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Physician-Assisted Suicide, the Doctrine of Double Effect, and the Ground of Value*

F. M. Kamm

I

In this article, I shall present three arguments for the permissibility of physician-assisted suicide (PAS), and then examine several objections of a “Kantian” and non-Kantian nature against them. These are really objections against certain types of suicide. I shall focus on active PAS (e.g., when a patient takes a lethal drug given by a physician, in which case both the physician and patient are active). I shall assume the patient is a competent, responsible, rational agent, who gives his being in physical discomfort (pain, nausea, etc.) as the reason for intending his death. I am assuming, therefore, the pain while a source of suffering does not undermine his rational agency in a way that threatens responsibility for choice.⁠¹ Current legal proposals for permitting PAS focus on procedures

* I thank audiences at the California Polytechnic University at Pomona, the Los Angeles Law and Philosophy Discussion Group, the Central European University, the World Congress of Philosophy in Boston, the Wittgenstein Symposium, Kirchberg-am-Wechsel in Austria, and the Universidad Torcuato Di Tella for comments. In addition, I am grateful to Richard Arneson and an anonymous editor for written comments.

1. The arguments I present would also apply to passive PAS (e.g., when a patient refuses treatment, intending to die, and has a doctor stop sedation so that he can take a lethal drug) and to euthanasia (E). (For discussion of why this is “passive,” see my “Physician-Assisted Suicide, Euthanasia, and Intending Death” [hereafter cited as “PAS, E, and ID”], in Physician Assisted Suicide: Expanding the Debate, ed. Margaret P. Battin, Rosamond Rhodes, and Anita Silvers [New York: Routledge, 1998], pp. 26–49.) Passive E can also be distinguished from passive PAS: in the former, the doctor either does not start, or else he stops, life-saving treatment. In the latter, he stops, or does not start, non-life-saving aid, and this enables the patient to end his life either actively or passively. Active voluntary E can be distinguished from PAS by the fact that in E (a) the doctor does the act which finally causes death, and (b) the doctor must intend death. In PAS, the doctor only may intend death, while the patient must intend death for it to be a suicide. Some would say this is so in PAS because the doctor may only wish to give the patient a choice whether to die. But I think that a doctor who gives a patient a lethal drug for his use is only assisting suicide at all if she gives it once the patient has formed the intention to commit suicide himself. Hence, the doctor is not merely making possible a choice, since the choice has been made. Still, she may only wish to facilitate the patient’s doing whatever he chooses and not herself intend

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that determine the patient to be competent; hence they are concerned with showing that when (and only when) one knows that a still-rational being would die is PAS permissible. This insistence that we may only aid in the destruction of a being once we have certified its high status may strike many as perverse.

Furthermore, in the cases of PAS I shall consider, I assume death is in the patient’s interest. In this respect, the cases are like euthanasia (E), though in general PAS is unlike euthanasia in that it does not conceptually require that death be in the patient’s interest. How can death be overall in someone’s interest? Suppose death shortens a person’s life so that the life has fewer bad things in it and does not deprive him of any significant good things because there would not have been any. Then death might be in someone’s interest because his shorter life is a better thing than his longer life would have been. For example, we could imagine, independently of any question of active termination, that someone could prefer, because it would be better for him, that he was created to a life of sixty years with no pain in it than to be created to a life of sixty-one years where the last year was full of pain. This could be so even if death is bad not only when it deprives us of goods but because it puts an end to us.² Putting off our being all over may not be worth every misery, especially since we cannot be immortal in any case. Someone does not have to continue on experiencing good things (e.g., relief from pain) in order for the shorter life to be better for him. In any case, I shall assume this is so, and none of the criticisms of the arguments I make takes issue with this point.³

It is possible that there are completely different ways of deciding that death would be best for someone besides weighing the forthcoming goods and bads. For example, some insist that we must consider how what will happen from now on completes the life the person has already had—the same future attached to different pasts might render one life, but not another, bad overall.⁴ But, in addition, it may be that some near future event will be so bad that even if it would eventually be followed by an outweighing degree of good, one should not have to go through it. There is a deontological quality to this reasoning—for just

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² On this distinction, see my *Morality, Mortality* (New York: Oxford University Press, 1993), vol. 1.
³ For more on death as a benefit, see my “PAS, E, and ID.”
⁴ Ronald Dworkin seems to take this view in *Life’s Dominion* (New York: Simon & Schuster, 1993).
as the deontologist says that there are some things one need not do to promote best consequences in general, the reasoning claims that there are some things a person might reasonably not go through even to promote the best consequences for himself.\(^5\)

II

Now I shall present two arguments for the permissibility of PAS and one argument for a duty of a doctor to engage in PAS. I do not claim that these arguments are correct, only that they are plausible starting points for discussion.

A. The Four-Step Argument

Assuming patient consent,

1. A doctor may permissibly relieve pain in a patient (e.g., by giving morphine), even if she knows with certainty that this causes the death of the patient as a foreseen side effect soon, because death can be a lesser evil and pain relief can be a greater good.\(^6\) Call this the morphine for pain relief case (MPR).

2. A doctor may permissibly intentionally cause other lesser evils to the patient for the sake of his medically relevant greater good (e.g., she might permissibly intentionally cause him pain temporarily if only this would keep him from falling into a permanent coma).\(^7\)

3. When death is a lesser evil for a person, it is morally permitted to treat it as we treat other lesser evils.\(^8\)

4. Therefore, when death is a lesser evil and pain relief is a greater good for the same person (just as it is in step 1), it is also permissible to intentionally cause death, or assist in its being intentionally caused, to stop pain.

Call this the Four-Step Argument. It applies to terminal and nonterminal cases.

