman, 84.

¹³This distinction helps to illuminate a portion of the PAS debate. Advocates for PAS claim a moral right to physician-assistance-with-suicide, but are also seeking a legal right to protect their moral claim. But cf. Holleman, 85. Holleman terms a moral right an “ideal,” because he claims that rights said to be granted by God, or by the laws of nature or by some

right is a right of noninterference, one that guarantees that no other person has *an obligation to act or to interfere*.¹⁴

What is clear, then, is that the meaning of “right” is varied: at times carrying the weight of law, at other times bearing the weight of morality, and sometimes carrying both meanings congruently. Generally speaking, since people are the primary subjects of rights,¹⁵ whether individually or corporately, the claiming of rights also implies a responsibility (an act of duty or duties) on behalf of the person holding them or on behalf of the one obligated by them (whether that act is permissible or forbidden). While the above sources help clarify the meaning of the word, the historical background will also add important understanding.

The Natural Rights’ Heritage

There is a distinct chronological order to the evolution of rights, but there is also an interesting “*kairos*,” or epochal development to this aspect of human life. In the language of

other transcendental source, are not true rights--only ideals. These do not become rights, according to Holleman, until the “ideals” are granted by an authority willing and able to enforce them. See also Cranston, 4-5. This type of right, for example, the right to know what goes on under one’s roof, is termed a “moral right.” A positive right is enforceable, according to Cranston, whereas, a moral right is not necessarily enforceable.

¹⁴The term “negative” right will be used in this thesis to refer to a person’s obligation to *refrain from* doing something. Compare Beauchamp and Childress, 73. Cf. Battin, *Death Debate*, 163-64. Battin terms this sort of right a “noninterference” right, which means that a person has *no obligation to do an act* and that other persons have a corresponding obligation not to interfere.

¹⁵Compare, however, Singer, 95-101. Singer holds a position that humans are not the only beings that can be described as “persons.” A *person* is a being that is “capable of conceiving itself as a distinct entity existing over time.” A person’s “right to life,” for example, would be determined valid if that “person” is capable of desiring to continue to live as a distinct entity. He also believes that only a being that is capable of conceiving itself as a distinct entity existing over time could have such a desire. He concludes that some nonhuman animals are persons with rights, and he rejects the doctrine that places the lives of members of the human species above the lives of members of other species (117). His view has implications for an unborn foetus, an infant, and a mentally incapacitated adult. His view also links to end-of-life decision-making where physical or psychological issues related to terminal illness affect a person’s desire to live. Singer, however, does not address clearly the issue of what responsibilities a nonhuman “person” might have as a possessor of a right.

epochs, the period of time from Ancient Greece through the Renaissance demonstrates a formative rights' epoch, that was characterised by certain general features. Rights were linked, even though loosely, to deity.¹⁶ While an individual might be said to have rights, this did not mean that the individual recognised himself as an individual, or that the individual was seen as independent from his attachment to the *Polis*. Rights, then, were associated broadly with communities like the city-state, the church, or even the state as a whole.¹⁷ Rights were characterised also by duties, regardless of whether those duties were perceived to be good or bad.¹⁸

Origin of Rights: Ancient Greece

Rights have their historical antecedent in "natural rights" in ancient Greece.¹⁹ Among the pre-Socratics there was the general belief that "unwritten laws" had a divine origin and were believed "to take precedence over (possibly faulty) human laws."²⁰ The Stoics later

¹⁶McKirahan, 409; and J. B. Schneewind, *The Invention of Autonomy: A History of Modern Moral Philosophy* (Cambridge: Cambridge University Press, 1998), 18. Schneewind writes that Cicero believed natural law was the legislation of the gods and was not alterable by human rulers.

¹⁷Cranston, 3. Certain ancient Greek cities enjoyed rights, freedom of speech, and equality before the law.

¹⁸Schneewind, 80.

¹⁹Cranston, 1. Cranston writes that the twentieth-century name "human rights" was known traditionally as "natural rights" or the "rights of man." The idea of natural law as a universal moral law that transcends the law of states is not new. It is an idea that has "permeated" European politics for more than two thousand years (11). Cf. Carl Wellman, *An Approach to Rights: Studies in the Philosophy of Law and Morals* (Dordrecht: Kluwer Academic Publisher, 1997), 15. Wellman states that human rights are the theoretical descendants of what were once called natural rights. He adds that these are rights that one possesses not by virtue of some special status, but simply as being human. Cf. Michael Bertran Crowe, *The Changing Profile of the Natural Law* (The Hague, Netherlands: Martinus Nijhoff, 1977), 234.

²⁰McKirahan, 409-10, 412. Of note is the belief in this age that the *nomoi* were thought to be universal in the sense that all people at all times recognised them or that they at least *should* be recognised even if people did not. Of importance to this thesis is the way people would invoke "unwritten laws" whenever it suited their advantage. They would do this as a way

combined natural law with the concept of natural rights and embodied both in their elementary principles of justice. These they believed were apparent to the eye of reason.²¹ Aristotle, writing on political justice, speaks of natural law--a law which has validity everywhere and is not dependent upon either acceptance or rejection by human beings.²² While natural law and natural rights were considered valid in ancient Greece, it is noteworthy that they did not carry any specific obligation, on behalf of the one invoking them, to act. In fact, "human rights" fell into the category of rights that were not necessarily warranted by law.²³ Rights are not a modern discovery, according to Crowe. They are as ancient as natural law itself. He writes that rights depend upon law--natural rights upon natural law.

If it could be said that ancient Greece provided the root system for rights, then early Christianity helped the idea of rights to flourish. Christianity put great stress on natural law and understood it to be a part of the law of God, and it believed the Creator's law was higher than

of invoking a higher authority when human laws were evil (412).

²¹Cranston, 10-11. Cf. Copleston, 1: 395-96. The Stoics believed that a virtuous life was lived in accordance with nature and that a life lived in accordance with nature is a life lived in accordance with right reason. One was to live life according to the principle, *logos*, that is active in nature. This consisted in submission to the divinely appointed order of the world. See Schneewind, 17. Schneewind writes that the Stoics can be credited with introducing natural law to the Romans.

²²Aristotle, 189. He states that there are two types of political justice: natural and legal. The latter takes the form of law; the former is, as stated above, valid everywhere. Aristotle did not believe that natural laws were immutable, except in the case of the gods where "justice presumably never changes" (190). He believed that in our world there is such a thing as natural law, but that everything is subject to change.

²³McKirahan, 412. McKirahan describes the differences between *physis* (nature, universal, things by nature that are necessary to all humans, 392) and *nomoi* (laws formally enacted and enforced by the state, 391). He contrasts the two concepts which included, among other things, a difference concerning what weight or authority *physis* was to be given. Generally, *nomoi* was given a prescriptive meaning (how things ought to be) and *physis* a descriptive (how things are) meaning. Some, however, attributed a prescriptive dimension to *physis* (392). McKirahan's description provides an early example of uncertainty related to the best way to ground human rights' claims.

positive law.²⁴ Even though the concept of rights was still in its infancy, and could not be described with the same depth of meaning as in this century, it can be said that there was a developing awareness of the concept.

The Middle Ages and Rights

The medieval papacy could be described as a period where popes continued to assert the right to enthrone and dethrone kings, as well as the exclusive right of jurisdiction in all church affairs. Political and spiritual matters were held firmly in their hands.²⁵ Yet, under the umbrella of papal authority, Thomas Aquinas (unknowingly) initiated an intellectual framework for rights. He linked natural law and eternal law,²⁶ recognising God to be the eternal legislator because he was the Creator.²⁷ Man, through the use of reason, had a natural inclination to do good, to know God's truth, and to live in society.²⁸ Aquinas' work bore implications for the coming Renaissance, and while his work would not prove to be the most significant event in the development of rights, it did provide a seminal influence in the forthcoming evolution of thought about man's relationship to authority (primarily government and church). It was in the Renaissance that the idea of man's worth and role in nature, though ill-defined, and still composed of classical and Christian notions, was to gain its greatest prominence.²⁹

²⁴Crowe, 10-11.

²⁵William R. Estep, *Renaissance and Reformation* (Grand Rapids, MI: Eerdmans, 1986), 13.

²⁶Crowe, 174-75.

²⁷*Ibid.*, 173. See also Schneewind, 19-21.

²⁸Thomas Aquinas *Summa Theologica*, 1a2ae.94.2. Cf. Crowe, 178.

²⁹*Ibid.*

The Renaissance and Rights

The notion of individual rights had not been a part of the legal ideas of Ancient Greece³⁰ (or Rome for that matter), and while some moral idea of natural rights was conceived in Ancient Greece, it had not yet been linked to the freedom to live as one (recognised as having a separate identity and interests apart from government and church) preferred.³¹ It was in the Renaissance that the focus on the individual functioning in society, guided by the use of his own reason began to emerge. This was aided by the re-emergence of a cluster of Ancient Greek ideas concerning the dignity of man.³² Natural law theory contained also the idea that man possessed the ability to reason for himself and had the power to determine for himself his own ends.³³

An unexpected outgrowth of this growing individual awareness was man beginning to question the authoritative claims of institutions.³⁴ It would not be accurate to state that man at this point was emerging fully from the cocoon of institutional control, but some change was occurring. While a hallmark of Renaissance humanism was the assumption that it was possible to mould the development of the personality by education,³⁵ Renaissance thinkers had not yet discovered the idea that man possessed certain rights that are linked to his nature as man.³⁶

³⁰Isaiah Berlin, *Four Essays on Liberty* (Oxford: Oxford University Press, 1969), 129.

³¹Ibid.

³²Charles Trinkhaus, *The Scope of Renaissance Humanism* (Ann Arbor, MI: University of Michigan Press, 1983), 344.

³³Jacques Maritain, *The Rights of Man and Natural Law*, trans. Doris C. Anson (New York: Gordian Press, 1971), 60.

³⁴Alan Bullock, *The Humanist Tradition in the West* (London: Thames and Hudson, 1985), 17-18. Bullock states specifically "religion" and "science."

³⁵Ibid., 11. Hence "reason."

³⁶Maritain, 65.

Man soon began to associate and ground his worth (dignity) in natural law, however, and reached the conclusion, in his new-found self-valuation, that he both possessed and was the subject of rights, and that he had the right to expect respect from others because of his value.³⁷

This significant modulation occurred within the development of natural law after the Renaissance, when natural law was restated in secular, modern, individualistic terms.³⁸

Events Surrounding and Leading to the Secularisation of Rights

It is a curious twist of history that the epoch of reform that opened the way for man's direct link to God (deity) apart from the assistance of the Church proved also to be the epoch where man's need of God was brought into serious question. As humanism continued its uneven forward development,³⁹ a new notion of rights, separated from direct attachment to deity, began to emerge. Up until this point in history, laws created rights, but from this point forward, rights were viewed as being a part of man's rational and sociable nature.⁴⁰

The Reformation and Rights

It is curious, and somewhat ironic, to think that the one receiving credit for the secularisation of natural law (and, subsequently, rights) was a Christian writer who may never have intended this to occur. A watershed in the history of ideas occurred with the publication of *On the Law of War and Peace*, the work of Hugo Grotius (1625). Grotius believed that God was the author of nature and its law, but his *Prolegomena* introduced the possibility that natural law would remain valid even if there were no God--or if the affairs of men were of no concern

³⁷Ibid.

³⁸Cranston, 11.

³⁹See thesis, ch. 3, p. 147ff.

⁴⁰Schneewind, 80.

to him.⁴¹ Grotius initiated unwittingly the secularisation of the natural law even though a non-religious approach had been taking shape since Ancient Greece.⁴² He did this in several ways.

In his thinking, rights were not derived *from* laws, but were those foundational tenets *from which* laws themselves derived. Rights, unlike before, were viewed as belonging to each person “prior to and independently of” the person belonging to any community.⁴³ A right was a moral quality of a person that made it possible to have or do something lawfully.⁴⁴ The norm practised in Ancient Greece was reversed here, with focal attention now being given to the individual. Until Grotius, rights were thought to be created by laws.⁴⁵ Now laws were created because rights already existed for the individual. This supported his idea that a central pillar of society was the individual’s right to pursue his own good.⁴⁶ Grotius also believed that rights were “alienable,”⁴⁷ a position that changed in the next era when the Enlightenment political fathers referred to the “inalienable rights” of their citizenry as they drafted the French and American declarations.

The philosophical formulations of Grotius also proved to be an important catalyst for the removal of natural law from the jurisdiction of moral theologians. Now natural law became

⁴¹Crowe, 223-24.

⁴²Alexander Passerin D’Entreues, *The Medieval Contribution to Political Thought* (New York: Humanities Press, 1959), 23. Aristotle conceived the state as the fulfilment and end of human nature. Later, Thomas Aquinas felt that the state, as part of the natural order, was to be “considered in the general frame of the divine direction of the world, and is entirely subservient to that direction.”

⁴³Schneewind, 80.

⁴⁴Ibid., 78.

⁴⁵Ibid., 80.

⁴⁶Ibid., 81. Life in the community was still important. Grotius’ position serves as a middle way between the natural law epoch and the modern era to come.

⁴⁷Ibid. He believed that rights provided no guarantee against personal slavery or governmental authority.

the responsibility of lawyers and philosophers.⁴⁸ This opened the way for the secularisation of natural law and rights. Such rights' discussion before (for example, Aquinas) had been attached to the notion of deity, but from this time forward this approach began to change. Numerous writers on ethics and the foundations of politics followed Grotius in using natural law language, but detaching it from specific doctrines of any particular religious confession.⁴⁹

The Reformers, themselves, served to widen the separation of natural law from a divine impetus. They also did this unknowingly by advancing the focus on human reason.⁵⁰ The individual need not confess to the priest when he or she could go directly to God.⁵¹ This helped centre the question of morality within the mind and heart of the individual. Martin Luther, as an example, was willing to defend what he perceived to be the truth, and to defy institutional (albeit religious) authority, even to the point of personal death,⁵² desiring to "believe freely and be a slave to the authority of no one. . . ."⁵³ Luther's reform was not only theological, but political, social, and cultural as well. Luther did believe, however, that the individual was accountable to God, and that a certain level of morality was within the reach of all men.⁵⁴ Luther believed the natural law to be embedded in the Ten Commandments and that men could apprehend it. Even though he held a deep belief in God's authority, he helped set the stage for an individual to exercise his morality apart from an outside authority, even if that external

⁴⁸Ibid., 82.

⁴⁹Ibid.

⁵⁰Alister E. McGrath, *Reformation Thought: An Introduction*, 2d ed. (Oxford: Blackwell, 1993), 40-41.

⁵¹Ibid., 54.

⁵²Roland H. Bainton, *Here I Stand* (New York: New American Library, 1950), 92. These are a portion of the words spoken by Luther in his celebrated debate with John Eck.

⁵³Ibid.

⁵⁴Ibid.

authority was the Church.⁵⁵ While Luther and other Reformers propelled forward the concept of individual rights in large measure, they still did not advance a claim to certain rights based on the worth of the individual. This assertion would take place in the next era.

The Enlightenment and Rights

The Enlightenment opened broadly the way for awareness of human rights with several circumstances paving the way for this awareness. First, even though not all Enlightenment thought was anti-God or anti-religion, there was a belief that science was the way to truth.⁵⁶ Another example was the Enlightenment belief that a person could use his own understanding without the guidance of another.⁵⁷ Enlightenment man was encouraged to use his freedom to make public use of his reason in all concerns. Enlightenment man also believed that the ability to think for oneself and to determine for oneself what was morally right and wrong was inherent in everyone.⁵⁸ This ability was by virtue of the human capacity for reasoning, which was innate.⁵⁹ This did not mean that Enlightenment thinkers abandoned morality in the traditional sense. These thinkers were revolutionary in their ideas about the “sources” of morality, but not yet revolutionary in their particular moral opinions.⁶⁰ One unrecognised result was a widening separation of the notion of rights from their foundation in deity.

⁵⁵Ibid., 176.

⁵⁶Peter Gay, ed., *The Enlightenment: A Comprehensive Anthology* (New York: Simon and Schuster, 1973), 17-19.

⁵⁷Immanuel Kant, “What is Enlightenment?” in *The Enlightenment: A Comprehensive Anthology*, ed. Peter Gay (New York: Simon and Schuster, 1973), 384.

⁵⁸Immanuel Kant, *Groundwork of the Metaphysic of Morals*, analyzed and trans. H. J. Paton (New York: Harper & Row, Harper Torchbooks, 1964), 71-72.

⁵⁹Sullivan, 14.

⁶⁰Rachels, 18-19.

As the Enlightenment unfolded, further attention was given to individual rights. Political individualism emerged, unlike the variety known in Ancient Greece.⁶¹ Ryan states that the state was made the supreme good in Ancient Greece (and Rome), and that the individual was a mere means. John Locke presented the different view that every man had the right and duty to preserve himself and everybody else as much as was humanly possible.⁶² There was a “fundamental” law of preservation and, while Locke did not demonstrate the truth of this claim,⁶³ its impact was important.

Locke’s ideas set new boundaries to protect the individual from governmental intrusion, much like the previous Reformation challenges to church authority. Locke’s writings were epoch-shaping because they laid down the key idea that all men were naturally in a state of perfect freedom to order their actions and dispose of their possessions and persons as they saw fit.⁶⁴ In theory, an individual could then exercise a moral and political right to act as he or she determined without external interference. Locke grounded this political claim to noninterference in natural law,⁶⁵ but this was not an easy position to occupy. He, in effect, sought to strengthen his ideas by supplementing his Enlightenment rationalism and empiricism with divine revelation.⁶⁶

⁶¹John A. Ryan, “Individualism,” transcribed by Bob Elder in New Advent online *Catholic Encyclopedia*; internet, available at <http://www.newadvent.org/cathen/07761a.htm>; accessed 2 June 2004.

⁶²John Locke, *Two Treatises of Government*, ed. Peter Laslett (New York: Cambridge University Press, reprint edition, 1997), 98.

⁶³Ibid.

⁶⁴Ibid., 269.

⁶⁵Ibid., 98.

⁶⁶Ibid., 88-89. Locke believed human reason required assistance and, in his belief, the Holy Scriptures (God’s divine written revelation), buttressed human reason.

Locke did not believe that human reason left unaided was properly sufficient to sustain man in the business of morality.⁶⁷ He is important because he demonstrated the often uneven awkwardness that is characteristic of rights'-oriented thinking. One of his feet seems planted squarely in empiricism and rationalism, but then he seems compelled to place the other foot in the realm of some outside (or higher) authority.⁶⁸ This did not mean to say that he believed the reverse of Grotius. Natural law was a part of Locke's rationalism in which he believed that empirical facts about the created world and human behaviour and even the workings of deity could be observed and interpreted rationally.⁶⁹ This did not mean, however, that man was set free to live as he chose without accountability to anyone or anything other than himself. Locke recognised that there could be no orderly exercise of rights without some order in society.⁷⁰ Rights included duty. This indicated a faint cry for the individual to be valued as a "whole" morally and politically responsible being.⁷¹

Thomas Paine extended and clarified further the ideas of political individualism with his claim that civil rights were grounded in man's natural rights. He was careful, however, to write that he did not intend to touch upon any sectarian principle of religion. What he intended to show was that an impediment to tracing the rights of man back to man's creation was the intervention of "upstart governments, thrusting themselves between, and presumptuously

⁶⁷Ibid.

⁶⁸Locke is not unusual in this regard. Bentham felt that laws and sanctions were necessary to get people to act in a certain way. See John Stuart Mill, *On Liberty*, 102-3.

⁶⁹Locke, 88.

⁷⁰Ibid., 271. The state of Nature, he believed, had a law of nature that governed it. This law obliged everyone.

⁷¹Holleman, 51. Holleman cites Maritain as being the one who viewed humans as an "open whole" as opposed, for example, to utilitarians who viewed man as part of the whole. Holleman means by "open whole" that individuals are not complete unto themselves, but that they also have need of communion with others.

working to un-make men.”⁷² Paine meant, by natural rights, those rights that “appertain” to man in light of his existence.⁷³ Paine was revolutionary with his claim that civil right grows out of a natural right.⁷⁴ Just as Paine had written to establish clear political boundaries around the individual, Jean-Jacques Rousseau’s “social contract” clearly set the individual apart from the state. In his view, the state was merely the outcome of a freely crafted compact by individual actions.⁷⁵

The evolution of thought from Locke to Rousseau, across a broad political spectrum, helped set the stage for greater attention to moral considerations. What Rousseau envisioned and applied politically was also applied morally with Scottish “common sense morality.” By definition, common sense morality is derived from nature and is common to a great majority of mankind. This great majority of individuals, when they arrive at the age and use of reason, are able to form a “common and uniform judgment.”⁷⁶ This common-sense morality is not derived from education or habit, but is instinctive or natural to mankind.⁷⁷ The influence of common-sense morality on the subject of individual rights lies at the point of authority. The individual’s reason is not merely a subjective rule, but it is the only rule--there is no other higher, or

⁷²Thomas Paine, *Rights of Man* (Mineola, NY: Dover Publications, 1999), 29.

⁷³Ibid., 30.

⁷⁴Ibid., 30-31. Cf. Battin’s discussion of natural rights and suicide. Battin, *Death Debate*, 163-74. Cf. Beauchamp and Childress, 71. The authors cite the theoretical history (moral and political) of rights and the “freedoms from established orders of religion, society, and state” that grow out of the rights’ tradition.

⁷⁵Ryan, “Individualism.” Cf. Jean-Jacques Rousseau, “Selections from the Social Contract,” in *The Making of Society: An Outline of Sociology*, ed. V. F. Calverton (New York: Random House, Modern Library, 1937), 149-50. Rousseau claimed that the sooner man shakes off the political yoke and reclaims his right to liberty the better. The individual was the original holder of rights, not the state.

⁷⁶S. A. Grave, *The Scottish Philosophy of Common Sense* (Oxford: Clarendon Press, 1960), 112.

⁷⁷Ibid.

external, authority that he is bound to consider.⁷⁸ While the new political ideas of men like Locke, Paine, and Rousseau were significant, these men had not yet begun to apply intellectual or rational rights to the affairs of daily life.

The influence of men like Paine and Rousseau was invaluable, however, to the formation of France's *Declaration of the Rights of Man* and the United States' *Declaration of Independence*. The French Declaration states that the aim of all political association was the preservation of the natural and inalienable rights of man.⁷⁹ The *Declaration of Independence* in the United States speaks of "inalienable" rights as entitlements that are granted by the laws of nature and nature's God.⁸⁰ While God was mentioned, the authority or force behind natural law, however, was justice or morality.⁸¹ When positive law coincides with natural law, however, it has the authority both of force and of justice.⁸² The application of both documents served to increase the strength of human rights by giving them the force of both natural law and positive law. Perhaps the framers of each document embraced the inherent tension, but necessary relationship, between natural law and positive law. One might believe that this was the zenith in the evolution of rights'-oriented theory, the place where natural law and positive law finally combined to give the individual a full expression of rights. This was not the end to the

⁷⁸Ryan, "Individualism," n.p.

⁷⁹A. H. Robertson and J. G. Merrills, *Human Rights in The World: An Introduction to the Study of the International Protection of Human Rights* (Manchester: Manchester University Press, 4th edition, 1996), 3. Note also the evolution of thought from Grotius' "alienable rights" (see thesis, 60-61) to the "inalienable rights" found in these documents.

⁸⁰Holleman, 84. Cf. Hamilton Albert Long, *The American Ideal of 1776: The Twelve Basic American Principles* (Philadelphia, PA: Your Heritage Books, 1976), 25. Long writes that God-given rights are sometimes called natural rights, meaning rights that are possessed by man under the Laws of Nature. These rights are possessed under the laws of God's creation and, therefore, are held by created mankind as gifts of God.

⁸¹Cranston, 14.

⁸²Ibid.

development of rights, however, because a fresh philosophical development was to come that would re-introduce another ancient Greek philosophical perspective of the individual.

John Stuart Mill, Hedonistic-Utilitarianism, and Rights

John Stuart Mill sought to establish the individual's everyday political and moral liberty by his writing on utility. His belief was simple: the only reason that power can be exercised rightfully over a member of a civilised society, against his will, is to prevent harm to others.⁸³ This strong statement concerning the individual derived from Mill's HU theory which emphasised the value of individual security.⁸⁴ A person had rights by virtue of being human and was sovereign over his own life. Mill's basis for this claim was similar to natural law proponents in that the focus was the individual, but dissimilar in that he believed moral principles were not derived *a priori*. Mill believed that the principle of utility that held pleasure to be the highest good lay at the root of all morality.⁸⁵ Mill's thinking had been influenced

⁸³Mill, *On Liberty*, 135.

⁸⁴Mill, *Utilitarianism*, 71-72. Mill's chief concern with rights was centred on preserving individual security--personal protection against harm (71). He believed that a desire to protect one's own security garnered such intense feelings (he terms it an "animal element" or "thirst for retaliation"), that it produced a claim with the "character of absoluteness" (72). He believed that every human being's powerful feelings for security demanded a responsiveness on the part of others until his claim for security became a moral necessity. What all persons felt concerning security, since everyone alike shared the same sentiment, changed the "oughts" and "shoulds" about life into "musts." Mill believed a person could claim justice as a moral right (67). He believed that both rights and justice grew originally out of conformity to law, but eventually an injustice was defined as violation of a law that "ought to exist." Even though Mill's theoretical belief is fraught with difficulties and has received criticism, this brief review helps to introduce how Mill believed rights and justice were linked in HU.

⁸⁵*Ibid.*, 253-54. Cf. C. B. Macpherson, *The Political Theory of Possessive Individualism: Hobbes to Locke* (Oxford: Clarendon Press, 1966), 2, vii. Macpherson names what he terms a "unifying assumption," "possessive individualism." He summarises the propositions that comprise possessive individualism as follows: (1) what makes a person "human" is freedom from dependence on the will of others; (2) freedom from dependence on others means freedom from any involvement with others except those contacts which the person enters voluntarily with an eye for his own interests; and (3) the person is essentially the proprietor of his own "person and capacities" for which he owes nothing to society (263-64). While Mill believed that the principle of utility was the glue that bound people together, MacPherson differs in that he does not include this as the unifying element of political society.

greatly by the philosophy of Epicurus, whose hedonism was practised in detachment from community. Mill's writings were aimed toward transforming the ideal of moral rights into positive rights, or those which are backed by laws.⁸⁶ Even taking into account the difference between Mill's view and the traditional natural rights' view, the commonality at root was the individual.

Rights' Heritage and HU

The growth of the concept of rights, from the period of ancient Greece forward, had developed along the lines of natural law theory, and later was buttressed by a Christian understanding that rights of human beings are rooted in creation and the law of God.⁸⁷ Mill, however, sought to develop HU empirically apart from an *a priori* understanding of morality. Mill's divergent stream in the formation of rights included a rejection of a natural law approach to securing human rights; however, his theory resembled natural law tenets by recognising the basic value of an individual. Mill's approach to rights sought to establish something that natural law had not articulated throughout its history; namely, providing protection for the individual—for security (non-interference) and room “to expand and flourish according to our own conception of what that entails.”⁸⁸ Mill's conception of a right to non-interference, a liberty right, was based upon the belief that *security* was the “most vital of all interests,” and a value no one could do without.⁸⁹ Mill, in his consideration of rights, did not go so far as to

⁸⁶Holleman, 86-87. Cf. Stephen Lukes, “Five Fables about Human Rights,” in *The Human Rights Reader: Major Political Writings, Essays, Speeches and Documents from the Bible to the Present*, ed. Micheline R. Ishay (New York: Routledge, 1997), 234. Stated succinctly, to the utilitarian “what counts is what can be counted.”

⁸⁷See thesis, 92-94.

⁸⁸John Skorupski, ed., *A Cambridge Companion to Mill* (New York: Cambridge University Press, 1998), 502. See also West, 157. Mill, however, recognised particular cases where some other social duty was so important as to overrule a person's rights.

⁸⁹Mill, *Utilitarianism*, 71.

develop the notion that dignity was bound up with rights.⁹⁰ This idea of human rights and personal dignity was forthcoming in the new century.

The Twentieth Century and Rights

The new century brought much in the way of change: two world wars, a world economic depression unlike any before, and the emergence of a new human rights' emphasis. Some things about rights' discussion remained unchanged (i.e. the focus on the individual). Prior to this century, rights' discussion had been centred largely on the right to ownership of one's property (including oneself) and the right to be left alone (unless one's actions might be harmful), but a new ingredient was now added. The advent of the *Universal Declaration of Human Rights* brought to the forefront rights' discussion that centred on the obligation those rights might impose upon others.

While the lofty human rights claims of the *Universal Declaration* were not enforced by law or were readily attainable,⁹¹ the document helped to spawn at least forty state constitutions in the following years.⁹² These constitutions enacted laws that protected individual human rights. It is somewhat ironic that, while the *Declaration* has influenced much in the way of

⁹⁰Berger, 290. Mill's HU does not extend to the full complexity that many current writers give to the notion of human dignity and morality (ibid., 291). Mill used the language of dignity, but he never analysed the concept. PAS advocates today sometimes argue that some people face a loss of dignity during a terminal illness. Even though Mill affirmed the dignity of human beings, for example, by championing women's rights and suffrage for all, his focus was not upon expounding upon the notion of dignity itself.

⁹¹For example, the costs of universal healthcare alone would be astronomical, not to mention the difficulty of delivering that healthcare to all individuals. See also Carl Wellman, *Real Rights* (New York: Oxford University Press, 1995), 4. Wellman writes that even in the most affluent societies today, the rapid rise in costs related to medical technologies and traditional medical treatments are seriously threatening the quality of medical care. In the United States, many cannot afford to purchase needed drugs or receive advice and treatment from physicians. In the United Kingdom, every citizen is eligible to receive urgently needed treatment under the National Health Service (hereafter, referred to as the NHS), but these treatments are often delayed for some period of time due, in part, to a lack of public funding.

⁹²Robertson and Merrills, 30.

protection and preserving life, there has also been a developing movement toward ending individual life.

As people pondered potential human rights' violations, they began to turn their focus to an area of perceived (and permitted) intrusion. In the healthcare industry, technology made it possible to forestall death and extend life well beyond its normal (and, at times, desirable) limits. In the 1970s, patients sought and gained the right to refuse medical treatment,⁹³ which evolved into the 1980's right to die, followed by the 1990's right to determine the time and the manner of one's own death.⁹⁴ Human rights' discussions now included, at times, a discussion of a right to die.

Patient Rights

Patient autonomy and the delineation of patients' rights have assumed a prominent role in medical ethics.⁹⁵ In fact, the patient autonomy role has been identified as a movement that reflects basic American natural rights' heritage.⁹⁶ An important feature of this movement is the

⁹³Robert M. Veatch, *A Theory of Medical Ethics* (New York: Basic Books, 1981), 47. Veatch writes that the Patients' Rights Movement has been the most important expression of liberal western political philosophy in medicine. The PRM encompasses a broad coalition of those who are unhappy with the paternalism and "good consequences" (seemingly, beneficence) of traditional medicine. The movement includes advocating freedom of choice for or against treatments for the terminally ill. Veatch also writes that this movement reflects the basic American natural rights' heritage. Many of the basic ethical commitments of this secular ethical tradition, according to Veatch, were incorporated in the 1973 Patient Bill of Rights (PBR).

⁹⁴Jack Coulehan, "The Man with Stars Inside," in *Annals of Internal Medicine*, vol. 126, no. 10 (May 1997): 799-802. Cf. Battin, *Least Worst Death*, 279. Battin writes that the right to suicide (including assisted suicide) is a fundamental human right on a par with the right to life, to freedom of speech, and to worship.

⁹⁵Thomas May, *Autonomy, Authority and Moral Responsibility* (Boston: Kluwer Academic Publishers, 1998), 4.

⁹⁶Veatch, 47. The PBR summarises many of the deeply held convictions of lay people and some physicians who are beginning to question the Hippocratic heritage. Veatch goes on to state that the Patients' Bill of Rights (PBR) has no legal standing. The PBR couches moral advice in terms of what is in the patient's best interests from his own point of view, whereas the Hippocratic tradition couched moral advice in terms of what is of most benefit to the patient

surfacing of claims that extend beyond the right to be left alone--the right of basic noninterference.⁹⁷ The intent of these claims is to generate an obligation upon another to provide the resources necessary to exercise one's chosen option.⁹⁸ One example is the "right to healthcare," which is increasingly thought to extend beyond the mere choosing of one's healthcare service. This type of right is being used to assert that someone would be obliged actually to deliver the health service irregardless of the patient's financial responsibility.⁹⁹

Another example of claim-obligation, based upon rights, is the assertion that a patient has the right to die, to determine the time and manner of his death, and to receive assistance with that death.¹⁰⁰ The doctor, in essence, would be obliged to provide assistance with the suicide of a patient. Suicide,¹⁰¹ according to this view, is seen as a right in view of an individual's general liberty to do as he or she chooses, provided that his or her choices do not

from the physician's standpoint (48).

⁹⁷Veatch, 48.

⁹⁸Ibid.

⁹⁹Ibid. This sort of right is termed an "entitlement right." It lays claim, for example, on the NHS in the UK to provide primary care or on Medicare in the US to provide abortions. Cf. Brett and McCullough, 1347. The "entitlement right" illustrated in the examples above also may be termed a "positive right." Brett and McCullough state that such a right endorses the patient's prerogative to select a particular intervention and implies a "coexisting obligation" on the physician to make that intervention possible. They also state that the principle of autonomy further justifies positive rights.

¹⁰⁰See section claim, 50.

¹⁰¹Suicide itself is defined as "one who dies by his own hand" and "one who commits self-murder." *OED*, 2d ed., s.v. "suicide." Cf. Ronald W. Maris, "Suicide Rights and Rationality," in *Suicide and Life-Threatening Behavior, A Special Issue--Suicide and Ethics* 13, no. 4 (Winter 1983), ed. Margaret P. Battin and Ronald W. Maris (New York: Human Sciences Press, 1983): [7] 223. Maris uses the descriptive term "intentional self-destruction" for suicide. Cf. British Medical Association, *Medical Ethics Today: Its Practice and Philosophy* (London: BMJ Publishing Group, 1993), 174. According to the BMA, suicide in the medical context occurs when the act of death is performed by the patient. Assisted suicide is, by these definitions, something of an oxymoron. Thus, the use and implications of the term "right" with PAS is questionable.

harm the interests or violate the rights of another person.¹⁰² Suicide is construed in this case as a liberty right like that which was propounded by John Stuart Mill.¹⁰³ This type of right is now heralded as a fundamental human right on the same level as the right to life, liberty, freedom of speech, and worship.¹⁰⁴

Suicide as a Liberty Right?

A movement to permit “assisted” suicide¹⁰⁵ emerged in the midst of the blossoming human rights’ movement when, as early as the 1930s, philosophical discussions about euthanasia had arisen.¹⁰⁶ A slow evolution of ideas led to the change in the legal status of suicide, which had historically been treated as a felony in early English law and was the subject of harsh penalties--both religious and civil.¹⁰⁷ For example, the decedent’s property was forfeited to the crown, the body was publicly desecrated, and the burial could not take place in consecrated ground.¹⁰⁸ This would not be surprising in light of the status of human rights (in relation to governmental controls) at that particular time. France had relaxed its penalties

¹⁰²Battin, *Least Worst Death*, 278.

¹⁰³Ibid. “Liberty Right” means a “negative right,” meaning the right to noninterference.

¹⁰⁴Ibid., 279. Battin extends this sort of thinking on rights to include a right to choose one’s death in accordance with one’s own values (193). The right-to-die movement seeks governmental protection of what is believed to be a fundamental human right. Cf. Ronald Dworkin, *Taking Rights Seriously* (Cambridge, MA: Harvard University Press, 1977), 198-99. Dworkin has stressed the importance of government protection of rights. He states that the point of this claim is to preserve human dignity and to provide political equality which grants the same freedoms to all.

¹⁰⁵Although suicide was illegal, persons began to consider seeking help in taking their own lives.

¹⁰⁶Humphry and Wickett, 13.

¹⁰⁷Battin, *Death Debate*, 17.

¹⁰⁸Ibid.

against suicide following the revolution in 1789, but it was almost two hundred years later that the decriminalisation law was changed in England.¹⁰⁹ This legislation took place in 1961.

Many states in the United States also had laws that made suicide a criminal offence. The general trend in Europe and America has been to drop, or at least elect not to exercise, criminal sanctions against suicide or the one attempting to commit suicide. Battin believes this change in the legal aspects of suicide is due to the increased acceptance of deterministic models of suicide where suicide is seen largely as an involuntary symptom of illness and/or psychosocial pressures.¹¹⁰

Battin may be accurate in assigning some clinical influences in the changing legal aspects of suicide, but of greater importance is a “long and complex” philosophical influence as well.¹¹¹ The discussion of suicide can be dated to Ancient Greece where the philosophical schools discussed its permissibility.¹¹² Even though individual identity was still bound together with the state, there was a developing recognition of individual responsibility. The growth of interest in and discussion of suicide does not emerge without reason, but actually parallels the evolution of ideas concerning human rights and autonomy.¹¹³ While suicide had long been a part of moral discussion, it was not until late-to-post-Enlightenment that some began to count it

¹⁰⁹It is important to note why suicide was decriminalised in the UK. Compare Kamisar, 229. The fact that suicide is no longer punished does not mean that government approves of such acts, that it recognises an individual right to “self-determination,” or that “personal autonomy” extends this far. The decriminalisation came about not because suicide was deemed a human right, but because punishment was seen as unfair to innocent relatives.

¹¹⁰Ibid. A deterministic model of suicide (involuntary), however, seems to undercut a claim that suicide is a “rational” act of self-determination.

¹¹¹Ibid.

¹¹²Ibid.

¹¹³Compare Humphry and Wickett, 1-19. Humphry and Wickett give a detailed historical perspective on the development of ideas surrounding suicide. See also thesis, ch. 3.

as a human right.¹¹⁴ Schopenhauer's argument, for example, concerning the permissibility of suicide was based upon a person's "unassailable title" (hence, right) to his own life and person.¹¹⁵ Humphry writes of Nietzsche's influence on the suicide discussion when the German philosopher wrote of suicide as "a strong consolation . . . one can get through many a bad night with it."¹¹⁶ The important point is not so much that Nietzsche wrote of suicide, but the reason *why* he wrote about suicide. His emphasis targeted the right for someone to decide himself about what he did with his own body.¹¹⁷ At the close of the nineteenth century, the French sociologist Emile Durkheim published *Le Suicide*, which examined the act as a social phenomenon and placed it in the realm of social policy.¹¹⁸ Suicide, while still illegal and considered to be socially taboo, had been added to the rights' discussion across a broad spectrum--philosophical, sociological, legal, and--eventually--medical.

These philosophical and sociological viewpoints merged with the medical when a German psychiatrist-philosopher coined the term *Selbstmord*--"balance-sheet suicide"--in citing

¹¹⁴It is important to note that not all Enlightenment thinkers viewed suicide in a positive light. Locke, 270-71. Locke states that while man is in a state of "uncontrollable liberty" as it concerns the disposal of his person or possessions, he does not have the liberty to destroy himself. He adds that everyone is bound to preserve himself and "not to quit his station willfully." Locke believed that reason, based on the law of nature, taught this. Cf. Kant, *Groundwork*, 89, 96-97. See also Sullivan, 56. Sullivan writes that Kant "contended that we have a strict negative duty not to commit suicide only in order to avoid a life promising more pain than pleasure." For Kant, to destroy one's own life would be a contradictory use of the same self-love that wills moral improvement or benefit for one's life.

¹¹⁵Arthur Schopenhauer, "On Suicide"; internet, available at http://www.Hackvan.com/publstig/life/Schopenhauer_On_Suicide_1.html; accessed 12 May 2004.

¹¹⁶Humphry and Wickett, 10.

¹¹⁷Ibid. Humphry's and Wickett's analysis seeks to link changes in attitude about the permissibility of suicide to the long development of personal autonomy. Cf. Battin, *Death Debate*, 86-87.

¹¹⁸Humphry and Wickett, 11. Cf. Battin, *Death Debate*.

examples of apparently rational suicide.¹¹⁹ A bridge was crossed in the next three decades as rational suicide was melded into euthanasia and assisted suicide. In 1931, for example, an English health officer¹²⁰ presented a talk, “A Plea for Legalisation of Euthanasia,” that appealed for a change in the law.¹²¹ Euthanasia societies emerged soon thereafter in both the United Kingdom and the United States. It is possible that the combined growth of humanism/autonomy and human rights would exert influence on a perceived impediment to human progress--suicide legislation. The focus, as indicated before, would not be upon law itself, but upon the *perceived restriction* it placed on individual rights to bodily privacy and self-determination.¹²² This allows for a careful examination of rights within the context of the DPR.

How Are “Rights” Evident in the Doctor-Patient Relationship?

General “Rights” Considerations

The DPR implies by its designation that some interaction will occur between the physician and the patient. A wide variety of interaction that occurs between doctor and patient does not involve rights. However, since both the physician and the patient are human beings, and both possess and exercise rights by virtue of their humanity, the relationship has the

¹¹⁹Humphry and Wickett, 11. Humphry believes that the “concept of physical and mental pain,” at this point, was “considered by physicians and writers as a possible justification for ending one’s life.”

¹²⁰Dr. C. Killick Millard was health officer for the city of Leicester.

¹²¹Humphry and Wickett, 13. Millard subsequently drafted a bill entitled the “Voluntary Euthanasia Legalization Bill.” The British Voluntary Euthanasia Society was formed in 1935 specifically to promote the bill. A similar bill, patterned after Millard’s, was presented to the Nebraska (United States) state legislature in 1937. Millard’s bill was defeated in the House of Lords and the Nebraska bill was never acted upon.

¹²²*Ibid.*, 241. In the case of Karen Ann Quinlan, a main argument used to authorize the removal of life support was the right to privacy. Keown, 225-28. Quinlan’s case, while not a suicide case, was a watershed case that established a further medical-legal bodily privacy foundation for subsequent ethical issues surrounding death (*Roe v. Wade* had established privacy boundaries for a woman wanting to have an abortion).

potential for conflict should there be a difference between how each party interprets its own rights.¹²³

The medical profession has attained a high level of authority,¹²⁴ and medical practitioners apply this authority through direct and intimate contact with patients on an almost daily basis. In his illness, the individual patient often perceives his own bodily dignity and worth to be at risk, a threat which generates a deep concern for preservation. At the same time, the circumstances of his bodily illness may induce his acceptance of the physician's judgment. When such decisions are made, especially when the suggested course of treatment or medical decision lies contrary to the desires of the patient or those of his family, the patient may feel that his rights have been disregarded.¹²⁵

A perceived breach of a patient's "rights" will often become the focus¹²⁶ when he feels he has not been privy to, or consulted about, the information concerning the disposition of the

¹²³Compare Edmund Pellegrino, *Humanism and the Physician* (Knoxville, TN: University of Tennessee Press, 1979), 98. Of course, such potential collision is not unique to the DPR alone. A concern for rights is normative in democratic societies where people expect a broad protection of their privilege to exercise autonomy. Jim Ife, *Human Rights and Social Work: Towards Rights-Based Practice* (Cambridge: Cambridge University Press, 2001), 61. Cf. Beauchamp and Childress, 71. While the authors acknowledge the important role of civil, political, and legal rights in protecting the individual from societal intrusions, they state that individual interests are often at odds with communal interests. A hallmark of Western culture is the deeply ingrained spirit of individualism that pervades all phases of public life--including the DPR. This individualism is so entrenched within the culture that it is nearly impossible for individuals to think in terms of the collective whole. It is not unusual for individuals to claim boldly their individual rights, even to the neglect of others or in the presence of authority.

¹²⁴Paul Starr, *The Social Transformation of American Medicine: The Rise of a Sovereign Profession and the Making of a Vast Industry* (New York: Basic Books, reprint edition, 1982), 4.

¹²⁵*Ibid.*, 5. Starr writes that doctors offer a "kind of individualized objectivity" and "authoritative counsel." The circumstances of sickness promote the acceptance of their judgment. Whenever pain or fear of death is involved, the patient has a special "thirst for reassurance and vulnerability to belief." This assessment by Starr has meaning also for the discussion on physician paternalism that will follow in the third chapter of the thesis (173).

¹²⁶James F. Childress, "Paternalism and Health Care," in *Medical Responsibility: Paternalism, Informed Consent, and Euthanasia*, ed. Wade L. Robison and Michael S. Pritchard (Clifton, NJ: Humana Press, 1979), 19.

management of his own case.¹²⁷ The expectation on the part of many patients is that they will be involved in such decision-making.¹²⁸ The potential for conflict, is present in the DPR, and is especially exacerbated to the degree that the patient's illness is life-threatening. Although the question of patient rights is--to a certain degree--generally accepted, a variety of complex issues and philosophies both surround the subject of, and claims to, these prerogatives. "Rights" may even be applied in different ways within the DPR.

Negative Rights

One such rights' application is the negative right. A negative right implies that a healthcare provider is obligated to refrain from doing something.¹²⁹ Competent patients have a right to choose to seek a physician for help with a health issue, a right to discuss the physician's suggested course of treatment, and a right to decline that course of treatment. This recent phenomenon, a right to decline a suggested treatment, touches upon a patient's negative right, i.e. the right to noninterference. If, for example, a physician recommends a therapeutic abortion, the female patient can refuse that suggested procedure. The doctor (or even the state) would, on one level, be expected to refrain from interfering in some way with a woman's right to procreate, and, on a more significant level, to refrain from committing assault.

A more likely scenario involves a patient's right to forego, for example, a suggested medical procedure and to be left alone by the doctor. A patient may request that his doctor

¹²⁷Pellegrino, 98.

¹²⁸This is not to imply that all patients are involved in decision-making because there are patients who do not wish to be involved. Compare Carl E. Schneider, *The Practice of Autonomy: Patients, Doctors, and Medical Decisions* (New York: Oxford University Press, 1998), 41. Schneider demonstrates that while some patients wish to be informed about their medical situations, a substantial number do not want to make their own medical decisions, or even to participate in those decisions in a significant way. The elderly are less likely than the young, for example, to want to make medical decisions, and the graver the illness the less likely the patient is to *be able* to make medical decisions.

¹²⁹Beauchamp and Childress, 73.

cease treatment of his terminal illness in order to permit the disease to run its course allowing life to end. This seems clear-cut, but the reality is far different. New technologies make it possible, more than ever before, to extend life well beyond its natural boundaries. Some patients and their families express concern that their requests for treatment to cease have been overlooked or ignored. The application of this right does carry some limitations,¹³⁰ but this sort of negative right is well known to be grounded in the principle of respect for autonomy.¹³¹ In the end-of-life decision-making, although the patient most often does not choose the time and place for his or her own death, the patient still desires the right to forego further painful treatment or decide when he or she is ready for death.¹³² The patient, even if the doctor suggests the application of life-extending technologies, has the right to decline the suggested treatment regimen and *allow the illness to take its course*.

Positive Rights

Another rights' application is a positive right. Complexity and controversy surround the issue of positive rights in the DPR because this form of right obligates someone *to do something* on behalf of the one claiming the right. A patient, for example, may make a positive right claim with the belief that he or she is entitled to certain medical goods and services

¹³⁰This sort of right has its limits, however, especially if the patient's illness presents a threat to the health of others. An example would be a person who has tuberculosis and poses a health risk to others. The health concerns of others, in certain circumstances, will override the right to noninterference.

¹³¹Compare Brett and McCullough, 1347.

¹³²British Medical Association, *Euthanasia*, 39. There is often a desire on the part of the patient to put an end to painful treatment. Cf. David Cook, *Patients' Choice: A Consumer's Guide to Medical Practice* (London: Spire, 1993), 159. Cook writes that a patient does not have a right to die, but he can request that a physician allow him to die. What he does not have the right to do is to expect the physician to kill him. The right to die will be examined in greater detail in a following section of this chapter (81-82; 117ff.).

irrespective of the ability to pay.¹³³ Such a right would be grounded in the claims of justice where fair and equal treatment for all is the aim.¹³⁴ Even though such a claim is discussed in human rights' discourse, the basis for such a right is hard to establish and such a programme all the more difficult to implement.¹³⁵

The reality is that healthcare resources are limited, and finding a way to distribute them equitably would prove to be controversial.¹³⁶ The implications of such a right and the sheer magnitude of the obligation it imposes upon the healthcare provider indicate something of the struggle over this type of right. Physicians on the whole are interested in their patients' needs and care about their well-being, but financial and resource obligations that a positive right claim imposes are but one aspect of the burden that this claim engenders. Doctors have responsibilities to other patients who also have rights, and deciding where best to allocate the resources of the medical profession is a significant aspect of the positive right debate.

As opposed to the negative right, whereby a patient may elect to exercise the right to choose *not* to pursue a recommended course of treatment,¹³⁷ a positive right cannot guarantee

¹³³Beauchamp and Childress, 73. Cf. the "Universal Declaration of Human Rights," Article 25.

¹³⁴Ibid.

¹³⁵Cook, *Patients' Choice*, 219. Cook writes that world starvation and global disease where millions suffer and die seem to cast some doubt on the effectiveness of claiming such a right.

¹³⁶Beauchamp and Childress, 348.

¹³⁷The basis for this positive right is the principle of autonomy that will be examined in ch. 3 of the thesis (147). Compare Brett and McCullough, 1347. There are limits to patient choices.

that a patient *may demand, and receive* any medical treatment he or she chooses.¹³⁸ A difficulty with positive rights lies with the supposition that the doctor is obliged to provide what the individual right-holder demands regardless of the impact it may have on the doctor, other patients with similar or greater needs, or the healthcare delivery system. An infertile woman may, for example, expect her doctor to provide the reproductive technology, no matter the cost, to enable her to become pregnant. She may base her claim on her positive right to procreation. If this expectation is acknowledged and granted as a “right,” the doctor (and even the state) may then be fully expected to provide the same level of care for each citizen who desires such aid.¹³⁹

Rights’ interactions, like healthcare provision and procreation, are common to the DPR, but they are not the only common occurrence where positive rights claims are made. Another area of growing impact is end-of-life decision-making. Some patients in pain and suffering request physician-aid-in-dying. While euthanasia and PAS have been discussed and, in some cases, practised throughout the centuries, the subject of physician-aid-in-dying has only become common in the last several decades. When mixed with the subject of rights, however, the issue becomes complex and controversial. It is not uncommon for a patient to request to be allowed to die. It is quite another matter for a patient to claim a right to physician assistance or to assume that a physician will be actively involved in bringing about the patient’s own death. The positive right-to-die claim has been posited *to oblige* the physician to supply assistance with or, in the case of euthanasia, directly cause the patient’s death.

¹³⁸Marcia Angell, “The Case of Helga Wanglie: A New Kind of ‘Right to Die’ Case,” *New England Journal of Medicine* 325, no. 7 (August 1991): 511-12. Angell makes this statement, but it is couched within an article where the hospital, not the family, wanted to terminate the care of Mrs. Wanglie. Cf. Stephen H. Miles, “Sounding Board: Informed Demand for Non-Beneficial Treatment,” *New England Journal of Medicine* 325, no. 7 (August 1991): 512-14. A patient’s positive right does not obligate the physician to injure them (i.e., mutilation), or provide inappropriate therapies (i.e., amphetamines for weight reduction), or therapies that have no value (i.e., laetrile for cancer).

¹³⁹British Medical Association, *Euthanasia*, 98.

Why Is a “Right-to-Die” Claim Significant in the Doctor-Patient Relationship?

A claim to a right-to-die, aside from being somewhat strange in light of the fact that death is inevitable for all human beings,¹⁴⁰ highlights two other realities in the DPR. First, although the fact that patient-death is not uncommon in the DPR, the focus on death has been heightened by the advent of medical technologies that can prolong the act of dying. A patient may fear the kinds of circumstances which often accompany a long drawn-out death--among which may be the loss of dignity, loss of privacy, loss of control over one’s environment, the perceived inevitable dehumanisation that institutional and technological factors bring to the scenario and, not least, the threat of financial insolvency that may accompany a lingering death. Patients also fear that physicians may overstep boundaries with the use of the technology.¹⁴¹ Patient physical and emotional anxieties are serious enough realities to warrant solutions regarding patient-rights’ considerations, yet the other facet which feeds the complexity is the expanding philosophical discussion and debate that serves as a backdrop to the issue of rights.

The second reality which affects the DPR--the taproot of the rights’ issue--derives from the concept of the individual and evidences itself in some patients’ notions that pain and suffering are to be avoided at all costs and that personal happiness is the supreme goal. If the pleasure/happiness goal cannot be achieved, then life is not worth living. For example, some terminally ill patients, in order to end their suffering, preserve their dignity, and maintain as much physical, emotional, and financial control over the dying process as possible, are requesting that physicians provide them with the knowledge and means necessary to kill themselves. Patients reason that these requests and subsequent actions are morally sound because the consequences are beneficial to them. For example, although individual patients

¹⁴⁰Cook, *Moral Maze*, 140.

¹⁴¹Ch. 3 of the thesis examines this fear in greater detail within the section on medical paternalism (173).

may be killed, this action may be regarded as beneficial or of ultimate good, because the patient's pain and suffering have been eliminated, the financial drain has been brought to closure, and scarce medical resources may even be reallocated and maximised elsewhere. Such reasoning, however, raises additional concerns that surround end-of-life decision-making and PAS.

So Where Does This Lead?

One concern growing out of the heavy emphasis Westerners place on individual happiness is that a claim of a "right-to-die," even if established under the premise of patient happiness and beneficial consequence, carries an implied obligation on the part of a physician to assist a patient with his suicide. Physicians approach this question from many different philosophies of life, any or all of which may be applicable to the DPR. Physicians consider it morally significant to assess how these are applied and might affect the relationship they have with their patients.¹⁴² Central among the considerations is the search for equal justice for both patients and doctors.

The question has implications for the physician's own personal autonomy by infringing upon his own right to noninterference when it obliges him to kill. Thus, the attitude that PAS is beneficial and just, by offering good consequences to some terminally ill patients, obscures another important moral concern--that is, justice from the physician standpoint. The abovementioned patient interpretation of justice bears similarity to Mill's HU, but it is certainly not the only approach. If a patient's claim now obliges a doctor to assist with a patient's suicide, then such a claim needs to be examined closely through the filter of justice, because such a claim may raise historical, moral, legal, and medical questions. The following discussion will examine this critical area of justice.

¹⁴²Compare Beauchamp and Childress, 44-119.

Justice, Hedonistic-Utilitarianism, and Physician-Assisted Suicide

Introduction

This section examines the claim that a physician is morally obliged to satisfy a patient's preferences in the DPR, even to the level of assisting a terminally ill patient with suicide, on the ground of justice. Along with autonomy and mercy, justice has also been cited as grounds for physician-assisted death.¹⁴³ Such a claim has implications for the DPR as well as traditional physician paternalism.¹⁴⁴

Traditionally, justice has been foundational to the practice of striving to ensure that a patient, or groups of patients, received equal care or were not in some way being discriminated against.¹⁴⁵ Some who cite justice in support of PAS now view the denial of PAS in a terminal illness as being discriminatory, and hence, an injustice.¹⁴⁶ This has legal implications (since

¹⁴³Patient autonomy will be examined in ch. 3 of the thesis (147). Battin (113-23) discusses the claim of justice as it relates to euthanasia. See Battin, *Least Worst Death*, 113. She cites Ramsey's position, among other positions, on people who are "irretrievably inaccessible" to human care. Battin's view is not a recent one. Compare Paul Ramsey, *The Patient as Person: Explorations in Medical Ethics* (New Haven, CT: Yale University Press, 1970), 160-64. Ramsey, himself, asks if there are any "specifiable" just (and charitable) qualifications of one's duty to care for the terminally ill ("dying"). He then offers a sketch of two possible justifiable qualifications: hastening the dying of a comatose patient ("irretrievably inaccessible") and taking positive steps to "usher out" a patient whose pain cannot be "kept at bay." In these cases he says medical killing might be justified. His comments have implications for the DPR because he believes the choice in the matter should be left to the physician and not the "moralist" (161).

