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Is medically assisted death a special obligation?

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ABSTRACT

Several distinct arguments conclude that terminally ill patients have a right to a medically assisted death; two are especially influential: the autonomy argument and the non-harm argument. Both have proven convincing to many, but not to those who view the duty not to kill as an (almost) absolute constraint. Some philosophers see the source of such a constraint in general (deontological) moral principles, other in the nature of the medical profession. My aim in this paper is not to add one further argument in favour of medically assisted death. Rather, I want to shed light on a kind of reason that, to my mind, has not been previously highlighted or defended, and that might shake the principled conviction that doctors are never allowed to actively assist their patients to die. Specifically, my purpose is to show that doctors (as members of the medical profession) have a special duty to provide medically assisted death to consenting terminally ill patients, because (and insofar as) they have been participants in the process leading to the situation in which a patient can reasonably ask to die. In some specific ways (to be explained), they are involved in the tragic fate of those patients and, therefore, are not morally allowed to straightforwardly refuse to assist them to die.

Several distinct arguments conclude that terminally ill patients have a right to a medically assisted death; two are especially influential: the autonomy argument and the non-harm argument.[1–3] Both have proven convincing to many, but not to those who view the duty not to kill as an (almost) absolute constraint. Some philosophers see the source of such a constraint in general (deontological) moral principles, other in the nature of the medical profession.

My aim in this paper is not to add one further argument in favour of medically assisted death. Rather, I want to shed light on a kind of reason that, to my mind, has not been previously highlighted or defended, and that might shake the principled conviction that doctors are never allowed to actively assist their patients to die. The existence of such kind of reason does not amount to a full-fleshed, independent, argument, and is not applicable to every possible case of medically assisted death, but it does apply to many relevant cases and can supplement and reinforce other, more traditional, arguments. Specifically, my purpose is to show that doctors (as members of the medical profession) have a special duty to provide medically assisted death to consenting terminally ill patients, because (and insofar as) they have been participants in the process leading to the situation in which a patient can reasonably ask to die. In some specific ways (to be explained), they are involved in the tragic fate of those patients and, therefore, are not morally allowed to straightforwardly refuse to assist them to die.

The argument I want to advance takes as a starting point the non-harm argument. After some preliminary clarifications (see sections Preliminary clarifications and Is death harmful for hopelessly ill patients?), I briefly introduce the non-harm argument, and explain what is right about it, and, at the same time, why it can be disputed, appealing either to general deontological reasons or to reasons concerning the nature of the medical profession. In the PAD as a special obligation towards the hopelessly ill patients section, I develop my argument, trying to show that it can, at least in many cases, provide plausible moral reasons to debunk the deontological constraint against medically assisted death (which is, in fact, a deontological constraint against killing). In the Objections section, I address several possible objections, with the hope that my answers will help to clarify the content and scope of my argument. A brief conclusion closes the paper.

PRELIMINARY CLARIFICATIONS

Some preliminary clarifications are in order. First, I will make no distinction between medically assisted suicide and active euthanasia, that is, between providing a terminally ill patient the means necessary to commit suicide and directly causing the death of the patient by, for example, inoculating a lethal substance. I use 'physician-assisted death' (hereafter PAD) to refer to both. PAD contrasts with an alternative behaviour, accepted by most philosophers as morally permissible (and most jurisdictions as legal): the withdrawal of medical treatment, including life-support measures (as respiration, hydration and nutrition) in terminally ill patients.[i]

Second, some clarification about the kind of patient that, on my view, qualifies for PAD. So far, I have used the expression 'terminally ill patients'. According to the usual sense of this expression, a terminally ill patient is one facing imminent death who *may or may not* be suffering severely. Non-terminally ill patients, on the other hand, do not face imminent death, but may be suffering with no hope of recovery (this is the case of long-lasting diseases like amyotrophic lateral sclerosis or multiple systems atrophy). In my view, the imminence of death is not essential for the discussion of PAD. What is essential is whether the patient has any

[i]For the view that withdrawing life-support measures is a case of withdrawing medical treatment, see ref. 4. As will be evident below, my argument will also give support to medical practices similar to PAD, as, for example, terminal sedation or 'palliated starvation' (for a defence of this kind of measure see ref. 5). Still, there may be other reasons against these options, but I do not want to consider them here.