B. Alternative Four-Step Argument

Assuming patient consent,

1. A doctor may permissibly relieve pain (e.g., by giving morphine), even if she knows with certainty that this causes death in the same patient

5. I discuss the so-called Texas Burn Victim Case in this way in my *Morality, Mortality* (New York: Oxford University Press, 1996), vol. 2.

6. I assume that death is not only a lesser evil, but the least evil of the alternatives to pain in the circumstances. I thank Seana Shiffrin for this point. Ordinarily, doctors give the painkiller themselves, but we might also imagine a case of “assisted pain relief,” in which the doctor provides the morphine and the patient takes it.

7. Again, here we might also imagine a case in which a doctor gives the patient the means of causing the lesser evil of pain and the patient intentionally causes it.

as a foreseen side effect soon (and even if death is a greater evil than pain), because death is unavoidably imminent in any case (e.g., in a terminal patient) and at least pain will then stop.

2. A doctor may permissibly intentionally cause other (even greater) evils that are unavoidably imminent anyway *in order to* produce (even lesser) goods in the same patient. (For example, suppose it is worse to be blind than to be deaf. If a patient will shortly be blind anyway, it would be permissible to intentionally cause his blindness if only this would prevent him from also going deaf.)

3. When death is an imminent evil for a person, it is morally permitted to treat it as we treat other imminent evils.

4. Therefore, a doctor may permissibly intentionally cause death, or assist in its being intentionally caused, when death is imminent anyway in order to stop pain in the same patient (even if death is a greater evil and relief of pain is a lesser good).

In this *Alternative Four-Step Argument*, we need not assume that a shorter life with less suffering can be better for someone than a much longer one with more suffering, only that it is in one’s interest to die somewhat sooner when death would come soon anyway and dying sooner reduces suffering. It may be easier to accept than the Four-Step Argument since we only cause or assist in causing what would occur soon anyway.

C. *Argument for a Duty of a Physician to Engage in PAS*

Assuming patient consent,

1. A doctor has a duty to treat pain (e.g., with morphine), even if she foresees with certainty that it will make her cause the patient’s death soon, because death is a lesser evil and pain relief is a greater good, or because death is unavoidably imminent anyway (even if it is a greater evil) and pain stops.

2. A doctor would have a duty to intentionally cause evils (e.g., pain, blindness) for a patient’s own medical good when the evils are lesser and the goods to be achieved greater, or when the evils are unavoidably imminent anyway (even if greater) and we can thereby achieve a medically relevant good.

3. When death is a lesser or imminent evil for a person, it is morally permitted to treat it as we treat other lesser evils.

4. Therefore, a doctor has a duty to intentionally cause the patient’s death or assist in its being intentionally caused when death is a lesser evil and pain relief a greater good for the patient or when death is imminent anyway and pain relief is a good.

Call this the *Duty Argument*. It is important because some have claimed that doctors’ professional ethic in particular implies that they cannot engage in PAS.

The general structure of these three arguments is to show that, in some carefully circumscribed cases, if we may permissibly kill someone
or assist in causing his death where we merely foresee the death occurring soon, even with certainty, but do not intend it, we may also kill him, intending the death, or assist him in intentionally causing his own death. This structure is to be contrasted with another one, employed by some other philosophers.9 They argue that if we may let someone die (e.g., omit or terminate medical treatment) when he intends his own death, then we may assist him by giving him lethal medication which he takes when he intends his death. I have criticized this alternative argument on the following ground (among others): it is often permissible to let someone die when the person intends his death, even when death is against the patient’s overall best interest and does not prevent an event which he could reasonably want to avoid regardless of future good. This is because the alternative is forcing treatment on him and this we must not do if he is competent. But it is not necessarily permissible to give a lethal substance to someone that he will take when death is neither in his overall best interest nor helps him avoid an event that he could reasonably wish to avoid regardless of future good. However, if we may give someone a painkiller to stop pain and do foresee that the painkiller will also kill him, this will only be because the scenario in which he dies sooner is either overall better for him or helps him avoid an event one could reasonably wish to avoid regardless of future good.10 Hence, this crucial and controversial judgment must be already present in the first premise of each four-step argument, while it is not in the let-die-hence-assist-to-kill argument.11 And this judgment is already endorsed by those (e.g., Catholic moral theologians) who, I believe, can support MPR.

Why is the best interest judgment only relevant in the case where we give something to the patient that will cause his death but not when we allow him to die by nontreatment? Philippa Foot argued that when we actively interfere with people, we must be concerned not only with what they will for themselves but also whether we harm them.12 Both their right to autonomy and our duty not to harm apply. If we give the patient a death-producing drug, even when he takes it himself, and even if we just foresee his death, I think this dual condition on active interference applies. When we let the patient die, even by disconnecting support, not interfering with autonomy is the only consideration. This is


10. Henceforth, for convenience, I will speak only of death being in the patient’s best interests, but I should be understood to include the possibility that it instead prevents an event one could reasonably wish to avoid regardless of future good.

11. The three four-step arguments and criticism of the “Philosophers’ Brief” presented here build on my previous discussions in “A Right to Choose Death?” and “PAS, E, and ID.”

because if we do not let the patient die, we will be interfering with him against his wishes. By contrast, if we do not help a patient avoid pain or carry out a suicide he will for himself, when we think it is not good for him, we do not interfere with him. We respect his right to autonomy, which is essentially a negative right not to be interfered with. It is true that we will not be promoting his autonomy as a value (i.e., we will not be seeing to it that his own values determine his life). But it is a mistake to assimilate autonomy as a value to autonomy as a right. In sum, we can insist on considering his good as well as his will when the alternative does not involve our violating his right to noninterference.

