

AGAINST THE RIGHT TO DIE¹

ABSTRACT. For some patients, a right to receive euthanasia will not enhance autonomy in the morally relevant sense. Even if these patients choose wisely whether to exercise their right to die, they will still be harmed by having been given it. Perhaps, then, physicians should have permission to administer voluntary euthanasia, but patients should not have a right to receive it.

Key Words: autonomy, euthanasia, Kant, paternalism

In this paper I offer an argument against establishing a right to die, but I do not consider how my argument fares against countervailing considerations, and so I do not draw any final conclusion on the subject. The argument laid out in this paper has certainly inhibited me from favoring a right to die, and it has also led me to recoil from many of the arguments offered for such a right. But I am very far from an all-things-considered judgment.

My argument is addressed to a question of public policy – namely, whether the law or the canons of medical practice should include a rule requiring, under specified circumstances, that caregivers honor a patient's request to be allowed or perhaps even helped to die. This question is distinct from the question whether anyone is ever morally entitled to be allowed or helped to die. I believe that the answer to the latter question is yes, but I doubt whether our moral obligation to facilitate some people's deaths is best discharged through the establishment of an institutional right to die.

I

Although I believe in our obligation to facilitate some deaths, I want to dissociate myself from some of the arguments that are frequently offered for such an obligation. These arguments, like

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many arguments in medical ethics, rely on terms borrowed from Kantian moral theory – terms such as ‘dignity’ and ‘autonomy’. Various kinds of life-preserving treatment are said to violate a patient’s dignity or to detain him in an undignified state; and the patient’s right of autonomy is said to require that we respect his competent and considered wishes, including a wish to die. There may or may not be some truth in each of these claims. Yet when we evaluate such claims, we must take care not to assume that terms like ‘dignity’ and ‘autonomy’ always express the same concepts, or carry the same normative force, as they do in a particular moral theory.

When Kant speaks, for example, of the dignity that belongs to persons by virtue of their rational nature, and that places them beyond all price (Kant, 1964, p. 102), he does not seem to be invoking anything that requires the ability to walk unaided, to feed oneself, or to control one’s bowels. Hence the dignity invoked in discussions of medical ethics – a status supposedly threatened by physical deterioration and dependency – cannot be the status whose claim on our moral concern is so fundamental to Kantian thought. We must therefore ask whether this other sort of dignity, whatever it may be, embodies a value that’s equally worthy of protection.

My worry, in particular, is that the word ‘dignity’ is sometimes used to dignify, so to speak, our culture’s obsession with independence, physical strength, and youth. To my mind, the dignity defined by these values – a dignity that is ultimately incompatible with *being cared for* at all – is a dignity not worth having.²

I have similar worries about the values expressed by the phrase ‘patient autonomy’; for there are two very different senses in which a person’s autonomy can become a value for us. On the one hand, we can obey the categorical imperative, by declining to adopt any maxim that could not rationally be endorsed by the party affected by our action – that is, by the patient. What we value in that case is the patient’s *capacity* for self-determination, and we value it in a particular way – namely, by according it *respect*. We respect the patient’s autonomy by regarding his hypothetical participation in our decisionmaking as a constraint on what decisions we permit ourselves to reach.

On the other hand, we can value the patient’s autonomy by making it our goal to maximize his effective options. What we value, in that case, is not the patient’s capacity but his *opportunities*

for self-determination – his having choices to make and the means with which to implement them; and we value these opportunities for self-determination by regarding them as *goods* – as objects of desire and pursuit rather than respect.

These two ways of valuing autonomy are fundamentally different. Respecting people's autonomy, in the Kantian sense, is not just a matter of giving them effective options. To make only those decisions in which others could rationally join is not necessarily to give *them* actual decisions to make, nor is it to give them the means to implement their actual decisions. Indeed, a decision to leave decisions, and the means of implementing them, in other people's hands is sometimes a decision in which they could *not* rationally join, for reasons that I shall presently examine.

As with the term 'dignity', then, we must not assume that the term 'autonomy' is always being used in the sense made familiar by Kantian moral theory; and we must therefore ask ourselves what sort of autonomy is being invoked, and whether it is indeed something worthy of our moral concern. I believe that, as with the term 'dignity', the answer to the latter question may be no in some cases, including the case of the right to die.

