THE ETHICS OF ASSISTED DYING

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Abstract

I argue in this research report, based on Kantian considerations and the autonomous preferences of patients, that assisted dying is morally permissible in circumstances where the person concerned can no longer live with dignity because he can no longer bear his pain and suffering, and he autonomously wants to die. That assistance may take the form of assisting the person to commit suicide by providing him with a lethal drug or injecting him with a lethal drug in an act of voluntary active euthanasia. I argue in the first instance for the moral permissibility of suicide in the relevant circumstances, because only if suicide is permissible will assisted dying be permissible. Not all instances of suicide are morally permissible. I consider objections to my argument by advocates of the sanctity of life and also by those who favour passive but not active euthanasia.

Declaration

I declare that this research report is my own unaided work. It is submitted for the degree of Master of Arts, Applied Ethics for Professionals, in the University of the Witwatersrand, Johannesburg. It has not been submitted before for any other degree or examination in any other university.

Elizabeth Ann Bagley

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Introduction

Darkling I listen; and, for many a time
I have been half in love with easeful Death,
Call'd him soft names in many a mused rhyme,
To take into the air my quiet breath;
Now more than ever seems it rich to die,
To cease upon the midnight with no pain
John Keats, "Ode to a Nightingale"

(Bok, 1998: 101)

As people in the developed world are living longer and longer, thanks in large measure to advances in technology that can keep them alive for extended periods of time, they are often also succumbing to afflictions that cause them extreme pain or find that their quality of life is severely compromised. Certain patients who are terminally ill or who suffer from a progressive illness for which there is no cure or from an illness that renders them entirely helpless or dependent may want to end their pain, suffering or dependency. To this end they may want to determine how and when they should die. In some such cases suicide is an option but suicide can be a messy business. Non-medically trained patients would be ignorant with regard to the type and quantities of drugs they would need to ingest to end their lives. For other patients their condition may physically prevent them from committing suicide by any means. It is generally accepted that competent, rational patients have a right to refuse medical treatment, even if such a refusal

may knowingly lead to their death. Letting a patient die, either because the patient has refused life-sustaining treatment or because the patient has requested that such treatment be withdrawn, seems to be regarded by many as morally acceptable. On the other hand assisted suicide or voluntary euthanasia is considered to amount to the killing of the patient and is deemed by many to be morally reprehensible.

Terminology

In this Research Report I will use the terminology 'assisted dying', as Sheila McLean (2007: 12) does, to cover both assisted suicide and voluntary euthanasia as described below.

McLean (2007: 10) defines assisted suicide as providing the means for a person to commit suicide. This assistance may, for example, take the form of a doctor prescribing a lethal drug. When the time arrives for the act to be committed the person would have the prescription filled and take the drug, thus ending his[1] life. The assistance need not necessarily be provided by a doctor. A pharmacist might also provide the lethal drug or a family member or friend may supply poison to be ingested. A third party may provide a gun with which the person wishing to end his life may shoot himself. The person kills himself, but is only able to do so thanks to the assistance provided by a third party. The final act in the causal chain of death is carried out by the person himself (Frey, 1998a: 27). For purposes of

this Research Report I will focus in the main on physician-assisted suicide where a doctor provides a patient, at the patient's request, with a lethal drug in order to enable him to commit suicide and he does so. Judith Jarvis Thomson calls these cases "drug-providing cases" (Thomson, 1999: 498). It should be noted, however, that the arguments I intend to advance would also apply in principle to cases where the assistance is provided by, for example, friends or family members and also, arguably, where death is caused by means other than the ingestion of a lethal drug.

Voluntary euthanasia is defined by McLean (2007: 10) as *actively* taking steps to end another person's life at the request of that person, and James Rachels says that it "occurs whenever the patient, while in a rational frame of mind, requests death and is killed deliberately" (1993: 33).[2] The final act in the causal chain of death is not carried out by the patient himself (Frey, 1998a: 27). I will focus on instances where "the patient is not capable of taking the lethal drug himself, and what he requests is that the doctor inject it" (Thomson, 1999: 498). Thomson calls these instances "drug-injecting cases" (Thomson, 1999: 498). Again I would point out that although I refer to a doctor's actions, the arguments I intend to advance would

[1] References in this Research Report to the male gender shall be deemed to include references to the female gender and *vice versa.*

[2] Voluntary euthanasia is often distinguished from non-voluntary and involuntary euthanasia. According to Rachels, non-voluntary euthanasia "occurs when the patient is unable to form a judgment or voice a wish in the matter and, therefore, expresses no desire whatever, but is killed deliberately or allowed to die" (1993: 33). Involuntary euthanasia "occurs when a conscious terminally ill patient says that she does not want to die but is killed anyway" (Rachels, 1993: 33). I will not deal further with either non-voluntary or involuntary euthanasia.

also apply in principle to cases where the steps taken to end the patient's life at the latter's request are taken by other third parties, and also where death is caused by means other than the injection of a lethal drug.

There is a school of thought that holds that it is immaterial from a moral point of view whether the final step is taken by the patient or by the doctor, although causation is often thought of as the dividing line between physician-assisted suicide and voluntary active euthanasia: "in both cases ... doctor and patient act together to kill the patient" (Frey, 1998b: 54). In this report I will not distinguish between assisted suicide and voluntary euthanasia except where the distinction makes a difference to the argument.

A distinction does need to be drawn between active and passive euthanasia.

Active euthanasia involves a doctor taking "direct action designed to kill the patient" (Rachels, 1975: 78). Rather than letting the patient die, the patient is killed deliberately.

Allowing patients to die for humane reasons is what is known as passive euthanasia. It is widely accepted as morally permissible by, among others, the American Medical Association (Rachels, 1975: 78). Such patients may or may not be in a position to have their pain controlled but will often be suffering from an incurable illness and their quality of life will have been severely compromised.

Thesis Statement

In this Research Report I will argue for the moral permissibility of assisted dying in certain circumstances, based on the autonomous preferences of the patient. I intend to defend the moral permissibility of assisted suicide as defined by McLean (2007: 10) and (voluntary) active euthanasia as defined by McLean (2007: 10) and Rachels (1993: 33).

The moral problem at stake that is to be addressed is whether it is morally permissible for a doctor (or other third party) "deliberately to bring about the death of [the] patient in response to a serious request from the patient that he do so, and when the wish to die is rational, fixed, and immovable" (Warnock and Macdonald, 2009: xiii). This problem applies both to cases where "a doctor [or other third party] actually administers the lethal dose by injection" (voluntary active euthanasia) and those where he merely "places a lethal dose by [the] patient's bed, with instructions to take it orally" (assisted suicide) (Warnock and Macdonald, 2009: xiii). Certain arguments against assisted dying will not apply in circumstances where the assistance is provided by a non-physician and *vice versa*. In relation to assistance provided by a physician, an argument against assisted dying referred to by Battin is the "argument from the integrity of the profession" (Battin, 2003: 681f). This argument is, *inter alia*, along the lines that doctors are not permitted to kill their patients because they are meant to help them and save their lives. If it is morally permissible for doctors to assist their patients to die the relationship of trust between them will break down. Although, as Battin

claims, this argument is a weighty one, I believe that in the circumstances under consideration in this Research Report there is no breakdown in the trust relationship between doctor and patient. On the contrary, I submit this relationship is strengthened when the patient knows that his doctor understands his position and respects his wishes. Nevertheless, despite its importance, I do not intend to deal further with the argument from the integrity of the profession due to space constraints. Issues concerning the nature of the profession, the role that doctors should play in relation to their patients and related matters are complicated issues and warrant a full discussion in their own right.

There is obviously a distinction between the moral and the legal permissibility of assisted dying. As pointed out by Rachels (1993: 56), it is believed that in some cases it may be morally right to provide assistance but unlawful to do so and in others, while it may be lawful it will not be morally right. If it can be established that the provision of assistance is morally permissible in certain circumstances, it would ultimately be necessary to consider how any legal impediments are to be removed. I will not deal with these impediments or their removal in this Research Report nor with the moral acceptability or otherwise of legalising assisted dying as a social practice.

My argument for the moral permissibility of assisted dying will be strengthened if I am able to show that suicide is morally permissible. Jeff McMahan submits that it should be permissible for a third party to do an act for a person at the latter's

request if that person is permitted to do that act himself (McMahan, 2003: 463). This means that if a particular action is permissible then it should also be permissible for a third party to assist someone to perform that action. Thus if action *a* (suicide) is not wrong then assisting someone to perform action *a* (assisted dying) is also not wrong. As Thomson points out, one can only think that assisting in a suicide is morally impermissible if one thinks that suicide is morally impermissible (Thomson, 1999: 507). In the first instance, therefore, I will argue for the moral permissibility of suicide.

At the outset I will deal with the meaning of "autonomy". Once I have identified autonomy's salient features, I will seek to explain why autonomy is morally important, and then go on to examine whether the moral importance of autonomy underwrites, *prima facie*, the permissibility of suicide. I intend to show that the autonomous preferences of rational, competent, informed agents should be respected, even if those preferences entail self-killing. Having put aside the argument from the integrity of the profession, and on the basis that McMahan's above submission is correct, namely that if something is permissible, then assisting with it is also permissible, I will show, on the basis that suicide is morally permissible, that so too is assisted dying.

In Section II of this Research Report I will consider objections by sanctity of life proponents, and in Section III I will consider arguments both in favour of and against the view that passive euthanasia is permissible but active euthanasia is not.

The purpose of those sections is to show that the arguments of both sanctity of life proponents and those who argue that passive but not active euthanasia is permissible should not override the exercise by an autonomous agent of his decisions regarding the conduct of his life, including the ending thereof. Proponents of the sanctity of life regard the value of a continued life as intrinsic and disregard the judgment of the person himself regarding the value of his life and whether he can continue living with dignity. Those who favour passive euthanasia but who argue that active euthanasia is impermissible disregard the autonomous preferences of patients who wish to die, and the end result for these patients may be a slow, lingering death and prolonged suffering.

In the final section of the Research Report however I will argue that autonomy should not be the overriding principle in all circumstances. The circumstances in which a person proposes to end his life are, I believe, all important. I will deal with those circumstances when suicide and assisted dying are morally permissible, and when they are not, based on Kantian considerations.

Section I – Autonomy and the Morality of Suicide

In this section I will argue that suicide and thus assisted dying are morally permissible on the basis of the autonomous preferences of the individual. At the outset it is necessary to deal with the meaning of "autonomy".

Among the salient features of autonomy is the freedom to decide for oneself what course of action to follow in a given set of circumstances. Often different options will present themselves and an autonomous agent will choose the one he believes to be most appropriate to achieving his goals.

To be autonomous, according to John Christman, is to have the capacity "to be one's own person" (2015: 2) rather than be guided by what others believe is in one's own best interests. Thus an autonomous agent is self-governing and lives his life based on rules and policies that he himself has devised (Buss, 2013: 1). According to Christman the "idea of self-rule contains two components: the independence of one's deliberation and choice from manipulation by others, and the capacity to rule oneself" (2015: 3). The autonomous agent, Beauchamp submits, "is capable of deliberation and consequent action" (1993: 84). If a person is autonomous he alone can decide what is good for him based on his own conception of value (Christman, 2015: 10). Different people will obviously value different things and regard them as important. Something that is valuable to one person may have no value to another. The life choices of one are not the life choices of another.

The autonomous agent has to draw his own conclusions regarding what he has reason to do, based on the facts relevant to the decision that he has to make. An agent can be regarded as autonomous "relative to some action-guiding norm or

value only if, upon critical reflection of that value" (Christman, 2015: 13) the agent can identify with or approve of that value. According to Beauchamp:

> The autonomous person ... must be able to grasp and appreciate the significance of pertinent information, form relevant intentions, and not be controlled either by external or internal forces that the person cannot resist (1993: 84).

In other words, his decisions are "not coerced or otherwise caused by conditions beyond the control of the agent" (Beauchamp, 1993: 84).