To return to all the four-step arguments, they are directed against the common use of the doctrine of double effect (DDE) to rule out suicide. The DDE says that it is impermissible to intend lesser evil, even as a means to a greater good, but it is permissible to pursue greater good by innocent means, even foreseeing that lesser evil will certainly occur as a side effect. We need not deny that the distinction between intending and foreseeing evil sometimes makes a moral difference in order to hold that sometimes the distinction makes no moral difference. It may make no difference when the lesser evil is A’s pain, when we have A’s consent and the greater good is A’s life: we may act merely foreseeing the pain or intending it, as premise 2 in each argument claims. Some (e.g., Quinn) have claimed that whenever the lesser evil and greater good are intrapersonal, the intending/mere-foresight distinction does not matter. (Although Quinn also argued that it was intending use of the person without her consent, not other evils, that the DDE should focus on.) It is when we would bring about lesser harm to one person without his consent in the course of helping others that the intention/foresight distinction may matter morally.13

One might deny this by insisting that when some lesser evils, for example, death, are at issue, intention is not permitted even intrapersonally, though as premise 1 in each argument claims, bringing them about with foresight is permissible. Premise 3 in each argument specifically claims that death is no different from other lesser or imminent evils with respect to the intention/foresight distinction in the intrapersonal context.

Hence, attempts to show that death is to be treated differently from other lesser evils, even in the intrapersonal context, could be a way to show that the DDE is relevant here. They could also be attempts to show that while the DDE is not relevant here, death, unlike other lesser evils, may be neither foreseeably nor intentionally brought about. We shall consider both these issues in what follows.

Can variants of the Four-Step Argument be applied to cases not involving pain relief? Some of the steps of a variant of the Four-Step Argument may not be satisfied, even when death is a lesser evil. Suppose a person will produce great paintings if he is given a drug that will, as a foreseen side effect, soon cause his death. We can assume that producing great paintings is a greater good for him and death is a lesser evil. Still, it may not be appropriate for a doctor to give drugs to produce paintings if death is a side effect of the drug. This is because the Four-Step Argument is made on the assumption that the greater good is a medically appropriate goal, and it is a problem in the philosophy of medicine (which I cannot here discuss) whether this goal is medically appropriate. If we cannot assume the permissibility of doing what we merely foresee will cause death, we cannot use a four-step argument to justify giving someone lethal pills if, for example, he intends to kill himself because only the onset of death will prompt last-minute brilliant painting. So I suggest what I shall call The Test: see if you can get the first step in a four-step argument, in order to see if eliminating a condition or pursuing a goal permits intending death.

How about death to end psychological suffering? The Test says: would we give a drug that puts someone to sleep in order to stop such psychological suffering if we foresee that the drug would rapidly kill as a side effect with no improved quality of life first? If not, then giving pills to a patient who intends to kill himself in order to end such psychological suffering would not be sanctioned by the Four-Step Argument. How about incontinence? Would a doctor give a drug to cure incontinence when she foresees that the drug will rapidly kill a patient? If not, then PAS for incontinence will not be endorsed by the Four-Step Argument. Would we give a patient a drug for his illness that as a side effect will soon cause death rather than give him a safer but more expensive drug because the cheaper drug will not be a financial burden for his family? If not, then the Four-Step Argument does not imply that we may perform PAS because his treatment is draining the family’s finances. Of course, the application of the (rough) test I have suggested—see if you can get the first step in a four-step argument—may yield positive, rather than negative, responses to these questions.14

There are many objections that could be raised to these four-step arguments. In considering these objections, I shall focus on two problems I

14. This test is rough because there are special cases where failure to get the first step does not indicate we may not do PAS. The exceptions are not inconsistent with the spirit of the four-step arguments. On this, see my “PAS, E, and ID.”
believe are critical. (1) Does the objection show that PAS is wrong? (2) If it does, must it also rule out giving the morphine for pain relief when it is foreseen with certainty that it will soon cause death? It will be a big problem for any objection if it also requires us to give up the permissibility of MPR when this foreseeably causes death soon. The recent Supreme Court decisions in Vacco et al. v. Quill et al. and State of Washington et al. v. Glucksberg et al. concluded that such death-hastening, palliative care was legally permissible at least in terminal cases—Premise 1 in the Alternative Four-Step Argument—and two justices (O’Connor and Breyer) emphasized that one important reason why they did not find laws against assisted suicide unconstitutional was that palliative care, even if it caused death sooner (and soon), was legally permitted.\textsuperscript{15} If moral objections cannot be raised to PAS without also undermining morphine for pain relief which causes death soon, the legal distinction may be undermined as well; both will be justified, or neither. My general point will be that Kantian objections to suicide also rule out MPR, and objections based on the DDE will rule out other procedures that seem morally and legally acceptable.

One Kantian objection to the four-step arguments is that, in PAS, but not in MPR, a person is treated as a mere means, and this violates the Categorical Imperative of Morality to always treat persons also as ends-in-themselves. How might PAS treat a person as a mere means if (a) the person himself consents to death, and (b) death (is assumed) to be overall in his best interest? Ordinarily, we think that if we seek someone’s overall good, we cannot be treating him as a mere means, but must be treating him also as an end-in-himself, at least if he consents.

Perhaps (a) and (b) are insufficient for permissibility if we treat rational humanity in a person as a mere means to what is good for him merely as a sentient being (e.g., pain relief). But when does this occur? It occurs in one sense if we see rational humanity in ourselves as merely an instrument for getting a positive balance of sentient good over evil in our life, and we are willing to eliminate rational humanity when the balance is evil over good. We do not attribute intrinsic worth to being a rational agent.\textsuperscript{16} But if this is an objection to PAS, it can also be an objection to MPR, raising problem 2. This is because if we give too little weight to the value of being a rational agent in itself, the evil of pain will too quickly serve as a justification for taking morphine even when it causes death as a side effect. Hence, this sense in which we could see rational humanity as a mere means does not distinguish between intending death (a necessary condition for suicide) and causing pain relief with mere

\textsuperscript{15} See their separate concurring opinions.