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hope of recovery and whether that patient is experiencing severe suffering. I will assume that both conditions must be met in order to qualify for PAD. To avoid misunderstandings, I will use, stipulatively, the expression 'hopelessly ill patient.'[ii] A hopelessly ill patient is one who has no hope of recovery *and* is in a situation of severe physical and/or psychological suffering. A non-hopelessly ill patient, instead, has reasonably good hopes of recovery or is not in a situation of physical and/or psychological suffering. Admittedly, the distinction is controversial, since there are many intermediate states. Still, I will assume that there are some clear cases, and I will be referring to these in my argument.

Third, I will always be assuming that PAD is performed with the consent of the patient. The discussion of cases in which the patient is unable to give consent, which includes the debate about PAD in children, is a very difficult one and goes beyond the scope of this paper.[iii] Still, I must say that the reason in favour of PAD I advocate here does in fact apply to cases in which there is no consent. The requirement of consent must therefore be defended on independent grounds.

Finally, while my discussion will be conducted on the ethical/moral level, my aim is to provide a moral reason that can contribute to justifying a legal right to PAD, and to the incorporation of PAD as a practice belonging to the medical profession.

IS DEATH HARMFUL FOR HOPELESSLY ILL PATIENTS?

Opponents of PAD often accept that refusal of treatment is a basic right of all patients (both hopelessly ill and non-hopelessly ill patients). This right is not based on the idea that maintaining the treatment causes a harm to the patient, or that death is a benefit for them. In fact, this might not even be the case, especially in non-hopelessly ill patients. Rather, the right is based on a more basic right to physical integrity, that is, the right not to have one's body invaded without consent.[iv]

In addition to the physician's duty to respect this right to physical integrity, there is a further duty that opponents of PAD usually defend as well: the almost absolute (or at least very strong) duty to not actively kill an innocent person, regardless of whether she wishes to die. This duty explains why, according to these philosophers, PAD should not be allowed, even if consented to. This in fact is the very same reason we find the prohibition against killing a *non*-hopelessly ill patient on request, as well as the prohibition against assisted suicide and homicide on request in general, to be morally plausible.[v]

Assuming the existence of these two duties (the duty not to invade the patient's body without her consent and the duty not to kill), opponents of PAD seem to have a general, consistent picture about the professional duties involved in life and death decisions: consensual removal of treatment in both hopelessly ill and non-hopelessly ill patients is morally permissible, or even required (and, therefore, should be legal), whereas assisting death in both hopelessly ill patients (PAD) and non-hopelessly ill patients or healthy persons (assisted suicide and killing on request) is morally impermissible (and, therefore, should be illegal).

It is at this point that the non-harm argument enters the fray, by insisting that, from the point of view of the patient, the continuation of life in conditions of hopeless illness can constitute a harm. It is true that, as I said, according to the opponents of PAD, this harm is not what justifies the removal of treatment in hopelessly ill patients. It is also true that in non-hopelessly ill patients, the duty to remove (or not to begin) treatment persists, even in cases where surviving is clearly beneficial. But for hopelessly ill patients, who suffer from an incurable and debilitating disease, accompanied by extreme physical and psychological suffering, the continuation of life itself can be considered, at least in some cases, to be a harm. Let us call a 'harmful life' a life that is harmful to the person who lives that life. By this expression I do not mean that it is life, strictly speaking, that is harmful. Neither do I mean that such a life is full of harm or that it only contains harmful experiences. What I mean is that the balance of positive and negative experiences of life is negative for that person. This implies that dying is, for that person, a net benefit, in comparison to remaining alive (including remaining alive under the best available palliative care).