II

A moral entitlement to be allowed or helped to die is less likely to flow from principles of autonomy or respect, in my opinion, than from principles of simple benevolence. I strongly believe that a person's life can sometimes be made worse by being prolonged, and that a swift and painless death can then be a benefit (Velleman, 1991). I also believe that the harm of continuing to live can sometimes be sufficiently grave that causing or even allowing someone to undergo it would be morally wrong; or, conversely, that the benefit of death can sometimes be sufficiently important that providing it is morally obligatory. I therefore believe that someone can be morally entitled to be helped or allowed to die.

Furthermore, I believe that the proper goal of medical science is, not to prolong human life *per se*, but rather to make human life better – often by prolonging it, of course, but also by relieving pain, restoring function, or facilitating natural processes. And I know of no cogent reason why facilitating the process of death, when death would be a benefit, is a less appropriate activity for medical practitioners than that of facilitating the process of birth. I

therefore believe, not only that a patient can have a moral right to passive or even active euthanasia, but also that his physician may be the appropriate person to provide it.

Given my distaste for the 'dignity' with which many people say that they wish to die, I probably favor euthanasia in fewer cases than some members of the medical ethics establishment. But I do favor it, and I do appreciate the moral urgency of providing it to those who are harmed by the prolongation of their lives.

III

How can I think that death is sometimes a benefit to which a person can be morally entitled, and still argue against establishing a right to receive it? My answer, in its most general form, is that not all benefits – not even all morally significant benefits – can or should be secured by institutional rights.

Here a further clarification of 'the right to die' is in order. At present, there are institutional barriers that prevent or at least inhibit physicians from facilitating the deaths of patients to whom death would be a benefit. Since these institutional barriers hinder the provision of what I regard as a morally significant benefit, I am in favor of finding some way to remove them. And one might think that the removal of institutional barriers to morally justified euthanasia could in itself be described as the establishment of an institutional right to die.

Yet what 'the right to die' usually denotes, and what I have accepted it as denoting for the purposes of this paper, is not the mere absence of institutional barriers to justified euthanasia but the presence of an explicitly formulated, positive right to euthanasia, a right vested in patients by law or other institutional rules. Establishing a right to die, in this sense, is only one way of removing the barriers to justified euthanasia, and it is a rather extreme way of removing them. All that need be entailed in removing the barriers to justified euthanasia, strictly speaking, is a permission for caregivers to practice it, with the patient's consent; whereas the right to die would entail not just a permission but a positive obligation to practice euthanasia (or to give way to someone willing to practice it) at the patient's request.

Of course, merely permitting voluntary euthanasia might not guarantee that the benefit of death was provided in every case in which it was morally urgent. Patients' informed and earnest

requests to die may well be the most reliable indicator of when death would be beneficial. Hence merely permitting rather than requiring caregivers to honor such requests would entail allowing for a gap between the need for euthanasia and the supply. What's more, a mere permission would fail to embody any moral rights of self-determination that patients may have in respect to their own deaths, since merely permitting voluntary euthanasia would still leave the ultimate decision in the hands of the caregiver rather than the patient.

But placing the decision in the hands of the patient is precisely what I am going to argue against. What is problematic about the right to die, in my opinion, is precisely that feature by virtue of which it exceeds a mere permission for caregivers to practice voluntary euthanasia – namely, that it gives the option of euthanasia directly to patients.

IV

Yet how can I oppose giving the option of euthanasia to patients? One way, of course, would be to argue that giving this option to patients, even under carefully defined conditions, would commit us to assisting in some deaths that would not in fact be beneficial (Kamisar, 1970). But the argument that interests me does not depend on this strategy. My worry about the right to die is not that some patients might mistakenly choose to die when they would be better off living.

In order to demonstrate that I am not primarily worried about mistaken requests to die, I shall assume, from this point forward, that patients are infallible, and that euthanasia would therefore be chosen only by those for whom it would be a benefit. Even so, I believe, the establishment of a right to die would harm many patients, by increasing their autonomy in a sense that is not only un-Kantian but also very undesirable.