¹⁴⁴Physician paternalism is one of the subjects covered in ch. 3 of the thesis.

¹⁴⁵Cook, *Patients' Choice*, 228-29.

¹⁴⁶Compare the "equal protection" Supreme Court case, *Vacco v. Quill*, as an example of this argument in the form of PAS. The Equal Protection clause of the United States Constitution embodies a general rule that States must treat like cases alike, but may treat unlike cases on a separate basis. The question was whether it was discriminatory (and hence unjust) to permit a patient to refuse life-saving treatment, but to make it a crime for a physician and patient to engage in PAS. George J. Annas, "The Bell Tolls for a Constitutional Right to Physician Assisted Suicide," *New England Journal of Medicine* 337, no. 15 (October 1997): 1099. A question whether it is just to maintain a distinction between refusing life-saving treatment and choosing to hasten death is a philosophical consideration as well. See Paul Ramsey, 163. Ramsey likens this decision to an injured, slowly dying soldier who must be left behind in jungle warfare by his comrades. Ramsey says such extreme cases place one into

PAS is unlawful in most jurisdictions), compelling further reflection on the moral implications of such an argument as well.

This chapter examines one aspect of justice--i.e., the moral justness of PAS in the DPR. Justice is one of a group of medical moral values often associated with an alliance of principles sometimes identified by the title, "common morality,"¹⁴⁷ and given key consideration in medicine. Current discussions debate whether a consensus of "common morality" actually exists,¹⁴⁸ and the varying meanings of the word "justice," together with its multiple applications, make it difficult to reach an agreed level of understanding.¹⁴⁹

In order to clarify the concept of justice as it relates to PAS in the DPR, together with its accompanying PAS claim, the term "justice," like the term "rights" in the previous section, will be examined. This survey will explore key historical contexts where the word was discussed, experienced developmental change, and came to constitute the grounds for PAS, including its origin and use in Ancient Greece, its development through the Middle Ages into the Enlightenment, its further definition in the writings of John Stuart Mill, and its twentieth-

another moral realm where the normal distinction between acts of omission and acts of commission might be abrogated.

¹⁴⁷Beauchamp and Childress, 100. Chs. 3 through 6 in the book offer an expanded discussion of the four common morality principles--autonomy, nonmaleficence, beneficence, and justice. Cf. Cook, *Patients' Choice*, 228-29. See also the examination of autonomy in ch. 3 of this thesis (147).

¹⁴⁸See Alan Gewirth, "Common Morality and the Community of Rights," in *Prospects for a Common Morality*, ed. Gene Outka and John P. Reeder Jr. (Princeton, NJ: Princeton University Press, 1993), 29-52. Gewirth describes in some detail the evidence for and objections to a "common morality." His description reveals a complexity to any conceptualisation of a common morality, as well as the controversy which surrounds its claims. For example, he outlines two core objections (ethnocentric and egoistic) to a common morality. Not all would agree with the universality of the principles of a common morality that are claimed to form the basis of human rights, especially those formed from a Western individualist viewpoint. A claim is that the conception of self in Western culture is foreign to much of the world (40) and an obstacle to establishing a universal common morality.

¹⁴⁹Sidgwick, 264. Sidgwick, himself, noted the difficulty of defining the term and admitted that the result was often disputed.

century development within the medical-ethical arena. The evolving concept of justice has implications for current medical practice.

Justice Defined

“Justice,” according to the *OED* has several meanings, each of which may be applicable in a variety of contexts. For example, justice is the “conformity of an action or thing to moral right, or to reason, truth, or fact; rightfulness; fairness; correctness; propriety.”¹⁵⁰ The word may be used to describe a characteristic of a person or a group. In this sense, justice is defined as the quality of being morally just or righteous, including the principle of just dealing and the demonstration of this quality in action. The concept of justice connotes just conduct, integrity, and rectitude. Justice also carries the idea of authoritative action or force. In this sense, it means “the exercise of authority or power in maintenance of right; vindication of right by assignment of reward or punishment; requital of desert.”¹⁵¹

The following core ideas and applications may formulate a general definition of justice. *Rightness and wrongness of attitudes and actions, or conforming to a standard*, attach a moral dimension to the meaning of the word. The *exercise of authority or power in the maintenance of right* is yet another application of justice. From the earliest of times, these core elements were evident in the development of the term.

Origin of Justice: Ancient Greece

Ideas about justice did not develop in a cultural or conceptual vacuum. Ancient Greece was a fertile seedbed for the definition and application of the concept which emerged in this Pre-Socratic cultural and philosophical milieu. The term was used to convey different

¹⁵⁰*OED*, 2d ed., s.v. “justice.” When the concept of justice is applied to law, for example, a legal decision rendered might be considered unjust or fair, implying that the law conformed to moral right, to right reason, or to some standard of fairness which is consistent to or with the rest of law.

¹⁵¹*Ibid.*

conceptions of how the world, made up of a variety of different elements, was nevertheless an ordered whole.¹⁵² “Justice” before Plato would not be considered an established philosophical concept or principle; it was rather an “orally-managed” idea.¹⁵³ Several key ideas began to emerge as the word evolved in meaning.

The Greek term for justice, *dike* (then *dikaiosune*), came to represent a concept central to Greek moral and political philosophy. The term was disseminated by the Greeks to their heirs in the European tradition.¹⁵⁴ While it may not be accurate to say that the concept was of regulative importance yet to the Ancient Greeks, it may be noted that Hesiod isolated and converted it into a formal topic of discussion.¹⁵⁵ Hesiod codified justice by describing what justice *did*, yet he failed to *define* the concept. In a similar vein, Heraclitus wrote of justice “catching up with people.”¹⁵⁶ By this he did not mean that people would necessarily be arrested and tried in court, but that they would likely not enjoy their reasonably good reputations forever.¹⁵⁷ While the term was still in its formative stages, it was gaining moral shape and influence.

¹⁵²G. E. R. Lloyd, *Methods And Problems in Greek Science* (New York: Cambridge University Press, 1991), 150.

¹⁵³Eric A. Havelock, *The Greek Concept of Justice: From Its Shadow in Homer to Its Substance in Plato* (Cambridge, MA, 1978), 2. Havelock uses the term “orally-managed” to convey descriptively the idea that the term was in its developmental stages and had not yet been, for example, codified.

¹⁵⁴*Ibid.*, 13.

¹⁵⁵*Ibid.* Cf. McKirahan, 70. Hesiod wrote of the world having moral order with the inferior divinities performing their functions as assigned by Zeus. Thus, “Justice” was mitigated by Zeus, and he was the “guarantor of justice through a system of rewards and punishments.”

¹⁵⁶*Ibid.*

¹⁵⁷Havelock, 267.

Contained within the idea of justice was a rule of reciprocity, that which was required to keep “regularity” in both cosmic and human affairs.¹⁵⁸ Parmenides viewed justice as regularity, custom, accepted order--what was to be expected of normal behaviour.¹⁵⁹ The moral authority of the term was identified, in part, with the gods. Indeed, the idea of reciprocity was so much a part of the concept of justice that, at times, retributive acts which corrected an injustice were also included.¹⁶⁰ Thus, the concept of justice by the end of the early Greek period had begun to reflect both that which was inside a man as well as that which was operative in society.¹⁶¹

The Hippocratic position on justice may also be included within the Pre-Socratic era. It offers a focussed view of the use of the concept of justice in a particular context. The Hippocratic physician pledged to treat all of his patients equally.¹⁶² The context for such an application was indeed broader than today, and it is Carrick who believes that the Hippocratic

¹⁵⁸Ibid. See also McKirahan, 141-42. The authors state that from God’s perspective, a view superior to a human one, all things are “beautiful, good, and just,” whereas humans think some things have negative qualities [unlovely, bad, and unjust]. The implication is that it must be wrong to think anything unjust, for example, when one has gained the correct view of things. It is possible that the order in the *kosmos* is not morally or aesthetically neutral, but is good and beautiful. In this case, one can see a primitive, albeit developing, view that equated moral good with being just.

¹⁵⁹Havelock, 268. See also McKirahan, 158-59. Parmenides is best known for a poem that he wrote in a style that was common to Homer and Hesiod and that connoted wisdom and authority. There is the way of mortals (no true reliance) and the way of Truth that has divine origins. Parmenides is a “knowing mortal” who has received a divine revelation. Of note is that Justice is viewed as the gatekeeper that allows only those sent by Right to enter. Justice and right behaviour, it appears, were of divine origin and must be communicated to man. In this sense it can be said that justice has moral force and authority because of its origin with the gods.

¹⁶⁰Havelock, 267.

¹⁶¹Ibid., 306.

¹⁶²Paul Carrick, *Medical Ethics in Antiquity: Philosophical Perspectives on Abortion and Euthanasia*, Philosophy and Medicine, ed. H. Tristram Engelhardt Jr. And Stuart F. Spicker, no. 18 (Dordrecht, Holland: D. Reidel Publishing Co., 1985), 184. However, a physician was not obliged to take a patient or to provide charitable medical care.

Oath may “certainly” be credited with helping to focus the eyes of Western medicine on at least five central medical ethical issues.¹⁶³

One of those five issues, for example, was justice in the distribution of health services.¹⁶⁴ Similarly, the Hippocratic Oath (P6) required “equal treatment” of patients regardless of their sex or status, whether free or slave.¹⁶⁵ Even though justice was not regulated by law at this time, it is apparent that the Hippocratic physician was at least aware of its moral value and sought to conform his behaviour to the constructs of perceived justice as it related to patient care.

Justice was given a clear conceptual framework during Plato’s era. Plato was the first writer after Hesiod to deal with the problem of justice as a topic, “converting it into a conceptual entity and making it a normative principle.”¹⁶⁶ It is possible that Plato’s “justice” vocabulary—that is, just or unjust--was a reflection of the effect of increasing legal procedure and practice in the Greek city-states.¹⁶⁷ His examination of justice is found prominently in *The Republic*, where his overall aim is to show that a person is better living justly than unjustly.¹⁶⁸ Plato’s view is grounded in the Greek view of virtue, that value which makes it possible for

¹⁶³Ibid., 180. The core issues are: patient confidentiality, abortion, euthanasia, truth-telling, and justice in the distribution of health services.

¹⁶⁴Ibid.

¹⁶⁵Ibid., 183-84. The Hippocratic physician’s pledge to give equal treatment to patients was for the most part “uncharacteristic” of the Greek and Roman world.

¹⁶⁶Havelock, 14.

¹⁶⁷Ibid., 297.

¹⁶⁸Norman O. Dahl, “Plato’s Defense of Justice,” in *Philosophy and Phenomenological Research* 51, no. 4 (December 1991): 809, 811. See also David Sachs, “A Fallacy in Plato’s Republic,” *Philosophical Review* 72 (1963): 141. Sachs states that the main argument of the *Republic* is the argument about justice and happiness; namely, the just man is happier than the unjust man.

people to live a typically human life and to live that life well.¹⁶⁹ The just man, according to Plato, was the man in whose soul justice existed, and this man would be happier than the unjust man. For men to live well requires a balance of virtue and justice, both individually and within society.¹⁷⁰ In Plato's *Republic*, justice occurs when the three parts of society exist in harmony: "the philosophic," "the pugnacious," and "the commercial" spirits. Justice is not only demonstrated by external behaviour toward others, but exists as an "internal order of the soul" which produces that right behaviour.¹⁷¹ Furthermore, the just man was one who recognised the value of right living, whether obligatory, or virtuous, and would be motivated to support, safeguard, or protect it.¹⁷² Plato's view of justice, therefore, contained a moral dimension coupled with a sense of the obligatory. One who desired to be happy would practise justice, thereby demonstrating a link between justice and virtuous or right human behaviour.

Aristotle saw justice from two perspectives: from the vantage point of individual responsibility, and from that of the state. Aristotle believed an unjust person was one who broke the law, who took advantage of another, i.e. who acted unfairly.¹⁷³ "Just" also meant law-abiding, and Aristotle illuminated his views with several examples which demonstrated this characteristic: brave conduct constituted not leaving one's post or taking flight; temperate conduct refrained from committing adultery or assault; and patient conduct refused to mete out

¹⁶⁹Plato, 353; see also Dahl, 810.

¹⁷⁰Sachs, 151.

¹⁷¹Injustice, according to Plato, is the opposite state of harmony or balance when internal discord and factions prevail. See Plato, 139-43.

¹⁷²Dahl, 810. Dahl likens Plato's conception of justice as "internalist." There is a necessary connection between value and motivation. If a person values something, then he or she will be motivated to protect and preserve it. See also Carrick, 113. Carrick believes that the highest value in Plato's system was justice.

¹⁷³Aristotle, 172.

blows or abuse upon another person.¹⁷⁴ “Just” had civil connotations, meaning that which was lawful or fair (equitable),¹⁷⁵ or anything that tended to produce or conserve happiness, “and the constituents of happiness,” within a political association.¹⁷⁶ For Aristotle, the emphasis upon the legal aspects of justice is demonstrated in such political associations. Justice in each of these examples indicated both a moral responsibility that one person had toward another person, or group of others, and the moral responsibility of a legal, constituted body toward its subjects.

The combined Platonic and Aristotelian development of justice established a broad framework for the concept. Justice after this period in Ancient Greece became conjoined to the notion of human wellness, both morally and legally. Even though the ancients did not examine justice with a future cultural intent in mind, they did establish the structure upon which later thinkers would build emerging notions of humanism.

The Middle Ages to Enlightenment: An Era of Re-emerging Humanism

The scholastic theologian of the Middle Ages, Thomas Aquinas (1224-1274), synthesised Greek thought and Roman Catholic doctrine into a Christian philosophy. He accomplished this by connecting the ideas of virtue and justice, contained in classical antiquity, with similar ideas recurrent within Christian thought, which resulted in his belief that “natural law” could be discovered by the exercise of right reason. He was aided in this development by the writings of Aristotle and was able to reach the conclusion that right action would promote and aid the realisation of human flourishing.¹⁷⁷ The result was a rational foundation to ethics

¹⁷⁴Ibid., 173.

¹⁷⁵Ibid., 172.

¹⁷⁶Ibid., 173.

¹⁷⁷John Haldane, “Medieval and Renaissance Ethics,” in *A Companion to Ethics*, ed. Peter Singer (Cambridge, MA: Basil Blackwell, reprint edition, 1994), 141.

that introduced a compelling and attractive path to virtue.¹⁷⁸ In Aquinas' system, justice was placed in the realm of relationship to God and viewed as covering the whole of man's relationships with other persons.¹⁷⁹ Any obligation to just action would be related to the law of God and derived from a reasoned application of virtue. The effect of Thomist theology was to transform the goal of virtue in Aristotelian moral theory by adding both supernatural assistance and a supernatural result--the state of *beatitudo*, or "blessedness."¹⁸⁰

Aquinas' association of justice with deity highlighted a stream of thought which had been attaching to the word from its inception and demonstrated his particular moral understanding of the term.¹⁸¹ Hugo Grotius' writings, although arguing from a decidedly non-Thomistic approach, provided a moral counterweight to the views of Aquinas.¹⁸² Grotius was, in fact, credited with establishing modern natural law and that law's secularisation. Writing some three centuries after Aquinas, he believed that fundamental *injustices* occurred when someone took another's property, when a person failed to keep his word, and when a violator of another's rights went unpunished.¹⁸³ One may see demonstrated in Grotius' views of *injustice*

¹⁷⁸Ibid.

¹⁷⁹Thomas Aquinas *Summa Theologica* 1a2ae.66.4; see also Schneewind, 78.

¹⁸⁰Haldane, 142. In Aristotelian moral theory, the individual sought the state of flourishing (*eudaimonia*), and in Thomist moral theory, the individual sought blessedness (*beatitudo*).

¹⁸¹Stephen Buckle, "Natural Law," in *A Companion to Ethics*, ed. Peter Singer (Cambridge, MA: Basil Blackwell, reprint edition, 1994), 167. Buckle writes that in both ancient and medieval accounts it was believed that the law of nature was, in some sense, placed in us by God (or the gods). See also Haldane, 142. Aquinas gave place to the religious dimension of morality, but he also combined it with a "broadly rationalist theory." He moved along a path between two philosophical groups: those that held to a naturalistic version of Aristotelian eudaimonism and those that claimed divine law to be a source of obligation rooted in God's legislative will.

¹⁸²Haldane, 144. Hugo Grotius was "deeply hostile" to the religious associations of Thomistic moral philosophy, but who, nonetheless, developed ideas similar (though unknowingly) to Scholastic ideas.

¹⁸³Schneewind, 79.

the concomitant core ideas of justice--the elements of moral rightness and the implication that one's freedoms were legally protected. Even though writing as a Christian (like Aquinas), Grotius' perspective on justice was humanistic in that his stated authority for right behaviour was constituted from the natural law within human nature and demonstrated the exercise of right reason.¹⁸⁴ Whether the source of authority was divine or human in origin, the concept involved fair treatment of people and articulated the awareness that human wellness was diminished when justice was absent. Aquinas and Grotius each served as pivotal catalysts for the continued development of the concept of justice.

Enlightenment thinkers like John Locke and Immanuel Kant further refined justice both in its definition and its application. John Locke recognised the element of fair dealing when writing on justice. He believed that all persons were created in a state of equality.¹⁸⁵ While Locke drew authority for his ideas on justice from natural law and deity, Kant's authority for thought was lodged in categorical imperatives based upon human reason. Kant's aim was to help man establish and sustain his freedom apart from absolute governmental power,¹⁸⁶ and

¹⁸⁴Buckle, 167. See also Schneewind, 78-80. Schneewind pinpoints the uniqueness of Grotius' position on rights and justice. He discusses how Grotius differed from Aquinas and Luther in his belief that justice and rights were grounded within a person. This belief that rights were grounded within a person was not totally innovative, but it was through Grotius that the idea of rights as natural attributes of individuals began to hold a prominent place in modern European thought (81). Grotius' views began to open the way for a shift in moral focus to the "inner life" or moral quality of a person. Virtues like rights and justice now came to be viewed as being grounded within a person and were not necessarily attached to a deity or to another external source of authority, for example, a government.

¹⁸⁵Locke, 269. Locke recognised that equality in all areas was the ideal; however, he believed that there was to be no subordination or subjection unless the Lord and Master of all creation should, by "manifest Declaration [sic] of his will set one above the other."

¹⁸⁶Sullivan, 11.

apart from the need to conform to mores based upon supernatural revelation.¹⁸⁷ In addition, he saw that the overriding characteristic of a good state was justice.¹⁸⁸

To ensure that just dealings took place, and that human autonomy was preserved, Kant proposed a pre-political principle of legislation based upon human reason alone. This principle was to derive its authority from the reasoned moral thinking of ordinary people.¹⁸⁹ Moral obligation, according to Kant, must arise from a law that a man himself must legislate.¹⁹⁰ He termed his proposal the “Universal Principle of Justice.”¹⁹¹ The principle linked to human autonomy because it meant that just civil arrangements would only be those that allowed for the most freedom for everyone equally.¹⁹²

An important characteristic of his proposal was that claims of justice could originate from an autonomous individual within the bounds of civil and religious authority and obligate others morally. A second characteristic was a two-stage notion that an autonomous individual must first settle what was right before then determining what was good.¹⁹³ Kant’s views on justice, considered within the greater context of humanism, indicate one part of the broad understanding of human development. Kant’s belief that human reason was the authority behind decision-making helped to shape the claim that a person might judge for himself what is

¹⁸⁷Schneewind, 151; and Kant, *Groundwork*, 110-11.

¹⁸⁸Sullivan, 11.

¹⁸⁹*Ibid.*, 12-13.

¹⁹⁰Schneewind, 151.

¹⁹¹Sullivan, 11.

¹⁹²*Ibid.*, 12. A person was to behave in such a way that his choices were compatible with the greatest amount of external freedom for everyone. Kant believed that the “Universal Principle of Justice” in an enriched form was also the basic moral norm for personal life as well.

¹⁹³Schneewind, 151.

morally binding for his own life.¹⁹⁴ Kant's view that ordinary people can choose to act justly by "consciously applying abstract moral principles"¹⁹⁵ was a view advocated by Jeremy Bentham and others.¹⁹⁶ Although Bentham advanced a utilitarian theory that could be used for decision-making, it appeared to call for calculations that ordinary people would find difficult to make. John Stuart Mill's theory, however, advanced a variant form of autonomy and justice; namely, that good consequences *determine* what is right.¹⁹⁷ Believing that a person should have as much freedom as possible, and that justice rendered a single individual's happiness as equal to that of any other,¹⁹⁸ it remained to be seen whether this view would promote individual well-being or if the pursuit of the happiness of the many might actually yield unhappy consequences for the individual.

John Stuart Mill, Hedonistic-Utilitarianism, and Justice

John Stuart Mill addressed Bentham's theories in his *Utilitarianism*, where Mill suggested that common sense moral principles may be known intuitively.¹⁹⁹ He believed that

¹⁹⁴Kant, *Groundwork*, 80. Kant wrote that everything in nature works according to laws and only a rational being has the power to act "in accordance with his idea" of laws (principles). This is why he or she has a will (he also termed *will* as *practical reason*). Will is the power a person has to select goals, to form rules for achieving them, and finally to act on those rules. Cf. Sullivan, 114-16.

¹⁹⁵Kant also discussed the origin of evil and man's predisposition to evil. He held man to be personally accountable for his decisions. Since man possesses a powerful desire to maximise pleasure over pain, he must undergo a moral revolution. Man battles with his inward predisposition to do good and his desires. Compare Sullivan, 134. See also Kant, *Groundwork*, 122. Kant writes of the inner battle of desire and the use of reason to bring it under control. Kant expressed, by his views, a somewhat optimistic view of man's inner goodness and individual ability to overcome evil desires. See Sullivan, *Introduction*, 147, footnote 3.

¹⁹⁶Schneewind, 151. Thomas Reid's common-sense morality is another example of such a view.

¹⁹⁷Kant believed a person first determined what was right, then actions were to follow.

¹⁹⁸Mill, *On Liberty*, 319.

¹⁹⁹Mill would allow, as an example, common sense moral principles like Reid's beneficence, acting fairly toward others, and truth-telling. Schneewind, 151-52. Compare Mill,

these principles represented the collected wisdom of mankind about those “consequences” of actions that were “desirable” and “undesirable.”²⁰⁰ The basis for moral decision-making, therefore, was a first principle, or common ground of obligation, that lay at the root of all morality. Mill called this common ground the GHP and believed that, in usual or new cases, direct appeal to the principle of utility was appropriate and would lead to conclusions that would be acceptable to common sense. If individuals made decisions in this way, the result would be a just and equitable society.

Mill, writing specifically about justice, believed also that judgments about fairness and equality were important.²⁰¹ He believed that justice implied not only something which was right *to do*, but would also be wrong *to fail to do*. For Mill, justice also meant something that an individual could claim as his or her moral right.²⁰² Mill, at this point, remained within the historical boundaries of the concept.²⁰³ His contribution to the development of justice was to propose a set of moral rules which would guarantee human well-being. While he recognised the essential social nature of morality and that society has a moral end--that is, the moral good of

On Liberty, 251-55. Yet, it should also be stated that Mill believed the GHP both took precedence and was at the root (253) of these intuitive principles. He believed that an individual’s moral faculty only supplied him with general principles of moral judgments, not for perception of concrete doctrines of morality (252). Mill believed that the GHP was essential in order to perceive the concrete doctrines of morality (254).

²⁰⁰Schneewind, 152.

²⁰¹Mill, *Utilitarianism*, 82. Mill claims that “justice is the name for certain moral requirements which, regarded collectively, stand higher in the scale of social utility and are therefore of more paramount obligation, than any others.” Barrow, 158-59. Barrow writes that utilitarianism is “understood to incorporate a principle of impartiality.” He also states that this “formal distributive principle” derives its substance from happiness. All are to be treated the same out of respect for happiness unless a reason for discrimination can be provided. Though happiness (eudomonia) to Plato did not mean the same as happiness (pleasure) to Mill, justice carried the same core meaning.

²⁰²Mill, *On Liberty*, 305.

²⁰³See definition, 3.

its members²⁰⁴--it was the self-conscious goal of the greatest happiness for the greatest number that was at the centre of his claims concerning justice.²⁰⁵ Mill believed that human well-being would be preserved if each person's happiness was equal in degree and was valued exactly as much as another person's happiness,²⁰⁶ adding to the historic understanding of justice--a utilitarian philosophical interpretation by grounding justice in the GHP.²⁰⁷

Whether intentional or not, Mill united several streams of thought that had been developing since the Renaissance,²⁰⁸ establishing a philosophical framework that made it possible to link together individual autonomy, rights' claims, and justice. His view was unique. From this point forward a person could theoretically begin to cite claims of fairness, based upon individual preferences about happiness, and use moral arguments to do so. Of course, Mill's theories neither gained unqualified acceptance, either in his own day or in the present day, nor do they belong to the realm of verified truth. Yet, his philosophy, like that of Kant before him, was used by later generations of thinkers to buttress arguments for the preeminence of autonomous authority. Those arguments may be heard most recently in the PAS/DPR dialogues²⁰⁹ and are ideas which engender sharp debate.

When viewed together under the overall rubric of justice, Aquinas's view of justice based upon a Christian conception of natural law, Grotius's conceptions of justice based upon a

²⁰⁴Davidson, 183.

²⁰⁵Davidson, 183. See also Mill, *On Liberty*, 127, 135. Mill established clear autonomy boundaries in *On Liberty*. Cf. Schneewind, 152. Schneewind notes that Mill and others wrote from a context where vindicating moral autonomy was an important concern.

²⁰⁶Mill, *On Liberty*, 319.

²⁰⁷This was a part of Mill's contribution to the ongoing development of autonomy and humanism. This addition also has implications for the PAS debate where Mill is cited in support of autonomy claims (71-72).

²⁰⁸Ch. 3 will examine the origin and development of human autonomy (147).

²⁰⁹Battin, *Least Worst Death*, 278; see also McLean and Britton, 29.

secular understanding of the same, and Kant's theory of justice based upon human reason alone, provide a trilogy of advances that helped to secure further the theoretical foundations of justice. Mill's HU, while an attempt to further secure claims of justice, actually creates the possibility that an individual claim of justice may be overridden to satisfy the justice claim of the aggregate GHP.

Critique of Mill's Approach

Mill's view of justice bore far-reaching implications. It is important to recognise that his theory has its critics. The first point of criticism involves the *just distribution of satisfactions* related to the rightness and wrongness of certain acts and is stated by non-utilitarian and utilitarian thinkers alike. While equal distribution of fairness is important in Mill's idea of justice, John Rawls and other non-utilitarians believe that it would not matter to a utilitarian how this sum of satisfactions is distributed among individuals.²¹⁰ It is this angle of the argument that is problematic for the non-utilitarian.

For example, Rawls counters the utilitarian view by arguing that, since utilitarian justice as a precept derives, in part, from the goal of achieving the greatest balance of happiness for the greatest number, utilitarian justice actually necessitates, in effect, that the greater (happiness) gains of some would compensate for the lesser (happiness) losses of others.²¹¹ Rawls further questions why the violation of the liberty of the few might be viewed as justifiable as long as the greater good is shared by the many.²¹² Rawls' skepticism of Mill's view of justice derives

²¹⁰John Rawls, "The 'Separateness of Persons' Objection," in *Utilitarianism and Its Critics*, ed. Jonathan Glover (New York: Macmillan Publishing Co., 1990), 91.

²¹¹*Ibid.*, 91-92.

²¹²*Ibid.* But compare Mill, *On Liberty*, 316. Mill recognised the importance of society observing the moral rules that forbid hurting one another. He believed it was their observance "alone" that preserved the peace between human beings. If they were not observed, each person would see another person as a potential enemy. Mill, it appears, had a high view of a man's moral capacity and a willingness to choose the good over evil.

from the corresponding notion that morality is structured around the self-governing individual, stemming from his or her preferences about happiness.²¹³

Arthur Holmes agrees with Rawls in identifying this dependence upon personal preference to define happiness as a weakness in Mill's argument, adding that when Mill spoke of equal justice, he defined it as the state of "maximal utility." In other words, one should respect the rights and liberties of another for the sake of recognising the common good.²¹⁴ Holmes rightly questions whether this principle is sufficient to ensure equal justice for all persons.²¹⁵ Thus, differences between the arguments of non-utilitarians and Mill rely, in part, upon the varied perspectives about the justness or unjustness of an act and its relation to its moral assessment.²¹⁶ Yet, non-utilitarian writers were not the only ones to challenge Mill on this notion.

J. J. C. Smart, writing from a utilitarian perspective, recognises not only an uncomfortable weakness in utilitarianism, but one that he identifies as an irony of the theory.²¹⁷

²¹³See Schneewind, 155-56.

²¹⁴Arthur Holmes, *Ethics: Approaching Moral Decisions* (Downers Grove, IL: InterVarsity Press, 1984), 45.

²¹⁵Ibid. See also John Rawls, *A Theory of Justice* (Cambridge, MA: Belknap Press, revised edition, 1999), 445. Rawls states, in contrast to Mill, that justice-as-fairness is not a maximising theory. Rawls believes that it is, instead, based upon the minimum ground of the capacity for moral personality, and that this capacity alone is sufficient to render justice "fair" (443).

²¹⁶Tziporah Kasachkoff, "Utilitarianism and Justice," in *Moral Philosophy: An Introduction*, ed. Jack Glickman (New York: St. Martin's Press, 1976), 648.

²¹⁷Smart and Williams, 69-70. Smart cites H. J. McCloskey, "A Note on Utilitarian Punishment," *Mind* 72 (1963): 599. McCloskey writes of the possibility of horrible consequences in certain exceptional cases. An example of this consequence may be found in the illustration of a small town sheriff who can prevent serious riots, where hundreds of people will be killed, only by "framing" and executing as a scapegoat an innocent man. While the utilitarian may be unhappy about the situation, he may ultimately arrive at the decision to act unjustly. The point is that the innocent man must die in order to save the hundreds from a possible deadlier riot, thus exposing a weakness of the utilitarian "Greatest Happiness" argument. In this theory, there can be no guarantee of just distribution of satisfactions.

Sometimes, he says, an individual commits an injustice in his pursuit to obtain or realise happiness. Since people have egoistic tendencies as well as beneficent ones, a person could be prompted and succumb to act wrongly, even very wrongly.²¹⁸ Therefore, the fewer times the utilitarian has to choose between the lesser of two evils, the better pleased he will be.²¹⁹ This is an irony of the theory--that in pursuing the greatest happiness, a person could negatively affect the happiness of another.

Tziporah Kasachkoff argues, that for most people, the rightness or wrongness of an act corresponds to the perception of its justness or unjustness.²²⁰ Both Kasachkoff and Rawls agree that the right precedes the good, and that no utilitarian view can adequately incorporate a person's common sense convictions.²²¹ Their argument counters that of Mill's, however, which suggests that utilitarian principles would lead to conclusions that common sense also would find to be appropriate.²²² While Mill does stress justice as a key element, the problem with Mill is that he seems to have two separate principles at work at the same time: the principle of justice and the principle of utility. It is conceivable, using Mill's HU theory, that an action may maximise the sum of good in the world (GHP) and yet be unjust in the distribution of the sum.²²³ Another difficulty for Mill's utilitarianism lay in the fact that *preferences differ significantly* from person to person, leaving the determination of what is considered right action, or the good, based solely upon the satisfaction of individual desires. Non-utilitarians, like Rawls, argue that principles of right action--i.e., justice, cannot be derived simply from the

²¹⁸Smart and Williams, 71.

²¹⁹Ibid.

²²⁰Kasachkoff, 648.

²²¹Schneewind, 155.

²²²Ibid., 152.

²²³Frankena, 41.

satisfaction of individual desire. In fact, he questions whether a valid conclusion could be drawn about what was good simply from the premise of personally desired satisfaction,²²⁴ since some people obviously condone bringing pain to others in great numbers in their quest to find their personal desires met.

Nevertheless, despite criticisms that Mill's utilitarian view fails to ensure a just distribution of satisfaction for all persons, and that common sense alone does not always lead to moral and/or appropriate behaviour, his utilitarianism has been, nonetheless, influential in the moral and legal debate concerning PAS. Beauchamp and Childress, for example, elaborate at length on the application of Mill's utilitarian principles in medicine,²²⁵ while advocates cite Mill as support for both autonomy and PAS claims. The medical-ethical arena, from both physician and patient perspectives, is one place where utilitarian views are used to call for action, to cite claims based on justness and fairness, and to buttress arguments from varied sides of the question, all clamouring for justice in the modern medical context.

Twentieth-Century Medicine and Justice

H. Tristram Engelhardt notes that people who live in modern, pluralistic societies long for a unified view of justice.²²⁶ Both the concept of "fairness" and determining what is "just" in

²²⁴Schneewind, 155-56. See also Rawls, *Theory of Justice*, 27-30. Henry Sidgwick provided something of a middle ground by attempting to show that the intuitionist view about the foundations of morality could, in fact, be used by the utilitarian viewpoint (153). He said that while the utilitarian method needed an intuition at its foundations, this method was, nonetheless, essential in order to settle moral disputes (152). Furthermore, he had difficulty in finding in "Common Sense" [sic] any definite agreement as to clear principles from which natural rights could be systematically deduced. Thus, he proposed one clear mode of systematizing these rights brought under one principle--"Freedom from Interference." This universal establishment of the right to freedom would be, in his view, the complete realisation of "Justice" (153), which he qualified as not only freedom but "all other benefits and burdens" that should be distributed justly, or free, from arbitrary inequality. See Henry Sidgwick, 274.

²²⁵Beauchamp and Childress, 47-55. Cf. British Medical Association, *Medical Ethics Today*, 74, where Mill's autonomy view is cited as relating to the autonomy of children.

²²⁶H. Tristram Engelhardt Jr., *The Foundations of Bioethics*, 2d ed. (New York: Oxford University Press, 1996), 3, 10. Engelhardt believes this view of justice to be one that was once

the medical community have become essential components in the widespread debate which continues to rage at the beginning of the new millennium. The debate is fuelled by the various interpretations surrounding, and applications of, the term “justice.”²²⁷ Several moral theories, through which principles of justice are often filtered, contribute to the conversation,²²⁸ as do new definitions which threaten to supplant traditional meanings of the term. Vast inequities associated with access to healthcare and health insurance, together with dramatic increases in the cost of that healthcare, only exacerbate the tensions.²²⁹

Basic Meaning

Though controversial rhetoric surrounds the word, its meaning, and its application in medicine, a basic terminology has been used to define justice in the medical arena: fairness, desert (that which is deserved), and entitlement (that to which one is entitled).²³⁰ Beauchamp and Childress note that a situation calling for justice to be meted is present whenever a person is due “benefits or burdens” because of their “particular properties or circumstances.”²³¹ This aspect of “benefits due” may come about because a person has been productive and has earned a just apportionment or is entitled to specific assistance of some kind. Conversely, a person

found in religious communities. Whether or not his construct is accurate as to the *definition* of that community’s values may be questioned. His work clearly recognises that communities long for clearly articulated and implemented concepts of justice.

²²⁷Cook, *Patients’ Choice*, 228.

²²⁸Beauchamp and Childress, 334. The authors list utilitarian, libertarian, egalitarian, and communitarian theories as possibilities. See also van Zyl, *Death and Compassion*, who writes on the subject of euthanasia and justice from the perspective of virtue ethics. Each of these moral theories claims to apply justice with validity.

²²⁹Beauchamp and Childress, 326.

²³⁰Ibid., 327. Cf. Cook, *Patients’ Choice*, 228. Cook writes that an essential element is treating patients fairly. This includes making sure similar cases are treated similarly and different cases are treated differently.

²³¹Beauchamp and Childress, 327.

may have been harmed in some way, and because of damages assessed, would be entitled to compensation.²³² A valid claim based on justice would seek either appropriate redress for a harmful consequence or the fulfilment of benefit promised in the case of entitlement.²³³

An injustice claim, on the other hand, would involve either the *commission* of a wrongful act against another person or the *omission* (whether conscious, subconscious, or unconscious denial) of a benefit perceived to be rightfully due, at least in the mind of the aggrieved party. The concept of injustice also includes the failure of an individual or an entity to distribute burdens fairly (in this context, perhaps medical resources, responsibilities, or costs).²³⁴ Cook provides another perspective on the meaning of justice by showing that, while the concept itself is often embodied in the laws of the land, the end value of implemented justice is to ensure equal treatment for people--to eliminate the "wrong kind of discrimination" against persons or groups. Cook's perspective echoes an ethos of traditional medicine that seeks to go beyond the mere letter of the law in treating people fairly.²³⁵

Complex issues surround medical justice, aspects of which determine for patients, medical healthcare personnel, and institutions, the standards of moral right and wrong, fairness, benefits due, burdens assigned, correctness and propriety, equality, and the stewardship of resources by governing entities. These issues remain both difficult to define and even more difficult to regulate. To illustrate how the argument for justice is used to inform decisions

²³²Ibid.

²³³Ibid.

²³⁴Ibid.

²³⁵Cook, *Patients' Choice*, 229. The example here of the result of applied justice is actually one of "Utilitarian ends," as opposed to a "value" in itself. The question is whether treating people fairly is valuable in itself, or because it results in greater happiness for the most people (preventing negative discrimination). See also Cook's advocacy of fair treatment that goes beyond legal requirements which is, in some ways, congruent with the Hippocratic statement (cf. P6) that called for physicians to treat patients equally, even in an era when medicine was poorly regulated.

regarding public policy, one example may be found on the battlefield of resource allocations, using the BMA's suggested list of guidelines as the methodological tool.

Guiding Principles for Just Medical Resource Allocation Decisions

A central question pervading the discussion regarding the distribution of healthcare resources is exactly what constitutes the guiding principles which aim to establish the "justice" or "fairness" of that care. A survey of four of the BMA's most commonly held principles illustrates the concept of justice as it is applied to current medical resource allocations.²³⁶ The following principles are options that might be employed alone or in combination with others within the DPR and wider medical contexts.²³⁷ It may be well to note at the onset that, while ostensibly seeking to provide justice for all concerned, the reality is that some of the principles are not necessarily ethical, acceptable, or even practical.²³⁸

First, *treating patients equally* means that a doctor treats similar cases in a similar fashion and different cases in a different fashion. Fairness lies near the centre of the concept of

²³⁶Cook, *Patients' Choice*, 214-19. Beauchamp and Childress, 329-31. British Medical Association, *Medical Ethics Today*, 309-13. The BMA lists and describes these "guidelines" for dealing with the problem of rationing healthcare resources in a just manner.

²³⁷While it is recognised that these principles might be applied alone or in combination, they will be discussed individually in the thesis.

²³⁸Compare British Medical Association, *Medical Ethics Today*, 309-13. One example of a questionable "guideline" concerns the selection criterion (311) which would dispense *treatment according to merit*. For a positive example, if a patient donates blood, she might be given priority later when she needs a transfusion. Negative examples might include patients whose own past health patterns contribute to their diseases and who might not receive treatment, or patients whose ill health relates to smoking, abuse of alcohol or drugs, high-risk sporting activities, poor dietary choices, or unsafe lifestyles and who could potentially be excluded from state-funded medical treatments. A more substantial concern for such a selection criterion would attach to the patient whose disease is due to genetic predisposition rather than to lifestyle. It would be difficult to assess how responsible an individual is for his or her misfortune. Still a different example altogether is the nontreatment of a patient's sexually transmitted disease which would potentially put more people at risk and force the innocent dependents of the patient to bear the cost of nontreatment.

justice where the aim is “no bias or unwarranted discrimination.”²³⁹ This is a worthy ideal; however, the principle is open to challenge from many different perspectives. An example of a challenge to this principle already has been levelled in court cases involving PAS, as was the case in 1997, when the United States Supreme Court overturned a Second Circuit court ruling, upholding New York State’s ban on assisted suicide under the Equal Protection Clause of the United States Constitution.²⁴⁰ The United States Supreme Court case demonstrates the reality that a guideline of this nature would be difficult to assess accurately and to apply equally.

Some patients have claimed this principle of “treating patients equally” to argue that to offer free medical care to those who cannot pay for their healthcare is an example of fairness or justness. They postulate, however wrongly, that fair distribution of resource allocations means that those patients who are able to pay for treatment receive it, and others who are unable to pay for it should still receive treatment (treating patients equally), albeit in the form of charity. The mistaken notion is that charitable care is necessarily just.

Beauchamp and Childress help distinguish between equal distribution of healthcare and charitable care. Charitable care is virtuous, but not necessarily just.²⁴¹ Regardless of economic viability, justice is served when other considerations are brought to bear upon the case, such as desert, entitlement, “no bias or unwarranted discrimination,” and treating similar cases in a similar fashion and different cases in a different fashion (medical diagnosis and treatment decisions). Thus, “treating patients equally” is a fairness goal which has been easily misappropriated and misinterpreted. The argument surrounding treatment based upon financial stability, however, raises a question which a second guideline addresses.

²³⁹See Cook, *Patients’ Choice*, 217-18. See also British Medical Association, *Medical Medical Ethics Today*, 313. Compare Beauchamp and Childress, 341-42.

²⁴⁰*Vacco v. Quill*.

²⁴¹Beauchamp and Childress, 349-50.

A second principle dealing with just distribution of resources concerns the practice of *treating patients according to the ability to pay*. In the current United States' healthcare system, those patients able to afford quality health insurance receive treatment. At the same time, the poorest patients may also receive government assistance, indigent, or "charity" care. The ones often failing to receive care, however, are those sick persons who work but cannot afford health insurance.²⁴² High medical costs prohibit their access to regular healthcare. Stated plainly, the better one is able to *pay* for healthcare, the better healthcare one *receives*. A realistic concern for the terminally ill patient in the middle category (with no healthcare) would be his inability to receive sufficient and sustained comfort throughout the often lengthy process of dying. If economics rather than justice for all patients is the primary impetus for the delivery of healthcare, the potential for injustice is ever-present.²⁴³

²⁴²See Cook, *Patients' Choice*, 217; and British Medical Association, *Medical Ethics Today*, 309. See also Timothy Quill, *A Midwife Through the Dying Process: Stories of Healing and Hard Choices at the End of Life* (Baltimore, MD: Johns Hopkins University Press, 1996), 216. The unstable healthcare delivery system in the United States has not escaped the view of advocates of a right to die. Quill writes that healthcare in the United States is undergoing radical reform. Today it is driven more by the need to control costs than by guidelines for improving quality and access. Quill noted that forty million Americans (at the time of publication) were without health insurance, and the number was growing. Beauchamp and Childress, 348. The authors state that thirty-seven million Americans (note the 1994 publication date) are without healthcare insurance. They also add that roughly 7 percent of uninsured Americans are uninsurable by current underwriting practices (note, too, that these policies do change, but that this statement reflects a general condition). Cf. British Medical Association, *Medical Ethics Today*, 300. The BMA adds perspective by clarifying that "cost" does not necessarily refer only to monetary considerations. The BMA is quick to add that a focus on financial costs primarily (for example, those who advocate the desirability of low-cost services) would contribute to . . . "low morale, stress, loss of compassion in healthcare providers, and reduced quality of relationship with patients." There are a number of articles in media sources that direct attention to the chronic nature of limited access to healthcare. Compare Charlotte Huff, "Texas Has Greatest Percent of Uninsured," *Fort Worth (Texas) Star Telegram*, 30 September 2002, sec. A, 1, 11. The article states that 14.6 percent of Americans were uninsured in 2001. This is approximately forty-one million people.

²⁴³Maxwell J. Mehlman, "Economic Motives for Physician-Assisted Suicide"; internet, available at [http://www.thedoctorwillseeyounow.com/articles/bioethics/asst suicide_6/](http://www.thedoctorwillseeyounow.com/articles/bioethics/asst%20suicide_6/); accessed 24 April 2004. Mehlman writes that the debate about PAS is filled with concern over the role of economic factors.

A third commonly held principle is to treat *according to need* which is the most basic and widely used standard for medical judgment.²⁴⁴ When applied to the just allocation of medical resources, the issue is complex, involving such weighty decisions as deciding whether a patient lives or dies, applying ordinary or extraordinary treatment options, or distinguishing between reasonable and unreasonable patient requests. Each patient and physician routinely make assessments, whether consciously or unconsciously, regarding what is essential for the life of that patient. When the two differ about what constitutes “true need,” the potential exists within the DPR for conflict at worst and stress at best.²⁴⁵ The physician may determine that the patient’s “need” is merely a “wish” and refuse to do what the patient desires. An infertile woman may desire to have a child, for example, and consider fertility treatments a “true need,” a conviction with which her doctor may disagree. The discussion of “need” might be complicated further by resource limitations and obligations. Typically, the greatest and the most urgent patient needs receive priority. This principle is used to invoke, interact with, and often challenge the notion of justice when the patient perceives that his own interests either have not been considered or his medical condition has been relegated to lesser-priority status in the face of another’s greater need of resources.

A final commonly held principle used to assess the concept of justice in resource allocations is *treating according to the right to treatment*. This tenet implies a “fair distribution” based upon a “right” for all persons in need to receive medical care. However, even if such a claim could be considered binding, many problems collect around this guideline. Much confusion and debate surrounding right’s claims exist. For example, patients and doctors wonder whose rights are to be protected, what constitutes having the “right” to treatment, what

²⁴⁴British Medical Association, *Medical Ethics Today*, 312. Cook, *Patients’ Choice*, 214-16.

²⁴⁵The issue of conflict between doctors and patients has deeper implications than assessing the validity of patient “need.” The subjects of patient autonomy and physician paternalism will be discussed in ch. 3 of the thesis (147, 173).

kind of treatment and how far that treatment will apply to the individual patient's illness, and what governing body determines who chooses the "rights" and the "treatments" which will be addressed in applying this principle.²⁴⁶

People claim the right to live, a right to have an abortion, a right to have a baby, and even, of late, a right to die.²⁴⁷ However, insuring that a patient has a right to *treatment* does not serve as warranty for the result; nor does it necessarily guarantee that the treatment would follow the desires of the individual patient in question. The successful implementation of the principle of treating according to the right to treatment, then, rests upon a strong consensus among the medical community, physicians, and patients, who work within present medico-legal systems to provide equitable care for the greatest number of persons.²⁴⁸

²⁴⁶See thesis, ch. 1, 36-39. A central concern in the PAS debate has centred on the source of ultimate authority in decision-making. Religion, government, and medicine have been cited as areas of imposed authority.

²⁴⁷See Cook, *Patients' Choice*, 219. One might note here that outside the realm of this specific context (patient treatment within the resource allocation discussion), are the overwhelming realities of the logistical difficulties associated with global diseases, like the AIDS epidemic, for example, or worldwide starvation. These and other global health issues are dire and complex situations with implications of monumental proportions. The sheer numbers of patients or victims in each of these examples is staggering. A viable solution seems to remain far beyond the financial reach of most governments or private agencies at this time. The principles articulated above, then, are not yet used to inform decisions about justice for persons affected by these issues.

²⁴⁸Cook, *Moral Maze*, 141. "Rights," such as the right to honesty and respect apply to patients and doctors equally. It remains questionable, however, whether it is just to *require* a physician to treat any given person. Some advocates of this position insist that every person has a right to a physician's treatment, which would then place a burden on that physician to perform the specified treatment. Neither aspect is necessarily true, however, for there may be cases in which a patient *does not* have the right to a physician's care. Furthermore, even should the patient gain the right to treatment, that physician may not be compelled to act as the patient desires. A patient, for example, might desire an unlawful course of treatment. Herein lies a weak argument in the PAS debate.

Another faulty argument is heard when people confuse the concepts of justice and charity, and suggest solutions to modern healthcare problems based upon misconceptions of the terms. Beauchamp and Childress indicate that proposals to alleviate unfair distribution of healthcare and resources have often centred not on justice but on charity, benevolence, and compassion toward sick persons. See Beauchamp and Childress, 349. While a doctor may treat a patient without charge out of compassion, or as a "charity case," and while his action may be commendable in many respects, it does not follow that charity is equal to "justice."

Patient rights, and the way that those rights are acknowledged and addressed by the medical community, often influence patient perceptions about whether justice has been served. A closer look at the medical principles listed above, particularly the first three guidelines from the perspective of the patient, reveals a significant reason for some of the patient unrest within the last three decades. Whether a medical decision regarding justice revolves around treating a patient equally, according to his ability to pay, or according to his need, the primary agent in control is rarely the patient. For example, the patient's inability to be in control of his own life may be a product of happenstance or necessity.

It may be a result of public policy unconditionally applied. It may be the result of a physician's decision or his healthcare programme's provisions (or lack thereof). Regardless of the reason, the reality is that the patient often perceives himself to be without input into the decisions made on his behalf which affect his future condition.²⁴⁹ In seeking the care of a physician, a patient expects interaction about his condition and course of treatment. When this communication does not satisfy the patient's expectations, the patient sometimes suffers.²⁵⁰

Resource allocations may also contribute to the patient's distress by limiting the range of options for care, whether that is in the UK or the US.²⁵¹ In fact, the justice-based goal of universal access to healthcare coverage often conflicts with current pressing healthcare practices connected to healthcare financing and delivery systems that allocate resources and their treatments with sometimes severe restrictions.²⁵² The place where expectations of the ideal and the reality best meet together with the concept of justice is in the DPR.

²⁴⁹In the United States where managed healthcare is prominent, sometimes the doctor is not in control either.

²⁵⁰Cook, *Moral Maze*, 141.

²⁵¹Compare Beauchamp and Childress, 365.

²⁵²*Ibid.*, 375.

Justice Applied in the Doctor-Patient Relationship

The allocation of resources within the medical environment is one area of justice that is both hotly debated and difficult to depersonalise.²⁵³ Debate rages over claims of equal distribution of scarce resources, or if possible discriminatory action has occurred in distribution, giving rise to moral questions regarding human life and the best use of financial and other assets.²⁵⁴ One moral feature was recognised a generation ago when Ramsey discussed whether there was a line of moral reasoning that would aid in determining how one might answer the question of resource allocation. He clarified the issue by illustrating the moral dilemma a physician faces when he or she must choose among medically eligible patients, inviting a broader discussion of what moral model will ultimately be chosen and exercised, and whether the patient is to help make those decisions. Ramsey's moral analysis was helpful, particularly regarding the latter point.

Despite the centuries' long development of the term justice, which took a decisive turn when the individual was given consideration in claims about justice, medical praxis has lagged in acknowledging patient rights to participate in the decisions concerning his or her own health issues. In medical history, the emerging views of the patient, patient rights, and patient justice have loosely paralleled the corresponding growth of the broader views concerning autonomy, human rights, and justice. Cast in terms of the individual, the patient is an autonomous being, and his rights as a human being guaranteed for him certain rights associated with his own medical care.²⁵⁵

²⁵³Cook, *Patients' Choice*, 229. See also British Medical Association, *Medical Ethics Today*, 299-316. Cf. Beauchamp and Childress, 326-94. Their entire chapter on justice contains a key discussion of the subject of resource allocation. See also Cook, *Patients' Choice*, 208-21. Cook offers a clear overview of resource allocation with an eye to the patient.

²⁵⁴Ramsey, 239. Cf. Starr, 382. Starr writes that the cost question was the catalyst for examining other deficiencies, including the 1970's lists of medicine's inadequacies.

²⁵⁵See thesis, ch. 1, 34-39. The case of the treatment of a terminally ill patient, for example, has become a moral and ethical focus in the PAS debate.

The concept of justice, or “fairness,” became significant as he interacted with the various constituencies from his healthcare arena, particularly as funds, distribution of resources, treatment options, and competition with other patients for the same services grew increasingly complex. The potential for moral conflict in this progression emerged as patients consulted with their healthcare personnel, particularly if unrest and indecision characterised the latter’s views of patient access and control regarding healthcare.²⁵⁶ Still today the questions addressed by both patients and physicians revolve around the best methods to employ to help patients, how good patient health will result from those treatment decisions, whose definition of what is ultimately “good for the patient” will predominate, and how justice will be employed to ensure the fulfilment of that “good” ideal.

Justice and the Definition of “Good”

One area where the claims of justice are often applied in the DPR concerns the definition of what is best, or the “ultimate good” for the patient.²⁵⁷ The doctor’s view and his

²⁵⁶Beauchamp and Childress, 326. The authors ask a chapter-opening question whether or not inequality in access to healthcare is a moral problem in discussing the difficulty of balancing patient claims with beneficence. Engelhardt notes the same (121). H. Tristram Engelhardt Jr., *The Foundations of Bioethics* (New York: Oxford University Press, 2d ed., 1996), 121.

²⁵⁷See Cook, *Patients’ Choice*, 210. Decisions about an individual patient’s healthcare still largely depend upon the physician. Establishing priorities in healthcare at local or public policy levels is also an area in which patients have little input. One tool that has been developed by health economists for such decision-making is “Quality Adjusted Life Years” (QALYS). The approach attempts to measure the quality of life (hereafter referred to as QL) in terms of the number of years that a patient might be given from a particular treatment. It also seeks to measure QL enjoyed by the patient. Compare British Medical Association, *Medical Ethics Today*, 304. See also Beauchamp and Childress, 368-69. The authors cite Oregon’s use of QALY (the Beauchamp and Childress acronym does not include the “S” used in Cook’s work) as one that raises questions of justice. The authors note that utilitarian criteria are used as part of the Oregon plan where the “life-sustaining impact of a treatment is weighed.” Medical judgment of quality life years, however, may not correlate with patient self-estimations, and these self-estimations may vary radically from one patient to another, forming the question, “What type of endpoint is worth paying for?” The determination of what is a patient’s “ultimate good,” therefore, derives not as much from the relationships between patients and their doctors as much as from a formulaic assessment tool that may by-pass patient input. The answer to this question, of course, depends upon how patient quality care is assessed. Some research entities

determination of what constitutes “good” often shape the medical decisions made within the DPR.²⁵⁸ For example, a patient might view her preference for a costly fertility treatment as the “ultimate good” for her life, worthwhile because it offers the potential to satisfy her concept of personal happiness--i.e., to bear a child. While her doctor might agree that her goal to become a mother is a good one, he may still refuse to recommend the treatment, not because he does not believe it would be good for her to be pregnant, but because the treatment, for a variety of reasons, may not be the best option.

Questions about what is *best*, or what is “ultimate good” for patients, evoke input from many corners of the medical community. The *best* use of resources, considerations regarding “well-being over a lifetime,” and fairness also figure into decisions made about patient treatment. The latter consideration, what is “fair treatment,” in part grows out of the practice of excluding patients from key decision-making opportunities regarding their health. Fairness, a key element in justice, implies that a person is given equal opportunity to choose options best suited to his happiness or well-being, inasmuch as he is able, based upon the principle of the worth of human life.²⁵⁹

The centuries’ long development of human autonomy, rights, and justice has contributed to this positive view of human worth. Dworkin recognises such a need for human beings to experience a sense of worth, especially as he relates this idea to a government’s responsibility in protecting an individual citizen’s rights. He states that the government’s role is

use individual/group patient test scores.

²⁵⁸Starr, 379. Starr notes that at one time medical professionals were thought to be best equipped to decide how to organise the healthcare needed by Americans. This view, he states, began to change in the 1970s.

