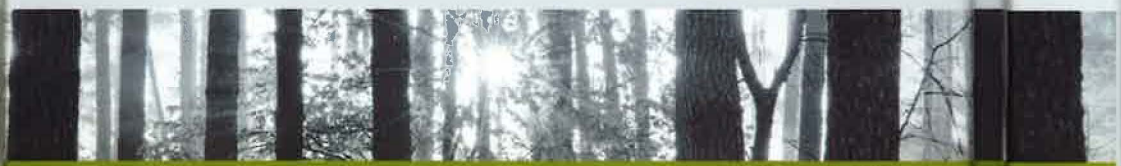
chapters in *Ethics at the End of Life: New Issues and Arguments*, all published
r the first time, focus on recent thinking in this important area, helping initiate
and lines of argument that have not been explored previously. At the same time,
r can use this volume to become oriented to the established questions and
ns in end-of-life ethics, both because new questions are set in their context, and
e most of the chapters—written by a team of experts—survey the field as well
to it. Each chapter includes initial summaries, final conclusions, and a Related
section.

Contents

Davis is Professor of Philosophy at California State University, Fullerton. He has
ed articles on various aspects of end-of-life care.

S/PHILOSOPHY



Cover image: © Shutterstock.com

outledge

ISBN 978-1-138-82975-6

Ethics at the END OF LIFE

EDITED BY John K. Davis

Routle

Ethics at the END OF LIFE

NEW ISSUES AND ARGUMENTS

EDITED BY

Ethics at the End of Life

New Issues and Arguments

Edited by John K. Davis

Routledge
Taylor & Francis Group
NEW YORK AND LONDON

First published 2017
by Routledge
711 Third Avenue, New York, NY 10017

and by Routledge
2 Park Square, Milton Park, Abingdon, Oxon, OX14 4RN

Routledge is an imprint of the Taylor & Francis Group, an informa business

Library of Congress Cataloging in Publication Data
Names: Davis, John K. (Associate Professor of Philosophy), editor.
Title: Ethics at the end of life : new issues and arguments / edited by John K. Davis.
Description: 1 [edition]. | New York : Routledge, 2016. | Includes bibliographical references and index.
Identifiers: LCCN 2016048693 | ISBN 9781138829756 (hardback)
Subjects: LCSH: Death—Moral and ethical aspects.
Classification: LCC BJ1409.5 .E84 2016 | DDC 179.7—dc23
LC record available at https://lccn.loc.gov/2016048693

ISBN: 978-1-138-82975-6 (hbk)
ISBN: 978-1-315-72795-0 (ebk)

Typeset in Times New Roman
by Apex CoVantage, LLC

Contents

Contributors

Michael Cholbi is Professor of Philosophy at California State Polytechnic University, Pomona. He has published books on the ethics of suicide and on Kant's ethics and is currently completing a monograph on philosophical issues related to grief and bereavement.

Taylor W. Cyr is a graduate student at the University of California, Riverside, who is interested in various topics at the intersection of metaphysics and ethics, especially free will, moral responsibility, death, and immortality.

John K. Davis is Professor of Philosophy at California State University, Fullerton. He has published articles on various aspects of end-of-life care.

Colin Farrelly is Professor in the Department of Political Studies at Queen's University. His publications on aging include articles in the *BMJ*, *Biogerontology*, and *Bioethics*. His book titled *Biologically Modified Justice* is forthcoming with Cambridge University Press.

Thomas S. Huddle, MD, PhD, FACP, is Professor of Medicine in the Division of General Internal Medicine at the UAB School of Medicine in Birmingham, Alabama. He teaches internal medicine and clinical ethics and writes about medical education and medical ethics.

Nancy S. Jecker, PhD, is Professor at the University of Washington. She is coauthor of *Wrong Medicine: Doctors, Patients, and Futile Treatment, 2nd edition* (Johns Hopkins Press) and coeditor of *Bioethics, 3rd edition* (Jones and Bartlett).

Bruce Jennings is Adjunct Associate Professor at Vanderbilt University. His publications include: *The Hastings Center Guidelines for Decisions on Life-Sustaining Treatment and Care Near the End of Life* (2013) and *Ecological Governance: Toward a New Social Contract with the Earth* (2016).

Jens Johansson is Associate Professor of Practical Philosophy at Uppsala University. His main research areas are the philosophy of death and personal

identity. He is coeditor of *Oxford Handbook of Philosophy of Death* (2013; with Ben Bradley and Fred Feldman).

Paul T. Menzel, PhD, is Professor of Philosophy emeritus at Pacific Lutheran University. He has published widely on moral questions in health economics and health policy. His most recent writings are on end-of-life issues, including advance directives for dementia.

Benjamin Mitchell-Yellin is Assistant Professor of Philosophy in the Department of Psychology and Philosophy at Sam Houston State University.

Geoffrey Scarre is Professor of Philosophy at Durham University, UK. In recent years he has taught and published mainly in moral theory and applied ethics. His books include *Death* (2007) and *On Courage* (2010), and he is currently editing *The Palgrave Handbook of the Philosophy of Aging*.

James Stacey Taylor teaches philosophy at The College of New Jersey. His books include *Stakes and Kidneys* (Ashgate, 2005), *Practical Autonomy and Bioethics* (Routledge, 2009), and *Death, Posthumous Harm, and Bioethics* (Routledge, 2012).

Eric Vogelstein is Assistant Professor in the Department of Philosophy and the School of Nursing at Duquesne University in Pittsburgh, Pennsylvania. He specializes in bioethics and ethical theory.

Introduction

John K. Davis

End-of-life ethics was among the first topics to develop when modern medical ethics got going in the early 1970s. It is well developed. It is not, however, static. This volume is a collection of new articles on various aspects of end-of-life ethics, with a focus on cutting-edge work and new issues. It is meant both to display recent thinking in end-of-life ethics and to initiate new issues and new lines of argument that have not been explored before. At the same time, a reader can use this volume to become oriented to the established questions and positions in end-of-life ethics, both because new questions are set in their context and because most of the chapters survey the field as well as adding to it.

The chapters are organized by topic, and the order of the topics reflects the order in which someone deliberating about the end of life might consider those topics. It is natural to begin with questions about when and whether a patient may be better off dead (or at least has a life that is no longer worth living). Those questions are covered by the chapters in Part I, which develop connections between end-of-life ethics and the now-lively topic of philosophy of death. However, it is inevitable that we will not agree about those questions in all cases, and therefore the next set of issues concerns whose answer is decisive—that is, who gets to decide whether a patient is better off dead. Those issues are addressed by the chapters in Part II, which discuss when a patient with diminished competence may make that decision, how such decisions might be made in advance, and who makes them if the patient cannot. Once a decision has been made that a patient's life should no longer continue, questions arise about the proper way to end it. Many people believe that letting the patient die is morally permissible, but that killing, suicide (killing oneself), and physician-assisted suicide are not permissible. The two chapters in Part III question those constraints. Parts II and III represent the core of end-of-life ethics as it is usually understood. Part IV groups together three chapters that raise largely new issues. The first two concern the relationship between the patient and other parties, and explore the ethics of grief and solidarity between the patient and others. The final chapter discusses the farthest frontier of all: the

possibility of slowing aging and extending life far beyond its present biological limits.

Most discussions of end-of-life ethics note that patients are sometimes better off dead, or at least do not benefit from continued life. In Chapter 1 Geoffrey Scarre asks whether there is any sense in the idea that a patient could be "better off dead." After all, if death involves nonexistence (a possibility we should not rule out), it is hard to see how nonexistence is good or bad for someone who no longer exists (how can anything be good or bad *for* you if there is no *you*?). Scarre considers what makes a life a "worth living," whether a life has intrinsic value (and not merely instrumental value) apart from its value for the one living it, whether someone might rationally think that suffering makes his or her life more worth living, and whether such judgments are objective or subjective. Scarre concludes that some patients really are better off dead, but that judgments about this are heavily subjective in nature, and that it's hard to generalize about which lives are worth living.

Whether a patient can be better off dead can be seen as the flip side of some well-known questions about the harm of death: if death involves nonexistence, how can death be bad for the one who dies? In Chapter 2 Taylor W. Cyr surveys several aspects of that question, including the two main positions on the issue. According to the first view, *the deprivation account*, death is harmful to the one who dies not because death is bad for that person but because death deprives him or her of further life that would have been good for that person. In short, it is not the state of nonexistence that is bad; it is the absence of a good existence. According to the second view, *Epicureanism*, death is *not* harmful to the one who dies. Cyr discusses several arguments for and against each of these views.

The traditional puzzles about the harm of death assume that we cease to exist when we die, but what if that is false? After all, many people claim to have had near-death experiences in which they briefly experienced an afterlife. Does the existence of an afterlife make a difference to questions about whether a patient can be better off dead, or whether death is ever harmful to the one who dies? Benjamin Mitchell-Yellin argues that it does not. In Chapter 3 he discusses the harm of death and the desirability of immortality, and concludes that the existence of an afterlife has less importance for those issues than one might think.

When we ask whether, when, and how a patient might be better off dead, we are also raising questions about *how* bad death would be for that patient (i.e., the condition of being dead, not the process of dying). We tend to think that death is more tragic the earlier it comes in life, for younger people have more years of potential life to lose. This is a deprivation account of what we might call the *severity* of death—how bad or tragic a death is. Jens Johansson explores this issue in Chapter 4, points out that a person's life expectancy at

the time of death is not the only relevant factor in determining how bad death is for that person, and defends the deprivation account of the severity of death against two objections.

When we ask whether a life *should* end, we must also ask when it *does* end. Modern medicine can keep patients alive for years in a state of permanent unconsciousness. Such patients are warm, they breathe, and they metabolize, but their consciousness and personality are forever gone. Are they still alive? Is the body alive but the patient dead, or are both dead? How can there be two kinds of death, and if there are, do we die twice? If not, when *do* we die? In Chapter 5 John Davis surveys and evaluates several criteria and definitions of death, and argues that death occurs when all capacity for experience is forever gone. Patients, in other words, are essentially sentient beings, and they die when they lose the capacity for sentience.

There is no consensus on when life is no longer worth living, and there may never be. We can settle such questions, therefore, only by settling the question of who gets to settle the question—that is, who gets to decide when the patient should no longer be kept alive. Up to the 1960s and 1970s, doctors tended to decide what was best for the patient, sometimes without informing or consulting the patient. By the 1960s and 1970s, a series of court cases established the doctrine of informed consent. Now nothing could be done to the patient without informing the patient and getting the patient's consent. This was matched by a consensus among medical ethicists that providers should follow a principle of respect for patient autonomy. However, we do not respect the decisions of *all* patients—just those who are competent and autonomous.