But how does an autonomous person decide between different courses of action? He has to consider his desires, beliefs and values and then, having so considered, weigh the consequences of various actions open to him.

According to Sarah Buss's 'coherentist' account of personal autonomy, "an agent governs her own action if and only if she is motivated to act as she does because this motivation coheres with ... some mental state that represents her point of view on the action ... constituted by her ... evaluative judgments regarding which actions are (most) worth performing" (Buss, 2013: 3). The action that is ultimately decided upon will be informed by his desires, beliefs and values.

A commonly held view is that an agent's reasons for action arise in the first place from his beliefs and desires. Beliefs are generated in the mind based on whatever evidence is available to the agent in the form of his experiences and other beliefs. Normally, if they are brought about in the right way, his desires are generated by whatever is good for the agent. Based, then, on his beliefs and desires so generated he deliberates rationally on his best course of action. An agent can be said to be acting freely and thus be responsible for his actions if his actions track his reasons (consisting of his beliefs, his desires and his values) and when the way he acts is in his control and a function of his choices (Bagley: 2010).

Another account of personal autonomy identified by Buss is the 'responsiveness-to-reasoning' account. Advocates of this account hold that "the essence of self-government is the capacity to evaluate one's motives on the basis of whatever else one believes and desires, and to adjust these motives in response to one's evaluations" (Buss, 2013: 4). An agent acts based on the consequences he expects to flow from following his beliefs and desires.

An autonomous agent is "directed by considerations, desires, conditions, and characteristics that are not simply imposed externally upon one, but are part of what can somehow be considered one's authentic self" (Christman, 2015: 2). He is able to determine his own goals and "assess the reasons relevant to pursuing some ends and not others" (Buss, 2013: 6). He has the capacity to reflect on and endorse his desires, values and commitments (Christman, 2015: 7). Autonomy

can be equated with a set of competences, which include the capacity to choose deliberatively, rationally, and objectively, to respond to reasons, to think critically and reflectively (Christman, 2015: 4), and to exercise self-control based on desires and values that are of the agent's choosing (Christman, 2015: 3).

For the desires, beliefs and values on which an agent's reasons for action are based not to be capricious they need to be appropriately grounded. Where the agent's desires are alien ones, for example addictive or obsessive desires or desires inappropriately acquired such as by brainwashing, it may well be that the agent is compelled to act because of those desires. In such instances the agent's actions would not reflect his autonomous will. Because of the infringement of the agent's autonomy his actions are not based on his considered judgment. However, an agent is taken to be in charge of his actions where his desires are acquired normally. An agent may well have conflicting desires but in normal cases before acting the agent will deliberate on the appropriate action for him, taking into account all his desires, representing what is good for the agent (subjective goods), his beliefs, and his values (objective goods). Freedom or autonomy depends on actions or the inputs for action, namely the agent's desires and beliefs, being brought about in the right way (Bagley: 2010).

In terms of what Buss calls a 'reasons-responsive' conception of autonomous agency, "an agent does not really govern herself unless her motives, or the mental processes that produce them, are responsive to a sufficiently wide range of

reasons for and against behaving as she does" (Buss, 2013: 4). In terms of this conception an autonomous agent considers the advantages and disadvantages of the options open to him and believes that he has sufficient reasons to act as he ultimately does. According to Buss "an autonomous agent is someone who can change her mind when she discovers good reason to do so" (2013: 5).

Another salient feature of autonomy is that it calls for the decisions of rational, well-informed, competent people to be respected. If a person is autonomous, he is at liberty to decide his own fate and how he wants to live his life, provided that in the process he causes no harm. According to the harm principle of John Stuart Mill:

> The only purpose for which power can be rightfully exercised over any member of a civilized community, against his will, is to prevent harm to others. ... His independence is, of right, absolute. (Mill, 1859: Chapter 1, paragraph 9, cited in Beauchamp, 1993: 100)

Mill does qualify his view by submitting that interventions of a temporary nature are allowable to ascertain the intention of the agent and to warn him of the consequences of his intended action. Once these steps have been taken however "the person should be free to choose whatever course he or she desires" (Beauchamp, 1993: 100). According to Tom Beauchamp "Mill firmly insisted

that, in the final analysis, each person is the rightful guardian both of his or her health and fate, and that we all are the greatest gainers from a system that allows us this liberty" (1993: 101).

The choices of autonomous agents should be respected even if others view them as potentially harmful to the agent. According to Beauchamp the principle of respect for autonomy "asserts an obligation to respect the decision-making capacities of autonomous persons by not limiting their liberty to effect their choices" (1993: 84). Individual freedom and choice is believed to be important for personal development and Beauchamp submits that some philosophers are of the view that "autonomy rights take precedence over all other moral considerations" (1993: 85).

> To respect such self-determining agents is to recognize them as having a right to determine their destiny. Such respect entails a due regard for their considered evaluations, choices, and view of the world, even if it is strongly believed that their evaluation, choice, or outlook is wrong and potentially harmful to them. To respect their autonomy it is not necessary to respect their actual *views* but only to accord to them the *right* to have their opinions and to act upon them (unless the action itself involves some moral violation). (Beauchamp, 1993: 84f)

In summary, I have identified the following as salient features of autonomy:

- the freedom to decide for oneself what course of action to follow in a given set of circumstances;
- to be one's own person rather than be guided by what others believe is in one's own best interests;
- choices between different courses of action open to one are made based on a consideration of one's desires, beliefs and values, and the consequences of the various possible actions – these considerations give rise to one's reasons for action, and the ability to change one's mind when circumstances change;
- the decisions of rational, well-informed, competent people, who have the capacity to choose deliberatively, rationally and objectively, and to think critically and reflectively, should be respected, on the basis that they should be at liberty to decide their own fate.

Having identified a number of salient features of autonomy it is necessary to consider why autonomy is important.

Without freedom of choice, people become puppets in the hands of others. They lose their agency to those who decide what is good for them. This lies at the heart of dictatorships, even benevolent ones, where citizens are prevented from exercising their free will.

A person should be entitled to decide what is in his own best interests, taking into account all his desires, beliefs and values and based on an adequate understanding of the situation, the options open to him, and the likely consequences to flow from different courses of action. According to John Harris "[t]he point of autonomy, the point of choosing and having the freedom to choose between competing conceptions of how, and indeed why, to live, is simply that it is only thus that our lives become in any real sense our own" (1995a: 11). Self-government is seen as important to leading a fulfilling life (Christman, 2015: 7) because only then is one able to live one's life according to one's own reasons and motives (Christman, 2015: 1).

Another reason for the importance of autonomy is that agents should be allowed to make their own mistakes. Making mistakes is critical for learning and growing. Intervention against the will of an autonomous agent for the good of the agent shows less respect for the agent as a person than if he is allowed to make his own mistakes (Christman, 2015: 9). This assumes that the agent has the ability to reflect on the options open to him and to choose accordingly in his own best interests (Christman, 2015: 9).

I would point out that my exposition of the meaning of "autonomy" and its salient features is not meant to be an exposition of Kant's meaning of the term, and thus references in this Research Report to "autonomy" should not be construed in the

Kantian sense. Nevertheless I believe that Kant's Categorical Imperative provides support for the principle of respect for autonomy as I have dealt with it. Kant's dignity principle is expressed as follows by Thomas Hill:

> always act so that you treat humanity (that is, autonomy and rationality) never simply as a means, but always as an end in itself (that is, as something with 'unconditional and incomparable worth'). This applies to 'humanity' in oneself as well as in others. (Hill, 1983: 93)

The dignity principle, by requiring that everyone should be treated as an end and never merely as a means, calls for autonomy to be respected. If we fail to respect the decisions of rational, well-informed, competent people and deny them the right to determine their own destiny, we are surely not treating them as ends in themselves. If we deny them the freedom to make their own decisions, based on what they believe is in their own best interests, and instead substitute what we believe would be good for them, then we are treating them merely as means to some other end. Similarly, if we override their decisions giving rise to their reasons for action because we believe that their desires, beliefs and values are incorrect or inappropriate, we are not treating their humanity as something with unconditional and incomparable worth.

Again, to summarise, the following are the reasons for autonomy's importance that I have identified:

- without freedom of choice, people become puppets in the hands of others who decide what is good for them, and are prevented from exercising their free will;
- one is only able to live one's life according to one's own reasons and motives if one is self-governing. That is why self-government is important to leading a fulfilling life;
- if one is able to reflect on the options open to one and to choose accordingly in one's own best interests, one should be allowed to make one's own mistakes;
- Kant's dignity principle calls for autonomy to be respected.

Having considered the salient features of autonomy and its importance, it is necessary to examine whether the moral importance of autonomy underwrites, *prima facie*, the permissibility of suicide. I will argue that an autonomous agent should be entitled to take his own life and thus should also be entitled to request assistance in dying. That assistance may or may not be forthcoming.

An autonomous agent may well have a plan for how he wants his life to go. Suicide may never have been part of his initial plan. He may have intended to live a long and flourishing life. If his circumstances change in ways that he did not anticipate this may necessitate making new life plans (Buss, 2013: 8), and for any number of reasons he may decide that he would be better off by ending his

life because he no longer finds it worth living (Beauchamp, 1993: 70). Such a person may choose death in order to obtain relief from physical pain or psychological anguish or in order to protect the interests or well-being of a third party. In some cases suicide is used "as an instrumental way to solve problems in living" (Beauchamp, 1993: 80). According to Michael Cholbi "death is generally not chosen for its own sake" (2013: 7), but in order to satisfy other aims of the autonomous agent's choosing.

Because the choices of autonomous agents should be respected, provided no harm is caused, the reasons why they choose to end their lives should also be respected. An agent's choices and reasons for action will reflect what he autonomously believes is in his own best interests and what is good for him, taking all his desires, beliefs and values into account, and having carefully deliberated and assessed his future prospects (Cholbi, 2013: 15).

An agent may decide that due to "sickness, old age, and other misfortunes" his life is sufficiently miserable "that continued existence is worse than death" (Cholbi, 2013: 15). If he decides, based on his autonomous preferences, that his life is no longer worth living he should be entitled to choose death. His reasons may include being in a precarious financial position, such that his "self-killing is compelled by extreme and unavoidable personal misfortune", or being so ashamed by certain behaviour of his, such that his "self-killing results from shame at having participated in grossly unjust actions" (Plato, 1926: 873c-d, cited in Cholbi, 2013:

9f). To intervene against his will for his own good to try and prevent his death shows a lack of respect for his autonomy and for his carefully thought out choices, and involves a judgment "that the person is not able to decide for herself how best to pursue her own good" (Christman, 2015: 8).

Thus, if a person is informed, autonomous, mature and responsible (Beauchamp, 1993: 113) with carefully thought out plans (Beauchamp, 1993: 98) his decision to end his life should be respected. It is for each individual to decide for himself what is good for him and suicide should be a matter of free choice for competent individuals.

In order to make a rational judgment about one's own death it is necessary to compare "the overall goodness of one's life as it would be if it continued on its present course and the overall goodness of one's life if that life ended before its present course" (Cholbi, 2013: 30). If it is chosen rationally and is in accordance with a person's self-interest, taking into account the situation in which he finds himself, then suicide is morally permissible (Cholbi, 2013: 29, 34), whereas "to act contrary to reason is immoral" (Finnis, 1995a: 29). According to Cholbi "Kantians might claim that suicidal choices must be respected if those choices are *autonomous*, that is, if an individual chooses to end her life on the basis of reasons that she acknowledges as relevant to her situation" (2013: 29). John Donne holds, according to Cholbi, that "there may be circumstances in which reason might

recommend suicide" (2013: 13). It may appear rational to a person that he can achieve greater happiness by dying (Cholbi, 2013: 14).