²⁵⁹Kelner and Bourgeault, 758. The authors state that a prolonged dying process that is marked by medical interventions can produce for a patient a life that he or she might not choose. See also Dworkin, *Life’s Dominion*, 180, 209-10. Dworkin writes descriptively about the loss of dignity that often accompanies being kept alive by doctors who see patients not as people but as “battlefields.”

to protect rights; in part, to preserve human dignity.²⁶⁰ Patients may also wrestle with deeper issues of an existential variety that lie beyond the pale of medical technology or a doctor's control. For example, patients often face a moral crisis of trying to maintain QL when faced with an advancing illness, or to maintain emotional and physical stability when their diagnosis or prognosis is unknown, both of which are important and worthy of physician sensitivity and awareness.²⁶¹

Whether these weighty decisions concern routine health or terminal care, the delivery of "ultimate good," "fair," and "just" healthcare is a legitimate perplexity in America, where the reality of privatised health insurance leaves the uninsured and less financially able often deprived of necessary treatment. Similar questions surface also in the United Kingdom where financial constraints seem to be a perennial issue, impacting physician and hospital decisions regarding the level and quality of care offered to patients.²⁶²

Veatch, by way of example, illustrates this evaluative process at work in a discussion of the just allocation of resources and the assessment of what is best for the patient related to

²⁶⁰Dworkin, *Taking Rights Seriously*, 198-99; and see also idem, *Life's Dominion*, 210-11.

²⁶¹Linda Ganzini and Susan Block, "Physician-Assisted Death: A Last Resort?" *New England Journal of Medicine* 346, no. 21 (May 2002): 1663-65; internet, available at http://www.deathwithdignity.org/resources/articles/nejm_5-23-02.htm; accessed 7 December 2002. Studies on Oregon ALS patients indicated that patient requests for PAS were based upon concerns with loss of autonomy, control, independence, and the ability to pursue pleasurable activities. HIV patients have cited the fear of worsening symptoms and of function as well as the progressive loss of the ability to maintain close relationships as reasons for requesting PAS. What may be concluded is that the basic fears regarding encroaching loss of autonomy or independence, affecting relationships and daily routines, is common to both groups requesting PAS.

²⁶²See Beauchamp and Childress, 369. See also British Medical Association, *Medical Ethics Today*, 299. The BMA states that it has been questioned whether the NHS was ever really expected to pay for itself. Traditionally priority has been given to medical need and to welfare maximisation, leaving those with learning disabilities, mental illnesses, the physically disabled, and the elderly most often vulnerable.

xenotransplants.²⁶³ He would argue for the autonomy of a competent patient to enter into a voluntary agreement with his doctor to receive healthcare. Veatch considers the autonomy claim of the patient to be a primary element in the DPR when both parties understand that the requested treatment will bring “well-being over a lifetime.”²⁶⁴ The patient expects that his desired course of treatment will be followed by the physician and that the patient’s own “ultimate good” will be the result. This ideal progression does not always follow, however.

Many other factors enter into the DPR at the point of determining what the patient perceives as “good” or “just,” often placing stress on the DPR. When these assessments are made, including such routine matters as treatment costs,²⁶⁵ they can leave a patient groping for a sense of justice and fair treatment. This potential for friction in the DPR exacerbates when

²⁶³Robert M. Veatch, *Death, Dying, and the Biological Revolution: Our Last Quest for Responsibility* (New Haven, CT: Yale University Press, revised edition, 1989), 204. Veatch writes that those who are more concerned with autonomy and fairness than with maximising utility would find a prohibition of xenotransplantation hard to justify. The utilitarian argument might be to forego the transplantation of a baboon heart into a child because it is difficult to determine how much good eventually will come from xenotransplantation.

In a case, for example, of a young adult mother with two small children, a utilitarian calculation of the aggregate good of performing a transplant may be required. The just course of action would be that which would maximise the aggregate good. Of course, it might be in the interest of a utilitarian to grant such a costly procedure for a young mother because of the negative aggregate utility (the privation of young children left without their mother) that such a prohibition might incur. Veatch, however, fails to take into account what the general effect of the procedure would be on the general population. See also Beauchamp and Childress, 335-36. Here the authors discuss the limit of a utilitarian approach as it relates to individual rights. When the utilitarian focus is aggregate welfare, the possibility exists that weak or vulnerable persons might be harmed.

²⁶⁴Compare Veatch, *Death, Dying and the Biological Revolution*, 204-5. Veatch argues for a theory of justice that “considers well-being over a lifetime as the basis for allocating resources.” He asserts that “fairness” requires that a person be given the opportunity to have well-being over a lifetime that is equal to the well-being of others over the same period, an idea which assumes, of course, level playing fields from which to start. Veatch’s view begs the question, however, because it assumes that the patient’s view of well-being is the sole arbiter of fairness in such decisions. The basis of such a patient right’s perspective is tenuous at best, because it assumes a universal positive right to healthcare. Further, his view is weighted heavily toward the patient’s PH assessment. This could create a medical-financial nightmare. His view also places medicine in the unfortunate and impossible role of “leveling the playing field.”

²⁶⁵Cook, *Patients’ Choice*, 210.

patients and doctors hold differing views about extending life in the face of critical end-of-life choices. Doctors, for example, have new technologies and drugs that enable them to sustain life and to treat previously irremediable diseases; yet, these are not merely costly, straining the limited resources available to physicians, patients, and the medical system, but often levy emotional and physical burdens which those patients and their families must decide whether or not to take. QL questions relate to the definition of “good” for *all* persons involved.

Verhey corroborates that human finitude adds to the difficulty of these decisions about “patient good.”²⁶⁶ Since human beings are finite, and medicine—even for all of its advanced technical wizardry—is also limited in what it may accomplish, tough choices sometimes must be made.²⁶⁷ One of the most poignant places where questions about justice arise is at the point of terminal illness. Patients and their families seek treatment based upon a perceived claim to “justice” when technological intervention, which may or may not be available, may extend life. Yet, even hospital administrators operate within the harsh realities of choices when dealing with a finite source of funds with which to purchase equipment and operate medical units.

At a different level, human and time resources are also finite. Nurses and doctors struggle with the inability to meet the medical and relational needs of dying patients while other patients, concurrently, call for physicians’ attention and time from a perceived equal claim for “just” treatment.²⁶⁸ Finite limitations, then, contribute to the confusion which exists when claims of justice affect the DPR, especially when an individual patient’s desires for his own “ultimate good” either actually go unmet or are perceived to have done so. The disparity and complexity of representative views render the application of guiding principles difficult.

²⁶⁶ Allen Verhey, “Sanctity and Scarcity: The Makings of Tragedy,” in *On Moral Medicine: Theological Perspectives in Medical Ethics*, ed. Stephen E. Lammers and Allen Verhey (Grand Rapids, MI: William B. Eerdmans Publishing Co., 2d ed., 1998), 975. He uses the term “tragedy” in reference to the “Sophoclean” proportions of these decisions.

²⁶⁷ *Ibid.*, 976.

²⁶⁸ *Ibid.*

Summary

Discussions regarding the search for definitions and applications for the concept of justice are important. Because no widely recognised consensus has yet been reached concerning *meaning*,²⁶⁹ the practice of wielding the term “justice” very often confounds, rather than elucidates, the arguments people and institutions use to call for specific actions. Differences in views about what is the “ultimate good” for patients, the stewardship of resource allocations, and even human finitude, affect decision-making and further complicate the DPR, even more so when basic terminology remains unclear. Nevertheless, because the root concepts inherent within the idea and practice of justice historically were fairness, desert, and entitlement, these elements impact how medical care is expected to be practised in its moral and ethical dimensions.²⁷⁰

Justice has been used to claim that a physician is obliged to satisfy a patient’s preferences in the DPR, even to the level of assisting a terminally ill patient with suicide. This claim may not be based upon the historical view, however, for in the long development of the term in medical circles, “justice” has consistently championed the preservation and enhancement of human life. Despite the historical view, PAS proponents still claim that sometimes a justice claim obliges a doctor to aid a patient’s preferences by providing the knowledge and means necessary for suicide. The converse argument is *also* used in support of PAS--some proponents question whether the acts of *prohibiting* or *denying* PAS are, in fact, “just.” Today, in addition to the rights’ and justice claims, PAS advocates question the fairness or rightness of *requiring* a terminally ill patient to suffer a painful and protracted death. PAS advocates emphasise one feature of the principle of beneficence which refers to a moral

²⁶⁹Beauchamp and Childress, 326-27.

²⁷⁰Kelner and Bourgeault, 758. The authors cite R. Blauner, “Death and Social Structures,” *Psychiatry* 29 (1966): 378-94. Eighty percent of patients, for example, die in hospitals and long-term care institutions. The nature of the bureaucratised system means that the dying process is often subjugated to the hospital’s requirements.

obligation for a physician to act for the benefit of others. In some cases this would mean assisting with the suicide of a patient. It is believed the physician is obliged morally to further the broad continuum of patient preferences,²⁷¹ even assisting with a patient's suicide, which in some cases is believed to be a legitimate patient interest. The phase of this stance which supports "medical killing" is the content of the next section.

Medical Killing, Hedonistic-Utilitarianism, and Physician-Assisted Suicide

Introduction

The final claim addressed by this chapter is that medical killing is sometimes permissible and, indeed, even morally obligatory for physicians, especially when the two principles of autonomy and mercy are present in selected circumstances.²⁷² Sincere physicians,²⁷³ philosophers,²⁷⁴ and grassroot supporters²⁷⁵ advocate this permissibility of the

²⁷¹See ch. 1, 36-37.

²⁷²Battin, "Is a Physician Ever Obligated?" 32-33, 36-37. Battin writes that all sides recognise these two fundamental moral principles, but she admits there may be differences in belief about their relevance in the issue of PAS. Timothy E. Quill, "Physician-Assisted Suicide Is Moral," in *Physician-Assisted Suicide*, ed. Daniel A. Leone (San Diego: Greenhaven Press, 1998), 17. Quill reasons that PAS motivated by compassion can be moral and ethical, if not legal. Sissela Bok, "Euthanasia," in *Euthanasia and Assisted Suicide: For and Against*, ed. Gerald Dworkin, R. G. Frey, and Sissela Bok (New York: Cambridge University Press, 1998), 110. Such a claim might at face value seem contradictory in light of the medical principle of non-maleficence, but this claim is receiving a hearing in current medical dialogues. The idea of a physician taking a life raises ghosts of past war atrocities and fears of recurrences. PAS advocates insist, however, that such atrocities would not become reality again. See, Quill, "Physician-Assisted Suicide," 16. Cf. Humphry and Wickett, 46. Humphry and Wickett reason that the Nazi euthanasia programme failed because it was clandestine instead of voluntary, and because it lacked mercy. Beauchamp and Childress, 231-32, 239-40.

²⁷³Quill, "Physician-Assisted Suicide," 17. While not using classical utilitarian language, Quill's reasoning suggests a consequentialist approach. Suicide, he determines, can be rational, if the circumstances are hopeless for the terminally ill patient. Joseph J. Fins and Matthew D. Bacchetta, "Framing the Physician-Assisted Suicide and Voluntary Active Euthanasia Debate: The Role of Deontology, Consequentialism, and Clinical Pragmatism," *Journal of the American Geriatric Society*, 43, no. 5 (May 1995): 563-68.

The authors outline three representative positions in the PAS/VAE debate. Consequential arguments, according to the authors, form the bulk of the literature on the subject. Quill's position, stated above, fits patterns of consequential approaches to PAS/VAE.

medical killing claim within the medical community. At the same time, spokespersons in the same categories²⁷⁶ oppose strongly any change in the historical position that the philosophy and practice of medicine has opposed killing patients. Advocates and opponents have lined up to give and garner support on either side of the issue, and much has been written to argue for the respective positions. The possibility that medical killing may be legalised engenders moral concerns, even implications, for the DPR. In the midst of a shifting cultural and medical climate, conceptual distinctions are difficult to establish, leading to confusion when trying to determine the exact meaning of, and boundaries for, medical killing.

Cf. Marcia Angell, "Helping Desperately Ill People," 17. Angell writes that the problem of aiding people who face prolonged dying is so great that "we cannot ignore it." Lee, et al., 310-15. The authors conducted a survey among physicians in Oregon and found that 60 percent thought PAS should be legal in some cases, indicating at least some openness to the idea among one segment of the medical community in that state.

²⁷⁴Battin, *Ethical Issues in Suicide*, 109. Battin writes, "The death of a person who is less happy than average is to be welcomed provided, of course, that death does not produce new unhappiness for surviving individuals." She also comments that where a balance of benefits over injury will accrue to others from the suicide of a person, then it may seem that the suicide ought to be encouraged, since there would be no harm to the deceased (107). See also Rachels, *End of Life*, 156. He writes that the utilitarian argument from mercy still has considerable force even if the promotion of happiness and the avoidance of misery are not the "only" morally important things. Stating that these are still very important, he points out that should an action *decrease* misery, the misery reduction would render the action commendable.

²⁷⁵Compare Larry R. Churchill and Nancy M. P. King, "Physician-Assisted Suicide, Euthanasia, or Withdrawal of Treatment: Distinguishing Between Them Clarifies Moral, Legal, and Practical Positions," in *British Medical Journal* 315, no. 71701 (July 1997): 137-38. Polls show 60 percent of the American public favours legal reforms that would permit PAS to end the suffering of competent patients. For similar assertions, see also Meier, et al., 1193.

²⁷⁶British Medical Association, *Medical Ethics Today*, 157-58, 174-77. Edmund Pellegrino, "Doctors Must Not Kill," *Journal of Clinical Ethics* 3, no. 2 (Summer 1992): 95. Pellegrino argues that doctors should not kill, even out of compassion. Cook, *Patients' Choice*, 156. Luke Gormally, ed., *Euthanasia, Clinical Practice and the Law* (London: Linacre Centre for Health Care Ethics, 1994; reprint edition, 1995), 42. Humphry and Wickett, 162-69. Humphry and Wickett name a number of individuals who oppose euthanasia--including former United States Surgeon General, Dr. C. Everett Koop, and the UK's Malcolm Muggeridge. Muggeridge, now deceased, headed the Festival of Light movement at the time Humphry's and Wickett's book was printed. Cf. the anti-euthanasia advocacy group "International Task Force on Euthanasia and Assisted Suicide: About the International Task Force"; internet, available at <http://www.internationaltaskforce.org/about.htm>; accessed 2 February 2001.

Before evaluating the section claim, therefore, it is important to lay the groundwork for the discussion by defining the term “killing” and its various forms of common usage. Next, just as the previous sections traced the terms “rights” and “justice” across periods of broad paradigmatic changes, here the term “killing” will be examined in Ancient Greece, the Christian Era through the Middle Ages, the Renaissance, the Enlightenment, and the nineteenth-century to the present medical-ethical environment. Finally, the concept of medical killing will be analysed from the standpoints of medical ethics, utilitarianism, and law, as each of these contexts relates to PAS and the DPR.

“Killing Defined”

To “kill,” according to the *OED*, means “to put to death,” or “to deprive of life,” to “slay” or “slaughter.”²⁷⁷ In its early use the word implied personal agency and, most often, the use of a weapon. In general terms today, the word is used loosely, connoting various causes which might ultimately lead to a shortened lifespan--i.e., accidents, overwork, grief, drink, or disease.²⁷⁸ Just as this broad range of meanings and possible applications of the word may be found in current cultural parlay, the same is true about its usage by the medical community.

The meaning of “killing” has important implications for medicine where life-and-death situations occur on a regular basis. “Killing” represents a cluster of ideas that surround a central condition--that is, direct causation of another’s death.²⁷⁹ While the focus of killing within the realm of medicine specifically crystallises upon the ideas of intent and causation,²⁸⁰ the broader connotations related to medical killing render definitions complex. One of the sources of this complexity is the related concept of “allowing one to die.”

²⁷⁷*OED*, 2d ed., s.v. “kill.”

²⁷⁸*Ibid.*

²⁷⁹Beauchamp and Childress, 220.

²⁸⁰British Medical Association, *Medical Ethics Today*, 150.

Clarification

The distinction, if any, between killing a patient and allowing her to die has been the cause of serious discussion about the moral, ethical, even legal, implications of such deaths.²⁸¹ Thus, whether there is a *medical* distinction between “killing” and “allowing one to die” is important to determine. In either case, the *actor*, or *agent* of death must be considered. The one who acts as *agent*, or the cause of the death, historically has been linked to the responsibility for or consequences connected with the death. The distinction between the concepts is also significant because it bears implications for the related medical situations which form the basis of the PAS debate: between suicide and foregoing treatment and between homicide and natural death.²⁸²

In the instance of allowing a person to die, the central point is the absence of causal intervention or the decision *not* to employ treatment that would prolong life.²⁸³ These acts of omission themselves may seem simple enough to determine, whether from the patient’s or physician’s point of view. Yet, opponents of PAS argue that, if the physician makes the decision to allow a patient to die, to allow nature to take its course, to allow whatever may happen simply to happen, without intervention, his decision may be classified as “killing” if he intentionally withholds treatment from someone who *might* or *could* be treated *or*, for the purposes of this discussion, a patient who is terminally ill.

²⁸¹Raymond G. Frey, “Intention, Foresight, and Killing,” in *Intending Death: The Ethics of Assisted Suicide and Euthanasia*, ed. Tom L. Beauchamp (Upper Saddle River, NJ: Prentice Hall, 1996), 66. Frey questions whether there is a genuine distinction that may be extracted between *taking an action with the intent to cause death* and merely *foreseeing death as a result (“side-effect”) of one’s act*. If such a distinction may be extracted, Frey asks whether it may be used to evaluate moral differences between cases.

²⁸²Beauchamp and Childress, 219.

²⁸³Beauchamp, *Intending Death*, 7. In such a scenario the doctor might avoid intervening so that a “disease, system failure, or injury causes death” instead.

Today, terminal illness often extends for a lengthy period of time. Medical technology is sometimes used to sustain life, in many cases, well beyond the limits which would normally accompany the illness were intervention not used. The practice of using technology to sustain life has become a common flash point in the debate surrounding the issues of “killing” and “allowing patients to die” among some groups now seeking to clarify and alter established moral and legal boundaries that surround end-of-life decisions.²⁸⁴ The point is, PAS advocates argue, there is negligible moral difference between “killing” and “allowing to die” when it is certain that the patient would die relatively soon anyway.²⁸⁵ In this case, the argument reads, to forego treatment to allow death cannot be “meaningfully distinguished” from taking active steps to kill a person.²⁸⁶ In fact, a physician could be showing mercy to such a patient by

²⁸⁴Allen E. Buchanan, “Intending Death: The Structure of the Problem and Proposed Solutions,” in *Intending Death: The Ethics of Assisted Suicide and Euthanasia*, ed. Tom L. Beauchamp (Upper Saddle River, NJ: Prentice Hall, 1996), 24-25.

²⁸⁵This argument assumes that one can be truly certain when a person might die. See, for example, James Rachels, “Active and Passive Euthanasia,” *New England Journal of Medicine* 292, no. 2 (1975): 78-80; Ramsey, 162; and Beauchamp and Childress, 225. The authors reason that simply labeling an act as either “killing” or “letting die” does not help to determine whether one type of action is either “better or worse, or more or less justified,” than another type of action. They assert that the “rightness” or “wrongness” of an action depends not so much upon the act itself but, rather, upon the merit of the justification upon which the action is *grounded*. These authors would consider *essential* such factors as an agent’s motive (whether benevolent or malicious, for example), the patient’s request, the patient’s own motive, and the consequences of the act itself. Yet, the discussion these authors still avoid is the moral question concerning the nature of the action itself.

²⁸⁶There is a wealth of philosophical material focusing on the difference and/or distinction between killing and allowing a person to die. Authors discuss in intricate detail the issue and its implications related to euthanasia and physician-assisted-suicide. A representative sample of sources is cited here, where authors suggest that there are instances when the distinction between killing and letting die is, at times, morally insignificant. Rachels, “Active and Passive Euthanasia,” 78-80. Rachels wrote what is now considered a classic article on the subject. But see also Ramsey, 157-58. Ramsey dealt with the issue of hastening death six years earlier in his 1969 Lyman Beecher lectures at Yale Divinity School. See also Battin, *Least Worst Death*, 15-20. Beauchamp, *Intending Death*, 7.

Other authors write on the issue from different perspectives. See Cook, *Patients’ Choice*, 157-58, where he offers a concise and clear statement of the issue within a chapter on suicide and euthanasia. Cf. Gormally, 126-28, who discusses killing and justice along with Pellegrino, “Doctors Must Not Kill,” 95-102.

hastening death.²⁸⁷ Such claims, with their variant conclusions, add to other moral arguments, including those used at different points in the historical development of killing.

The topic of “killing” in the medical context surfaced at various times in history paralleling, in some instances, key developmental periods in the growth of humanism and autonomy.²⁸⁸ In order to clarify better the complexity of the issue, both when it occurred in history and in today’s debate, it may be helpful to examine historical discussions about distinctions between “suicide,” “killing,” and “allowing a person to die.” Interwoven throughout the developing understanding of the medical distinctions between the terms is a foundational question about what it means to be *human*.

Ancient Greece: Suicide and “Killing”

Ancient Greek medicine offers an early context for discussions about cases of “suicide,” “killing,” or “allowing patients to die.” The Hippocratic Oath, with its prohibition against physician-assistance-with-suicide, immediately comes to mind when one thinks of ancient medicine; yet today there is speculation about how widely the Oath was accepted and the prohibition practised. Attention has been given to the Oath’s apparent localised religious

²⁸⁷Rachels, “Active and Passive Euthanasia,” 78. Rachels adds to this argument another point, which is that of physician “mercy,” to justify the killing of a cancer patient who is in terrible agony. Thus, “mercy-killing,” or “euthanasia,” will be added to the discussion of this section.

²⁸⁸Humphry and Wickett, 8. See also, for example, the statement of Humphry and Wickett that a reawakened interest in individualism during the Renaissance aided a change in view about suicide. They see a link between a growth in humanism and a separation from the institutional controls of the Church. The implication is that Church views about suicide would, as a result, be brought into question. Their perceived link may or may not be the case but see, as another example from a slightly different context, W. K. C. Guthrie, *The Greeks And Their Gods* (London: Methuen & Co., 1950), 184. Guthrie writes of interstate warfare that characterised Ancient Greece from the fifth century onward and that helped to loosen the foundations of established traditions. This opened the way for natural philosophy, mysticism, and the sophist movement. Man’s religion might concern his individual soul and not his duty to the state. Both epochs were characterised partly by challenges to traditional concepts about being human. Paradigmatic changes were occurring in both epochs that may have more to do with changes in human concepts than any one individual factor, such as the loosening of Church controls.

influence and, in fact, to the likelihood that all of its injunctions were violated at one time or another from the period of Hippocrates through to Galen.²⁸⁹

Suicide, or self-killing, was known in Ancient Greece, practised relatively freely, and was aided by physicians in certain situations outside the boundaries of Hippocratic medicine.²⁹⁰ Suicides were categorised roughly as heroic and nonheroic. Suicide used to escape a “relentlessly painful illness or infirmity” fell into the latter category.²⁹¹ This kind of illness was thought to be incurable in nature and generally, though not always, linked in some way with advancing old age.²⁹² A doctor possessed lethal drugs, held the unique position to declare a patient untreatable and, if so requested, could provide a patient with an appropriate “cup of death.”²⁹³ In Ancient Greece, then, suicide was not unknown. This drinking of poison to cause

²⁸⁹Ludwig Edelstein, *The Hippocratic Oath: Text, Translation and Interpretation*, Supplements to the Bulletin of the History of Medicine, ed. Henry E. Sigerist, no. 1 (Baltimore: Johns Hopkins Press, 1943; reprint edition 1964), 63.

²⁹⁰See Edelstein, 9, 15. Edelstein paints a different picture of the Hippocratic physician when he writes that a patient would consult his own doctor first, or urge his friends to speak with the doctor. If his physician confirmed the seriousness or hopelessness of the case, the physician would suggest directly or indirectly that the patient commit suicide. Edelstein cites Pliny, *Epistulae*, I, xxii, 7 ff. Edelstein’s point is that suicide was both practised and accepted throughout antiquity, was aided by physicians, and that the Hippocratic influence was not as pervasive as it has been made out to be.

²⁹¹Carrick, 133.

²⁹²*Ibid.*

²⁹³*Ibid.* Carrick states that suicide was made easier in this period because by the late Hellenistic and Roman Imperial Period, the religious stigma attached to suicide had all but lost its force. Civil penalties against suicide, except in the case of soldiers and slaves (whose lives were considered valuable for militaristic and labour needs, respectively), were practically unknown by this time. Hemlock was one of a variety of methods used to commit suicide. Ludwig Edelstein, *Ancient Medicine*, ed. Owsei Temkin and C. Lilian Temkin and trans. C. Lilian Temkin (Baltimore: Johns Hopkins University Press, paperback edition, 1987), 11. Edelstein and, to a lesser degree, Carrick overemphasise the role of the physician in the ancient practice of euthanasia. The emphasis in Ancient Greece was on the *ways* a person might take leave of life with peace of mind, hence “good death.” The physician’s “cup of death” was but one of a number of ways that a *patient* might *choose to* commit suicide.

one's own death, provided by one's physician, however, does not correspond to the modern understanding of the term "euthanasia" or PAS.

In Ancient Greece, "euthanasia" was broader in scope²⁹⁴ and, in fact, was not practised at all in the sense of taking the patient's life for benevolent motives.²⁹⁵ The physician's Oath required him to attend primarily to his guild, to care for his patients, to preserve life according to established ethical parameters. The physician's reputation as a healer was highly prized; therefore, even if for beneficent reasons, for a patient to die would have severe negative consequences on the physician's own social and medical standing.²⁹⁶

In this period, involuntary euthanasia was not a part of the Greek's general concept of euthanasia at all. Instead, the broader concept of euthanasia included an element that is often included in the meaning of *voluntary* euthanasia today. A patient's prior consent was implied, based upon a genuine human concern for a patient's *psychological state of mind*. It was considered morally significant that a patient remain *free to make a reasoned decision* regarding the option to hasten or not to hasten his or her death.²⁹⁷ Even though this period was well before

²⁹⁴New York State Task Force on Life and the Law, 78. Carrick, 127. Carrick notes that the linguistic result of the development and subsequent use of hemlock in the fifth century B.C. was that these forms of suicide were sometimes, although not categorically, described as instances of "euthanasia." His conclusion about terming such acts as "euthanasia" begs the question, even if he notes that the focus with euthanasia was on a patient's state of mind, not on the means of death. There is an element of conjecture to Carrick's claim, notwithstanding his attempt at historical accuracy.

²⁹⁵New York State Task Force on Life and the Law, 78.

²⁹⁶Edelstein, *Ancient Medicine*, 51, 76-77. Reputation, in this sense, was lasting fame in the eyes of society. Physicians prized being well-considered in their communities and acquiring wide reputations for correct prognoses. See also Carrick, 89-90. Carrick attributes this physician-motivation to "acquit himself" well partly to acquire and preserve a good reputation, although surely there were other equally valid reasons, such as a desire to relieve human suffering, the value of human life, and even less altruistic reasons such as the financial gain which accrued to the accurate and "successful healer." A different question altogether is whether physicians may have been involved in the suicides of patients if such assistance was "unknown" or secret.

²⁹⁷Carrick, 128. Carrick writes that the notable exception to all of this discussion was infanticide.

the time when a patient might think of himself in terms of being an individual with independent autonomy, the concept of *voluntary* euthanasia, then and now, is similar in that such action would require the *choice* of suicide.

Other similarities include the general assumption that a physician would be involved in euthanasia primarily through diagnosis and prognosis,²⁹⁸ with the emphasis trained upon the patient's psychological state of mind. Moral appraisals seem to have been of secondary concern.²⁹⁹ Thus, a typical question in ancient Greece might have been whether the decedent met death *voluntarily*, with peace of mind and minimal pain. One further consideration supplies instruction to the Greek reflection on medical killing. Edelstein suggests that the primary reason for the Hippocratic proscription of euthanasia was the influence of Pythagorean religion which opposed the practice. Edelstein argues that the Hippocratic Oath was written by the Pythagoreans as a moral authority to limit a physician's role in these situations, regardless of the physician's motive concerning his patient.³⁰⁰

²⁹⁸Edelstein, *Ancient Medicine*, 11-12.

²⁹⁹While this psychological state-of-mind element remains a part of end-of-life discussions, today there is often an added concern--whether the death is *morally justifiable*. Carrick, 129. Carrick does not suggest that the Greeks were "oblivious" to the "moral challenge" presented by voluntary euthanasia. However, Carrick writes that the *focus* today is different--the question is whether euthanasia may be morally justifiable under any condition.

See also Erich H. Loewy, "Harming, Healing, and Euthanasia," in *Regulating How We Die: The Ethical, Medical and Legal Issues Surrounding Physician-Assisted Suicide*, ed. Linda L. Emmanuel (London: Harvard University Press, 1998), 52-53. Loewy points out that the discussion of Greek physicians targeted whether *doctors* should be permitted to hasten a death rather than the more "general" issue of whether *any person* should be allowed to kill. Edelstein, *Ancient Medicine*, 11-14. Edelstein indicates that since suicide was commonly practised, that there was no substantive ethical consideration given to the distribution of poison to a patient. Timothy E. Quill, "Death and Dignity--A Case of Individualized Decision Making," in *Arguing Euthanasia: The Controversy Over Mercy Killing, Assisted Suicide, and the "Right to Die,"* ed. Jonathan D. Moreno (New York: Simon & Schuster, Touchstone Book, 1995), 59. Quill, in the now classic case, writes of Diane's "preoccupation with her fear of a lingering death." Her psychological state played a primary role in his decision to assist with her suicide.

³⁰⁰For a counterview see Darrel W. Amundsen, "The Significance of Inaccurate History in Legal Considerations of Physician-Assisted Suicide," in *Physician-Assisted Suicide*, ed. Robert F. Weir (Bloomington, IN: Indiana University Press, 1997), 5. Amundsen writes that Edelstein's support for his view of Pythagorean authorship of the Hippocratic Oath is now

At the same time, it is interesting to note that Carrick also discusses at some length the Pythagorean opposition to suicide on religious grounds.³⁰¹ Correspondingly, he cites the contribution religious thought gave to Socrates' arguments against most forms of suicide.³⁰² It seems that a broader, though still ill-defined religio-moral current, perhaps flowing out of natural law, contributed to early moral awareness of issues like killing.³⁰³ Since Ancient Greek belief in the pantheon of gods, to a greater or lesser degree, was part of a framework which predated Christianity's influence on the subject of suicide, an earlier moral influence than has been previously considered may have some validity. However, the moral aspects of assisted death still seemed of lesser importance to physicians in Ancient Greece than the psychological state of the deceased. It was Christianity which ushered in a new viewpoint.

accepted by few, if any, specialists in ancient medical history.

³⁰¹Carrick, 134-36.

³⁰²Ibid., 137. Compare *Phaedo*, 62c-4, "No man has the right to take his own life, but he must wait until God sends some necessity upon him, as he has now sent to me" with Aristotle's opposition to suicide in *Nicomachean Ethics* V. 10.

³⁰³Guthrie, 184. Natural law discussions seem to resurface throughout history at key times of paradigmatic, social, or political changes. For example, see Daniel Westberg, "The Reformed Tradition and Natural Law," in *A Preserving Grace: Protestants, Catholics, and Natural Law*, ed. Michael Cromartie (Grand Rapids, MI: Eerdmans, 1997), 103. Westberg notes that there was a "rehabilitation" of natural law among Protestants in the late 1960s as a reaction against situational ethics. One stabilizing current of thought, apart from traditional monotheistic faiths like Judaism and Christianity, that influences issues like euthanasia and suicide during times of political or social change may be natural law. Natural law theory may be rooted in the human mind, nature, or in the mind of God and, as noted above (57, footnote 19), "natural law" and "natural rights" have a two thousand year history. See also Russell Hittinger, "Natural Law and Catholic Moral Theology," in *A Preserving Grace: Protestants, Catholics, and Natural Law*, ed. Michael Cromartie (Grand Rapids, MI: Eerdmans, 1997), 2. Hittinger believes that contemporary literature shows there is little or no agreement as to how the three foci (human mind, nature, or the mind of God) ought to be integrated. It is conceivable, then, that Edelstein's critique of Pythagorean religious influence is too narrow, and that a contributing factor to early moral reflection on death matters like euthanasia, may have originated from within a collective pool of natural law thought.

The Christian Era, and the Enlightenment

Early Christians opposed all suicide as being morally unacceptable.³⁰⁴ Augustine's (354-430) and Aquinas' (1225-1274) views provided an axis of opposition against suicide that influenced and shaped culture until the fourteenth and fifteenth centuries. Augustine's proscription against suicide was aimed primarily at a Christian culture that he perceived to be infatuated with self-martyrdom, while Aquinas' opposition to suicide, though not as intense, was equally uncompromising.³⁰⁵ In the medieval period, most physicians were priests, and the practice of medicine was regulated by the Church.³⁰⁶ If the Christian influence and Church control were powerful influences over the *lives* of individuals, it should come as no surprise that their influence would affect equally the philosophy, customs, and concept of *death*.³⁰⁷

With the coming Renaissance, however, the rebirth of interest in Classical Antiquity took hold. A shift from the Medieval Christian prohibition of assistance with suicide may be found most clearly in the person and writings of Sir Thomas More (1478-1535). More favoured

³⁰⁴Loewy, 53. See also Humphry and Wickett, 8; and Albert R. Jonsen, "Criteria That Make Intentional Killing Unjustified: Morally Unjustified Acts of Killing that Have Been Sometimes Declared Justified," in *Intending Death: The Ethics of Assisted Suicide and Euthanasia*, ed. Tom L. Beauchamp (Upper Saddle River, NJ: Prentice Hall, 1996), 43. Jonsen writes that during the first five centuries of the Christian era, the Church Fathers almost unanimously repudiated killing for any reason whatsoever.

³⁰⁵Robert N. Wennberg, *Terminal Choices: Euthanasia, Suicide, and the Right to Die* (Grand Rapids, MI: William B. Eerdmans Publishing Co., 1989), 55-57, 65-66. Augustine, *The City of God*, ed. with an introduction by Vernon J. Bourke, forward by Etienne Gilson, and trans. Gerald G. Walsh, Demetrius B. Zema, Grace Monahan, and Daniel J. Honan (Garden City, NY: Doubleday & Co., 1958), 441. Augustine wrote that the fundamental command of nature is that a man should cherish life and shun death. A man should work with all his "might and main" to keep himself alive and to preserve the union of body and soul.

³⁰⁶Loewy, 53.

³⁰⁷Helga Kuhse, "Euthanasia," in *A Companion to Ethics*, ed. Peter Singer (Cambridge, MA: Blackwell, 2d reprint edition, 1994), 294. Kuhse states that most historians of Western morals attribute Judaism and the rise of Christianity to the general belief that life has sanctity and must not be taken. To take a life is to usurp the prerogative of God to give and to take life. Christian writers also see the taking of innocent life as a violation of natural law.

a society where euthanasia would be accepted.³⁰⁸ In his *Utopia*, More advocated the act of ending a life tortured by disease (through starvation or by being given a “soporific”) to put the person painlessly out of his misery. This was to be strictly voluntary.

Michel de Montaigne (1533-1592) argued in a related fashion that suicide was not a question of Christian belief but one of personal choice.³⁰⁹ Such views were countered by philosophers like John Locke and Immanuel Kant.³¹⁰ Locke opposed suicide and based his opposition on the grounds that man is God’s property. He also believed that a person was not to take the life of another person unless it was to deliver justice upon the offender.

Kant opposed suicide as well, but for a different reason than Locke’s. Kant viewed suicide as a paradigmatic example of an action that violated moral responsibility, a statement that contradicted historical discussions surrounding the idea of killing, even in his day.³¹¹ Kant’s approach is important because it vocalised a growing moral awareness surrounding life-and-death issues and gave direct moral force to an individual human life. He emphasised self-restraint apart from institutional controls³¹² and believed that killing a human life was a serious

³⁰⁸Loewy, 53. See also Humphry and Wickett, 7-8. Loewy agrees with Humphry and Wickett that euthanasia has become more popular in the current climate because of the growth of the concept of individualism, an idea foreign during the Medieval period. The authors note that a reawakened interest in individualism was at the centre of More’s perspective on suicide. See Thomas More, *Utopia*, trans. Paul Turner (New York: Penguin Books, 1981), 102. In an era before medical regulation, More’s focus was more directed toward allaying human suffering than advocating any particular change within medicine. It is noteworthy, however, that common considerations in his view were individual choice and medical mercy.

³⁰⁹New York State Task Force on Life and the Law, 80. New York State Task Force cites Ferngren, 159-61.

³¹⁰Locke, *Two Treatises*, 271; see also Kant, *Groundwork*, 89, 96-97.

³¹¹New York State Task Force on Life and the Law, 81. Compare More, for example, who felt that two good reasons for choosing suicide were the presence of prolonged, unbearable pain and the fear of a worse form of death than suicide itself.

³¹²See also Battin, *Death Debate*, 106-12. Battin recognises the difference in Kant’s position. The Greeks might have viewed life from the *biological* or *intellectual* perspective, but Kant’s view of human life as a *moral* life was different from the Greek view. His moral life view recognised the “capacity to generate and observe moral principle or law” (106).

moral error in most circumstances. Kant's approach was different from that of Locke's in that the basis for his belief was not God's ownership of man, but of man, himself, as a moral end.³¹³ While his argument did not yet include the notion that a person could direct another individual to kill him, it bore significant implications for a person's choice to take his own life. Even though Kant was opposed to such use of one's autonomy, his writings were used to support this growing idea.³¹⁴

For example, the eighteenth-century Scottish philosopher, David Hume, argued for the moral permissibility of suicide based on the grounds of individual autonomy and social benefit. He believed a suicide could be deemed laudable if the person's death would benefit the group and the individual. He did not advocate the position that all suicides were justifiable, but he did argue that a life plagued by suffering was an acceptable warrant for a suicide decision.³¹⁵ These varied views about human life and death, and the interrelated questions regarding self-killing, emerged during the Enlightenment when a fundamental change occurred in the way people began to consider the notion of human potential.³¹⁶ A claim that philosophers either solely or knowingly introduced this change would be an exaggeration, but it was curiosity, in some

³¹³Battin, *Least Worst Death*, 24. Battin uses Kant's strong autonomy argument to imply that even in cases where death is sought, the choice of the autonomous person ought to be respected. Kant's view of man as a moral end was significant in itself, but somewhat ironic because his belief in SL and its protection was later utilised by, and used as an argument for, those who believed the choice to kill rests in the hands of the autonomous individual.

³¹⁴*Ibid.* Contrast with Kant, *Groundwork*, 89. Kant would disagree with Battin's logic. His principle of autonomy has been misapplied from his original intention; nevertheless, it is still cited as support for autonomous decisions regarding assisted suicide and euthanasia.

³¹⁵New York State Task Force on Life and the Law, 80-81. See also David Hume, "On Suicide," in *David Hume: Selected Essays*, ed. With an introduction by Stephen Copley and Andrew Edgar (New York: Oxford University Press, 1993), 323.

³¹⁶Frederick Copleston, *A History of Philosophy*, vol. 6, Modern Philosophy (New York: Doubleday, Image Books, 1994), 1-3. Copleston explains the two sides of the French Enlightenment: the negative, anti-Church, and anti-Christian side; and the more positive aspect that consisted of an attempt to understand man and the world in his "psychological, moral, and social life." Copleston writes of man's use of reason to explore his world and the growth and extension of the scientific outlook (3).

cases, even scepticism, that pushed back the boundaries of human discovery in many arenas. Several events occurred during this period that proved to influence future thought about medical killing.

The first was a resurrection of the atomism of Democritus and Epicurus (at least an Enlightenment form of it) in the writings of the astronomer-mathematician, Pierre Gassendi (1592-1655). While Gassendi did not agree with the entirely materialistic worldview of Epicurus, he did help to re-inject the notion into the mainstream of philosophical thought. Indeed, in this seventeenth century, an atomistic revival of sorts, a scientific form of atomic theory first emerged.³¹⁷ The atomistic revival was congruent with the emerging scientific worldview that became sceptical about that which could not be empirically proven--for example, the existence of and claims about Deity.³¹⁸ The materialistic atomism of Democritus and Epicurus also served to trace an emerging humanism, based upon human reason, and no longer thought to be totally dependent upon the perceived external control of ecclesiastical dogma or institutions.³¹⁹

Part of the excitement surrounding this new humanism related to individual autonomy and how it would relate to a wide variety of human concerns--including life and death. Voluntary euthanasia, as understood in the contemporary sense, was not discussed *per se* in the seventeenth century. There was, however, a noticeable similarity between the Enlightenment

³¹⁷Andrew G. Van Melson, *From Atomos to Atom: The History of the Concept 'Atom'*, trans. Henry J. Koren, vol. 1, Duquesne Studies Philosophical Series (Pittsburgh: Duquesne University Press, 1952), 81.

³¹⁸Copleston, 6:3. The Enlightenment philosophers' rejection of religion was based upon the belief that it was an enemy of intellectual progress and of "the unimpeded and clear use of reason."

³¹⁹It is overambitious to suggest that Enlightenment thinkers envisioned the results of their inquiries at the time, but it is important that these atomistic views were rediscovered and reinterpreted afresh. Democritean and Epicurean atomism had been rejected by the Ancient Greeks, the Church Fathers, and medieval philosophers alike, and had lain dormant for many centuries. See Van Melson, 91.

view of *suicide* and that of Ancient Greece--that is, the notion that individual choice should be freed from external constraint. This did not mean that suicide, or assistance with suicide, was now to be considered morally permissible. That particular aspect of the debate would surface in the next era.

The Nineteenth Century, the Impact of Mill's HU, and the Present Medical Environment

Medical euthanasia was broached as a subject in the early part of the nineteenth century through an oral essay presented by Carl F. H. Marx. Marx (1826) criticised physicians who treated diseases rather than the patient. He insisted that physicians were not expected to have remedies for death, but that they should seek such remedies for skilful alleviation of suffering and apply them when all other channels had closed.³²⁰ Many voices echoed this thinking in the next few decades.

In the latter half of the nineteenth century, L. A. Tollemache pled strongly for the legalisation of voluntary euthanasia based upon a mercy claim.³²¹ In 1889, Dr. Frank E. Hitchcock urged physicians not to ignore the needs of the terminally ill, especially those in pain, and to assist the patient in and out of his suffering. He linked the reasons for aiding the patient's death not to mercy, like Tollemache, but to fairness and justice.³²² Again, at the turn of the twentieth century, a British physician, Dr. C. E. Goodard, suggested ways to terminate absolutely hopeless cases of injury and disease based upon a compassion claim.³²³

³²⁰Humphry and Wickett, 10. See also Liezl Van Zyl, 2. Van Zyl writes that Dr. S. D. Williams, in 1872, was the first to use the term *euthanasia*, in the modern sense of the *act* of painlessly "putting to death those suffering from terminal conditions."

³²¹Humphry and Wickett, 11. Even though he advocated a mercy-claim justification for voluntary euthanasia, Tollemache recognised that a physician, even if responding to an agonised patient's entreaty, would be held liable for manslaughter under the law at that time.

³²²Ibid.

³²³Ibid.

The historical development of the concept of medical euthanasia might seem compelling at the level of relieving the suffering patient; however, advocates spoke no more authoritatively than did those physicians who opposed the practice. The growth of the movement to support medical euthanasia was unsteady, but perhaps not totally unexpected, given that active killing became a topic of suicide law reform in this time period.³²⁴ What was unexpected, and of sobering significance, was the introduction of a new claim that medical killing--for the physician--is sometimes permissible, even morally obligatory, when the twin principles of autonomy and mercy are present. This claim insisted that doctors should become causal agents in aiding death. In this period, then, the historical discussion of *self-killing*, or suicide, evolved into a different field of discussion, that of *physician-caused killing*.

A patient might have previously implored a physician to offer aid-in-dying, but to argue that his terminal illness now *obliged* his physician to perform that service added a perceived level of moral force to the plea. Some people cite Kant's pre-political principle of legislation, which was based on human reason alone, to suggest that *just* civil arrangements were those that allowed for the most individual freedom.³²⁵ Since Kant postulated that human reason was the authority behind decision-making that helped a person to determine what was morally obligatory, Kant's justice views may have served as a partial philosophical link to this new claim. After all, Kant believed that a person ought first to discover that which was right in order to determine that which was good.³²⁶ However, considering the fact that Kant was opposed strongly to the concept of suicide, based upon one's obligation to duty, he did not advocate the

³²⁴Battin, *Death Debate*, 17. Battin suggests that a contributing element to the change in attitude toward suicide was acceptance of deterministic reasons for suicide--suicide as an involuntary symptom of illness and/or psychosocial pressures, for example.

³²⁵See Sullivan, 12. However, Kant did not agree that justice obliged one person to assist another with death.

³²⁶J. B. Schneewind, "Modern Moral Philosophy," in *A Companion to Ethics*, ed. Peter Singer (Cambridge, MA: Basil Blackwell, reprint edition, 1994), 151.

intentional removal of a morally autonomous life from the world. Kant's views on justice and autonomy, therefore, may hardly be cited as valid catalysts for this philosophical shift.

The catalyst that *did* provoke a change in thinking regarding suicide and euthanasia was the atomism and empiricism found in the writings of utilitarians like John Stuart Mill. His ideas were seminal to this discussion of PAS because no historical and philosophical foundations had been established for such a conversation until the reintroduction of atomistic ideas birthed the early scientific method and the growth of humanistic rationalism from the Renaissance forward.³²⁷ Mill's theory, indeed, provided a distinct theoretical alternative and point of separation from the historical deontological moorings concerning killing. John Stuart Mill's utilitarian model must not be stated as being directly supportive of doctor killing. However, there are those who believe inductively that Mill would have supported such a position had he been presented with an occasion to write about it.³²⁸

Advocates of PAS use Mill to establish a link from Enlightenment thinking on autonomy (the negative freedom from institutional control, for example) to a modern form of autonomy. The modern understanding is likely more often seen as a positive freedom with inherent, morally binding obligations that may be used to compel others to act on one's behalf. It may be possible that Mill's utilitarian empirical concepts advanced a view of humanism that evolved into the claim that autonomy and mercy oblige a physician to assist a patient with his or her request for suicide. Mill's view of HU then, may be critical to the progression, helping to build the philosophical bridge that links the historical discussion of suicide with the current claims for physician-caused killing.

³²⁷Compare Ferngren, 155, 175-76. Ferngren states that suicide (as a principle) in the seventeenth century was thought to be in harmony with nature and reason.

³²⁸Battin, *Least Worst Death*, 278, 286; and McLean and Britton, 29.

Mill's Hedonistic-Utilitarianism and Humanism

Mill believed that the only reason why a person or entity should interfere with another's personal liberty was if the exercise of that personal liberty was a threat to others.³²⁹ Every individual was to be given as much freedom as possible and was to be sovereign over his or her life. Mill defined his theory of autonomy carefully--that is, "the sole end for which mankind are warranted, individually or collectively, in interfering with the liberty of action of any of their number, is self-protection."³³⁰ Mill believed that knowledge of right or wrong, and true or false, was to be gained from observation and experience.³³¹ In addition to knowledge, Mill believed that principles of morality were determined not *a priori*, but learned inductively as well. The foundation for Mill's system was one fundamental principle or law that served as the basis for all morality decisions.³³² The use of Mill's calculus would produce an individual who was autonomous, morally reasoning, who could reach a cogent decision on matters pertaining to his own happiness and well-being, including issues of life or death. Mill's view of autonomy, then, was a powerful point in his own structure, but there was another element in his system.

Mill's view of justice interjected a social nature to morality, whereby society has a moral end, and that self-governance will contribute both to individual and corporate "greater happiness." In Mill's justice, each person's happiness is to be considered in equal degree and to count exactly as much as another person's happiness.³³³ Mill's reasoned utilitarian view about individual autonomy, rights, and justice, later spawned other derivative arguments--from

³²⁹Mill, *On Liberty*, 135.

³³⁰Ibid.

³³¹Ibid., 253.

³³²Ibid.

³³³Ibid., 319.

emancipating individuals from institutional slavery in the U.S. to homosexual rights to medical killing, none of which Mill directly addressed in his own day.

Advocates of PAS use Mill's philosophical argument for autonomy and "greatest happiness" to claim that, since personal happiness is of supreme importance and future happiness might be threatened by suffering, then certain persons in specific medical situations may claim the right to bring that suffering life to an end. According to the argument, at this juncture a physician would be morally obliged to aid such a suffering individual in the desire to end his life because justice demands equal happiness for all and the alleviation of suffering would be the "greatest happiness" for that individual. Mill's utilitarian philosophy, then, was one plank in the progressive bridging of ideas that linked together autonomy, rights, and justice,--all issues of basic human concern. Medical killing is one of the primary concerns that combine these three concepts.

Utilitarianism and "Medical Killing"

Utilitarianism, as a normative view of what it is right to do, holds that the moral nature of an action is to be judged by an examination of its consequences.³³⁴ Both the performance of an action and its consequences are to be considered.³³⁵ To illustrate this argument, Hare writes that if he were to give a patient an overdose of a drug, a strict division between act and consequence might lead one to say the giving of the drug was the act and that the death was the consequence. Hare asserts that strict consequentialism includes both under "the consequences."³³⁶

³³⁴R. M. Hare, "Ethics: Utilitarianism," in *Encyclopedia of Bioethics*, vol. 1, ed. Warren T. Reich (London: Collier Macmillan, 1978), 424.

³³⁵Ibid.

³³⁶Hare, 424. This assessment is partly at the root of the PAS debate. Hare's point is debatable. See Donagan, 37-52. Some acts are morally right or wrong regardless of the consequences. See also Frankena, 16.

Other utilitarian writers and physicians agree with Hare and his assessment of killing, and would gauge the physician's assistance as acting as the causal agent in the patient's death.³³⁷ Although the emphasis in this debate is not primarily one of motive or intent, the weight of the argument is placed not on the cause, but on the result.³³⁸ The utilitarian might agree that, in the case of a terminally ill patient, the most a physician could do is to try to alleviate patient misery.³³⁹ In assisting with a death, the physician would focus primarily not on how the death occurred unless, presumably, the death was agonising (eg., by torture). Instead, the physician would assess whether the death eased the suffering and promoted greater happiness. If the death raised the level of happiness, then the death was considered to be good, depending, of course, upon when one calculated the consequences and of what they consisted. While intent may not be the most primary factor, it is important in this discussion to clarify the utilitarian perspective.

Rachels explains that intentional killing proceeds from motive and fulfills what one is trying to accomplish by an action,³⁴⁰ as in the case of Cain intentionally killing Abel, the first recorded murder in history.³⁴¹ However, according to utilitarianism, the possibility exists that

³³⁷See, for example, Jonathan Glover, *Causing Death and Saving Lives* (London: Penguin Books, 1977; reprint edition, 1990), 71. Glover writes that killing, to a utilitarian, is not intrinsically wrong but is only wrong in relation to the implications the killing has for happiness and misery. Cf. Battin, *Death Debate*, 93-98. Battin develops the classical utilitarian perspective in relation to suicide. Cf. James Rachels, *End of Life*, 156. In each of these sources the focus is on the end and not the means. If the death raises the aggregate happiness, then the means, in this case killing, was justified.

³³⁸Rachels, *End of Life*, 156. Rachels outlines a utilitarian argument from mercy. He states that killing a "hopelessly ill" patient at his own request, who is suffering great pain, would decrease the amount of misery in the world. Rachel's conclusion is that this sort of action is morally right. It should be noted that he does not state that it is legally right. He, of course, means that it is morally right from the utilitarian perspective.

³³⁹Smart and Williams, 30.

³⁴⁰Rachels, *End of Life*, 15.

³⁴¹See the Bible, Gen. 4:1-16 NIV (New International Version).

good consequences might render killing morally right. The aim or motive in the killing is the key determiner.³⁴² The utilitarian views the death of a terminally ill patient, whether by active means or by “letting die” as one and the same. Yet, tensions exist between utilitarian perspectives and actions based upon those views. While happiness as an *aim* does not correspond exactly to happiness as *consequence*, happiness can be both the motive *and* the result. The issue is seldom simple. The response to these tensions derives from how decisions are made and applies to the actions associated with “killing.” An alternative, natural law theory, still stands as a response to a utilitarian approach to killing. Whereas, Rachels would place the emphasis on motive in a utilitarian perspective on the rightness or wrongness of killing, a natural law approach would emphasise the rule against killing another innocent human being.³⁴³

Natural Law: a Classic Alternative to HU and Medical Killing

Natural law theory is not new, since it has been discussed since the ancient Greek philosophers attempted to identify the human goods that provided the foundation for the objective moral order.³⁴⁴ The idea inherent in natural law theory is that certain norms are common to mankind, that they are not manmade³⁴⁵ and, as such, the theory neither requires a religious belief nor a basis in deity.³⁴⁶ A central *norm* of natural law, and one that is central to

³⁴²Rachels, *End of Life*, 15. Nonintentional killing would be killing as the foreseen, but unintended, by-product of an action that is aimed at some other good, such as trying to increase the general utility. Consequential approaches to medical killing are but one of several possibilities since there are levels and varieties of intention in this one act.

³⁴³Pellegrino, “False Promise,” 71-72.

³⁴⁴Alfonso Gómez-Lobo, *Morality and the Human Goods: An Introduction to Natural Law Ethics* (Washington D.C.: Georgetown University Press, 2002), 126.

³⁴⁵*Ibid.*

³⁴⁶John Finnis, *Natural Law and Natural Rights* (New York: Clarendon Press, reprint edition, 1996), 48-49. Aristotle recognised a presumed belief in natural law such as, that true justice could be found among the gods, although he did not base his approach to natural law upon such a belief. See Aristotle, 190; and Gómez-Lobo, 128. See Finnis, *Natural Law and Natural Rights*. Finnis presents an argument for natural law and

this thesis, is the norm of forbidding the intentional killing either of an (innocent) fellow human being or oneself. This tenet, figuring prominently in the right-to-die debate,³⁴⁷ assumes that life is a basic good—one of the components of the most fundamental and basic human “goods.” Furthermore, this norm, which can be summed up in the injunction “do not kill,” is a core “value”³⁴⁸ that corresponds “to the drive for self-preservation” and the value of life.³⁴⁹ That life is a good prefaces all other conditions or circumstances, such as chronic illness, pain, and suffering, that occur in a person’s life and, as such, is to be valued intrinsically—meaning that life is worth having for its own sake.³⁵⁰ Without life a person cannot experience other goods.

An ethical proscription against killing, then, may be based upon a core natural law value.³⁵¹ For example, such a natural-law based ethical proscription against killing may be

its implications for rights, justice, responsibility, and authority in community. His approach provides an alternative to consequentialist theories. See also Gómez-Lobo, *Morality and the Human Goods*, who links morality to the protection of basic human goods, such as life, family, and community. He does so through a statement of natural law ethics, which argument presents a contrasting viewpoint from HU on SOL, rights, human autonomy, and responsibility. See also Germain Grisez, *The Way of the Lord Jesus*, vol. 1, *Christian Moral Principles* (Chicago: Franciscan Herald Press, 1983). Grisez has argued that life is an intrinsic good. He also argues that individuals, by their personal choices, contribute to their moral identities. His natural law approach, despite the title that may suggest otherwise, contrasts sharply with utilitarian reasoning that does not emphasise moral character in decision-making. This natural law approach has implications for end-of-life decision-making and medical killing as well, for all of these authors present a case for life’s value that can be applied as a nonreligious argument in contrast to utilitarian reasoning.

³⁴⁷See also Gómez-Lobo, 60-61.

³⁴⁸Finnis, *Natural Law and Natural Rights*, 86. Finnis uses several terms for *value* synonymously: “good,” “basic good,” and “well-being.” He does not use them, however, in the sense of “moral” good.

³⁴⁹Ibid. See also Gómez-Lobo, 10. Life is a basic good and, while it is not the only good, it is necessary for the “partaking” of other goods.

³⁵⁰Gómez-Lobo, 12.