It is important to stress that the fact that the patient sees her own life as a harmful life is a necessary condition for a life to be harmful, but not a sufficient one. The judgement that life is, under the circumstances, worse than death, should also be an objectively reasonable one. This is certainly controversial. One might argue that whether life is harmful or not is a purely subjective matter, and that nobody has the authority to say that the life of a patient is worse than death. However, the claim is less controversial than it seems, in my view. An objective standard of reasonableness is usual in the assessment of harms. It works not as a device to replace the victim's judgement (which is always a necessary condition), but to protect the victim from her own thoughtless or irrational decision.[vi]

In cases in which a patient, despite medical treatment, ends up in a harmful life condition, doctors seem to hold two potentially conflicting moral duties: the duty not to actively kill the patient they are treating, on the one hand, and the duty to stop an ongoing harm, namely, the patient's harmful life, on the other. Once the patient is in a harmful life condition, the withdrawal of treatment may be sufficient to cause the patient's death. In those cases, the duties are mutually compatible. But when the patient cannot die by herself or by the mere withdrawal of treatment, the duties seem to be in conflict. It is worth noting that, to some extent, the discussion on the legalisation of PAD, at least in some countries, has taken place around this conflict. Assuming consent as a necessary requirement, the discussion has been whether the duty to relieve the patient from an unbearable suffering is stronger than the duty not to kill.[vii]

[ii]This concept broadly follows the condition for PAD included in art. 2.1.b of the Dutch 'Termination of Life on Request and Assisted Suicide (Review Procedures) Act', according to which the doctor must hold the conviction that the 'patient's suffering was lasting and unbearable'.

[iii]See refs.6, 7 for the debate on PAD in children.

[iv]For a forceful defence of the right to refuse or interrupt treatment in non-hopelessly ill patients, see ref. 4. They cite several legal cases in the USA, in which such a right has been provided: to patients with gangrene, to Jehovah's Witnesses and others.

[v]There is a 'consistent' liberal position, according to which assisted suicide and homicide on request should not be, in general, legally forbidden. But defenders of PAD, even those who appeal to the autonomy argument, do not usually hold this view. See ref. 3, trying to explain why the autonomy argument does not apply to non-hopelessly ill patients.

[vi]The case of patients in a permanent vegetative state is special, because we cannot say that they are suffering and it is not obvious that death is beneficial for them. Still, they seem to be plausible candidates for PAD. I do not want to discuss this point here, but I am inclined to think that remaining alive is harmful for these patients, at least in the sense that, their life being of such kind that it lacks any meaning, it is a perfectly reasonable decision to ask for PAD by way of an advance directive. For discussion on this issue, see ref. 8.

[vii]For the discussion in the Netherlands, see ref. 9.

Still, one might think that the conflict is not real, appealing to the following argument (the non-harm argument): consider first why doctors have a duty not to kill (non-hopelessly ill) patients, even at their request. One plausible reason that has been advanced is that doctors have a more general duty: the duty not to harm patients. Note that, just as it is impermissible for a doctor to kill a non-hopelessly ill patient (or a healthy person) at the patient's (or person's) request, it is equally impermissible for a doctor *to harm* a patient at her request. If a healthy person, even if fully competent, goes to a surgeon in order to have one leg amputated or both eyes removed, the surgeon would not be allowed to proceed.[viii] However, as we have seen, in the case of hopelessly ill patients (or at least of some of them) death is *not* a harm. On the basis of this premise, some philosophers have argued that the asymmetry between killing and letting die does not hold in the case of hopelessly ill patients, since death is not a harm and the underlying asymmetry is between harming and allowing harm.[10–12] Therefore, there is no conflict between the general duty not to kill and the duty to avoid harm: killing (with consent) a hopelessly ill patient may be (at least in some cases) not a way of harming, but, on the contrary, a way to *avoid* harm.