Cholbi submits that the conditions for rational suicide can be divided into "*cognitive conditions*, conditions ensuring that individuals' appraisals of their situation are rational and well-informed, and *interest conditions*, conditions ensuring that suicide in fact accords with individuals' considered interests" (Cholbi, 2013: 30). According to Cholbi:

> Margaret Battin identifies three cognitive conditions for rational suicide (a facility for causal and inferential reasoning, possession of a realistic world view, and adequacy of information relevant to one's decision), along with two interest conditions (that dying enables one to avoid future harms, and that dying accords with one's most fundamental interests and commitments). (2013: 30)

Although it can perhaps be argued that to choose to end one's life must of necessity be an irrational choice (Cholbi, 2013: 29), Beauchamp submits that suicide committed by an autonomous agent is justifiable if it can be defended by good reasons (1993: 112). As I have indicated above, part of what it is to be autonomous is to have the capacity to choose deliberatively, rationally and objectively, and to think critically and reflectively.

There is good reason to think that an agent who is autonomous, competent, rational and informed is entitled to make his own life plans. He may change those plans as the circumstances of his life change, and if he chooses death because he believes that his life is no longer worth living, his choice should be respected. Therefore, on the basis of autonomy, suicide is morally permissible. We are all entitled to be the masters of our own destiny (Beauchamp, 1993: 101).

As mentioned above, I am operating from the premise that if an act is permissible, then assisting someone to perform that act should also be permissible. On the basis of my conclusion that suicide is morally permissible, assisting someone to die should also be morally permissible. McMahan points out that the only reason some patients who are capable of killing themselves may seek assistance to do so is "in order to ensure that their own action is painless, minimally shocking to others, and successful" (McMahan, 2003: 460).

As McLean argues "[f]orcing someone to survive against their own considered preferences is an insult to the respect owed to that person" and if there is no question regarding the person's competence "their choice for death should be respected, even if it involves direct assistance" (2007: 102).

A patient and his doctor, both of whom are "competent, informed and autonomous" (Frey, 1998a: 34), may voluntarily enter into an agreement in terms

of which the doctor undertakes to assist his patient to die. I concur with Rachels that such an agreement is a 'private affair' between 'consenting adults' (1993: 59).

However autonomy does raise some awkward questions. For example, is autonomy the ability to govern oneself even if one's choices are depraved or morally worthless? (Christman, 2015: 9). Why is autonomy valuable when it is used by an agent to make "morally skewed choices"? (Christman, 2015: 7).

I will argue in Section IV that the principle of respect for autonomy is not absolute and should not be the sole or overriding consideration governing the morality of suicide (and thus of assisted dying) in all situations (Beauchamp, 1993: 85f). There are certain suicides that I will identify in Section IV where the agent appears to be violating Kant's dignity principle by demonstrating a lack of self-respect and even some where the actions, although chosen by the agent, do not appear to be fully autonomous. In addition, however, I will argue in Section IV that, notwithstanding my apparent support earlier in this section for suicide based on reasons that include personal misfortune or shame, the permissibility of suicide on autonomy-based grounds should be limited to those circumstances identified in that section which underwrite the permissibility of assisted dying. Thus, based on Kantian considerations and considerations of autonomy, I will deal in that section with those circumstances in which suicide and assisted dying are morally permissible and when not.

Before doing that however it will be necessary for me to consider objections to my argument by sanctity of life proponents (Section II) and by those who argue that passive euthanasia is permissible but active euthanasia is not (Section III). Proponents of the sanctity of life regard the value of a continued life as intrinsic and disregard the judgment of the person himself regarding the value of his life and whether he can continue living with dignity. Those who favour passive euthanasia but who argue that active euthanasia is impermissible disregard the autonomous preferences of patients who wish to die, and the end result for these patients may be a slow, lingering death and prolonged suffering. I will seek to show that these arguments should not override the exercise by an autonomous agent of his decisions regarding the conduct of his life, including the ending thereof.

Section II – Sanctity of Life Objection

The argument I have advanced regarding the moral permissibility of suicide would raise objections from proponents of the sanctity of life. They hold that a life "is valuable just by virtue of being a human life" (Cholbi, 2013: 18), irrespective of how wretched that life may be for the person whose life it is. Thus they argue that life should never be intentionally terminated (McMahan, 2003: 463).

John Finnis is of the view that human bodily life is an intrinsic and basic human good "which one may never rightly choose to destroy" (Finnis, 1995a: 30), and that every basic and intrinsic good of a person gives one reason not to choose to destroy the basic good of human life (Finnis, 1995c: 66). He avers that all human beings have their humanity in common, that is the capacity to live the life of a human being (Finnis, 1995a: 30), and "a being that once has human ... life will remain a human person while that life ... remains" (Finnis, 1995a: 31) irrespective of the condition in which he finds himself. According to Finnis "[t]o lose one's life is ... to lose one's very reality as a human being", that is "a being with the radical capacity to deliberate and choose" (Finnis, 1995a: 31). Finnis believes that "[e]very living human being has this radical capacity for participating in the manner of a person ... in human goods" (Finnis, 1995a: 31).

He argues that every human being is equal because they have human bodily life which is the life of a person and the dignity and intrinsic value of a person. Human bodily life is "not a merely instrumental good" (Finnis, 1995a: 32). If one refuses to choose to violate the life of a person whose human bodily life is in an impaired condition, "one respects the person in the most fundamental and indispensable way" (Finnis, 1995a: 32). Finnis's view is that "[r]espect for persons and the goods intrinsic to their well-being requires that one make no choice to violate [the good of human life] by terminating their life" (Finnis, 1995a: 33). To make such a choice because it is believed that the person concerned would be better off dead "violates a basic and intrinsic good of human

persons, and denies such [person's] still subsisting equality of value and worth, and [his] equal right to life" (Finnis, 1995a: 33). Finnis, as a proponent of the doctrine of double effect, which I will discuss a little later in this section, draws a clear distinction between intended actions and unintended side-effects. He thus accepts that death may be unavoidable (although still bad) and the action that causes it permissible if it was unintended but came about in pursuit of some intended good end. It is thus clear that Finnis's view rules out both suicide and any form of assisted dying, in all of which cases death would be intended, and both by the giver and the receiver of any assistance.

Having outlined Finnis's argument for the sanctity of life, I will now deal with a logical consequence that follows from his view.

Finnis believes that a person "suffering from hopeless debility or illness, or from intense and intractable pain" (Finnis, 1995c: 65), and who as a result judges that he would be better off dead "irrationally ignores the incommensurability of the personal goods and bads ... involved in the life and death of anyone", and treats his dignity "unreasonably ... as if it were a factor which like money or other instrumental goods can be weighed in a balance and found wanting" (Finnis, 1995c: 66). According to Finnis "[i]t cannot be reasonable to form the *judgment* that all things considered this person would be better off dead" (Finnis, 1995c: 66).

While it may be unreasonable for a third party, whether a family member or a doctor, to form such a judgment, it is perfectly reasonable for an autonomous agent to judge that in the circumstances *he* would be better off dead, because this is the only way in which he can deal with the unbearable position in which he finds himself, due, for example, to his precarious financial position, his shame in having committed a grossly unjust act, or his pain and suffering. This is not, as Finnis asserts, to "treat humanity in oneself ... as a mere means" (Finnis, 1995a: 29), contrary to Kant's dignity principle, but to respect the agent's autonomy and his dignity. Such a judgment is not a simple consequentialist judgment of weighing harms and benefits, or pleasures and pains. He may have judged that he can no longer live a dignified life and is no longer "capable of valuing [his] own existence" (Harris, 1995a: 9) because of the situation in which he finds himself. Whether or not his life continues to have value is surely a decision for the person alone to make. He is the ultimate valuer.

Proponents of the sanctity of life disregard totally the value of his life placed on it by an autonomous agent and whether it is flourishing or wretched. Just because it is a human life, they hold that it has intrinsic value, irrespective of the condition in which the agent finds himself and whether or not he can participate in any way in a fulfilling or meaningful life. The wishes of the individuals concerned are important and if their decisions are rational and well-informed they should be respected. If they regard "their own life as diminished in value *to them*, it does not follow that they are any the less a full person and hence fully entitled to have

their life respected by others" (Harris, 1995b: 44). We show respect for the value of the lives of autonomous agents and their desire to control their own destiny by respecting their wishes regarding the manner and timing of their own death (Harris, 1995b,c: 44, 57).

An autonomous agent will consider his desires, beliefs and values which will give him reasons to follow a particular course of action. He will consider the consequences of the actions open to him, not merely in simple utilitarian terms but in terms of how he can best deal with the intolerable situation in which he finds himself. A person who is competent, rational and well-informed should be at liberty to decide for himself what is in his own best interests and whether he is able to bear his circumstances. Self-determining agents are not treated with dignity if their decisions are not respected and they are denied their autonomy to decide for themselves what is good for them. If their decisions are overridden and they are denied the right to determine their own destiny because sanctity of life proponents believe that their judgment is irrational, this is to force them to live in a way that is not of their choosing and to serve as a means to someone else's ends. Because human life is the kind of good it is, Finnis regards it as irrelevant whether or not the life is good *for a particular person.* If the person believes that it is good for him for his life to end, he should be free to choose suicide and to receive assistance to bring his life to an end. The best interests of the individual concerned are seemingly unimportant for Finnis. To force people who are "suffering from hopeless debility or illness, or from intense and intractable pain"

(Finnis, 1995c: 65) to stay alive against their wishes does not seem to me to be furthering the interests of anyone. I am supported in this view by Thomson. According to her, whether an event would be good for a person turns on his condition, and she considers the idea that there is also pure goodness, which is above and beyond goodness in this or that way, to be a serious mistake (Thomson, 1999: 512).

Finnis claims that to believe "that one's human life in certain conditions or circumstances retains no intrinsic value or dignity, or on balance no net value, so that one's life is not worth living and one would be better-off dead" (Finnis, 1995c: 70) is an error of judgment "philosophically and morally" (Finnis, 1995a: 33). These moral errors by those who want assisted dying result in a claim, Finnis believes, "that death – and thus being killed – is *no harm* (indeed may be a benefit)" and thus "do the most vulnerable members of our communities [those who may be killed by way of non-voluntary or involuntary euthanasia] the great injustice of denying, in action, the true judgments on which depend both the acknowledgment of their dignity and their right to life (and so too all their other rights)" (Finnis, 1995a: 34).

But, firstly, no one is entitled to end the life of a person against his will (Harris, 1995b: 44). One can condemn non-voluntary and involuntary euthanasia on the basis of a lack of respect for autonomous agency and yet favour assisted dying at the request of the patient concerned.

Secondly, an autonomous agent who is "suffering from hopeless debility or illness, or from intense and intractable pain" (Finnis, 1995c: 65), and who wishes to die is not harmed by being killed and indeed, in his own opinion, would be better off dead. His circumstances make it impossible for him to continue his life with dignity and, as Harris claims, "such intrinsic value as life retains is not so important as to deny people the right autonomously to terminate their own life along with its remaining intrinsic value" (Harris, 1995b: 44). Neither are the loved ones of such an agent harmed. While they will be sad for their loss, their love and affection would surely cause them to wish for the patient to be relieved of his suffering. Everyone benefits.

There are however qualifications or *caveats* to Finnis's view, and I will now deal with certain of them.

Advocates of the sanctity of life do have sympathy for the pain and suffering of terminally ill patients. For example, Finnis believes that there is a moral distinction "between giving drugs *to kill* and giving the same drugs *to suppress pain*" (Finnis, 1995c: 63) while "foreseeing that the drugs in that dosage will cause death" (Finnis, 1995a: 27). In the latter instance the doctor's action is morally permissible and the patient's death is "an unintended consequence (side-effect) of pain-relief" (Finnis, 1995a: 27). Although the resulting death is bad, the doctor's action is regarded as morally different from one carried out with the

intention of killing the patient. Finnis is thus a proponent of the doctrine of double effect (DDE), which emphasises "the distinction between causing a morally grave harm as a side effect of pursuing a good end and causing a morally grave harm as a means of pursuing a good end" (McIntyre, 2014: 1). This doctrine has been described by Darwall as the "moral difference between causing harm or evil as an unintended side-effect of an intended action or policy and intending the harm or evil directly, either as an end or as a means to an end" (Darwall, 2003: 31). One of the traditional formulations of this doctrine is the following:

> A person may licitly perform an action that he foresees will produce a good effect and a bad effect provided that four conditions are verified at one and the same time:
>
> 1. that the action in itself from its very object be good or at least indifferent;
> 2. that the good effect and not the evil effect be intended;
> 3. that the good effect be not produced by means of the evil effect;
> 4. that there be a proportionately grave reason for permitting the evil effect. (McIntyre, 2014: 2).