³⁵¹There is a counter view that natural law might allow, at times, that the instinctive drive for self-preservation may be overridden by a wish to preserve one’s dignity and autonomy. Telfer states that “Human beings also have by nature the capacity to use reason to consider their own greatest welfare and ask whether instinct is serving them well, and the decision that existence is no longer worth having is one which exercises just those faculties

grounded on the principles of practical reason, meaning “the principles which are known through themselves to all.”³⁵² The first principle of practical reason rests upon the premise that “what is good ought to be pursued, [and] what is bad avoided,” and upon the claim that the principle is a self-evident *a priori* proposition.³⁵³ This first principle makes a claim, about how a person *should* act. If something is good, then it is rational to pursue it, and if something is bad, then it is rational to avoid it.³⁵⁴

which are traditionally thought to be peculiarly human. We might also say that it is particularly characteristic of human nature to wish to preserve its own dignity and autonomy. I would therefore argue that the formula of Natural Law need not be seen as ruling out either suicide or voluntary euthanasia.” See <http://www.euthanasia.cc/telfer.html>. Of course, a natural law counter-claim would assert that this approach is counterintuitive to the first principle that what is good (hence, life) ought to be pursued. Gomez-Lobo argues that Telfer’s view is misconceived. Life, as such, is not “bad” in itself, but things like chronic illness and pain that happen to people, are bad. Furthermore, Telfer’s argument fails to account for a person’s self-sacrifice or martyrdom. Gómez-Lobo, 10-13.

³⁵²Gómez-Lobo, 126. See also Thomas Aquinas, *Summa Theologiae* I-II, q. 94, a. 2. See also Aristotle, 190. When referring to those who held to the immutability of natural law, Aristotle described such belief with the analogous phrase that “fire burns both here and in Persia.” While he believed in the existence of natural law, but held as dubious the belief in the immutability of such law, his analogy underscores his assumption that some principles are “known through themselves to all.”

³⁵³Gómez-Lobo, 127. Gómez-Lobo provides a detailed account of the first principle of practical reason in chapter one (pp. 1-5). He uses the term “practical reason” in its philosophical sense meaning the capacity to use one’s rational powers to guide him or her in what he or she does. Such a principle of practical rationality provides a guide for what one *ought* to do. Good action is that which is valued by a person or that which is worthwhile, and bad action is that which is not valued or is not worthwhile. As such, the terms “good” and “bad” are nonmoral. A person, for example, might be exhorted to earn good grades or to avoid purchasing a bad car, which is an appeal to a general principle of practical rationality. Mill, *Utilitarianism*, 1987), 11-12. Mill believed the GHP to be the one fundamental law at the root of all morality, or if there were several laws, the GHP would be the law to which one would turn whenever there was a conflict between other varying principles. The thesis calls into question such a claim as well as the usefulness of HU as a comprehensive theory for end-of-life ethical decision-making, especially as it relates to medical killing.

³⁵⁴*Ibid.*, 4. In applying this notion of “rational” pursuance and “rational” avoidance, the claim could be made that the taking of one’s life would be considered “bad” (to be avoided), based upon the natural law belief that life is a basic good and is to be valued. Yet, there are those who sometimes view the taking of life as a good, some of whom are VAE and PAS advocates (*ibid.*, 11). Battin has claimed that sometimes suicide, in the case of illness and suffering, for example, can be a rational act. See Margaret Pabst Battin, *The Death Debate: Ethical Issues in Suicide* (Upper Saddle River, NJ: Prentice Hall, 1996), 115-16. Opponents of

While natural law theory provides a nascent perspective on basic values, such as the value of life, it *does* require an intermediate step in the application of such a principle to specific moral situations. Of significant importance, then, is the determination of *how* a person moves from a first principle (for example, life and its preservation) to practical guidance in moral living (for example, acting in order to enhance life and its preservation). There have been any number of moral approaches that sought to assist with such a move from moral principles to moral precepts—processes established upon such judgments as human “goods” to the right thing a person should do.³⁵⁵

Natural law theorists put forward “practical reason” as their intermediate principle.

Practical reason is the use of one’s rational powers to guide one in what to do. Such a conceptualisation is not new. Aristotle presented the idea of *phronesis*, practical wisdom, as the

“rational” suicide would offer a counter-claim, based upon the first principle of practical reason—that suicide is not a rational act. See Gómez-Lobo, 4-5.

³⁵⁵John Finnis, *Fundamentals of Ethics* (Washington D. C.: Georgetown University Press, 1983). Finnis offers examples of such attempts to provide “intermediate principles.” Several approaches include Kantian ethics, existentialist ethics, and utilitarian ethics. Aquinas assumed a theological ethic based upon divine revelation, which is outside the direct scope of this thesis. The thesis writer, while not adhering to a nonreligious natural law approach, recognises it as a plausible alternative to a utilitarian model. See also Dietrich Bonhoeffer, *Ethics* (New York: Touchstone Book, 1995), 85-89. Bonhoeffer’s “system” (method) of ethics, while counter to Mill’s inductive approach, is an *incarnational* model that rests solidly within the boundaries of an intrinsic moral ethic. Therefore, an intermediate religious principle based upon Bonhoeffer’s model of “ethics as formation” is equally as credible.

intermediate step.³⁵⁶ Kant supplied as his guiding principle a *categorical imperative*.³⁵⁷

Mill's intermediate principle is the Greatest Happiness Principle. Mill, of course, would agree that there are first principles, but he would go one step beyond to posit his intermediate step in the process; namely, that such principles are subservient to the GHP.³⁵⁸ He would deny, however, that one could know intuitively³⁵⁹ what is right and wrong in a particular case.³⁶⁰ He states that the GHP should be the basic law or principle at the root of all morality and goes so far as to state that it is indispensable.³⁶¹ Mill, according to this belief, would allow for a general first principle that life is a basic good, but he would subject all claims as to how one *should* or *ought* to apply this basic life principle, for example, in the case of PAS, to the GHP. While Mill could agree that life is a basic good, like natural law theorists, he rejected out of hand an ethic based upon nature or natural law.³⁶²

³⁵⁶See also Aristotle, 209-10. *Phronesis* (prudence) is that virtue that enables a person to reason between what is good and what is bad for him or her. See also Edmund D. Pellegrino and David C. Thomasma, *The Virtues In Medical Practice* (New York: Oxford University Press, 2003), 84. The authors state that Aristotle used the term *phronesis* to mean the virtue of practical wisdom, or a capacity for moral insight and the capacity "to discern what moral choice or course of action is most conducive to the good of the agent or activity in which the agent is engaged." Pellegrino and Thomasma write that Aristotelian *phronesis* is the link between the intellectual virtues which enable a person to attain intellectual truth and those virtues that dispose to good character. One can infer, then, that good action would follow. Such a perspective holds implications for beneficent medicine and an ethic of care.

³⁵⁷Immanuel Kant, *Groundwork of the Metaphysic of Morals*, trans. and analysed H. J. Paton (New York: Harper & Rowe, Publishers, 1964), 80-88. See also John Finnis, *Natural Law and Natural Rights*, 88-89; and Aristotle, 209-10.

³⁵⁸Mill, *Utilitarianism*, 11-12.

³⁵⁹This is contrary to Aquinas's belief that man could apprehend such principles.

³⁶⁰Mill, *Utilitarianism*, 11. Mill would allow for a moral faculty that supplies a person with the general principles of moral judgments, which is the point with natural law, but Mill believed the GHP served as the one fundamental principle or law at the root of all morality. See thesis, chapter 1, 10, for an exposition of Mill's HU. Of course, this does not make his belief, or theory, necessarily the case. The thesis writer takes exception to Mill's assumption.

³⁶¹Mill, *Utilitarianism*, 12.

³⁶²West, 37-38.

When Mill believed that man was bound to follow nature (the entire system of things) with all of his actions being “done through” and in “obedience to nature’s physical or mental laws,” he also believed that man should intervene and not leave things as they are.³⁶³ Nature did not instill the ideas of right and duty. According to Mill, man inculcated them.³⁶⁴ As a result, Mill’s belief that man was bound to follow nature was mildly deterministic. He contradicted himself, by adopting this belief, when he stated that man should devote his energies to improving the spontaneous course of nature.³⁶⁵ Furthermore, he believed that “killing,” “the most criminal act recognized by human laws,” was committed once to every being that lives by Nature—and in many cases “after protracted tortures.”³⁶⁶ Mill believed that this reduced to absurdity the claim that a person should model his or her behaviour on the course of Nature.

Mill seemed unable to find any other cause but Nature for the evil that befell man. In such a belief, he demonstrated, once again, that he believed morals should be grounded inductively upon the GHP as governing first principle rather than being grounded intuitively upon Nature’s laws. Mill’s presentation was of a mechanical, rather meaningless view of nature and man’s attachment to it.³⁶⁷

³⁶³John Stuart Mill, “Nature,” in *Three Essays on Religion* (New York: Henry Holt and Co., 1874), 64.

³⁶⁴West, 39. West quotes Mill’s 1849 letter to William Ward George.

³⁶⁵*Ibid.*, 38.

³⁶⁶Mill, “Nature,” 31; see also West, 38.

³⁶⁷Mill missed the point of Natural Law theory, however, especially when he laid the blame for man’s suffering (tortures) at the feet of Nature. There have been centuries-long debates about the origin and existence of evil and man’s relationship to it, yet one need not *necessarily* reject a natural law approach solely upon the reality of the existence of evil. Natural law theory, as was stated earlier, can also be based upon the nature law *value* that life is a basic good and, therefore, is to be protected without having to rely upon nature itself or human nature. Therefore, to adopt practical reason as an intermediate step to moral action is also a viable position.

Whatever intermediate step a person applies to moral action, the key for the idea of practical reason (wisdom) is that a person should act in such a way that he or she enhances, or at least does nothing to diminish, the basic goods—one of which is human life.³⁶⁸ Medicine, since the Hippocratic era, has embraced life as a good and has sought to protect it; hence, a proscription against medical killing. Natural law, then, emphasizes the sanctity of human life for the most basic of all reasons, and adds its historical weight on the side that would oppose the legalisation of PAS. Furthermore, it is questionable whether or not legalised PAS actually preserves this most basic human good.

Utilitarianism in Current Perspective

Rather than promote greater “happiness,” the legalisation of VAE and PAS in the Netherlands and PAS in Oregon has resulted in practices that could contribute to greater suffering for patients, their families, their doctors, and the legal and medical professions. Hendin notes the common practice of doctors who violate guidelines and cause non-consensual patient deaths. Eighteen percent of PAS cases in the Netherlands resulted in serious complications and doctors were required to intervene with lethal injections.³⁶⁹ In fact, evidence indicates that a number of patients experience VAE or PAS complications under the Dutch

³⁶⁸A counter argument to the PAS belief that beneficent medicine sometimes kills is the approach formulated and applied to medicine by Pellegrino and Thomasma, *Virtues In Medical Practice*, 84-91. The authors believe that “medicine, or more properly healing, is a practical enterprise requiring a fusion of technical competence and moral judgment” (ibid., 86). *Phronesis* (prudence) fulfills the role of providing the physician with good clinical judgment. See also Pellegrino, “Doctors Must Not Kill,” 98. Pellegrino argues that physicians are to help patients toward “wholeness” and medicine is a “healing” relationship, even when a cure is not possible. Therefore, it may be concluded, good medical judgment (*phronesis*) leads a physician not to kill, or not to aid in the killing of, his or her patient (ibid., 95). See thesis, 289-93 for the alternative development of a medical ethic of care.

³⁶⁹Foley and Hendin, “Oregon Experiment,” 166.

experience which actually *increases the potential for added suffering* on the part of patients and their families.³⁷⁰

Concurrent with these cases of complications and guideline violations, and a potential medical concern in the United States as well, is the fact that when serious PAS complications arise, or when PAS fails to accomplish its intended outcome at all, the event is often unknown or underreported.³⁷¹ In Oregon, for example, when a patient makes a request for assisted suicide, medical law requires that a physician must inform the patient that palliative care and hospice care are feasible options.³⁷² However, physicians are not required to be knowledgeable concerning ways to relieve “either physical or emotional suffering in patients.”³⁷³ While physical and emotional suffering and clinical depression are likely to occur during a terminal illness, the likelihood of complications with lethal dosages is also high.³⁷⁴ Furthermore, the Oregon Health Department has placed emphasis on doctor-patient confidentiality, but has not directed an equal

³⁷⁰Herbert Hendin, “The Dutch Experience,” in *The Case against Assisted Suicide*, ed. Kathleen Foley and Herbert Hendin (Baltimore: Johns Hopkins University Press, 2002), 97-121. See also Foley and Hendin, “Oregon Experiment,” 144-74.

³⁷¹Gregory Hamilton, “Oregon’s Culture of Silence,” in *The Case Against Assisted Suicide*, ed. Kathleen Foley and Herbert Hendin (Baltimore: Johns Hopkins University Press, 2002), 175-91. Hamilton writes of “possible added suffering” that PAS and VAE were expected to alleviate due to the occurrence of serious complications with PAS, or the failure of PAS to work at all.

³⁷²See also Foley and Hendin, “Oregon Experiment,” 145.

³⁷³Ibid. Most cases of suicide, and most of those who respond to terminal illness with a desire to hasten death, are suffering from depression (150). Depression, far and away, is the most important factor in a patient’s desire for death; ironically, however, the Oregon PAS law does not require either the presence or absence of the diagnosis of depression for cases of assisted suicide.

³⁷⁴See also *ibid.*, 166-67. Foley and Hendin state that Dutch studies have revealed that the normal 9-gram barbiturate dose (considered to be lethal) is not always enough to kill the patient, with some living more than three hours after ingestion (*ibid.*, 166). In some cases, families intervened and used pillows or plastic bags to kill the patient.

amount of attention to monitoring compliance with, or abuse of, the law.³⁷⁵ Details surrounding the practice of PAS in Oregon, then, have raised questions regarding the resulting greater happiness or greater suffering of patients and their families, the practice of PAS itself, and the now-noted significant risk of medical complications, the emotional and physical stressors which affect doctors, patients, and families, and the legal aspects of monitoring the practice of PAS to prevent abuse and violations on the part of physicians and medical personnel.³⁷⁶ The Oregon health Department's focus on possible negative utility related to PAS overlooks other significant moral concerns.

Placing the focus on correct medical *methodological* safeguards and legal procedures for VAE and PAS, whether in The Netherlands or in Oregon, while vitally important, are but two facets in a larger and more complex matrix of end-of-life treatments for terminally ill patients. There are also *moral* concerns that arise in such circumstances—concerns like beneficence and non-maleficence, truth-telling and trust, and maintaining an overall healing ethos of medicine. The potential hazards that legalised PAS pose to these key components of the historical practice of medical healing offset the potential “happiness” increases in the areas of medical and legal safeguards that have typically surrounded the arguments for legalisation of PAS.

A final trend to note in this section is one that has transpired in The Netherlands, where the practice of VAE/PAS has moved from legalised VAE/PAS to non-voluntary euthanasia and involuntary euthanasia.³⁷⁷ The Dutch experience, and the almost immediate post-Oregon legal

³⁷⁵See also *ibid.*, 160-61. The authors raise concerns about the “anonymity and secrecy” surrounding “physician practice of assisted suicide” in Oregon. They believe that such practice is contrary to standards of medicine, “which depend upon openness about facts, research data, and records to assess the appropriateness of treatment.”

³⁷⁶Hamilton, 175-91.

³⁷⁷See John Keown, “Euthanasia in The Netherlands,” 261-96. Keown cites the Rummelink Report as evidence VAE/PAS has already been bridged, and physicians are practising nonvoluntary and involuntary forms of euthanasia. See also Kamisar, “Physician-

challenges in the United States to allow PAS for the disabled, based upon a due process legal argument, are well-noted.³⁷⁸ Such practices raise questions concerning a slippery slope into greater killing, the subject of which is discussed in chapter four of this thesis, and simply adds greater challenges to the claims of PAS advocates that PAS brings greater happiness than suffering.³⁷⁹

Current Medical Ethics: “Killing” Applied Generally and Legally

Beauchamp and Childress define killing, from a medical perspective, as originating from a family of ideas that possess the central condition of direct causation of another’s death,³⁸⁰ namely, a circumstance in which one person intentionally causes the death of another human being.³⁸¹ The BMA, in comparison, does not specifically define the term killing, but defines medical killing in a discussion about cessation of treatment and euthanasia as

Assisted Suicide,” 225-60, esp. 244-45. Kamisar believes that once PAS is legalized, little would stand in the way of the legalisation of VAE. See also Gormally, ed., *Euthanasia Clinical Practice and the Law*, 201-18. Gormally offers evidence, that once VAE is legalised, no barrier will exist to the practice of nonvoluntary euthanasia. He cites legal and ethical evidence of a slippery slope from active euthanasia to nonvoluntary euthanasia.

³⁷⁸Andrew I. Batavia, “Disability and Physician-Assisted Dying,” in *Physician-Assisted Dying: The Case for Palliative Care and Patient Choice*, ed. Timothy E. Quill and Margaret P. Battin (Baltimore: Johns Hopkins University Press, 2004), 55-74. Batavia submitted a requested *amicus brief* along with *Vacco v. Quill* and *Washington v. Glucksberg*. See also Hamilton, 183. Hamilton writes of an official opinion issued by Oregon’s deputy attorney general that once assisted suicide is accepted, lethal injection may need to be provided because of the inability of some disabled persons to swallow. Such an opinion was seen as indication of a strategy to introduce lethal injection or “infusion and other more efficient forms of medicalized killing once the failure of oral overdoses is recognized.”

³⁷⁹See thesis, chapter 4, 312-17.

³⁸⁰Beauchamp and Childress, 220.

³⁸¹*Ibid.* It must be stated that Beauchamp and Childress assign the same definition to “letting die.” Their reasoning is that neither “killing” nor “letting die” occur by “accident, chance, mishap, and the like.” The difficulty with this reasoning is that not all of the above qualifiers reflect motive on the part of the physician or assistant.

“deliberately” cutting the “thread of life.”³⁸² Key ideas of intentionality and motives are contained in both Beauchamp and Childress and in the BMA definition,³⁸³ demonstrating that a consensus that killing is the intentional causation of another’s death still resides deeply within the medical-ethical psyche. Defining these terms is both complex and labour-intensive, for the term “killing” in medical circles has both general and legal applications.

The definitions of medical killing are similar in several ways. The obvious point of agreement is that in all discussions and definitions, one person takes the life of another. A simplistic reading might attribute a single, clear motive or intention to every death. Instead, however, the issues are neither lucid nor simple. Within the utilitarian approach, for example, an important feature that calls for additional examination is the question of possible implied obligation. In some instances, the strict application of this approach to killing carries the idea of obligation when one person might be obliged to kill another person either for the positive maximization of happiness for the many or, in the case of negative utility, when that death would reduce the level of unhappiness for the many.³⁸⁴

Current UK (the Suicide Act of 1961) and US laws forbid physicians to aid or participate in patients’ suicides.³⁸⁵ Whether violating the laws would constitute murder, as in the case of active euthanasia, or in the aiding and abetting of a suicide, as in PAS, would

³⁸²British Medical Association, *Medical Ethics Today*, 150.

³⁸³*Ibid.*, 149-50.

³⁸⁴Battin, *Ethical Issues in Suicide*, 98; see also Glover, 71-73.

³⁸⁵“No U.S. state now consider suicide a crime. Helping someone complete suicide, however, is criminally punishable in several states.” Encarta Suicide, “Suicide Facts: Encarta Explanation”; internet, available at <http://www.a1b2c3.com/suilodge/facenc1.htm>; accessed 19 May 2004.

depend upon the particular circumstances of the death,³⁸⁶ but it is currently unlawful deliberately to end a patient's life, even if the patient rationally requests such action.³⁸⁷

This law was applied to a recent year-2000 case in the UK involving a woman, Mrs. Diane Pretty who, having been diagnosed with motor-neurone disease, desired her husband to be granted immunity from prosecution for helping her to die with physician-assistance. Her lawyers challenged the standing law, arguing that the physician should be able to assist the husband with her desire to die.³⁸⁸ The authors claimed that "if death is in a patient's best interest then death constitutes a moral good."³⁸⁹

In the United States, the debate over medical killing elicits high emotion on both sides of the issue. It remains unlawful both to aid directly the suicide of an individual through euthanasia, and, in all states except Oregon, to assist with a patient's suicide.³⁹⁰ The United States Supreme Court ruled recently on two aspects of similar assisted suicide cases that set clear legal boundaries around medical killing. In both *Washington v. Glucksberg* (1997) and *Vacco v. Quill* (1997), the Supreme Court unanimously reversed two lower court decisions and upheld the constitutionality of state laws that forbid assisted suicide and, by direct association, PAS.³⁹¹

³⁸⁶British Medical Association, *Euthanasia*, 63. As of 2004, a new UK committee is reviewing suicide and assisted suicide.

³⁸⁷*Ibid.* See also Cook, *Patients' Choice*, 155.

³⁸⁸Len Doyal and Lesley Doyal, "Why Active Euthanasia and Physician Assisted Suicide Should Be Legalised," *British Medical Journal* 323, no. 10 (November 2001): 1079-80.

³⁸⁹*Ibid.*, 1079. The authors believe that acts of omission and commission are not as important to the "killing" event as the "justifiability . . . of the clinical outcome." This consequentialist argument states that the *cause* of the patient's death is not as important as that the patient *dies well*. The authors advocate legal changes that would relax restrictions concerning PAS within the DPR.

³⁹⁰Compare the *Oregon Death with Dignity Act* (1997).

³⁹¹See Loretta M. Kopelman and Kenneth A. DeVille, eds., *Physician-Assisted Suicide: What Are The Issues?* Philosophy and Medicine, ed. H. Tristram Engelhardt, no. 67 (Dordrecht:

The court was challenged to rule on a liberty interest in *Washington v. Glucksberg*. Washington's law against assisted suicide was challenged on the claim that it placed an undue burden on the terminally ill. The argument, based upon the similar argument that says women have a right to abortion, was that terminally ill patients have the accompanying right to access medical assistance. The Supreme Court, however, voted 9-0 to reject the argument citing over seven hundred years of Anglo-American common-law prohibition of assisted suicide, including current criminal law.³⁹² The Court did not see the right to *refuse lifesaving treatment* as parallel, or even similar, to the abortion precedent which *granted access to medical treatment*. In short, the Court ruled that assisted suicide is not a fundamental liberty interest protected by the Due Process Clause of the fourteenth Amendment to the Constitution.³⁹³

Having found that there was no personal liberty right to assisted suicide, the Court then turned its attention to the other case from New York, *Vacco v. Quill*. Unlike *Washington v. Glucksberg*, this challenge to a New York law prohibiting assistance with suicide was argued as a violation of the Equal Protection Clause of the fourteenth amendment to the Constitution. This clause requires that state action must treat like cases alike but may treat unlike cases in different ways. If states do not comply with this Equal Protection Clause, their decisions are then subject to judicial ruling.

The case was based on Quill's claim that, since individuals could refuse unwanted treatments that would result in their deaths, such refusals were indistinguishable from assisted suicide. In this case a patient's refusal of unwanted treatment was deemed parallel, or "like," a patient's right to receive physician assistance with his own death. The lower court had ruled against Quill on the basis that there is a difference between "allowing nature to take its course"

Kluwer Academic Publishers, 2001), 2.

³⁹²Ibid., 5.

³⁹³Ibid.

and “intentionally using an artificial death-producing device.”³⁹⁴ The Supreme Court ruled in a 9-0 vote that New York’s law prohibiting assisted suicide neither infringed upon a fundamental right nor discriminated against a single group.³⁹⁵

Chief Justice Rehnquist then responded to the lower court’s contention that refusing life-sustaining medical treatment “is nothing more or less than assisted suicide.” His answer upheld the majority opinion that “the distinction is widely recognised in both medical and legal traditions, and thus supported a sufficiently rational distinction upon which a state legislature can distinguish one action from another.”³⁹⁶ A significant issue that emerged from both of the cases, *Vacco v. Quill* and *Washington v. Glucksberg*, concerned to what degree individual liberty, or autonomy, obliges others to comply with a person’s PH aims. The ever-changing influence of autonomy bears implications for many areas including the DPR and medical killing.

Autonomy, the Courts, and the Doctor-Patient Relationship

As this section has shown, discussions about medical killing have emerged in the last generation along with patient autonomy claims.³⁹⁷ Defining legal moments in this progressive discussion further stretched the established boundaries with new cases,³⁹⁸ as the concept of patient control--whether autonomous or assumed--advanced within the healthcare context. For example, Timothy Quill responded to his patient “Diane’s” autonomous pleas to end her psychological pain and suffering when he assisted her with suicide, and in the Quinlan and

³⁹⁴Ibid., 7.

³⁹⁵Ibid., 8.

³⁹⁶Ibid.

³⁹⁷Ramsey, *Patient as Person*; and see Rachels, “Active and Passive Euthanasia,” New 78-80.

³⁹⁸Certain cases and names have become household names: Karen Anne Quinlan, Nancy Cruzan, and Anthony Bland. In the 1990s, it was “Diane,” Timothy Quill’s patient, and in 2000, Diane Pretty has become a focal point of the discussion.

Cruzan cases involving artificial hydration, certain privacy rights were assumed even if the patients could not state them.³⁹⁹

These much-publicised court cases and their accompanying arguments have elevated medical killing discussions to the arena of national, even global, concern. In a number of critical cases the courts consistently denied any constitutional or legal precedent that establishes a patient's claim to receive medical assistance with suicide. At the same time, a patient's personal autonomy and privacy in making decisions about his or her life have been not only the subject of intense consideration but, in some cases, protected. The rights of patients, and decisions regarding end-of-life issues, have continued to be critically important to the ongoing dialogue.

The legal response to autonomy regarding "medical killing" has been upheld within the DPR, particularly as it relates to PAS. This discussion, having evolved through the years, has now, in fact, resulted in the articulation of legal decision and law in some areas, such as in the state of Oregon.⁴⁰⁰ In cases where PAS has been practised, the general guidelines as laid out by physicians include the patient's voluntary, competent, repeated request, a physician's aid in deliberation, secondary and even tertiary medical assistance with the decision, the presence of suffering which has been determined to be unbearable by the patient, and the use of a means of death that is as painless and comfortable as possible.⁴⁰¹

³⁹⁹Beauchamp and Childress, 172.

⁴⁰⁰See the *Oregon Death with Dignity Act* (1997).

⁴⁰¹Beauchamp and Childress, 240. Cf. Howard Brody, "Assisted Death--A Compassionate Response to a Medical Failure," *New England Journal of Medicine* 327, no. 19 (November 1992): 1385-86. Brody's desire is to use medical interventions to result in death as long as the patient has been able to live a "natural lifespan." He states that this lifespan is measured ideally in biographical terms rather than by chronological age. He believes that a decision to assist a patient in death should be made on a case-by-case basis (1386) and that the patient's decision is of critical importance (1386). Timothy E. Quill, Christine K. Cassell, Diane F. Meier, "Sounding Board--Care of the Hopelessly Ill: Proposed Clinical Criteria for Physician-Assisted Suicide," *New England Journal of Medicine* 327, no. 19 (November 1992): 1381-82.

The debate in favour of medical killing, then, contains sincere expressions to advance the causes of medicine in a thoughtful, caring manner⁴⁰² as well as the intention to regulate the practice of assisted suicide in order to mitigate the risks of unregulated PAS.⁴⁰³ In all of these ways, proposed clinical guidelines consider the interrelated impact PAS will make on a patient, her family, and the doctor, as well as the consequences for future patients and the practice of medicine at large.⁴⁰⁴

However, the abovementioned clinical guidelines established to ensure adequate PAS safeguards beg a critical philosophical question concerning end-of-life patient care and medical killing. Some who support PAS assume that the clinical care taken to provide adequate medical safeguards for medical killing at the end of life somehow resolves the questions that remain concerning patient rights, justice, and medical killing. Some believe *also* that proper care taken to ensure good consequences answers all lingering questions about rights, justice, and medical killing.

Summary

The discussion concerning rights, justice, and medical killing, however, continues to require balanced evaluations of a complex matrix of philosophies; medical, ethical, and legal issues; HU; and PAS, along with the recitations of historical data and reviews of clinical boundaries and procedures. A growing corpus of literature also addresses the morality of assisted suicide in which both supporters and opponents register opinions concerning the consequences of PAS, from patients', physicians', and the medical community's perspectives.

⁴⁰²Beauchamp and Childress, 238. Beauchamp and Childress decry the lack of professionalism by Jack Kevorkian, but recognise the compassion of Timothy Quill. Cf. Brody, 1386. Brody writes specifically of Quill's compassionate response to what he terms a medical failure and exemplifies the literature that supports PAS, which often states the importance of showing ample compassion for patients and family who are making life-ending decisions.

⁴⁰³Fins and Bacchetta, 565.

⁴⁰⁴Ibid.

Some of these writers, arguing from a framework of HU in which they seek the GHP,⁴⁰⁵ use consequential reasoning to approach the DPR and arrive at propositions which may not be sustained either historically or philosophically. For example, notwithstanding their fairly primitive medical technological level, the Greeks' view of death did not focus so much upon extending natural life as much as to assist the forces of nature "... in finding a natural resolution of patient discomfort and disease."⁴⁰⁶ Thus, it would be historically inaccurate to postulate that doctors were "actively" (intentionally) involved in "assisting" patients with their deaths. Current philosophical speculation about acts and omissions and consequences was not a consideration in a medical environment that viewed death not as an enemy, but as a natural part of life. Philosophical justification of current medical killing, based upon Ancient Greek medical attitudes and practice, runs the risk of begging the question because, at that time, the focus at the time of death was not centred on acts and omissions and consequences.

Again, in the medieval period, the DPR was not a concern at the moment of life and death because the person most likely to be at the dying patient's bedside was a priest, and the patient's soul and eternal destination was of primary import rather than the extension of life. To say that a physician would intentionally aid a patient's death, for example, would be historically unsupported in this case because the prevailing view was that God was the only one who had the ultimate right to give and take a life. During the Renaissance, a slight change occurred in concepts about death with an emergence of views that supported suicide which might include medical assistance. To suggest that history would support medical killing would again be a misreading of the historical record because the focus was on an emerging individualism rather than any particular change in medical canons about killing.

⁴⁰⁵Ibid., 563-68. For example, consequential reasoning suggests that the doctor's action in the patient's death will lessen the collective pain and suffering of the patient, and thus, contribute to the PH of both the patient and the broader community.

⁴⁰⁶Carrick, 166.

As medical history progressed through the Enlightenment and into the modern period, however, and medical technology made it possible to extend human life--sometimes well beyond its normal limits--logical, rational philosophies were evolving concurrently. Utilitarian thinking was one view that some people thought could answer the medical life-and-death dilemmas created by medical advances. Utilitarianism supplied a framework that answered the consequentialist view of moral decision-making; as long as the "good" end was based upon the GHP. Such a consequentialist view has failed to silence all of the moral questions about individual human life, about rights, and about justice in the current medical-legal climate.

Thus far, the examination of rights, justice, and medical killing through the lense of HU has revealed several areas of concern. The first area of concern relates to the PAS view that there is a liberty right (right to noninterference) to suicide that is akin to Mill's harm principle. Mill's conception of individual rights was grounded in his hedonistic view that an individual had a moral right to shape and absolute sovereignty over living his life according to his own PH preferences. On this, PAS advocates base a claim that a patient has a right to suicide. This claim to a right to suicide is unfounded, however, because it is based on an incomplete view of Mill and individual rights. Mill did not believe rights were inviolable. In fact, Mill believed that an individual's right could be overridden in order to maximise utility. On this basis, it is conceivable that there are utilitarian calculations that would require an individual to yield his claim to a right to suicide.

Further, Mill's view of justice has been cited as a support for right-to-die claims. Such claims are predicated upon an understanding of Mill that overlooks a central criticism of his views on justice. The view that each person is to be counted equally with another is not the entire case with Mill. While he did cite such a claim, he also believed there were instances

when such a claim could be overridden by the greater claim of the GHP. It is conceivable that a justice claim by a larger group using a utilitarian calculus could render null a similar justice claim by an individual or a smaller group.

The examination of medical killing through the lense of HU produced similar questions about its usefulness. It was not clearly demonstrated that an HU calculus for assessing end-of-life decisions regarding medical killing is adequate to require changes in medical canons related to killing. Advocates of PAS use Mill's philosophical arguments for rights, justice, autonomy, and greatest happiness to claim a right to bring patient suffering to an end. The questions that surround the use of Mill to buttress claims for PAS cast doubt on the overall effectiveness of Mill's arguments in supporting a claim for medical killing.

Chapter 2's discussions have demonstrated that autonomy underlies each of the features discussed to this point. Mill's HU emphasises heavily the autonomy feature. PAS advocates also assign a powerful moral emphasis to autonomy, a force they claim obliges a physician to facilitate their requests in the DPR; and that sometimes includes assistance with suicide. This raises questions concerning the validity of assigning such force to the concept of autonomy. An examination of autonomy in the DPR also requires a careful inspection of the correlative notion of physician paternalism.

These two viewpoints (patient autonomy and physician paternalism) represent philosophical perspectives that have clashed at times, particularly in the case of the DPR. The concept of individual autonomy, then, with its concomitant nature and meanings, still lies at the centre of any discussion related to the subject of medical killing. This chapter's exploration of the claim that a physician is sometimes morally obliged to kill based upon twin claims of autonomy and mercy has proven to have insufficient historical, philosophical, or legal support unless, as autonomy advocates claim, a person assigns moral force to individual autonomy. The

third chapter, then, will examine the historical development of the remaining three key PAS features through the lense of HU: autonomy, physician paternalism, and SL.

CHAPTER 3

AUTONOMY, THE DOCTOR-PATIENT RELATIONSHIP, AND THE “SANCTITY OF LIFE” IN RELATION TO PHYSICIAN-ASSISTED SUICIDE AND HEDONISTIC-UTILITARIANISM

Introduction

Respect for autonomy is one of a core of medical values which, together with a loose confederation of other principles, is often identified by the rubric, “common morality.”¹ As a principle of medical ethics, the concept of individual autonomy, with its varied historical application, has received intense scrutiny. Although little sustained agreement exists about the nature or claims of patient autonomy, the respect for *autonomous choice* is a foundational theme that runs deeply within common morality discussions.² It is not a simple matter to examine autonomy because the concept has undergone much change through the centuries. The discussion is important, however, because of the emphasis placed on the term in the current PAS and DPR dialogues and the ensuing claims derived from the notion.

Current PAS claims related to autonomy, rights, and justice, as demonstrated in chapter 2, draw support from John Stuart Mill’s HU foundation. HU attempts to strengthen individual autonomy, rights, and justice by emphasising noninterference with an individual’s PH preferences and providing a measure of self-governance. The chapter discussion raised, however, some significant questions about HU rights-and-justice claims that are used to buttress an autonomy argument for PAS. Even so, the chapter indicated that autonomy

¹Cook, *Patients’ Choice*, 224-29. Cf. Beauchamp and Childress, 100-102, 120. The authors define common morality as being pluralistic, meaning two or more nonabsolute tenets form the general level of normative statement. Common morality theories rely heavily upon ordinary shared moral beliefs for their content. Cf. Henry Sidgwick’s “morality of common sense.” Sidgwick, 337-61.

²Beauchamp and Childress, 120. The authors devote four chapters (3-6) to the discussion of four principles of common morality: autonomy, nonmaleficence, beneficence, and justice.

continues to provide an important foundational plank in the PAS philosophical platform and, thus, opened the way for a deeper examination of autonomy in this chapter.

PAS advocates cite Mill's autonomy views as support for claims against medical and physician paternalism. After all, Mill sought to establish clear boundaries around the individual in order to safeguard a person from outside interference. Further, both patients and physicians, through the vantage point of their own perspectives (patient autonomy and physician paternalism), at times approach the DPR with differing views about life and its sanctity. This difference of viewpoint alone can breed tension, but the added element of an end-of-life terminal illness can elevate the tension and become a cause for misunderstanding and disagreement, if not conflict. Autonomy, physician paternalism, and SL, as such, are three interrelated concepts that provide fertile ground for exploring end-of-life PAS claims. This chapter will examine these three related PAS features--autonomy, physician paternalism, and SL--and evaluate them, when applicable, in light of Mill's HU theory.

Autonomy, Hedonistic-Utilitarianism, and Physician-Assisted Suicide

A claim of this chapter is that the DPR is currently being influenced by a new, *and perhaps over-accentuated*, emphasis on patient autonomy causing, in turn, critical changes in the way the notions of physician paternalism and "SL" are being viewed by medical decision-makers. This emphasis on autonomy draws some of its support from key concepts within HU. Additionally, there is a long history of the concept of human autonomy, and much literature that details its growth and evolution through the centuries.³ This historical framework, which illuminates the changes in the established concept of the term, as well as the influence from HU, provide a rich foundation from which to examine the term's usage.

³Schneewind, *Invention of Autonomy*, 4. Schneewind writes of a seventeenth-century change in the established conceptions of morality as obedience that occurred as a result of emerging conceptions of morality as self-governance.

The evolution of the notion of “autonomy,” together with the intermittently related concept of physician paternalism, will be examined in several of the critical historical contexts where the concepts were discussed. These contexts include origins in ancient Greece, further development in the fourteenth-fifteenth-century Renaissance, and again in the sixteenth-century Reformation. The word autonomy will also be examined in seventeenth-eighteenth-century Enlightenment thinking, its definition amplified in Mill’s nineteenth-century writings on utility, and its meaning rendered in the modern medico-legal arena. Autonomy also will be explored both in relationship with, and in contrast to, physician paternalism, and for its interconnection with SL.

As the notion of “autonomy” developed, it influenced the DPR as patients insisted upon greater opportunities for input when it came to making decisions regarding patients’ own health. These changing notions about human health then interconnected with the concept of the sanctity of human life, bringing focussed attention upon the present nature of the DPR. When the medical community addressed PAS, these three features (autonomy, physician paternalism, and sanctity of human life) became central to the arguments, both for and against the practice. A good working definition for each concept, then, is important for the purpose of this chapter. The first notion to consider is autonomy, with its rich historical meaning and varied application.

What is Autonomy?

Defined

Autonomy was originally a compound word in ancient Greek civilisation and carried no single meaning.⁴ The *OED* gives a broad definition of the word in several historical contexts. Originally the word was used in a political context and meant “the having or making of one’s own laws,” meaning that a state had “the right of self-government, of making its own laws and

⁴Beauchamp and Childress, 68. The two Greek words were *autos* and *nomos*.

administering its own affairs.”⁵ A definition alone, of course, cannot indicate how the historical context shaped the development of the term. Thus, in the case of “autonomy,” the following broad historical overview of the concept’s usage will illustrate stages in its development.

Ancient Greece

The concept of autonomy has had an uneven evolution throughout history. In fact, the progression of the term may be more easily traced from ancient Greece along political and literary links rather than chronological ones. The concept came to be applied in ancient Greece to citizens who established their own norms or laws primarily in political and military affairs.⁶ The word, however, did not yet extend to include the notion of individual liberty. It was not until much later that the idea of individual freedom, so important in modern Western culture, became a part of the meaning.⁷

⁵*OED*, 2d ed., s.v. “autonomy.”

⁶Cook, *Patients’ Choice*, 224-29. Cf. Beauchamp and Childress, 100-102, 120. The authors define common morality as being pluralistic, meaning two or more nonabsolute tenets form the general level of normative statement. Common morality theories rely heavily upon ordinary shared moral beliefs for their content. Cf. Henry Sidgwick’s “morality of common sense.” Sidgwick, 337-61.

⁷Berlin, 129. Cf. Ostwald, 47. *OED*, 2d ed., s.v., “autonomy.” In the seventeenth century, “liberty to live after one’s own laws,” “liberty to follow one’s will,” and “personal freedom” became added features of the word and changed its meaning. See also Richard Lindley, *Autonomy* (Atlantic Highlands, NJ: Humanities Press International, 1986), 6. Lindley writes that individual autonomy has been regarded as of enormous importance in the Western political tradition since the late eighteenth century. Compare Schneewind, *Invention of Autonomy*, 4. He writes that during the seventeenth and eighteenth centuries an emerging conception of autonomy as self-governance began to challenge the established conceptions of morality as mere blind obedience based upon supernatural revelation.

Renaissance Humanism and Autonomy

The long leap forward through the centuries from ancient Greece to the Renaissance⁸ may suggest that there is but scanty background to the examination of “autonomy.” The concept did not suddenly reappear without reason on the Renaissance political and philosophical landscape, however.⁹ The Medieval Period (fifth-thirteenth centuries) promoted individual, albeit limited, learning, which provided a foundation for the coming Renaissance (fourteenth-fifteenth centuries), as its monastic scribes and other scholars preserved and studied the ancient classics.¹⁰

Following the fall of Constantinople during the Fourth Crusade, Western Europe experienced an explosion of new trade routes, the fusion of cultures between East and West, and the rediscovery of the classics, particularly the Greek and Latin classical heritage. The old political-ecclesiastical union of the Medieval Period began to unravel, ushering in revolutionary changes in society.¹¹ A new interest in the study of history and the development of the idea of “perspective,” together with a “sentimental nostalgia” for past civilisations, became catalysts for receiving the knowledge and skills of the east as the classics were

⁸William R. Estep, *Renaissance and Reformation* (Grand Rapids, MI: William B. Eerdmans Publishing Co., reprint edition, 1995), 18, 20. Estep’s concise, yet pithy, overview of the Renaissance states that even though the era was identifiable and separate from the “Low Middle Ages,” it does not mean that the Renaissance had no roots there.

⁹Walter Ullmann, *Medieval Foundations of Renaissance Humanism* (Ithaca, NY: Cornell University Press, 1977), vii. Ullmann writes that Renaissance humanism is “strongly embedded” in the “antecedent medieval past.” Of significance is his statement that Renaissance humanism and its relevant manifestations are “incomprehensible” without the ecclesiological background. Ullmann writes, “Precisely because Renaissance humanism evolved from its medieval environs, it moulded the complexion of society and decisively shaped its thought processes, its outlook, and philosophy.” Estep states that fourteenth century dissent took many forms (political, religious, economic, and intellectual) that indicated that the Constantinian “symbiosis” (referring to the union of the Catholic Church with the Roman Empire) was falling apart. Cf. Estep, 20.

¹⁰Ibid., 13. Cf. Frederick B. Artz, *Renaissance Humanism 1300-1550* (Oberlin, OH: Kent State University Press, 1966), 16.

¹¹Estep, 20. Estep uses Yoder’s terminology (“symbiosis”) to describe the slow dissolution of the union between the Catholic Church and the Roman Empire.

reintroduced,¹² resulting in a new era--the Renaissance. This period “rebirthed” patterns of thinking and learning¹³ that sought to recover that “lost,” or “forgotten” knowledge. Called *via moderna*, this new way of thinking applied the recently rediscovered knowledge in fresh ways.

One instance of this application concerned the notion of the individual. The ancients had believed, for example, that one could mould personality development by education. This idea was recaptured in the Renaissance,¹⁴ so much so that the changing ideal of education that marked the Italian Renaissance, an ideal that included developing the individual human personality to its fullest extent, became a pivotal element in the redefinition of the term “autonomy.”¹⁵ This is one of the ways in which the ancient view of *humanism*¹⁶ gained both renewed life in the Italian Renaissance and redefinition as a result of the freshly acquired study of ancient literature in its original language.

A leading figure in this rebirth of interest in classical antiquity was an Italian named Petrarch (1304-1374),¹⁷ whose desire was to recapture the old Roman glory and reshape the present in accordance with ancient political and moral values. Part of his contribution was his perspective that an individual should resolve to leave his own mark on time, whether

¹²Myron P. Gilmore, *The World of Humanism: 1453-1517* (New York: Harper & Row, Publishers, 1952), 236. Cf. Frederick S. J. Copleston, *A History of Philosophy*, vol. 3, *Late Medieval and Renaissance Philosophy* (New York: Doubleday, Image Books, 1993), 207-9.

¹³Trinkhaus, 4, 13. Cf. Bullock, 13-14, 17. Copleston, 3:210.

¹⁴Bullock, 11.

¹⁵Copleston, 3:208.

¹⁶The term comes originally from the Latin *humanitas* and is the Roman version of the Greek concept of *paideia*, or education of a child. This concept is not to be confused with the term *humanism*, which is of near-recent origin, formulated in 1803 by a German pedagogue. See Trinkhaus, 4, 13. Cf. Bullock, 13-14, 17.

¹⁷Compare Copleston, 3:207. Copleston notes the absurdity of trying to assign clearly defined temporal dates to the Renaissance, but insofar as the Renaissance involved a rebirth of “literature and a devotion to classical learning and style,” it may be stated to have begun as early as the twelfth century.

militaristic, political, literary, or pietistic.¹⁸ Indeed, it has been stated that the Renaissance was the era when human beings began to think of themselves as “individuals.”¹⁹

During the Renaissance, the specific cognates in the term “individual autonomy” were not mentioned *per se*. It is important to note, however, that human experience in Renaissance “thought” buttressed the authoritative claims of neither religion nor science.²⁰ Instead, whether strategic or merely consequential, human experience actually challenged traditional authority.²¹ The tensions created by the Reformation and Counter-Reformation, together with elements of “pagan” philosophical currents in Renaissance thought, challenged the old authoritative claims of the Church. What actually emerged from within the Renaissance was a new type of “man” who was shaped by the “imitation of antiquity.”²²

The dignity of man, since antiquity, had been associated with a cluster of ideas that blended with biblical concepts of the nature and role of man in the universe within the history of the Judeo-Christian tradition.²³ This conception of what constituted “man” changed as the Renaissance idea of human dignity became additionally coloured by the fresh study of, and

¹⁸Trinkhaus, 13-14.

¹⁹McGrath, 41. McGrath cites Jacob Burckhardt for the idea, but adds that there is “powerful evidence” for strongly collective values in the Renaissance. Cf. Estep, 20-21. Estep refers to Burckhardt’s analysis as well and states that “political circumstances and Italian genius combined to give birth to the first modern man.” It was in the Renaissance that man became consciously aware of his individualism. This was a separating feature between the Renaissance and its antecedent era.

²⁰Bullock, 17.

²¹Compare Louis Bouyer, *Erasmus and the Humanist Experiment* (London: Geoffrey Chapman, 1959), 26, 34. Bouyer writes that the rebirth of the Classics brought with it a revival of paganism and its culture. He said this “was profoundly anti-Christian,” and by the second generation of Renaissance humanism it became “insistent” and seemed likely to dominate the entire movement. Copleston, 3:208. Copleston is more reserved in his assignment of paganism to the Renaissance, but he does note that some of the humanists were “pagan” in outlook. He terms an aspect of the Renaissance as “amoral individualism,” in the sense that the focus was not opposition to Christianity *per se* as much as to developing human personality to the fullest.

²²Bouyer, 34.

²³Trinkhaus, 344.

emphasis upon, “natural laws.”²⁴ The new Renaissance man imitated the Greek *arete* of the ancients by seeking to accomplish great, heroic deeds.²⁵ Thus, though ill-defined, dignity was acquired through the study of the liberal arts, or *humanitas*, and was linked with the Petrarchan ideal of high civic, pietistic, literary, or military achievement.²⁶

Renaissance thought was further aided by three important developments: the increased integration of classical scholarship with literary composition in the vernacular, the translation of Plato and the Neoplatonists, and the spread of the new invention of printing.²⁷ Each of these developments opened doors to ever-increasing numbers of people being influenced by the classics. Two significant bridges connected the Renaissance to the following era--the Reformation.

The idea of learning as a conduit to improving oneself was one such bridge.²⁸ The watchword was *ad fontes*, or “back to the original sources,” referring to the desire to reclaim the intellectual and artistic resources of the classical period.²⁹ Another bridge into the Reformation was the mechanical invention of the printing press. While the press itself was not capable of spawning intellectual change, it became the vehicle people used to mass-market

²⁴Ibid., 343.

²⁵Bouyer, 34-35.

²⁶Trinkhaus, 343.

²⁷Ibid., 23-24. Bouyer, 37. Cf. Gilmore, 186-90, 191-94, 206. The printing press made possible the growth of the secular reading public. Humanism, to this point, largely characterised the clergy and operated within the circles of their private domains. Italians like Marsilio Ficino (1433-1499), for example, spent a lifetime translating the works of Plato from Greek to Latin and trying to reconcile Neoplatonism of the Florentine variety with Christianity, further advancing Renaissance philosophy. Ficino placed an emphasis upon freedom of the will and the duty of intellectuals to try to apprehend higher things so as to ascend toward a union with the divine. This, he believed, was the true end of man, although not everyone agreed with his assessment.

²⁸Gilmore, 206.

²⁹McGrath, 45.

their ideas.³⁰ Having thus acquired his dignity through *humanitas*, the Renaissance individual then applied his new knowledge and values to his own life and his surrounding culture, opening up whole ranges of questions the answers to which bore implications for the changing expression of autonomy.³¹

Reformation Humanism

If the printing press was the single most important new invention for sixteenth-century scholarship,³² then Erasmus (?1467-1536) represents the generation which seized upon its use and maximised the opportunity.³³ Thousands of copies of books, manuscripts, pamphlets and treatises, letters, and the like were printed and circulated, widening greatly the dissemination of the *via moderna*, exemplified in the teachings of the humanist scholar, Erasmus. This flood of fresh reading material resulted in an ever-broadening secular reading public,³⁴ in whose hands

³⁰Elizabeth L. Eisenstein, *The Printing Press as an Agent of Change: Communications and Cultural Transformations in Early Modern Europe*, 2 vols. (New York: Cambridge University Press, 1979). Eisenstein discusses the revolutionary nature of the “book culture” which arose from the Medieval “scribal culture” and its interrelatedness to the Renaissance (vol. 1, 181-225). Estep, 95-96. Myron P. Gilmore, 186. Cf. Bard Thompson, *Humanists and Reformers: A History of the Renaissance and Reformation* (Grand Rapids: William B. Eerdmans Publishing Co., 1996), 39-46.

³¹Trinkhaus, 13-14.

³²Gilmore, 189. Erasmus joined forces with Johann Froben, ca. 1514, to see some of his projects “through the press.” See John C. Olin, ed., *Christian Humanism and the Reformation: Selected Writings of Erasmus with His Life by Beatus Rhenanus and a Biographical Sketch by the Author*, 3d ed. (New York: Fordham University Press, 1987), 15. Lewis W. Spitz, *The Renaissance and Reformation Movements* (Chicago: Rand McNally, 1971), 306. Spitz points to the importance of the printing press related to the mass dissemination of ideas when he writes that between 1500 and 1517 German printers turned out but forty books per year. Once the Reformation was launched, however, the figure “rocketed to five hundred titles” per year in Germany alone.

³³Gilmore, 189. See also Henry Osborn Taylor, *Erasmus and Luther* (New York: Collier Books, First Collier Books ed., 1962), 38. Taylor writes that Erasmus’ influence was “tenfold greater” because he spent his entire strength making books that were of “enormous educational effect.” Erasmus also chose his cities of residence according to the availability of facilities for the printing of his books (33).

³⁴Gilmore, 187. Cf. Thompson, 42-43. He “extended the circle of a lay intelligentsia” to nonmonks and learned orders. Of course, had the reading populace been exposed to different

the printed word became the weapon of individuals with political ideas. In a real sense, the press became a wedge between a church struggling to retain its control and a people who were increasingly bombarded by new philosophical formulations concerning their own individual values.³⁵

Erasmus of Rotterdam used the printing press to introduce another catalyst for the growth of autonomy. While a loyal Catholic, he emphasised the value of “inner” religion, instead of mere external moral observance.³⁶ This is significant because Erasmus’ “inner religion” was cultivated by the individual, no longer necessarily solely by the church.³⁷ Erasmus reached a much wider circle than had earlier humanists.³⁸ Under his influence, external authority structures were challenged by a growing concept of individual authority, thereby adding this notion to the definition and practice of *humanitas*.

His Reformation counterpart, Martin Luther (1483-1546), was responsible for further modifying the term “humanism.” Although Luther’s humanism was more strictly biblical in tone, both he and Erasmus believed the church should return to its earlier purity and practice. Luther sowed seeds of autonomy when he read the scriptures as an individual, interpreted them in ways that were contrary to those of the established church, and then applied them against abuses he saw within the church. Both men challenged the church in ways that both defined and permeated the Reformation, even though each man approached the matter of reform somewhat differently. Erasmus was more conciliatory and Luther more militant in his

literature, the result perhaps could just as easily have been an anti-autonomy stance which could have squelched the concept of the individual.

³⁵Gilmore, 186.

³⁶McGrath, 40-41, 54. See also Olin, 9.

³⁷James McConica, *Erasmus* (Oxford: Oxford University Press, 1991), 47. Erasmus was concerned with the “interiorizing of conviction,” and “meaning it.” Christendom’s enemies would be conquered by the allure of truth manifested in the lives of Christ’s followers.

³⁸John Huizinga, *Erasmus and the Age of Reformation* (New York: Harper Torchbooks, 1957), 39.

approach; nevertheless, their contrasting styles, their conflict over ideas and attitudes, and their individual reflection on human worth advanced different aspects of the Reformation's humanistic movement in its slow evolution toward individual autonomy.

While it is true that neither Erasmus nor Luther, despite all incumbent discords, sought intentionally to eliminate the church entirely, what was unseen by these men in their lifetimes was the effect their reform would have upon the growth and spread of autonomy in subsequent eras. People felt freed at last to use their minds and to act in ways which would effect changes in the culture that surrounded them.

Enlightenment Humanism

In the Enlightenment,³⁹ the interest in classical antiquity continued but with an ever-increasing emphasis on the individual use of human reason.⁴⁰ As Kant illustrated, "Enlightenment" was the ability of a man to use his own understanding without another's guidance.⁴¹ An indication of this use of reason was the emerging separation between the individual and the traditional source of authority--the Church. Scientific methodology soon became the tool to discover truth, leaving behind Christianity and other supernatural revelation or faith-based expressions of authority.⁴² It was at this time that a clearer secular picture of

³⁹*The Oxford Companion to Philosophy*, 1995, s.v. "Enlightenment." The term will be used to mean the period also known as the Age of Reason. The Enlightenment marked a philosophical development between the seventeenth and the eighteenth centuries that focused on the use of one's reason without the external guidance of another. Cf. Peter Gay, ed. *The Enlightenment: A Comprehensive Anthology* (New York: Simon and Schuster, 1973).

⁴⁰Kant, "What is Enlightenment?", 384.

⁴¹Ibid.

⁴²Gay, 17. Gay also notes that Enlightenment thinkers were not "anti-God" or anti-religion" *per se*, but that they agreed, for the most part, that religion and Christianity were not the sole pathway to truth or happiness (17, 19).

autonomy began to emerge. Kant noted that the Enlightenment required nothing but “freedom,” and by that term he meant the freedom to test one’s reason openly.⁴³

The Petrarch of the Enlightenment was John Locke (1632-1704) who added his emphasis upon “individual” political liberty, and advocated the position of noninterference from the State as a corollary.⁴⁴ In the emerging Enlightenment, philosophers like Kant and Locke expressed their desire for the right to be freed from external interference and from the dual chains of Church and State authority.⁴⁵ John Locke’s emphasis upon using the rational mind to solve current problems was another important feature of Enlightenment autonomy. The Church might be interested in the eternal, but the enlightened man was interested in the present. This emerging view shared origins with the Renaissance union of man and nature,⁴⁶ and took voice in the work of Thomas Paine.

Thomas Paine (1737-1809), whose literary work proved to be a moving force in America’s separation from Great Britain, was a passionate advocate of man’s freedom from governmental interference based upon God-given natural rights.⁴⁷ The chief goal of

⁴³Kant, “What is Enlightenment?,” 386.

⁴⁴John Locke, *Second Treatise*, 8. Cf. Kant, “What is Enlightenment?” 386.

⁴⁵Locke, *Second Treatise*, 8; see also Kant, *Groundwork*, 105-8. Cf. Sullivan, 15. Note that the aspect of individual freedom emphasised here was still, at this period, *freedom from* interference and not *freedom to be or to do* what one pleased.

⁴⁶Bullock, 52-54.