Autonomy means "self-determination," roughly speaking, but there is more to it than that. We need a concept of autonomy that captures the precise sense in which a patient's desires are truly her own, and not the result of some interference or irrationality. Competence is a particularly difficult concept to pin down; merely being conscious, adult, and "not crazy" is intuitively plausible but not quite right. We need a definition and criterion of competence that capture cases where we think the patient has made an irrational choice, but do so without requiring us to second-guess whether his or her choice is a good one. In Chapter 6 James Stacey Taylor addresses these challenges, and explains how the concepts of autonomy and competence apply to end-of-life decision-making in general.

Very often patients are deeply and permanently demented or unconscious, and cannot make decisions about whether and when to end their lives. When the patient cannot make that decision, who does? Sometimes patients use a legal document known as a *living will* to make decisions about their medical care in advance, including decisions to reject further care and to die. However, living wills have been controversial. Some ethicists argue that if the patient is permanently incompetent, or better yet, permanently unconscious, the patient's

previous intentions and values cannot now be attributed to the patient, and the patient's past intentions and values have no moral authority (i.e., we are not ethically required to honor them). Instead, these critics argue, surrogate decision-makers should do whatever is in the best interests of the patient as he or she is *now*. Eric Vogelstein defends this view in Chapter 7, arguing that we can respect the autonomy of currently incompetent patients only by respecting the desires and values the patient currently has, not the ones he used to have. He also questions the view that what is in a patient's current best interest depends partly on the patient's prior values.

Not all patients who are incompetent near the end of life are unconscious, and there are degrees of dementia. Some patients are demented or otherwise incompetent but still capable of having desires or making decisions, at least on simple matters. It is possible for such patients to have different judgments and desires than they had earlier, when they were competent and wrote a living will. However, they may be too demented to comprehend their own advance directives or reevaluate them in a reasoned way, so they cannot quite rethink or reconsider their earlier decisions. They cannot be said to have changed their mind in the sense of consciously forming a new intention for their current medical treatment, but they do have cognitive states that at least resemble a change of mind. Should we respect their advance directives, or should we treat these as cases where the patient changed his or her mind, and respect the patient's current values? Paul T. Menzel discusses such cases in Chapter 8, and argues that many of these cases involve a change of mind. Menzel argues for a refined concept of change of mind and contends that we should respect the patient's current values, not the patient's earlier choices, even if the patient is now too incompetent to understand and revise his or her earlier decision.

By the 1990s the medical profession had largely come to agree that withdrawing or withholding life support is often the right decision, at least when the patient's quality of life is very low. This produced a new problem: sometimes the patient's surrogate decision-makers (typically family members) refuse to terminate life support, perhaps because they do not believe the prognosis, or they cannot let go, or they do not want to be responsible for a relative's death, or they believe that all human life is sacred, or they think the patient's quality of life is better than the providers tell them it is. In response, many medical professionals and ethicists invoke *medical futility* to justify refusing to provide life support in such cases. An intervention is futile in this sense when it will not achieve the goal of treatment, not because it is difficult or unlikely to succeed, but because it is simply not going to produce that result under any realistic circumstances. The idea is that, just as physicians can unilaterally refuse to provide interventions like antibiotics for a viral infection (antibiotics work on bacteria, not viruses), they can also unilaterally refuse to provide life support when it is futile to do so because doing so confers no benefit on the patient.

grounds of futility does not respect patient autonomy and gives too much power to providers. In Chapter 9 Nancy S. Jecker defends this use of the concept of futility against these objections. She argues that these objections are based on an excessively broad conception of patient autonomy, and that there is a social agreement among physicians and society that supports such refusals.

Most patients who wish to die, or who no longer benefit from continued life, die when the doctors withdraw or withhold whatever is needed to keep the patient alive (life support, cardiopulmonary resuscitation, antibiotics, and so on). This is described as "letting die." However, there are patients who are in a condition bad enough that they wish to die, but they do not require life support, CPR, antibiotics, or other interventions to stay alive. Letting them die in the usual way is not an option. Their lives can be terminated only by killing them. Many ethicists believe that killing such patients is wrong even in cases where letting die would be morally permissible if they were on life support and otherwise in the same medical condition.

Everyone, however, requires food and water. Some patients receive this by tubes, others by mouth, but both groups can refuse food and water. This is a trend; it is becoming more common for patients to intentionally end their lives by refusing food and water. This need not involve the pangs of starvation and painful dehydration. It can be paced and managed with palliative care so that it is not hard on the patient, yet still leads to death. However, there is some controversy over this practice. Some ethicists oppose it because they believe that only medical treatments are morally permissible to refuse, and they think that delivering food and water, even by intubation, is not a medical treatment. Some object that withholding food and water from the patient is a kind of killing (or suicide, given that the patient requests this), and that killing (and suicide) is morally wrong.

In Chapter 10 Paul T. Menzel argues that currently competent patients have a moral right to refuse food and water (even if we consider it a form of suicide, which Menzel does). However, Menzel also says it is less obvious that this right extends to cases where the decision was made in advance, when the patient was competent, and the patient is now permanently incompetent. Menzel also discusses two problematic features of advance directives that refuse food and water. First, incompetent patients usually retain a desire to eat. Second, providing food and water is basic personal care. Menzel argues that the first objection fails in cases where the advance directive clearly addresses the future patient's desire to eat, and that the second objection fails on the grounds that if patients have a right to refuse medical care, they also have a right to refuse personal care.

Menzel undermines the prohibition against killing patients by arguing that withdrawing food and water is a form of letting die. However, there are other ways to challenge that prohibition. One well-known work-around concerns

the amount of morphine needed to kill the pain may suppress respiration and kill the patient too. Even so, the patient's pain needs to be addressed, and it seems cruel to prolong the patient's agony just because he is not on life support. Some ethicists have argued that this practice is morally permissible because the moral rightness of treating pain outweighs the moral wrongness of killing a patient. The most developed version of this argument invokes the doctrine of double effect. According to one formulation, this doctrine says that an action that has a foreseeable effect (killing the patient) is morally justified if that effect is not intended, and that effect is necessary to achieve a proportionately good effect (i.e., good enough to outweigh the wrongness of the unintended effect).

Thomas S. Huddle discusses the doctrine of double effect in Chapter 11. He is skeptical that it can be made to work, primarily because he is skeptical that defenders of the doctrine can overcome the "problem of closeness." The problem is that it is hard to draw the distinction between intended effects and unintended but foreseen effects in a way that prevents the doctrine from justifying actions that seem clearly immoral. For example, a terrorist who sets off a bomb killing dozens of civilians could argue that he foresaw but did not intend to kill them; his real intention was to weaken the government he considers his enemy and thereby liberate his own people. Even if we assume for discussion that the government he opposes really is tyrannical and unjust, and that his people are oppressed and have the right to rebel, his action seems immoral, yet the doctrine seems to justify it. Defenders of the doctrine must solve the problem of closeness. Huddle is skeptical that they have succeeded.

The doctrine of double effect is supposed to justify some cases of killing without also justifying other forms of killing, such as euthanasia and physician-assisted suicide. However, some ethicists argue that euthanasia and physician-assisted suicide are morally permissible. They reject the claim that there is a morally relevant distinction between killing and letting die, and their view is now coming into the mainstream. At the time I am writing this, euthanasia and physician-assisted suicide are still illegal in most places, but euthanasia is legal in the Netherlands, Belgium, Columbia, and Luxembourg, while physician-assisted suicide is legal in the Netherlands and the American states of Washington, Oregon, Vermont, New Mexico, Montana, and California. Huddle addresses the killing/letting die distinction, and the more general doing/allowing distinction it is drawn from. He surveys a variety of arguments for and against the moral relevance of that distinction, and concludes that the doing/allowing distinction is not a good basis for objecting to physician-assisted suicide.

Most writing on end-of-life ethics focuses on the person whose life is ending, but there are other affected parties to consider, particularly the patient's family. Providers who engage in moral reasoning in the clinic routinely consider the interests and wishes of family members. Theoreticians, however, have not.

But two of our contributors break new ground by considering parties other than the patient. In Chapter 12 Michael Cholbi explores the ethics of grief in the setting of surrogate decision-making about end-of-life care. He argues that grief makes it much more difficult for surrogate decision-makers (who are usually relatives of the patient) to be rational and make decisions that comply with what the patient wanted, or would have wanted had she considered the situation. He also offers some practical suggestions for dealing with this.

Bruce Jennings approaches end-of-life decision-making from another angle in Chapter 13, where he uses the concept of solidarity to propose an alternative to the individualistic model of end-of-life decision-making, in which the patient makes decisions alone, to a form of shared decision-making based on concern for others and on mutuality and a relational interpretation of autonomy liberty, dignity, justice, and other more traditional concepts.

The last chapter considers the ultimate end-of-life care: the possibility that we might be able to postpone the end of life far beyond present limits, not by keeping a patient alive in an elderly and senescent condition but by slowing, halting, or reversing aging itself. Until perhaps 15 years ago, this possibility was highly speculative and not widely considered plausible. Over the last few years, however, many well-known geroscientists at major universities have begun making public comments to the effect that slowing aging in humans may well be possible, and might be achieved within the coming century. Not everyone is convinced this is a good idea. Some of those who are opposed argue that extended life would not be a good life, that we might grow bored, or fail to use our time well, or that our lives would lose some of their meaning. Some people are concerned about bad social consequences, such as the possibility that the world will face a Malthusian disaster if everyone extends their life, or that a world where life extension is too expensive for everyone to get it is an intolerably unjust world.

In Chapter 14 Colin Farrelly addresses the justice objection to life extension and the Malthusian concerns. Farrelly argues that justice requires accelerating the development of life extension so we get it sooner, and that failing to develop it when it is possible is an injustice, for that failure condemns billions of people to the chronic diseases of late life. Until now, it was not possible to protect people from the suffering and indignities of senescence, but now it is, so now controlling aging becomes a requirement of justice. He agrees that justice requires making it available to as many people as possible, and that we must be careful not to let it produce excessive population pressure or damage to the environment.

And with Chapter 14 we have gone from asking whether anyone can ever be better off dead to asking what ways of ending life are morally permissible, to asking whether life has to end on any timetable at all, and what ways of failing to extend it are unjust. Perhaps the right to die will be eclipsed by the right not to age.

Cebuhar, J.K. (2015) *The Practical Guide to Health Care Advance Directives*, West Des Moines, IA: Murphy.
Fagerlin, A. and C.E. Schneider (2004) "Enough: The Failure of the Living Will," *Hastings Center Report* 34(2): 30–42.
Sumner, L.W. (2011) *Assisted Death: A Study in Ethics and Law*, Oxford: Oxford University Press.