This belief is sometimes expressed in public debate, although it is rarely developed in any detail. Here, for example, is Yale Kamisar arguing against "Euthanasia Legislation":

Is this the kind of choice ... that we want to offer a gravely ill person? Will we not sweep up, in the process, some who are not really tired of life, but think others are tired of them; some who do not really want to die, but who feel they should not live on, because to do so when there looms the legal alternative of

euthanasia is to do a selfish or a cowardly act? Will not some feel an obligation to have themselves “eliminated” ... (Kamisar, 1970)?

Note that these considerations do not, strictly speaking, militate against euthanasia itself. Rather, they militate against a particular decision procedure for euthanasia – namely, the procedure of placing the choice of euthanasia in the patient’s hands. What Kamisar is questioning in this particular passage is, not the practice of helping some patients to die, but rather the practice of asking them to choose whether to die. The feature of legalized euthanasia that troubles him is precisely its being an option offered to patients – the very feature for which it’s touted, by its proponents, as an enhancement of the patients’ autonomy. Kamisar’s remarks thus betrays the suspicion that this particular enhancement of one’s autonomy is not to be welcomed.

But what exactly is the point of Kamisar’s rhetorical questions? The whole purpose of giving people choices, surely, is to allow those choices to be determined by their reasons and preferences rather than ours. Kamisar may think that finding one’s life tiresome is a good reason for dying whereas thinking that others find one tiresome is not. But if others honestly think otherwise, why should we stand in their way? Whose life is it, anyway?

V

A theoretical framework for addressing this question can be found in Thomas Schelling’s book *The Strategy of Conflict* (1960), and in Gerald Dworkin’s paper ‘Is more choice better than less?’ (1982). These authors have shown that our intuitions about the value of options are often mistaken, and their work can help us to understand the point of arguments like Kamisar’s.

We are inclined to think that, unless we are likely to make mistakes about whether to exercise an option (as I am assuming we are not), the value of having the option is as high as the value of exercising it and no lower than zero. Exercising an option can of course be worse than nothing, if it causes harm. But if we are not prone to mistakes, then we will not exercise a harmful option; and we tend to think that simply *having* the unexercised option cannot be harmful. And insofar as exercising an option would make us better off than we are, having the option must have made us better off than we were before we had it – or so we tend to think.

What Schelling showed, however, is that having an option can be harmful even if we do not exercise it and – more surprisingly – even if we exercise it and gain by doing so. Schelling's examples of this phenomenon were drawn primarily from the world of negotiation, where the only way to force one's opponent to settle for less may be by proving that one doesn't have the option of giving him more. Schelling pointed out that in such circumstances, a lack of options can be an advantage. The union leader who cannot persuade his members to approve a pay-cut, or the ambassador who cannot contact his head-of-state for a change of brief, negotiates from a position of strength; whereas the negotiator for whom all concessions are possible deals from weakness. If the rank-and-file give their leader the option of offering a pay-cut, then he may find that he has to exercise that option in order to get a contract, whereas he might have gotten a contract without a pay-cut if he had not had the option of offering one. The union leader will then have to decide whether to take the option and reach an agreement or to leave the option and call a strike. But no matter which of these outcomes would make him better off, choosing it will still leave him worse off than he would have been if he had never had the option at all.

Dworkin has expanded on Schelling's point by exploring other respects in which options can be undesirable. Just as options can subject one to pressure from an opponent in negotiation, for example, they can subject one to pressure from other sources as well. The night cashier in a convenience store doesn't want the option of opening the safe – and not because he fears that he'd make mistakes about when to open it. It is precisely because the cashier would know when he'd better open the safe that his having the option would make him an attractive target for robbers; and it's because having the option would make him a target for robbers that he'd be better off without it. The cashier who finds himself opening the safe at gunpoint can consistently think that he's doing what's best while wishing that he'd never been given the option of doing it.