⁴⁷Paine, 30, 65. Cf. Thomas Paine, “Independence--A Natural Right,” in *The Liberal Tradition in American Thought*, ed. Walter E. Volkonner (New York: G. P. Putnam’s Sons, 1969), 50. Paine felt that government was at best a necessary evil. Government was established to restrain the vices of men. Cf. Harold Nicolson, *The Age of Reason: The Eighteenth Century* (Garden City, New York: Doubleday & Co., 1961). Compare Thomas Hobbes, *Leviathan*, ed. with an introduction and notes by J. C. A. Gaskin (New York: Oxford University Press, 1998), 86-88. Hobbes held the view that all men possessed natural rights, but his view of man was markedly different from writers like Paine and Locke. Man was warlike, was governed only by his own reason, and had a right to everything, even the body of another person (87). Each person was to use his rights for self-preservation. A person could transfer some of his rights to another for protection, but could not give up all his rights (i.e., the right to defend himself against attack). Hobbes felt that all men were brutish and that government was needed to keep them from harming one another. Men would transfer their rights to a sovereign and establish a

government was to preserve the natural rights of man--liberty, property, security, and the freedom to resist oppression.⁴⁸ Other natural rights were the rights of the mind, and the rights of acting as an individual for one's own comfort or happiness, as long as one did not injure or interfere with another's pursuit of the same.⁴⁹ In his *Declaration of the Rights of Man and of Citizens*,⁵⁰ Paine stated that men were born free and should always have the right and opportunity to continue to live freely and equally within those rights. The resultant idea of individual political liberty, a term synonymous with the notion of freedom,⁵¹ was premised on the then-radical concept that a person should have the right to make determinations concerning his own life.⁵² This was believed to be a natural right grounded simply in the fact that the person was human, having been created by God.

Jean Jacques Rousseau (1712-1778) pushed the concept of autonomy further by introducing the Age of Sensibility with his "Social Contract" of 1762. He believed that all individuals were born free and equal and that the depravity of civilised institutions had stifled or, in some cases, robbed them of freedom and equality through injustice and corruption.⁵³ He, therefore, believed that individuals were justified in using force to ensure freedom for others.⁵⁴ Rousseau further believed that each individual might have a private, or personal, will in

contract (89). This contract became the great *Leviathan* to which men owed their peace and defence. The *Leviathan* had absolute power and was above the law as long as it secured order within the state.

⁴⁸Paine, *Rights of Man*, 65.

⁴⁹Ibid., 30.

⁵⁰Ibid., 65.

⁵¹Berlin, 121.

⁵²Lindley, 6-7, 9. Lindley believes the concept of individual autonomy has been central to the "liberal" political tradition which, rather insufficiently, he defines as the type of political system found in the UK and the US (7).

⁵³Jean Jacques Rousseau, "Forcing a Man to Be Free," in *The Portable Age Of Reason Reader*, 167. Cf. Nicolson, 416.

⁵⁴Rousseau, 167. Cf. Nicolson, 417.

addition to the general will one might express as a citizen.⁵⁵ Rousseau's thought demonstrates an extended stage of development of the concept of autonomy in which there was a noticeable awareness of, and difference between, the "individual-as-a-person" as over against the "individual-as-citizen."⁵⁶

Men like Paine and Rousseau began not only to view the individual as someone who should be free from outside interference, but also to advocate the liberty of that individual to act contrary to the State if that freedom were jeopardised. The French and American revolutions serve as examples of the application of this new way of thinking about the roles of citizens and their governments. The notions of individualism and identity spawned the concept that government was to be at the disposal of the people and not people for the sole disposal of government without checks and balances to curtail the potential abuses of individual or political power. This does not suggest that every humanist of the Enlightenment era used the specific term *autonomy* when discussing self-rule or self-governance; yet the evolving concept of individual autonomy formed the backdrop to ongoing discussions of political and personal liberties--ideas considered radical, even in a revolutionary age.

Immanuel Kant (1724-1804) was one of the premier Enlightenment writers whose concept of autonomy remains influential even today. While it is true that the elements of ancient autonomy, those of self-rule and constraining external interference, are contained in Kant's view of autonomy, he also believed that a person was morally autonomous if he were free from coercion in the use of his reason and resultant action according to his will. The centre of autonomy for Kant was human reason. Interference with that human reason or autonomy could be either physical, like a State's control over one's property, or more subjective, such as

⁵⁵Rousseau, 166. An important distinction about the Renaissance in contrast with the Middle Ages was the emergence of man the "citizen," whereas before he had been man the "subject." See Ullmann, viii.

⁵⁶It is of note that what has been perceived as an "anti-authority" current within the developing concept of humanism may instead be a refocusing of where that authority lies.

the institutional Church's influence over one's belief system and attending actions involving the will. If nothing else, Kant's perspective on autonomy indicates that, while the concept contains nuances of meaning, it remained clearly within the general scope of the ancient definition.

By the end of the Enlightenment the definition of autonomy had evolved to the point that man, as individual, had begun to wrestle with the notion of authoritative structures that shaped and even, sometimes, controlled his manner of living. Both Church and State now came under the light of rational scrutiny, and at some points their authoritative claims were challenged. It is important to note, however, that as the concept modified in subtle ways as it was applied in new contexts, limits on individual autonomy still remained. For example, individuals were still limited in their challenges to the authoritative claims of church and government. Since the notion of "freedom of thought" had not yet reached the point where it became an ideal that championed full liberty from external constraint, Enlightenment man still lived, in large measure, under the unified umbrella of governmental and ecclesiastical authoritative structures. This notion of challenging authoritative structures even more thoroughly from the claim of autonomy became a central feature in the nineteenth century, especially in the writings of John Stuart Mill.

John Stuart Mill's Nineteenth-Century Humanism

John Stuart Mill writes of the long battle between "Liberty" and "Authority," and "Government" and the slow evolutionary contest between subjects, or classes of subjects, in the struggle to liberate the individual.⁵⁷ By *liberty*, Mill meant *freedom from the tyranny of political rulers*.⁵⁸ Mill's philosophy of the individual shows further development from that

⁵⁷Mill, "On Liberty," 126-27, 135, 205.

⁵⁸Ibid.

which was articulated in the Enlightenment.⁵⁹ Enlightenment thinking, found in spokesmen like Paine and Rousseau, as well as events like the French and American revolutions, was echoed in Mill's "progress of human affairs," for Mill's writing reflects changes that took place *after* the revolutions. While the Enlightenment thinkers had rejected a philosophical foundation based upon supernatural revelation, for the most part they still reflected a transcendent, rather than immanent God and considered the implications of His existence for humanity.⁶⁰

Mill, on the other hand, while not antagonistic toward religion,⁶¹ was clearly man-centred in his positions,⁶² confident in man's capability to pursue happiness, to reason for himself, and to act apart from divine impetus. In comparison with the Enlightenment writers of the previous era then, Mill built stronger boundaries around the concept of the individual--a noteworthy change from pre-Enlightenment humanism.

Mill, for example, defined the autonomous individual as one who possessed liberty of thought, feeling, tastes, and pursuits.⁶³ Mill advocated that an individual's personal liberty was

⁵⁹Ibid. He writes of a time when in the "progress of human affairs" . . . "men ceased to think it a necessity of nature that their governor should be an independent power, opposed in interest to themselves," 127.

⁶⁰Locke, *Two Treatises*, 151. Cf. Paine, *Rights of Man*, 28. Most Enlightenment writers believed that a God, or Governor of the Universe, existed and that mankind felt obliged to worship Him. Furthermore, a moral code ought to be followed in order to establish an orderly society, which included reparations for wrongdoing and a reward system that was both present and future in its scope. These common elements, expressed in Lord Herbert of Cherbury's *De Veritate*, first published in 1624, were accepted in variant forms and included in most writings of the Enlightenment period.

⁶¹Mill, "On Liberty," 241. Mill, in a larger discussion of testing in the public education arena, states that there is nothing wrong with examining an atheist in the evidences of Christianity, for example, as long as he is not required to profess a belief in Christianity.

⁶²Ibid., 139. Mill was sceptical of religion because its power was often wielded by an hierarchy or by the "spirit of Puritanism." Cf. 136, where Mill shows his high view of man by labelling man as a "progressive being." The ground for moral decision-making is man alone. If man chooses to seek the wisdom of deity, then that is considered to be good, but there is no dread of deity if man chooses to look elsewhere for help. Note that the vestiges of man-centred humanism of the Renaissance are still evident in the developing thought of autonomy here as well.

⁶³Ibid., 138.

to be respected deeply,⁶⁴ so much so that he placed severe limitations on the possibility of outside interference with that liberty.⁶⁵ Contrary to those who postulated interference in the exercise of individual freedom upon the basis of morality or physical good, Mill believed the only reason to interfere with a person's freedom (liberty) was to prevent harm to another.⁶⁶ A free person was absolutely sovereign over his own body and mind.⁶⁷ This self-sovereignty Mill believed to be a right for all humankind⁶⁸ was in contrast to Thomas Paine and other Enlightenment writers who based man's autonomy on God-given natural rights. Mill did not base his conceptions of autonomy upon God-given (*a priori*) natural rights; rather, he chose to base his conceptions of the same upon empirical grounds and the GHP. This, once again, like Mill's claims concerning rights and justice, was a departure from the historical development of autonomy. In so doing, Mill separated himself distinctly from the ancient ideas of human dignity⁶⁹ and the reemergent Renaissance focus of human dignity grounded upon natural laws. Mill based man's autonomy, then, upon the individual alone *and the GHP*.

Furthermore, whereas Kant centred autonomy in human reason, Mill centred autonomy in an individual's desire for his own greatest happiness. Even though Kant and Mill centre their approaches to autonomy in differing sources, the concept of self-rule is still present in the term, as well as the idea of limiting the interference of coercive "others," whether those influences are governmental, ecclesiastical, or even the "tyranny of the majority."⁷⁰

⁶⁴Berlin, 127-28; and Lindley, 44.

⁶⁵Mill, "On Liberty," 135.

⁶⁶Ibid.

⁶⁷Cf. Schneewind, *Invention of Autonomy*, 1.

⁶⁸Mill, "On Liberty," 135.

⁶⁹See thesis, 152. The notion of human dignity since antiquity had been associated with a cluster of ideas that blended together nature and Judeo-Christian traditions.

⁷⁰Ibid., 127-30. Mill states that a time came when it appeared to men that it would be much better for the various magistrates of the State to be "their tenants or delegates, revocable at their pleasure." He also notes that society can restrict the freedom of the individual in a

Mill's distinguishing shift in the definition of autonomy from Enlightenment thought, then, lies in his detachment of the concept from a link to deity. What had begun with Renaissance humanism in general had now evolved into nineteenth-century individualism. The idea of personal autonomy had emerged; however, it had yet to receive preeminent status.⁷¹ That would come in the following era.

Twentieth-Century Humanism and Beyond⁷²

Mill's view of autonomy provided support for the late-twentieth century's modern understanding of the concept. Noninterference with an individual's personal freedom, as well as the maximum liberty for autonomous action, solidified into key elements within the concept's general definition.⁷³ At the end of the twentieth century, the dialogue concerning PAS used Mill's emphasis on the self-governing individual to claim that the individual is to be morally free in every respect with the limit of inflicting harm upon others.⁷⁴

The principle of autonomy gained preeminence, especially in the medico-legal arena, within the last three decades of the twentieth century.⁷⁵ In contemporary biomedical ethics, the

much more damaging way than can government. He labels this the "tyranny of the prevailing opinion or feeling." See thesis, ch. 4, 228-29. However, Mill's GHP conceivably could fall into a tyranny of the majority.

⁷¹Compare the statement of Beauchamp and Childress.

⁷²For the purpose of this thesis, references to this time period will be stated in terms of the present and will include the first four years of the twenty-first century.

⁷³Mill, "On Liberty," 135, 138.

⁷⁴Ibid., 184. It is important to note, however, that even in Mill's era, the principle of autonomy did *not* carry the added emphasis of obliging another person or group to perform some action to ensure the happiness or desire of a specific individual.

⁷⁵Lamb, 112. Lamb states that PRA has grown to "considerable stature." Norman L. Cantor, *Advance Directives and the Pursuit of Death with Dignity* (Bloomington, IN: Indiana University Press, 1993), 2. Cantor writes that "patient control" over medical intervention has now become both the legal and medical norm. See also Beauchamp and Childress, 272, in which the authors state that medicine, especially in the last thirty years, has been confronted with the patient's need to "make an independent judgment."

word *autonomy* refers to the position of individual authority from which personal choices and preferences are made that determine the outcome of a person's life.⁷⁶ The concept carries the idea of *self-rule* and the *capacity both to choose and to make one's own rational decisions*. This means that the person, or patient in the medical context, has the expectation that she will be free to make her own decisions, regardless of how ill-defined, irrational, or limited her understanding of her situation or medical condition may be.⁷⁷

How is Autonomy Evident in the Doctor-Patient Relationship?

It is important to establish a link between the historical development of autonomy and the DPR. To begin, general agreement exists about what constitutes the essentials of autonomy: namely, liberty and agency.⁷⁸ An autonomous person demonstrates liberty when he is free from coercion and exercises his ability to make an independent decision. Second, an autonomous person also demonstrates the capacity for intentional action that can be explained by reference to his own goals or purposes. The evolution of the concept of autonomy has not changed historically in relation to these features.⁷⁹ Today, US patients choose freely whether to go to a doctor in the first place and then, within the confines of certain limitations, choose which

⁷⁶Beauchamp and Childress, 58.

⁷⁷Beauchamp and Childress, 123. For example, the elderly patient may exhibit various degrees of understanding and independence.

⁷⁸Ibid., 121. Cf. Lindley, 6; and McLean and Britton, 20-21. Of course, it must be noted that any individual is "autonomous": whether she chooses to admit it or exercise it may be a different point altogether. In fact, one cannot be forced *to choose*, or to exercise individual choice *to do something*. When a patient has exercised the choice *not to select an option*, the patient has actually made an intentional determination. If patients are acknowledged as having the *liberty to act*, the notion of "agency" may then take both active and passive forms in the medical context.

⁷⁹Compare Renaissance humanism where men began to view themselves as individuals (thesis, 152) and where man began to react against any compulsion to do the will of the Church (thesis, 155-56). See Enlightenment humanism where man began to react against political compulsion (thesis, 157-60). Cf. Mill's more fully developed views that autonomous individuals should be free from outside interference and free to pursue their own life plans and purposes (thesis, 160-63).

doctor(s) to see. Patient autonomy is often exercised through free choices a patient makes concerning acceptance or refusal of treatment, accepting or rejecting recommended hospitalisation, and accepting or foregoing end-of-life treatment, just to name a few examples.

To assert that the word “autonomy” still carries much of its original meaning, however, is not to say that its implications have remained static. There are those who now interpret its meaning to advocate practically whatever one desires.⁸⁰ The notion of “autonomy,” as a result, has become the dominant consideration in medical-ethical decision-making. Its corollary implications and their applications, such as moving from *noninterference* in medical treatment to *positive liberty* emphases, have sparked fresh debate within the context of the DPR. Some patients and PAS advocates assert that the principle of patient autonomy now *obliges* the physician to satisfy the patient’s desires, including such practices as ordering certain medical tests or procedures, permitting end-of-life decision-making to be made primarily by the patient and his family, and even aiding a patient with his own suicide.

Cultural Shifts

These changes within the autonomy definitions, implications, and their applications may indicate a broader cultural shift, similar in many respects to the sweeping changes reflected in the earlier Renaissance period. As was demonstrated in this chapter, the Renaissance and Reformation were both engendered, and were furthered in part, by revolutions in culture that facilitated a climate for deeper moral consideration; for example, the invention

⁸⁰Beauchamp and Childress, 70-71. The authors discuss rights’-based theories. See Paul Kurtz, ed., *Humanist Manifestos I and II* (Amherst, New York: Prometheus Books, 1973), 17. The section entitled “Ethics,” states that ethics is autonomous and situational. “Ethics stems from human need and interest.” Human life has meaning for the individual when one creates and develops one’s own future. The *Manifesto* does state elsewhere that humanists believe in maximum individual autonomy with social responsibility (18). See Humphry and Clement, 28. The authors recall the 1960’s era and use, as an example, Tom Hayden’s Students for a Democratic Society belief that a democracy should ensure that society be “organized” to encourage independence in people. See also *Dictionary of Medical Ethics* (1981), s.v., “moral autonomy.” The dictionary distinguishes between autonomy, libertarianism, and individualism. See Daniel Callahan, “When Self-Determination Runs Amok,” *Hastings Center Report* 22, no. 2 (March-April, 1992): 50-55, esp. 52.

of the printing press that opened the doorway for the spread of Renaissance humanism. Today, a parallel exists with the advent of computerised technological information systems and the mass distribution of knowledge at the fingertips of society. Part of the information disseminated through the media and internet is medical in nature, and patients now often freely access information about their medical questions independent of their physicians. A patient's potential for conflict with his physician increases if and when the patient's own research does not lead to conclusions which correspond with those of his physician.

A second similarity demonstrates a cultural shift. Tremendous conflict arose in the Renaissance, Reformation, and Enlightenment era about the often coercive control which was perceived to have been exercised by both Church and governments over people, individually and collectively. Today, similar unrest may be felt when doctors, other medical authorities, and courts use medical technology to provide legally mandated treatment for patients, sometimes in contradiction to the desires or financial capability of family members.⁸¹

A third comparison involves the questions, often termed *moral questions*, which surface when a patient's desires are left unsatisfied. A catalyst for growing Reformation and Enlightenment humanism was the moral argument which arose out of the struggle between institutional control and the growing notion of individual autonomy. This moral outcry, added to complex perceptions of injustice in many arenas, joined together into a cause for revolt against political tyranny. While social, political, and ecclesiastical situations in the US and the UK in no way parallel the pre-French Revolutionary period, current medical literature reveals a growing struggle with the moral nature of medical authority and its perceived injustice or, at least, threat to patient autonomy. An examination of this specific struggle within the DPR yields insight into the state of cultural humanism at present.

⁸¹Compare the cases of Tony Bland (UK) and Karen Ann Quinlan (US) where court involvement, early on, caused lengthy delays and hindered family desires to end medical treatment.

Perspectives: The Relationship Between Patients and Physicians

A focus on patient autonomy alone would be one-sided. Since patients' judgments now sometimes differ from longstanding medical values,⁸² the practical result of this clash is that the exercising of patient autonomy runs counter, in some cases, to the established medical obligation to act beneficently toward the patient.⁸³ Since the prevailing climate in medicine increasingly favours patient autonomy--that is, the fulfilling of a patient's will--"physician paternalism" has been cited as one form of interference with those ends. It is, therefore, important to examine the validity of the claim that a physician who refuses to grant a patient's autonomous choice of treatment is "paternalistic" in his treatment of his patient.

There are at least two areas of the relationship between physicians and patients where differences in values may occur, thereby leading to potential conflict. These areas represent places where the patient is most vulnerable in the DPR, and where medical authority and practice most often become an issue with a patient. The first area is that of informed consent, a practice instituted in order to safeguard a patient's interest in the DPR. Informed consent consists of two aspects, which are the information given by the physician and the consent given by the patient.⁸⁴ The "autonomous patient," therefore, is entitled to receive clear information from the doctor about her condition and should have dominion over her own body so as to make decisions about her treatment.⁸⁵

Respect for autonomy centres on the patient's privilege to refuse the doctor's suggested course of treatment, even if the patient's understanding is less than the physician's understanding, or even if the patient makes the wrong choice. *The Patient Self-Determination*

⁸²Beauchamp and Childress, 210.

⁸³Ibid.

⁸⁴Samuel Gorovitz, *Doctors' Dilemmas: Moral Conflict and Medical Care* (New York: Oxford University Press, paperback edition, 1985), 38. Patient competence, while not specifically noted, is essential to "informed consent."

⁸⁵This is true except in cases of an emergency or of diminished capacity.

Act of 1990, for example, is public law in the United States, guaranteeing the right of competent adults to make their own medical treatment decisions. Patients in the UK or US may choose treatment from several alternatives.⁸⁶ They may also refuse treatment.⁸⁷

Yet, for all of the emphasis upon, and legal protection of, patient consent, studies have shown that some physicians seem reluctant to accommodate patient preferences.⁸⁸ In these studies, when faced with patient challenges, physicians asserted their dominance, resorting to the use of persuasion techniques based upon the claim of their medical expertise.⁸⁹ Doctors suggest supporting reasons for this physician-response. Doctors may discuss the medical situation with their patients, but the patient may not understand clearly either his medical condition or treatment options.⁹⁰ Doctors might also find it nearly impossible to explain a medical matter well enough to bring the patient into full understanding. In another scenario, the patient may be relatively well and willing enough to participate in life-and-death decisions, or he may not be capable of so doing.⁹¹ The underlying issues which create conflict between patient autonomy and physician paternalism are not only real, but are also complex.

It is important to clarify that the DPR is not merely one-sided, with physicians currently at the total mercy of patient responses based upon autonomy. Patients may also make requests

⁸⁶BMA, *Euthanasia*, 39. Compare the updated version in BMA, "End of Life Decisions," 3. Cf. Brett and McCullough, 1347-51. Cf. Cook, *Patients' Choice*, 159. Cook writes that free and autonomous individuals can decide what they want to happen to them.

⁸⁷Cook, *Patients' Choice*, 228. Marcia Angell, "Case of Helga Wanglie," 511-12. BMA, "End of Life Decisions, 1. All references to a right to refuse treatment refer to competent adult patients.

⁸⁸Marrijoy J. Kelner, and Ivy L. Bourgeault. "Patient Control Over Dying: Responses Of Health Care Professionals." *Social Science Medicine* 36, 6 (March 1993): 757.

⁸⁹Kelner and Bourgeault, 757. Cf. Carol Moody, "The Right to Refuse Medical Treatment," *Hospital & Health Services Administration* 31, no. 1 (Spring 1991): 147-53. The article gives legal insight into the issues involved in these cases.

⁹⁰Gorovitz, 39-40.

⁹¹Gordon L. Snider, "The Do-Not-Resuscitate Order," *American Review of Respiratory Disease* 143 (1991): 666.

of physicians and have their views discussed, all within certain boundaries. A patient request for treatment neither guarantees employment of said treatment, nor obliges a provider or a healthcare system to carry out such treatment.⁹² Autonomous patients are not free to demand that a physician injure them, provide “plausible but inappropriate” therapy (for example, amphetamines for weight reduction), or order therapy that has no value.⁹³

While some confusion about end-of-life decision-making grows out of the current rhetoric concerning the right-to-die debate, an important clarification is that patients already have a choice about their end-of-life decisions. This basic right is rooted in American constitutional freedoms. The patient has the right to decide when he or she is ready for death and to have that decision acknowledged by caregivers.⁹⁴ The patient is free to choose to forego life-prolonging procedures⁹⁵ and for his illness to take its natural course ending in death. This right-to-die is qualified by the corresponding limit that, while the patient can expect care and support in terminal illness, the patient cannot expect the doctor to kill.⁹⁶ The *Patient Self-Determination Act of 1990* “requires healthcare institutions to disseminate written information at the time of admission about the patients’ rights under state law to refuse treatment and to formulate advance directives.”⁹⁷ This is not a new concept. Since the turn of the twentieth

⁹²Miles, 513. BMA, “End of Life Decisions,” 3.

⁹³Miles, 513. Compare end-of-life requests in BMA, “End of Life Decisions,” 3. If a patient requests a “doctor to contravene the rules laid down by the regulatory body, the General Medical Council or the doctor’s own conscientiously held views, then the request can be denied.

⁹⁴BMA, *Euthanasia*, 3. “The BMA emphasises that doctors should accede to a request not to prolong a patient’s life of treatment which the patient does not want. . . .”

⁹⁵Angell, “Case of Helga Wanglie,” 511.

⁹⁶BMA, “End of Life Decisions,” 3. The conclusion is “. . . the BMA’s policy, approved by its membership at several annual representative meetings, is that doctors should not actively intervene to end life or give assistance to this end.” Cook, *Patients’ Choice*, 159. “A patient cannot force a doctor to act contrary to the law or to his conscience.”

⁹⁷Lawrence O. Gostin, “Deciding Life and Death in the Courtroom from Quinlan to Cruzan, Glucksberg, and Vacco: A Brief History and Analysis of Constitutional Protection of

century, the United States Supreme Court has “recognized that the competent person has a constitutionally protected ‘liberty interest’ in refusal of unwanted medical treatment.”⁹⁸ The Supreme Court, with the Cruzan case, now extended this significant liberty interest to include the refusal of life-sustaining treatment.⁹⁹

At this point, it may be beneficial to note that much of this discussion regarding the DPR is still more theoretical than practical. Indeed, while autonomy may be guaranteed by law, this end-of-life autonomy is not always put into practice by either patients or their physicians. For example, studies have shown that while patients largely wish to be informed about their medical circumstances, a substantial number of them do not want to make their own medical decisions. Findings show that they might not even care or want to participate in their own medical decisions in a significant way.¹⁰⁰ Furthermore, another important study determined that even when physicians were given detailed reports on their patient’s prognosis and were told their patient’s feelings about CPR, the treatment of pain, receiving information, and advance directives, “no significant change occurred in the timing of DNR orders, in physician-patient agreement about DNR orders, in the number of undesirable days [patients experienced], in the prevalence of pain, or in the resources consumed.”¹⁰¹ Similarly, the study determined, in spite

the ‘Right to Die,’” *Journal of the American Medical Association* 278, no. 18 (November 1997): 1524. For information on “advance statements,” see also the British Medical Association; internet, available at <http://www.bma.org.uk/public/bmapas.nsf/guidevw/terminology>; accessed 18 July 2001. For information on “advance directives,” see also American Medical Association PolicyFinder—Current Opinions of the Council on Ethical and Judicial Affairs, “E-2.225 Optimal Use of Orders Not to Intervene and Advance Directives”; internet, available at http://www.ama-assn.org/apps/pf_online/pf_online?f_n=re.../CEJA&&nth=1&&st_p=0&nth=1; accessed 18 July 2001.

⁹⁸Gostin, 1524.

⁹⁹Ibid.

¹⁰⁰Schneider, 41. Schneider writes that the graver “the patient’s illness, the less likely the patient is to want to make medical decisions.”

¹⁰¹Schneider, 208-9. The study was titled “SUPPORT” (Study to Understand Prognoses and Preferences for Outcomes and Risks of Treatments). It focused on over nine thousand seriously ill patients in five prominent teaching hospitals across four years.

of the emphasis upon better communication between patients and their doctors, that patients did not alter their preferences about DNR orders, their communication with physicians, or even their overall satisfaction with their care.¹⁰² Given these significant, if not surprising results, the observation may be made that patient autonomy is expressed at times by choosing to make no decision concerning treatment simply by deferring to the advice of the doctor,¹⁰³ or sometimes, as an odd juxtaposition, requesting assistance with suicide.¹⁰⁴ The latter request conflicts with law in most places.

The law in the UK and in the US, except for the state of Oregon, prohibits doctors from complying with a patient's request for suicide assistance. Proponents of PAS argue that the principle of respect for autonomy should also include, in some specific cases, the right to a doctor's assistance with suicide.¹⁰⁵ Their argument is based in part upon their understanding of autonomy. The working definition of this thesis is that autonomy historically included liberty and agency. Liberty includes freedom from external interference and the ability to make a free decision; agency includes the capacity for intentional actions. Some PAS proponents interpret these notions of liberty and agency to mean that a competent and autonomous patient should receive assistance with suicide upon his request. While the request is not intended to oblige the doctor to violate his conscience, the request should still be honoured, based on the principle of

¹⁰²Schneider, 209.

¹⁰³“SUPPORT” showed that patients were often dissatisfied with their physicians; perhaps more with a physician's apparent lack of concern or personal contact rather than with a violation of autonomy. The differences in values may relate to such disparate reasons as physician etiquette at one end of the spectrum or to medical paternalism on the other end. Still, patients were likely to defer to the advice of their physicians, despite registering dissatisfaction.

¹⁰⁴*The Oregon Death with Dignity Act*, sections 2.01, 3.06; internet, available at http://www.islandnet.com/~deathnet/ergo_orlaw.html; accessed 16 June 2000.

¹⁰⁵Battin, *Least Worst Death*, 112-13; cf. McLean and Britton, 25. For a practical application cf. *The Oregon Death with Dignity Act*, sections 3.01, 3.02. Competent patients who make their request “voluntarily” and act “voluntarily,” among other requirements, are considered suitable candidates for physician-assistance-with-suicide.

respect for autonomy. The patient should be able to make this request and “receive” physician assistance with his own suicide. The latter scenario is currently allowed by case law in Oregon,¹⁰⁶ however much the new law departs from historic definitions of autonomy by moving beyond “noninterference” toward an added positive liberty claim. PAS advocates would consider a refusal of a PAS request to be a paternalistic infringement upon the patient’s autonomy--that the doctor, hospital policy, or government, was interfering with the patient’s right to dispose of his own person in the manner he selected.

This challenge of paternalistic infringement introduces the other perspective in the discussion of autonomy, that of medical and physician paternalism. Medical paternalism is not new and has been perceived to have imposed limits on patient autonomy. These limits to autonomy, such as the overriding of a patient’s wishes concerning treatment, or the ordering of tests or surgery without adequate input from the patient, have contributed, at times, to the tension between values patients hold and those inherent within the medical profession.

One problem in the current debate surrounding patient autonomy is the claim that it reduces morality to the arbitrary decisions of patients.¹⁰⁷ Factors exacerbating this perception may include the regulation of medical practice and imposed barriers to the acquisition of many medical services¹⁰⁸ or medical crises which occur when patients cannot govern themselves due to temporary constraints like illness, depression, or ignorance.¹⁰⁹ The exercise of patient

¹⁰⁶Amy D. Sullivan, Katrina Hedberg, and David W. Fleming, “Legalized Physician-Assisted Suicide in Oregon--the Second Year,” *New England Journal of Medicine* 342, no. 8 (February 2000): 598-604. Oregon legalised PAS in 1997. Sixteen patients died from PAS in 1998, and twenty-six patients died in 1999 from PAS. See also Beth Casper, “42 Use Suicide Law in 2003”; internet, available at <http://www.dwd.org/fss/news/sj.03.10.04.asp>; accessed 13 May 2004. Casper writes that in 2003, forty-two people used the law, compared with thirty-eight in 2002; twenty-one in 2001; twenty-seven in 2000 and 1999; and sixteen in 1998.

¹⁰⁷Lamb, 113. Compare Berlin, 123. Berlin terms this attitude “frustrating my wishes.” “The wider the area of noninterference, the wider my freedom” is the core idea behind the position. Hence, to limit a person’s wishes has become, for some, interference with autonomy.

¹⁰⁸Brett and McCullough, 1347.

¹⁰⁹Beauchamp and Childress, 121.

autonomy includes such aspects as privacy, consent, confidentiality and choice; however, individual autonomy itself has never been an absolute in society. Personal rights and freedoms have usually been restricted, for several reasons: to minimise the possibility that a patient will harm himself; to minimise harm to others; and to minimise harm from others.¹¹⁰ The view of the medical profession that life is of worth, regardless of a patient's physical circumstances,¹¹¹ has historically been founded upon a moral view that places limits on autonomy and feeds the debate at a foundational level. The next section of the chapter will examine this issue of medical paternalism.

Physician Paternalism

The medical profession wields a persuasive claim to authority by virtue of professional training, technological expertise, and recognised certification. This authority may be viewed in several ways.

The Question of Authority

Physician authority may be earned. Doctors are present at critical transitions in a patient's existence, and they serve as intermediaries between science and private experience.¹¹² Sickness, by its very nature, creates conditions that promote the patient's acceptance of his physician's judgment. The doctor offers a personal relationship and authoritative counsel at this critical time,¹¹³ earning the patient's trust and, thus, the right to instruct and be followed. Others view authority differently. Some patients relinquish their authority to their physicians,

¹¹⁰Cook, *Patients' Choice*, 228.

¹¹¹Gormally, 131-32.

¹¹²Starr, 4.

¹¹³*Ibid.*

as has already been shown, for a variety of reasons.¹¹⁴ Still others see the exercising of authority truncated when some doctors, in an effort to leave the decision-making to their patients, provide no leadership at all—even though their patients perceive they cannot make these most weighty decisions themselves without their physicians' guidance.¹¹⁵

Exercising Authority

Factors affecting physicians' exercising of authority are numerous. First, the level of the patient's competency is one of several such factors affecting the DPR and the exercise of physician authority. Differences in age and cognitive ability between doctors and patients also sometimes dictate how physicians' instructions and recommendations are perceived by patients.¹¹⁶ Another factor is that doctors typically are motivated by good intentions, having the best interests of their patients in mind.¹¹⁷ When a patient entrusts his health into the care of a physician, he often voluntarily relinquishes his own autonomy in exchange for his physician's authority. While perhaps not ideal, this exchange of patient autonomy (which can be an exercise of autonomy) for physician authority is one of the scenarios sometimes present in the DPR.

Another factor associated with physician authority is the setting of the hospital itself. Medical decisions in hospital are governed by legal and regulatory guidelines that safeguard

¹¹⁴Schneider, 41. Studies indicate that, while patients wish to be informed about their circumstances, a substantial number want neither to make their own medical decisions nor to participate in the decisions in a substantial way. The elderly or those with graver illnesses, for example, are less likely to want to make their medical decisions.

¹¹⁵Dame Margaret Turner-Warwick, "Paternalism Versus Patient Autonomy," *Journal of the Royal Society of Medicine Supplement* 87, no. 22 (1994): 16.

¹¹⁶Gary R. Anderson, "Paternalism," in *Health Care Ethics: A Guide for Decision Makers*, ed. Gary R. Andersen and Valerie A. Glesnes-Anderson (Rockville, MD: Aspen Publishers, 1987), 179.

¹¹⁷*Ibid.*, 180.

autonomy.¹¹⁸ Everything from limits placed upon visiting hours to restrictions regarding a patient's diet fall under this category. Physicians, nurses, and other advocates must act as liaisons and gatekeepers between patients and the governance of the healthcare system.

A further factor in a physician's exercising of authority deals with the present reality that his decisions affect persons other than his individual patient. Sometimes the patient's wishes or desires, if granted, may impose an unfair burden upon others, particularly if those desires would require an inordinate percentage of the common community resources.¹¹⁹ Prudence in the allocation of resources is a major consideration for all sides in the medical debate. Still another reason a physician may exercise authority over a patient's desires may be when the patient's choices, wishes, or actions violate a medical moral principle.¹²⁰ All of these factors make the exercising of authority a complex issue. Physician authority, no matter how it may be perceived, acquired, or administered, coupled with the factors affecting its exercise, still requires some justification.

Historically, this justification has been rooted in the principle of physician beneficence. While not an exact parallel, the principle is as ancient as the Hippocratic Oath's injunction to "do good," or at least, to "do no harm."¹²¹ The exercise of this principle of beneficence has contributed to some of the tensions concerning patient autonomy in the last three decades, especially when the principle has been used by physicians to deny PAS requests from their patients or their patients' families. Nonacquiescence to patient choices, wishes, and actions has

¹¹⁸Ibid., 181.

¹¹⁹Childress, 20. The BMA stresses that in prescribing and treating patients, doctors must remember their duty to other patients as well.

¹²⁰Ibid.

¹²¹Hippocrates, *Hippocrates*, vol. 2, trans. W. H. S. Jones (Cambridge: Harvard University Press, 1967. Childress, 18-19. To "do good" does not exactly correspond with to "do no harm," although they are linked by PAS advocates to advocate a change in the historic meaning of physician beneficence. See thesis, ch. 1, 32-34.

received close attention.¹²² Indeed, it is in this fact that physician authority can often interfere with patient autonomy, self-determination, and liberty that raises a question about physician paternalism, even if the justification for the physician's action is that of beneficence. The concept of paternalism must first be defined before the claim may be examined as to its possible influence on patient autonomy.

Paternalism: Etymology and History

Paternalism, as defined in the *OED*, is “the principle and practice of paternal administration; government as by a father; the claim or attempt to supply the needs or to regulate the life of a nation or a community in the same way a father does those of his children.”¹²³ In comparison with the word “autonomy,” the etymology of the word “paternalism” is much shorter. In fact, its specific usage dates back only to the 1880s.¹²⁴

The ancient Hippocratic Oath shows several similarities with the definition of paternalism, however, and suggests a longer history to the idea. A Hippocratic physician entered into a solemn agreement concerning his medical education. As a pupil, the physician-to-be regarded his teacher as equal to his parents.¹²⁵ The pupil shared his life with his teacher, financially supported his teacher, and made the teacher his adopted father.¹²⁶ The definition, “government as by a father,” was modelled upon this relationship. Further, the Hippocratic corpus provided the earliest example of a new *model* of medicine, or *medical praxis*, which was borne out of a theoretical foundation. The Hippocratic physician, then, worked within a philosophical structure that was practised in the physician's moral relationships.

¹²²Tannsjo Torbjorn, *Coercive Care: The Ethics of Choice in Health and Medicine* (London: Routledge, 1999), 5.

¹²³*OED*, 2d ed., s.v. “Paternalism.”

¹²⁴*OED*, 2d ed., dates the origin of the term at 1881.

¹²⁵Edelstein, *Hippocratic Oath*, 39.

¹²⁶*Ibid.*

Some medical historians believe that the Pythagoreans influenced at least part of the Hippocratic ideal.¹²⁷ This may be possible, although little else is known of the Pythagorean School other than the prime motive of Pythagorus was his desire to establish a society favouring a way of life characterised by morality.¹²⁸ Edelstein's internal examination of the Oath revealed the Pythagoreans' influence upon the Hippocratic Oath's prohibition of suicide,¹²⁹ indicating that the Hippocratic Oath possessed a moral and beneficent tone. The Oath's structure and tone was intended to regulate how physicians were to conduct their affairs. The Hippocratic model then, demonstrated medical values and moral commitments in the exercise of medical skills, to seek the good, welfare, interests, needs, and values of the one being aided.¹³⁰ The Hippocratic Oath combined these obligations with general rules for physicians. It then delineated what constituted physician helpfulness: continence, secrecy, and self-regulation.

It may be said that a rudimentary expression of paternalism exists within the principle of beneficence, for the principle of beneficence refers first to a moral obligation to act for the benefit of others, an ideal that first emerged in the Hippocratic model.¹³¹ Paternalism contains the Hippocratic ideal that seeks the good, welfare, needs, interests, and values of the one being aided, all of which are acts motivated by a desire for the *benefit* of others and not their harm.¹³²

¹²⁷Edelstein, *Hippocratic Oath*, 15, 60-61, 64. Henry E. Sigerist, *A History of Medicine: Early Greek, Hindu, and Persian Medicine*, vol. 2 (New York: Oxford University Press, 1961), 231.

¹²⁸W. H. S. Jones, "Philosophy and Medicine in Ancient Greece," no. 8, Supplements to the *Bulletin of the History of Medicine*, ed. Henry B. Sigerist (Baltimore: Johns Hopkins Press, 1946), 1.

¹²⁹Edelstein, *Hippocratic Oath*, 15.

¹³⁰Nigel de S. Cameron, *The New Medicine: The Revolution in Technology and Ethics* (London: Hodder & Stoughton, 1991), 23.

¹³¹Beauchamp and Childress, 260.

¹³²*Ibid.* Cf. Earl E. Shelp, ed., "To Benefit and Respect Persons: A Challenge for Beneficence in Health Care," *Beneficence and Health Care* (Dordrecht: D. Reidel Publishing

Although not equivalent, a physician was, at worst, to do no harm and at best, to do good for his patients.

The definition of paternalism includes the secondary statement, “government as by a father,” implying a body of knowledge or skill not yet possessed by those the father oversees, and the stewardship entrusted to the father to protect or defend the weaker ones in his care. The principle of medical beneficence, then, includes the physician’s primary responsibility to use his or her knowledge and skill for the patient’s medical benefit.¹³³ It should also be added that, as early as Hippocrates,¹³⁴ physicians were free to rely almost entirely on their own judgments¹³⁵ about the needs of their patients, although medical consultants have been routinely used throughout history. It was later when patients began to question the bounds of authority in the DPR and suggest that their own opinion should not only be consulted, but, in some cases, accepted over those of the medical community. This spirit and attitude emerged in Enlightenment thought.

The nineteenth-century institutional churches of Europe rarely protested against the status quo. Instead, by their silence, they supported state policies which perpetrated such evils

Co., 1982), 200-201, 204.

¹³³Beauchamp and Childress, 272; and Cook, *Patients’ Choice*, 227. Cook states that patients need the skill, advice, and genuine concern of their doctors. This is part of beneficent paternalism, but can lead to negative paternalism when heavy overtones of protection infringe upon the patient’s dignity, participation in the DPR, or opportunities for autonomous choice, for example. See Harold Y. Vanderpool, “Doctors and the Dying of Patients in American History,” in *Physician-Assisted Suicide*, ed. Robert F. Weir (Bloomington, IN: Indiana University Press, 1997), 43-47. Vanderpool presents an historical overview of the “dreadfulness” of hospital dying from 1952-1970 that reveals a quite different view of physician paternalism. Vanderpool writes of a “priority of prolonging life” and of doctors who “often cannot bear the thought of losing a patient” (44). Doctors, at times, sought to “control” what patients and families knew (45). At other times, patients, whose pain could not be controlled, were “euthanized” (45). These actions have been cited to foster an awareness of a form of negative paternalism that some patients decry.

¹³⁴Beauchamp and Childress, 272. The authors cite *Epidemics* and the celebrated expression, “As to disease, make a habit of two things--‘to help or at least to do no harm!’”

¹³⁵Ibid.

as slavery, child labour, and starvation. Kant advocated liberality of government (as opposed to the “illiberality” of tyranny), that was limited to protect life and freedom.¹³⁶ His view recognised an individual’s freedom and capacity to determine his or her own conception of happiness and to pursue it so long as the pursuit was undertaken in a lawful fashion.¹³⁷ It would be paternalistic, according to Kant’s view, if a government were to assume total responsibility for the happiness of its citizens by predetermining what and how that happiness was to be applied to the lives of its citizens.¹³⁸ In Kant’s day, overt paternalism did not generally spark negative responses by citizens. However, post-Enlightenment changes in the meaning and application of autonomy to include the individual would reach a stage where conflict erupted between autonomy and paternalism.¹³⁹ The late twentieth century witnessed the repercussions of this development.

Paternalism at Work

Paternalism takes varied forms, of which state paternalism and medical paternalism are two types that are perceived to restrict individual autonomy. Government in liberal democracies, according to Lindley, is premised on the idea that citizens should have the right to determine the course of their own lives.¹⁴⁰ Although quite narrow in its definition, Feinberg explains that paternalism, as the “liberty-limiting” principle called “legal paternalism,” justifies state limitations to protect individuals from harming themselves “or, in its extreme version, to

¹³⁶Sullivan, *Introduction to Kant’s Ethics*, 8.

¹³⁷*Ibid.*

¹³⁸*Ibid.* Beauchamp and Childress, 273. Kant, according to the authors, was concerned with a government that “cancels freedom.”

¹³⁹See ch. 3, 1, for Schneider’s assessment of autonomy.

¹⁴⁰Lindley, 9.

guide them, whether they like it or not, toward their own good.”¹⁴¹ Kantor offers examples of “state paternalism” when he writes of compulsory vaccinations or the requirement of prescriptions for drugs, although neither of these examples accurately reflects the concept of paternalism. His point is that the government, in these cases, limits the liberty of individuals for their own sake or for the sake of the population at large.¹⁴²

In like manner, “medical paternalism” would be exercised when a physician justifies patient coercion, albeit subtle coercion, or overrides a patient’s preferences to protect a patient from harm. This negative connotation assumes, of course, that there are contrary patient preferences that a physician dismisses. The physician might base such action on the principle of medical beneficence, but this judgment and its subsequent course of action now raise questions related to the current definition of autonomy. Paternalism has come to mean, in late twentieth-century medical terminology, the “. . . interference with a person’s freedom of action or freedom of information, or the deliberate dissemination of information, when the alleged justification for interfering or misinforming is that it is for the good of the person who is interfered with or misinformed.”¹⁴³ In the presence of such an array of working definitions, then, interpreting the term correctly involves several important aspects for consideration.

Several common ingredients of paternalism may be listed at this point. First, paternalism includes stewardship or oversight arising from the *possession of certain skills or knowledge designed expressly to help others*. Next, and similar to the point above, it includes a

¹⁴¹Heta Häyry, *The Limits of Medical Paternalism* (London: Routledge, 1991), 51. Joel Feinberg, as quoted in Häyry. The author also quotes Jeffrie Murphy (51). He defines paternalism as the “coercing of people primarily for what is believed to be their own good.” Richard Arneson adds that restrictions on a person’s liberty are justified exclusively by consideration of that person’s good or welfare and that the restrictions may be carried out either against his present will or against his own prior commitments (52). This, however, is a narrow and autonomy-devaluing interpretation.

¹⁴²Jay E. Kantor, *Medical Ethics for Physicians-in-Training* (New York: Plenum Medical Book Co., 1989), 16-17.

¹⁴³Allen E. Buchanan, “Medical Paternalism,” in *Paternalism*, ed. Rolf Sartorius (Minneapolis, MN: University of Minnesota Press, 1983), 62.

desire to exercise oversight in a helpful way through supplying the needs or regulating the life of the patient *for a specific period of time*--hence, fatherly administration to provide that which is lacking. Paternalism also includes, at times, *interference with the free choices* and decisions of a patient *in order either to "do good or to prevent harm"* to the patient.¹⁴⁴ Lamb writes that the principle of autonomy, for all of its history, is a relative latecomer to medical ethics and foreign to much of medical practice.¹⁴⁵ This would explain part of the reason for current conflict in the DPR. The next section of the chapter examines *where* paternalism might be evident as doctors and patients relate to one another.

Where is Paternalism Evident in the Doctor-Patient Relationship?

All things being equal, the DPR is not level ground when a patient consults a doctor about his ailment(s). The doctor has knowledge and experience in assessing symptoms, rendering diagnoses, and treating illnesses. The patient, being ill and needing some assistance in returning to health, exercises his choice in seeking the aid of a physician. The physician, in turn, exercises his choice in agreeing to treat the patient. This scenario, although rather attenuated in the UK system, occurs each day in healthcare contexts.

A physician seeks to protect the patient who is ill and in a clinic or hospital, and the doctor has a plan of treatment that he believes to be the best course of action for the patient. The doctor also has a degree of interest and concern for the patient that motivates her to spare the patient pain and harm,¹⁴⁶ and likely has the wherewithal to make decisions to provide direction. The physician, for example, may order an uncomfortable diagnostic procedure which may be necessary to determine the best way to alleviate the patient's pain, and follow up with a

¹⁴⁴Compare Cook, *Patients' Choices*, 227.

¹⁴⁵Lamb, n.p. Cf. Beauchamp and Childress, 210. The authors write of the change in patients' judgments in the last thirty years, often very different from the medical values of care and healing. The popularity of patient autonomy rights as over against physicians' professional obligations toward beneficence has created conflict.

¹⁴⁶Anderson, 178.

treatment that counteracts the patient's stated preference against the procedure. In this case, the physician may look beyond the patient's anxiety to provide what she feels is best for her patient.

On the other hand, the physician may perform the same diagnostic procedure to determine whether the patient's illness is contagious and poses a health threat to others as well.¹⁴⁷ In yet more serious cases, a physician may override a patient's preferences because the patient demonstrates limited capacity or impaired cognitive ability, such as the after-effects of a seizure or the result of a stroke. All of these physician actions have been labelled "paternalism" by advocates of patient autonomy, although one would be hard-pressed to find the negative consequences to patients in these examples implied by the definitions used by Buchanan and others.

A true and deeper level of negative paternalism may occur when the physician dismisses a patient's request altogether without observing the mutual respect necessary in an effective DPR. For example, the doctor may think that his expertise or skill leads him to believe that the patient's choice would be harmful, that it would not faithfully represent that patient's normal course of action, or even the careful choice of a normally prudent person.¹⁴⁸ In some instances a physician may disseminate only partial information or disregard a patient's request for information if he feels this may be of harm to the patient.¹⁴⁹ When physicians act in

¹⁴⁷Battin, *The Death Debate*, 147-48. Battin terms "soft" paternalism as a doctor's action that is justified because of a patient's illness or because a patient is inadequately informed. "Hard" paternalism takes place when a doctor overrides a patient's actions when he perceives the harm to his patient to be very great.

¹⁴⁸Gerald Dworkin, "Paternalism: Some Second Thoughts," in *The Theory and Practice of Autonomy*, Cambridge Studies in Philosophy (New York and Cambridge: Cambridge University Press, 1988), 124. Hard paternalism, according to Dworkin, is sometimes justified even if the action is fully voluntary on the part of a person.

¹⁴⁹Buchanan, "Medical Paternalism," 62. See Vanderpool at thesis, ch. 3, 178, footnote 133.

these ways, these actions have the potential to influence negatively their relationships with their patients¹⁵⁰ who often consider such actions to be “negatively paternalistic.”

The impact of paternalism upon the DPR is significant in that both physicians and patients have offered compelling surface arguments to justify behaviours based upon paternalism or autonomy. At the heart of the discussion lies physician and patient values, many of which have moral overtones. For example, the physician’s own feelings and beliefs can be powerful. In the case of a physician who does not believe it is right for him to assist a patient in suicide, it is not likely that he will choose to suppress his personal convictions for the sake of patient autonomy.¹⁵¹ Patient autonomy advocates do not often question kind intentions on the part of physicians. However, deliberate interferences with the preferences of patients are an open source of conflict, and Mill’s harm principle for support of physician noninterference has become their philosophical warrant.¹⁵² These advocates insist that unless someone other than the patient is in jeopardy, the patient’s request should be granted.¹⁵³

These moral reflections on the parts of patients and physicians are heightened when the patient requests that the physician assist him with suicide. If the patient is ill and a physician interferes with a general treatment regimen, this action provokes less tension in the paternalism debate than if the patient is terminally ill and his physician interferes with his request for assistance with suicide. The competing views in the PAS debate are at such a level of intensity

¹⁵⁰Of course, the potential necessarily exists, even if only with attendant family members, because the fact is that some patients either do not *know* of their physicians’ decisions or do not *care*.

¹⁵¹van der Maas and Emanuel, “Factual Findings,” 166.

¹⁵²Mill, “On Liberty,” 135. “. . . the only purpose for which power can be rightfully exercised over any member of a civilised community, against his will, is to prevent harm to others. His own good, either physical, or moral, is not a sufficient warrant.”

¹⁵³Compare Glover, 75. See also Rachels, *End of Life*, 181. Rachels believes there should be no interference with autonomy unless a person is harming another. He also believes one should not interfere with a person even if it is for his own good.

that the physician's refusal to assist the patient with suicide then becomes a much graver aspect of the dialogue.

The two scenarios are different in the respect that, in the latter situation, the physician is requested to act contrary to an established medical principle, even though autonomy advocates now claim that "mercy" is an appropriate physician response to a patient's request for assistance with suicide and that, sometimes, the proper response is for that physician to assist with that suicide. The argument claims that, should the physician comply with the request, he would thereby demonstrate his kind intent which is encompassed within the principle of physician beneficence. The physician is left torn between two arguments. If he chooses not to comply with the request, he is most likely deemed to be "unmerciful" or paternalistic. If he agrees to assist with the suicide, he chooses an action which runs contrary to the established norms of historic medical practice.

Summary

Opponents of PAS often cite the Hippocratic tradition in support of physician paternalism, even though the Hippocratic tradition weakens at the point of its deontological nature and lack of grounding in any theory of values.¹⁵⁴ Conversely, strong advocates of patient autonomy believe individuals ought to be granted the greatest degree of autonomy possible, all the while acknowledging that safeguarding autonomy also means protecting both physicians and patients from deeper degrees of negative paternalism.¹⁵⁵

This complexity of the arguments for and against autonomy and paternalism lead to questions regarding appropriate actions for both patients and physicians in the DPR. The ability to determine clearly where physician paternalism may be beneficial, and when it may interfere negatively with the patient's autonomy, is blurred by a lack of mutual agreement in the DPR.

¹⁵⁴Pellegrino, *Humanism*, 99.

¹⁵⁵Glover, 74.

The issues are muddied still further by the fact that a patient's desire for medical aid may indeed imply a preference for paternalistic intervention in the first place. Mill believed that an individual best knew his own interests, but that the nature of medicine was such that the physician often asserted, and even co-opted, the patient's own "best response" to the physical illness. Mill believed that this interference was a greater evil than any errors a person, physician or patient, might otherwise make.¹⁵⁶ This dilemma of patient autonomy versus physician paternalism leads to a further question.

If patients are fearful of the potential present misuse of physician knowledge or authority in the DPR,¹⁵⁷ then the potential future misuse of an argument from mercy bears implications as well. This means that a physician, who has authority to use the knowledge and means necessary to terminate life, might interject his values about this form of "mercy" in a way that is harmful to patient preferences.¹⁵⁸ Moral concerns surface at this level of discussion about positive and negative paternalism that require an examination of a final PAS feature, the SL, which will be examined in the final section of the chapter.

Sanctity of Life

Introduction

Having examined the historical and philosophical interrelationship between autonomy and the DPR within the context of the PAS and HU debate, the argument seems to coalesce at a

¹⁵⁶See Dworkin, "Paternalism," in "Paternalism," ed. Rolf Sartorius (Minneapolis, MN: University of Minnesota Press, 1983), 25; first published in *The Monist* 56, no. 1 (January 1972): 65.

¹⁵⁷Pellegrino, *Humanism*, 120.

¹⁵⁸Battin, *Death Debate*, 145. Physician paternalism, for example, might range from simply helping to undo "antiquated suicide arguments" brought on by superstition or fear to altering circumstances in cases where, in what would otherwise seem to be an irrational and undesired choice for suicide, the decision for suicide becomes both rational and desired.

crucial underlying and deeply held value; namely, the “SL.”¹⁵⁹ The claim of this chapter is that the DPR is currently being influenced by a new, *and perhaps different*, emphasis on patient autonomy causing, in turn, changes in the way the notion of “SL” is being viewed by medical decision-makers. Both doctors and patients believe that human life carries deep significance and value and is to be accorded the utmost respect; nonetheless, interpretations and applications of this fundamental principle of respect for life often vary greatly within the DPR.¹⁶⁰ One of the more simplistic reasons for differences in the interpretation and application of the SL principle could be attributed to the varied virtue-characteristics that both patient autonomy and physician paternalism presently exhibit and pursue. In an “autonomy model,” qualities like respect for autonomy and privacy take the forefront, while in a “paternalistic model,” virtues like beneficence, care, and compassion are chief.¹⁶¹ These differences in view may occur anywhere along a spectrum that includes medical tests and procedures, end-of-life decision-making and, in some instances, a patient’s request for physician-aid-with suicide.¹⁶² A person’s own view about life’s value, whether that person is the doctor or the patient can, and often does, influence decisions.¹⁶³

¹⁵⁹See *ibid.*, 99. Battin acknowledges that the principle of the value of life in Western culture has primarily Judeo-Christian origins, and is also called the principle of *SL*. She also states that although the term “sanctity” locates the roots in “conceptions of life as God-created,” the term is used widely in current bioethics discussions without religious import. Terms like “value of life,” “respect for life,” “SL,” “inviolability of life,” and other like concepts are used reciprocally. This thesis will employ the term “SL” in its global sense, being inclusive of, but not limited to, religious import, unless so noted.

¹⁶⁰For example, see thesis, 193-94, for discussion of patient values that may now be different from medical values and run counter to the established medical professional obligation of beneficence.

¹⁶¹Beauchamp and Childress, 272-73, 464.

¹⁶²See thesis, 182-83, for the larger moral reflection on the aspect of positive liberty emphases which have emerged in discussions of patient autonomy in the DPR.

¹⁶³Pellegrino, *Humanism*, 100-101. Pellegrino writes that the physician is also a person, like the patient, whose values “invariably” colour his professional acts. Pellegrino would likely agree that values about the SL figure into these judgments.