11 Suicide, Physician-Assisted Suicide, the Doing-Allowing Distinction, and Double Effect

Thomas S. Huddle

Summary

It is likely that most philosophers view suicide as a legitimate exercise of autonomy, while most physicians would decline to participate in physician-assisted suicide (PAS). This chapter surveys recent discussion supporting and opposing PAS. Highlighted are two argumentative strategies essential to PAS opponents: the doctrine of doing and allowing (the DDA) and the doctrine of double effect (the DDE). Opponents of PAS claim that the DDA and the DDE can specify a moral difference between PAS and common medical practices. Once PAS is thus set apart, the case against it rests upon its incompatibility with the patient's moral status or with the physician's role. Some supporters of PAS deny that the DDA and the DDE can morally distinguish licit and illicit actor contributions to negative outcomes. Without the aid of the DDA and the DDE, PAS must be morally assimilated to withdrawal of support and terminal sedation and opponents of PAS who accept these common medical practices must be deemed to be inconsistent. Other advocates of PAS accept the DDA, the DDE, or both, but deny their bearing on PAS, holding that death for the terminally ill patient requesting it is not a negative outcome. The author concludes that the DDA and the DDE have so far withstood the objections of their critics but that opponents of PAS are now on the defensive insofar as their opposition relies upon asserting the inviolability of human life or an incompatibility of PAS with medical practice.

Introduction

While suicide has been of perennial interest to philosophers, the contemporary debate over physician-assisted suicide (PAS) and active euthanasia (AE) dates from the exchange between Glanville Williams and Yale Kamisar in 1958 (Kamisar 1958; Williams 1958). Williams argued for permitting PAS on the grounds of respecting autonomy and relieving suffering. Kamisar argued that legalization would lead to abuses. While their debate was conducted as a

policy dispute, the issue was taken up by philosophers in the ensuing decades. Suicide continues to be a disputed topic in the philosophical literature, but PAS has become somewhat less controversial there, having served as a kind of limiting case of the broader topic. Whatever philosophers may say about suicide more generally, most view PAS in the right circumstances as permissible and, perhaps, obligatory for physicians. Strikingly, the medical profession in the United States remains mostly at odds with this growing consensus among philosophers (with, of course, notable exceptions to the prevailing group opinion in both groups).

In what follows I will briefly discuss the ethics of suicide and then turn to physician-assisted suicide and active euthanasia. My focus will be on two argumentative strategies used by opponents of PAS and AE to morally distinguish those acts from two common medical practices: the withdrawal of life support and terminal sedation. The two strategies respectively invoke the doctrine of doing and allowing (the DDA) and the doctrine of double effect (the DDE). Much of the philosophical dispute over PAS and AE has turned on whether they can be meaningfully distinguished from pervasively accepted medical practices using the DDA and the DDE. If not, PAS opponents would be in the uncomfortable position of denying the permissibility of physician actions that do not differ in principle from other actions that physicians routinely perform.

Suicide

Whether it is permissible to take one's own life has, of course, been debated since ancient times. Much turns on how one chooses to set the boundaries of "suicide." The more capacious one's concept of suicide, the more plausible it is to suppose that some suicides, at least, are permissible. Durkheim notoriously believed that suicide could be identified in acts absent an actor's intention to die. Suicide for Durkheim was any volitional act known by an actor to be likely to result in death, so that the martyr, the soldier braving mortal danger to save a comrade, or the mother sacrificing herself for a child are every bit as much suicides as the despondent man's successfully intended life-ending overdose (Durkheim 2010: 43). Most philosophers have sought a narrower definition that demands a suicidal actor's intention of dying, with a broader or narrower sense of intention. For instance, Michael Cholbi suggests that we should consider as suicide intentional self-killing, with a person's self-killing being intentional "just in case her death has her rational endorsement in the circumstances in which she acts so as to bring about her death" (Cholbi 2011: 28). Rational endorsement of one's death need not imply the usual sense of intention. That is, it need not imply that one acts having one's death as a goal. Such a definition would thus include acts resulting in the death of the actor that many would deny to be suicide, such as the soldier covering the grenade with his body to save his comrades. This move draws the normative sting of "suicide" and opens the way to the suggestion that suicide may sometimes be permissible. Opponents of suicide's permissibility are more likely to prefer a narrower definition, according to which admirable acts such as the soldier's sacrifice of himself for his comrades would be excluded, reserving the suicide designation for acts more narrowly intended as self-destructive. On the latter view, suicide would properly retain its traditional sense as a concept normatively charged in a negative way, analogous to murder.

The semantic dispute thus bears on the substantive issue of suicide's permissibility. Recent arguments for the permissibility of suicide give the most weight to the importance of respecting rational autonomy, given that choosing to end one's life may sometimes be a rational choice. Criteria for judging a suicidal choice to be rational vary from relatively demanding accounts, according to which death must be not only "what the patient really wants, at the deepest, most reflective level" (Battin 2003: 697) but also in her interest as judged independently of her wants, to accounts that would allow a choice of death to be permissible even if it were against the chooser's interest so long as the choice was competently made (Cholbi 2012: 288–292).

Opposition to the permissibility of suicide often appeals to the sanctity of life, the position that human life is intrinsically valuable and, properly, inviolable apart from some carefully managed exceptions (often including self-defense, capital punishment, and just war). The sanctity of life position is often characterized by advocates of suicide's permissibility as a religious doctrine (Battin 2005: 94). While it is certainly associated with religion (Ramsey 1968), opponents point out that the conviction that human life is valuable in itself and ought not to be violated is a widespread and powerful moral sentiment that transcends religion (Shils 1968). I suspect that R.F. Holland was right to identify the fault line in discussions of suicide not at the divide between religion and irreligion nor even at the appeal (or lack thereof) of the notion that human life is somehow sacred or special. Holland cites the example of Captain Oates, the member of Scotts's expedition in the Antarctic who was endangering his fellow explorers because of his increasing weakness.

> On the day before his death Oates had said that he could not go on and had proposed that the rest of the party should leave him in his sleeping bag. "That we could not do" says Scott, whose account of the upshot is as follows:
>
> > "He slept through the night before last, hoping not to wake; but he woke in the morning-yesterday. It was blowing a blizzard. He said, 'I am just going outside and may be some time.' He went out into the blizzard and we have not seen him since. . . . We know that poor Oates

> was walking to his death, but although we tried to dissuade him, we knew it was the act of a brave man and an English gentleman" (Scott's Last Expedition, vol. i, p. 462).
>
> (Holland 1980: 150–152)

Ought one to call Oates's act a suicide? Many who argue for suicide's permissibility likely would; many opposed would wish to call it something else—an act of self-sacrifice the best description of which is determined by Oates's primary intention in walking into the blizzard: that of relieving his fellow explorers of the burden of his presence. He took himself off so that his companions could go on unencumbered by him. His death in the blizzard was a side effect of that action. Holland suggests that the divide in attitudes to suicide is between those for whom a construal of Oates's action as both noble and non-suicidal is important and those for whom it is of little moment whether Oates is held to be no suicide or a suicide but an honorable one.

On one side of this fault line is the sense that our human life is prior to the stream of choices made and directions taken that it makes possible; our life's continuation should therefore remain outside the realm in which we assert our wills. Self-sacrificial acts resulting in death do not do violence to this conviction as the act of suicide is in part constituted by an actor's primary aim of self-destruction—which was not Oates's primary aim. On the other side of the line is the determination that my life is my own—it may be placed in my scale of value and retained or relinquished at my pleasure. My choice to end my life is simply one more choice in the series of my choices in how to live my life. That choice deserves respect just as do my other self-regarding choices that harm no one else. Oates's decision is well described as a choice to end his life and we ought to view it none the worse for that. Holland labels those on these opposing sides as respectively bearers of a religious ethics (regardless of whether accompanied by religion) or as humanists.

Moving the ground from suicide considered generally to PAS and the plight of the terminally ill moves us to the context in which proponents of suicide's permissibility can make their strongest case. For whom if not for a suffering, terminally ill patient might a decision to end one's life be warranted? Accusations of disloyalty to life have little bite for the suffering patient who is near death. Philosophers hesitant to endorse suicide in general often find an option for PAS in the terminally ill far easier to favor.

The role of physicians introduces the complication of another party's participation in the suicidal act. In addition to justifying PAS in general, those of its proponents who see physician participation as (at least sometimes) obligatory have the additional task of arguing for PAS as an essential implication of the physician's role. The rest of this chapter will focus on suicide and euthanasia in the medical context—that is, on PAS and physician participation in

active euthanasia. Philosophical positions range from those holding all PAS to be intrinsically wrong through those holding at least some PAS to be permissible to those holding some PAS to be obligatory. Much of the argument has revolved around the cogency of moral distinctions asserted by opponents of at least some PAS between actor contributions to intended vs. merely foreseen negative outcomes (differentiated by the doctrine of double effect, the DDE) and between active and passive contributions to negative outcomes (differentiated by the doctrine of doing and allowing, the DDA). These distinctions are necessary for those seeking to prohibit certain kinds of actions as bad in themselves (e.g., suicide) while acknowledging the inevitability of actor causal involvement in negative outcomes. Both are implicated in Holland's suggestion that Captain Oates can be exonerated of the charge of suicide. Can Oates's act be best described as relieving his comrades of a burden while avoiding its description as suicide? That is, was Oates's death a side effect of his walking into the blizzard to remove himself from his comrades? Or must we say that Oates must have intended his death and was thus a suicide?

In Oates's case the DDA and the DDE run together, as (at least some) opponents of suicide would wish to characterize his death-producing act as both producing death passively (through allowing rather than doing) and producing it unintentionally (as a side effect). It is important to note that this parallelism does not always hold. The DDA and the DDE are complementary; an active relation to a negative outcome may be foreseen or intended, as may be a passive relation. The DDA maintains that sometimes allowing a negative outcome is permissible when doing it is not; the DDE maintains that sometimes foreseeing a negative outcome from what one does or allows is permissible when acting or omitting while intending that outcome would not be.

In the debate over PAS, the negative outcomes (according to PAS's opponents) in question are the deaths of patients. Physician involvement in patient death may be active or passive (doing and allowing in this case corresponding to killing and allowing-to-die; the K/ATD distinction) and death may be intended or merely foreseen. Opponents of PAS maintain that PAS (or at least some PAS) may be categorically prohibited while passive and unintended causal involvement in patient death may sometimes be permitted. Advocates of PAS have often proceeded by attacking these distinctions and claiming that PAS opponents are inconsistent in permitting some physician actions resulting in patient death and forbidding others that, PAS advocates hold, are morally indistinguishable.