Options can be undesirable, then, because they subject one to various kinds of pressure; but they can be undesirable for other reasons, too. Offering someone an alternative to the status quo makes two outcomes possible for him, but neither of them is the outcome that was possible before. He can now choose the status quo or choose the alternative, but he can no longer *have* the status

quo without *choosing* it. And having the status quo by default may have been what was best for him, even though choosing the status quo is now worst. If I invite you to a dinner party, I leave you the possibilities of choosing to come or choosing to stay away; but I deprive you of something that you otherwise would have had – namely, the possibility of being absent from my table by default, as you are on all other evenings. Surely, preferring to accept an invitation is consistent with wishing you had never received it. These attitudes are consistent because refusing to attend a party is a different outcome from *not* attending without having to refuse; and even if the former of these outcomes is worse than attending, the latter may still have been better. Having choices can thus deprive one of desirable outcomes whose desirability depends on their being unchosen.

The offer of an option can also be undesirable because of what it expresses. To offer a student the option of receiving remedial instruction after class is to imply that he is not keeping up. If the student needs help but doesn't know it, the offer may clue him in. But even if the student does not need any help, to begin with, the offer may so undermine his confidence that he will need help before long. In the latter case, the student may ultimately benefit from accepting the offer, even though he would have been better off not receiving it at all.

Note that in each of these cases, a person can be harmed by having a choice even if he chooses what's best for him. Once the option of offering a concession has undermined one's bargaining position, once the option of opening the safe has made one the target of a robbery, once the invitation to a party has eliminated the possibility of absence by default, once the offer of remedial instruction has implied that one needs it – in short, once one has been offered a problematic choice – one's situation has already been altered for the worse, and choosing what's best cannot remedy the harm that one has already suffered. Indeed, choosing what's best in these cases is simply a way of cutting one's losses.

Note, finally, that we cannot always avoid burdening people with options by offering them a second-order option as to which options they are to be offered. If issuing you an invitation to dinner would put you in an awkward position, then asking you whether you want to be invited would usually do so as well; if offering you the option of remedial instruction would send you a message, then so would asking you whether you'd like that

option. In order to avoid doing harm, then, we are sometimes required, not only to withhold options, but also to take the initiative for withholding them.

VI

Of course, the options that I have discussed can also be unproblematic for many people in many circumstances. Sometimes one has good reason to welcome a dinner invitation or an offer of remedial instruction. Similarly, some patients will welcome the option of euthanasia, and rightly so. The problem is how to offer the option only to those patients who will have reason to welcome it. Arguments like Kamisar's are best understood, I think, as warning that the option of euthanasia may unavoidably be offered to some who will be harmed simply by having the option, even if they go on to choose what is best.

I think that the option of euthanasia may harm some patients in all of the ways canvassed above; but I will focus my attention on only a few of those ways. The most important way in which the option of euthanasia may harm patients, I think, is that it will deny them the possibility of staying alive by default.

Now, the idea of surviving by default will be anathema to existentialists, who will insist that the choice between life and death is a choice that we have to make every day, perhaps every moment.³ Yet even if there is a deep, philosophical sense in which we do continually choose to go on living, it is not reflected in our ordinary self-understanding. That is, we do not ordinarily think of ourselves or our fellows as continually rejecting the option of suicide and staying alive by choice. Thus, even if the option of euthanasia won't alter a patient's existential situation, it will certainly alter the way in which his situation is generally perceived. And changes in the perception of a patient's situation will be sufficient to produce many of the problems that Schelling and Dworkin have described, since those problems are often created not just by *having* options but by *been seen* to have them.

Once a person is given the choice between life and death, he will rightly be perceived as the agent of his own survival. Whereas his existence is ordinarily viewed as a given for him – as a fixed condition with which he must cope – formally offering him the option of euthanasia will cause his existence thereafter to be viewed as his doing.

The problem with this perception is that if others regard you as choosing a state of affairs, they will hold you responsible for it; and if they hold you responsible for a state of affairs, they can ask you to justify it. Hence if people ever come to regard you as existing by choice, they may expect you to justify your continued existence. If your daily arrival in the office is interpreted as meaning that you have once again declined to kill yourself, you may feel obliged to arrive with an answer to the question 'Why not?'