The argument, however, is less powerful than it might seem. Claiming that killing a hopelessly ill patient is not harmful (or that it is even beneficial) is ambiguous. Killing might be, on balance, not harmful, but it might, at the same time, be, *pro tanto*, harmful. Therefore, even in cases where the outcome of the balance between harm and benefit is that death is a benefit (all things considered), that reason may still work (at least from a deontological perspective) as a decisive reason against killing.[ix] In fact, deontologists typically defend the possibility of moral prohibitions to act, despite the acts being, in some cases, all things considered, beneficial. This objection shows that, even if the main reason against killing is that killing is a kind of harm, we cannot infer that killing a hopelessly ill patient is not wrong from the premise that it is not (all things considered) harmful. The point must be a normative, substantive, one.[14]

Even if the objection is right, it seems that the substantive argument needed is not difficult to provide. The reason is that the substantive (deontological) position we should endorse in order to defend the prohibition of PAD seems highly doubtful, even for deontologists. It is certainly true that deontologists believe that we are not allowed to actively harm (eg, kill) a person in order to achieve an overall benefit or prevent a more serious overall harm (eg, harming one to prevent more instances of the same harm in other persons). It is more difficult to defend the position that it is impermissible to harm one person (with her consent) in order to prevent that *same* person from suffering a more serious harm. For example, a deontologist may well deny that I may cut off one of John's legs in order to prevent five other people from having their legs cut off (or even from suffering a more serious harm). It seems less plausible to defend the position that I am not allowed (with his consent) to cut off John's leg in order to prevent *John* from suffering a more serious harm (such as death). If, for a hopelessly ill patient, life is, all things considered, harmful for him/her, and death is the only way to avoid that harm, then the fact that killing is always *pro tanto* wrong seems to be an insufficient basis for the deontological prohibition against killing.

Still, one might argue that the reason against killing is different from the reason against harming, or that it is a special kind of harming. Even if a hopelessly ill patient is in a harmful life condition, the *pro tanto* reason against killing (against producing this special kind of harm) might trump other reasons, like relief from suffering. Imagine that I find a person in a desert who is dying in extreme pain; I cannot help her in any way. She desperately asks me to kill her, which, under the circumstances, is the most beneficial thing to do. I might still reject her request, with the argument that killing an innocent human being is morally impermissible.[x]

This kind of deontological reason against killing can be strengthened by considerations internal to medical ethics. According to this view (inspired in the Hippocratic Oath), the medical profession, by its own nature, is incompatible with doctors killing their patients, even when death is an overall benefit for them. According to Leon Kass, for example, '[f]or the physician, at least, human life in living bodies commands respect and reverence—by its very nature. […] The deepest ethical principle restraining the physician's power is not the autonomy or freedom of the patient; neither is it his own compassion of good intention. Rather, it is the dignity and mysterious power of human life itself […]'.[16] In a similar vein, Daniel Callahan argues that killing cannot be part of the medical practice, because the desire to die is not a matter of health. Doctors are not in the business of evaluating the quality of life of their patients or the question of the meaning of life. This goes beyond the proper scope of the medical profession.[17]

In sum, the situation thus far seems to be the following: the fact that death can be, all things considered, beneficial for the patient can be a strong reason for PAD. But it must be a reason of compassion or beneficence. According to many opponents of PAD, this is insufficient, because there is an absolute constraint against killing, which is founded on the value of human dignity and (or) the nature of medical profession. It is not my purpose to assess or discuss these arguments against PAD.[18] Whatever their value, my aim in the following sections is to defend the existence of a strong reason in favour of providing PAD and of considering PAD to be (contra Kass and Callahan) part of the medical practice.

PAD AS A SPECIAL OBLIGATION TOWARDS THE HOPELESSLY ILL PATIENTS

One way to debunk the strong deontological stance against killing is to oppose the negative duty involved (the duty not to kill) with a special positive duty. Even for deontologists, special duties may compete with and displace general negative duties.