Physician-Assisted Suicide, the Doctrine of Doing and Allowing, and the Killing/Allowing-to-Die Distinction

The DDA asserts that one may sometimes morally distinguish acts/omissions resulting in similar negative outcomes according to the kind of actor agency

involved (active or passive). That it can matter whether a harm comes about through one's doing it or allowing it seems, at first glance, highly plausible. As Philippa Foot remarked, there appears to be a moral difference between buying a winter coat and thereby omitting to send the cost of the coat to Africa (such that a child dies whom the money might have helped) and murdering someone to get the money to buy a winter coat (Foot 2002). Specifying the distinction between doing and allowing in a way both true to our usual ways of drawing it and also properly exclusive of counterexamples has, however, proven extraordinarily difficult (see Woolard 2012). Much of the difficulty may be due to two presumptions commonly held by both attackers and defenders of the distinction: (1) that the target of the distinction is causal relationships among natural facts, and (2) that one may consider the moral importance (or not) of the distinction separately from the way the distinction is drawn on the natural fact/causal level. In what follows I will presume that a cogent distinction between doing and allowing (and between killing and allowing-to-die) can be drawn and consider both attacks on and defenses of the moral importance of the distinction.

The K/ATD Distinction Is Never of Moral Importance Per Se

The most thoroughgoing attacks on the moral importance of the distinction between killing and allowing-to-die have been mounted since the late 1970s by James Rachels, Michael Tooley, Dan Brock, and Peter Singer, among others (Rachels 1979; Brock 1985; Singer 1993; Tooley 1994). The strategy has been to suggest that PAS is not different in any morally important way from the medical strategy of allowing terminally ill patients to die. If that is true, PAS opponents should either accept PAS or disown a pervasively common medical approach to terminal illness. Moral equivalence between the two ways of acting is demonstrated through comparing cases in which actor intentions, patient wishes, and an outcome of death are held equal and the only factor differing is whether the act leading to death is a doing or an allowing. Our intuitions lead us (claim proponents of PAS) to the conclusion that there is no intrinsic moral difference between killing and allowing-to-die. That is, there is no important moral difference between otherwise similar cases in which a difference resides solely in the kind of causal relevance (doing vs. allowing) an actor has to a patient's death. A recent example of such cases is L. W. Sumner's Douglas, who is dying of pancreatic cancer and may choose either to refuse treatment or be euthanized:

> Chemotherapy holds out the possibility of slowing the dying process somewhat but the side-effects of the treatment are severe; without it Douglas will soon die from his cancer. Let us say that Douglas has two means of managing his dying process: refusing treatment (letting death happen) and requesting euthanasia (making death happen). So as to keep other factors equal, as much as possible, we will assume that euthanasia is legal in Douglas's jurisdiction, that he would satisfy the criteria for it, and that his physician is willing to administer it. Furthermore, we will stipulate that Douglas will experience no more suffering by refusing treatment than by requesting euthanasia. Douglas is indifferent between the two options: he will give informed refusal to chemotherapy and informed consent to euthanasia.
>
> (Sumner 2011: 95)

In case 1, we are invited to imagine Douglas refusing treatment and then dying; in case 2, Douglas requests euthanasia, receives it, and dies. The two cases are similar except for the "bare difference" of Douglas dying by killing in case 1 and by allowing-to-die in case 2. The conclusion Sumner suggests we should draw is that there are no grounds for asserting an ethical significance to the causal "bare difference" in this case. If there is no such ethical significance, then relevantly similar extensions from licit allowing-to-die to licit killing may be made in terminally ill patients.

How do pairs of cases such as Sumner's show that there is no moral importance in whether a death comes about through doing or allowing? The cases are constructed so that morally important aspects of the transition from life to death are equalized. Once all of these have been identified and stipulated to be the same in each case, then one is forced to conclude (so advocates of this strategy contend) that the bare fact of death coming about through doing vs. allowing cannot be morally important. For instance, James Rachels suggests that wrong-making aspects of killing and allowing-to-die might include the patient's death itself, the actor's intentions in being causally related to said death, and effects of the patient's death on other people. Rachels notes that all of these aspects of a terminally ill patient's death may be the same whether the death comes about by killing or allowing-to-die. Ergo, these aspects are sufficient to determine the moral valence of either killing or allowing-to-die, and that valence must be independent of the bare fact of death occurring through doing or allowing (Rachels 1979: 165). Morally important differences between cases of actively and passively causing death reside in agent and patient wishes and intentions and in outcomes, not in activity or passivity per se.

From the suggestion that there is no difference between activity and passivity in producing death in the two Douglas cases, it is a further step to conclude that activity or passivity in causing death is invariably of no moral importance, whereas intentions and outcomes in such cases can always be morally determining independently of activity or passivity. The latter conclusion follows from presuming a fixed relation between moral and natural properties of cases.

Dan Brock suggests that moral properties must supervene on descriptive properties (e.g., whether an act is a doing or an allowing) in an invariable way. Thus the absence of moral importance in the differing causal structure of otherwise similar cases implies that moral significance could never reside in the causal structure of a case (as regards an agent doing vs. allowing) per se (Brock 1985: 861). If once a descriptive property is not morally important, then it should never (of itself) be important. While this position has a certain intuitive plausibility, it has been shown to fit badly with our intuitions about important cases. For instance, the moral difference between doing and allowing seems profoundly important in Foot's pair of cases mentioned earlier. Yet in a pair of cases in which harm is done vs. allowed by an agent defending himself against an aggressor, the moral difference between harm coming to the aggressor through doing versus allowing may be trivial or nonexistent (Kagan 1988: 18). It would seem that the same kind of causal difference between agents and agent-related harms in contrasting pairs of cases can be of variable moral importance across situations. The position that moral and natural properties are related in a fixed way cannot accommodate that result.

The K/ATD Distinction May Sometimes Be Morally Important

The contention that an agent's active or passive causal relation to a patient's death is invariably of no moral importance in itself has been attacked by nonconsequentialist philosophers, beginning with Philippa Foot. Foot attacked the equivalence of a pair of cases offered by Rachels. In Rachels's cases, Smith drowns his nephew in the bathtub whereas Jones observes his nephew drowning but fails to rescue him. Both intend their nephew's death (Rachels 1975). Foot acknowledged that Smith and Jones were blameworthy in each case but denied that the cases were equivalent: drowning the nephew was an offence against justice, whereas the failure to rescue an offence against charity. Our rights not to be drowned extend further than our rights to be rescued. While Smith's act and Jones's omission might have the same moral valence, the moral importance of their respective involvement in their nephew's death differed (Foot 1977). In this pair of cases, the moral difference between Smith and Jones does not affect the moral valence of their involvement in their nephews' death but moral differences between acts and omissions might be important in other cases—as the moral significance of killing or allowing-to-die is not determined by the causal character of doing or allowing in any possible case. It is determined instead by how activity or passivity figures morally in the situation in which an actor is causally related to an outcome. And the moral significance of activity or passivity will vary in differing situations.

The same point is made by Frances Kamm, who considers a doctor transplanting organs to save needy patients while knowingly using a chemical that will seep into the next room and kill a patient there. Such an act would be impermissible. On the other hand, if faced with one patient needing care and other patients needing transplants, the doctor might permissibly transplant the needy patients while leaving the one patient unattended to. Presuming that both the one patient and the patients needing transplants will die without treatment, it is permissible to let the one patient die in this latter case to save more than one. She takes these cases to show that when death is merely foreseen but not intended as in both cases, killing (in the case of using the chemical) is of a different moral valence than letting die (the one patient unattended to) (Kamm 2007: 147). Even if the K/ATD distinction is not morally important in all cases, it may be important in some.

The distinction may be morally important to physicians facing requests from terminally ill patients in the following way: requests to be allowed to die issue from a patient's right to non-interference or bodily integrity, which demands observance by physicians. Requests for assistance in dying appeal to no such negative right but to a positive right (if right it is) to a particular service. As negative rights are more pressing than positive rights, a patient's demand in the case of withdrawing therapy is exigent in a way that an otherwise similar demand for PAS cannot be (Kamm 1999: 590–591). Proponents of a physician obligation to provide PAS suggest in response to this way of pressing the K/ATD distinction that a patient's right of bodily integrity or non-interference is derivative from a right to self-determination, which is primary. Rights to withdrawal of treatment and to assistance in suicide ought to be viewed as equally pressing implications of the patient's right to autonomy (Brock 1999: 525–527; Dworkin 2009: 379).

Foot, Kamm, Sumner, and others who deny that an invariable moral significance always attaches to causal relations of doing or allowing (and that that significance is none) generally view PAS as permissible (or obligatory) in at least some circumstances. Patients that are terminally ill who wish assistance in dying do not have differing rights violated by physicians who may either kill them or allow them to die. Willing patients may waive rights to life and rights of non-interference do not apply. While whether an act is a killing or an allowing-to-die may sometimes be morally important, it is not important, these ethicists would maintain, in the usual kinds of cases in which assistance in suicide might be requested by terminally ill patients. That being so, PAS is presumptively at least permissible if patients wish for it and if the outcome of patient death is beneficial rather than harmful.

This position on PAS is probably the most common in bioethical discussion and is held by many who would oppose the legalization of PAS on policy grounds. If the permissibility of PAS is not foreclosed by an agent's activity in achieving a patient's death, then foreclosure, if PAS is foreclosed, must issue in some manner from the patient's status or the doctor's role. That is, PAS may

be forbidden on the grounds of the sanctity of life, on grounds of respect for persons, or for reasons specific to the doctor-patient relationship. Opponents of PAS focusing on physician participation in suicide generally suggest that PAS is incompatible with the physician's role.

The K/ATD Distinction Is Always Important (or Always Important in the Medical Context)

Those who would prohibit most or all PAS share with the liberal nonconsequentialists who would permit it an acknowledgement of the possible importance of the K/ATD distinction and the DDE. Where they part company is in an unwillingness to consider one's own death as simply one more harm or benefit to be weighed against others and factored into one's autonomous welfare-promoting decisions. That unwillingness follows from the special status of human life according to those who take these views: Kantians and proponents of natural law.

A. Natural Law

The natural law tradition takes there to be valid ethical norms and standards that are prior to human choices. These take the form of "basic goods" that are known to be such either through reflection or through human inclinations that are the occasion for reason's recognition of given goods as basic (Murphy 2001: ch. 1; Finnis 2004). Unlike the goods of consequentialists, the basic goods in natural law are not to be weighed against one another. They are fundamental and incommensurable. Human life is one of the basic goods. Natural law theorists generally assess the good of life differently than their consequentialist and non-consequentialist opponents. These latter tend to see the value of life in the higher rational capacities made possible by biological life in human beings. In the absence of these capacities, or even in their presence given an autonomous choice to dispense with life if, say, its benefits are judged to be exceeded by its burdens, a decision to die through either active or passive means may be reasonable.