I think that our perception of one another's existence as a given is so deeply ingrained that we can hardly imagine what life would be like without it. When someone shows impatience or displeasure with us, we jokingly say 'Well, excuse me for living!'. But imagine that it were no joke; imagine that living were something for which one might reasonably be thought to need an excuse. The burden of justifying one's existence might make existence unbearable – and hence unjustifiable.

VII

I assume that people care, and are right to care, about whether they can justify their choices to others. Of course, this concern can easily seem like slavishness or neurotic insecurity; but it should not be dismissed too lightly. Our ability to justify our choices to the people around us is what enables us to sustain the role of rational agent in our dealings with them; and it is therefore essential to our remaining, in their eyes, an eligible partner in cooperation and conversation, or an appropriate object of sympathy and respect.

Retaining one's status as a person among others is especially important to those who are ill or infirm. I imagine that when illness or infirmity denies one the rewards of independent activity, then the rewards of personal intercourse may be all that make life worth living. To the ill or infirm, then, the ability to sustain the role of rational person may rightly seem essential to retaining what remains of value in life. Being unable to account for one's choices may seem to entail the risk of being perceived as unreasonable – as not worth reasoning with – and consequently being cut off from meaningful intercourse with others, which is life's only remaining consolation.

Forcing a patient to take responsibility for his continued exist-

ence may therefore be tantamount to confronting with the following prospect: unless he can explain, to the satisfaction of others, why he chooses to exist, his only remaining reasons for existence may vanish.

VIII

Unfortunately, our culture is extremely hostile to any attempt at justifying an existence of passivity and dependence. The burden of proof will lie heavily on the patient who thinks that his terminal illness or chronic disability is not a sufficient reason for dying.

What is worse, the people with whom a patient wants to maintain intercourse, and to whom he therefore wants to justify his choices, are often in a position to incur severe financial and emotional costs from any prolongation of his life. Many of the reasons in favor of his death are therefore likely to be exquisitely salient in their minds. I believe that some of these people may actively pressure the patient to exercise the option of dying. (Students who hear me say this usually object that no one would ever do such a thing. My reply is that no one would ever do such a thing as abuse his own children or parents – except that many people do.)

In practice, however, friends and relatives of a patient will not have to utter a word of encouragement, much less exert any overt pressure, once the option of euthanasia is offered. For in the discussion of a subject so hedged by taboos and inhibitions, the patient will have to make some assumptions about what they think and how they feel, irrespective of what they say (See, Schelling, 1984). And the rational assumption for him to make will be that they are especially sensible of the considerations in favor of his exercising the option.

Thus, even if a patient antecedently believes that his life is worth living, he may have good reason to assume that many of the people around him do not, and that his efforts to convince them will be frustrated by prevailing opinions about lives like his, or by the biases inherent in their perspective. Indeed, he can reasonably assume that the offer of euthanasia is itself an expression of the attitudes that are likely to frustrate his efforts to justify declining it. He can therefore assume that his refusal to take the option of euthanasia will threaten his standing as a rational person in the eyes of friends and family, thereby threatening the

very things that make his life worthwhile. This patient may rationally judge that he's better off taking the option of euthanasia, even though he would have been best off not having the option at all.

Establishing a right to die in our culture may thus be like establishing a right to duel in a culture obsessed with personal honor. If someone defended the right to duel by arguing that a duel is a private transaction between consenting adults, he would have missed the point of laws against duelling. What makes it rational for someone to throw down or pick up a gauntlet may be the social costs of choosing not to, costs that result from failing to duel only if one fails to duel by choice. Such costs disappear if the choice of duelling can be removed. By eliminating the option of duelling (if we can), we eliminate the reasons that make it rational for people to duel in most cases. To restore the option of duelling would be to give people reasons for duelling that they didn't previously have. Similarly, I believe, to offer the option of dying may be to give people new reasons for dying.

IX

Do not attempt to refute this argument against the right to die by labelling it paternalistic. The argument is not paternalistic – at least, not in any derogatory sense of the word. Paternalism, in the derogatory sense, is the policy of saving people from self-inflicted harms, by denying them options that they might exercise unwisely. Such a policy is distasteful because it expresses a lack of respect for others' ability to make their own decisions.