There are two relevant kinds of special duties to distinguish in this context.[xi] On the one hand, doctors have special duties in the sense of role-based duties. The doctor-patient special

[viii]There are difficult cases, though. For example, it is discussed whether doctors are allowed to amputate persons with body dysmorphic disorder or with body integrity identity disorder. Without taking a position on this issue, it seems to me that, if we defend the permission to proceed in these cases, it is because we think the person is, in a recognisable sense, not healthy. Accordingly, the amputation would be a medical procedure. Thanks to an anonymous reviewer for making me aware of this kind of case.

[ix]I understand '*pro tanto* harmful' in the sense of being a harm that provides a genuine moral reason against it, even in cases where, all things considered, the outcome is not harmful.[13]

[x]For this position, see ref. 15, where Gorsuch defends what he calls 'inviolability-of-life view' (see pp. 163–166).

[xi]For the distinction between different kinds of special duties and correlative rights, see ref. 19. I use 'duty' and 'obligation' as synonymous.

relationship is the source of several special duties and rights, which define crucial aspects of the medical profession. On the other hand, special duties or obligations may arise when we perform certain kinds of actions. Promising brings about the special obligation to perform the promised action, harming brings about the obligation to compensate, etc. Both kinds of special duties often combine: a father may have special duties towards his child because of the parental role and some special duties towards his child because he promised her something. Interestingly, sometimes both kinds of duties are mutually reinforcing, as when the father has an especially strong obligation to repair the harm he inflicted to his child.

Let us explore what kinds of special duties are involved in the case of doctors dealing with hopelessly ill patients. If the life of a hopelessly ill patient is harmful, one relevant question is: who (if anyone) bears responsibility for that harm? There is a (special) sense, in which, at least in many cases, the situation of a harmful life can be (partially) attributed to medical treatment itself. Medicine saves and prolongs life, but at the risk of placing patients in a harmful life condition. Of course, I am not speaking of doctors who contribute to that harm intentionally or negligently. The kind of responsibility I am highlighting here holds also in cases in which doctors are not morally responsible (in the sense of being blameworthy) for the harmful life condition of patients. Even in these cases, doctors may still bear responsibility, in the sense of being required to stop or undo a harm to whose existence they have contributed. The underlying general idea is that, when I perform actions intending to benefit a person, and such actions (after producing a benefit for some time) end up placing that person in a worse position than she would be without my intervention, I have a special duty to free her from such a worse situation and place her (insofar as it is possible) at least as well off as she would have been without my intervention.

The general structure of the interaction between the doctor (or the medical institution) and the patient can be schematised as follows. Suppose that there are four states that you can be in: A, B, C and D. For you, A is better than B, B better than C and C better than D. You are now in B and, unless I act in some specific way X, you will fall into C. According to the special relationship we have, I have the duty to help you avoid C, and assist you in achieving the best state, A. Therefore, I perform X. Unfortunately, X (in conjunction with your underlying condition and other factors) causes your health to decline into state D. Now you are in D. I can perform an action Y that places you at C. Do I have the special obligation to perform Y, if you consent that I do so? Remember that D is harmful in comparison to C (C is the condition you would have been in had I not performed X). By doing Y, I will simply be avoiding (or stopping) part of the harm I caused you by doing X. Even assuming that my entire intention was to help you by doing X, it seems that I have a strong moral reason to perform Y, that is, to stop the harm to which I causally contributed. Note that this is the case, even if my doing X, before resulting in your fall into D, had temporarily benefitted you, for example, by allowing you to achieve A for a while (or by prolonging B). Once this temporary benefit elapses and you fall into D, a condition that is worse than the condition you would be in had I not done X (condition C), I do have the special obligation to avoid, interrupt or undo such a harm (D) by placing you at C.

In my view, the doctor-patient relationship, in cases of PAD, has this general structure, at least in many cases. In order to cure a disease, doctors sometimes contribute to producing a condition that is even worse than death (harmful life). In those cases, they have the special obligation to prevent or stop such a condition and return the patient to the situation she would have been in without their intervention.