The natural law theorist replies that human life's value is intrinsic rather than instrumental; and that if its intrinsic value is especially evident in human life's higher capacities, those capacities cannot be severed from the biological substrate in which they appear for purposes of assigning value to life (e.g., Murphy 2001: 101–105). To maintain otherwise is to suppose that bodily life is something persons possess but that remains distinct from what persons are; to commit oneself, that is, to a dualistic theory of personhood that, the natural law theorist contends, flies in the face of human experience (Finnis 1993: 567–569). Human life, then, is of fundamental value and may be taken only in strictly limited contexts (e.g., war, self-defense, capital punishment) outside of

which killing is forbidden. Allowing-to-die, on the other hand, is sometimes permissible when the intention of withholding or withdrawing treatment is avoidance of burden rather than death.

B. The Kantian Tradition

Contemporary Kantians tend to be more permissive than natural law theorists as to suicide, but an argumentative strategy common among consequentialists and non-Kantian liberal non-consequentialists is closed off to them, as it is to natural law theorists: that is, assessing one's future life (or death) in terms of harms and benefits and possibly opting for death on grounds that, given the overall balance, one would be better off dead.

The Kantian denies that the person is simply a nexus of interests the balance of which may rightly determine life or death decisions. Value inheres in persons on account of our rational nature, a value expressed in the specifically Kantian notion of dignity. Personal interests deserve to be furthered for the sake of the person whose interests they are. But the value inhering in the person is independent of her interests and she is not permitted to extinguish her own person on behalf of her interests. To do so is incoherent—it is to act against an end (the person) on behalf of that which has value only in relation to that end (Velleman 1999: 611–613, 624–625). This stance appears to close off the possibility of prudential suicide. Although Kant himself indeed viewed suicide as prohibited, contemporary Kantians have generally avoided this implication.

The most plausible route to permissible suicide for the Kantian has been the suggestion that if a person's rational nature is sufficiently degraded, then a point might be reached at which its Kantian dignity might be better honored by destruction rather than by preservation of its degraded remnant.[1] While so far more permissive than natural law theory as to suicide, Kantian views may be more demanding in regard to withdrawal of lifesaving therapy. While the Kantian is not obligated to preserve life at all costs, she has a defeasible duty to preserve her rational agency. That duty may give way to important moral projects or to the necessity of avoiding immorality. Kantians (and non-Kantians) plausibly suggest, however, that on the Kantian view, the duty of self-preservation cannot be defeated by the prospect of future suffering. So a refusal of lifesaving treatment, possibly justifiable if aimed at reducing the burdens of others, cannot be grounded in the prospect of one's own future life made burdensome under the treatment (McMahan 2002: 482; Gunderson 2004).

C. The Medical Context

The most common medical approach to physician involvement in patient death is to forbid active participation categorically but to hold allowing-to-die to

be not only licit in the terminally ill but also obligatory in cases of treatment refusal. The medical community offers a contrast with the bioethics community in that the medical community in the United States is still substantially opposed to PAS.[2] As with Kantians and natural law theorists, those physicians who hold to the traditional proscription on PAS vindicate the importance of the K/ATD distinction and the DDE in regard to their relevance to the patient outcome of death on the ground of the special importance of human life. Much medical argument against PAS presumes that patient death is a negative outcome if it is a result of active physician agency—and focuses on vindicating the DDA or the DDE as means of distinguishing PAS from withdrawal of support or terminal sedation (e.g., Sulmasy and Pellegrino 1999). And medical argument favoring PAS generally echoes the bioethics case in its favor (e.g., Quill et al. 1997).

The case against PAS in the medical context turns on considerations about human life as it does elsewhere, but it invokes considerations specific to illness and the relations of the ill to the physicians who care for them. The most important such arguments have been offered by Edmund Pellegrino and Leon Kass. Both suggest that scrutiny of the doctor-patient relationship leads to dispositive conclusions about the norms of medical practice antithetical to PAS. The suggestion is that there are facts about illness such as the weakness, frailty, and vulnerability of patients who are ill; and facts about the doctor's healing role—her aims of relieving suffering and restoring health and her position of power in relation to the patient's weakness. The facts of illness and of the physician's role imply norms that should govern medical practice (Pellegrino 2001). These tell against the bioethicist ideal of a patient's rational autonomy as an end toward which physicians should aim (Pellegrino and Thomasma 1987). What patients need from physicians are, primarily, care and guidance aimed at help, healing, and the relief of suffering. PAS is incompatible with what patients need from physicians and with what physicians offer patients in proper doctor-patient relationships. Why, it might be asked, should the physician's aim of relieving suffering not sanction PAS in circumstances in which only death might end suffering? Kass echoes the natural law suggestion that one can benefit a person by killing him only if a person's body is a possession of that person rather than the person himself—that is, only if some form of dualism is true. His objection to dualism, however, is founded not upon abstract philosophical considerations but upon the character of the doctor-patient relationship:

> The patient presents himself to the physician, tacitly to be sure, as a psychophysical unity, as a one, not just a body, but also not just as a separate disembodied person who simply has or owns a body. The person and the body are self-identical. True, sickness may be experienced largely as belonging to the body as something other, but the healing one wants is the wholeness of one's entire embodied being . . . This human wholeness is what medicine is finally all about.
>
> (Kass 2002: 33)

So, the argument goes, some form of body-self monism rather than dualism is presumed by the doctor-patient relationship and, granted such monism, a decision to commit suicide to benefit oneself is incoherent.

Needless to say, arguments against PAS based upon the character of the doctor-patient relationship have not impressed PAS advocates. The most important difficulties are first, that the doctor-patient relationship is not a timeless ideal but instead a product of the varying cultures in which it occurs. Why ought we to view the traditional Western ideal as dispositive on the matter of PAS? Second, the doctor-patient relationship, however idealized, underdetermines the ethics of medicine at the end of life. It is simply not clear that the imperatives to heal and relieve suffering such as physicians in most (or all?) times and places might acknowledge necessarily proscribe PAS if one does not build such a proscription into those imperatives at the outset (Arras 2001). To their opponents, Kass and Pellegrino appear either to simply stipulate the norms of medicine or else to illicitly derive them from particular extant medical practices.

The DDE

The DDE is essential for physicians wishing to maintain a prohibition on PAS or active euthanasia while conducting medical practice in generally accepted ways, including withholding and withdrawing life-preserving treatment in the terminally ill and relieving pain and suffering when such relief might contribute to patient death. The DDE asserts that acts with similar negative outcomes may sometimes be morally distinguished by whether the negative outcomes are intended or merely foreseen. Formally stated, the DDE holds that acts/omissions with both good and bad outcomes may sometimes be permissible:

1. if the act/omission is itself licit.
2. if the good outcome is the intended outcome.
3. if the bad outcome is neither intended as an end nor as a means to the actor's end.
4. if the (at least permissible) intended end in acting is sufficiently valuable that the bad outcome (a side effect of the act) is tolerable in light of that end.

As with the sanctity of life, the DDE is often considered to issue from religious doctrine, and it is indeed closely associated with Catholic theological

reflection. Its philosophical champions point out, however, that it is an expression of the demands not merely of Catholic religion but of many traditions of serious moral thinking and of ordinary morality (Wiggins 2006: 253–254; Wedgwood 2011: 391). In medicine at the end of life, the DDE permits physicians to withhold or withdraw life-preserving treatment while avoiding a description of those acts as the active killing of patients, in spite of the fact that death is among the outcomes of treatment withdrawal. In withholding or withdrawing treatment the physician invoking the DDE intends not the patient's death but relief of a burden imposed by the treatment or avoidance of imposing that burden while tolerating the foreseen side effect of the patient's death. Thus according to the DDE, withholding and withdrawing life-preserving treatments, if intended as burden relief, may be properly described as acts of burden relief that have the side effect of allowing the patient's disease to end her life.

Consequentialist and Non-consequentialist Assessment of the DDE

Thoroughgoing consequentialists, naturally, will have none of the DDE.[3] As what matters about acts are their outcomes, the distinction between intended effects and side effects is simply contrived. Actors are similarly responsible for all of the effects of their actions, and there are no distinctions to be drawn between their morally important effects for purposes of assigning agency. The DDE is simply a smokescreen for obscuring consequentialist judgments. In the case of physician care for patients at the end of life, physicians often judge a patient's death to be preferable to continued life under treatment. They invoke the DDE to disguise from themselves that bringing about the patient's death is the best description of what they are doing when they administer life-ending pain relief or withdraw life-preserving treatment (Rachels 1986: 93–96; Singer 1993: 209–210; Harris 1995: 36–39). Of course if one grants the consequentialist premise that only outcomes matter in act description and assessment, this analysis readily follows.

Most bioethicists have not been able to accept the counterintuitive results of the consequentialist assimilation of intended and unintended but foreseen effects of action as that account offers no means of distinguishing agency in pairs of cases that strike most as morally very different. Such pairs of cases typically contrast scenarios in which the outcomes are similar but in which agent intention figures differently in producing those outcomes. The pairs of cases might include the following:

Terror vs. Strategic Bomber. The strategic bomber intends to destroy the munitions factory but foresees that deaths of innocent civilians will also result from his bombing. The terror bomber intends the deaths of innocent civilians as a means to hasten the end of the war.

Trolley vs. Bridge. In trolley, a trolley is on a track headed toward five people confined to the track who will die if the trolley continues unimpeded; the actor may switch the trolley to another track where one person confined will die. In bridge, the trolley is headed down a track toward five but on top of a bridge above the track is a fat man whose body would stop the trolley. The actor has the option of pushing the fat man off the bridge onto the track in the path of the oncoming trolley to save the five.

Craniotomy vs. Hysterectomy. In craniotomy a fetus in the birth canal threatens the life of the mother; the doctor, aiming at saving the mother's life, crushes the fetus's skull to remove the fetus from the birth canal. In hysterectomy, the gravid uterus is cancerous and the doctor must remove it to save the mother's life.

In pairs of cases like these, although the outcomes are similar, most judge the respective acts in strategic bomber, trolley, and hysterectomy to be permissible while the analogous acts in terror bomber, bridge, and craniotomy are not (or are less so). That is, in the first case of each of the three pairs one may act to produce a good effect while foreseeing harm. In the second case of each pair it is not (or less) permissible to act intending harm as a means to one's legitimate end.

The DDE would appear to be well suited to distinguish the cases in these pairs. In each pair, the plausibly permissible case is one of seeking a legitimate end while causing an unintended harmful effect. The good end is not produced directly by means of the harmful effect and the end is important enough to permit the harmful effect. In the contrasting case in each pair, the harmful effect is a direct means to the good end.