\textsuperscript{16} This is how I understand Thomas Hill, Jr.’s version of the Kantian objection to suicide in his “Self-Regarding Suicide,” in his Autonomy and Self-Respect (Cambridge: Cambridge University Press, 1991).
foresight of death. Likewise, if we treat rational humanity as having intrinsic value so that only a great deal of pain could override the worth of its continuing, we will not have treated rational humanity as a mere means (in the sense we are now examining) in either PAS or MPR.\textsuperscript{17}

But if we allow pain to override the intrinsic weight of rational humanity, we do not give the latter unconditional and incomparable value. To have unconditional value is to have value always, but that does not yet mean to have overriding value, which is transmitted by incomparable.\textsuperscript{18} I have said in an earlier article on this subject: “Suppose life involves such unbearable pain that one’s whole life is focused on that pain. In such circumstances, one could, I believe, decline the honor of being a person, as we might acknowledge the great (and normally overriding) value of being a person . . . [and yet] allow that some bad conditions may overshadow its very great value.”\textsuperscript{19} David Velleman objects to this on Kantian grounds.\textsuperscript{20} The quote he finds objectionable comes from a passage in which I was defending the right to take morphine for pain relief, not the right to commit suicide in certain situations. Hence, I assume he objects to it as a reason for taking pain medication, too.\textsuperscript{21} He says: “Kamm says that the value of a person normally ‘overrides’ the value of other goods, but can be ‘overshadowed’ by conditions that are exceptionally bad. . . . But . . . value for a person stands to value in the person roughly as the value of means stands to that of the end: in each case, the former merits concern only on the basis of concern for the latter. And conditional values cannot be weighed against the unconditional value on which they depend” (p. 613).\textsuperscript{22} He says this rules out suicide when done for the reason that life is not good enough for the person.

So now we should consider that we may be treating the person as a mere means if we do not give him incomparable value relative to things that are merely good for him. I will call this the second sense of treating persons as mere means.

\textsuperscript{17} It is a problem with the account of Kantian objections to suicide given by Hill in “Self-Regarding Suicide” that none of the objections really aim at suicide per se; i.e., they do not distinguish between intending death and doing what we foresee leads to death.

\textsuperscript{18} On the distinction, see Thomas Hill, Jr., “The Formula of the End-in-Itself,” in his Dignity and Practical Person (Ithaca, N.Y.: Cornell University Press, 1993). I thank Richard Arneson for calling this discussion to my attention.

\textsuperscript{19} Kamm, “A Right to Choose Death?” p. 21.

\textsuperscript{20} J. David Velleman, “A Right of Self-Termination?” in this issue, pp. 606–28; Velleman criticizes the position I took in “A Right to Choose Death?” I am grateful to him and to the editors of Ethics for allowing me to read his article.

\textsuperscript{21} My aim in that earlier article, as in Sec. II of this one, was to show that if MPR is permissible, PAS would be, and if PAS were impermissible, MPR would be.

\textsuperscript{22} Velleman speaks of unconditional value, but I believe he means incomparable value to the extent these differ. See above, note 18.
I now wish to consider in some detail Velleman's response. There are several important components in his view.\textsuperscript{23}

1. He agrees that pain relief and sometimes even death might be best for someone.\textsuperscript{24} He then argues (p. 611) that someone is rationally obligated to care about what is good for a person, only if they care about the person. This claim by itself, I believe, would create no problem for the permissibility of PAS, since one way of showing that one cares for someone is to seek what is good for him, and this, he agrees, may be death.

2. But Velleman moves from discussing mere caring about a person—which could occur even if the person is not worth caring for. He goes on to discuss the claim that bringing about something good for a person is important only if the person is important (i.e., is really worth caring for). If the person had importance merely as an instrument to something else, there would have to be something else which had true importance in itself. But, he says, we assume that people do have importance in themselves.

The form of this argument is quite general: that \( Y \) is good for something matters only if that something matters. In other words, the value of what is good-for-something happening is dependent on the value of the thing. Velleman says (p. 614): “But what would it matter how much I lost or gained if I myself would be no loss?” On the basis of these remarks, I interpret Velleman to be constructing a reductio argument whose general structure is as follows:

1. Suppose it matters that \( X \) not be in pain (i.e., that \( X \) have one of the things that is good for him), simply because this would be good for him.

2. That \( X \) not be in pain (i.e., have one of the things that is good for him) could matter in this way only if \( X \) matters in himself.\textsuperscript{25}

3. If it is permissible to dispose of \( X \) independent of concern for any

\textsuperscript{23} If my remarks do not accurately represent Velleman's view, I believe the arguments I present are intrinsically worth considering in any case.

\textsuperscript{24} He agrees that death might be in a person's best interest on occasion, even if seeking what is in his best interest is disrespectful of him as a person.

\textsuperscript{25} It is not entirely clear to me that in a Kantian view, if a property \( Z \) makes it important that \( X \) have things that are good for it, \( Z \) also makes it important that \( X \) have things that are good for it in ways other than as a specifically \( Z \)-bearing entity. For example, if the capacity for rational autonomy gives a creature \( (X) \) incomparable value, what is good for fostering its rational autonomy will have value. If pain did not interfere with \( X \)'s rational autonomy, \( X \)'s being out of pain might be a good for \( X \) that it is not important that \( X \) have. If this were true, it would also affect Velleman's basic argument that the importance of people makes it important that they not be in pain. I shall simply assume that what makes people important gives them an importance that makes it important that they not be in pain.
other worthwhile thing (while X retains the characteristics that supposedly make it important that he have what is good for him for no other reason than that it would be good for him), X does not matter.