Of late, however, while some PAS advocates claim that respect for a person's individual autonomy sometimes obliges a physician to assist a terminally ill patient with suicide, serious conflict has ensued inside culture and medicine over such a claim. The conflict could be viewed simply as one philosophical flashpoint along a battlefield between autonomy and physician paternalism, yet the intensity of the reaction suggests that something even deeper than philosophical differences has occurred. That which has triggered the conflict seems to be the result of the moral significance attached to the claim. The value assigned to the human species, especially at the end of life when illness prevails, runs deeply through the present discussion in culture and medicine. Yet, the claim of this section is that a lack of agreement within common morality concerning a value-basis for life's "sanctity" hinders the reaching of a moral consensus on PAS and other forms of medical killing.

This section of the thesis, therefore, will examine issues relating to SL from the moral perspective that recent autonomy discussions have brought into the DPR. The discussion will include an examination of key features that shed light upon the debate: definitions and usage of the term, an historical overview of the traditional medical "SL" perspective; divergent claims represented by "SL" and "Quality of Life" (QL) advocates; how end-of-life treatment decisions have been impacted by dehumanizing cost and technological advances; and the moral significance of such pivotal end-of-life decisions raised by the examination of the SL value.

"Sanctity of Life": Etymology and Usage

The "SL" principle is not a formal concept listed in dictionaries like the *OED*. The "idea" is an amalgam that has been developed from two complementary sources: revelation (theological) and reason (natural law and philosophy).¹⁶⁴ SL from a Christian perspective is rooted in the doctrine of God as Creator and holds that humanity, having been created in God's

¹⁶⁴Fisher, 316. See also Singer, 84. Singer recognises both the religious and secular facets to SL, but approaches the principle from a secular perspective in this work.

image, is infinitely precious to God and made for an eternal destiny.¹⁶⁵ The core of the religious principle holds that one ought never intentionally to kill the innocent. God's law/command explicitly forbids the taking of innocent human life.¹⁶⁶ Human dignity also belongs intrinsically to human beings equally, including the notion that one cannot lose one's inherent human dignity by acting in ways that are at variance with human dignity.¹⁶⁷ Traditional secular versions of the principle of sanctity of human life stress the equal dignity of all citizens.¹⁶⁸ Broadly, human dignity or worth currently depends upon two requirements: a human being having "developed presently exercisable psychological abilities for understanding, choice, and rational communication" and a human being "actually exercising such abilities in the enjoyment of an acceptable quality of life."¹⁶⁹

Regardless of the SL position one adopts, the fusion of ideas contained within SL is deeply embedded in law and ethics throughout the world, is expressed in human rights' documents, and is basic to common morality.¹⁷⁰ The phrase, "SL," originates from a number of streams which converge into a "values-pool." The specific application of the word-idea

¹⁶⁵*Westminster Dictionary of Christian Ethics*, s.v., "life, sacredness of."

¹⁶⁶Exod. 20:13.

¹⁶⁷Gormally, 119. Gormally states, ". . . one ought never to adopt any course of action or omission intended to terminate the life of an innocent human being."

¹⁶⁸*Ibid.*

¹⁶⁹*Ibid.*, 120. See also Singer, 125-26. Singer believes an "irreplaceable being" is one who is conscious of himself as a being existing not only at the present, but also as a being who existed in the past, and who will probably exist in the future.

¹⁷⁰Explanations of SL vary along a spectrum. Fisher, 317. Fisher states that the idea has informed medical ethics as far back as Hippocrates. See Carrick, 134-36. Carrick states that the Hippocratic Oath centres our attention on ". . . the value and respect we may or may not ascribe to human life." He also states that the Oath "proclaims a bias" that favours life and the living and it makes no apology for it. See also Daniel Callahan, "Defending the Sanctity of Life," *Society* 38, no. 5 (July/August 2001): 16. Callahan writes that the phrase "SL" is not a traditional religious concept and has "no fixed meaning." See also Singer, 84. Singer states that SL is "deeply rooted in our society and is enshrined in our law." See also thesis, ch. 2, 84, footnote 144.

depends upon, among other elements, the perspectives from which the streams emerged and the eras or contexts in which its concepts were both defined and applied.

Definitions and Usage

Callahan believes that almost nothing is more important for human welfare than humans deciding how they will value themselves.¹⁷¹ Yet, for all of its import, there is no commonly held definition for the cluster of descriptors which define the value of human life. The *OED*, for example, has no definition listed for the term “SL,” although the separate cognates are clearly enumerated throughout history. This quest for the meaning and value of life is as old as Hellenism.

Historical Medical Perspectives: Sanctity of Life

Ancient Greece

The Hippocratic position on respect for human life, as has been demonstrated,¹⁷² was likely influenced by the Pythagorean strict belief in foregoing any action that might prematurely end another person’s life. Life was believed to be in the possession of God.¹⁷³ The medical view of life has included a devotion to human interests among which one focus--the protection of human life--has been anciently rooted in principles within the Hippocratic Corpus.¹⁷⁴ One such Hippocratic principle, “to help, or at least do no harm,”¹⁷⁵ has served as a

¹⁷¹Callahan, “Defending the Sanctity of Life,” 18.

¹⁷²See thesis, ch. 2, 125-26, for discussion of Pythagorean influence on the Hippocratic proscription against killing.

¹⁷³Carrick, 134-36. Yet, importantly, not even the Pythagoreans chose to endorse the respect for human life ethic unconditionally. The Pythagoreans and Christians, for that matter, did not hold that human bodily life had absolute value *per se* simply because it was human life. They would not have endorsed such a secular principle. The value placed upon human life by Pythagoreans and Christians was conditional, at least partly, on the higher principle that God valued man. See also *Phaedo*, 62b-c where Socrates states that the gods are the keepers of men, and that men are one of their possessions.

¹⁷⁴J. K. Mason, *Human Life and Medical Practice* (Edinburgh: Edinburgh University Press, 1988), 3-4. Mason provides an overview of the move within medicine from the

primary medical standard that guided physicians toward supporting a basic human goal--that is, health.¹⁷⁶

Hippocratic medical humanism established, and still maintains, several key elements that stem from a belief in the SL. One of the most important of these elements is the concern for the patient's well-being.¹⁷⁷ This concern, documented as long ago as ancient Greece, describes physicians and physician helpers assisting the patient by promoting in the patients hope, courage, and trust.¹⁷⁸ The Hippocratic physician believed that health was beneficial,¹⁷⁹ and he practised his craft with the intent to cure and restore the patient.¹⁸⁰ This seeking to cure patients was tempered by the reality that not every disease could be healed; nevertheless, an overall intention to improve the quality of the patient's life was central to his craft. The

Hippocratic position of endowing life with an absolute value to a position of preserving QL. He states that this indicates a shift away from the historic Hippocratic position.

¹⁷⁵Hippocrates, "Epidemics I," in *Hippocrates*, vol. I, trans. W. H. S. Jones (Cambridge, MA: Harvard University Press, 1923), 165.

¹⁷⁶Thomas Percival, *Percival's Medical Ethics*, ed. Chauncey D. Leake (Baltimore, MD: Williams and Wilkins Co., 1927; reprint, Huntington, NY: Robert E. Krieger Publishing Co., 1975), 19. Leake comments that the Greeks "did not bother" about the details of ethical practice. The guiding principle was that the physician should help or at least "do no harm" to suffering humanity.

¹⁷⁷Chauncey D. Leake, "The Humanist Tradition in the Health Professions," 1, 4. Edelstein, *Hippocratic Oath*, 63. Edelstein says the Oath was true in the sense that it enjoined the physician to be helpful. He writes that at the end of antiquity, medical practice began to conform to the state of affairs which the Oath had envisioned. Carrick, 89.

¹⁷⁸Leake, 3.

¹⁷⁹Carrick, 36. The Hippocratic School adapted to the medical needs of patients. In the Classical period, patients tended to be the wealthy patrons who were able to follow the regimen of proper exercise, climate, diet, rest, etc. prescribed by physicians. In the Hellenistic period, economic necessity and the political pressures of being an "active, involved middle-class citizen trying to earn a decent living" may have forced a change in the thinking of some. Citizens were likely to modify their belief in perfect health and settle for one that was more suited to the business of their day. In either view, the physician sought to improve the health of the patient.

¹⁸⁰*Ibid.*, 69, 83. Taking into account the differing viewpoints about the meaning of the statements on abortion and euthanasia (4), a Hippocratic physician placed a high value on human life both individually and in relationship with others (8).

physician practised medicine within a community of like-minded physicians, all of whom, ideally, aimed to deliver patients back into their community relationships.¹⁸¹ In fact, the desire to restore a patient to wellness was *because* life itself was considered to be a “good.” The ethos of medicine centred on preserving life, and even though the SL principle cannot be said to have been binding for all physicians, it can be said that there was a generally held duty to protect life.¹⁸²

In this way, medical humanism in the Hippocratic era generally elevated the value placed upon human life. Likewise, Hippocratic medical humanism helped to establish a synergy between the physician and patient,¹⁸³ based upon the common desire for patient wellness which resulted in a moral bond between them. This bond was to last for centuries and served medicine well.¹⁸⁴ The Hippocratic Oath, indeed, gained general acceptance in the future Christian eras, particularly undergirding medical opinion as it hardened against suicide and abortion.¹⁸⁵

¹⁸¹Ibid., 69-70. Sections P2 and P7-P8 all indicate an interrelatedness between physician and patient as well as physician and community.

¹⁸²Ibid., 167.

¹⁸³Hippocrates, “Epidemics I,” 165. Hippocrates believed that the physician was servant of the art, and that the patient was to “co-operate” with the physician in combating his disease.

¹⁸⁴Pellegrino, *Humanism*, 99. Pellegrino adds that a further reason for a change in views about the Oath is that its norms are no longer regarded as unchanging absolutes (97). It became a contention in the most recent thirty years, when patient claims became the primary focus in the DPR, that the Oath did not leave room for a consideration of patient values. The claim was that the Oath was written by physician(s) for physicians, that patient values about life at times run counter to those of doctors, and that the Oath itself may be no longer adequate to inform physician values.

¹⁸⁵BMA, *Handbook*, 9.

The Christian Era

After the Pythagorean and Hippocratic eras, the high ideals of the Oath in regard to SL were picked up and broadcast strongly through Christianity in the following centuries.¹⁸⁶ Christians made the value of “bodily life at least partly if not totally conditional on the higher and antecedent principle that God valued man.”¹⁸⁷ In the early Christian era, this high view of human value grew. The Middle Ages, where doctors were most often priests, assured the continuance of this sort of religious SL view.¹⁸⁸

As time passed, the Hippocratic Oath became the nucleus of all medical ethics in all epochs and in all countries in which monotheism in its purely religious or secularised form was the accepted creed--even the “embodiment of truth.”¹⁸⁹ Jews, Christians, and Arabs felt the Oath’s impact. The “mediaeval” doctors, men of the Renaissance, scientists of the Enlightenment, and scholars of the nineteenth century also embraced the ideals therein.¹⁹⁰

The Hippocratic Code called for a deep concern the physicians were to show for their patients. The translation from its broad principles of high standards for health caretakers, however, began to decline when cultural, political, and technological changes brought about the arrival of the Great Industrial Revolution.¹⁹¹ It was Thomas Percival’s (1740-1804) *Code of Medical Ethics* that served as a bridge between two paradigms.

¹⁸⁶Edelstein, *Hippocratic Oath*, 63-64. The Oath was a bridge between “heathendom” and the new belief, Christianity, that found agreement with its principles.

¹⁸⁷Carrick, 136.

¹⁸⁸See thesis, ch. 2, 127.

¹⁸⁹Edelstein, *Hippocratic Oath*, 64.

¹⁹⁰Ibid.

¹⁹¹See thesis, 150-61, for a parallel discussion of the growth of autonomy and corresponding cultural changes from the Renaissance through the Enlightenment.

The Great Industrial Revolution to the Present

Roughly, the eighteenth century was the period when modern medical ethics emerged, and when the middle classes were “undermining the aristocratic order, and with it the tripartite establishment of physicians, surgeons, and apothecaries.”¹⁹² It was not until Percival that the transition was made to the current medical system, when he formulated a code of medical ethics that was based upon the Hippocratic ideal, but was also adapted and well-suited for the time in which he lived.¹⁹³ Part of his contribution to medical humanism was the assumption that the proper goal of medicine was the patient’s best medical interest, and on this basis he reached conclusions about the physician’s character traits.¹⁹⁴ His Code became a guidebook for interpersonal relationships between physicians and patients and became the foundation for medical codes that followed.¹⁹⁵ His ethics identified an unresolved tension that began to emerge between patient benefit and the development of medical science.¹⁹⁶ While it may not be said that patients or physicians were yet fully conscious of this tension in Percival’s day, he exposed

¹⁹²BMA, *Handbook*, 9-10.

¹⁹³Percival, 1. Leake qualifies the meaning of “medical ethics” with the statement that Percival’s ethics referred “chiefly” to the rules of Percival’s etiquette developed in the medical profession. It aimed to regulate the professional contacts members of the medical profession had with one another. See also Pellegrino, *Humanism*, 119. Pellegrino states that Percival adapted the Oath to the spirit of eighteenth-century England.

¹⁹⁴Beauchamp and Childress, 465. See also Percival, 20, 23-24, 36-37. Percival’s work helped with the transition from the broad principles of Greek medical ethics to the current system. The eighteenth century was a period when the philosophical significance of law and order in nature became generally appreciated. Prior to Percival, the medical profession tried generally to manage its ethical problems on the basis of good taste and personal honour, but Percival changed the emphasis in medicine to rules of proper conduct. His work was limited in scope, however, in that it did not draw a clear distinction between the incidental etiquette of medical practice and the fundamental ethical problems of the profession.

¹⁹⁵Beauchamp and Childress, 465. Cf. Thomas Tung and Claude H. Organ Jr., “Ethics in Surgery: Historical Perspectives,” *Archives of Surgery* 135, no. 1 (January 2000): 1; internet, available at <http://archsurg.ama-assn.org/issues/v135n1/full/ssa9023.html>; accessed 28 January 2000.

¹⁹⁶Lisbett Haakonssen, *Medicine and Morals in the Enlightenment: John Gregory, Thomas Percival and Benjamin Rush*, Wellcome Institute Series in the History of Medicine (Amsterdam: Rodopi, 1997), 149.

the incipient strain that would eventually become open conflict in the present-day DPR. When physician values and goals about life and health, ever-advancing medical technology, and differing patient goals intersect in a context where patient autonomy has gained preeminence, the potential for schism seems inevitable. Percival's work was, in this way, a laboratory in which this incipient DPR conflict provided a rudimentary theoretical framework for addressing physician and patient concerns.

Mill, with HU, sought to provide a more empirical view of life and its value than had previously been established through the centuries. The ethos of Hippocratic medicine had centred on preserving life, and while an SL principle was not considered to be binding upon physicians, there was a generally physician-recognised duty to protect life.¹⁹⁷ Christianity provided a SL underpinning through the centuries, especially with its prohibitions against killing.¹⁹⁸ The Christian SL view was conditioned upon the higher and antecedent principle that God gave value to man.¹⁹⁹ Mill, however, sought to replace such an *a priori* understanding of life with his empirical HU approach. He represents a point of departure from history in that he proffered a scientific approach to moral concerns, not the least of which was ethical concerns related to securing for individuals self-protection and self-development. His HU introduced a truly secular approach to moral decision-making,²⁰⁰ an approach that would portend conflict for traditional Hippocratic medical ethics. By introducing a qualitative PH dimension to HU, Mill also, quite unknowingly, provided a platform for future individual PH quality of life claims to be lobbied for in a wide range of social areas. One such area would be the DPR.

¹⁹⁷Ibid., 191.

¹⁹⁸Ibid.

¹⁹⁹Ibid., 192.

²⁰⁰The claims of deity and/or the Church would no longer necessarily shape SL considerations.

In eras to follow, medical codes were written with a mixture of professional obligations, ideals, and virtues, but always influenced by Hippocratic's and Percival's medical ethics. For example, the 1957 code of the American Medical Association listed the prime objective of the medical profession as rendering service to humanity. The physician was bound in the code to be upright, pure in character,²⁰¹ and diligent and conscientious in caring for the sick. It also endorsed several Hippocratic virtues, and most significantly, the Hippocratic proscription against medical killing.²⁰² Medicine still sustained the Hippocratic respect for the SL.²⁰³

Current Medical Situations

Physicians have, from the time of Hippocrates, both justified the use of authority and exercised it fully in the DPR, under the guiding principle of beneficence. Conflict emerged in the DPR, as the last section of the thesis described,²⁰⁴ at the point of beneficence or a physician's nonacquiescence with his patient's choices, wishes, and actions when those choices would lead to medical killing.²⁰⁵ Both patient autonomy and physician paternalism viewpoints offer reasonable surface arguments, but sharp differences exist between the positions and an impasse seems to remain.

Differences between physician and patient values often surface whenever a physician interferes with, or overrides, a patient preference, but most especially with end-of-life

²⁰¹Percival, 20. Leake writes that the simple criterion of medical etiquette for physicians for two thousand years has been professional dignity. The criterion includes leading a pure and moral life, and trying to be, in the "highest sense of the word," a philosopher. Whether most physicians today would agree with this statement is clearly another matter.

²⁰²See the AMA's *Code of Medical Ethics*, 1957.

²⁰³The Hippocratic values, while serving as a guide to those within the profession, were not, as yet, reflective of patient input.

²⁰⁴See thesis, ch. 3, 184-85.

²⁰⁵See thesis, 175, footnote 119. See also Torbjorn, 5; and Pellegrino, *Humanism*, 98; and see thesis, 174-76.

decisions. Supporters of patient autonomy have called for physicians to assist patients with suicide when those patients state such a preference, believing that this is sometimes the merciful response to a terminal illness. Although this is a different moral argument than the values-variations cited above, the repeated cry for sanctioned mercy-killing has become louder in the most recent three decades, but not solely as a result of evolving medical technologies that have made it possible to extend life well beyond former normal limits. The emerging medical wizardry has been but a precipitating cause and must not be mistaken for the crisis itself. The current focus over satisfying patient desires evolved over the centuries as seeds of autonomy were planted, nurtured, and eventually grew into a full-orbed humanism that demonstrates, at times, differing core values from medical paternalism.

At the heart of the issue are the varying values concerning the *meaning* of “life” and who *exercises control* over “life.” Traditional medical paternalism holds to a view of life, the “SL” position, which increasingly runs counter to the current view of patient autonomy.²⁰⁶ This latter view of autonomy, which includes the individual’s qualitative, self-calculation of PH, and developed through the centuries, seeks to ensure that man is given complete moral freedom to make decisions about his life without any external interference.

Sanctity of Life

The SL position is comprised of two parts: first, that “the value of life exceeds all other values” and, second, that “all lives are of equal value.”²⁰⁷ As such, this position is neither

²⁰⁶Gormally, 118.

²⁰⁷Peter Suber, “Against the Sanctity of Life”; internet, available at <http://www.earlham.edu/~peters/writing/sanctity.htm>; accessed 23 November 2003. See also “Euthanasia”; internet, available at http://bbc.co.uk/religion/ethics/sanctity_life/euthasanct.shtml; accessed 23 November 2003. The BBC online article states that human life is a basic good or a “good in itself rather than as a means to an end.” The article also states that “all human beings are to be valued, irrespective of age, sex, race, social status or their potential for achievement.” Dworkin, *Life’s Dominion*, 11. Dworkin states this view in terms of abortion and also euthanasia. He also terms the sacredness (sanctity) of life view as life’s *intrinsic* value.

originally nor solely a traditional religious concept,²⁰⁸ although the world's major religions categorically affirm life's sanctity. The point is that the principle, from a secular perspective, states that all human life has intrinsic value, and that all human life is presumed to have rights and interests that are worthy of protection.²⁰⁹ The principle is not an isolated or recent concept, having a history that dates back to the time of Hippocrates.²¹⁰ In more recent times, the essence of this position on life's value has been incorporated into the UN Declaration of Human Rights.²¹¹

The flurry of interest surrounding the principle is due, in part, to the rise of medical technologies that make possible the prolongation of life itself. Doctors have the dual responsibility to preserve life and to ease suffering and, as Cook states, sometimes these two aims conflict.²¹² Sometimes doctors and their patients have difficult choices to make because SL does not mean that life must be preserved at all costs.²¹³ Traditional moral and ethical formulations that sought to articulate value judgments were always difficult, but have become increasingly complex in light of life-preservation technologies. Names like Anthony Bland and Karen Quinlan have become household names and their circumstances reminders of the powerful technologies that can sustain life almost indefinitely. Many thinkers, both inside and outside of the medical community, now question the reasonableness of sustaining life at all costs.

²⁰⁸Callahan, "Defending the Sanctity of Life," 16. See also Richard M. Gula, *Euthanasia: Moral and Pastoral Perspectives* (Mahwah, NJ: Paulist Press, 1994), 25. See also Cook, *Patients' Choice*, 161.

²⁰⁹Gula, 25. Callahan, "Defending the Sanctity of Life," 16.

²¹⁰Callahan, "Defending the Sanctity of Life," 16.

²¹¹*Ibid.* Article 2 states that "everyone has a right to life, liberty, and security of person" and Article 6 states that "everyone has a right to recognition everywhere as a person before the law."

²¹²Cook, *Patients' Choice*, 133.

²¹³*Ibid.*, 161.

Current Changes in the Sanctity-of-Life View

Medical tradition, until most recently, favoured the view that the patient's treatment was determined primarily, perhaps above all, according to the judgment of the doctor, who usually called for maximum life preservation.²¹⁴ This idea is longstanding, for it links back to the deep-seated Hippocratic principle that reflects maximum life preservation as the doctor's primary "duty to do no harm" to his patient.²¹⁵ The good doctor did not always seek to preserve life at all costs, but the good doctor did act humanely. Even the PAS advocates argue that the good doctor always "helped" the patient on his or her way when appropriate. The features of medical humanism *to heal, or be of benefit, or to do no harm to patients*, have remained largely unchallenged throughout the centuries;²¹⁶ yet, in recent years a new emphasis has been added--that of *planned death*. Death itself has always been an acknowledged medical reality; yet the practice of medicine, until recently, has never been fixated upon "*death delivery*" or bringing about the *death* of patients. The recent attempt by PAS advocates to incorporate "merciful killing" within medical humanism is without precedent in the codes of medical ethics. Thus, the addition of merciful killing to the philosophy or practice of medical humanism introduces a new principle that is contrary to the established medical ethos of benefiting, or preserving, life.

Do No Harm: The Principle of Nonmaleficence

Opponents of physician-aid-in-dying cite the Principle of Nonmaleficence (NM) as a defence against physician involvement in medical-killing. NM undergirds a physician's obligation not to inflict harm intentionally to a patient.²¹⁷ This principle historically has been

²¹⁴Cantor, 1.

²¹⁵Stuart J. Horner, *Professional Opinion: Medical Ethics in England in the Eighteenth Century*, occasional paper no. 3 (Preston, Lancashire: Centre for Professional Ethics, University of Central Lancashire, 1997), 3.

²¹⁶See 152-53, footnotes 9-13.

²¹⁷Beauchamp and Childress, 189.

associated closely with the maxim, "Above all [or first] do no harm."²¹⁸ Even though the origin of this saying is obscure, and is not expressly stated within the Hippocratic corpus, nevertheless, an obligation of beneficence and of NM *is* clearly expressed in the Hippocratic Oath²¹⁹ although, in its day, not all physicians bound themselves to its precepts. The Oath introduced an incipient form of beneficence and NM which developed along the centuries into its present form. In a time when no "medical industry" existed as such, physicians were beginning to demonstrate an overall respect for life and its preservation--still one-sided, because the Oath was written by physicians for physicians. Unlike the present-day DPR, the patient's perspective was not in view at this time.

In the current climate of technological and scientific-medical advances, however, the patient's view has taken precedence. The historical development of the Hippocratic orientation toward physician duty and the SL perspective no longer provide the sole basis for medical decision-making. Beauchamp and Childress recognise that many present-day controversies in biomedical ethics involve the terminally ill, the seriously ill, and the injured, so they propose a framework for decision-making about "life-sustaining" procedures and assistance-in-dying that differs from the traditional model. At the centre of their framework is an interpretation of the principle of NM that sanctions, rather than "suppresses," QL judgments.²²⁰ Assuming a stance that is characteristically utilitarian, Beauchamp and Childress state that utilitarians and non-

²¹⁸Ibid. The actual key to understanding NM, though, relates to how "harm" is interpreted. Advocates for both sides of the PAS debate use the term. For example, PAS advocates charge that harm may be found in keeping the patient alive and continuing his suffering. PAS opponents argue that harm occurs when the physician helps to end the life.

²¹⁹See ch. 2, 130-34, for the discussion of euthanasia as it was defined and practised in Ancient Greece. The Hippocratic Oath says, "I will use treatment to help the sick according to my ability and judgment, but I will never use it to injure or wrong them." In Ancient Greece, a general "do no harm" principle arising from an intention to help patients prevailed, although some Pre-Christian Greek or Roman physicians participated in voluntary euthanasia.

²²⁰Beauchamp and Childress, 189-90.

utilitarians alike hold to a principle of NM,²²¹ and that QL assessments are often linked to treatment choices. Beauchamp and Childress propose a framework that would allow “patients, guardians, and healthcare professionals” in certain circumstances to accept or refuse treatments after considering the “benefits and burdens of those treatments.”²²²

Ordinary Versus Extraordinary Treatments

Several guidelines, one of which pertains to extraordinary (heroic) and ordinary treatment, have developed in “religious traditions, philosophical discourse, professional codes, and the law to specify requirements of NM in health care.”²²³ Certain distinctions between ordinary and extraordinary treatments have been used to justify and condemn decisions to give up life-sustaining treatments. The distinction has been employed to help determine whether an act that results in death should count as killing, especially as culpable killing.²²⁴ This difference has implications for a traditional SL view. In an earlier time, it was used by Roman Catholic theologians to deal with the problem of surgery before the development of antisepsis and anaesthesia. At that time it was used to help determine whether a patient’s refusal of treatment should be considered a suicide. Refusal of ordinary means of treatment was long considered a suicide, but the refusal of extraordinary means was not.²²⁵ Traditionally, the rule held that

²²¹Ibid., 190.

²²²Ibid.

²²³Ibid., 196. The other guidelines are: withholding and withdrawing life-sustaining treatment, artificial feeding and life-sustaining medical technologies, and intended effects and merely foreseen effects. Beauchamp and Childress argue that these distinctions, including the extraordinary and ordinary treatments above, are all untenable. They suggest that these traditional distinctions are outdated and are even, in some instances, morally dangerous. The authors recommend that these distinctions be replaced by the distinction between obligatory and optional means of treatment and by an account of the benefit-burden ratio. For a representative statement of the sixteenth-century Roman Catholic origin of the terminology, “ordinary” and “extraordinary treatment,” see also Wennberg, 125-27.

²²⁴Beauchamp and Childress, 200.

²²⁵Ibid. Families and physicians also were not held to be culpable if they withheld or withdrew extraordinary means of treatment from patients.

ordinary treatments could not be abandoned, but that extraordinary treatments could be legitimately waived.²²⁶ This rule has a well-known history in medical practice, legal decisions, and Roman Catholic casuistry.²²⁷

The rationale undergirding this distinction between ordinary and extraordinary means is the idea that there is *a crucial moral difference* between intentionally halting ordinary treatment and intentionally halting extraordinary treatment.²²⁸ In the traditional view, life implied “benefit” and death implied “harm.”²²⁹ The distinction is cast into urgent terms when terminal illness is at the forefront of treatment decisions. This difficulty lies in the tension between the physician’s care for his patient’s ultimate well-being, his duty to “heal,” the limits that might be imposed on the physician in light of a “SL” ethic that absolutely prohibits the intentional termination of life, and his view of all human life as of infinite value and intrinsic worth.²³⁰ The BMA states accurately that a noticeable shift has occurred toward more decision-making being based on “QL” assessments, particularly in the US, where the issue of patient autonomy and the QL of a particular patient would be adjudged either acceptable or

²²⁶Beauchamp and Childress, 200. See also Richard A. McCormick, “Quality of Life, The Sanctity of Life,” *Hastings Center Report* 8, no. 1 (February 1978): 30.

²²⁷Beauchamp and Childress, 200.

²²⁸Helga Kuhse, “Debate: Extraordinary Means and the Sanctity of Life,” *Journal of Medical Ethics* 7, no. 2 (June 1981): 74. Beauchamp and Childress, 200-202. Medical professionals are not in complete agreement as to what type of treatment falls within each category. The terminology originated with Roman Catholic theologians who used the distinction to determine whether a “patient’s refusal of treatment should be classified as a suicide” (200). At one time, a refusal of ordinary means of treatment was considered to be a suicide, but the refusal of extraordinary means of treatment was not. Beauchamp and Childress believe such criteria that seek to distinguish between ordinary and extraordinary treatment is relevant only “if some deeper moral consideration makes them relevant” (201). The authors conclude that the traditional terminology of ordinary (“usual” and “customary”) and extraordinary (“unusual” and “uncustomary”) treatment is “morally irrelevant” (202).

²²⁹BMA, *Medical Ethics Today*, 154.

²³⁰Kuhse, 75.

unacceptable.²³¹ Yet, QL decision-making in the modern medical arena involves necessarily broader considerations than either a patient autonomy model or physician-beneficence model indicate.

Influences Upon "Quality of Life" Decision-making

QL is both discussed and used as a qualifier under the rubric of "healthcare." However, the difficulty is in knowing how to measure such a gauge. One thing is clear in a pluralistic culture. No *absolute* value is placed on life itself.²³² An emphasis upon QL is pervasive in the contemporary culture. Life, for most individuals, must be perceived as worth the living and, as such, must contain some measurable quantifier of "quality." In the medical context, where resources are scarce and patient choice and autonomy are central, this notion of "quality-measurability" has received more attention and is now being directed toward the assessment of patients' lives.²³³

The *patient autonomy perspective*, in an end-of-life situation involving a terminal illness, offers but one example of a QL option. The patient may weigh the benefits and burdens of life-prolonging medical treatment and determine that the quality of his future life, with its attendant medical or physical constraints, may not be worth the prolongation of his life. From a *physician-beneficence perspective*, when QL is so sufficiently low that a medical intervention produces more harm than benefit for a patient, it may become justifiable to withhold or withdraw treatment.²³⁴

²³¹BMA, *Medical Ethics Today*, 165. These assessments of "acceptability" or "unacceptability" are equally true of terminally ill patients whether the state of incapacity is present or not.

²³²Cook, *Patients' Choice*, 134.

²³³*Ibid.*

²³⁴Beauchamp and Childress, 215-16.

Still another theoretical QL option would be the medical community's determination that the prognosis of a specific patient's QL following therapy *would be less than* that of a second patient in need of the same scarce resources.²³⁵ This sort of judgment would, in this scenario, involve persons other than the initial patient. In reality, the decision might be made outside of the context of his DPR. Indeed, analysts now attempt to determine the monetary value of a life in order to state benefits in relationship to costs with the aim of developing consistency across the medical community's practices and policies.²³⁶

End-of-Life Treatment Decisions

Freedom to Act Versus Cost Containment

Since illness often compromises one feature of autonomy--the ability of patients to aim toward achieving their personal goals--medical humanism seeks to help patients toward physical restoration in order to help make life goals, particularly health goals, a reality. This primary goal of patient well-being is indeed ancient. Despite the fact that healthcare has never operated purely outside the considerations of economic feasibility, nonetheless, the primary goal of patient well-being has been compromised of late by competition from the high cost of delivering that beneficial healthcare.²³⁷ The growing realities of healthcare rationing and cost containment make changes in life-value determinations within the medical community an issue of deep concern for all levels within the system, from the NHS in the UK to the privatised healthcare market in the US.

²³⁵Suber, "Against the Sanctity of Life."

²³⁶Beauchamp and Childress, 303-5.

²³⁷Mason, 4. Mason reasons that the differential allocation of resources, whether on financial or other grounds, is an indication of a shift away from the Hippocratic position. Mason also notes a shift from a focus on the absolute value of life toward an ethos that focuses on QL. See also Marcia Angell, "Sounding Board: Rationing by Any Other Name," *NEJM* 336, no. 23 (June 1997): 1668-71. Ever-rising costs make beneficial health services too expensive in some cases.

Considerations of financial and resource allocations carry severe implications for SL issues. For example, physicians in the UK have developed standards that incorporate economic realities into medical judgments that affect human life. The UK physician serves as “gatekeeper” in several ways. For example, physicians may routinely deny potentially beneficial healthcare to patients by simply not making the patient aware of a possible treatment,²³⁸ or replying simply with a “no,” when a request is made for a particular treatment or, more specifically, deeming a patient too old for long-term dialysis.²³⁹

Patients in the NHS have a high respect for their doctors, in spite of the fact that physicians must make difficult decisions relative to cost and that the goal of physical restoration is, at times, postponed. Patients realise that healthcare costs must be kept under control.²⁴⁰ Even though patients in the UK do not seem to blame their physicians for rationed care and often long delays for treatment, a potential moral concern still arises when economics take precedence over humanitarian needs.

The US healthcare situation is markedly different in terms of the delivery of healthcare and cost containment, yet the outcome is very similar to that of the UK in terms of patient-care cost analysis. Since healthcare costs keep rising, the American physician as “gatekeeper” is seen as the guardian of society’s resources, even though more than forty million Americans do not presently have healthcare.²⁴¹ This expectation of resource stewardship takes the physician out of the primary role of patient well-being advocacy and, instead, removes his platform

²³⁸William B. Schwartz and Henry J. Aaron, “Rationing Hospital Care: Lessons from Britain,” *New England Journal of Medicine* 310, no. 1 (January 1984): 54.

²³⁹*Ibid.*, 55. A physician may make exceptions to the rules and divert more resources to a patient in whom he is interested. Cost-review systems by tenured physicians who are employed on salary are designed to prevent such gross abuse as cited above.

²⁴⁰The system of healthcare delivery in the UK is geared to provide the basics of health care to the maximum number of people.

²⁴¹Quill, *Midwife Through the Dying Process*, 216.

advocacy to the side of the institution or healthcare organisation.²⁴² Through negative or positive incentives, the physician may be forced to conserve costs in a wide range of areas: testing, treatments, operations, hospitalisations, and referrals for consultation.²⁴³

If a physician is placed in the position of a “negative” gatekeeper, then she may be pressured to restrict the use of medical services of all kinds, but particularly those that are most expensive. Again, the possibility exists for moral conflict whenever considerations of cost or the institution come before the patient’s well-being.²⁴⁴ Physicians whose medical praxis is undergirded by SL values bear uniquely difficult burdens in light of the financial and technological resources that often limit the expectations of patients and their families. Patients, in their own right, deal with the difficulties of growing technology from a very different perspective.

Freedom from Interference Versus Technological Concerns

A patient’s illness interferes with his own freedom by rendering him vulnerable, often even compromising his ability to associate with his physician as a person with equal dignity. The burgeoning technological aspect of healthcare has impacted this relationship both positively and negatively. On the one hand, the goal of patient well-being has been sustained since antiquity, and continues to be the impetus for improvements in medical care. Medical

²⁴²Compare David A. Axelrod and Susan Dorr Goold, “Maintaining Trust in the Surgeon-Patient Relationship: Challenges for the New Millennium,” *Archives of Surgery* 135, no. 1 (January 2000): 2; internet, available at <http://archsurg.ama-assn.org/v135nl/full/ssa9027.html>; accessed 28 January 2000. Axelrod and Goold write of the tension between a physician’s financial interest and a patient’s health interest. “Surgery, therefore, often to a greater degree than other medical specialties, has been the target of employer and government attempts to limit expanding medical costs by expanding utilization review and managed care programs.”

²⁴³Edmund D. Pellegrino and David C. Thomasma, *For the Patient’s Good: The Restoration of Beneficence in Health Care* (New York: Oxford University Press, 1988), 172.

²⁴⁴Compare Axelrod and Goold, 1-14. The authors state that trust is low among Americans for surgeons. Among other things, high salaries, managed-care company profits, as well as an emphasis (by surgeons) on technical procedures to the neglect of interpersonal contact have been suggested as part of the problem. The authors call for reflection on the moral underpinnings of the surgeon-patient relationship.

technology makes it possible, now more than ever before, to extend life and postpone death, and added a new dimension to end-of-life care that is unprecedented in the history of medicine. To extend life well beyond its normal limits is, in most instances, considered to be a medical success; after all, the physician's task has been to preserve life, to "do good and not harm" his patients.

At the same time, questions arise regarding the wisdom of applying new technological advances categorically. Today's technological-medical environment spawns questions about the cost-success ratio. Advanced technology costs money and it, at times, yields only marginal success in patient health. Medical technology and the ever-burgeoning healthcare industry brought about new ways of thinking about healthcare in the 1970s when people began to compare the ever-rising cost of medical care with doubts about its long-term effectiveness. People questioned whether their health had improved enough to justify the increased costs and the development of newer and more expensive technologies. In many sectors, healthcare consumers determined that their health had not improved enough to warrant the cost increase.²⁴⁵

Questions about cost-success ratios challenge medical humanism at the point of moral concern, because when health management is reduced essentially to an equation related to cost versus extended-life years, the sanctity aspect of that life has the potential to be diminished. In their autonomy, patient-consumers seek healthcare providers to supply a "good return for money," like any other service industry. There is great benefit in wise financial management. However, a negative impact of patient autonomy exists if priority is granted to financial

²⁴⁵Starr, 380, 408. Starr writes of the change that took place in America's GNP as a result of healthcare costs. He also writes that Americans began to recognise that their health did not increase at the same rate as those costs. He notes that the concern with medical care was simply a part of a larger concern people had with institutional control (schools, rehabilitation of criminals, medical care, and government were all areas of concern). People began to criticise and accuse these services of a form of social control.

determinations as over against the value of human life. The devaluation of life's sanctity holds the potential for loss of human dignity.

Some patients are now exercising their autonomy in a new way, based upon the QL claim, that seeks to oblige the physician to satisfy the patient's desires, even to the point of killing. This occurs when end-of-life decisions take centre stage for the patient who is also often unaware of the dehumanizing impact of cost and technological considerations. While not necessarily, or even categorically so, the QL argument often weakens when thoughtful consideration is given to technological considerations or medical cost ratio determinations.

In the present health environment, even a slight shift toward technological and financial interests in healthcare, coupled with the easing of the "do no harm" principle in the treatment of individuals, may seem to benefit the patient whose preference is to control costs and is sceptical of some uses of life-sustaining technology. In reality, the pressures facing both patients and their physicians in this swirling matrix of medical change call for a reconsideration of the moral implications of end-of-life decisions.

Summary

The previous chapter highlighted several areas of critical concern that related to autonomy, the discussion of which has been a primary focus of the present chapter. The claim of this chapter is that the DPR is currently being influenced by a new, *and perhaps over-accentuated*, emphasis on patient autonomy causing, in turn, critical changes in the way the notions of physician paternalism and "SL" are being viewed by medical decision-makers. One indication of the overstress being placed on autonomy is its rise to preeminence in the DPR.

A key contributor in the development of such a rise in autonomy was the nineteenth-century theoretical views of John Stuart Mill's HU. Mill based autonomy upon the individual alone and the GHP.²⁴⁶ He established clear boundaries around a person by claiming that the

²⁴⁶See thesis, ch. 3, 162.

person should be free from any outside inference. This intersects medicine at the point where doctors interfere paternalistically with the free choices and decisions of a patient in order to “do good or to prevent harm” to the patient.²⁴⁷ Differences between patients’ values and physicians’ values often surface whenever a physician interferes or overrides a patient preference, especially with end-of-life decisions. Autonomy advocates believe that respect for patient autonomy obliges a physician to assist a patient with suicide. The focus on satisfying individual desires (in this case, a patient’s desires) evolved over centuries as humanism developed, but this perspective has been heightened, in part, by the influence of HU. However, Mill, while championing the individual autonomy and rights of persons, never claimed that either autonomy or rights were inviolable. It is a mistaken application of Mill’s concepts to interpret their influence as a *carte blanche* for guaranteeing an individual’s security (which cannot ever be absolutely guaranteed) and/or PH preferences.

Furthermore, deliberate interference with the PH preferences of patients also is an open source of conflict in the DPR. PAS advocates cite Mill’s “harm principle” for support of physician noninterference which has become their philosophical warrant.²⁴⁸ Advocates insist that unless someone other than the patient is in jeopardy, then the request of the patient should be granted. This, however, fails to take into consideration the GHP. Mill’s autonomy principle was subject to the principle of utility. It is conceivable that the patient’s PH preferences might be overridden to satisfy the claims of the GHP. It also is conceivable that a patient’s PH preferences would create negative utility for either his family or another group.

Something more is required, then, than a simple PH preference in order to evaluate the strength of an individual patient-claim to PAS. Further, it is not entirely clear that the “harm principle” was ever intended to become the “trump card” of individual autonomy claims as

²⁴⁷See *ibid.*, 175.

²⁴⁸Mill, “On Liberty,” 135.

some would believe in the current patient-autonomy movement.²⁴⁹ Open discussion about the possibility of greater harms to the ethos of medicine, patients, physicians, and culture as a whole is warranted, prior to making changes in medicine related to PAS. Changes in the healthcare industry, the influences of HU upon medical philosophy and patient autonomy, and medical-technological advancements as a whole, have created a need for patients and members of the medical community at every level to try to reach a consensus on a set of values to be given priority, especially in end-of-life situations. The current cultural debate on VAE and PAS draws attention to such a need.²⁵⁰ This chapter has shown that supporters of PAS, for example, use the argument from mercy as a basic reason for allowing physicians to assist their patients with suicide. This has sparked intense debate because any act of killing, whether motivated by mercy or otherwise, challenges the fundamental beneficent/nonmaleficent aim of medical humanism and constitutes a deviation from medical practice that has been sustained for more than two thousand years.

The debate itself surrounding merciful acts of medical killing demonstrates that voices outside the medical establishment are sounding new arguments against the medical value they desire to see modified. To permit merciful acts of killing would represent a change in medical values. Some advocates of medical mercy killing support such a change as a manifestation of compassionate medicine. In other words, they say, PAS is sometimes a compassionate response to a terminal illness.²⁵¹ If one examines the issue solely from its consequences, this

²⁴⁹Ibid., 136. Mill always regarded utility as the ultimate appeal on all ethical questions. He viewed utility to be grounded on the permanent interests of man as a progressive being. These interests, in his view, authorised the subjection of individual spontaneity to external control, but only included those actions that concerned the interest of other people. It is conceivable, then, that PAS is one such circumstance that warrants further investigation related to the effect it would have on the greater utility of medicine or culture as a whole.

²⁵⁰The debate surrounding PAS in the UK and US is one facet of the larger cultural debate over merciful medical killing.

²⁵¹See thesis, 32.

might seem reasonable.²⁵² Others believe that to sanction mercy killing would be a detriment to the ethos of medical humanism, a view that also seems reasonable given its traditional endorsement of the physician's duty to extend life.²⁵³ These conflicting values compete for the common-ground platform from which future medical practices regarding PAS will derive. Moral concerns permeate these values.

The moral dimension is important in end-of-life decision-making when a physician must make a judgement between costs and the patient's life. This chapter has shown that there are, at times, radically different ideas about how to demonstrate respect for life and enhance the patient's dignity in the health setting.²⁵⁴ A predominant argument for physician-assistance-with-patient-suicide is the argument that kindness helps to preserve the patient's values about dignity when disease has robbed him or her of that state. "Dignity" is not easily defined and supported. The obligation of physicians to demonstrate compassion for the terminally ill by assisting with suicide opens another moral concern. Medicine is a moral enterprise because it deals with the good and welfare of others, and the introduction of merciful killing seems to contradict this aim of medicine.²⁵⁵ While some would view life's quality as a major

²⁵²James Rachels, "Active and Passive Euthanasia," in *Matters of Life and Death: Crises in Bio-Medical Ethics*, ed. John E. Thomas (Toronto: Samuel Stevens, 1978), 91. See also Rachels, *End of Life*, 156. See also Marvin Kohl, *The Morality of Killing: Sanctity of Life, Abortion and Euthanasia* (Atlantic Highlands, NJ: Humanities Press, 1974), 71.

²⁵³Leon R. Kass, "Death with Dignity and the Sanctity of Life," *Commentary* 89, no. 2 (February 1990): 42-43; and Callahan, "Defending the Sanctity of Life," 18-19. One intersection in the larger cultural debate over the SL is the morality of physicians assisting with suicide.

²⁵⁴Laurence J. Schneiderman, Kathy Faber-Langendon, Nancy S. Jeckev, and S. A. Gadow, "Nurse and Patient: The Caring Relationship," *American Journal of Medicine* 96, no. 2 (February 1994): 31-43. See also Laurence J. Schneiderman, Kathy Faber-Langendon, and Nancy S. Jeckev, "Beyond Futility to an Ethic of Care," *American Journal of Medicine* 96, no. 2 (February 1994): 110-14. The authors write that caring goes beyond good intentions or simple kindness and includes psychological or religious and physical components. It takes into consideration the patient's social context and specific goals.

²⁵⁵Albert R. Jonsen, "The Therapeutic Relationship: Is Moral Conduct A Necessary Condition?" in *The Clinical Encounter: The Moral Fabric of the Patient-Physician Relationship*, ed. Earl E. Shelp, *Philosophy and Medicine*, ed. H. Tristram Engelhardt Jr. and

determinant of its value, there are others who view life as a basic and necessary condition of all other good things.²⁵⁶ Life, overall, as a quantity or whole, is viewed as significant. Quality and quantity of life features are both premised upon medical humanism's belief that life is a good. The moral debate surrounding PAS considers the issues of quality *and* quantity, especially in light of technological advances making life-extension possible.²⁵⁷

The potential overuse of medical technology to extend life is a crucial question of the debate, one which often overlooks the deeper moral concern. Since both medical humanism and patient humanism view life as an intrinsic "good," then the conflict over the morality of physician killing is rooted in this deeper moral issue. The HU and PAS debate regarding how best to balance patient preferences and beliefs with those of medical humanism, in light of their moral questions, now invites a more careful examination. The weaknesses of the key features of the PAS arguments, as filtered through HU, point to moral considerations that remain to be explored. These considerations will be the subject of the final chapter.

Stuart F. Spicker, no. 14 (Dordrecht: D. Reidel Publishing Co., 1983), 267.

²⁵⁶Basil Mitchell, "The Value of Human Life," in *Medicine, Medical Ethics and the Value of Life*, ed. Peter Byrne, 34-46 (Chichester, England: John Wiley & Sons, 1990), 35.

²⁵⁷Mason, 7.

CHAPTER 4

HEDONISTIC-UTILITARIANISM AND PHYSICIAN- ASSISTED SUICIDE: WEAKNESSES, MORAL CONCERNS, AND CONCLUSIONS

Introduction

This thesis has examined whether HU provides sufficient moral ground to warrant a change in medical canons regarding medical killing, encompassing six features of the HU and PAS debate--rights, justice, medical killing, patient autonomy, medical paternalism, and SL. The thesis examination of the centuries-long historical and philosophical development of each feature has yielded a fresh vista from which to examine HU and PAS. The issue of PAS itself seems to have crystallised the elements into a complex philosophical confederation which has not yet gained full common consensus from the cultural-medical community. Nor has the confederation of arguments provided the clear common ground which will be necessary to advance legal means to change the medical canons regarding mercy killing.

The thesis has demonstrated that individual considerations like rights, justice, autonomy, and SL contributed important developmental steps in an ages-long evolution of the concept of the individual as a whole, a concept which has significant implications for the phenomenon of patient end-of-life decision-making. Such a discussion is morally significant when examining the viability of the research question about the change in medical canons related to medical killing, especially since these six features (rights, justice, medical killing, patient autonomy, physician paternalism, and SL) have been used to claim support for two primary PAS arguments: the arguments from beneficence (or mercy) and the principle of respect for patient autonomy. If, however, philosophical and moral support for these two foundational arguments is tenuous, then further examination of medical killing is warranted

before changes are made in medical canons related to PAS. This judgement to suspend action might bear possible implications for other forms of medical killing as well.

This chapter, then, will evaluate the features above, as examined historically and through the philosophical framework of HU, in order to identify components of the argument which HU fails to address adequately in the PAS debate. The chapter also will address four moral concerns which surfaced as a result of the examination of HU and the six core features in the PAS debate. In its final pages the chapter will offer observations on the research question, provide an alternative way forward as a direct response and critique to Mill's HU, and draw clear conclusions in the PAS discussion's ethical considerations. The chapter discussion turns now to the difficulties associated with the PAS debate arguments.

Developmental and Hedonistic-Utilitarianism Problems with Physician-Assisted Suicide Debate Arguments

The HU philosophical system has been viewed as a support that undergirds the various concepts which address and inform questions that have surrounded the call to legalise PAS. For more than thirty years, the debate has intensified and been rendered more complex when advocates of either side have added and combined features to buttress the arguments that call for changes in medical canons regarding medical killing. This section of the paper will address the unresolved tensions arising from the application of the HU perspective to the six features as they have been used as philosophical constructs in PAS arguments.

Rights

John Stuart Mill placed a primary emphasis upon individual rights, believing that a right was a person's valid claim upon society to protect the person in possession of it, either by the force of law, or by education, or by public opinion.¹ He believed a right was grounded in

¹Mill, *Utilitarianism*, 71.

the GHP² and, while his views on rights demonstrate some correlation with the historical view of the term, his belief that the word itself is grounded in utility reflects a point of divergence. This section will delineate the similarities and the differences in the meaning of the concept and analyse the impact the HU view of a right exerts on PAS.

As has been shown, the history of “rights” is divided generally into several developmental eras. From the inception of the term “right” until the present a conceptual complexity emerged from within a milieu with spiritual, philosophical, political, and social influences. Ancient Greek culture provided the nexus from which the concept took form. While it is certain that the term continued to undergo a long evolutionary development, it is equally as certain that the concept continues to bear some of its original meaning. For example, the notion of “rights” was formed from within a seedbed of ideas associated with natural law and natural rights. A part of this heritage included links to deity as well as institutions like the Church, “*polis*,” and even the wider state. It was believed that a “right,” as stated above, would be experienced within relationships to others in community, but it was also believed that a right was self-evident.³ One could arrive at the concept of “individual rights” through human reason. Even while individuals did not think of themselves as individuals-with-rights as apart from the state at this time, nonetheless, the concept of “rights” did contain this idea of application to the individual in its meaning.

This inherent polarity between the term’s communal and individual features contributes, at times, to some difficulty in establishing a clear perspective on the meaning of a “right.” This polarity, when the communal and individual perspectives collide, hints at something deeper than a simple clash of perspectives. Though the term in its earliest forms and applications indicates a fledgling attempt to establish and preserve certain *safeguards* for the

²Ibid.

³See thesis, ch. 1, 56-58.

individual, the possession of a “right,” even with the moral force of natural law and natural rights, has never fully guaranteed individual persons protection against external interference.⁴

A second developmental era was characterised by the secularisation of rights during the Renaissance and Reformation. Several key changes transpired in thinking about rights at this time. Natural law and rights had been associated with deity up until this point, but now it was conceived that natural law (hence, rights) would remain valid even if there were no God. While this did not mean that reference to or inclusion of deity in developmental consideration of a right was shunned entirely, the new emphasis did highlight one feature of the move away from supernaturally based authority that was underway.⁵ Further, a fresh emphasis was placed on a right as the possession of an individual which was a different vantage point from Ancient Greece where rights were generally associated with communal attachments.

It is of significance to note that even though various aspects of a culture may undergo momentous change--similar to those which transpired in the Renaissance and Reformation eras--and influence the application of a core concept, like “rights,” this change and influence did not mean that fundamental features of the core concept were necessarily jettisoned. It remained true for this developmental epoch that the formative elements remained even though the inner tensions and deeper issues of how best to preserve individual rights *had not been resolved*. While the growing concept of the individual advanced along with the conceptual understanding of “rights,” the notion had not yet matured to a level that would grant more than moral force to a “right.” This development was forthcoming, but the lingering issue of how best to ensure the rights of the individual still dangled without direct address.

A third developmental era advanced the notion of a “right” when several key events shaped the perception and application of “rights.” One key event was a new belief that science was the way to truth and, while the Enlightenment could not be characterised as entirely anti-

⁴See also HU discussion to follow below.

⁵See thesis, ch. 1, 60-63.

God or anti-religion, it may be stated that one result of the Enlightenment was a further separation of the idea of rights from any foundation in deity. An important catalyst for such a result was the continuing emphasis placed upon the individual as the focal point for “rights.” Empiricism began to inform the great issues that affected human growth and advancement: political, legal, philosophical, spiritual, and social. While it would not be fair to state that the Enlightenment was characterised either by the wholesale suppression of any institutional claim upon an individual or the full emancipation of an individual, it may be stated that the era opened the way for greater emphasis to be focussed upon these two themes.

The Enlightenment was, however, an era agitated by political changes. *Individual rights* figured prominently in political discussions and, eventually, were themselves codified in key French and American political documents. Natural law and natural rights were coupled now with nascent human rights'-oriented laws.⁶ Yet for all of the change, the focus in rights' discussions was directed toward external entities, thus leaving unexamined the inner etymological and moral tension between communal and individual interests. Like the previous era, the deeper question of how best to protect, preserve, and enhance humanity--the consideration of the qualitative dimension to the notion of rights--had not been fully addressed in the Enlightenment era either.

Perhaps the most significant era of change in the understanding and application of “rights” is the span of years between John Stuart Mill and the present. This era was indeed the time when “right,” as applied to the individual, figured most prominently. This epoch was characterised by two key developments. The first development occurred when John Stuart Mill sought, through his utilitarian writings, to establish further a foundation for human liberty and well-being. His efforts helped to extend the Enlightenment conceptualisations of human autonomy by giving the concept a moral and empirical basis. Mill based his theory upon a

⁶See *ibid.*, 67-68.

single principle--in this case, the GHP. His theory made it possible to insert a PH component into rights'-formulations.⁷

Mill sought to ground rights solely in mankind and, while he did not openly claim to be anti-God, he chose to relinquish a God-given, natural-rights' basis for support of individual rights. From one view, Mill's HU theory provided a philosophical vehicle for wedding "individual" PH preferences to human rights' claims. HU provided an important seminal ingredient that became characteristic of twentieth-century human right's applications--the overarching principle of a qualitative measurement for PH preferences.⁸ From another point of view, however, HU, because of its emphasis on the GHP, did not address clearly the longstanding internal tensions that were inherent within the concept of "rights." Rather, HU compounded the tension because it became conceivable, using Mill's calculations, for an individual's claim to "rights" to be overridden by the "rights'-claim" of the many. An individual's rights were not securely safeguarded under the umbrella of the GHP. This failure of HU theory to ensure or protect absolutely the "rights" of the individual exposes a weakness in PAS arguments that makes use of Mill's HU principles on rights.

⁷See *ibid.*, 96.

⁸See *ibid.*, 69. See the "Universal Declaration of Human Rights"; internet, available at <http://www.universalrights.net/main/declarat.htm>; accessed 27 April 2004. The Declaration casts its rights' claims in qualitative terms that an individual might use to oblige a government or institution to provide. See also James V. Spickard, "Human Rights, Religious Conflict, and Globalization. Ultimate Values in a New World Order," *Journal on Multicultural Societies*, vol. 1, no. 1 (1999); internet, available at <http://www.unesco.org/most/v11n1spi.htm>; accessed 27 April 2004. Spickard writes that the belief in innate human rights has received increasing circulation worldwide. It is interesting to note that Spickard believes rights are a product of the European Enlightenment that grew out of the West's struggle against monarchy. He writes of how early on rights were an useful tool for people who desired freedom from tyranny. He then states that the human rights' movement as recognised in the Universal Declaration of Human Rights, along with other United Nations documents to follow, specified a "host" of rights that the world's governments were to *guarantee* [italics mine] to their citizens. Such rights' language, in the Declaration, according to Spickard, ". . . clearly makes society the individual's servant rather than the other way around." Spickard follows by addressing a most recent generation of rights' claims that people exercise today: rights to support anything that they think necessary for dignity and freedom.