Although non-consequentialist philosophers generally view the cases in pairs like these to be morally distinguishable, many deny that the DDE can do the work required to distinguish them. Attacks have focused on whether intending harms as means to benefits is actually impermissible and, perhaps more fundamentally, on whether intended and merely foreseen harms can be consistently and reliably distinguished if a sufficiently broad account of intention is in play. The latter point has been pressed by James Rachels, Judith Thomson, Alison McIntyre, and, more recently, Thomas Scanlon. All suggest that absurd consequences follow from holding the moral permissibility of actions to turn on the intentions of individual actors. On the other hand, if intention is construed sufficiently broadly, then the distinction between intended and foreseen in the important cases disappears (McIntyre 2001: 242–247). Scanlon argues the inadequacy of actor intentions for underwriting act permissibility using the case "prime minister," in which the prime minister of a country at war is asked to decide whether to bomb a munitions factory when civilian casualties

in the area surrounding the factory may be anticipated (Scanlon 2009: 19–20). According to the DDE as per Scanlon, the permissibility of the bombing will turn on whether the pilot intends the deaths of the civilians—which seems highly implausible.

If intentions have a decisive role in determining the permissibility of actions with good and bad effects, it would also seem to follow that actors could manipulate the permissibility of such actions by simply aiming their intentions at the good effect and away from the bad effect. Thomson posits a dying patient in pain so severe that the dose of morphine required to relieve the pain will also kill the patient. Is administering that dose permissible? According to the DDE, the answer is yes if the doctor intends only relief of pain and no if the doctor intends the patient's death (Thomson 1999: 514–515). But Thomson suggests that the permissibility of this or any act ought to follow from facts about the act, not about the state of mind of the actor. Intentions have a bearing on whether an act may be virtuous or vicious for an actor; they have none on whether a given act is morally permissible. Thomson and Scanlon hold that differences between the pairs of cases such as those earlier, which the DDE has been wrongly taken to illuminate, are actually accounted for by other principles.

Others are reluctant to jettison the importance of intentions to the moral assessment of acts and defend variants of the DDE as attacked by Scanlon and Thomson. The suggestion is that the importance of intentions to the moral assessment of acts is built into our morality—it is simply not plausible that intentions may be dispensed with in the moral assessment of acts (Wedgwood 2011: 391–392). Much of criminal law presumes that intention can either partly constitute offences (e.g., murder) or aggravate them. And in ordinary life we are concerned not merely with what is done but also with the spirit and intention of an actor's doing. The DDE simply voices what ordinary morality demands of actors faced with situations in which acting will produce both positive and negative outcomes: when it is permissible that innocents be the victims of acts performed for good ends, it cannot be that they become so through the actor's use of them to attain the good end. Thus while the corvette commander may depth-charge the U-boat to save the convoy, incidentally killing survivors in the water, he may not save the convoy by an agreement with the U-boat commander that the convoy will be spared if the U-boat commander is permitted to machine-gun the survivors in the water (Wiggins 2006: 250).

Ralph Wedgwood, Jeff MacMahan, and David Wiggins suggest that the costs of giving up the DDE are too high, in spite of the challenges presented to it by DDE skeptics, such as Thomson and Scanlon. An alternative response to Thomson and Scanlon is offered by FitzPatrick, who suggests that they have misconstrued the DDE at the outset. The DDE does not speak to the intentions

of particular agents; it is directed instead at specifying what intentions would be acceptable in any agent performing a given action in a good cause. In the case of the pilot flying the mission against the munitions plant, the function of the DDE is not to affirm or condemn the actions of pilots flying the mission with differing intentions. It is merely to deem the mission permissible because a pilot could fly the mission seeking victory in the just war without being involved in bad intentions (as a tactical, but not as a terror bomber). The criticisms of Thomson and Scanlon are evaded by construing the DDE not as a constraint on act justification operating through scrutiny of individual actor intention; the DDE instead warrants acts through the specification of intentions with which any actor might permissibly perform an action in a good cause (FitzPatrick 2013).[4]

The Medical Context

Most liberal non-consequentialist philosophers who defend the DDE would nevertheless deny that it prohibits PAS or active euthanasia in terminally ill patients in the right circumstances—that is, if such patients' lives had become burdensome to them and they wished for aid in dying. The suggestion would be that the DDE does not bear on such cases; death for such terminally ill patients is not a negative outcome and there is therefore no difficulty with intending a patient's death while acting in such a way as to bring it about. Or, if the DDE does bear, it might actually be held to prefer acting while intending death to acting while merely foreseeing it—as the moral significance of intending rather than foreseeing harm would reverse if the outcome were beneficial rather than harmful. Jeff McMahan suggests an analogous result for the DDA, as does Robert Young (Young 2007: 96). That is, one should prefer bringing about death actively to doing so passively in terminally ill patients when death would benefit them. If the DDA is valid and death is beneficial rather than harmful, active euthanasia should be more imperative than passive euthanasia (McMahan 2002: 461).[5] As in the case of the DDA, physicians who invoke the DDE to distinguish acceptable withdrawal of support or terminal sedation from unacceptable active euthanasia do so from a determination that their role forbids their participation in killing (Sulmasy and Pellegrino 1999). As we have seen, that conclusion follows from considerations about human life or about human life as exhibited in the patient role in relation to the physician role. Even if one grants physician opponents of PAS the premise that patient death at physician hands is a negative outcome if a result of active physician agency, however, PAS opponents must contend with a more elaborated version of the attack on the DDE through the posited manipulability of intentions as per Thomson mentioned earlier: the so-called problem of closeness.

The DDE and the Problem of Closeness

According to some opponents of the DDE, if the distinction between intending and foreseeing can be morally meaningful in cases such as strategic bomber, it can be similarly meaningful in cases such as terror bomber and, thus, permit acts such as terror bombing that the DDE is meant to block. The thought is that a sophisticated terror bomber can make use of the DDE if he simply aims his intention away from the deaths of civilians as means to achieving the end of the war; what is necessary for terrorizing the enemy population is not civilian deaths; it is merely the widespread conviction on the enemy side that civilians have died. This will come to pass if motionless civilian bodies are observed in the rubble of the bombing; that is all that is necessary to achieve the terror bomber's end and that is all that the sophisticated terror bomber intends. That civilians will be killed in the course of producing dead-appearing bodies in the rubble is, for this terror bomber, a regrettable necessity that he foresees but does not intend. The sophisticated terror bomber has fixed his intentions solely on the good aspects of his action's outcome, which may then be deemed intended; the bad aspects of the outcome can be relegated to side effects (Bennett 1995: 210–213).

If the DDE blesses the action of sophisticated terror bomber, principled distinctions between outcomes intended and those merely foreseen would appear to be impossible. A physician opposed to PAS who disconnects a terminally ill patient's ventilator may say to herself that she intends only relief of the burden of the ventilator and not the killing of her patient. But then the greedy nephew disconnecting his rich uncle's ventilator may intend only his own receipt of his uncle's bequest; he may view his uncle's death as a mere side effect of his action aimed at getting the bequest.[6] If we convict the nephew of intending his uncle's death, because his action is "too close" to killing his uncle for that act to be deemed unintended, must we not also convict the physician of intending her patient's death, whatever she may say? Either intentions are sufficient to determine morally relevant act descriptions, in which case actors can justify acts the DDE would usually be held to condemn; or natural facts determine proper act description, in which case actors are condemned for acts we generally seek to excuse through the DDE.

Possible Ways Forward from the Problem of Closeness

It is unclear that there is, at present, a way out of the DDE's problem of closeness. The difficulty arises through the question of how one picks the appropriate description of an act for moral assessment by the DDE. DDE opponents suggest two alternatives, both of which present difficulties. One is to accept an actor's view of her act as regards what is intended and what foreseen. This

leads to implausible results. The sophisticated terror bomber in bombing civilians intends only motionless bodies in the rubble, not dead civilians. His act is therefore bombing-while-intending-motionless-bodies-but-not-civilian-deaths. Thus his "act itself" is licit, meeting the first condition of the DDE. Even if one goes on to disqualify the sophisticated terror bomber's act by the DDE's proportionality condition, this conclusion as to the apposite moral description of the sophisticated terror bomber's act seems wrong.

Yet the alternative approach to apposite act description is no less problematic for the DDE. If one holds that certain alternative act descriptions are "too close" to what the actor is doing to be deemed unintended no matter that said descriptions are said to be unintended by the actor, there is no clear way to exempt analogous act descriptions from being deemed intended in the case of those actors whose actions we wish the DDE to deem licit—strategic bomber, bystander in trolley, and hysterectomy doctor. In each case, the action just is, respectively, killing civilians, killing the one, or killing the fetus in spite of actor intentions otherwise.

Attempts by the DDE's defenders to cope with the problem of closeness divide over their view of the apposite description of acts for moral assessment by the DDE. A minority are willing to bite the bullet of an actor-determined view of apposite act description. More often, following Anscombe (Anscombe 2005), defenders seek a principled way to deem some action descriptions "too close" to what an actor ostensibly intends to be deemed unintended for purposes of moral act assessment. Finally, some defenders of the DDE similarly insist on a role for natural facts in determining apposite act description but find the problem of closeness to be intractable. These discussants seek to replace the traditional DDE with other principles that would do similar work without depending upon a distinction between outcomes intended and those merely foreseen.

Actors Determine Morally Apposite Act Descriptions

The problem of closeness does not arise for John Finnis because actors doing evil while directing their intentions away from said evil fall foul not of the DDE but of constraints on producing evil as a side effect of one's intended act. Finnis argues for an actor-determined view of apt description of intentional actions. So the sophisticated terror bomber may be said to really intend only motionless bodies in the rubble and not the deaths of the civilians he bombs to hasten the end of the war (Finnis 1991). The DDE, then, does not bear on a comparison between sophisticated terror bomber and strategic bomber, as the difference between them is not one of a negative outcome intended vs. foreseen. The sophisticated terror bomber is condemned independently of the DDE: because it is prohibited, in the circumstances, to produce the evil of dead civilians, even as a side effect, if the only end to be gained by doing so is terror.

Natural Facts Determine Morally Apposite Act Descriptions

Most adherents of the DDE seek to block an exclusively actor-determined construal of what is intended by an act. In the case of the sophisticated terror bomber, their suggestion would often be that bombing-while-intending motionless bodies in rubble is "too close" to bombing-while-intending civilian deaths for there to be a meaningful moral distinction between the two putative intentional acts. For purposes of construing intention they are the same act, because bombing-while-intending motionless bodies in rubble just is bombing-while-intending civilian deaths. The sophisticated terror bomber is trying to decompose an intention and attach himself to a subpart of it while repudiating the remainder; but the intention in question, the DDE adherent maintains, resists such decomposition as the candidate subparts are "too close" to be pulled apart. The strategic bomber has no such difficulty because bombing-while-intending the destruction of the munitions factory is far enough apart from bombing-while-intending civilian deaths that the one act need not be equated to the other, so that civilian deaths resulting from strategic bombing can be classed as side effects rather than intended effects.