4. If X does not matter, that X gets what is good for him because it is good for him does not matter.

5. Suppose it is permissible to dispose of X independent of concern for any other worthwhile thing (while X retains the characteristics that supposedly make it important that he have what is good for him for no other reason than that it would be good for him).

6. It does not matter that X not be in pain simply because this would be good for him. (The denial of 1.)

This argument is supposed to show that there is no justification for PAS to end pain for the sake of X. I shall refer to this as the Reductio (of dependent value) Argument. Notice that this reductio argument applies equally to killing oneself and killing and assisting in killing another. But it might be said that, in the Kantian view, there is a particular incoherence in making use of one’s agency to destroy one’s own agency. If so, there is a self and other asymmetry that the Reductio Argument does not account for.

The Reductio Argument is distinct from another reductio argument in Velleman’s article. He quotes (p. 612) my description of the right to life as a protected option whether to live or die. (I borrow this view from Joel Feinberg.26) But, he says, why is it important to protect people’s options if it is not important to protect people, and if it is important to protect people, this means that they have no option to kill themselves so long as they are rational beings. This is a reductio of there being a right to life as a protected option to live or die. Call it Reductio 2. One possible problem with Reductio 2 is that the importance of protecting people is not the presupposition of the importance of protecting people’s option to live or die. Rather, the presupposition of protecting the option is the importance of respecting people, and this does not, on its face, rule out their retaining the option to not live. (My reason for speaking of a right to life as a protected option was only to show that from the idea of a right to life alone, one could not derive a duty to live. This leaves it open that one does have a duty to live for some other reason.)

One concern about the Reductio Argument is raised by considering its implication for cases: it seems to imply that we would not be morally justified in euthanizing a cat to stop its pain. For it seems reasonable to me to say that my cat’s being out of pain matters just because it would be good for my cat.27 According to Velleman, this can be true only if my cat matters. I suggest my cat matters intrinsically, not just because it matters


27. Though Kant might disagree, as he attributes no intrinsic worth to animals.
to me. According to step 3, the permissibility of destroying the cat to stop its pain would imply that it does not matter. Hence, its being out of pain would not matter because it is good for the cat. According to the Reductio Argument, there is a dilemma: if its being out of pain matters because it would be good for it, it would be wrong to kill it to put it out of pain. If it is not wrong to kill the cat to take it out of pain, then it does not really matter for the cat’s sake if the cat is out of pain. So why kill it? But this seems wrong; it is not impermissible to euthanize cats when we are trying to achieve what is good for them because we think they matter intrinsically to some degree.

This Cat Example suggests several grounds for objecting to step 3 in the Reductio Argument:

1. That it is permissible to destroy X independent of concern for other worthwhile things does not necessarily imply that X does not matter. The loss of someone may matter, but less than getting rid of her pain matters. For this to be true, the fact that the value of X being out of pain is dependent on the value of X should not be enough for us to conclude that the value of X being out of pain is less than the value of X. That is, something’s having value may be necessary in order for it to give rise to something that has more value than it. For example, a beautiful scene in nature may give rise to even more valuable reflection on it only because it has value.

2. We should distinguish between (i) the value of something, and (ii) the value of being that thing, or put another way, the value of there being that thing or its continuing to exist. It may be that a person’s not being in pain does not have greater value than the person does, but it has greater value than the existence of the person or the continuing existence of the person. We certainly might choose not to create a person because he would be in pain. Also, in the light of the nonovershadowed value of a person, because a person is so important, we might decide that it is not only important that a person be out of pain but that it would be permissible for the person not to live on in pain. In this connection, consider again Reductio 2. Velleman says the presupposition of the importance of protecting the person’s options is the importance of protecting the person. The sense of “protecting the person” that would make the presupposition true is probably “protecting the integrity or character of the person” rather than “the continued existence of the person,” for why would the continued existence of the person be a ground of the value of his current options? In this sense, PAS may protect the person, even if it eliminates him, for it protects the fulfillment of his reasoned

28. Perhaps, it might be said, because more pain in the world is an intrinsic evil, even if it happens to what doesn’t matter. But could a Kantian argue this additional pain is a moral evil?

29. I owe this example to Franklin Bruno.

30. I owe this point to Franklin Bruno.
choices. Notice that in the passage Velleman quotes, I say that the “value of being a person” (emphasis added) may be overshadowed, but when Velleman comments on the passage, he says, “Kamm says that the “value of a person . . . can be ‘overshadowed’.” But these values may be worth distinguishing.

One could also say that if one eliminates the person to avoid future deterioration of rational humanity—not just to avoid things that are no good for the person as a sentient being—elimination of the person does not indicate that its value is being overridden. This is something Velleman might agree with, though (as we shall see below) he actually only discusses justifying suicide in cases where rationality is already diminished at the time of suicide. These are supposed to be cases in which a property which makes it important that good things happen to someone is no longer present.