The second critical development occurred in the twentieth century when the concept of “right” was further enhanced and applied in a different way, and a specific place where the modification appeared was within medicine. “Rights” discussions turned toward establishing a “right” for an individual to end his own life and the obligation that “right” might impose upon another person, such as his physician.⁹ Today “patients’ rights” claims reflect the two fundamental twentieth-century shifts in PAS discussions: PH preferences and a right to end individual life. Some patients assert their PH preferences in reaction to real and perceived medical intrusions within the DPR. Other patients’ PH preferences relate to real or perceived deficiencies in some aspect of healthcare. Today a terminally ill patient might use a “right to die” PAS claim, which might mean, depending on how the law interpreted the claim, that a doctor could be obliged to provide assistance with the suicide of the patient. Another example might be a simple request to provide health services based upon a right to healthcare. These sorts of right’s claims are based upon a perceived liberty¹⁰ or entitlement right¹¹ that emerge from patient autonomy claims.¹²

As has been presented, however, the development of the concept of “rights” remains somewhat incomplete. A *right* by its very nature contains unresolved internal tension when applied to both individual claims and communal claims.¹³ Although there has been a centuries’-long swing of the pendulum toward individual “rights,” a valid need exists to establish and maintain balance between individual and communal expressions.

Further, when HU employs the notion of “rights,” the resulting propositions neither bear the moral authority to oblige another to act in behalf of the right-holder, nor do they

⁹See thesis, ch. 2, 71-72.

¹⁰See *ibid.*, 71.

¹¹See *ibid.*, 72.

¹²See *ibid.*, 71-72.

¹³See *ibid.*, 56.

wholly preserve personhood, protecting the individual from external interference or coercion.¹⁴ The argument of “rights” falls short of equal application when one individual’s greatest-happiness desire would legally oblige another individual to act contrary to the second individual’s own best interest. While the use of the HU philosophical construct has been intended ultimately to help to alleviate the suffering of terminally ill patients and their families, its application to “rights” has led to questions concerning whether this tool is actually adequate to the task and whether it satisfies the claims of justice.¹⁵

Justice

Mill, in the last chapter of *Utilitarianism*, claims that if the principle of utility is satisfied, then the requirements of justice are also satisfied, since justice is built into the principle of utility.¹⁶ Mill’s view of justice correlates with the historical development of the word in several ways, but his belief that the word reflects the principle of utility departs from the historical view of the meaning of justice. This section will delineate the similarities and the differences in the meaning of the concept and will analyse the impact the HU view of justice exerts on PAS.

The early history of “justice” included several key components that aided with the development of important boundaries for the term. “Justice” was used to convey different conceptions about how the world was an ordered whole. In the *pre-Socratic* era, the nascent meaning of the word “justice” included a sense of balance, maintaining regularity in cosmic and human affairs. The word also held moral connotations, for the concept was perceived to have been derived from the gods. “Justice” included not only what was operative in society, but also what was contained inside a person, as justice was linked to happiness in Platonic

¹⁴See *ibid.*, footnotes 84, 68-69, 97-100.

¹⁵See *ibid.*, 100-101. See also Frankena, 41. Individual rights can be overridden unjustly. See also 99, footnote 219.

¹⁶Mill, *Utilitarianism*, 80-81.

thought.¹⁷ Central to the word were the core ideas of equality and fairness and a moral concern to maintain the well-being of individuals within the community.¹⁸

By the time of Plato and Aristotle the term was given a clear conceptual framework. It is significant to note that Plato developed a clear view of virtue that included justice, and the just person was one who demonstrated a balanced life, inwardly and in relation to the community at large. Aristotle followed by emphasising the individual and civil responsibility. Justice, from its inception, developed a balanced mutuality between individual responsibility to another or a group and the state's responsibility to its citizens. Remaining in the concept, however, was an uncertainty as to whether the management (application) of the moral authority in the word would fall to an individual, a group, a state, or some combination of these.¹⁹

The Reformation/Enlightenment brought about a significant change in the development of justice. Natural law within human nature could now produce "right behaviour" in individuals that could result in both personal and societal justice.²⁰ The term was influenced by the evolving growth in the conceptions of humanism, so much so that the inherent mutuality and accountability for justice shifted gradually until it was believed that a claim of justice could originate from an autonomous individual and oblige others morally.²¹ Justice and just behaviour, it was believed, could be apprehended by human reason unaided by any external source. This does not mean that thinkers of this period were not aware of the mutuality contained within the meaning of the term, but it does seem likely that a word like "justice,"

¹⁷See thesis, ch. 2, 88-89.

¹⁸See *ibid.*, 89-90.

¹⁹See *ibid.*, 90-91. In Aristotelian thought, justice implied a moral responsibility that an individual had toward another person or group, as well as the moral responsibility that a legal, constituted body had toward its subjects. There was, however, no clear delineation of how an infringement of justice would be corrected.

²⁰See *ibid.*, 92-93.

²¹See *ibid.*, 94.

with its meaning carefully associated with human concerns, was influenced by cultural changes in *human* understanding. For example, yet another focus of justice whereby a morally autonomous and reasoning individual could generate a justice claim appeared in the same era. Still other significant developments in the term were to emerge from within John Stuart Mill's HU framework.

John Stuart Mill's utilitarian theory provided another critical change in conceptions about justice that established the possibility for an individual to make a justice claim based upon PH preferences. He theorised that one person's *happiness*, supposedly equal in degree, counted for exactly as much as another person's happiness. Thus, in theory, the one individual's qualitative PH judgment about justice, if pursued, would oblige any number of other individuals to act on the first person's behalf.²² Within Mill's system, however, the inherent relational balance contained within the concept of justice was newly made to depend upon the GHP of the individuals involved, whether a small group or a nation of citizens.²³

This understanding of justice was a key difference between Mill and other philosophers writing about the concept. Mill believed that each person had an equal claim to *happiness*. Whereas in the previous epoch, the gravitational pull of humanism led toward a shift in focus toward an individual, John Stuart Mill's HU conferred upon the individual additional authority when he added the possibility of that individual's qualitative PH claim. Yet, even though Mill's conceptions of justice were meant to ensure individual security for each person, any individual's PH calculus could become, at times, subordinate to the GHP. A person's equal claim to happiness, for example, might be limited by the "inevitable conditions of human life" and "the general interest."²⁴ Mill believed that while each person had a "right" to equality of

²²See Mill, *Utilitarianism*, 80-82.

²³Ibid., 81. See Mill's footnote number 3 where he writes that utility means "equal amounts of happiness are equally desirable."

²⁴Beauchamp, *Philosophical Ethics*, 111.

treatment, he also believed there were instances when some “recognized social expediency” might require the reverse. The significance of individual limits could, in some instances, result in limited justice as applied to the individual.

Mill believed that human character may be influenced generally to practise the GHP; hence, justice would prevail through public education and opinion.²⁵ Where this fails, however, laws and social arrangements are designed to place the happiness or interests of every individual in harmony with the whole.²⁶ Herein lies an inherent weakness in HU: the internal tension between the egoistic and universal facets of utilitarian conceptualisation. An individual’s PH preferences cannot be guaranteed because they often defer to the GHP of the many when required. Someone must, of course, interpret the PH of the many. How to determine *who* this individual or group may be, and whether the GHP for all persons may indeed be actualised, is a tension which still remains in HU theory.

Another weakness in Mill’s theory was his belief that justice was grounded in the GHP. Mill’s statement of the GHP presupposes a deeper foundational principle which places his views about justice on even weaker theoretical ground. Mill’s formulation of the GHP rests upon a belief that a person should act in ways that will bring about the greatest possible balance of good over evil in the universe,²⁷ which implies a basic obligation that a person “do good” rather than harm.²⁸ Without this more basic obligation there could be no sense of duty to attempt to achieve a greater balance of good over evil in the world.²⁹ It is conceivable, then, that a sincere utilitarian calculation of justice might actually be unjust whenever the end

²⁵Ibid., 108. See Mill, *Utilitarianism*, 65.

²⁶Beauchamp, *Philosophical Ethics*, 108.

²⁷Frankena, 45. Frankena means by “good” and “evil” nonmoral good and evil. Mill uses the terms happiness/pleasure and unhappiness/pain. See Mill, *Utilitarianism*, 16-17.

²⁸Frankena, 45.

²⁹Ibid.

calculation fails to consider the deeper obligation to “do good.”³⁰ HU, if applied as such, leaves open a possibility that there is a more foundational duty other than the GHP to which a person is obliged. This has broad implications for moral decision-making contexts, of which one example includes the area of medical decision-making. The following discussion serves by way of example to show how HU’s principles are sometimes applied to the notion of “justice” in the medical context.

Utilitarian principles of justice, when applied to healthcare, commonly involve competing exchanges between individuals and corporate needs. These exchanges have implications for individual patient justice. For example, prepaid health maintenance programmes in the US (for example, Health Maintenance Organisations [HMOs] and Preferred Provider Organisations [PPOs]) often establish medical plan benefits based on utilitarian principles.³¹ Such programmes usually include patient care for common “enrollee health needs” at a flat fee held in concert with “active management of both the delivery system” and “the medical care that is actually delivered to individual patients.”³² In a managed-care system the focus emphasis can shift from an ethic of service to one associated with a particular patient to a population-based ethic. Clinical decisions must include not only the patient’s welfare, but also the welfare of all enrollees in the health plan, society at large, any investors in the plan whose capital is at risk, and even the self-interests of the physician.³³

³⁰Ibid.

³¹Beauchamp and Childress, 335.

³²Peter R. Kongstvedt, *Essentials of Managed Health Care*, 2d ed. (Gaithersburg, MD: Aspen Publishers, 1997), 37. Whether the financing system is an HMO, PPO, or another model, the term used to describe each is usually a managed-care system.

³³Edmund D. Pellegrino, “Managed Care: An Ethical Reflection (Managed Healthcare as Practiced in 1998 Not Compatible with Christian Ethics),” *Christian Century* (August 12, 1998): 1; internet, available at http://www.findarticles.com/cf_dls/m1058/n22_v115/21066277/p1/article.jhtml; accessed 11 February 2004.

Furthermore, utilitarians also often favour social programmes that protect public health and allocate basic healthcare equally to all citizens if the GHP is served. This allocation could render individual rights indefinite or tenuous (like a right to healthcare), however, if overall utility maximisation changes (which it often does) at any time.³⁴ An outgrowth of maximising net social utility is the possible deflation of the worth and value of an individual life.³⁵

Utilitarian justice, when applied to healthcare system decisions, can fail to give adequate attention to individual value, and, therefore, be incapable of solving the dilemmas expressed by the individual patients for whom the system exists in the first place. Of further concern is the intrinsic value of human life and the inadequacy of HU to provide adequate support for the value of individual life.

Medical Killing

A claim that medical killing is sometimes permissible for physicians and, at times obligatory, raises significant moral concerns. The thesis demonstrated a long and complex historical development for the concept “to kill” or “to put to death.”³⁶ The cluster of ideas contained within the concept of “medical killing” surrounds a central condition; namely, direct causation of another’s death.

Debate has ensued because medicine has historically been about helping patients toward wellness and life instead of *causing* their deaths. A central issue with medical killing, however, is whether a physician is warranted to use medical expertise and technology to assist a patient with his or her desire to end life before an illness claims it. While it is true, in some cases, that a doctor can maintain life indefinitely with life-extending medical technology and

³⁴Beauchamp and Childress, 335. Even utilitarians dispute whether individual rights are genuine rights if they are contingent upon social arrangements that maximise net social utility.

³⁵See Smart and Williams, 69-71, and thesis, ch. 2, 98, footnote 213. The implication of Smart’s example is that a single life could be devalued and harmed, if needed, in order to maximise happiness for the many.

³⁶*OED*, 2d ed., s.v. “kill.”

can also refrain from using technology when he determines its use is futile, the focus with assisted suicide is somewhat different from a simple decision to use medical expertise and technology in a *different way*. There is a deeper philosophical argument at root, and this argument serves as a catalyst for decisions about medical killing. The philosophical argument in question here claims that there is sometimes no significant philosophical or medical distinction, with regard to either acts or omission, between “killing” and “allowing to die” in a terminal illness. However, this critical difference concerning a moral distinction between killing and allowing to die is not a new one.

Ancient Greece

Historically, social and political ideas in Ancient Greece influenced attitudes toward “killing” and “allowing to die.” An individual’s identity was derived from his attachment to the state and, as such, a weak or sickly individual was considered a burden to the body politic. Therefore, suicide, feticide, infanticide, and euthanasia, as a means by which the preservation of the state was enhanced, were not assigned the same moral disapprobation that they receive in Western culture today. Yet, even if an exact comparison is somewhat elusive, there were several moral features of ancient practices, like those of euthanasia, that were similar to medical discussions today.³⁷

First, a doctor was not the direct cause of the patient’s death. In fact, such an action would have been considered to be *prima facie* homicide.³⁸ At the very least, there seemed to have been some awareness of moral implications related to a distinction between “killing” and “allowing to die.”³⁹ The *meaning* of the term “euthanasia” did not mean “active killing for

³⁷New York State Task Force, 78. Ancient Greek euthanasia did not carry the same meaning then as it does in the current context, where it means to kill a person for benevolent motives.

³⁸Carrick, 128.

³⁹*Ibid.*, 47-49.

benevolent motives” as it does today. The concept implied, rather, a genuine human concern for the patient’s psychological state of mind and the moral concern exhibited by the physician for a patient’s plight.

Consideration was given to “allowing to die” and the meaning that would have for patients. A physical, if not moral, separation was made between “active killing” and “allowing to die.”⁴⁰ The *moral* circumstances surrounding the actual decisions to end life are instructive. In fact, other than supplying the drug, a physician was generally detached from the patient and his decision to end life. The *moral* significance was attached to the *patient being able to make a free and reasoned decision* whether or not to hasten his own death. The concept said nothing of the morality of a doctor assisting a patient’s death. In several notable areas moral concern seemed to have been lacking.

Moral Myopia

It is noteworthy that a morally reasoning individual was considered to be the primary determinant of whether self-killing was justified. Yet, even with behavioural (psychology) and physical (terminal illness) considerations, moral consideration of killing may be more complex than the above-stated approach might indicate. The thesis demonstrated a communal basis in moral formations. The attention given to self-killing and euthanasia across the centuries focuses most directly on the question concerning whether an individual has moral authority, accountability and responsibility beyond himself.⁴¹ Along with these moral-formations discussions, other historic expressions of the term have also been morally instructive in the “medical killing” examination.

⁴⁰Ibid.

⁴¹See thesis, 118-45. While it seems morally ironic that the evolution of human autonomy, grounded at least partly upon a human life’s intrinsic value, might be applied in this self-destructive fashion, some advocates suggest that it may be that some responsibilities (e.g., to oneself) override others.

Moral Ambivalence: A Special Case

Some moral ambivalence existed in Ancient Greece with respect to a form of “killing” and “allowing to die.”⁴² This hesitancy was evident, for example, in the practice of infanticide. This form of “killing” or “allowing to die” was practised without punishment in Ancient Greece if, for example, a newborn child was malformed and perceived to pose a liability on the family or state resources. If parents did not want a child, he or she could be abandoned or sold into slavery. Infanticide roughly took two forms: active and passive. Active infanticide meant certain termination of the infant’s life, and passive infanticide meant abandoning the infant to experience the likelihood, but not always the certainty, of life’s termination.⁴³ Carrick states that the passive approach probably lessened, in the minds of parents, the sense of moral responsibility for their deed.⁴⁴ Active killing of an infant possibly carried more moral blame than, for example, passively allowing the child to die from exposure.⁴⁵ This suggests, whether motivated by personal or state reasons, that some moral and/or psychological distinction was

⁴²The Ancient Greek moral view about killing or allowing to die was radically different from the Judeo-Christian moral views upon which US and UK modern culture still, for the most part, at least legally, rest. See Carrick, 110-24 for an examination of various philosophical perspectives on infanticide and feticide, or abortion.

While not a form of medical killing *per se*, infanticide, for example, provides a platform from which to examine an early moral approach to “killing” and “allowing to die.” While the circumstances of the death were different, passive forms of infanticide, like abandonment or exposure, were not considered to be the same as “killing” or even *intending* a child to be killed. With exposure, the parents may have been interested only in ridding themselves of the burdens and liabilities of the infant, since it was often believed that a child did not become a *person* until she had been fed for the first time (128). Passive forms of killing, then, were thought to be less culpable than intentional acts of taking lives, thus indicating some awareness of a moral distinction between killing and allowing to die.

Singer’s view that humans who are not self-aware are not to be considered persons or to have a life worth living, bears some resemblance to the Ancient Greek cultural perspective that a child was not a person until he or she had eaten a first meal. His argument to eliminate a distinction between killing and allowing to die is not entirely convincing, however, because the *moral* focus in killing or allowing to die does not rest solely upon the result (minimising pain and maximising pleasure), but also includes the agent and his intent.

⁴³Carrick, 108.

⁴⁴Ibid.

⁴⁵Ibid.

made surrounding the act of taking a life, whether the death occurred actively or passively. The intent of the actor, in this case the parent, whether active (direct) or passive (indirect), was a key contributor in assessing blameworthiness.⁴⁶ In Ancient Greece there was at least a minimal innate awareness that when an individual took another person's life, or allowed that person's life to be extinguished, it was a deed morally questionable and worthy of blame.⁴⁷ Such moral concern with taking an infant's life remained despite a cultural practice of infanticide.⁴⁸

Moral fault, then, might be assigned to killing or allowing another to die in Ancient Greece, whether the cause of death was infanticide, euthanasia, or even murder. Even though some might argue that there is no real medical distinction between acts of killing or letting die, there seems to be some historical evidence to the contrary. When, in Ancient Greece, physicians might have supplied a drug to assist a patient's suicide, thus leaving the choice of death to a morally reasoning individual, the supplying of the drug did not necessarily mean that patient autonomy alone was the only moral criterion for assessing the validity of a request for assistance with suicide.⁴⁹ Similar observations may be made about current PAS discussions concerning patient autonomy.

Autonomy

Autonomous individuals demonstrate liberty when each is free from coercion and exercises the ability to make an independent decision. Further, an autonomous individual

⁴⁶Ibid.

⁴⁷Ibid., 48, 108, 128. In the case of murder, infanticide (in comparison with exposure) and involuntary euthanasia, there was some awareness of moral culpability.

⁴⁸Ibid., 101, 108. Plato endorsed infanticide because, in certain cases, it promoted the "greatest long-term benefit for the entire community" (113). Plato's student, Aristotle, believed that infanticide was morally justifiable by a similar belief that overpopulation would have a negative impact on the well-being of the state (115).

⁴⁹Other criteria for consideration of a patient's request for suicide were possible. For example, a doctor might be concerned with the status of his reputation, and he also might be motivated by the prospect of financial gain through the sale of lethal drugs. See Carrick, 154-55, and thesis, 218, footnote 16.

demonstrates the capacity for intentional action that can be explained by reference to his or her own goals and purposes. The concept of autonomy has not changed historically in relation to these core features of liberty and agency.⁵⁰ There are those, however, who now interpret its meaning to advocate practically whatever one desires.⁵¹

Autonomy developed slowly through the ages, but several key changes in its meaning have been discussed in the thesis. Initially, autonomy did not indicate that a person was an individual with an identity separate from that of the state but that a person was free within the context of a “*polis*” to interact with laws, primarily in political or military affairs. The concept of autonomy began to change focus, however, in the Renaissance when people began to think of themselves as individuals.⁵² Notions of autonomy were applied to the study of the human personality through the rediscovery of the ancient Classics. This growing individual awareness produced new challenges to traditional authority, for example, the Church.

The Enlightenment led to a further separation of the individual from the traditional sources of authority as scientific methodology became a tool by which “Enlightened Man” discovered truth. This methodology drove deeper the wedge between the authoritative claims of the Church and the state and the individuals over whom they exercised jurisdiction. Authority was challenged as individuals began more clearly to conceive of themselves as whole persons apart from attachment to such institutions. Clearly, the establishment of new laws designed to protect individuals served to enhance conceptions of autonomy.

John Stuart Mill’s views on autonomy set strong boundaries around an individual. Mill, while not anti-God or religion, did not establish man’s autonomy on “God-given” natural rights, but on man alone.⁵³ Mill also centred man’s autonomy in a desire for an individual’s

⁵⁰See thesis, ch. 3, 164.

⁵¹Beauchamp and Childress, 70-71.

⁵²See thesis, ch. 3, 152.

⁵³Ibid., 161-62.

own greatest happiness. Mill's philosophy contains a weakness in that it cannot retain the ground it claims for the individual. Simply stated, Mill's GHP requires the *subordination of individual happiness* to the greater happiness of the many.⁵⁴ It is conceivable, then, that an autonomous person might be required, by a literal application of the theory, to relinquish his or her claim to PH for the greater happiness of the many. Ironically, Mill's HU philosophy that was conceived as a *means* for guaranteeing an individual's autonomy also serves potentially as an instrument to undermine it. At this stage in the development of autonomy, an emerging reality became evident. The individual now stood, at least in theory, as a fully autonomous source of authority in decision-making.

Twentieth-century thinkers applied Mill's theory. Individuals began to assert "rights' claims" on various entities, calling for changes based solely upon the principle of respect for autonomy. Coupled with Mill's GHP, an individual could now make PH claims upon other persons, groups, or institutions with what he/she perceived to be moral authority. The medical arena became a primary focus of such claims.

The thesis has demonstrated the slow progression of ideas that led to the present context, where autonomy advocates invoke claims of moral authority upon others which the advocates perceive to be inherent in the concept of autonomy. What is often left unrecognised is that the lengthy history of the term "autonomy" centred upon establishing safeguards around an individual rather than building a bridgehead for tearing down perceived opposition to individual autonomy claims. Further, the development of autonomy along individual lines often runs aground at the point of moral authority. Autonomy advocates seem to imply that an individual's PH desire, although in actuality, rarely unlimited, is a sufficient source of moral authority to oblige action on a claimant's behalf. Simply put, individuals now use autonomy

⁵⁴It is also possible that both an individual and a community might agree that PAS, for example, is morally required. However, to maximise utility would require also a potentially undesirable result--the distribution of PAS, in such circumstances, on a wide scale. This might not be conducive to the greatest general balance of pleasure over pain.

claims to impose upon others their own desires--the very thing against which the historical development of the notion of autonomy had attempted to safeguard. The DPR is one place where a patient may make an autonomy claim that he feels obliges his physician's compliance.

Physician Paternalism

As the developmental section illustrated, the areas where conflict often emerges in the DPR are *informed consent* and *end-of-life decision-making*, both of which raise the question of identifying the ultimate source of authority. Physician paternalism has been cited as one hindrance to the fulfilment of a patient's will. A patient might claim that his or her autonomy has been infringed and that a doctor has overstepped the bounds of authority.

The truth is that the issue of authority is complex and, at times, confusing. The doctor, by virtue of his or her training, technological expertise, and certification carries much authority.⁵⁵ His level of authority may be strengthened when a patient may not wish to exercise her own authority in the DPR and may relinquish control to the physician. Conversely, confusion may arise when a doctor may assert no leadership at all, even though a patient may desire guidance in making a decision. All of these possibilities may be complicated further by the level of patient competence in perceiving and understanding her medical situation, the legal and regulatory guidelines that safeguard autonomy, and the potential for unfair burdens, financial or otherwise, placed on others because of a patient's decisions.⁵⁶

Yet, at the core of situations where authority is exercised, underlying principles exist. In the case of doctors, the principles of beneficence and nonmaleficence are significant influences in the exercise of authority. Physicians feel a moral obligation to "do good," or at least, to "do no harm" to their patients. This, however, conflicts, at times, with a principle of respect for patient autonomy. Each of these positions is grounded in a set of beliefs or values about life

⁵⁵Ibid., 173.

⁵⁶Ibid., 174-75.

and the potential for conflict, even moral conflict, exists whenever end-of-life choices are being made by both physicians and patients.

The physician principle of beneficence and the patient “principle of respect for autonomy” are protean concepts as the history and development of each has demonstrated. As such, because they are ever-shifting, they may not always be relied upon to provide consistent and suitable sources of moral authority. At the same time, it must be said that each principle illustrates a need for some source of common-ground consensus that will better serve the interests of both patients and physicians as they make decisions together in the DPR. This platform is crucial because of the direct need to clarify several issues related to the PAS debate, among which may be the foundational question about the ultimate value and meaning to be assigned to life.

Sanctity of Life

Historically, medicine has held to the view that life is good and that life is to be preserved.⁵⁷ This view has, of late, begun to clash with contrasting life-values of some patients. It is true that physicians have, at times, exercised technology in a quest to extend life in such a way that it conflicts with a patient’s desires, but it is entirely too simplistic to state that the reason for conflict in the DPR is solely related to differing aims between doctors and their patients.

A central question related to the value of life is about what man is and why he exists, and whether physical illness devalues the individual any or at all. A corollary to these questions is one of meaning. Terminal illness often raises questions about the meaning of life in the face of pain and suffering. A hindrance to constructive examination of these weighty concerns has been the somewhat narrow view that focuses on a patient’s physical or

⁵⁷Ibid., 190.

psychological perceptions alone when making end-of-life choices associated with assisted suicide. Moral decisions at end-of-life invite deeper reflection.

The PAS discussion holds up for consideration divergent views of life's sanctity—among which are a Christian view and a secular view. The Christian view holds that human life, having been created in God's image, is infinitely precious to God and made for an eternal destiny. At the core of this view are the religious principles that one ought never to kill intentionally the innocent, that human dignity is intrinsic to all human beings equally, and that one must not forfeit one's inherent dignity by acting in ways that are at variance with human dignity.⁵⁸

Somewhat like the Christian view, the traditional secular view also stresses the equal dignity of all citizens. Broadly speaking, however, the secular view holds that human dignity and worth depend upon the following requirements: exercising freedom from external restraint; possessing developed, exercisable psychological abilities for understanding, choice, and rational communication; and exercising such abilities in the enjoyment of an acceptable QL. Even though the views have a core ingredient in common (for example, equal dignity), there is at the root of each view a significant difference in assessing life's value. This has implications for end-of-life decision-making.

In the Hippocratic tradition, there was a *prima facie* belief that a doctor should avoid any action that might prematurely end another person's life. The protection of human life was firmly rooted in the Hippocratic corpus. At the root of Hippocratic medicine's SL view was a concern for a patient to be restored to health and return to his community relationships. Hippocratic medicine helped to establish a synergy between a doctor and patient based upon a common desire for patient wellness, a relationship which resulted in a moral bond between them. This common desire for patient well-being lasted through centuries and strengthened in

⁵⁸Ibid., 187-88.

the Christian era, where the value of physical life was among many emphases (e.g., spiritual/asceticism) which linked to the higher principle that God valued man.

The DPR changed, in the time of Percival, from the standpoint of the physician to a focus upon the patient's view. Percival recognised the potential for DPR tension between a patient's goals, medical technology, and a physician's goals.⁵⁹ One of the reasons for the current conflict in the DPR, especially as it relates to end-of-life decisions, is connected in part to this fully-emerging patient view of autonomy that has developed across the centuries. Sometimes the patient's view is different from that of his physician.⁶⁰

Patients and doctors can agree that life has intrinsic value and that human life carries inherent rights and interests worthy of protection. Traditional moral and ethical formulations have been rendered much more difficult at life's end due, in part, to life-extending medical technologies. Of particular moral concern is a medical view that may, at times, seek to extend life at whatever cost. When technology is used as an instrument to impose life rather than as an aid to preserve life, this action raises moral concerns about the limits of the application of medical technology at the end of life.

This chapter's evaluation of the historical and philosophical features of the PAS debate has revealed points of weaknesses, especially as the theory of HU has been applied by PAS advocates. These weaknesses have not yet been addressed satisfactorily so that a recommended change regarding medical killing in medical canons may be either sustained or justified. What has surfaced in the discussion is a number of related, if not integral, moral concerns which both arise from, and inform, the PAS debate. Life's value is found in more than physical, materialistic, or psychological data. It may be suggested, therefore, that the moral concerns which remain unaddressed will have significant implications for further discussions concerning the legalisation of medical killing.

⁵⁹Ibid., 192-93.

⁶⁰Ibid., 194.

Four Moral Concerns

Whereas the ends of medicine have been to care for and to restore the health of sick individuals and relieve their suffering, the ethical dimension in the medical profession historically has not so much focussed upon ethical *ideals*, either solely or primarily, as upon their *application to people*.⁶¹ The practice of medicine, humanly and technically, involves the application of actions motivated by ethical principles *by* human beings (physicians) *to* human beings (patients) in relationship. Of significant import to the PAS debate is this ethical dimension of medicine that relates both ideally and practically.⁶² It is the ethical dimension of the discussion that will be the focus of this section of the chapter.

Several key moral concerns surfaced as the PAS debate features were evaluated. Among these concerns are three which derive from the DPR and must be addressed, since the DPR is the laboratory where the current application of ethical ideals and practice coalesce.⁶³ These three concerns are: (1) the historic departure from *physician-protection-of-life* to *physician-assistance-with-death*;⁶⁴ (2) a question about whether assistance with suicide is indeed moral at all;⁶⁵ and (3) the potential for fostering distrust in the medical community.⁶⁶ A

⁶¹Ezekiel J. Emanuel, *The Ends of Human Life: Medical Ethics in a Liberal Polity* (Cambridge, MA: Harvard University Press, 1991), 14.

⁶²Earl R. Babbie, *Science and Morality in Medicine: A Survey of Medical Educators* (Berkeley, CA: University of California Press, 1970), 12. Babbie writes that interpersonal relationships are important in the DPR, because the character of the relationships between doctors and their patients ultimately either supports or threatens the basic beliefs (moral) held in general society. On the other hand, physicians like Lasagna argue that medicine is not a moral enterprise at all. See Jonsen, 268.

⁶³Babbie, 12.

⁶⁴See thesis, ch. 4, 222-27.

⁶⁵*Ibid.*, 223-24.

⁶⁶*Ibid.*, 258-59, footnotes 164 and 165.

fourth moral concern, the threat of “greater killing,” is a “slippery slope” argument which PAS opponents fear may become a reality should medical canons be changed.⁶⁷

The twentieth century brought wartime experiences that contributed to a certain loss of innocence and idealism. In the same period, scientific progress created new technologies in medicine that raised new moral questions about human decision-making. The BMA, in writing about the modern moral dilemmas in medicine, states that the past offers no solutions to the new and evermore complex problems in medicine.⁶⁸ Contemporary medical ethics seems to be unwilling, at present, to draw upon the past for help. After all, it is true that the pluralistic Western culture, with its liberal political philosophy, makes it difficult to appeal to any widely held religious or philosophical system as a basis for medical decision-making.⁶⁹ Whether the BMA assertion is true or not may be argued. In fact, this section will offer some discussion, drawn from the past, which will contribute to clearer thinking about these complex moral dilemmas.

First Moral Concern: The Historical Departure from Physicians Protecting Life to Physicians Assisting Death

The Scope of the Argument in Support of Allowing Physicians to Kill

Supporters of PAS argue that terminally ill patients should receive assistance with suicide based on the claim of mercy or compassion.⁷⁰ Proponents are careful, however, to list qualifications for the use of PAS: the patient is to be experiencing *irreversible suffering*, he is

⁶⁷Ibid., 262.

⁶⁸BMA, *Handbook*, 10.

⁶⁹Emanuel, *Ends of Human Life*, 36-37.

⁷⁰Battin, *Least Worst Death*. A leading example is Battin who bolsters from mercy her guarded argument for assisted death.

incurably ill, and he must make repeated requests for assistance with suicide.⁷¹ Advocates like Quill state that it is difficult to prosecute legally physicians who assist with suicide motivated by *compassion*.⁷² In fact, the act of assistance is often considered to be morally sound if the motive for acting is pure, which implies compassion.⁷³ A companion form of assisted death, VAE, also claims validity in the mercy argument because the compassionate physician who helps the patient end his life enables the patient to escape from “useless suffering.”⁷⁴

The thesis has demonstrated that a primary fulcrum in the PAS debate is the autonomous patient requesting assistance with death. Physicians, it is asserted, are obliged to assist patients with their requests, based upon mercy, as an extension of the principle of beneficence. It might seem odd, in light of its etymological root, to link “beneficence” with “killing,” since the word beneficence means “doing good” or “active kindness,”⁷⁵ although it must be acknowledged that in order to ease suffering, beneficence is related to both aspects. The meaning of beneficence in medical ethics now, however, includes the notion of a “duty” to help others further their important and legitimate interests both when it is possible and with minimal risk to the physician.⁷⁶ Beauchamp and Childress also include the idea of moral obligation in the notion that a physician is to act for the benefit of others and to help them

⁷¹Timothy Quill, “Physician Assisted Suicide Is Moral,” in *Physician-Assisted Suicide*, ed. Daniel A. Leone (San Diego: Greenhaven Press, 1998), 17.

⁷²*Ibid.*

⁷³Timothy Quill, “Physician Assisted Suicide,” 16-17. Quill says that if the act of assistance is initiated by the physician, or motivated by greed, then the decision to assist in suicide is no longer morally sound.

⁷⁴A. B. Downing, “Euthanasia: The Human Context,” in *Euthanasia and the Right to Death: The Case for Voluntary Euthanasia*, ed. A. B. Downing (London: Peter Owen, 1969), 23. Of course, this argument begs the question concerning when one’s suffering is determined to be “useless.”

⁷⁵*OED*, 2d ed., s.v. “beneficence.”

⁷⁶Shelp, 201. Shelp quotes Beauchamp and Childress, 201, 260.

further their legitimate interests.⁷⁷ PAS supporters reason that it is beneficent, and in the legitimate interest of the patient, to eliminate the patient's pain. This idea parallels Mill's initial view of beneficence.⁷⁸ True utility is achieved when happiness is experienced through maximising pleasure and minimising pain. Mill believed this could be achieved through proper education in utility so that human beings would be motivated by an inner impulse that leads them to promote the general good.⁷⁹ In this case, the elimination of the patient's pain and suffering through death both helps the patient and decreases the level of pain and suffering of society depending, of course, at what point the calculation is made.

Secondary support for this beneficence-claim for PAS comes from other areas as well. For example, statistics seem to indicate that doctors' *attitudes toward death are changing*, so that there is a "drastic" decrease of belief in an afterlife.⁸⁰ Another area of support comes from a change in age-old perceptions among some doctors that the death of a patient is a mark of failure or ultimate defeat; hence, the substitution of the idea that beneficence actually may *aid* the patient more by easing his suffering.⁸¹ Still another area of support comes with a change in the ultimate good that may result when a patient *chooses* his death. If a patient chooses to terminate his own life at a *specific point*, for example, then the patient is not under the ultimate control of death. Advocates of PAS like Quill list as a reason to help patients with suicide the desire to help patients maintain their dignity and control over life, on their own terms, until

⁷⁷Beauchamp and Childress, 260.

⁷⁸Shelp, 202. Compare Mill, "Utilitarianism," 268-69.

⁷⁹Mill, "Utilitarianism," 268-69.

⁸⁰George Annas, "Rights of the Terminally Ill Patient," in *Matters of Life and Death: Crises in Bio-Medical Ethics*, ed. John E. Thomas (Toronto: Samuel Stevens, 1978), 106.

⁸¹Quill, *Midwife Through the Dying Process*, 1; and Annas, "Rights of the Terminally Ill Patient," 106.

death comes.⁸² Advocates of PAS, then, use a variety of arguments to support a change in medical canons regarding killing.

The Scope of Arguments Against Allowing Physicians to Kill

General: Medicine's Healing Ethos

There are several counter arguments offered by those who do not support PAS, or who do not agree with the use of the principle of mercy and beneficence in this manner. Pellegrino argues that when physicians kill patients, even as a compassionate act, it fundamentally distorts the healing relationship.⁸³ He believes that physician-assisted death is a "serious violation" of the moral nature and purposes of medicine which, historically, promoted the preservation and healing of life.⁸⁴ Until recently, this generally recognised healing framework supplied a widely-accepted moral standard for medical decision-making.⁸⁵ Perhaps originating in the Hippocratic-Pythagorean School and amended many times across the centuries, nonetheless it existed and remained at the heart of the DPR. Even though the standards within various physicians' codes were often violated, this basic core principle remained constant--that medicine supports and

⁸²Quill, "Death and Dignity," 693.

⁸³Pellegrino, "Doctors Must Not Kill," 95-102. Pellegrino, *Humanism*; Edmund D. Pellegrino, "The Place of Intention in the Moral Assessment of Assisted Suicide and Active Euthanasia," in *Intending Death: The Ethics of Assisted Suicide and Euthanasia*, ed. Tom L. Beauchamp, (Upper Saddle River, NJ: Prentice Hall, 1996), 163-83; Pellegrino and Thomasma, *Philosophical Basis of Medical Practice*; Pellegrino, *For the Patient's Good*; and Pellegrino and Thomasma, *Virtues in Medical Practice*. Pellegrino offers a contrasting view of beneficence to that presented by Mill and HU.

⁸⁴Ibid., 98.

⁸⁵BBC News, "Helping the Terminally Ill to Die"; internet, available at <http://newsvote.bbc.co.uk/mpapps/pageto.../news.bbc.co.uk/2/hi/health/3549673.stn>; accessed 21 March 2004. The article notes that a reason why physicians are against euthanasia and assisted suicide is the belief that it would undermine the basic ethos of a caring profession, and it would lead to a deterioration in the DPR.

protects human life. Medicine is historically a healing relationship that has as its long-term goal the restoration and cultivation of health.⁸⁶

Specific: Historical Emphasis on Humane Treatment

The BMA notes that society, in view of the medical profession's special expertise and the patient's vulnerability, expects high standards from medical professionals. High standards apply not only in relation to scientific education and clinical skill, but also to professional and humane conduct.⁸⁷ This has been the case, for the most part, throughout history although, in some instances, the expectations for quality healthcare were as abysmal as the services rendered, and in others the penalties for failure to meet standards were quite demanding. In ancient Babylon, for example, Hammurabi's *Code of Laws* (1790 B.C.) regulated the fees of physicians proportionate to the status of their patients. If the surgery proved fatal to the patient, the physician's hands were cut away. There was a value scale to human life, however, and if the patient were but a slave his replacement would suffice.⁸⁸ Hammurabi's external oversight through law served to regulate the practice of medicine somewhat, and provided a more humane care for patients as it called for the protection of human life. Professional self-regulation, from another perspective, may be traced back at least to the Hippocratic Oath (fourth century B.C.).⁸⁹ In a day when there were no medical schools, no examinations, and no formal procedures for certification and licensure,⁹⁰ the Oath reflected a system of medical

⁸⁶Pellegrino, "Doctors Must Not Kill," 98. When the goal of restoration to health is impossible, medicine has still sought to support and protect human life. How this is to happen is a matter of varied debate.

⁸⁷BMA, *Handbook*, 9.

⁸⁸*Ibid.*

⁸⁹*Ibid.*

⁹⁰Amundsen and Ferngren, 18.

principles in a context where obligations to abide by any standard were rare.⁹¹ The overall Hippocratic Corpus provided the earliest example of “new medicine,” one that developed a theoretical basis for medical practice.⁹² The fifth century B.C. offered medical craftsmen philosophical constructs that helped them to examine the nature of man.⁹³

In mediaeval Christian Europe, the attitude of pre-Christian medical humanism still provided general guidelines for the conduct of physicians.⁹⁴ Alongside these guidelines the equally ancient traditions of medical etiquette, manners, and deportment flourished, thus aiding the physician in building the confidence of his patient.⁹⁵ Modern medical ethics, but with the same key cultural variations, emerged toward the end of the eighteenth century in a time of great social change.

Thomas Percival laid the foundation for modern medical ethics when, as an outgrowth of his initial desire to solve a controversy over medical behaviour between hospital personnel, he wrote a guidebook of professional conduct.⁹⁶ With this guide the bridge between ancient and modern medical ethics was crossed. Each successive generation has amended and reapplied codes of ethics based, in part, upon Percival’s work. Each subsequent medical code also contained at least one statement concerning the preservation of human life.⁹⁷ This idea of preserving life faced a new challenge to its meaning and application in the modern period when

⁹¹Edelstein, *Hippocratic Oath*, 59.

⁹²Amundsen and Ferngren, 11.

⁹³*Ibid.*, 11.

⁹⁴BMA, *Handbook*, 9.

⁹⁵*Ibid.*

⁹⁶*Ibid.*, 9-10.

⁹⁷*Code of Ethics of the American Medical Association* 1847, 1957, and 1980. Cf. the *International Code of Medical Ethics of the World Medical Association* 1949, amended 1968, and 1983. Compare “Appendix III: World Medical Association Declaration of Helsinki,” *Law, Medicine & Health Care*, 19, nos. 3-4 (Fall-Winter 1991): 264-65. *The World Medical Association Declaration of Helsinki* 1964 was amended in 1975, 1983, and 1989.

the argument of extending beneficence became the ground from which to argue some forms of physician-killing.⁹⁸ These challenges to the moral standards of the previous centuries is worthy of careful note.

Specific: An Alternative Ethic of Care

The standards of ethical conduct that govern the DPR have changed drastically in the last generation with “the center of gravity” of clinical decision-making shifting “almost completely from the physician to the patient.”⁹⁹ Pellegrino believes that the principle of autonomy gained force in Western culture on the “inchoate stirrings of social change” that had

⁹⁸The thesis addresses the specific challenges of PAS, but abortion is another related, but extremely complex, facet of the larger medical question regarding the preservation of life. In one respect, abortion resembles a portion of the thesis argument; namely, the involvement of a physician in an act of harm to an innocent life in order to extend beneficence to another life, or to the life of the innocent foetus itself. Further, both abortion and PAS discussions involve autonomy claims--which claims have been integral parts of the thesis focus. The abortion discussion, however, differs from the present PAS dialogue in several ways. First, an unborn child, unlike a terminally ill patient, is unable to make an autonomous choice to end his life, notwithstanding a claim of “vicarious consent.” See Charles E. Curran, *Issues in Sexual and Medical Ethics* (Notre Dame: University of Notre Dame Press, 1978), 79, 85. Curran’s abortion autonomy argument differs somewhat from a PAS autonomy argument. The scope of PAS, by design, requires a competent patient to make repeated requests to die and does not by design include “vicarious” or proxy consent. The aim of PAS is to allow a terminally ill patient to make the decision whether or *not* to commit suicide. Further, unlike a terminally ill patient who can decline unwanted medical treatment, an unborn child is *not* able to decline such treatment. Second, since an unborn child *cannot* express his desire about whether to continue living, a moral question concerning the rights and responsibilities medicine might have toward that unborn child must be raised. Differences in the definition of what constitutes human life are deeply divisive at this point, since some abortion advocates argue that an embryo is not yet a human life, and thus assume that any consideration of the choice of life or death from his perspective is a moot point. See Singer, *Practical Ethics*, 86-87. By way of contrast, in the case of PAS, even if a patient is *unable* to express a choice regarding living or dying, the assumption is *not* that the patient wants life to be ended.

Dworkin recognises the deeper preservation-of-life question and seeks to address it from within the moral complexity that surrounds a doctor’s involvement with abortion. He reasons that very few people would consider it morally justifiable for a third party, even a doctor, “to kill one innocent person to save another.” Dworkin seeks to direct the focus away from the act of killing and toward clarifying life’s sanctity and its meaning. See Dworkin, *Life’s Dominion*, 32. Yet, unlike Dworkin, this thesis additionally directs specific attention to the *moral nature* of a physician’s action with regard to killing, most specifically as it relates to PAS.

⁹⁹Pellegrino and Thomasma, *Virtues in Medical Practice*, 54.

challenged deeply the traditional Hippocratic model of the physician-patient relationship. Coupled with social change was the “formal analysis” of Beauchamp and Childress’s *Principles of Bioethics* (1978 edition), which included as one of its four principles the principle of autonomy. The principle of autonomy has experienced worldwide appeal both inside and outside of medicine. Pellegrino and Thomasma believe that the principle seeks to balance the “enormous power of expert knowledge” that is so pervasive in industrialised, technologically-oriented societies. Autonomy, according to Pellegrino and Thomasma, has particular appeal in medical relationships and it counters the historical dominance of either benign authoritarianism or paternalism in the traditional ethics of medicine.

The image of the physician has changed in this time frame as well from a figure carrying “technical and moral authority” to an image of “protector, facilitator, and advocate for the self-determination of the patient.”¹⁰⁰ A complex array of social, political, philosophical, religious, and medical forces has been credited with influencing the changes in the DPR. The emphasis upon, and influence exerted within, the DPR by patient autonomy has fostered the emergence of several models of the physician-patient relationship.¹⁰¹ At first glance, such models seem to protect the patient’s right to self-determination, but any autonomy-based view is actually “illusory,” and bears implications for the DPR.¹⁰² This type of model becomes especially crucial when the patient who holds this view is faced with a terminal illness and is making end-of-life decisions.

An autonomy-based model, where a patient establishes a contract with a physician, truly undermines physician trust and it fails to provide a realistic understanding that a patient is “vulnerable,” “lacks the power to heal herself,” is likely in “pain, anxious, frightened and

¹⁰⁰Ibid., 56.

¹⁰¹Ibid. The authors list autonomy-driven models like a *consumer model* and a *negotiated contract model*. They well note that these models may not engender personal commitment or trust on the part of either physician or patient.

¹⁰²Ibid.

perhaps distressed.”¹⁰³ The patient, no matter the view of autonomy, is actually often not equal in bargaining power with a physician.

The reality is that autonomy-inspired models are not able to offer the protection of a patient’s self-determination, and to a considerable degree are “illusory” and “even dangerous” to patients and doctors.¹⁰⁴ Pellegrino and Thomasma warn that absolutisation of autonomy-based models is morally perilous.¹⁰⁵ Warnock is cautiously supportive of patient autonomy when patients face “overinterventionist” or “overdogmatic” doctors, but she has expressed concern, as well, that autonomy may be given too much prominence.¹⁰⁶ She warns that there are “numerous difficulties in ensuring that a patient has really been brought to understand the alternatives on offer,”¹⁰⁷ and adds that there are many situations, “especially when someone is asked to decide on treatment or the withdrawal of treatment not for himself but for his child or parent,” where the burden of making such a decision is almost intolerable.¹⁰⁸ In Warnock’s view, it would be “disastrous to be so enthusiastic for the principle of autonomy that paternalism was quite abandoned.”¹⁰⁹ She advocates a balanced model that offers proper support to patients.

The thesis has demonstrated that there is no way to circumvent a physician’s character, or values, or influence in the current DPR setting,¹¹⁰ thus inviting an alternative approach to the

¹⁰³Ibid., 56-57.

¹⁰⁴Ibid., 56.

¹⁰⁵Ibid., 57.

¹⁰⁶Mary Warnock, “Views and Reviews: ‘Principles of Health Care Ethics,’” *BMJ* 308 (9 April, 1994): 988-89.

¹⁰⁷Ibid.

¹⁰⁸Ibid.

¹⁰⁹Ibid.

¹¹⁰Pellegrino and Thomasma, *Virtues in Medical Practice*, 57. Pellegrino and Thomasma write: “the physician’s virtues are habitual dispositions to act in such a way that the ends of medicine are enhanced and enriched. See comments at footnote 100.

current medical culture of end-of-life decision-making as supported by HU. Pellegrino and Thomasma provide an alternative “healing relationship” approach to the current “physician-aid-in dying” model.¹¹¹ Their “*end-oriented beneficence model*” is based upon the specific historic ends¹¹² of medicine. These ends of medicine are strengthened by the application of foundational principles.¹¹³ Attendant to these core principles are the three subsidiary principles of truth telling, promise keeping, and confidentiality that can be derived from the ends of medicine.¹¹⁴ While these principle cognates and their application in the DPR comprise a physician’s role in the healing relationship, it also is important to recognise the duties incumbent upon a patient.

Patients share with a physician the obligation to “act according to principles and in fulfilment of duties that will attain and not obstruct these ends.”¹¹⁵ The patient is obliged to provide honestly to the physician the data he or she needs, comply with the agreed-upon treatment regimen, “disclose conflicting advice or doubts about the advice given, consider the needs of the physician as a human being, and respect the physician’s autonomy and moral values.”¹¹⁶ Indeed, misapplied autonomy-based models can actually erode the very value--self-determination--that such models seek to protect and even create a climate of distrust in the DPR.¹¹⁷

¹¹¹Ibid., 170-71, and 193-94.

¹¹²Ibid., 193. The authors use the term “ends” in the classic teleological sense. They believe that these “ends” are health, cure, the care of illness, and a right and good healing decision.

¹¹³Ibid., 194. According to the authors, the three ends of medicine are supported by the principles of beneficence/nonmaleficence, autonomy, and justice.

¹¹⁴Ibid.

¹¹⁵Ibid.

¹¹⁶Ibid.

¹¹⁷Ibid., 57. The authors state that no evidence exists that a relationship based on mistrust is any more protective of patient autonomy than one based on trust--on a covenant rather than a contract, for example.

A more robust physician-patient model, such as an *end-oriented beneficence model*, recognises that the current moral complexities call for a clearer assessment of the nature and meaning of beneficence--what is meant by acting in a patient's best interest--and how this relates best to end-of-life concerns such as medical killing.

Discussions of "Beneficence," "Nonmaleficence," and "Killing"

The debate concerning PAS has been confused somewhat by a lack of clarity with the terminology used by both sides. By definition, "beneficence" has not, until recently, carried the idea of promoting an act of harm. PAS exceeds the current stated rules of the principle of beneficence in medical ethics.¹¹⁸ To allow for killing under the present umbrella of beneficence then, would require an expanded definition, as well as a broader application of HU theory.

Utilitarian theory stresses beneficence as a central concept, according to Beauchamp and Childress, because it is conceived as an aspect of human nature that spurs one to act in the interest of others.¹¹⁹ Mill would qualify this somewhat generous definition by stating that the sacrifice made for others would be wasted if beneficence does not tend to increase the sum total of happiness. Mill would stress that the happiness pursued must contribute to the general good as Utilitarians deem it--the greatest happiness of the greatest number.¹²⁰

Utilitarianism also redefines the historic term, "beneficence," to buttress its philosophical construct, allowing the term to be shaded by an evolving theory. As "beneficence" has been applied to the act of killing, it has blurred the historic meaning of the word to cloud the difference between the care given to ensure that a patient experiences a "good" death, and a physician's active assistance with a patient's death. The term "beneficence" also relates to the community-at-large, because family members, friends, and

¹¹⁸Beauchamp and Childress, 262.

¹¹⁹Ibid., 260.

¹²⁰Mill, "Utilitarianism," 268-69.

society are often perceived to have gained as the patient received assistance with death; an opportunity for each individual to have explored and confronted the inner self.¹²¹ The historic idea of beneficence as it related to caregiving was straightforwardly positive, including few, if any, alternative definition nuances. Its parallel term, like the opposite side of the same coin, is the notion of “nonmaleficence.” However, just like the notion of beneficence, which is evolving in meaning and application, the meaning of its counterpart is changing as well.

While in the attention given to the principle of beneficence the matter of maleficence is often overlooked, other spokespersons, like Frankena, include the ingredient of *normaleficence* as a primary consideration.¹²² He ranks four aspects of beneficence, the first of which is nonmaleficence: that one ought not to inflict evil or harm. Next in his list are three obligations of beneficence: that one should *prevent evil* or harm to another; and should *remove evil* or sources of harm to another; and finally, that one should “do or promote good.”¹²³ For Frankena, nonmaleficent action ranks ahead of beneficent action. Before one may “do good,” one must have the intention to “avoid doing evil or harm.” Frankena sees beneficence and nonmaleficence as joined in a single principle.

The authors Beauchamp and Childress also speak to this issue and, while they do not propose a normative ranking or hierarchical structure to the principle, they do favour utilitarian calculations to balance benefits, risks, and results of actions. Using their application of the principle of utility,¹²⁴ obligations of beneficence may, at times, override obligations of

¹²¹Pellegrino, “Doctors Must Not Kill,” 97.

¹²²Judith Wilson Ross, Sister Corrine Bayley, Vicki Michel, and Deborah Pug, *Handbook for Hospital Ethics Committees* (Chicago: American Hospital Publishing, 1986), 12-13. Compare also Beauchamp and Childress, 190.

¹²³Beauchamp and Childress, 190-92.

¹²⁴*Ibid.*, 260-62.

nonmaleficence, but they suggest no *a priori* rule that favours *avoiding harm over providing benefit*.¹²⁵

Neither of these above approaches, however, clarifies moral end-of-life decision-making. Not all moral matters may be addressed through utilitarian calculations of benefits and harms. Quill himself expressed an “uneasy feeling” about the crossing of spiritual, legal, professional, and personal boundaries after writing his patient’s prescription.¹²⁶ The principles of beneficence and nonmaleficence invite more careful moral scrutiny. While beneficence and nonmaleficence may be sometimes linked to each other in concept, there is, however, a distinct difference between these two terms and the historic concept of “killing.”

Historically, the term “killing” has meant the direct causation of another’s death. Advocates of PAS use the word in a “technical” or strictly “biological” sense,¹²⁷ in contrast with the traditional interpretation which implies personal agency as part of its meaning.¹²⁸ Rachels defines “intentional” killing as “what one is trying to *accomplish* by an action,” not in the sense of “knowing exactly what someone *did*” (for example, Cain killed intentionally his brother Abel in the Bible).¹²⁹ Rachels presents a utilitarian viewpoint because, according to his view, actions are neither right nor wrong in and of themselves. If the goal is to minimise pain and maximise pleasure, then the action is deemed to be right.¹³⁰ “Killing” for the utilitarian, then, may include the medical purpose to alleviate the extreme pain of a patient and thereby, because of its result, be considered to be a “right” action.

¹²⁵Ibid., 191.

¹²⁶Quill, “Death and Dignity,” 693.

¹²⁷Quill, “Physician-Assisted Suicide,” 16. Oddly, Quill states that “killing” patients is technically correct, but that it incorrectly suggests a physician-driven act.

¹²⁸*OED*, 2d ed., s.v. “kill.” Rachels fails to consider the additional fact that Cain killed in anger.

¹²⁹Rachels, *End of Life*, 15.

¹³⁰Ibid., 154-55.

Opponents of PAS use the term in its traditional sense and assign moral responsibility to the one who kills, although they propose variations in the degree to which culpability is assigned. According to spokesmen like Callahan and Pellegrino, the legalisation of PAS would be hazardous to the medical profession because this position departs from that which physicians have taken throughout the history of the profession.¹³¹ Callahan, for example, in summing up the distinction between killing and “allowing to die,” and calling attention to the difference between causality and culpability, does not assign blame to the physician who stops treatment in the case of a lethal disease. For Callahan, the physician is not the “killer.” The disease is the cause of death. Therefore, there is no culpability in allowing a patient to die of the natural results of his illness.¹³² Callahan does, however, point to an underlying morality when he alludes to hazards associated with PAS other than physical or legal. The danger is tied to the harm that would follow if the line between killing and letting die were erased.

Previously, biological factors were agents in the death of a terminally ill patient, but the present PAS scheme suggests that the doctor should replace the natural cause of death as an intentional agent, working in conjunction with the patient and/or his family.¹³³ Callahan reasons that to permit doctors to kill patients, based on the belief that there is no difference between “killing” and “letting a patient die,” interjects moral confusion into the argument. This confusion, he argues, lies between the direct physical cause of death or its *causality* and the *culpability* for the death. Historically, the *cause* of a terminally ill patient’s death was the natural consequence of disease, and there was no culpability assigned to such a death since it was a natural result of natural biological processes. PAS advocates claim, however, that a death by natural causes or a death by suicide results in the same *end*--namely, the cessation of a

¹³¹Daniel Callahan, “Self-Extinction: The Morality of the Helping Hand,” in *Physician-Assisted Suicide*, ed. Robert F. Weir (Bloomington, IN: Indiana University Press, 1997), 69-70. See also Pellegrino, “Doctors Must Not Kill,” 98.