While this approach to the problem of closeness has a good deal of intuitive appeal, the difficulty is in specifying the distinction between acts "too close" to be separated in intention by an actor and those sufficiently far apart to permit such separation. Thomas Cavanaugh argues that this distinction follows straightforwardly from a sufficiently rigorous theory of intention. He considers cases such as craniotomy doctor and sophisticated terror bomber and contends that an adequate theory of intention, such as Michael Bratman's, implies that each of these actors intends harm whereas hysterectomy doctor and strategic bomber do not. Bratman suggests that intention involves volitional commitment to a plan encompassing means and ends. In craniotomy and terror bomber, the deaths of the fetus and of civilians figure as means in the respective actors' plans. In hysterectomy and strategic bomber they do not (Cavanaugh 2006: 112–117). The problem of closeness, then, does not arise. The difficulty for Cavanaugh's contention, as Dana Nelkin and Samuel Rickless point out, is that intentions to harm in craniotomy doctor and sophisticated terror bomber do not follow from Bratman's theory without a stipulation the theory does not make: the equation of destroying the fetus's head and bombing civilians until they are motionless with harm (Nelkin and Rickless 2015). That is, it must be held that each of these actions just is harming. Yet if that is so, the actions of hysterectomy doctor and strategic bomber must be similarly harmful vis-à-vis the fetus and the civilians—as in each case their action also just is killing the fetus and the civilians. The problem of closeness is back.

William FitzPatrick suggests that the closeness problem can be surmounted by distinguishing constitutive and causal relations of acts to outcomes (FitzPatrick 2006). If a given act merely causes an outcome, the outcome may be unintended. If an act constitutes an outcome, then the outcome is too close to the act to be unintended. So being rendered motionless in the rubble of bombing constitutes being killed; if the first is the intended aim, then so is the second, whereas bombing while aiming at the destruction of a munitions factory may cause civilian deaths but said bombing doesn't constitute those deaths. It is therefore intelligible to consider civilian deaths in strategic bomber as side effects rather than intended effects.

Natural Facts Determine Apposite Act Descriptions and the Resultant Problem of Closeness Is Intractable

Warren Quinn argued that there was no clear way to distinguish outcomes of acts intended from those foreseen and that a cogent DDE could not be founded upon the intended vs. foreseen distinction (Quinn 1989). His suggestion was to modify the DDE, removing its dependence on distinguishing intended from foreseen outcomes. Quinn's DDE focuses instead on the relation between actor intention and the harms conveyed to victims of acts having both good and bad outcomes. The DDE should be taken to prefer, ceteris paribus, harmful indirect agency (harm conveyed by an act to victims incidental to the actor's project) to harmful direct agency (harm conveyed to victims through victims' deliberate involvement in the actor's project). For Quinn, sophisticated terror bomber is morally suspect compared to strategic bomber because his civilian victims are part of his terror-producing project, whereas strategic bomber's victims, which similarly count as intended, are completely incidental to the mission of bombing the munitions factory.

A variant of Quinn's solution to the closeness problem has recently been defended by Dana Nelkin and Samuel Rickless (Nelkin and Rickless 2014). The difficulty with Quinn's tack is that it solves the closeness problem by redirecting the DDE away from its original target, the wrongness of intending harm or evil as such. Many of the DDE's defenders would like to say that the special wrongness of sophisticated terror bomber is not intending harm as part of a project but simply intending (rather than merely foreseeing) harm. Quinn's strategy shares the weakness of other patient rather than agent-centered accounts of deontological constraints: of failing to acknowledge the force of a constraint not merely against evil happening but also against one's own participation in it.[7] It is indeed worse to intend evil deliberately than incidentally, but the moral force of the DDE follows from its condemnation of intending evil, simpliciter.

Other Possibilities for Addressing the Problem of Closeness

Recently some have suggested the possibility of a middle position between the actor-determined and natural facts-determined view of morally apposite act

description for purposes of act assessment by the DDE. The suggestion is that neither actor intentions nor natural facts suffice to specify what an act "just is" in a given context. Instead, act descriptions for purposes of scrutiny by the DDE are generated by normative standards.

One such suggestion is that of Ralph Wedgwood. Wedgwood (2011) shares Finnis's view that actor intentions determine morally apt descriptions of intentional acts. In contrast to Finnis, however, Wedgwood suggests that the DDE compares not acts producing intended vs. foreseen evil (as construed by the actor) but instead intended vs. foreseen bad states of affairs (considered agent neutrally). So while the sophisticated terror bomber intends only motionless bodies in the rubble, this state of affairs in our world is also civilian deaths, and is, hence, bad. The strategic bomber intends the munitions factory's destruction and produces the same number of civilian deaths as sophisticated terror bomber. Both bombers produce similarly bad states of affairs as regards civilian deaths, but one is intended and the other only foreseen. So the DDE holds strategic bomber's act to be so far preferred to sophisticated terror bomber's. The problem of closeness appears to be averted by moving from act descriptions as determined by actor construals to descriptions as mandated by agent-neutral standards of goodness and badness.

The other suggestion here is that the normative standards determining apt act descriptions for scrutiny by the DDE are not those of an impersonal scheme of agent-neutral values but instead the standards of relevant human practices or conventions.[8] It is in the context of these practices that acts take on their moral significance and, hence, their proper descriptions. Actors intend as they do when they act, but what they are doing (the apposite act description for purposes of the DDE) is not determined by reference either to their mental states or to what they do purely as a matter of natural facts. Terror bombing, in the context of just war theory and practice, is an illicit act. Seen in that light, no matter what the terror bomber's intentions it fails the first condition of the DDE, that an act be licit in itself. Married to FitzPatrick's gloss on the DDE, that it is intended to pass judgment not on individual actors' act tokens but on act types, this approach yields a particular understanding of the DDE's first provision: the act itself—that is, the act as characterized by the norms that bear on the actor in the human practice(s) in which the act is situated—must be licit.

It is human practices or conventions, on this view, that determine not only the morally apposite description of an act but also how lines may be drawn between intended and foreseen outcomes of given acts for purposes of the DDE. In medicine, the physician need not intend death when disconnecting the terminally ill patient's ventilator. The greedy nephew who disconnects his rich uncle's ventilator cannot be held not to intend his uncle's death. The difference follows from the norms that bear on the physician and on the nephew. Applied to the DDA, the approach would hold that lines between doing and allowing

(or between killing and allowing-to-die) are similarly dependent upon practice norms. The approach is broadly consonant with an increasingly large body of research suggesting that our ascriptions of both causation and intention are value-laden.[9] It holds, its champions suggest, the promise of intelligible lines between intended and foreseen that can avoid the problem of closeness and so far vindicate the DDE.

Conclusion

The past forty years has seen an increase both in philosophical acceptance of suicide and in skepticism of argumentative strategies often used to maintain a prohibition on suicide while permitting some acts that have one's own death as an outcome: the DDA and the DDE. Defenders of the DDE and DDA are likely now a minority among moral philosophers (McMahan 2009: 345). Both "doctrines" continue, however, to be vigorously defended in current discussion. Physicians, most of whom would deny PAS to be a necessary aspect of their role, have not (yet?) been deprived of these particular avenues for defending common medical practices while proscribing PAS and active euthanasia. That said, physicians opposed to PAS are on the defensive as to their reluctance to countenance physician participation in PAS. Positions upholding human life's inviolability ("sanctity" is falling out of currency) have lost ground in the past forty years of philosophical discussion even if far less so in U.S. medical practice. While the prospects of PAS in the United States policy arena remain murky, it is generally favored in philosophical if not in medical discussion. Lines of philosophical resistance may emerge in discussions of philosophical anthropology, in particular in bioethical debates over the nature and implications of personhood. The character of personhood as exhibited in the patient role may prove a fruitful starting point for developing a better account of the implications of assisted suicide for physicians than we now possess.

Related Topic

Chapter 10, "Refusing Lifesaving Medical Treatment and Food and Water by Mouth" by Paul T. Menzel

Notes

1. The state at which this point is reached varies in the writings of Kantian theorists. The mere prospect of loss of rational agency is enough for Thomas Hill, Jr. David Velleman suggests that a patient tyrannized by pain or who finds pain unbearable might be at the requisite point. Michael Cholbi, who argues that neither pain nor the prospect of dementia robs patients of Kantian dignity, suggests that that dignity is sufficiently compromised for suicide to be an option in the patient who is so

depressed as to have lost all interest in her own well-being and happiness. (See Hill 1983; Velleman 1999; Cholbi 2010.)

2. Of course the generalization obscures various complexities. Polling suggests that U.S. physician support of PAS availability in recent years has been up to the 50% range, although far fewer physicians express a willingness to participate. U.S. medical organizations are and have been unanimously opposed to PAS with the recent exceptions of the Oregon and California Medical Associations. The Oregon Medical Association took a position of neutrality on the 1994 ballot measure to legalize assisted suicide in Oregon but reversed itself three years later. The California Medical Association announced a policy of neutrality on PAS legalization in California in May 2015. In spite of vigorous challenges to medical prohibitions on PAS, there is still a consensus at the level of recommendations by influential medical organizations that PAS is impermissible. That consensus relies on the use of the DDA and the DDE in distinguishing PAS and active euthanasia from withdrawal of support and terminal sedation. (See Truog et al. 2008.)
3. That is, consequentialists committed exclusively to maximizing the good as a moral measure of human action. Those preferring "satisficing" to maximizing or who avoid maximizing by introducing into consequentialism a distinction between positive and negative duties would demur from the view attributed in this paragraph (e.g., Slote and Petit 1984).
4. A similar critique of Scanlon is offered by Stuchlik (2012). Stuchlik suggests a distinction between permissibility (of acts independently of actors) and liceity (what a given actor can permissibly do); the DDE is about the former rather than the latter.
5. Frances Kamm, who accepts the DDA but rejects the DDE, argues for a physician duty to provide PAS from more general physician duties to seek greater medical goods for patients in spite of producing at the same time lesser medical evils. In the case of terminally ill patients for whom death would be a benefit, acting while intending the patient's death is not morally different from similarly acting while merely foreseeing it (Kamm 2007: 150, 153–154).
6. This case is Dan Brock's. (See Brock 1992: 10–12.)
7. For a discussion of agent and patient-centered accounts of deontological constraints, see Alexander and Moore (2015).
8. The general approach to the DDE suggested in the paragraphs ahead is taken by Chappell (2013). A similar approach to the DDA in the context of medicine is suggested by Huddle (forthcoming).
9. The seminal experimental work suggesting that intention ascriptions are often value-laden was done by Joshua Knobe (2003). For a recent summary of the development of this line of research and attempts to explain its results, see Alfano and Loeb (2014: 2.3). Judgments that given acts are doings or allowings are similarly affected by moral appraisals. (See Cushman et al. 2008.)