3. As described above, Velleman tries to support the Reductio Argument by reference to an analogy to the means-end relation: the value of what is good for a person stands to the value in a person as the value of the means stands to the value of the end to which it is a means. In the means-end case, it is clear that the value of the means cannot overshadow the value of the end; for example, it would make no sense to get rid of the end for the sake of the means. And the value of the end cannot overshadow the value of the means, for as long as the end has value, so do the means. But I think the analogy is imperfect and does not support the Reductio Argument. In the means-end case, the value of the end is to be identified with the value of the existence of the end, since an end is here understood as something we try to bring about. I have suggested above that this may not be true in the case of the person. It is clear that Kant did not think that persons are ends in the sense that we must bring them into existence. What is good for the person (pain relief) may take precedence over the existence of the person without taking precedence over the value of the person, in a way that the means cannot take precedence over the existence of the end. Furthermore, even Velleman seems committed to denying the second prong of his analogy. This is because he believes that the continuing existence of the person can take precedence over doing what is good for the person, since he admits that what is good for the person may be his death. By contrast, the end, he says, cannot take precedence over the means to it. What is good for a person does not necessarily involve commitment to his existence, what is a means to an end does involve the existence of the end. This accounts for the problem with the analogy.

Just as he moved beyond an argument based on caring to the Reductio Argument, Velleman seems to move beyond the general reductio argument (which can also be applied to cats). He claims (pp. 611–12) that the particular value people have in themselves is dignity and this makes them worthy of respect. (This is, presumably, not true of cats.)
Often, respecting a person (unlike caring for him) will conflict with doing what is good for him (e.g., in paternalistic action), and it may be so when it comes to assisting suicide. This is a special argument which may make the Reductio Argument unnecessary. Unlike the Reductio, it need not deny that doing what is good for the person has no value (because the person is something of such low value that we may help eliminate it). That is, the question is, directly, whether the permissibility of eliminating a person for reasons of his pain relief indicates lack of respect for him qua person, even if the permissibility of doing so would not drain all value from doing what is good for the person for his sake, as the Reductio Argument claims.

We now need another argument to support the claim that suicide for reason of pain relief shows lack of respect. Before considering this argument, let us take stock of where we are.

The Reductio Argument was intended to show that the value of relieving pain for the person's sake cannot override the value of the continued existence of the person. If it does not succeed in showing this, it is still possible that both PAS for pain relief and MPR are compatible with treating rational humanity in a person as an end and not as a mere means. It need not violate the first sense of treating as a mere means, that is, giving no intrinsic weight to rational humanity and it also will not violate the second sense because, for all that has been said so far, at least, giving unconditional and incomparable weight to the continued existence of rational humanity does not seem to be a part of not treating people as mere means. But notice that if the Reductio Argument succeeded in its criticism of PAS, it should also rule out MPR and raise problem 2. This is because in MPR one would be causing the death of a person for the sake of what is good for him as a sentient being (pain relief). We do this by using something that is essentially a lethal agent (i.e., certainly death-inducing as well as pain-relieving in the circumstances), even if we do not intend its lethal properties.

VI

The additional argument one finds in Velleman to support the claim that one cannot respect a person if one eliminates her to stop pain is what I shall refer to as the exchange argument. It also supports the second sense of treating a person as a mere means, that is, not giving her unconditional and incomparable value. If it succeeds, it will also show that MPR is impermissible. Velleman claims that suicide is immoral when committed on the ground that life is not worth living and it is in one’s interest to die, for then one is trading one’s life for benefits or for relief from harms. He says (p. 614): “I think Kant was right to say that trading one’s person in exchange for benefits, or relief from harms, denigrates the

31. As David Sanson emphasized to me.
value of personhood," and (p. 616), "The Kantian objection to suicide, then, is not that it destroys something of value. The objection is not even to suicide per se, but to suicide committed for a particular kind of reason—that is, in order to obtain benefits or escape harms. And the objection to suicide committed for this reason is that it denigrates the person’s dignity by trading his person for interest-relative goods, as if it were one of them."

Let me reconstruct and extend the exchange argument.

1. To exchange rational humanity for things that have interest-relative value (i.e., things that have value only because they are in the interest of persons) implies that rational humanity has only interest-relative value.

2. Things that have interest-relative value have a price.

3. Rational humanity would then have a price, rather than dignity.

Indeed, on the Kantian view, to have a price just means that something is exchangeable for something else. Consider some objections to this argument:

i. According to Kant, beautiful things (e.g., art) have a value beyond price, though not the dignity that persons have. Most would say (though perhaps Kant would not, given his theory of beauty) that beautiful things have intrinsic value, even if no one cares about them and they satisfy no human interests. Yet we may permissibly exchange beautiful things for money or food. The permissibility of exchanging them for things that have interest-relative value and a market price does not imply, I believe, that they only have interest-relative value. It implies that what has intrinsic aesthetic value has only finite value and could be permissibly exchanged for what has only interest-relative value (e.g., food). But this does not show that beautiful things have only interest-relative value rather than intrinsic aesthetic value. That we can exchange one thing for another does not mean that they share the same essential nature or type of value. The same might be true of persons.

ii. More important, I think that an exchange that puts a price on something in a pernicious sense, sometimes referred to as commodification, does not arise in the context of PAS or MPR. Consider the following scenarios: (1) I will take away your severe pain by giving you a pill that does not kill you, only if you will then let me take out your kidney so that I can use it. (2) I will take away your severe pain by taking out your kidney, because this acts as a cure for the pain. (3) I will take away your severe pain by giving you a pill that does not kill you, only if you will then let me help you kill yourself because I would like you to die. (4) I will take away your severe pain by helping you to kill yourself, because death eliminates the pain.

In (1), we would say that we have placed a price on a kidney: someone has gotten paid something (a pill for pain relief) in return for giving it up. This raises the problem of commodification of a human body part.
But in (2), an ordinary case of doing what gets rid of pain, it does not seem appropriate to say—even Kant would not say—that we have placed a price on a kidney. Nevertheless, it has been exchanged for pain relief. But we did something to it because that caused pain relief, without intermediate exchanges of it for something else that causes pain relief. Kant, who thought it was inappropriate to sell one’s hair, would not have objected to cutting it off to relieve pain.