But my argument is not paternalistic in this sense. My reason for withholding the option of euthanasia is not that others cannot be trusted to exercise it wisely. On the contrary, I have assumed from the outset that patients will be infallible in their deliberations. What I have argued is – not that people to whom we offer the option of euthanasia might harm themselves – but rather that in offering them this option, *we* will do them harm. My argument is therefore based on a simple policy of non-maleficence rather than on the policy of paternalism. I am arguing that we must not harm others by giving them choices, not that we must withhold the choices from them lest they harm themselves.

X

I have been assuming, in deference to existentialists, that a right to die would not alter the options available to a patient but would, at most, alter the social perception of his options. What would follow, however, if we assumed that death was not ordinarily a genuine option? In that case, offering someone the choice of euthanasia would not only cause his existence to be perceived as his responsibility; it would actually cause his existence to *be* his responsibility for the first time. And this new responsibility might entail new and potentially burdensome obligations.

That options can be undesirable because they entail obligations is a familiar principle in one area of everyday life – namely, the practice of offering, accepting, and declining gifts and favors. When we decline a gift or a favor that someone has spontaneously offered, we deny him an option, the option of providing us with a particular benefit. And our reason for declining is often that he could not have the option of providing the benefit without being obligated to exercise that option. Indeed, we sometimes feel obligated, on our part, to decline a benefit precisely in order to prevent someone from being obligated, on his part, to provide it.⁴ We thus recognize that giving or leaving someone the option of providing a benefit to us may be a way of harming him, by burdening him with an obligation.

When we decline a gift or favor, our would-be benefactor sometimes protests in language similar to that used by proponents of the right to die. 'I know what I'm doing' he says, 'and no one is twisting my arm. It's my money [or whatever], and I *want* you to have it'. If he's unaware of the lurking allusion, he might even put it like this: 'Whose money is it, anyway?'

Well, it is his money (or whatever); and we do believe that he's entitled to dispose of his money as he likes. Yet his right of personal autonomy in disposing of his money doesn't always require that we let him dispose of it on us. We are entitled – and, as I have suggested, sometimes obligated – to restrict his freedom in spending his money for our benefit, insofar as that freedom may entail burdensome obligations.

The language in which favors are declined is equally interesting as that in which they are offered. What we often say when declining a favor is, 'I can't let you do that for me: it would be too much to ask'. The phrase 'too much to ask' is interesting because it is

used only when we haven't in fact asked for anything. Precisely because the favor in question would be too much to ask, we haven't asked for it, and now our prospective benefactor is offering it spontaneously. Why, then, do we give our reason for not soliciting the favor as a reason for declining when it's offered unsolicited?

The answer, I think, is that we recognize how little distance there is between permitting someone to do us a favor and asking him to do it. Because leaving someone the option of doing us a favor can place him under an obligation to do it, it has all the consequences of asking for the favor. To say 'I'm leaving you the option of helping me but I'm not *asking* you to help' is to draw a distinction without a difference, since options can be just as burdensome as requests.

XI

Clearly, a patient's decision to die will sometimes be a gift or a favor bestowed on loved ones whose financial or emotional resources are being drained by his condition. And clearly, death is the sort of gift that one might well want to decline, by denying others the option of giving it. Yet institutional rules guaranteeing the option of euthanasia would in effect guarantee the option of giving this gift, and they would thereby prevent the prospective beneficiaries from declining it. Establishing a right to die would thus be tantamount to adopting the public policy that death is never too much to ask.

I don't pretend to understand fully the ethics of gifts and favors. It's one of those subjects that gets neglected in philosophical ethics, perhaps because it has more to do with the supererogatory than the obligatory. One question that puzzles me is whether we are permitted to restrict people's freedom to benefit us in ways that require no active participation on our part. Someone cannot successfully give us a gift, in most cases, unless we cooperate by taking it into our possession; and denying someone the option of giving us a gift usually consists in refusing to do our part in the transaction. But what about cases in which someone can do us a good turn without any cooperation from us? To what extent are we entitled to decline the favor by means of restrictions on his behavior rather than omissions in ours?