Examples outside the medical realm may also support the same conclusion. Imagine again that I can rescue a person from death in a desert, although the probability of saving her is not high. Without my aid, she would die very quickly and painlessly from a severe head wound. With my best intentions, I try to save her. I cure her wound, stop the bleeding and infection. Now she is feeling better. She can now live for a long time. However, I unexpectedly find out that I cannot remove her from the desert, and there, she will unavoidably experience a long and painful death. She then asks me to kill her. I think she has a right against me to assist her to die because I have the duty to undo the harm I inflicted on her by placing her in a condition that is worse than the condition she would be in had I not intervened. Compare this situation with a similar one, in which I simply find someone dying a long and painful death in the desert and cannot save her. If that person asks me to kill her, I might appeal to the deontological constraint against killing, even if death would be a benefit for her. That kind of reason, however, is not available for me in the first scenario: since I myself put the person in a harmful life position, I have the special duty to free her from it.

In essence, the situation in which a hopelessly ill patient asks for PAD is structurally similar to the first desert scenario, because it follows the general structure I delineated above. If we think that there is a special duty in those non-medical examples, we should think the same for the case of PAD. In both cases, it seems that the deontological duty not to kill *a willing person*, even when killing prevents an all things considered harm, must be an agent-relative or agent-centred duty. The moral reason operating behind this duty is not based on a right held by the potential 'victim', but on features of the agent and his action. As I said before, sometimes this kind of unconditional duty is defended very broadly, as a duty that every human being has towards other human beings. Sometimes, it is conceived of rather as a duty that is inherent to the medical profession: doctors are not in the business of killing. Whatever the merits of these arguments, this kind of agent-relative reason against killing must yield when killing is the only way to undo or interrupt a harm that *the agent herself* has inflicted (or has contributed to producing), even if she is not to blame for that harm and has acted in a perfectly justified way. In these cases, the patient holds a right to the remedy, that is, to be freed from the harm, *against* the doctor. And it seems that agent-relative or even role-relative duties are weaker than, and displaced by, a duty correlative to a right held by the patient.

OBJECTIONS

It might be objected that, if my argument is correct, it should also apply to non-hopelessly ill patients. For example, a patient suffering a severe, but recoverable, depression might consider her life harmful; therefore, the doctor would have the special obligation to assist her to die, or to kill her on request. This, so goes the objection, would be counterintuitive and conflict with the accepted premise, that, in cases of non-hopelessly ill patients (or healthy persons), the mere desire to die does not grant doctors the moral right to assist in suicide or to kill on request (although they would be required to withdraw treatment on request of this patient).

The answer to this argument is that there is a significant difference between non-hopelessly ill patients (or healthy persons) and hopelessly ill patients in the following respect: In the case

of hopelessly ill patients, the decision to end one's life because it is harmful is a reasonable one, at least in some cases; in the case of non-hopelessly ill patients, on the other hand, it is not. The depressed patient, insofar as she is mentally competent, has a right to refuse treatment, but this is not because we consider it a reasonable decision, but because we recognise a right to refuse medical intervention, *despite* the fact that her decision may be unreasonable, on the basis of a right to physical integrity. The right to physical integrity (and, therefore, to refuse treatment) only requires that the patient be mentally competent, but it does not require that the decision be objectively reasonable. The right to PAD, on the other hand, if it is going to be sufficiently strong to override an agent-relative duty against killing, must meet the stronger requirement of being objectively reasonable. When we accept the refusal of treatment in hopelessly ill patients, on the other hand, two reasons converge. First, we respect (as with the non-hopelessly ill patient) the right to refuse any medical treatment. Second, withdrawing treatment prevents or interrupts a harm: that of continuing to exist in a miserable condition. When stopping treatment does not cause death, the second reason remains unfulfilled. At least when the harm of continuing to live under such conditions has (partially) been produced by the medical treatment, there is a reason to actively stop such harm.