Similarly, it could be said, in (3) we place a price on life, and perhaps we thereby treat it as less than it is worth, though not necessarily because any exchange signals the intrinsic equivalence of whatever is exchanged, which was the point of objection i. But in (4), we do not place a price on life, even though we eliminate a rational human being to get rid of pain, and hence, in a sense, exchange a life for pain relief. If there is no price placed on a kidney in (2), why should we think there is a price placed on a person in (4)?

My tentative conclusion is that neither the reductio nor exchange argument shows that it is impermissible to eliminate a still-rational person in order to stop pain consistent with not treating the person as a mere means in the senses of “mere means” we have been discussing.

VII

So far, we have dealt with support for, and objections to, the views that we treat a person qua rational being as a mere means if we give no intrinsic weight to rational humanity, or if we do not give her continuing existence unconditional and incomparable value relative to what is good for the person as a sentient being. However, there is a third sense of treating the person and the rational humanity in him as a mere means that comes closer to dealing with the DDE objection: suppose our balancing pain versus life does not reveal that we see rational humanity in our lives as having no intrinsic weight or no great intrinsic weight. Still, on the occasion when we sacrifice it to stop pain we are (a) acting against rationality, (b) with no eventual good for rational humanity per se to be achieved by that act, (c) because the person’s death is an intended causal link to no pain. This is to treat the death of the person as a means—the complaint of the DDE. So perhaps, on that occasion, rational humanity in the person is also treated as a mere means. Clause b distinguishes between death and doing relaxation techniques to go to sleep, even though sleep will stop rational agency. This is because going to sleep at night will help promote further and better functioning of the rational agent qua rational agent in the future. Dying will not.

But when we give morphine in MPR, we also act against rational humanity on an occasion when this will not further it in the future. If these things (clauses a and b, not c) make what we do objectionable, MPR will also be ruled out if PAS is. Nevertheless only in PAS and not in MPR do we intend the destruction of the person as a causal means. However,
even in PAS we do not specifically intend, though we foresee, the destruction of rational agency per se. The death of the person is treated as a means, but that may not mean that the rational humanity in the person is treated as a mere means. In this sense, PAS is not so far from MPR. 32 Suppose it is destruction of rationality that is morally most important, not death of a remaining nonrational body. Then, in not aiming at the first, PAS is similar to MPR, from the point of view of the intended/fore-sight distinction.

By contrast, consider terminal sedation, which is currently employed when painkillers do not work and whose legal permissibility the Supreme Court also endorsed. By ‘terminal sedation’ I mean only that which puts a patient to sleep as long as he is in pain until the underlying disease kills him. I am not conceiving of it as involving the removal of food and water with the intention of causing death. If one did this, the cause of death need not be the preexisting disease but rather starvation and dehydration. Nor am I imagining that the sleep-inducing drug itself causes death. In terminal sedation, we intend (not merely foresee), on an occasion, the cessation of rational agency, though this will not be conducive to future rational agency. We even intend to prevent future rational agency, all done as a means of stopping pain. So a variant of clause c is true: (c′) the end of rational agency is intended as a causal link to there being no pain. Hence, if aiming against the continued existence of rational agency for pain relief is what constitutes an impermissible use of persons as mere means, terminal sedation will be ruled out as well as PAS even if it does not hasten death. Indeed, because it more specifically targets eliminating rational agency for pain relief, it may, on a Kantian view, be worse than suicide and MPR. But is it really wrong? If it is not wrong, then this would be reason to think that satisfying a, b, and c was not a sufficient condition for mistreating people.

Suppose that instead of terminal sedation, we could induce non-terminal Alzheimer’s disease as a causal means to pain relief. We are imagining that dementia will cause pain relief. Could it be morally impermissible to use this route to pain relief, even if terminal sedation for pain relief were permitted? Wherein lies the difference? One hypothesis is that dementia is a perversion of consciousness and agency, unending sleep is the simultaneous end of rational agency and of the human being’s attempt to act or consciously think at all. Hence no acts or thoughts exhibit a perversion. To induce dementia may be disrespectful of the person, while inducing the sleep would not be. Death is the simultaneous end of rational agency and of the person, so it is not a perversion of

32. I owe this point to Janos Kis. He suggests that, in most cases, in aiming at destroying the person, we really aim only at destroying her body which is in pain. If dualism were true, we would be quite happy to have the disembodied mind continue on. But would we specifically eliminate the mind to get rid of mental pain?
agency and thought. Hence the moral value of causing it may be closer to terminal sedation than to causing dementia in our imagined case.

There is a further difference between terminal sedation and death which is worth considering. In terminal sedation we are aiming at stopping rational agency as a means to stopping pain. We will give sedation whenever pain is present, and we foresee that pain will be continuously present until death. Hence we foresee continuous deliberate sedation until death. But this is still different from putting someone now into a sleep which cannot be ended because we foresee that pain will continue until the end. Yet we could imagine a hypothetical case in which doing this is necessary in order to stop pain. Here we would intentionally exchange all possibility of consciousness and rational agency for relief from pain. Call this superterminal sedation. It is this which is closest to death-for-pain-relief. If it is permissible with patient consent, then the argument for PAS is strengthened and the argument against it based on the DDE is weakened.

Notice that Velleman’s Kantian position seems not to distinguish between ordinary terminal sedation and superterminal sedation. It rules them both out. Those who would permit terminal sedation but not superterminal sedation are not concerned with the exchange of rational agency per se for pain relief. They are concerned with inducing the end of the possibility of rational agency.