Another question, of course, is whether we wouldn't, in fact,

play some part in the deaths of patients who received socially sanctioned euthanasia. Would a medically assisted or supervised death be a gift that we truly took no part in accepting? What if 'we' – the intended beneficiary of the gift – were society as a whole, the body that established the right to die and trained physicians in its implementation? Surely, establishing the right to die is tantamount to saying, to those who might contemplate dying for the social good, that such favors will never be refused.

These considerations, inconclusive though they are, show how the theoretical framework developed by Schelling and Dworkin might support remarks like Kamisar's about patients' "obligation to have themselves 'eliminated'". The worry that a right to die would become an obligation to die is of a piece with other worries about euthanasia, not in itself, but as a problematic option for the patient.

XII

As I have said, I favor euthanasia in some cases. And of course, I believe that euthanasia must not be administered to competent patients without their consent. To that extent, I think that the option of dying will have to be presented to some patients, so that they can receive the benefit of a good death.

On the basis of the foregoing arguments, however, I doubt whether policymakers can formulate a general definition that distinguishes the circumstances in which the option of dying would be beneficial from those in which it would be harmful. The factors that make an option problematic are too subtle and too various to be defined in a statute or regulation. How will the option of euthanasia be perceived by the patient and his loved ones? How will it affect the relations among them? Is he likely to fear being spurned for declining the option? Would he exercise the option merely as a favor to them? And are they genuinely willing to accept that favor? Sensitivity to these and related questions could never be incorporated into an institutional rule defining conditions under which the option must be offered.

Insofar as I am swayed by the foregoing arguments, then, I am inclined to think that society should at most permit, and never require, health professionals to offer the option of euthanasia or to grant patients' requests for it. We can probably define some conditions under which the option should never be offered; but

we are not in a position to define conditions under which it should always be offered; and so we can at most define a legal permission rather than a legal requirement to offer it. The resulting rule would leave caregivers free to withhold the option whenever they see fit, even if it is explicitly and spontaneously requested. And so long as caregivers are permitted to withhold the option of euthanasia, patients will not have a right to die.

XIII

Let me offer one further reflection. The foregoing arguments make me worry even about an explicitly formulated permission for the practice of euthanasia, since an explicit law or regulation to this effect would already invite patients, and hence potentially pressure them, to request that the permission be exercised in their case. I feel most comfortable with a policy of permitting euthanasia by default – that is, by a tacit failure to enforce the institutional rules that currently serve as barriers to justified euthanasia, or a gradual elimination of those rules without fanfare. The best public policy on euthanasia, I sometimes think, is no policy at all.

This suggestion will surely strike some readers as scandalous, because of the trust that it would place in the individual judgment of physicians and patients. But I suspect that to place one's life in the hands of another person, in the way that one does today when placing oneself in the care of a physician, may simply be to enter a relationship in which such trust is essential, because it cannot be replaced or even underwritten by institutional guarantees. Although I do not share the conventional view that advances in medical technology have outrun our moral understanding of how they should be applied, I am indeed tempted to think they have outrun the capacity of institutional rules to regulate their application. I am therefore tempted to think that public policy regulating the relation between physician and patient should be weak and vague by design; and that insofar as the aim of medical ethics is to strengthen or sharpen such policy, medical ethics itself is a bad idea.

NOTES

¹ This paper began as a comment on a paper by Dan Brock, presented at the Central Division of the APA in 1991. See *The Hastings Center Report* 1992, 22, March/April, 10–22. For comments on the ideas presented here, I am indebted to Brock, Elizabeth Anderson, David Hills, Yale Kamisar, and Patricia White.

² Here I echo some excellent remarks on the subject by Felicia Ackerman (Ackerman, 1990).

³ The *locus classicus* for this point is of course Camus' essay 'The myth of Sisyphus' (Camus, 1959).

⁴ Of course, there are many other reasons for declining gifts and favors, such as pride, embarrassment, or a desire not to be in someone else's debt. My point is simply that there are cases in which these reasons are absent and a very different reason is present – namely, our desire not to burden someone else with obligations.

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