¹³²Callahan, “Self-Extinction,” 78-79.

¹³³*Ibid.*, 78.

patient's life, so there is no difference in moral significance. PAS opponents, however, recognise that a physician's assistance includes intentionality concerning the death of the patient and, perhaps, a hastening of the final event. The implication for these thinkers is one of moral *culpability*, whether that assignation of culpability comes from ecclesiastical, societal, or legal sources.¹³⁴

The legalisation of PAS would alter what Ladd calls the "internal morality of medicine."¹³⁵ According to Ladd's definition, a physician should "refrain from doing anything *to or for* a patient that does not have a clear medical purpose," for without this medical purpose, a patient's death would be regarded as "killing."¹³⁶ Ladd associates the term "killing" with a body of norms or ethical constraints and requirements that govern the physician-patient relationship.¹³⁷ Ladd reasons that there is a moral difference in medicine and, perhaps, even philosophy¹³⁸ between the terms "letting die" (refraining from futile treatment) and "killing" (action that has no clear biological "healing" medical purpose). The *actor* (or physician) in the act of assisting with suicide will be affected morally by the death of the patient. As has been shown in chapter 2, much has been written about the "distinction without a difference," in support of the underlying mercy argument that, sometimes, the most merciful response to terminal illness and suffering is a "kindness" (beneficence) that can kill. For Ladd and others,

¹³⁴Ibid.

¹³⁵John Ladd, "The Internal Morality of Medicine: An Essential Dimension of the Patient-Physician Relationship," in *The Clinical Encounter: The Moral Fabric of the Patient-Physician Relationship*, ed. Earl E. Shelp, Philosophy and Medicine (Dordrecht: D. Reidel Publishing Co., 1983), 210. Cf. Pellegrino, "Doctors Must Not Kill," 98. Pellegrino defines the "internal morality of medicine" as ". . . the moral obligations that devolve upon physicians by virtue of the nature of medical activity." Overall, Pellegrino stresses that medicine is fundamentally a healing relationship.

¹³⁶Ladd, 210. This use of the term does not imply wholesale acceptance of its definition.

¹³⁷Ibid., 209.

¹³⁸Ibid., 209-10.

there must be an alternative to physician killing to avoid the moral dilemma inherent in the intent, action, and consequences such a practice brings into the medical context.¹³⁹

Summary

The debate surrounding physician involvement in PAS hinges upon many factors. Traditionally, the DPR has been one of stability through the centuries by the consistent exercise of the principle of beneficence by physicians toward patients. Tension in the current PAS debate surrounding the principle of beneficence appears to be centred at the point of the difference of opinion concerning life's value which becomes apparent, for example, when one examines the application of terms like "killing" *versus* "allowing to die." The reigning confusion in terminology, which both sides use, and the considerations of culpability and the effects of patient death upon those who help make that death possible, have yet to be properly clarified. These ongoing tensions between competing ethical views have slowed, if not made impossible heretofore, the process of reaching consensus in the matter.

Second Moral Concern: A Question About Whether Assistance with Suicide Is Indeed Moral

Moral concerns surrounding doctors who assist patients with suicide may not be settled simply by referring to an ontological framework. A valid question in medical *morality* is whether there is some "justifiable philosophical foundation" for a set of *binding obligations* on all those who profess to heal.¹⁴⁰ It follows that, if there were, a question concerning whether a *binding moral* obligation would be perceived to attach to the legal acceptance of PAS. With

¹³⁹Ibid., 209. Compare Ronald E. Cranford's, "The Physician's Role in Killing and the Intentional Withdrawal of Treatment," in *Intending Death: The Ethics of Assisted Suicide and Euthanasia*, ed. Tom L. Beauchamp (Upper Saddle River, NJ: Prentice Hall, 1996), 161. Of course, Quill reasons that PAS should be legalised for this reason, falling back on the argument for autonomy as support for this position; see Quill, *Midwife Through the Dying Process*, 1.

¹⁴⁰Pellegrino and Thomasma, *Philosophical Basis of Medical Practice*, 192. The AMA, BMA, and the GMC have clearly stated sets of obligations regulating treatment of patients. To what extent these are *moral* is another point.

these queries in mind, the focus of this section is the DPR and whether a binding set of moral obligations either remains or exists to cover this relationship and what may be said about the morality of the act of assisting patients with suicide.

The Morality of Practising Medicine

In the present pluralistic medical environment, Pellegrino and Thomasma report, fewer physicians accept a religious foundation for professional ethics. Fewer still claim to be true to all of the injunctions of the Hippocratic Oath, especially with specific reference to the matter of euthanasia.¹⁴¹ Even codes of professional ethics mention moral positions less frequently.¹⁴² This absence of overt reference, however, does not necessarily argue that current medical practice is either devoid of a moral base or must abandon such a tenet, even though some might argue otherwise.¹⁴³ In fact, the reality that the practice of medicine has to do with “good ends” and the well-being of others qualifies it as moral in nature.¹⁴⁴ Since the DPR involves human beings in relationship, the DPR will reflect the general level of morality associated with each of the entities in the DPR.¹⁴⁵

As has been demonstrated, the nature of medicine as a healing craft has historically imposed on the physician certain moral obligations such as the avoidance of treatment thought to be futile, burdensome, or not in the patient’s best interests.¹⁴⁶ The fact that physicians

¹⁴¹Ibid.

¹⁴²Ibid., 193.

¹⁴³Jonsen, 268. At least one physician, Louis Lasagna does not believe medicine is a moral enterprise, but he does believe there are many occasions where a physician can act immorally.

¹⁴⁴Ibid., 267.

¹⁴⁵Babbie, 12.

¹⁴⁶Pellegrino, “Doctors Must Not Kill,” 96. All of these obligations are, of course, highly debatable, but serve as examples of the ways in which physicians have historically perceived themselves to be responsible for patient welfare.

throughout history have found it profitable to craft codes and oaths to serve as guiding standards for the ethical practice of medicine serves to indicate, among other things, that an ethical thread runs through medical practice.¹⁴⁷ Emanuel notes rightly that the codes of medicine were often broken by individuals whose “moral perceptions may have been defective.”¹⁴⁸ An interest in “morality” or “behaving morally” has historically existed in medical practice.

Terminology

The term “moral” means “pertaining to character or disposition, considered as good or bad.”¹⁴⁹ The term also means “pertaining to the distinction between right and wrong, or good and evil, in relation to the actions, volitions, or character of responsible beings.”¹⁵⁰ “Morality” is “moral qualities or endowments” and “the doctrine or system concerned with conduct and duty.”¹⁵¹ A certain degree of ethical continuity existed from the time of Hippocrates until the middle of the last century.¹⁵² Science, technology, and social change began, at that time, to produce rapid changes in healthcare and the biological sciences, some of which, in turn, seemed to produce challenges to the longstanding moral obligations between physicians and patients.¹⁵³ In contemporary biomedical ethics, specifically with regard to the PAS debate,

¹⁴⁷Emanuel, 13. Other reasons for writing moral codes may exist, such as the delineation of benefits to patients or the evolution of medical canons.

¹⁴⁸*Ibid.*, 12-13. Cf. Pellegrino and Thomasma, *Philosophical Basis of Medical Practice*, 192-93.

¹⁴⁹*OED*, 2d ed., s.v., “moral.”

¹⁵⁰*Ibid.*

¹⁵¹*OED*, 2d ed., s.v., “morality.” See also *Cambridge International Dictionary of English* (1995), s.v., “morality.” Morality is defined as a “personal or social set of standards for good or bad behaviour and character, or the quality of being right, honest or acceptable.”

¹⁵²Beauchamp and Childress, 3.

¹⁵³*Ibid.* An example of scientific advancement, as applied to medicine, for example, is the sustaining of a terminally ill patient’s life through technology.

finding a stable medical/communal consensus about right and wrong conduct has proved to be somewhat elusive.

The Prevailing Climate

Beauchamp and Childress, while not expressly utilitarian, offer a “common morality” framework for thinking about moral issues related to PAS.¹⁵⁴ These authors do not draw a moral distinction between “killing” and “allowing to die.” For them, the labelling of an act as “killing” or “allowing to die” does not solely determine if one form of action is better or worse, or one more or less justified than another. In actuality, neither “killing” nor “allowing to die,” according to the authors, is wrongful *per se*. For example, a brutal murder (killing) is considered worse than foregoing treatment for a person who is in a persistent vegetative state (letting die). On the other hand, however, letting someone die who might have otherwise been saved (letting die) could be worse than some specific instance of a physician killing his patient in response to that patient’s own request (assisted killing).¹⁵⁵

While both the murder and the allowing of the patient to die of neglect as described above may be *prima facie* wrongful deaths, perhaps all of the deaths could be justified in some way according to this system. The point is that, for Beauchamp and Childress, the doctor’s motive, the patient’s request, and the consequences of the act together will place the act of death on the “moral map” and allow its judgement to be assessed.¹⁵⁶ The following case study further explains the rationale.

¹⁵⁴Ibid., 260-61.

¹⁵⁵Ibid., 225.

¹⁵⁶Ibid.

Case Study

The actor's involvement, the patient's request, and the consequences of the act are evident in the DPR situation which included Dr. Timothy Quill and his forty-five-year-old leukaemia patient. She had been his patient for many years and several members of her family had, as a group, come with her to the decision, through the counsel of Dr. Quill, that it was time for her to commit suicide. The patient was competent, and all reasonable alternatives for the relief of her suffering had been discussed and rejected. Dr. Quill prescribed the barbiturates she both desired and took,¹⁵⁷ committing suicide with his assistance. Beauchamp and Childress list nine reasons why they considered Quill's case one of "justified assisted suicide."¹⁵⁸ The story is now well-known, and while his involvement was labelled by some observers as "unsettling" and "unjustified," his actions have been met with guarded approval.¹⁵⁹

An application of classical HU reasoning would produce the same verdict concerning Dr. Quill's situation. An action is morally right, according to HU, if the action either increases happiness in the world or decreases the amount of misery. The "killing" of a hopelessly ill patient at her own request, like Quill's action, would decrease the amount of suffering in the world and, thereby, render the action "morally right."¹⁶⁰ The point of this section is that, even though an interest in "morality" or "behaving morally" has prevailed in medical practice through the centuries, the current public and medical climate seems to be shifting from traditional understandings of "killing" or assisting with death, to more complex justifications of the act, based upon ultimate benefit calculations.

¹⁵⁷Ibid., 239-40.

¹⁵⁸Ibid., 240.

¹⁵⁹Ibid.

¹⁶⁰Rachels, *End of Life*, 154-55.

“Consequentialist” Decision-Making

The use of consequential reasoning, when analysed morally, takes on a somewhat different perspective. In the scenario above, the patient “*ought not* to have to continue suffering,” and the moral doctor is one who “*ought to do* whatever is necessary” to bring about an end to her suffering. The consequentialist decision is reached by balancing the benefits and burdens to determine their acceptability. Since the *result* was sufficiently good (the consequence was the end of suffering), the *action* (assisted killing) was justified. To state Quill’s action in moral terms, he aimed at death, or killing, to relieve his patient’s suffering. In order to soften the notion of “killing,” one might lessen the impact by emphasising the merciful motives.

In other words, the good results became sufficiently weighty to make the end result, or killing, justified. The end simply justified the means. The consequentialist line of reasoning carries the potential for moral harm; for example, primary dependence upon mechanical or utilitarian calculations to determine a patient’s final decisions, which may in turn affect negatively a patient’s dignity. One must be careful to give attention to both dignity and autonomy in these matters, both when the patients can, and when patients no longer have the capacity, to reason clearly.

Balancing Human Dignity and Autonomy

Beauchamp and Childress argue that the loss of cognitive capacity and suffering can so “ravage and dehumanize” patients that death “is in their best interests.”¹⁶¹ In contrast, by limiting the search for meaning in life to the mechanical, which is a utilitarian calculation, one may miss many other, even moral, facets of life that give life meaning--such as illness itself. Medicine applied to human activity is moral, in part, because of the nature of illness. Depending upon the severity of their ailing conditions, people are often vulnerable, weak, and

¹⁶¹Beauchamp and Childress, 240.

in need of the special skills the physician possesses, including human contact and reassurance.¹⁶² Because of the mechanisation of life and death through medical technology and loss of personal contact with familiar surroundings, hospitalised patients often perceive a loss of dignity, what has been called “technological neglect.”¹⁶³

The manner in which Kevorkian’s PAS deaths occurred seemed to place the emphasis on the biological aspects of the patient’s life to the neglect of the social, with their families absent. Although PAS rests centrally upon the principle of autonomy, the question arose as to whether Kevorkian’s patients were truly exercising autonomy or freedom from interference, especially in light of Kevorkian’s ancillary emphasis upon publicity and the circumstances surrounding patient selection. For example, Dr. Jack Kevorkian’s van, suicide machine, media glare, and limited knowledge of his patients were cited as contributing to the loss of those patients’ dignity. Dr. Kevorkian did not seem to balance the autonomy of his patients with a preservation of their dignity.

The issues of autonomy and dignity are not limited to patients, however. Dr. Quill might also have questions about his own autonomy in the situation in which he found himself. He may himself have been a victim of his own patient’s insistence on committing suicide. His unease with the boundaries being violated suggests that he, too, felt his circle of autonomy somewhat breached, although it would be speculative to infer from the report cited any suggestion that there was some sort of psychological transference and countertransference between himself and his patient. PAS advocates present stringent guidelines to safeguard the practice of preserving autonomy and dignity for the patient. However, these guidelines should also be carefully considered and equally applied to each party in the DPR. The promise to

¹⁶²Pellegrino and Thomasma, *Virtues in Medical Practice*, 35-36.

¹⁶³Compare Beauchamp and Childress, 237-38. The source is used as one of many that gives details about the death of Janet Adkins. The authors state that Kevorkian’s action is a case of unjustified killing.

preserve autonomy and dignity for *both patients and physicians* has not yet been adequately addressed by the PAS arguments.

Summary

Based upon their varied sources, the *binding set of moral obligations*, which once served medicine historically, seem to be of less consequence in the current *milieu*, particularly when HU calculations are used both to quantify and qualify end-of-life decision-making. Guidelines that establish *moral judgements* about physician and patient behaviour have yet to gain a consensus; however, balancing autonomy and dignity considerations are critical for both parties in the DPR. The possibility that physician and patient trust in medicine will erode rises from within a context where primary focus is placed upon GHP calculations. Such calculations run the risk of eclipsing autonomy and dignity considerations in the DPR.. For example, one of the crucial ingredients in any discussion regarding the value and equal treatment of human beings is the climate of trust from which all parties derive equal hearing. This leads to the third moral concern--regarding trust in the medical context.

Third Moral Concern: The Potential for Codifying Distrust in the Medical Community

Background and Terminology

The *OED* defines trust as “confidence in or reliance on some quality or attribute of a person or thing, or the truth of a statement,” or the word can mean “the quality of being trustworthy; fidelity; reliability; loyalty; and trustiness.”¹⁶⁴ Beauchamp and Childress define trust as the confidence that another will *act with the right motives* in accord with moral norms.¹⁶⁵ “Trust is a confident belief in and reliance upon the ability and moral character of

¹⁶⁴*OED*, 2d ed., s.v. “trust.”

¹⁶⁵Beauchamp and Childress, 469. They also say that this is the most important ingredient in making the choice of one physician rather than another. This position, to act with right motives in accord with *moral norms* seems odd, however, in light of the authors’ emphasis upon consequentialism.

another person.”¹⁶⁶ Trustworthiness, as Beauchamp and Childress have declared, is a prominent virtue in healthcare in general and in the DPR specifically.¹⁶⁷ Three separate examples illustrate, at differing levels, the importance of physician trustworthiness.

The case study involving Dr. Quill raises the moral concern of truth-telling. Quill admitted, after the fact, to withholding the truth about the patient’s cause of death. When he chose not to tell the truth, and the truth itself became known, the wider community of observers reacted to Dr. Quill’s action, which opened up the medical community to speculation and the potential reinforcement of general mistrust.¹⁶⁸ Dr. Quill’s lack of truth-telling, when the loss of his professional status seemed to be placed in jeopardy, raises a larger moral question concerning what other unforeseen stresses to a doctor’s professional status might lead to similar behaviour and contribute to a broader loss of trust in doctors.

Another example may be found in Dr. Kevorkian’s behaviour, which has also been called into question by the medical community, in part, because of the overall atmosphere of distrust it created within the medical and wider communities.¹⁶⁹ Dr. Kevorkian operated outside recognised medical and legal boundaries that had been established precisely to foster a climate of trust between patients and their doctors.

Still another eminent British physician, Dr. Michael Irwin, admitted to helping at least fifty people to die, one of whom was not a patient of the doctor, but who was supplied with a

¹⁶⁶Ibid.

¹⁶⁷Ibid. The specific definition of trust is neutral in the PAS debate in that both sides use the definition to buttress their positions. For example, PAS advocates might include physicians working to be merciful and to end the suffering of their patients as having the “right motives.”

¹⁶⁸Quill, “Death and Dignity,” 694.

¹⁶⁹Beauchamp and Childress, 238. Kevorkian’s “. . . abuse, lack of social control, physicians acting without accountability, and unverifiable circumstances of a patient’s death . . .” raised all the fears present in arguments about killing in medicine. Kevorkian’s behaviour was veiled somewhat by the privacy that envelopes the DPR.

plastic bag to help with asphyxiation.¹⁷⁰ The latter doctor knew that assisting with suicide was, and still is, a crime in England. This volitional act in an illegal manner did not deserve trust. The presence of trust, or the lack thereof, was at least a question in each of these cases. The meaning of the word implies a moral basis, but the actual practice of tracing “trust” in medical history, as observed in codes of ethics, warrants some observations.

Historical Weight

The Hippocratic corpus advises bluntly the physician to conceal most things from the patient. The Hippocratic physician was not to reveal the patients’ present or future condition.¹⁷¹ Percival’s code, which served as the model for the first AMA code in 1847, allowed for “beneficent deception” for patients with gloomy prognostications.¹⁷² The Declaration of Geneva does not mention veracity at all except that the physician himself “promises solemnly” to adhere to its tenets.¹⁷³ In fact, the AMA codes do not mention honesty or truthfulness at all until 1980. In that latest code, the physician pledges to deal honestly with his patients and colleagues.¹⁷⁴

¹⁷⁰Mark Austin, “Doctor Admits Killing 50 People,” in *The Sunday Times* no. 9, 021 (20 July 1997), n.p. While these are cases which have the potential to impact negatively the DPR, it must be said that PAS advocates do not agree, citing that the willingness for a physician to assist in PAS *increases* trust/confidence in the DPR.

¹⁷¹Tom L. Beauchamp, “Medical Ethics in the Age of Technology,” in *Traditional Moral Values in the Age of Technology*, ed. W. Lawson Taitte (Austin: University of Texas Press, 1987), 63.

¹⁷²*Ibid.*, 65.

¹⁷³*The World Medical Association Declaration of Geneva (1948) Physician’s Oath*; internet, available at <http://www.cirp.org/library/ethics/geneva/>; accessed 6 June 2002.

¹⁷⁴Beauchamp and Childress, 395. Cf. American Medical Association, *Principles of Medical Ethics*, Article II, 1980.

The Importance of Trust

Since the various codes of ethics do not render explicit the matter of trust, it might appear that there is little reason to question the potential for its erosion and how that loss might impact ethical considerations in medicine. Codes continue to be oaths or pledges taken by the physician and, while most often undergirded by his own sense of truth-telling and honour, medical codes seek to safeguard the ethical or moral actions of the physicians when they pledge to act in accordance with established norms of the profession. Trust is vital in normal human relationships and is particularly important in times when patients experience states of special dependence upon medical professionals in the DPR.

These states of special dependence may include “illness, old age, infancy, times where the patient is in need of healing, justice, spiritual help, or learning.”¹⁷⁵ The doctor elicits patient information, then structures and orders it in relation to a scientific theory of disease. He then must gather the information as accurately as possible and apply the logic that comes from the contemporary science of diagnostics together with appropriateness and sensitivity to the patient’s needs. All of this requires an honest relationship between doctors and patients, both of whom disclose information and have the patients’ best interests in mind.¹⁷⁶

Beauchamp and Childress see adherence to the principle of veracity as vital for a successful physician-patient relationship.¹⁷⁷ They base this belief upon respect for others, the patient’s right to know the truth, which involves the obligation of fidelity and promise-keeping by both physicians and patients, and the fact that trust is necessary for fruitful cooperation and

¹⁷⁵Pellegrino and Thomasma, *Virtues in Medical Practice*, 25. A physician can shape a decision by the way he presents factual data. He may interject his own values or prejudices about life, politics, or religion into the dialogue either openly or covertly (75).

¹⁷⁶Jonsen, “Therapeutic Relationship,” 278.

¹⁷⁷Beauchamp and Childress, 396.

interaction in relationships.¹⁷⁸ A patient's only real alternative is that of distrust, and that is rarely an helpful option.

Contributors to Distrust

Patient perspective. Varying levels of distrust manifest themselves in the current DPR. The most impersonal are at the *institutional level*. Patients, particularly in America, distrust large, impersonal, and bureaucratic medical institutions, fearing the commercialisation of medical care through advertising and entrepreneurialism and the potential loss of intimate contact in the DPR with their physicians.¹⁷⁹ Patients in America are also most likely to express distrust at the *financial level*, having grown weary of “pay-before-we-treat” policies, cost-control strategies, overall high charges for healthcare, as well as the conflicts of interest apparent between physician referrals and the practice of physician-investment/ownership of treatment centres.¹⁸⁰ Patients have grown distrustful on a popular or *individual level* as well. Growing cynicism among medical consumers, who observe some doctor's preferences for nine to five jobs, lengthy time off, and the retreat by doctors to “specialty” practice from general practice,¹⁸¹ when exacerbated by greed, often degenerates into filed suits of malpractice.

Physician Perspective. Physicians may also express concern about a medical-financial climate that is disruptive to trust. Part of the blame can be placed on cost increases due to rapid

¹⁷⁸Ibid.

¹⁷⁹Ibid., 470. Pellegrino and Thomasma, *Virtues in Medical Practice*, 71. Axelrod and Goold, 2. The authors write of the distrust created when patients are “forced” to see a certain physician due to cost control strategies.

¹⁸⁰Beauchamp and Childress, 470. Edward Shorter, *Doctors and Their Patients: A Social History*, reprint edition (London: Transaction Publishers, 1991), 229. Axelrod and Goold, 2.

¹⁸¹Beauchamp and Childress, 470. Pellegrino and Thomasma, *Virtues in Medical Practice*, 71. Axelrod, and Goold, 2. The authors write of the distrust created when surgeons become employees of the integrated health system or managed care firm. They no longer “work for the patient” alone, but work primarily for their institution or system. See also Shorter, 229, for the amelioration of the traditional practice of patients to view their physicians as “priests,” and “medicine as a series of secret holy rites.”

expansion of an aging population in both the US and the UK, together with the rising cost of technology. Surgery has been targeted by employers and government as a place to limit expanding costs. Tensions are created between physicians' financial interests and the interests, financial or otherwise, of their patients.¹⁸² Surgeons, as an example, believe this conflict can undermine trust in a physician's decisions and represents a serious threat to the physician-patient relationship.¹⁸³

Physicians distrust the present medical climate in another way. They recognise that a struggle exists between the paternalism of the traditional Hippocratic corpus and the new practical codes of ethics perceived necessary to make increasingly difficult real-life decisions, especially in relation to the ethical usage of advanced medical technology. On the one hand, a physician may be encouraged to emphasise beneficence and nonmaleficence (the Hippocratic tradition), and on the other hand, the same physician may feel pressured toward PAS decisions, based upon HU calculations, from groups citing autonomy and justice claims.¹⁸⁴ Physicians seek clear ethical guidelines upon which to base decisions.

An example of this dilemma may be the patient with severe leg *ischemia* and gangrene who refuses an amputation. His physician understands the need to respect the patient's autonomy and must decide whether to allow the patient to refuse the required lifesaving medical procedure. This respect for the right of patients to make their own healthcare decisions departs somewhat from the Hippocratic corpus, although this departure must not be taken to imply that Hippocrates would have insisted upon an amputation against the patient's wishes. Nevertheless, when patients wish to be left alone to allow the natural consequences of their life-threatening diseases to end their lives, physicians sometimes wrestle with both the

¹⁸²Axelrod and Goold, 2.

¹⁸³Ibid.

¹⁸⁴Axelrod and Goold refer to beneficence, nonmaleficence, autonomy, and justice as presented in Beauchamp and Childress.

principle of beneficence and their own desires to *do* what is best or to act in such ways that *clarify the best options* for their patients.

Specific Application of Trust to Physician-Assisted Suicide

The abovementioned factors contribute to the perception, if not reality, of distrust in normal medical decision-making, and even more so in the difficult end-of-life decision-making. Understandably, a lie told in the process of encouraging a patient to seek treatment at a centre where a physician has a financial interest is morally questionable. The subtle influence by a physician to pursue PAS, however, may have further moral implications. There are several reasons for serious consideration of the negative moral effects PAS could have on trust. First, there is the issue of patient trust in the physician's devotion to the patient's interests.¹⁸⁵ PAS opens a whole new range of potential doubts about physician-devotion in the minds of patients. Second, distrust could be created if physicians cross the lines drawn in the use of PAS.¹⁸⁶ When doctors act with the right motives according to moral norms, trust is more easily built in the DPR.¹⁸⁷ Third, distrust could be created in medicine as a whole when physicians join the state, government, or other confederacies, such as managed healthcare plans, as holders of the power

¹⁸⁵Leon R. Kass, "Physician-Assisted Suicide Should Not Be Legalized," in *Physician-Assisted Suicide*, ed. Daniel A. Leone (San Diego: Greenhaven Press, 1998); 79. See also Arnold S. Relman, "The Impact of Market Forces on the Physician-Patient Relationship," *Journal of the Royal Society of Medicine Supplement* 87, no. 22 (1994): 22. The medical profession, Relman claims, is different because the doctor, who is the provider of services, must be trusted to protect the consumers' (the patients') interests by acting as advocate and counsellor.

¹⁸⁶This touches upon the matter of slippery slopes to be discussed in the next section. See also Kass, 79. Kass believes that PAS would not stay confined to the terminally ill and mentally competent patient who freely and knowingly chooses PAS. He cites the example of Dutch doctors, forty percent of whom have performed involuntary euthanasia. It must be noted, however, that PAS detractors claim the threat of distrust as well.

¹⁸⁷Beauchamp and Childress, 469. See also Tony Sheldon, "Reprimand for Dutch Doctor Who Assisted Suicide," *British Medical Journal* 310, no. 6984 (April 8, 1995): 894-95. A medical disciplinary board in Amsterdam reprimanded Dr. Chabot for helping a depressed, but physically healthy, fifty-year-old woman to commit suicide. The Board concluded that the doctor's actions "undermined trust" in the medical profession. The action of the Board implies a moral standard that had been breached.

to exercise lethal force.¹⁸⁸ Medicine, whether it engages at the corporation or DPR level, wields great power--the power to cure and the power to kill. PAS raises questions about the trustworthiness and ethics of the medical profession at the point of the exercise of this medical power.¹⁸⁹

Summary

While it is not unusual for patients and physicians to harbour distrust for financial reasons, each from their own perspectives and for their own reasons, there is a possibility that a deeper moral concern involving trust is overlooked. The DPR is a relationship where both patient and doctor expect the other to act with right motives and to be a person of moral character. When patients and their doctors face end-of-life decisions, then the issue of trust is heightened because of the special state of dependency that enfolds a patient. The potential for greater and broader damage to trust is present with PAS because any compromise bears implications that extend beyond the death of a patient to lessen an atmosphere of trust in the wider community. One of those implications of a lessening of trust may raise questions about "greater killing."

Fourth Moral Concern: The Threat of Greater Killing

Delineations of the Slippery Slope Argument

The slippery slope threat of greater killing presents a final moral concern to be discussed in this section. PAS opponents claim, for example, that if PAS is initially allowed only for those who are in the end-stage of terminal illness, then one day PAS will be allowed for those who are not in the end-stage of terminal illness.¹⁹⁰ This form of the slippery-slope

¹⁸⁸Kass, 78-80.

¹⁸⁹Ibid., 78-79.

¹⁹⁰Beauchamp and Childress, 240. Although Beauchamp and Childress are not opponents of PAS, they have provided a complete list of nine conditions considered sufficient for justified assisted suicide.

argument is named the Psychological-Social version (PSV). The concern is that once the restraint against killing is removed for the terminally ill, then various psychological and social forces would likely make it harder to keep distinctions between the degrees of severity among patient illnesses.¹⁹¹

When PSV is applied to PAS, an act of assisting with the killing of a person at his own request invites social changes similar to those feared when the question of the legalisation of VAE was discussed.¹⁹² For example, it could lead to the subtle influence to kill those whose health problems and costs require larger proportions of the public's financial resources. In the US where more than forty million people are uninsured,¹⁹³ this presents a moral concern for the subtle coercion of a social policy that suggests that the incurably ill are social, economic, and emotional burdens.¹⁹⁴ Pellegrino also notes that as killing becomes bureaucratised and standardised, it remains impossible to contain VAE within specified boundaries.¹⁹⁵ The same would hold true with PAS, he says, because even if PAS is carefully monitored, laws cannot prevent abuses. Slippery-slope arguments often fall into such familiar traces that hearers sometimes dismiss them without due consideration.

Litmus Test: Qualifiers of the Argument

Battin lists four errors common to slippery-slope reasoning.¹⁹⁶ The first is a failure to identify clearly the feared outcome or lowest point of the slide. In the current PAS debate, one

¹⁹¹The matter of the slippery slope of social consequences has been addressed for the last decade. Compare Brody, 1385. A counter perspective is presented by Pellegrino, "Doctors Must Not Kill," 99-100.

¹⁹²Beauchamp and Childress, 230. See also Pellegrino, "Doctors Must Not Kill," 99-100.

¹⁹³Quill, *Midwife Through the Dying Process*, 216.

¹⁹⁴Pellegrino, "Doctors Must Not Kill," 100.

¹⁹⁵*Ibid.*

¹⁹⁶Battin, *Least Worst Death*, 22-23.

fear behind the legalisation of PAS is that there will be an absolute impossibility, in a democratic culture based on rights, to maintain the boundaries of PAS at the level of the terminally ill. The experience of the Dutch with VAE illustrates the point. There has been a slow, but steady, progression with VAE beyond the terminally ill to include the chronically ill and depressed.¹⁹⁷

The second error in the argument is a failure to identify the causal force that is presumed to fuel the slide from the current situation to the predicted bad outcome. To answer this critique, the causal force in America is feared to be economic in some shape or form. Insurers are already offering lump-sum payments, or payments on policies at a lesser amount, to the terminally ill.¹⁹⁸ Some predictors suggest that economic factors will one day merge with PAS to create advance payments, prior to death at a reduced amount, on life insurance policies for those who choose this form of death.¹⁹⁹ This practice, would surely encourage the death of individuals for monetary gain since, under the present system, this motive is already a reality.

The third argument error is a failure to identify the negative reality of the outcome. PAS is one step toward the *medicalisation* of death. Jack Kevorkian coined a technical term,

¹⁹⁷Alan D. Ogilvie and S. G. Potts, "Assisted Suicide for Depression: The Slippery Slope in Action? Learning from the Dutch Experience," *British Medical Journal* 309, no. 6953 (1994): 493. The authors cite the case of Dr. Chabot who assisted a depressed woman with her suicide. See Diane Raymond, "Fatal Practices: A Feminist Analysis of Physician-Assisted Suicide and Euthanasia," *Hypatia* 14, no. 2; internet, available at <http://www/iupjournals.org/hypatia/hyp14-2.html>; accessed 21 March 2004. Raymond discusses from a feminist vantage point, her belief that euthanasia is generally treated in moral isolation, but that, in reality, it may be seen as being linked to a number of complex issues in medical ethics. She states that it has implications for power inequality, resource allocation, social priorities, and QL.

¹⁹⁸Compare "Quality Care for the Dying: Glossary"; internet, available at <http://www.cs.virginia.edu/~jones/tmp352/projects98/group7/gloss.htm>; accessed 21 March 2004. The term used is "viatical settlement." A viatical settlement refers to a business where a private company pays a patient a portion of her life insurance while she is still living instead of the whole payment when she dies.

¹⁹⁹Compare Alexander Morgan Capron, "Sledding In Oregon," *Hastings Center Report* 25, no. 1 (January-February 1995): 34. Capron notes that presently the *Oregon Death with Dignity Act* protects wills and insurance policies from being affected by a person's taking his or her own life.

thanatiatrics, to describe death through human action that is “benevolent and altruistic in purpose.”²⁰⁰ His plans were many and varied and perhaps not altogether coherent. For example, his plan made room for patients to “opt for death.” Kevorkian’s plan also called for physician involvement in death that would extend beyond the mere termination of life to “permit exploitation of the enormous potential benefit that could accrue from the acquisition of organs for transplantation and the performance of daring and otherwise impossible human experiments under irreversible general anaesthesia.”²⁰¹

Kevorkian’s critics compared his ideas with the medical aberrations of Nazi Germany. The Nazi analogy stirs up much controversy when used as an example of the bottom of the slope. It does not serve to prove the point, say critics of its use, because the rationale of the Nazi programme was a *racist ideology*, not respect for autonomy.²⁰² Kevorkian himself criticises those who make the comparison of Nazi atrocities with his plan, for his would allow for “proper consent and controlled anaesthesia.”²⁰³ Kevorkian based his case, in part, upon the principle of autonomy.

Advocates of PAS and VAE also make claims which stand strongly upon the principle of autonomy. PAS advocates would question, for example, how a patient could actually commit suicide without the doctor’s help unless a patient was competent in the first place. This stance causes some opponents of PAS to call for caution. Current anti-PAS spokespersons draw comparisons between the “racist ideology” of Nazi, Germany, and current proposals

²⁰⁰Jack Kevorkian, “The Last Fearsome Taboo: Medical Aspects of Planned Death,” *Medicine and Law* 7, no. 1 (1988): 3.

²⁰¹*Ibid.*, 1.

²⁰²Beauchamp and Childress, 232. The authors also condemn the possible action taken by a gynaecology resident in the now famous “It’s Over Debbie” article in the *Journal of the American Medical Association* (1988).

²⁰³*Ibid.*, 4.

which classify the ill or infirm or poor or demented as somehow “sub-human”-- those who live lives that are “not worth living.”²⁰⁴

A fourth error is a failure to take account of the current state of affairs and “the predicted negative outcome.” The present medical environment, with its moral ambiguity that exercises utility (weighing benefits against burdens) in making moral decisions, creates the possibility for future abuses to occur. The relationship this has with the future negative outcome is personified again in the actions of Jack Kevorkian.

While Kevorkian may be considered to be an extreme case, the 1990s proved that even he could successfully sidestep the law and engage in the practice of PAS in the state of Michigan. His actions were not legally prevented and, while his actions brought moral condemnation from the medical community at large, he continued to practise PAS.²⁰⁵ Only when he crossed the boundary lines of VAE, with videotaped proof of his direct involvement, was he successfully prosecuted. It is of specific note, however, that the censure he incurred for PAS was for the reckless manner in which he conducted the procedures, not for actually assisting people in their deaths.²⁰⁶

The Dutch experience with euthanasia provides another example of compromised boundaries and a possible slide toward a future negative outcome. Euthanasia has not been limited to competent terminally ill adults who are enduring physical suffering. The regulation

²⁰⁴Singer, 95-99, 101. Singer’s social policy, which assigns worth to those who meet his narrow definition of “life,” rings closely true to the war crimes of a previous era. While Singer’s views may not be classified as “racist,” he does draw a distinction between “social classes.”

²⁰⁵Dr. Quill was prosecuted but not convicted for his role in the death of his patient. See also Ronald E. Cranford’s discussion for the potential for abuse in “The Physician’s Role in Killing and the Intentional Withdrawal of Treatment,” 160-61.

²⁰⁶Beauchamp and Childress, 238.

of the practice has not prevented involuntary euthanasia²⁰⁷ or the expansion of euthanasia to include severely disabled neonates and elderly persons suffering from dementia.²⁰⁸

These categories of thinking about “slippery slope” arguments also are helpful for reflecting upon both the present and the future with regard to HU’s applications of the features of the PAS debate. Opponents of PAS propose the slippery-slope argument in order to project what might happen if PAS were legalised. Instead of dismissing their concerns out of hand, an examination of the argument’s components is crucial. If these concerns prove to be valid, then the case for PAS needs to be reassessed.

Conclusions

In a morally ambiguous medical climate where procedural irregularities raise more concerns than merely the considerations of planned death, the potential for further negative moral outcomes may indeed be a reality. A primary moral problem is that legalising PAS may set a foot in the direction of “negative” solutions toward dealing with mitigating miseries rather than stepping toward positive goods to promote.²⁰⁹

Thesis Conclusions

The research question inquired whether HU provides sufficient moral ground to warrant a change in medical canons regarding medical killing. Mill’s philosophy, as noted, has long been considered a useful philosophical framework for social policy that aims to improve the

²⁰⁷Kass, 79.

²⁰⁸Charles E. Rice, “Abortion, Euthanasia, and the Need to Build a New Culture of Life,” *Notre Dame Journal of Law, Ethics & Public Policy* 12 (1998): 514.

²⁰⁹Timothy Quill’s assistance with suicide raised some questions in the medical community, but even he received general praise for his compassionate response to the patient’s need and his suggested plan for assisting with future suicides. Moral light should be shed on the matter of the hopelessness, or even meaninglessness, patients are expressing in the current medical environment--a hopelessness that leads them to choose PAS as an alternative to life. The topic of meaninglessness, while perhaps necessary to the PAS discussions, is beyond the scope of this thesis.

conditions of human life by the exercise of rational principles,²¹⁰ but it was not known what impact the theory might exert in the medical debate concerning PAS. The thesis examined the two core principles of HU: hedonism and consequentialism. Hedonism states that the only thing that is good in itself is pleasure, and the only thing bad in itself is pain. Decision-makers in the DPR, when applying HU, would be obliged to pursue pleasure/happiness as the supreme good. The second principle of HU is consequentialism. The consequentialist principle determines the rightness or wrongness of an action by the goodness or badness of the results that follow from the action.

In the case of PAS, a typical utilitarian calculation would evaluate whether an action, for example, a physician's assistance with a patient's suicide, was right or wrong based upon whether the action produced good results--in this case a greater balance of pleasure/happiness over pain/unhappiness. Right action in this case would be adjudged solely on the ground that the consequences of the physician's action were better than any and all other consequences produced for the general well-being of all who were affected by the actions of the physician. Such a scenario creates immediate tensions within the DPR, not the least of which are related to the singular theory of value espoused by Mill, the tension also relates to Mill's theory of action.

Mill's HU: Certainty of Conflict

Mill's ethical theory, as conceived, runs immediately *counter to established medical canons* which have been historically based upon a deontological ethical model that emphasises moral action related primarily to duty, rather than to ends or consequences. The application of Mill's theory, in whole, or in part, to *medical-ethical* decision-making ensures certain conflict with the historical medical principles that are ingrained deeply within medicine.

Notwithstanding the disregard Mill held for intuitive ethical theories, and the conflict this

²¹⁰See thesis, intro., 2.

creates within medicine, his theory requires the adherent to hold to an *exclusive* theory of value (PH) and to *maximise* this value *for the many* (GHP). While this may have some useful application to governmental health policy on a macro level, it cannot secure the rights and provide adequately for the claims of justice on a micro level—the traditional DPR, for the DPR represents more than a medical-technological-financial encounter between a physician and a patient. The DPR represents a moral healing relationship and the moral nature of this encounter is never more important than when a patient and his or her family faces end-of-life decisions brought on by a terminal illness.

One of the primary canons of medicine is that “life is a good” and this canon is grounded deeply in “other-than-biological” or mechanical *moral* realities and urgencies. This is an ancient philosophical and medical perspective. The Ancient Greek philosophers themselves sought to examine the world through the lense of independent rational thought, and a characteristic of their age was to grapple with the “why” of life and death.²¹¹ They sought to discover the connections or “stuff” of man’s inseparable link between himself and the world (cosmology) and man’s moral relationship with others in the same world (moral community). Through varying approaches to the discovery of what comprised the “good life” these philosophers demonstrated the near impossibility of reaching a consensus about that which comprised the supreme good and the best moral path to take in order to attain that good. Mill, however, claimed to have determined the supreme good and the pathway to attain it. It is not simply the fact that Mill’s cosmology is mechanical that is a hindrance to HU’s effective application to medical-*moral* concerns, it also is the fact that *Mill seeks to decipher moral complexities cosmologically and empirically with the aid of a highly-debatable moral calculus* that makes HU’s application to medical-moral concerns untenable.²¹²

²¹¹See *ibid.*, ch. 1, 33.

²¹²See Mill, ch. 1, 6, 8.

From within this seedbed of philosophical questioning and speculation, Epicurus, who was later followed by John Stuart Mill, equated decisively happiness with pleasure. Pleasure alone constituted happiness. Mill's HU added variation to the PH theme by reasoning that "ultimate good" was the greatest happiness of the greatest number. Mill patterned his theory after Epicurus who, as an "atomist," believed that a material worldview gave rise to moral responsibility.²¹³ Nothing had been created *out of* the nonexistent, and nothing was destroyed *into* the nonexistent. Epicurus and Mill both held that the world was the result of inevitable natural processes, but no part of the world, inorganic or organic, was the result of any purpose.²¹⁴ For them, man was required to fashion his own moral existence in order to find meaning and purpose.

Mill's insistence that PH and "happiness alone is the only thing desirable"²¹⁵ is a dubious claim because people simply do not desire certain things because of the pleasure such things give to them.²¹⁶ To reduce moral valuation in the DPR to the level of a hedonic calculus (quantifying/qualifying PH) is not feasible and cannot ensure accuracy in *moral* decision-making for either doctors or patients. Mill's further insistence upon a mechanical view of organic, human, existence conflicts with the medical value—the sacredness of life. While such a view may provide various empirical advantages, for example, in medical research and the development of medical technologies, it conflicts with the medical principles of patient autonomy, rights, and justice—all of which support strongly the sanctity of life value.

Mill constructed his theory within a post-Enlightenment climate, a "scientific age" that held that matter was indeed connected to an ordered universe existing according to natural law

²¹³See *ibid.*, ch. 1, 42, footnote 76; and *ibid.*, 44, 47.

²¹⁴See *ibid.*, ch. 1, 43-44, footnote 86.

²¹⁵See *ibid.*, ch. 1, 11.

²¹⁶See Aristotle, 317- 18, who noted that people do not desire "knowledge" or "virtue" simply for the pleasure they bring.

(as he understood natural law), and that man must evaluate his role in light of physical properties that could be weighed and measured. In this new age, man would ascribe the norm in a world which was viewed as fundamentally purposeless and even hostile. Like Epicurus before him, Mill did not believe the world could have been created by the gods, so man was left to carve out an existence from within this, at times, hostile environment. The “scientific age” gave Mill an empirical basis for his utilitarian calculations. Man was left alone to hold centre place in moral decision-making. HU was for Mill, therefore, the bridge or empirical framework for individual moral decision-making, just as Hedonism had been to Epicurus before him.

Mill’s Moral Decision-making Model Applied to Physician-Assisted Suicide

The GHP calls simply for calculations that increase happiness and reduce pain for the many. Accordingly, an action to end a life should be judged as either right or wrong based upon whether it increases happiness or reduces misery for the many. PAS could be adjudged morally acceptable from such a perspective. It could be reasoned that the death of a person who is less than happy would be well-received, unless that person’s death produced new unhappiness for surviving individuals. Utilitarians are fully aware that such calculations carry the potential for negative results for a patient, but in a case where the balance of benefits over injury would accumulate to others from the suicide of a patient, then it appears that a suicide ought to be encouraged.²¹⁷

Mill argued strongly for an individual’s moral right to make his or her own decisions without interference, except when others might be harmed by the exercise of a person’s autonomy.²¹⁸ According to PAS advocates, this would mean that a person who desires PAS

²¹⁷See ch. 1, 67; see also 67, footnote 190.

²¹⁸See *ibid.*, ch. 2, 68, footnote 84.

should be free from external (governmental, ecclesiastical, or medical) interference²¹⁹ and able to direct the course of his or her life and death. Mill believed strongly that the principle of utility lay at the root of all morality.²²⁰ He desired to translate the ideal of moral rights into positive rights backed by law.

In the case of PAS, there are those adherents who would use such a tenet of HU to support a claim to *legalise* PAS. PAS advocates purport suicide to be a liberty right in their interpretation of the philosophical tradition of Mill,²²¹ that is, a right to non-interference. Mill did believe that “justice” (fairness and equality) was included in HU and that it was something that an individual could claim as his or her moral right.²²² He recognised the essential social nature of morality and that society has as its moral end the moral good of its members. However, he also believed that the self-conscious goal of the greatest happiness of the greatest number was at the centre of justice.²²³ He believed that each person’s happiness (well-being) would be preserved if each person’s happiness was equal in degree and was valued exactly as much as another person’s happiness.²²⁴ Mill’s construct made it possible for a person to link together individual autonomy, rights’ claims, and justice in a confederacy of sorts that would wield moral influence. PAS advocates today have reached back to Mill to find support for various aspects of PAS claims.²²⁵

²¹⁹See *ibid.*, thesis, ch. 1, 68-70, 71-73, footnote 195.

²²⁰See thesis, 132.

²²¹See *ibid.*, 109.

²²²See *ibid.*, 132.

²²³*Ibid.*, 133.

²²⁴*Ibid.*, 133.

²²⁵See *ibid.*, 109.

Supporting Physician-Assisted Suicide Claims: Mill's Model as a Moral Bridge

Such advocates of PAS use Mill to help establish a link from Enlightenment thinking on autonomy (noninterference from outside authority) to a modern form of autonomy (positive freedom with inherent morally binding obligations that may be used to compel others to act on one's behalf). Proponents, in the case of PAS, can cite claims of fairness, based upon their individual preferences about happiness and use a moral argument to do so.²²⁶ Mill's HU advances a view of humanism that can be forged into a claim that mercy and autonomy oblige a physician to assist a patient with his or her request for suicide.

As stated in the thesis, Mill's view may then be critical to the progression, helping to build a philosophical bridge that links historical discussion of suicide with current claims for physician-assisted killing.²²⁷ Advocates of PAS use Mill's GHP to claim that, since personal happiness is of supreme importance and future happiness might be threatened by suffering, then certain persons in specific medical situations may claim the right to bring their own suffering to an end. According to the argument, a physician would be morally obliged to aid such a suffering individual in the desire to end his life, because justice demands equal happiness for all and the alleviation of suffering would maximise happiness. A death, according to utilitarian calculation would be good if it raised the level of happiness. In utilitarian calculation the end (GHP) is the primary determiner in the action. Even though Mill's model has been used as support for PAS claims, this does not mean that it is without weaknesses.

Evaluating Mill's Model

A close examination of Mill's model for moral decision-making reveals weaknesses related to *individual rights*. An individual's self-governing PH preferences could be overridden

²²⁶See *ibid.*, 133.

²²⁷See *ibid.*, 171.

because he or she might be required to yield individual preferences for the greatest happiness of the many. It is conceivable that a person's rights might be overridden to satisfy the GHP. It is not certain, however, that Mill conceived of the application of individual rights in the way that some people are advocating rights today. Mill's GHP is evidence that, while he advocated strong autonomy claims to noninterference, he could not embrace positive rights' claims that might produce negative utility for the many. His theory does not make adequate provision for competing PH claims. His theory, then, may require external moral arbitration to settle some difficult issues related to conflicting PH preferences between an individual and those of either a particular group, or society as a whole.

Mill's view of justice stands to undermine individual autonomy claims as well, especially when the greater happiness gains of some would compensate for the lesser happiness losses of others. It is questionable how it can be considered justifiable to violate the liberty of the few in order to provide for the greater good of the many. Even though Mill believed each person had a right to equality of treatment, he also believed there were instances when some "recogni[z]ed social expediency" required the reverse. Mill believed that human character could be influenced to practise the GHP, hence justice would prevail.²²⁸

Mill's theory, however, has an inherent tension in the hedonistic side of his theory. Here again, his view of justice may require external arbitration to balance the justice claims of the individual with those of a group or society. Someone must interpret the PH of the many, but Mill does not designate who this person might be and if he (or they) might be trusted to articulate and apply the GHP for all persons. Those employing Mill state that the one qualified in the present medical environment to make a decision about PAS, and end-of-life decision-making, is the individual herself.

²²⁸See Tom L. Beauchamp, *Philosophical Ethics: An Introduction to Moral Philosophy* (New York: McGraw-Hill Book Co., 1982), 108.

Further, Mill's formulation of justice required that a person should act in ways that would bring about the greatest possible balance of good over evil in the universe, presupposing an underlying basic obligation to maximise pleasure and minimise pain. Mill also postulated that the GHP was the basis for moral decision-making. Mill's model for moral decision-making is flawed in some cases when applied to individual *autonomy* (patient and physician alike) in the DPR. It is not entirely certain that Mill conceived of, or would have agreed to his model of autonomy to be used as a means of moral obligation upon medicine to assist with a patient's suicide. His theory assumes that whatever the good and bad are, they can be measured and balanced against each other in some quantitative and qualitative way. There are challenging difficulties associated with measuring and balancing goods and evils in such a quantitative way, but especially so when the qualitative dimension is added to the computation. For example, in order to respect each patient's and physician's PH desires would require seemingly impossible calculations for timing, actions, and results.

Further, a patient and a patient's family might agree that a decision to receive assistance with suicide maximises the good (for example, a patient's QL view) on their part and demonstrates respect for a patient's autonomy. A physician, being equally autonomous, might disagree and, based upon the GHP, give equally valid reasons (for example, medicine's SL view) for denying the requested assistance. The principle of utility requires justice at this point, but it is conceivable that a physician's denial of the patient's PAS claim, for example, could be less "beneficent" but more "just" overall depending, of course, upon the definitions used by the persons involved.²²⁹ The reality is that physicians do not always infringe upon a patient's autonomy when patient claims are denied.

Tensions clearly lie between the expressions of autonomy and utility. On the one hand, it might seem to be the greatest good to grant a patient's autonomy claim and allow PAS. On the other hand, with a different set of circumstances, it might seem to be equally unjust to do

²²⁹See Frankena, *Ethics*, 45-49.

so. The criterion of justice might be said to overrule utility in such cases. Mill's concept of justice would require both patient and physician to count the effects of each action on everyone involved and to weigh equal effects equally in the computation of scores for each action, no matter who is concerned. In such cases, conceivably, the scores of both patient and doctor could come out even. If so, then the greatest happiness of the many must tip the balance to override the happiness of either the doctor or the patient. In either case, the doctor or the patient would have his individual autonomy overridden.

Application: A Way Forward

The thesis provides a comprehensive examination from an historical, medical-ethical, and philosophical perspective of the centuries-long development of key features related to the development of individual humanism. The key features give shape to human life and help to define the nature of human existence in community. One of the most probing realities of human existence that has perplexed and, at times vexed, mankind is the fact of death. From the earliest recorded times of nascent philosophical-theological investigation and speculation, life and death has been near the forefront of man's exploration of the cosmos and his place within the universe.

The medical world, a microcosm within the larger circle of the human life and death struggle, has evolved through the centuries as those within the medical community have laboured to provide help, healing, and hope to those who experience pain, sickness, suffering and, indeed, death. Both medicine and mankind, as a result of this life and death struggle, have become deeply intertwined in a moral relationship because both medicine and mankind have determined that life is a basic good well worth protecting and preserving.

The thesis has examined the philosophical model of hedonistic-utilitarianism for its impact upon a core value, the sanctity of life, from within one aspect of the medical microcosm (the DPR) and one event (PAS). In one sense, the long exploration of the complex issues of life

and death are resurfacing afresh from within this complex end-of-life medical-ethical matrix. From Hippocratic medicine forward to Percival, and forward once again to the present, with philosopher-physicians like Pellegrino a longstanding ethic of care exists that seeks to preserve and protect the basic value, life's sanctity, within the framework of the historic medical dyad—the DPR. If anything, the circumstances in the DPR are not simply concerned with the medical-technological facts about illness, pain, and suffering.

The thesis has demonstrated that John Stuart Mill is fundamental to the establishment of HU and that HU provides critical philosophical support to PAS. Mill, therefore, becomes a central influence upon PAS and the foundation upon which current PAS advocates debate. The thesis has also demonstrated that Mill's HU offers insufficient warrant to change medical canons regarding physician-assistance with suicide. Moreover, HU presents key moral and ethical challenges to the traditional medical-ethical and moral relationship between doctors and patients and produces unique challenges to the basic SL value. The thesis demonstrates that HU, as a theory of social reform, places undue stress upon the DPR and fails to provide a comprehensive, compelling argument for changes in the DPR that would enhance patient *well-being*, which is a primary goal of medicine. Furthermore, HU fails to provide protections for autonomy, rights, and justice, and it recasts the nature of beneficence in terms that are not well-suited, if not actually harmful, to medicine. Something more is needed to protect the autonomy and rights of patients *and* their physicians as well as to provide for the claims of justice in the face of an ever-burgeoning complex medical-technological-financial cosmos.

Among possible alternatives to HU, the thesis suggests that natural law theory, with its longstanding philosophical foundation, may be a parallel track for discussions about the central significance of SL. Recognising the pluralistic nature of Western Culture, with its current secular basis, the thesis suggests a foundational approach from a non-religious perspective. The thesis calls for the need of a medical model, like an *end-oriented beneficence model*,²³⁰ that

²³⁰See thesis, 292.

offers an alternative approach to the quality of life, autonomy-based models that are prevalent today. A holistic, healing approach like the “end-oriented beneficence model” presents a realistic view of the current need within the DPR for greater emphasis on *patient* self-determination that does not overwhelm and erode the centuries’-long development and confidence placed in *caring medicine* as a help toward healing and wholeness. This particular approach emphasises an ethic of care that is consistent with established medical canons and preserves SL. The model also provides a *holistic approach* to the moral relationship between the doctor and the patient. HU requires the focus to be placed upon results, whereas an *end-oriented beneficent model* focuses on both motives *and* ends in the DPR.²³¹

Summary

This study has answered the research question by clarifying certain features of the PAS debate and demonstrating weaknesses inherent in HU that impact negatively on medical practice, particularly in the DPR. Mill’s theory for social policy may have made some sense when it was first applied to provide support against the institution of medicine’s infringement upon individual autonomy, but it provides questionable assistance in current end-of-life medical decisions for the DPR. Even though Mill’s theory has inherent weaknesses related to personal autonomy claims, still Mill’s advocates apply elements of HU as support for the much more complex PAS claims.

Since the arguments of HU and PAS are untenable in supporting a change in medical canons regarding killing, it is neither medically necessary nor morally advisable until consensus may be reached on the value of life, and certainly not until the core PAS features of

²³¹The latter model also does not require PH as a first principle, but it does not discount its value in certain limited circumstances. PH, the desire to create a greater balance of pleasure over pain, is in one sense a useful aim within medicine, but its usefulness remains questionable as an overall theory of value, especially when coupled with a consequentialist theory of action. For example, to help a person to become restored to health, family, and community, while reducing and/or eliminating illness and pain and suffering is well within the goals of medicine. To establish PH as *the* greatest good is not a goal of medicine.

rights, justice, medical killing, autonomy, and paternalism are resolved to a better degree of satisfaction. The thesis concludes with the same question which began its discussion concerning the philosophical quest for meaning of life in the face of harsh realities like the current culture of death. The thesis proposes that a further investigation of PAS claims is mandatory, as is an examination of the ethical issues that surround end-of-life decision-making, before new medical canons are used as a legal warrant for the taking of another human life.

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