VIII

These points bear on a third argument that Velleman presents against suicide. I shall refer to it as the slavery analogy. He says that entering into slavery is morally wrong if done to acquire goods or avoid harms for the person because it attacks the worth of the person. Likewise, suicide of a rational being to avoid harms is wrong. But seeking death to avoid harm would be like entering into slavery to avoid harm only if death is like slavery. Its being like slavery should mean that we could substitute it for slavery in other contexts. In order to see if this is so, I shall take a somewhat circuitous route. I shall first consider how Velleman tries to justify some suicides.

Velleman says that suicide is permissible if one’s rationality is already being undermined in life. He believes that this may be so even when one is not demented. Indeed, he thinks that the case I describe in which pain is so unbearable that all one can do is focus on it is such a case. Strikingly, he says that in this case it is the unbearableness of the pain, not its painfulness, that makes suicide justifiable (p. 618). This is because not being able to bear the pain means that it is undermining one as a rational being. One is reduced to simply fleeing pain like an animal. Now, to be like this is to be reduced from the position of rational agent. From the moral point of view someone may permissibly kill himself (and we may permissibly assist him) rather than live on as a nonrational being.
Notice that Velleman is here describing someone for whom pain is not a reason to end his life, but rather a cause—it impels him—of his ending his life. This implies (as he concedes) that, in many cases, suicide is permissible only when it cannot be the choice of a rational, responsible person at the time it is to be done. This would create problems for the legal requirement of responsible, competent choice. But that the pain is not a reason for the person to kill himself—a reason he can act on—does not mean it is not a reason why the suicide is justifiable. (This would also be true if dementia were a good reason for the suicide of a demented person who cannot understand that it is a reason.)

I have questions about Velleman’s justification of suicide in the case where pain is so unbearable that all one can do is focus on it. It seems that he thinks that we should help someone in great pain to kill himself to remove him from an undignified state, not out of sympathy for his being in pain or out of respect for his choice. I think this is the wrong account of why we should act. For example, I think there is more urgency in helping a person in unbearable pain to die than in helping a demented person not in pain to die, yet the indignity might be the same in the two cases. Does this not show that we act to relieve the pain? It is possible, however, that an intermediate position is correct: when someone’s rational agency is greatly reduced, the way is open for us to simply focus on the pain. We then sympathize with him as we would with an animal and take the pain as a reason to help him commit suicide. We do not assist him in killing himself to end indignity per se, but, only because he is in an undignified state, it may be permissible to seek to end pain.33

In addition, when we think of someone in great pain, we may think of him as holding himself together by focusing on the pain itself. In this case, the pain is not unbearable, though if he does not focus on it, he will fall apart by being subject to it. Some might say that in this situation though one’s rational nature is still being exercised, it has a very restricted scope. On Velleman’s view, I do not think that this would be a sufficient compromise of rationality to justify suicide. If we nevertheless endorse a chosen suicide in such a case, would it be in order to stop the restriction of rational agency or because the person is in pain? I think it is the latter. For consider a case in which rational agency is also restricted, but not by pain. For example, a person can only focus on the dots on a wall. Is there urgency in eliminating his life?

Possibly, an intermediate position is available here, too: it is only when the scope of rational agency is so severely limited that we are permitted to focus on the pain and act in order to stop it. If this intermediate position were true, then it would not be necessary to say that the value of the existence of (wider ranging) rational agency was overridden by pain in order to justify suicide for the sake of getting rid of pain. The claim

33. I thank Barbara Herman for raising this possibility.
that avoiding harm cannot be a reason for suicide would still be wrong—it would be the pain, not its unbearableness, that was our reason for action—but the conditions in which avoiding pain could be a reason would be consistent with the value of the existence of unrestricted rational agency not being overridden.

But this leaves it open that there may be other cases in which the value of there being unrestricted rational agency is overridden. For example, suppose someone alternates between days on which he totally focuses on pain and others on which he is able to work without pain.\(^{34}\) Is it not possible that the pain should be so bad when it is present that it could outweigh the possibility of continued unrestricted rational agency completely? Or is it instead the fact that on alternate days the use of rationality is restricted that would justify suicide? How could this be so? When sleep regularly alternates with waking, it restricts rational agency and yet is not justification for suicide. In the case of alternating days, it also seems hard to adopt the intermediate position and say that because rationality is compromised, it is permissible to focus on the pain as a reason for suicide. This is because there is a lot of unrestricted rationality on alternate days. In this case, the patient could either take morphine that knocked out the pain but made rational agency impossible or commit suicide. If the importance of not exchanging rational agency is dominant, MPR will be ruled out as well as suicide. If MPR is permitted, suicide cannot be ruled out because it is wrong to exchange rational agency for pain relief.

But let us return to the slavery analogy. Suppose suicide is permissible to end the undermining of one’s rationality, and suicide and slavery are morally analogous. Then it should be no worse to become a permanent slave if this (somehow) eliminated the pain that was undermining one’s rationality than it would be to commit suicide (or go into terminal sedation or take MPR). But I doubt this is so. Becoming a slave seems more like jumping from the fire into the frying pan, at least with respect to insults to oneself as a rational being. Slavery involves alienating one’s rights—giving them over to someone else who then has power over one. Suicide, and taking pain relief that causes death, involves waiving one’s right to go living, not turning the right over to someone else.\(^{35}\) Above, we contrasted death with dementia that ended pain. Dementia was characterized as a perversion of an ongoing agency and consciousness. Slavery is different: the rationality of the agent is intact, but he is not treated properly by others. Death, I think, contrasts with both: it simply stops rational agency and consciousness simultaneously with stopping the person.

\(^{34}\) I owe this case to David Kaplan.

\(^{35}\) Feinberg makes this distinction in “Voluntary Euthanasia and the Inalienable Right to Life.”