As a proponent of DDE, intention for Finnis is all important. Intention rather than consequences determines whether an action is permissible or not. Why he regards intention as "well worthy of its central role in moral deliberation, analysis and judgment" is "because it picks out the central realities of deliberation and choice: the linking of means and ends in a plan or *proposal*-for-action *adopted* by *choice* in preference to alternative proposals (including: to do nothing)" (Finnis, 1995a: 26). According to Finnis "one who *intends* to destroy, damage or impede some instantiation of a basic human good necessarily acts contrary [to the practical reason constituted by that basic human good], i.e. immorally" (Finnis, 1995a: 29). He argues that there is thus a distinction between "[a]ccepting – knowingly causing – harm to basic human goods as side-effects" (Finnis, 1995a: 30) and forming an intention through the exercise of free choice by "*setting oneself* to do something" (Finnis, 1995a: 28). The former "will be contrary to reason only if doing so is contrary to a reason of another sort, viz., a reason which bears not on choosing/intending precisely as such but rather on acceptance, awareness and causation" (Finnis, 1995a: 30) of the harmful side-effects that will result from one's actions. It is not reasonable to reject an option that will result in harmful side-effects "if the feasible alternative option(s) involve *intending* to destroy or damage some instantiation of a basic human good such as someone's life" (Finnis, 1995a: 30).

However the person who wants to die is most concerned about the consequences either of his own actions if he is to attempt to take his own life and/or of those of

the third party who is to help him to die. Finnis believes it is wrong "to set aside moral norms which pivot on intention, and to make moral judgments by looking only to ends or expected or actual results" (Finnis, 1995c: 64). Harris on the other hand, as a consequentialist, opposes the views of those who support DDE. The person he argues "is surely less concerned about whether her untimely death is an intended consequence or a side-effect, than in whether or not it occurs at all" (Harris, 1995b: 39). I agree. The doctor's intention in administering the drugs is immaterial from the person's point of view, provided the end result is the same, namely that his death will have been brought about.

Finnis would concede this and allow that, from the person's point of view, the moral difference between intention and foresight collapses. However he believes that the person is morally mistaken to dismiss the intention with which an act is committed and to focus only on the consequences thereof. But I have argued that an autonomous agent in these circumstances who wants to die will not only make his decision regarding the ending of his life by weighing up harms and benefits but by considering whether he can continue a life with dignity. Harris argues that if the doctor and the patient both know that the drugs to be administered will kill the patient and if the patient does not want to die, then to administer them, even if the intention is the relief of pain, the doctor acts wrongly (Harris, 1995b: 38). If it is permissible for a patient to die under these circumstances the patient must have chosen to die (Harris, 1995b: 42).

Another qualification of Finnis's view is that, while he holds that any intent to terminate life "violates a basic and intrinsic good of human persons" (Finnis, 1995a: 33), he does propose that the autonomy of patients who request that treatment be withheld should be respected even if their death as a side-effect of doing so will result (Finnis, 1995a: 33). It is permissible to honour patients' requests to withhold treatment "even when one considers the requests misguided and regrettable" but only "[w]here one does not know that the requests are suicidal in intent" (Finnis, 1995a: 33). If the patient dies as a result this would be an unintended side-effect (Finnis, 1995a: 33). Where one does know that the request of a patient to withhold treatment is 'suicidal in intent', how is that patient's request to be dealt with? Finnis does not spell this out. It would appear that because, according to Finnis, the request should not be honoured and it would be wrong to do so, he believes that the patient should be forced against his will to undergo the treatment. In these circumstances then the patient's autonomy is not to be respected, despite Finnis's claim that "autonomy is indeed a great good" (Finnis, 1995c: 70).

Finnis believes that it is not unreasonable for a patient to welcome death in circumstances where this would put an end to his misery (Finnis, 1995a: 27). He goes on to say:

> It can be perfectly reasonable to *feel* that death would be a welcome relief for someone suffering from hopeless debility or

> illness, or from intense and intractable pain, and to *wish for* that relief from suffering which death promises to bring. (Finnis, 1995c: 65f).

While he acknowledges their reasonableness, he believes that those wishes should be ignored. In those circumstances the feelings and desires of autonomous agents are owed no respect. Finnis is of the opinion that we are forbidden from making a choice "to violate [respect for persons and the goods intrinsic to their well-being] by terminating their life" (Finnis, 1995a: 33). But those are the choices of third parties and not of autonomous agents. He appears to confuse death caused by voluntary euthanasia as a result of an autonomous agent's desire to die with death caused by involuntary or non-voluntary euthanasia. What is wrong is "to take autonomously valued life" (Harris, 1995c: 60). This is because no-one "has the moral right to force someone ... 'to die in a way that others approve' but which he himself finds unacceptable" (Harris, 1995c: 61).

Finnis claims that the exercise of autonomy "should be consistent with the rights of others and with all the other requirements of humane and decent behaviour" (1995c: 70). I agree. It is humane and decent to relieve the intractable suffering of an autonomous agent and to assist him to die, and no rights of others are infringed in the process. I agree that if exercises of autonomy are "injurious to other members of society" (Finnis, 1995c: 71) they can be overridden. But in the circumstances under consideration that is not the case.

Craig Paterson is also an advocate of the sanctity of life. He too submits that "any intentional rejection of human life itself cannot ... be warranted since it is an expression of an ultimate disvalue for the subject, namely, the destruction of the present person" (Paterson, 2003: 19). Human life, he claims, is a basic good (Paterson, 2003: 7). According to Paterson, a diminishment in flourishing does not cease "to instantiate any inherent good genuinely worth preserving" (Paterson, 2003: 11).

For Paterson death in itself is an objective evil, "not because it deprives us of a prospective future of overall good judged better than the alternative of non-being", but because "it ontologically destroys the current existent subject" (Paterson, 2003: 19). It is an evil "*for the kind of being* a human person is", even if it is not consciously experienced, because of "the *change in kind* it brings about, a change that is destructive of the type of entity that we essentially are" (Paterson, 2003: 19). He goes on to say that "[a]nything ... that drastically interferes in the process of maintaining the person in existence is an objective evil for the person" (Paterson, 2003: 19). It is for this reason that Paterson concludes that:

> any intentional rejection of human life itself cannot ... be warranted since it is an expression of an ultimate disvalue for the subject, namely, the destruction of the present person ... To deal with the sources of disvalue (pain, suffering, etc.) we

> should not seek to irrationally destroy the person ... (Paterson, 2003: 19f)

To choose death, even in these circumstances, is an "objectively irrational choice" (Paterson, 2003: 17).

Some of the logical consequences that follow from Paterson's view regarding the sanctity of life will now be dealt with.

According to Paterson we cannot "truly judge the worth of our own lives" and the fact that patients can exercise choice regarding their medical treatment "brings with it *the responsibility* of making choices that do in fact serve to promote rather than undermine the ends of integral human flourishing" (Paterson, 2003: 13). But surely the person himself is the one to judge whether his life is worth preserving and whether it is good for him. As mentioned above, Thomson is of the view that it is the condition of a person that determines whether something is good for him, and that it is a serious mistake to believe that there is also pure goodness, above and beyond goodness in this or that way (Thomson, 1999: 512). Proponents of the sanctity of life, however, as indicated in relation to Finnis's arguments, disregard totally the value of his life placed on it by an autonomous agent and whether it is a flourishing or a wretched life. They hold that it has intrinsic value just in virtue of being a human life, irrespective of the condition in which the agent finds himself and whether or not he can participate in any way in a fulfilling

or meaningful life. The wishes of the individuals concerned regarding the manner and timing of their own death are important, and if their decisions are rational and well-informed they should be respected by others (Harris, 1995b,c: 44, 57) as should their opinion that *to them* "their own life [is] diminished in value" (Harris, 1995b: 44). They should be entitled to control their own destiny (Harris, 1995c: 57). Being in an unbearable position is hardly the same as "a diminishment in flourishing" (Paterson, 2003: 11). A person in the relevant circumstances is concerned with his own flourishing, not the flourishing of all of humanity. The responsibility he has is surely firstly and foremost to himself. He needs to make choices that are in his own best interests. If he is unable to free himself from the condition in which he finds himself, such as his overwhelming financial difficulties, his shame brought on by his grossly unjust acts, or his pain and suffering, there is little, if any, contribution he can make to the lives of his family and friends or of society as a whole. His life will be consumed by coping with his anguish.

Paterson however qualifies his view as he is not an advocate of "the naive preservation of life at all costs" (Paterson, 2003: 13). He holds that "there cannot be said to be a duty to undergo a treatment that is not worthwhile (offering no reasonable hope of benefit to the patient), or that is considered medically futile" (Paterson, 2003: 13). This would seem to imply that in other cases there is such a duty imposed on the patient to undergo treatment against his wishes. But again, who is to judge whether or not it is "licit to withhold or withdraw life-preserving

treatment" (Paterson, 2003: 13). As I argued earlier, it is only the autonomous agent who can make such a judgment, which is not a simple consequentialist one of weighing harms and benefits, or pleasures and pains. A person who is competent, rational and well-informed should be at liberty to decide for himself what is in his own best interests and whether he is able to bear the circumstances in which he finds himself. Self-determining agents are not treated with dignity if their decisions are not respected and they are denied their autonomy to decide for themselves what is good for them. If their decisions are overridden and they are denied the right to determine their own destiny because sanctity of life proponents believe that their judgment is irrational, this is to force them to live in a way that is not of their choosing and to serve as a means to someone else's ends, rather than respecting their autonomy and their dignity. In the sorts of cases that Finnis and Paterson are considering, which Thomson calls "disconnecting" and "nonconnecting" ones (Thomson, 1999: 498), Thomson is of the opinion that a refusal to honour the patient's decision regarding his treatment amounts to "a battery" (Thomson, 1999: 499).

Unlike Finnis[3], Paterson accepts that it will sometimes happen that "a patient's suicidal intent to end life by refusal or withdrawal of treatment" (Paterson, 2003: 14) will not be overruled. That does not make the patient's decision right as far as Paterson is concerned and does not "amount to a policy of condoning the aiding and abetting of a suicide" (Paterson, 2003: 14), but "there is only so much that can

[3] Finnis, 1995a: 33

reasonably be done to protect patients from the consequences of their own wrongful decisions" (Paterson, 2003: 15). Thus in these circumstances Paterson believes that the patient's autonomy should be respected. As Beauchamp claims, in order to respect a person's autonomy "it is not necessary to respect [his] actual *views* but only to accord to [him] the *right* to have [his] opinions and to act upon them" (Beauchamp, 1993: 84f), provided the action involves no moral violation. Paterson also qualifies this view of his as he believes that doctors who respect patients' decisions in this regard will be making a principled decision to act intentionally "for a good objective, the common good of patients, and the community generally. This good objective being acted for may practically permit the consequence of resultant death as an unintended yet fair side effect of a good intention" (Paterson, 2003: 14). The good objective is presumably the patients' autonomy. According to Paterson "there need be no essential incompatibility between, on the one hand, placing severe restraints on interference with the persistent choice of patients, even though they are intentionally suicidal, and yet, on the other, still uphold the respect due to the good of human life" (Paterson, 2003: 14).