A further objection is that my argument unduly depends on a highly contingent and arguably irrelevant premise: that the situation of harmful life is the consequence of medical treatment. But patients might fall into that condition spontaneously, by way of accident, and it does not seem that this bears any weight on the permissibility of performing PAD. However, in the vast majority of cases, people do not fall into a harmful life condition spontaneously. Without any medical intervention, people normally die as a consequence of serious illness or accident. It is medicine that saves and prolongs their lives. In the Netherlands, where PAD is a legal practice, about 75% of people who request PAD are patients with cancer, who have presumably undergone medical life prolonging treatment for years.[xii] Nevertheless, it is not my purpose to argue that doctors are *always* responsible for the situations of hopelessly ill patients who ask for PAD. My point is that, even if there are cases in which medical treatment has not participated in creating the situation of hopeless suffering, the medical community, as social institution, cannot defend a blanket rejection of killing as a component of its professional obligations, because there are many cases, in which medical treatment is directly involved in creating harmful life conditions. Despite the best intentions that doctors surely have, and despite the temporary improvements that they may effect in the health of their patients, they have the professional obligation to stop or avert the harms to whose creation they have contributed.

Still, it follows from my argument that, if we compare the (realistic) situation of harmful life, where the patient suffers that condition as a consequence of medical treatment, with an (unlikely) situation, in which the patient suffers that condition spontaneously, the patient in the former situation has, at least from the moral point of view, a stronger right to be assisted to die. And this seems plausible to me. Killing a person experiencing extreme physical suffering who has not undergone any medical treatment (eg, someone who has been seriously hurt in war) would perhaps be morally permissible (for reasons of mercy), but not as a medical act and not as something that this person would have a right to receive *from* doctors.

The argument can also be objected to as contingent in a different sense. If my argument is right, it seems that the special obligation to provide PAD would only be held by the treating physician, not by others.[xiii] This implies that the right to PAD would be highly dependent on whether the treating physician is available (assuming we can easily identify a responsible doctor in the case of complex medical treatments). The answer to this concern hinges on a general question, which transcends the specific topic of this paper: the identity of the 'agent' responsible for the consequences of medical practice. I would advocate the idea that professional obligations are held collectively by the medical community as a whole, as it is understood that, once a doctor accepts membership in the profession, she accepts a kind of collective responsibility towards patients. If this view seems too strong, it stands to reason that a corporate obligation should fall on the entity (say the hospital) that administered the medical treatment, even if the individual physician is not the same. In fact, in cases in which physicians are state employees (or licensed by the state), the distinction between the 'medical profession' and the corporate entity may amount to no difference. But even if this is too strong, at the very least it still seems that the individual physician himself might bear this responsibility, which would override the *pro tanto* duty not to kill. Ultimately, whether this agent-relative duty can percolate up to higher level bodies (the hospital, the healthcare system, the medical profession as a whole, etc) becomes a secondary issue (albeit of enormous importance), which has no bearing on the nature of the special obligation itself.

It is worth stressing that defending a robust collective responsibility by the medical community to provide PAD as a special obligation can have consequences on some relevant connected issues, for example, on conscientious objection. For if the medical profession bears a collective special duty to undo a harm to which one (or more) of its members has contributed, it might be thought to be more difficult to justify conscientious objection by doctors unwilling to perform PAD. I do not want to enter into this difficult issue. Still, I would suggest that my argument is compatible with the possibility of doctors being conscientious objectors, insofar as the medical community can collectively guarantee the provision of PAD to hopelessly ill patients willing to die.[xiv]

The flipside of the previous objection is that it is not only doctors who can bear responsibility for the harmful life of hopelessly ill patients. What about a nurse or a psychologist who helps someone survive a severe (and unrecoverable) depression that then strikes again, or even a normal citizen who resuscitates a person on the street and leaves that person in a hopeless condition? Even pharmacologists and the whole pharmaceutical industry can be causally implicated in the harmful life of many patients. The problem of assigning responsibilities for harmful consequences to which different agents have contributed is always hard, not only in this kind of case.