References

Alexander, L. and M. Moore (2015) "Deontological Ethics," in E.N. Zalta (ed.) *The Stanford Encyclopedia of Philosophy*, URL = <http://plato.stanford.edu/archives/spr2015/entries/ethics-deontological/>.

Alfano, M. and D. Loeb (2014) "Experimental Moral Philosophy," in E.N. Zalta (ed.) *The Stanford Encyclopedia of Philosophy*, URL = <http://plato.stanford.edu/archives/sum2014/entries/experimental-moral/>.

Anscombe, G.E.M. (2005) "Action, Intention, and Double Effect," in M. Geach and L. Gormally (eds.) *Human Life, Action and Ethics: Essays by G.E.M. Anscombe*, Upton Pyne: Imprint Academic, 207–226.

Arras, J. (2001) "A Method in Search of a Purpose: The Internal Morality of Medicine," *Journal of Medicine and Philosophy* 26(6): 643–662.

Battin, M. (2003) "Euthanasia and Physician-Assisted Suicide," in H. LaFollette (ed.) *The Oxford Handbook of Practical Ethics*, Oxford: Oxford University Press, 673–703.

——— (2005) "Is a Physician Ever Obligated to Help a Patient Die?" in M. Battin (ed.) *Ending Life: Ethics and the Way We Die*, Oxford: Oxford University Press, 88–107.

Bennett, J. (1995) *The Act Itself*, Oxford: Clarendon Press.

Brock, D. (1985) "Taking Human Life," *Ethics* 95(4): 851–865.

——— (1992) "Voluntary Active Euthanasia," *The Hastings Center Report* 22(2): 10–22.

——— (1999) "A Critique of Three Objections to Physician-Assisted Suicide," *Ethics* 109(3): 519–547.

Cavanaugh, T.E. (2006) *Double-Effect Reasoning: Doing Good and Avoiding Evil*, Oxford: Clarendon Press.

Chappell, T. (2013) "What Have I Done?" *Diametros* 38: 86–112.

Cholbi, M. (2010) "A Kantian Defense of Prudential Suicide," *Journal of Moral Philosophy* 7: 489–515.

——— (2011) *Suicide: The Philosophical Dimensions*, Calgary: Broadview Press.

——— (2012) "What Is Wrong with 'What Is Wrong with Rational Suicide,'" *Philosophia* 40: 285–293.

Cushman, F., J. Knobe, and W. Sinnott-Armstrong (2008) "Moral Appraisals Affect Doing/Allowing Judgments," *Cognition* 108: 281–289.

Durkheim, E. (2010) *Suicide: A Study in Sociology*, G. Simpson (ed.), New York: Simon and Schuster.

Dworkin, R. et al. (1997) "Assisted Suicide: The Philosopher's Brief," *New York Review of Books* 44(5): 41–47.

Finnis, J. (1991) "Intention and Side-Effects," in R.G. Frey and C.W. Morris (eds.) *Liability and Responsibility: Essays in Law and Morals*, Cambridge: Cambridge University Press, 32–64.

——— (1993) "The 'Value of Human Life' and 'The Right to Death': Some Reflections on Cruzan and Ronald Dworkin," *Southern Illinois University Law Journal* 17: 559–571.

——— (2004) "Natural Law: The Classical Tradition," in J. Coleman and S. Shapiro (eds.) *The Oxford Handbook of Jurisprudence and Philosophy of Law*, Oxford: Oxford University Press, 1–39.

FitzPatrick, W. (2006) "The Intend/Foresee Distinction and the Problem of 'Closeness,'" *Philosophical Studies* 128: 585–617.

——— (2012) "The Doctrine of Double Effect: Intention and Permissibility," *Philosophy Compass* 7(3): 183–196.

——— (2013) "Intention, Permissibility and Double-Effect," *Oxford Studies in Normative Ethics* 2: 97–126.

Foot, P. (1977) "Euthanasia," *Philosophy and Public Affairs* 6: 85–112.

——— (2002) "Killing and Letting Die," *Moral Dilemmas and Other Topics in Moral Philosophy*, Oxford: Clarendon Press, 79–87.

Gunderson, M. (2004) "A Kantian View of Suicide and End-of-Life Treatment," *Journal of Social Philosophy* 35(2): 277–287.

Harris, J. (1995) "The Philosophical Case against the Philosophical Case against Euthanasia," in J. Keown (ed.) *Euthanasia Examined: Ethical, Clinical and Legal Perspectives*, Cambridge: Cambridge University Press, 36–45.

Hill, T.E. (1983) "Self-Regarding Suicide: A Modified Kantian View," *Suicide and Life-Threatening Behavior* 13(4): 254–275.
Holland, R.F. (1980) "Suicide," in *Against Empiricism: On Education, Epistemology and Value*, Totowa, NJ: Barnes and Noble Books, 143–157.
Huddle, T.S. (forthcoming) "What's a CIED Got to Do with It? The Implications of Deactivating Life-Sustaining CIEDs for the K/ATD Distinction," *Cambridge Quarterly of Health Care Ethics*.
Kagan, S. (1988) "The Additive Fallacy," *Ethics* 99: 5–31.
Kamisar, Y. (1958) "Some Non-Religious Views against Proposed 'Mercy-Killing' Legislation," *Minnesota Law Review* 42(6): 969–1042.
Kamm, F. (1999) "Physician-Assisted Suicide, the Doctrine of Double Effect, and the Ground of Value," *Ethics* 109(3): 586–605.
——— (2007) "Ending Life," in L.P. Francis, A. Silvers, and R. Rhodes (eds.) *The Blackwell Guide to Medical Ethics*, Oxford: Wiley-Blackwell, 142–161.
Kass, L. (2002) "'I Will Give No Deadly Drug': Why Doctors Must Not Kill," in K. Foley and H. Hendin (eds.) *The Case against Assisted Suicide; for the Right to End-of-Life Care*, Baltimore: The Johns Hopkins University Press, 17–40.
Knobe, J. (2003) "Intentional Action and Side Effects in Ordinary Language," *Analysis* 63(3): 190–194.
McIntyre, A. (2001) "Doing Away with Double Effect," *Ethics* 111: 219–255.
McMahan, J. (2002) *The Ethics of Killing: Problems at the Margins of Life*, Oxford: Oxford University Press.
——— (2009) "Intention, Permissibility, Terrorism, and War," *Philosophical Perspectives* 23: 345–372.
Murphy, M. (2001) *Natural Law and Practical Rationality*, Cambridge: Cambridge University Press.
Nelkin, D. and S. Rickless (2014) "Three Cheers for Double Effect," *Philosophy and Phenomenological Research* 89(1): 125–158.
——— (2015) "So Close, Yet So Far: Why Solutions to the Closeness Problem for the Doctrine of Double Effect Fall Short," *Nous* 49: 376–409.
Pellegrino, E. (2001) "The Goals and Ends of Medicine: How Are They to Be Defined?" in R.J. Bulger, J.P. McGovern, and D.P. Sulmasy (eds.) *Physician and Philosopher: The Philosophical Foundation of Medicine: Essays by Dr. Edmund Pellegrino*, Charlottesville, VA: Carden Jennings, 56–65.
Pellegrino, E. and D. Thomasma (1987) "The Conflict between Autonomy and Beneficence in Medical Ethics: Proposal for a Resolution," *Journal of Contemporary Health Law and Policy* 3: 23–46.
Quill, T., R. Dresser, and D. Brock (1997) "The Rule of Double Effect—A Critique of Its Role in End-of-Life Decision-Making," *New England Journal of Medicine* 337: 1768–1771.
Quinn, W. (1989) "Actions, Intentions, and Consequences: The Doctrine of Double Effect," *Philosophy and Public Affairs* 18(4): 334–351.
Rachels, J. (1975) "Active and Passive Euthanasia," *The New England Journal of Medicine* 292: 78–80.
——— (1979) "Killing and Starving to Death," *Philosophy* 54(208): 159–171.
——— (1986) *The End of Life: Euthanasia and Morality*, Oxford: Oxford University Press.
Ramsey, P. (1968) "The Morality of Abortion," in D.H. Labby (ed.) *Life or Death: Ethics and Options*, Seattle: University of Washington Press, 60–93.

Scanlon, T. (2009) *Moral Dimensions*, Cambridge: Harvard University Press.
Shils, E. (1968) "The Sanctity of Life," in D.H. Labby (ed.) *Life or Death: Ethics and Options*, Seattle: University of Washington Press, 2–38.
Singer, P. (1993) "Taking Life: Humans," in P. Singer (ed.) *Practical Ethics*, Cambridge: Cambridge University Press, 175–217.
Slote, M. and P. Petit (1984) "Satisficing Consequentialism," *Proceedings of the Aristotelian Society*, Supplementary Volumes 58: 139–163+165–176.
Stuchlik, J. (2012) "A Critique of Scanlon on Double Effect," *Journal of Moral Philosophy* 9: 178–199.
Sulmasy, D. and E. Pellegrino (1999) "The Rule of Double Effect: Clearing Up the Double Talk," *Archives of Internal Medicine* 159: 545–550.
Sumner, L.W. (2011) *Assisted Death: A Study in Ethics and Law*, Oxford: Oxford University Press.
Thomson, J. (1999) "Physician-Assisted Suicide: Two Moral Arguments," *Ethics* 109(3): 497–518.
Tooley, M. (1994) "An Irrelevant Consideration: Killing versus Letting Die," in B. Steinbock and A. Norcross (eds.) *Killing and Letting Die* (2nd Edition), New York: Fordham University Press, 103–111.
Truog, R.D., M.L. Campbell, J.R. Curtis, C.E. Haas, J.M. Luce, G.D. Rubenfeld, C.H. Rushton, and D.C. Kaufman (2008) "Recommendations for End-of-Life Care in the Intensive Care Unit: A Consensus Statement by the American Academy of Critical Care Medicine," *Critical Care Medicine* 36(3): 953–963.
Velleman, D. (1999) "A Right of Self-Termination?" *Ethics* 109(3): 606–628.
Wedgwood, R. (2011) "Defending Double Effect," *Ratio* 24: 384–401.
Wiggins, D. (2006) *Ethics: Twelve Lectures on the Philosophy of Morality*, Cambridge: Harvard University Press.
Williams, G. (1958) *The Sanctity of Life and the Criminal Law*, London: Faber and Faber.
Woolard, F. (2012) "The Doctrine of Doing and Allowing I: Analysis of the Doing/Allowing Distinction," *Philosophy Compass* 7(7): 448–458.
Young, R. (2007) *Medically Assisted Death*, Cambridge: Cambridge University Press.