Paterson denies that "a person would be 'better off dead' rather than continuing to live ... a life of severely diminished quality" (Paterson, 2003: 15). Because "[d]eath destroys the person ... the self, the potential beneficiary" (Paterson, 2003: 15) a benefit cannot be produced. He doubts that it can "truly be a rational act for a person to choose the destruction of self over the continuation of self, even a self

racked by the severe impositions of pain and suffering" (Paterson, 2003: 16). The idea "that death can really be said to be a benefit for the person who is dead" (Paterson, 2003: 17) is incoherent. This is because there needs to be "*a subject in existence* who is capable of being the bearer of the value or disvalue" (Paterson, 2003: 17) for a person to be harmed or benefited by a state. If death is desired by the person because of the intolerable situation in which he finds himself, the person is not harmed and will in fact benefit by having his degraded state brought to an end. Even if one concedes Paterson's point that death cannot be a benefit for the person who is dead, it cannot be a benefit for a patient to continue living a life "racked by the severe impositions of pain and suffering" (Paterson, 2003: 16).

According to Paterson consequentialism is often used "to justify the conclusion that certain lives are not worth living" (Paterson, 2003: 11). He then goes on to submit that the "complexity of human value, most significantly the incommensurability of certain goods, defies all such levelling attempts" (Paterson, 2003: 11). This is similar to the point made by Finnis that a person who believes he would be better off dead treats his dignity "as it if were a factor which like money or other instrumental goods can be weighed in a balance and found wanting" (Finnis, 1995c: 66). However, as pointed out above, a person "racked by the severe impositions of pain and suffering" (Paterson, 2003: 16) or a person who finds himself in any other unbearable position and who thus wants to end his life does not disrespect his dignity by treating himself as a mere means. His considerations will not focus on consequences alone, by measuring the burdens and benefits of continued life, but will be informed by his desires, beliefs and

values. But the consequences that are important to him are not the consequences of his death for society as a whole but the consequences for himself and his loved ones should he continue to live without dignity compared with the consequences of his dying. For such a person it is not a question of weighing the good of human life against the "travails of life" (Paterson, 2003: 20) nor is it just a matter of being incapable "of participating in a full array of the goods of life" (Paterson, 2003: 19). For him the "goods of life" are undermined as genuine *goods of life* intrinsic to a person's well-being because of his loss of dignity.

I have argued, contrary to Finnis's view, that it *is* reasonable for an autonomous agent to judge that in certain circumstances he would be better off dead. He will consider the consequences for himself and his loved ones of living and dying but his decision will also be informed by his desires, beliefs and values. It does not show a lack of self-respect if he decides to end his life, with assistance if necessary, because he finds his life unbearable and deprived of all happiness (Cholbi, 2013: 18), and he can no longer live with dignity. He will not be treating his humanity as a mere means. Self-determining agents are not treated with dignity if their decisions are not respected and they are denied their autonomy to decide for themselves what is good for them. The responsibility that autonomous agents have is to make decisions in their own best interests, taking into consideration any duties owed to others and provided their actions do not involve a moral violation (Beauchamp, 1993: 85). They do not, I submit, owe a duty to society as a whole if they decide to commit suicide or to request assistance to die.

It can hardly be said that the patient's death causes him any harm when he has requested it, and if he can no longer live with dignity it will benefit him to be relieved of his suffering. I have also argued that the reliance by the proponents of the sanctity of life on the doctrine of double effect is misplaced. What is paramount is the patient's wishes, taking into consideration the condition in which he finds himself. If he has requested assistance to die and both he and the doctor or other third party foresee the resulting death, the intentions of the doctor or other third party play no role in the permissibility or otherwise of the doctor's or third party's actions. If the patient's autonomy is to be respected it is his decision that is the important one.

Advocates of the sanctity of life argue that the value of human life is to be protected even when this is contrary to the interests and autonomous preferences of the individual concerned (McMahan, 2003: 467). While on the one hand Finnis recognises that autonomy is "a great good" (Finnis, 1995c: 70), on the other he ignores the wishes for death by those who are "suffering from hopeless debility or illness, or from intense and intractable pain" (Finnis, 1995c: 65). He also seems to believe that requests by patients for treatment to be withheld should not be honoured if one knows that those requests are 'suicidal in intent'. This implies that patients in those circumstances are to be forced to undergo treatment against their wishes. Paterson on the other hand does not advocate interfering with patients' choices even if one knows that their intentions in refusing treatment are suicidal. Despite regarding their decisions as immoral, he nevertheless shows

greater respect for the autonomy of patients. Sanctity of life proponents seem to have little regard for the negative value of the life for the autonomous agent whose life it is, as judged by that person. As Peter Singer argues, "the value of a continuing life is not intrinsic [as claimed by proponents of the sanctity of life] but extrinsic, to be judged on the basis of the individual's likely future quality of life" (Cholbi, 2013: 18f). Again this is a judgment to be made by the individual himself based on his autonomous preferences. According to Cholbi "where medical or psychological conditions reduce individuals to shadows of their former fully capable selves", to cut one's life short by means of suicide may be life-affirming rather than an "insult to the value of life" (Cholbi, 2013: 19).

Section III – Passive vs Active Objection

The earlier sections of this Research Report have dealt not only with assisted dying, but also with non-medically-related suicide. However, by the very nature of the objection to be considered in this section, the discussion will be confined to the narrower domain of the medical or end-of-life context, where patients wish to die and may request assistance in order to enable them to die.

Proponents of passive euthanasia would also object to my argument in favour of the moral permissibility of suicide because they believe that there is an intrinsic moral difference between killing a patient and letting a patient die, i.e. between an act and an omission. There are many in the medical profession who believe that

while killing a patient (active euthanasia) is always wrong, letting a patient die (passive euthanasia) is sometimes morally permissible. Thus they hold that it is sometimes permissible "to withhold treatment and allow a patient to die, but it is never permissible to take any direct action designed to kill the patient" (Rachels, 1975: 78). The statement of the American Medical Association (AMA) in support of this position reads as follows:

> The intentional termination of the life of one human being by another – mercy killing – is contrary to that for which the medical profession stands and is contrary to the policy of the American Medical Association.
>
> The cessation of the employment of extraordinary means to prolong the life of the body when there is irrefutable evidence that biological death is imminent is the decision of the patient ... (Rachels, 1975: 78).

Proponents of passive euthanasia, such as the AMA, are of the view that requests by patients for treatment to be withheld should be respected. They believe that if a patient wishes "to be disconnected from or nonconnected to intrusive life-saving treatment ... it is morally permissible for the doctor to accede to his request, because the doctor who accedes in those kinds of case does not kill but merely lets her patient die" (Thomson, 1999: 500). Thomson calls these "disconnecting" and "nonconnecting" cases respectively. In the latter "the patient requests that life-

saving treatment not be undertaken – as, for example, where he requests that he not be placed on life-saving equipment ..." (Thomson, 1999: 498). In the former "the patient requests that life-saving treatment currently in progress be discontinued" (Thomson, 1999: 498).

The reason for failing to connect a patient to life-saving equipment in an act of passive euthanasia is an omission that intends death. Thomson (1999: 501) argues that disconnecting a patient from life-saving equipment is an act rather than an omission as the doctor actively intervenes to discontinue treatment. Disconnecting does not happen all by itself. Nevertheless, whether one agrees with Thomson or not as to whether disconnecting is an act or an omission, it is regarded by many, including the AMA, as a form of passive euthanasia and death is intended. It should be noted, therefore, that the objection to my argument by those who are of the view that passive euthanasia is permissible but active euthanasia is not, is distinct from the objection by sanctity of life proponents dealt with in the previous section. On the latter view, any intentional destruction of life, which they regard as a basic human good, is morally impermissible, whether that intentional destruction is brought about by means of passive or active euthanasia.

Before considering arguments in support of active euthanasia, I will first look at arguments in favour of passive euthanasia, that is the view that passive euthanasia is permissible but active euthanasia is not.

Beauchamp (1978: 249) advances the argument from responsibility in order to show that the difference between killing and letting die is not always morally irrelevant. He seeks to prove that letting a patient die is permissible while killing the patient is not, and that there is a morally relevant difference between the two. He uses the actual case of Karen Quinlan who "was in a coma, and was on a mechanical respirator which artificially sustained her vital processes and which her parents wished to cease" (Beauchamp, 1978: 249). Her father "did not wish to kill his daughter" (Beauchamp, 1978: 249) but apparently thought that the doctors might be wrong in their conclusion that without artificial means she would die. If she were to be allowed to die by disconnecting the machines that were keeping her alive this would "allow for the possibility of wrong diagnosis or incorrect prediction and hence to absolve [everyone] of moral responsibility for the taking of life under false assumptions" (Beauchamp, 1978: 250). Beauchamp thus concludes that in this sort of case active euthanasia is wrong while passive euthanasia is permissible because "[a]ctive termination of life removes all possibility of life for the patient, while passively ceasing extraordinary means may not" (Beauchamp, 1978: 250). Karen Quinlan's life might not have ended, even if she had been disconnected from the mechanical respirator. Passive euthanasia allows for this possibility of continued life without artificial means which active euthanasia does not. If she had lived, clearly no one would have been responsible for taking her life.

Beauchamp himself raises an objection to his argument from responsibility. Whether one is culpable in the death of another depends on "the moral *justification* for choosing either a passive or an active means" (Beauchamp, 1978: 251). If a patient is killed, the one doing the killing is "causally responsible for his death" (Beauchamp, 1978: 251). But if treatment is ceased and the patient dies "the patient might have recovered if treatment had been continued" (Beauchamp, 1978: 251). Medical knowledge is not infallible. In such a situation of intentionally allowing a patient to die, the decision maker is not necessarily absolved of possible culpability. If the patient continues to be connected to the machines that are keeping him alive, he may recover from his underlying medical condition and not lose his life. Whether it is permissible in these circumstances to disconnect the patient in an act of passive euthanasia depends on whether or not the doctor was justified in the actions he took. If there was no justification for his actions, because there was a reasonable prospect that the patient would recover, he is not absolved of responsibility for the resulting death and passive euthanasia in the circumstances would have been impermissible. But the same applies in cases of active euthanasia: was the doctor justified in taking the actions he did, having taken the condition of the patient and his wishes into account. The doctor may be equally responsible for the patient's death because of a lack of justification whether the death is brought about by active or by passive means. Thus I agree with Beauchamp that his argument from responsibility fails to show a morally relevant difference between killing and letting die.

This objection is bolstered by Thomson's point in relation to disconnecting cases that "the doctor who disconnects does not stand by, doing nothing, she positively intervenes – she shuts off, or removes the patient from, the equipment that is keeping him alive" (Thomson, 1999: 501). Despite arguments to the contrary, Thomson's disconnecting cases are in fact instances of active rather than passive euthanasia (Thomson, 1999: 501). Those opposed to active euthanasia argue that in these cases the doctor "merely lets her patient die of the underlying medical condition" (Thomson, 1999: 501). Nature is being allowed to take its course, so they say. But actually it is the doctor who is causing nature to take its course.

The facts on which Beauchamp bases his argument from responsibility are distinguishable from cases of voluntary euthanasia, which are the focus of this Research Report. He is dealing with cases of non-voluntary euthanasia (which I am putting to one side, as mentioned earlier) in that he is not considering an autonomous agent who is competent and informed and has expressed a wish to die. In my defence of assisted dying I am concerned, as Thomson is, "with people who are terminally ill [and also those who are suffering from a progressive illness for which there is currently no cure, or from an illness which renders them entirely helpless and dependent] and who wish to be helped" to die (Thomson, 1999: 499).

Another argument advanced by Beauchamp in order to show that passive euthanasia is permissible but active euthanasia is not involves combining a wedge

argument with a rule utilitarian argument (Beauchamp, 1978: 251). According to Beauchamp, his wedge argument would cause us to find ourselves on a slippery slope because, with the introduction of a dangerous wedge, human life would be placed in a precarious condition by allowing killing "even under the guise of a merciful extinction of life" (Beauchamp, 1978: 252). Once some form of killing is legitimated, our basic principles "which instill respect for human life will be eroded or abandoned" (Beauchamp, 1978: 252). It is suggested that if voluntary euthanasia is allowed this may lead to involuntary euthanasia[4].