[xii]According to the Regional Review Committees on Euthanasia, in 2015 there have been 5516 cases of PAD in the Netherlands; 4000 were patients with cancer (73%) (https://www.euthanasiecommissie.nl/uitspraken-en-uitleg/p/p-2015/documenten/publicaties/infographic/infographic-knmg/infographic-knmg/euthanasie-in-cijfers-mei-2016).

[xiii]In fact, my argument has the (in my view, plausible) implication that doctors should be critically involved in PAD. See ref. 12 for the opposite position (that doctors should not be involved). For further discussion on this point in the Netherlands, see ref. 20.

[xiv]For recent discussion on conscientious objection in medicine, see ref. 21.

Still, I would suggest that the responsibility for the consequences of medical treatments should largely be borne by the medical profession. Doctors are, in an important sense, principal agents of medical procedures. Others (nurses, pharmacologists, ordinary citizens) play a secondary, instrumental or incidental role. Decisions on which the best treatment is and how to implement it are made by doctors.

Finally, one might argue that, insofar as medical treatment has provided some benefit to the patient (eg, by allowing a temporary health improvement), the special duty to end the harmful life of the patient is not as clear as my argument assumes. The thrust of my argument relies on the idea that we have the duty to undo a harm we have contributed to producing. But in the case of medical treatments that provide temporary relief, it seems that we should put that benefit on the balance as well. And it is not clear that the result of the medical treatment will always (or mostly) be, all things considered, harmful, even if the patient ends up in a harmful life condition.

However, at least in the context of special relationships, like the doctor-patient one, this is not convincing. Imagine that I (a doctor) can save Bertha's leg from a gangrene with a new, very strong medication M. Bertha takes M and, in that way, remains able to walk for some time. However, in some cases, M produces, as an unavoidable side effect, an unbearable headache after some time. The only way to stop the side effect is to suspend M and administer medicine N. N being ineffective against gangrene, implies that the leg must immediately be amputated. Unfortunately, Bertha gets the headache. Assuming that it is better to live without a leg than to suffer a constant and unbearable headache, it seems obvious that I must administer N to Bertha and amputate, if she consents to it. Where does my obligation come from? In part, the obligation is founded on my responsibility as a doctor to help Bertha to better her health. In this particular case, this might be sufficient to explain my duty. However, there is something more. The fact that it is I who contributed to Bertha's suffering the worse situation creates a further reason to care about her. I could not excuse myself from assisting her to revert her to the situation she would be in without my action of prescribing M. She has now a (special) right against me, as doctor, that may well displace other possible reasons against proceeding.

CONCLUSION

Harm-based and beneficence arguments for PAD claim that death, in the circumstances of hopeless illness, is not a harm (all things considered) and that choosing to die can be, in those circumstances, a reasonable decision. My argument is closely related to this kind of argument, insofar as I have defended the view that PAD is, in a sense, a benefit for the patient or, better, a way of preventing or interrupting an ongoing harm (what I have called 'harmful life'). The problem with this kind of argument is that, in cases of harmful life, the moral reason for killing (with the consent of the patient) conflicts with the moral reason against killing. We may think that the reason against killing vanishes when killing is not harmful (or prevents a harm); but, since killing is always *pro tanto* a kind of harm, we may always have a prevailing reason against killing. Such a prevailing reason has been defended both by appealing to human dignity and to principles of the medical profession. My argument tries to go one step further and shows that this reason cannot be final, at least when the person who kills has been involved in creating the harm that makes this life a harmful one. Now there is a strong, and often neglected, moral reason to carry out the request to die. Since medical treatment sometimes ends up creating a harmful life in hopelessly ill patients, the medical profession bears this very kind of reason. Moreover, providing PAD would be, in these cases, a genuine medical procedure.

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