He describes rule utilitarianism as "the position that a society ought to adopt a rule if its acceptance would have better consequences for the common good (greater social utility) than any comparable rule could have in that society" (Beauchamp, 1978: 252). Thus any action that is in accordance with a valid rule is a right action.

By combining his wedge argument with rule utilitarianism he argues that "the disutility of introducing legitimate killing into one's moral code (in the form of active euthanasia rules) may ... outweigh the utility of doing so, as a result of the eroding effect such a relaxation would have on rules in the code which demand respect for human life" (Beauchamp, 1978: 253). His conclusion is that it is

[4] I believe that Beauchamp in fact means non-voluntary euthanasia which, according to Rachels, "occurs when the patient is unable to form a judgment or voice a wish in the matter and, therefore, expresses no desire whatever, but is killed deliberately or allowed to die" (1993: 33). Involuntary euthanasia on the other hand "occurs when a conscious terminally ill patient says that she does not want to die but is killed anyway" (Rachels, 1993: 33).

important to maintain the distinction between active and passive euthanasia because "moral principles against active killing" are likely to have the effect "of promoting respect for life", whereas "principles which allow passively letting die" would not appear to undermine this effect (Beauchamp, 1978: 253).

It can be argued however that even moral principles which involve allowing people to die may erode respect for human life. Respect for human life may be promoted by a refusal to condone killing *and* by a refusal to allow people to die. Contrary to Beauchamp's argument, the wedge may be introduced by passively allowing people to die and so result in the same negative consequences of undermining respect for life that would flow from legitimating killing. In that event the distinction between active and passive euthanasia crumbles and active euthanasia is shown to be no morally worse than passive euthanasia.

Beauchamp seems to think that it may be plausible for active euthanasia to be justified in certain circumstances, just as killing in self-defence is sometimes justified. He concludes however that it is not, because in the case of the patient "there is no morally blameworthy action to justify our own" (Beauchamp, 1978: 254). In respect of "morally blameless lives", in which he includes defective newborns, "we are required to accept the judgment that their lives are no longer *worth living* in order to believe that the termination of their lives is justified" (Beauchamp, 1978: 254). By this line of thought Beauchamp would appear to be contemplating non-voluntary euthanasia. In respect of autonomous agents wanting active euthanasia the only judgment that is important is theirs. They

alone can decide whether their lives are worth living. For this reason I will not deal further with this argument of his. As indicated earlier, issues concerning non-voluntary euthanasia are not the focus of this Research Report.

I have considered a couple of arguments in support of the view that passive euthanasia is permissible but active euthanasia is not and found both wanting. Neither applies to voluntary euthanasia, with which this Research Report is concerned, and both fail to show a morally relevant difference between killing and letting die, that is between active euthanasia and passive euthanasia. Rachels (1975: 78ff) on the other hand advances an argument, with which I will now deal, to show that active euthanasia is not necessarily worse than passive euthanasia, contrary to the views of the AMA.

Rachels argues that killing someone (active euthanasia) is no morally worse than, or not morally distinguishable from, letting someone die (passive euthanasia). If the reasons driving the doctor's behaviour of either letting the patient die or killing the patient are humane ones, the moral position is no different whether the patient is allowed to die or whether the patient is intentionally killed (Rachels, 1975: 79). In order to show that active and passive euthanasia are not morally distinguishable he considers the following two cases that "are alike in all morally relevant respects, save that one is a case of killing and one is a case of letting die" (Perrett, 1996: 136):

> In the first, Smith stands to gain a large inheritance if anything should happen to his six-year-old cousin. One evening while the child is taking his bath, Smith sneaks into the bathroom and drowns the child, and then arranges things so that it will look like an accident.
>
> In the second, Jones also stands to gain if anything should happen to his six-year-old cousin. Like Smith, Jones sneaks in planning to drown the child in his bath. However, just as he enters the bathroom Jones sees the child slip and hit his head, and fall face down in the water. Jones is delighted; he stands by, ready to push the child's head back under if it is necessary, but it is not necessary. With only a little thrashing about, the child drowns all by himself, 'accidentally', as Jones watches and does nothing (Rachels, 1975: 79).

The only difference between the two cases, according to Rachels, is that "Smith killed the child, whereas Jones 'merely' let the child die" (Rachels, 1975: 79). The difference depends solely on the distinction between an act and an omission and the two acts involved are in all other respects morally equivalent. The bare difference between an act of killing and an act of letting die does not make an intrinsic moral difference (Perrett, 1996: 137). As Beauchamp points out, in Rachels' first case "death is caused by the agent, while in the second it is not; yet the second agent is no less morally responsible" (Beauchamp, 1978: 248). The

actions of both agents are unjustified and they carry an equal degree of moral responsibility.

Along similar lines, R.G. Frey argues that active euthanasia is not morally distinguishable from passive euthanasia. Unlike Thomson he seems to regard her disconnecting cases as passive euthanasia. According to him there is no moral distinction between cases "in which the doctor supplies the means of death and those in which he withdraws or withholds the means of (continued) life as the result of a valid request by the patient that features this withdrawing or withholding as part of a plan of death" (Frey, 1998a: 36). Rachels shares this view. He argues that the cessation of treatment which proponents of passive euthanasia would endorse is in fact 'the intentional termination of the life of one human being by another' (Rachels, 1975: 79f). That is the only reason, after all, for ceasing the treatment. Those who argue that there is a moral distinction contradict themselves - "they say they do not accept physician-assisted suicide or euthanasia, but they accept practices which are functionally equivalent to these" (Battin, 2000: 420). While supporters of the AMA view will probably deny this, in both sorts of cases considered by Frey, one where the doctor supplies "a pill that will produce death" (Frey, 1998a: 35) and the other where the doctor's "withdrawal of feeding tubes will ... produce death" (Frey, 1998a: 35), the termination of life is intentional and the doctor and the patient co-operate to achieve this end: "Both happen as a result of a request by the patient for assistance

in dying; both are effective in bringing about death; and both feature the patient and doctor acting together to produce that death" (Frey, 1998a: 35).

Those opposed to Rachels' Bare Difference argument would raise the objection that active euthanasia is morally worse than passive euthanasia because in the case of active euthanasia the doctor acts to kill the patient and is the cause of the patient's death (Rachels, 1975: 80). They would argue that in the case of passive euthanasia the cause of death is the patient's illness and the doctor does nothing to bring it about. However the doctor does act in cases of passive euthanasia by withholding or withdrawing treatment and his "decision to let a patient die is subject to moral appraisal in the same way that a decision to kill him would be subject to moral appraisal" (Rachels, 1975: 80). This is along similar lines to Thomson's point in relation to her "disconnecting" cases[5] discussed earlier in this section.

The Bare Difference argument is not meant to show that all cases of killing are morally equivalent to all cases of letting die. In certain circumstances it will be permissible to allow a patient to die at his request but not to kill him and *vice versa* (Perrett, 1996: 138f). Roy Perrett uses the example of an elderly relative from whom one wants to inherit. He argues that it is morally worse to let the relative die from pneumonia without her consent than it is to kill her at her request in order to relieve her pain and suffering from terminal cancer. On the other hand,

[5] Thomson, 1999: 501

however, he argues that it is morally worse to kill the relative without her consent than it is to allow her to die at her request from pneumonia in order to relieve her pain and suffering from terminal cancer. But what makes a moral difference in those cases is not the bare difference that one is an act of killing and the other an act of letting die, but extrinsic factors that are morally relevant, such as the motive of the doctor or other third party in relation to his act or omission and the condition and wishes of the patient (Perrett, 1996: 139). If a patient's condition can be cured and his pain and suffering relieved, the doctor would have acted wrongly whether he killed the patient or whether he allowed the patient to die (Rachels, 1975: 80).

It is possible to evaluate the agent for his actions separately from the evaluation of the act itself (Perrett, 1996: 137). In Perrett's examples, where the person wants to inherit from his elderly relative, even if his action were permissible because the relative's autonomous preferences were respected, his action would show "something morally bad" (Thomson, 1999: 516) about him as a person, because of his motive in carrying out that action. Thus the moral worth of a person who does a thing based on his motive for doing it can be distinguished from the moral permissibility or impermissibility of his doing it (Thomson, 1999: 518). If he acts without the relative's consent and disregards her autonomous preferences he acts wrongly, whether he kills her or whether he lets her die. The action itself is impermissible. The two acts of Smith and Jones, one of killing and the other of letting die used as examples by Rachels, are morally equivalent (Perrett, 1996:

137) and are equally impermissible. In addition, Smith and Jones are equally bad people.

It can also be argued that even if there is indeed a moral difference between active and passive euthanasia, sometimes active euthanasia will be morally preferable. For example, it is more advantageous for all concerned if a terminally ill patient is killed at his request (say by a lethal injection) than having to be allowed to die slowly and painfully as a result of treatment being withheld or withdrawn. Active euthanasia is morally preferable to passive euthanasia, if active euthanasia is the patient's autonomous wish, once the doctor and the patient have agreed that death is imminent, with or without treatment, and pain and suffering cannot be alleviated. This is because to favour passive euthanasia "is to endorse the option that leads to more suffering rather than less, and is contrary to the humanitarian impulse that prompts the decision not to prolong [the life of the terminally ill patient] in the first place" (Rachels, 1975: 78). What is important to recognise in respect of this argument is that it is not the consequences of the action alone that are important. While the patient will be relieved of his suffering, which will no doubt also bring relief to his loved ones, and scarce medical resources will be freed up, it is the right thing to do in the circumstances if the patient's autonomy is to be respected. If he is to die soon anyway he should be able to decide the manner and timing of his death.

As pointed out previously, the objection to my argument by those who are of the view that passive euthanasia is permissible but active euthanasia is not, is distinct from the objection by sanctity of life proponents dealt with in the previous section. Those who argue in favour of the sanctity of life, as we have seen, regard death and any intentional destruction of life as a great evil and thus morally impermissible, whether that intentional destruction is brought about by means of passive or active euthanasia. They rely on the doctrine of double effect to show that causing death is only permissible if it is an unintended side-effect of some intended good such as pain relief. They would find passive euthanasia where the patient's death is intended just as morally unacceptable as active euthanasia and therefore they draw no distinction between the two.

On the other hand, those who favour passive euthanasia are prepared to withhold treatment knowing full well that death will (ultimately) result, and do not view the resulting death as an unintended side-effect of an intended action. On the contrary, the patient's death is intended both by the patient and the doctor. Proponents of passive euthanasia regard their withholding or withdrawal of treatment as a humane way of ensuring that the suffering of terminally ill patients is not prolonged. However, from the patient's point of view, the doctor's refusal to assist him in bringing about his speedy death does not appear humane. Patients who wish to die do not have their autonomous preferences respected if they have to endure this sort of slow, lingering death. While Rachels also regards death as a great evil he points out that "death is no greater an evil than the patient's continued

existence" (Rachels, 1975: 80) in cases where it has been decided that euthanasia is desirable because of the circumstances in which the patient finds himself and the patient's wishes.

If the patients in question have expressed "an enduring, voluntary and competent wish to die" (Young, 2014: 4) their autonomy should be respected. It is morally permissible to honour their request that they should be killed in an act of voluntary active euthanasia rather than obliging them to endure further suffering, and arguments that passive euthanasia is permissible but active euthanasia is not are not convincing. Much of the focus of proponents of passive euthanasia, who are prepared to allow a patient to die but not to supply "the means of death" (Frey, 1998a: 36), seems to be on the doctor rather than the patient. The doctor rather than the patient is regarded as being in the best position to determine what is in the patient's best interests. If he believes there is no point in continuing to keep the patient alive because the patient is unlikely to be able to sustain life without being connected to machines, he may decide that the right course of action is to withdraw or withhold further treatment. The autonomous preferences of the ill patient are by and large disregarded, save to the extent that they involve requests that treatment be withheld or withdrawn. The result in many of these cases is a slow death and prolonged suffering, even if pain can be relieved. Active euthanasia is morally acceptable in cases where the agent requesting it is an autonomous rational agent who can no longer live with dignity either because "human life is no longer possible" (Hill, 1983: 90) or because of "gross

irremediable pain" (Hill, 1983: 91) and cannot end his life without assistance. Minimising the suffering of the patients in question and their significant others, who don't want to see the lives of their loved ones further degraded, not to mention the freeing up of scarce resources in the form of hospital beds and professional expertise, makes assisted dying in the relevant circumstances morally permissible. However I have argued that it is not only or mainly for consequentialist reasons that active euthanasia in certain circumstances is the morally preferable option. The overriding consideration is respect for the patients' autonomous preferences.

I have argued on the basis of Rachels' Bare Difference argument that active euthanasia is not morally distinguishable from passive euthanasia. If a terminally ill patient wishes to die and he and his doctor act together to intentionally bring about his death, it does not make a moral difference whether the plan of death involves the doctor injecting him with a lethal drug to end his life or involves the doctor withdrawing the life-saving treatment he is currently undergoing. The bare difference between the act of killing and the act of letting die does not make an intrinsic moral difference. I have also argued that if active euthanasia is indeed morally distinguishable from passive euthanasia, active euthanasia is, at least sometimes, morally preferable to passive euthanasia.

Section IV – Circumstances Governing the Permissibility of Assisted Dying

I have argued that suicide is morally permissible on the basis of the autonomous preferences of an agent. However there are restrictions on actions people may take in living the life they have planned for themselves. I may wish to achieve a certain goal and provided I don't harm others along the way (the harm principle articulated by John Stuart Mill), or engage in immoral activities in pursuit of that goal, I am free to make and act on my own decisions (Singer, 1993: 99). That same principle applies when it comes to deciding how one wants to die. But should respect for autonomy and non-interference be the overriding principle in all circumstances? In this section I will seek to show that autonomy cannot always be the determining factor, but nevertheless underwrites the permissibility of assisted dying in many instances.

A person's autonomy should not be permitted to license actions that may cause harm or violate his obligations to others (Beauchamp, 1993: 86; Cholbi, 2013: 29). That harm is not necessarily limited to physical harm. A person committing suicide may cause untold emotional harm to family and friends, and economic harm to creditors, employees and dependents unable to support themselves financially (Cholbi, 2013: 25). In those circumstances his suicide would be wrong (Cholbi, 2013: 25) and his autonomy has to take a back seat. Autonomy can thus not be an overriding consideration in all circumstances. An autonomous action that involves a moral violation is always impermissible. An agent's failure to

observe his obligations to others is a moral violation and thus impermissible. His duty to honour his obligations takes precedence over his autonomous wishes. The obligations we owe to third parties, whether these obligations take the form of emotional or financial support, love and affection owed to family and friends, or commitments we may have made, whether financial or otherwise, would thus rule out suicide by making it immoral in many instances. However if a person owes no obligations and will not cause harm to others by doing so, is it right for such a person to take his own life?

Certain suicides identified by Hill seem to be instances of unjustified self-destruction because the perpetrators believe that life isn't worth living (Velleman, 1999: 614) or that they're not "getting enough *out* of it" (Velleman, 1999: 612). As will become clearer from what follows, the view that the suicides in question are unjustified differs from the sanctity of life view, according to which the value of human life should be protected at all costs, irrespective of the condition in which the individual concerned finds himself. Proponents of the sanctity of life regard the value of a continued life as intrinsic and any intentional destruction of life as morally impermissible. However, as I will argue below, certain suicides are permissible, because the life of the person has become unbearable and he can no longer live with dignity. The impermissible suicides are wrong, not because of the intrinsic value of life, but because the perpetrators would by their actions be demonstrating a lack of self-respect and violating their own dignity.

Kant's dignity principle is expressed as follows by Hill:

> always act so that you treat humanity (that is, autonomy and rationality) never simply as a means, but always as an end in itself (that is, as something with 'unconditional and incomparable worth'). This applies to 'humanity' in oneself as well as in others. (Hill, 1983: 93)

I will now deal separately with the various impermissible suicides Hill identifies to show how they violate the dignity principle.

The first Hill characterises as "impulsive suicide" (Hill, 1983: 86) where an agent seemingly acts on the spur of the moment and out of character with his longer term values. To act impulsively would not appear to be honouring one's dignity. A person who acts impulsively is not stopping to consider his worth and is not valuing himself as a person. He is treating himself as a mere means to some impulsive end.

It can even be questioned whether to act on impulse can even be said to be acting autonomously. After all, an autonomous agent exercises self-control based on desires, beliefs and values that are of the agent's choosing. Being autonomous means being able to choose a course of action rationally and objectively. Such a person will think critically and reflect on the options open to him, and then choose an action that he believes will be most appropriate to achieving his goals

(Christman, 2015: 3f). An impulsive action is not one that is based on an agent's considered judgment, having weighed the consequences of that action. There are no good reasons informing that action. An agent who is truly autonomous will consider whether his action demonstrates respect for himself as a person.

Another impermissible category of suicide identified by Hill is "apathetic suicide" (Hill, 1983: 87) which, unlike impulsive suicide, is not as a result of "intense desire or emotion" but of a lack of interest in continued living and what the future may hold. An agent who respects his dignity is self-regarding and does not merely give up on life. He is proud of himself and his achievements. To be dignified is to put on a brave face despite adversity and live to fight another day, which may be better than the previous one. This is how one treats oneself as having 'unconditional and incomparable worth'. One values oneself.

Here, again, it can be argued that a person who has no interest in life is not autonomous. He doesn't care what happens to him. He is not weighing different options in order that his actions may be informed on the basis of his desires, beliefs and values, nor is he considering how he may achieve his goals. In fact he has no goals to achieve.

Hill's "apathetic suicide" seems to be closely linked to his "self-abasing suicide" (Hill, 1983: 87) which arises from "a sense of worthlessness or unworthiness" – this would be an instance of an agent treating himself "as a paltry and disposable

thing" (McMahan, 2003: 484). Such a person has no self-pride or self-esteem, and does not respect or value his dignity. He does not regard his humanity as an end in itself that is worth preserving.

Once again, it can be questioned whether a person in these circumstances can truly be regarded as an autonomous agent. He does not appear to display the characteristics that one would expect of an autonomous agent by having his actions informed by his considered judgment of what would be best in the circumstances. He is not choosing rationally and objectively based on good reasons for achieving his goals.

The three instances considered above all therefore seem to be cases where the actions, although chosen by the agent, are not fully autonomous. Even if they were autonomous actions, they would in any event exhibit an unsatisfactory failure of self-respect.

Hill also regards as a case of unjustified self-destruction his "hedonistic calculated suicide" (Hill, 1983: 87) where, based on his calculations, the agent aims "to obtain the best balance, over time, of pleasure over pain" (Hill, 1983: 88) by ending his life when he does. Such an agent would appear to be acting autonomously by deliberating on how he can achieve his goals. He has reasons for acting as he does and has chosen a course of action rationally and objectively. However he disregards his dignity by merely considering pleasures and pains in

consequentialist terms. But dignity cannot be weighed in the balance in this way. A person's dignity cannot be compared with the pleasures and pains of his life, as the hedonist would do. Dignity is without price whereas the agent in this case seems to attach a price to the value of continued living. He ignores his worth which is independent of his interests in living or dying.

All the above instances appear to be instances of the agent violating Kant's dignity principle by demonstrating a lack of self-respect.

An objection that may be raised to the above argument that the suicides in question are impermissible because they are a violation of the agent's dignity is Rachels' 'Best Interests Argument', which goes as follows:

1. If an action promotes the best interests of *everyone* concerned and violates *no one's* rights, then that action is morally acceptable.
2. In at least some cases, [suicide] promotes the best interests of everyone concerned and violates no one's rights.
3. Therefore, in at least some cases, [suicide] is morally acceptable. (1993: 48).

If one accepts that in the relevant circumstances the agent has satisfied any obligations he owes to others, no one's rights will be violated by his suicide. Particularly in the case of the "hedonistic calculated suicide" the best interests of

the agent would be promoted. If he has no interest in continued living and considers himself worthless it will also promote his best interests not to continue with his life. Even if he acts impulsively he will have believed on impulse that he is pursuing his best interests. It can also be argued that the best interests of everyone concerned will be promoted by the agent's death. He is not contributing positively in any way to his community by his poor attitude, and the removal of his negative influence will be to the benefit of all. Therefore Rachels' objection seems to succeed in showing that the suicides I have categorised as impermissible are in fact morally acceptable.

I will now deal with several rebuttals to that objection, to show that the Best Interests Argument does not succeed.

As David Velleman argues, people have value in themselves independent of their interests or what is good for them (Velleman, 1999: 615). A person's worth and his good are distinct forms of value (McMahan, 2003: 483) but it is only because a person has value that his interests have value (McMahan, 2003: 482). For a person to consider that his life is not worth living because of hardships he is experiencing is for him to put his interests above his value as a person. A person is defined by John Locke as "[a] thinking intelligent being that has reason and reflection and can consider itself as itself, the same thinking thing, in different times and places" (Locke, 1689, cited in Singer, 1993: 87). A person in the circumstances I have sketched may weigh the harms and benefits he expects to

flow from his continued life as a consequentialist would. He may conclude, on the basis that the potential harms he is likely to suffer outweigh the potential benefits of his continued life, that he would be better off killing himself.

However dignity is not something that can be weighed in the balance in this way. Dignity is without price and a person's dignity has a value independent of his interests in living or dying. The self-interested reasons for suicide that Rachels appears to be considering seem to attach a price to the value of continued living, whereas dignity is without price (Velleman, 1999: 619f). The agent's interest-independent worth is ignored and instead the agent denigrates his dignity (Velleman, 1999: 616) and his value as a person (Velleman, 1999: 621). He treats himself "as an instrument of [his] interests" (Velleman, 1999: 624). A person's dignity cannot be compared with the pleasures and pains of his life.

The heart of the problem with the Best Interests Argument can be found in its first premise. Leaving aside the violation of rights, whether an action is morally acceptable is determined solely on the basis of a consideration of the consequences of the action for everyone concerned. But this is not how a Kantian would consider the morality of an action. To cause harm to oneself in certain cases would amount to a failure to treat oneself with dignity as required by Kant's dignity principle and would not be morally permissible. For example, a parent may want to die in order that one of his organs may be donated to his child in order to save the child's life. For the parent to commit suicide in such

circumstances would amount to treating himself merely as a means and would contravene the dignity principle, even if he believed that his action would promote everyone's best interests. In these circumstances he would be acting autonomously, having carefully considered his options and deliberated on how best to achieve his goals. However his dignity should trump his autonomy. The same applies in the cases of the other impermissible suicides I have considered. In those cases of self-harm as well, the agents disregard their dignity and fail to demonstrate self-respect. Autonomy, even when present, cannot be the sole or overriding consideration governing the morality of suicide in all situations, even if no rights are violated and the best interests of everyone concerned are promoted by the action in question.

I have argued that in the instances identified by Hill and in certain other circumstances where the agent will inflict harm on himself, suicide is morally impermissible. In these instances the agent is failing to respect his dignity. But why is dignity so important? As I have argued above, humanity is an end in itself that is worth preserving[6]. Human beings have unconditional and incomparable worth and that is why they owe respect to others and to themselves. The agent denigrates his value as a person by committing suicide in the relevant circumstances. He treats himself as a means to achieve his interests and puts his interests above his value as a person. It is incumbent on all of us to value ourselves and it is wrong for us to regard ourselves as 'paltry and disposable

[6] Although it may appear so at first blush, this is not the same view as that advocated by Finnis and Paterson. Later in this section I will indicate how the view I argue for differs from theirs.

things'. To cause harm to oneself without good reason, even if the action promotes the best interests of everyone concerned, amounts to a failure to treat oneself as an end, contrary to the requirements of the dignity principle. Thus the Best Interests Argument does not succeed because it is not only the consequences of an action that are important in determining moral questions.

I have also argued that in several instances of impermissible suicide the agent's actions are not truly autonomous. His considered judgment has not been brought to bear on his actions and the resultant consequences. His actions are not chosen rationally and objectively based on good reasons. Even in instances where the actions are those of an autonomous agent they are nevertheless impermissible, as the agent is denigrating his dignity by failing to demonstrate adequate self-respect. His dignity in these circumstances should trump his autonomy.

There are people however who are either terminally ill, or who suffer from a progressive illness for which there is currently no cure, or who suffer from an illness which renders them entirely helpless and dependent and who wish to end their lives because of their suffering. If such a person can no longer sustain a life with dignity then such a person would not be morally wrong to take his own life. By doing so he would not be destroying something with dignity because his life has already been degraded by his suffering. Its worth has been eroded.

Similar sentiments are expressed by Hill. In his view suicide is morally permissible "when human life is no longer possible" (Hill, 1983: 90) and also in

order "to end gross irremediable pain" (Hill, 1983: 91). In the latter situation, suicide may be "understandable and unobjectionable" (Hill, 1983: 91), not because the patient is simply weighing pleasures and pains in utilitarian terms but because life "may be valuable to the agent *on condition that* continuing pain does not exceed some tolerable threshold" (Hill, 1983: 91). If a patient decides that such a life is not acceptable, because he is suffering from an incurable condition that renders him unable to continue functioning as a full human being, his decision to commit suicide "need not be from impulse, apathy, self-abasement, or pleasure/pain calculation" (Hill, 1983: 90).

Hill proposes the following modified Kantian principle to show why, under the above circumstances, suicide is morally permissible:

> A morally ideal person will value life as a rational, autonomous agent for its own sake, at least provided that the life does not fall below a certain threshold of gross, irremediable, and uncompensated pain and suffering. (Hill, 1983: 95)

Hill submits that his modified principle is not contravened by suicide in the circumstances under consideration, either "because the life that is ended lacks the potential for rational, autonomous agency" or because "the pain is such that it renders a person incapable of making any significant use of his human capacities" (Hill, 1983: 101). He draws the same conclusion in relation to euthanasia (Hill,

1983: 100). McMahan believes that people have a right to die "when life has become an intolerable burden and when continued life is not demanded by consideration of others" (McMahan, 2003: 460). If a person "can no longer live with dignity" (Velleman, 1999: 617), suicide is justified, as it "would constitute an appropriate expression of respect for one's person" (Velleman, 1999: 616). If life and dignity cannot both be sustained, death may be morally justified (Velleman, 1999: 617).

The crucial question that needs to be answered is how a decision should be made regarding which suicides are morally permissible and which not. Certain suicides have already been ruled out because they are either not committed by agents who are truly autonomous or involve impermissible self-harm because of a failure by the agents to respect their dignity. In Section I, I indicated initial support for suicide in circumstances where the agent decides that his life is no longer worth living due, for example, to old age, personal misfortune or extreme shame. However the dignity criterion also rules out the permissibility of suicide in those circumstances. There are, however, certain circumstances where, because of the situation in which they find themselves, autonomous agents who wish to end their lives are not evincing a failure to respect their dignity. Thus only in situations where the agent can no longer sustain a life with dignity is suicide morally permissible.

Having established the conditions under which suicide is morally permissible, it is necessary to turn to the circumstances under which assisted dying is morally permissible. As previously mentioned, if it is permissible to perform an action, then assisting a person to perform that action is also permissible. Thus in a situation in which suicide is morally permissible, then so too is assisting such a person to die. People in such circumstances should be permitted to request assistance to end their lives. That is not to say that the third party whose assistance is requested is morally obliged to provide assistance, but should he choose to do so it would not be wrong.

According to Robert Young, if certain necessary conditions are fulfilled, then provision should be made to enable the person concerned "to be allowed to die or assisted to die" (Young, 2014: 4). He has identified the following five conditions that must apply in order for assisted dying to be morally permissible.

The person concerned:

a. [must be] suffering from a terminal illness;
b. [must be] unlikely to benefit from the discovery of a cure for that illness during what remains of her life expectancy;
c. [must be], as a direct result of the illness, either suffering intolerable pain, or [must] only [have] available a life that is unacceptably burdensome (because the illness has to be treated in ways that lead to her being unacceptably

dependent on others or on technological means of life support);

d. [must have] an enduring, voluntary and competent wish to die (or [must have], prior to losing the competence to do so, expressed a wish to die in the event that conditions (a)-(c) are satisfied); and
e. [must be] unable without assistance to commit suicide (Young, 2014: 4).

I would make the following modifications to Young's conditions to govern the circumstances under which people should be permitted to request assistance to end their lives.

If a person –

(a) is "competent, informed, and autonomous" (Frey, 1998a: 34);
(b) is suffering from a terminal illness or from a progressive illness for which there is currently no cure, or from an illness which renders him entirely helpless and dependent;
(c) is, as a direct result of the illness, either suffering intolerable pain, or only has available a life that is unacceptably burdensome (because the illness has to be treated in ways that lead to him being unacceptably dependent on others or on technological means of life support);

(d) has an enduring, voluntary and competent wish to die (or has, prior to losing the competence to do so, expressed a wish to die in the event that conditions (b) and (c) are satisfied); and

(e) is unable without assistance to commit suicide,

then it is permissible for such an individual to be provided with assistance to enable him to be allowed to die or assisted to die. In addition, if a person who was competent, informed, and autonomous prior to the manifestation of conditions (b) and (c) had expressed an enduring, voluntary and competent wish to die in the event that conditions (b) and (c) are satisfied, then it is permissible for such an individual to be provided with assistance to enable him to be allowed to die or assisted to die.

What is of paramount importance is the condition in which the patient finds himself. It is not only or mainly that his interests will be served if he is assisted to die but that he can no longer continue living his life with dignity. His value as a person independent of his interests in relieving his pain and suffering is being degraded. If a person in such circumstances wishes to be the author of his own life story, his autonomy to choose how he wants to end his life should be respected (Singer, 1993: 99). He may have had different plans for his life but these plans have been rendered nugatory by the illness or condition that has befallen him. A person in such circumstances may wish someone to assist him to take action to end his life before it is further degraded.

According to Velleman "encouraging or assisting others in impermissible conduct is itself impermissible" (Velleman, 1999: 614). Therefore it is only in instances where suicide is justified because life and dignity cannot both be sustained and the other (modified) conditions identified by Young have been fulfilled that assisted dying is morally permissible.

The importance of the criteria identified by Young is that they clearly demarcate the conditions under which assisted dying is morally permissible and when it is not. A person who satisfies Young's criteria, as I have suggested they be modified, also satisfies Hill's modified Kantian principle. He is a rational, autonomous agent who has carefully thought through his decision, which is informed by his desires, beliefs and values. He has good reason to believe that ending his life is in his best interests and will not harm others. That he wishes to be assisted to die does not amount to a failure to demonstrate self-respect. He is not violating his dignity by giving up on life, acting impulsively, or regarding himself as worthless. Furthermore he is not merely measuring pleasures and pains in consequentialist terms. He is not weighing his dignity in the balance by comparing it with the pleasures and pains of his life. He is not attaching a price to the value of continued living. However his life has fallen "below a certain threshold of gross, irremediable, and uncompensated pain and suffering" (Hill, 1983: 95). He is choosing to end his life because "human life is no longer possible" (Hill, 1983: 90) and/or because he can no longer bear his "gross irremediable pain" (Hill, 1983: 91). He can no longer sustain a life with dignity

and wants it ended before it is further degraded. By doing so he is not denigrating his value as a person and ignoring his worth. He is no longer able to enjoy any of the goods of life and is in a position where he can no longer cope with his suffering.

Advocates of the sanctity of life view would disagree that it is permissible for a person who satisfies Young's criteria to be assisted to die. They would also of course disagree that it is permissible for a person in these circumstances to commit suicide, even if he could do so without assistance. Paterson, as we have seen, would countenance a request from a patient to refuse or withdraw from treatment, even if that request arises from "a patient's suicidal intent to end life" (Paterson, 2003: 14). Nevertheless he believes that such a decision by a patient is wrong. Finnis on the other hand holds that it is impermissible to honour patients' requests to withhold treatment if it is known that "the requests are suicidal in intent" (Finnis, 1995a: 33). I have argued that while humanity for its own sake is an end in itself that is worth preserving, a person's dignity does not require that human life should be preserved at all costs. A person whose life has fallen "below a certain threshold of gross, irremediable, and uncompensated pain and suffering" (Hill, 1983: 95) and who satisfies Young's criteria, as I have suggested they be modified, may find himself in a position where he can no longer sustain a life with dignity. Contrary to the views of sanctity of life proponents, such a person should be entitled to request assistance to die before his life is further degraded. Such assistance, if it is provided in accordance with the patient's request, need not be

limited to the withholding of treatment. There are many such patients who do not need machines to keep them alive and a patient in such a situation should be entitled to request that either a lethal drug be provided to him in order to enable him to commit suicide or, where he is not capable of taking the lethal drug himself, that he be injected with it (Thomson, 1999: 498).

The conditional statement I am advancing in support of the moral permissibility of assisted dying takes the following form:

If I am an agent who is autonomous, competent, rational and informed,

and if I can no longer live with dignity either because "human life is no longer possible" (Hill, 1983: 90) or because of "gross irremediable pain" (Hill, 1983: 91),

and if, as a result, I want to end my life, I may.

But if I cannot do so without assistance, then I am morally permitted to request assistance to die and a third party is morally permitted to assist me.

Conclusion

I have argued for the moral permissibility of assisted dying in circumstances where the person concerned can no longer live with dignity because human life is no longer possible and/or because he can no longer bear his pain and suffering, and he autonomously wants to die. That assistance may take the form of assisting the person to commit suicide by providing him with a lethal drug or injecting him with a lethal drug in an act of voluntary active euthanasia.

I have argued in the first instance for the moral permissibility of suicide because only if suicide is permissible will assisted dying be permissible. Although the decisions of rational, well-informed, competent people, who have the capacity to choose deliberatively, rationally and objectively, and to think critically and reflectively, should be respected, on the basis that they should be at liberty to decide their own fate, certain suicides are impermissible. That is because the principle of respect for autonomy is not absolute and should not be the sole or overriding consideration in all situations. Autonomous agents may not cause harm by their actions or violate their obligations to others. Kant's dignity principle demands that we treat humanity in ourselves and others as something with unconditional and incomparable worth, and never simply as a means but always as an end it itself. Impermissible suicides are those that violate the dignity principle by demonstrating a lack of self-respect. In other instances of impermissibility, the actions, although chosen by the agent, are not fully autonomous.

In order to arrive at the conclusions I have, I have considered objections to my argument by sanctity of life proponents. They hold the view that human life, as a basic good, may never be intentionally terminated. I have argued that, contrary to the sanctity of life view, the value of human life is not intrinsic but depends on the situation in which the individual finds himself. If he can no longer live a dignified

life he should be entitled to end it, with assistance if necessary, if that decision is based on his autonomous preferences.

I have also considered objections by those who are of the view that passive euthanasia is permissible but active euthanasia is not, which is distinct from the sanctity of life objection. Death is intended by acts of passive euthanasia. The sanctity of life view regards any intentional destruction of life as impermissible. Advocates of that view therefore draw no distinction between active and passive euthanasia.

Rachels' Bare Difference argument shows that active euthanasia is no morally worse than passive euthanasia. Extrinsic factors that are morally relevant, such as the motive of the doctor and the condition and wishes of the patient, may make a moral difference, but the bare difference between an act of killing and an act of letting die does not make a moral difference. Even if indeed active and passive euthanasia are morally different, at least sometimes active euthanasia will be morally preferable. For example, it is morally preferable for a terminally ill patient to be killed at his request than having to be allowed to die slowly and painfully as a result of the withholding of treatment.

It is not necessary that human life be preserved at all costs. If a person is competent, informed and autonomous, and wishes to die because he can no longer

live with dignity due to the unbearable condition in which he finds himself, it is permissible for him to be provided with assistance to enable him to die.

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