

## Beyond Beneficence: Moral Asymmetry and the Minimization of Suffering in End-of-Life Care

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### Article abstract

This paper critically examines the ethical foundations for minimizing suffering at the end of life. The reduction of suffering is a major concern in the ethical discourse of end-of-life care. Some thinkers privilege minimizing unwanted and unnecessary suffering at the end of life as much as possible. And yet, many others consider minimizing suffering an insufficient or risky justification for decision-making at the end of life. The desire to minimize suffering is considered equivalent to or entirely contained within utilitarianism or, in bioethics, the principle of beneficence. Here, I argue that it is a mistake to ground the desire to minimize suffering at the end of life in utilitarianism or beneficence, since these are morally symmetrical, and the commitment to minimize suffering is morally asymmetrical. As an alternative, I propose and develop the doctrine of least avoidable suffering (DLAS), which is grounded in negative utilitarianism — aka morally asymmetrical consequentialism. I assess DLAS against a series of end-of-life treatments and demonstrate that it aligns well with the ethical commitments of those who desire to minimize suffering at the end of life. I conclude that DLAS offers people, institutions, and physicians a formal, systematized, and defensible theoretical basis for the desire to minimize suffering at the end of life.

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ARTICLE (ÉVALUÉ PAR LES PAIRS / PEER-REVIEWED)

## Beyond Beneficence: Moral Asymmetry and the Minimization of Suffering in End-of-Life Care

Adam Braus<sup>a</sup>

### Résumé

Cet article examine de manière critique les fondements éthiques de la minimisation de la souffrance en fin de vie. La réduction de la souffrance constitue une préoccupation majeure dans le discours éthique relatif aux soins de fin de vie. Certains penseurs accordent une importance particulière au fait de réduire autant que possible la souffrance non désirée et inutile en fin de vie. Pourtant, beaucoup d'autres considèrent que la minimisation de la souffrance constitue une justification insuffisante, voire risquée, pour la prise de décision en fin de vie. Le désir de minimiser la souffrance est souvent considéré comme équivalent ou entièrement réductible à l'utilitarisme ou, en bioéthique, au principe de bienfaisance. J'argumente ici qu'il est erroné de fonder le désir de minimiser la souffrance en fin de vie sur l'utilitarisme ou la bienfaisance, puisqu'ils reposent sur une symétrie morale, alors que l'engagement à minimiser la souffrance est moralement asymétrique. Comme alternative, je propose et développe la doctrine du moindre mal évitable (DMME), fondée sur l'utilitarisme négatif, également appelé conséquentialisme moralement asymétrique. J'évalue la DMME au regard d'une série de traitements de fin de vie et montre qu'elle s'accorde bien avec les engagements éthiques de ceux qui souhaitent minimiser la souffrance en fin de vie. Je conclus que la DMME offre aux personnes, aux institutions et aux médecins une base théorique formelle, systématisée et défendable pour soutenir le désir de minimiser la souffrance en fin de vie.

### Mots-clés

soins de fin de vie, compassion, conséquentialisme, asymétrie morale, soins palliatifs

### Abstract

This paper critically examines the ethical foundations for minimizing suffering at the end of life. The reduction of suffering is a major concern in the ethical discourse of end-of-life care. Some thinkers privilege minimizing unwanted and unnecessary suffering at the end of life as much as possible. And yet, many others consider minimizing suffering an insufficient or risky justification for decision-making at the end of life. The desire to minimize suffering is considered equivalent to or entirely contained within utilitarianism or, in bioethics, the principle of beneficence. Here, I argue that it is a mistake to ground the desire to minimize suffering at the end of life in utilitarianism or beneficence, since these are morally symmetrical, and the commitment to minimize suffering is morally asymmetrical. As an alternative, I propose and develop the doctrine of least avoidable suffering (DLAS), which is grounded in negative utilitarianism — aka morally asymmetrical consequentialism. I assess DLAS against a series of end-of-life treatments and demonstrate that it aligns well with the ethical commitments of those who desire to minimize suffering at the end of life. I conclude that DLAS offers people, institutions, and physicians a formal, systematized, and defensible theoretical basis for the desire to minimize suffering at the end of life.

### Keywords

end-of-life care, compassion, consequentialism, moral asymmetry, palliative care

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## INTRODUCTION

The reduction of suffering is a major concern in decision-making at the end of life. Some thinkers privilege minimizing unwanted and unnecessary suffering as much as possible, and are generally in favour of palliative care, hospice, and the legalization of some forms of euthanasia. In this discourse, the moral obligation to minimize suffering has been considered equivalent to or entirely contained within the principle of beneficence, understood as the obligation to maximize benefits — including both minimizing suffering and maximizing positive welfare. The principle of beneficence is *morally symmetrical*, meaning unwanted and unnecessary suffering can be compensated morally by happiness.

However, the principle of beneficence alone is insufficient for end-of-life care if one's goal is to minimize suffering, as this principle may occasionally permit actions that increase suffering if they are outweighed by sufficiently large gains in overall welfare. If one is substantively committed already to minimizing suffering, one would need an ethical theory or framework that explicitly prioritizes the reduction of suffering rather than subsuming it under a broader utilitarian calculus. The commitment to minimize suffering could, I propose here, be more precisely and forcefully grounded in a *morally asymmetrical consequentialist* framework — one that categorically rejects avoidable suffering, regardless of how much it might be offset by increases in happiness beyond mere contentment (1-3).

In this paper, I argue for such an alternative ethical theory, which I call the *doctrine of least avoidable suffering (DLAS)*. While the principle of beneficence is rooted in utilitarianism, a symmetrical form of consequentialism, DLAS is grounded in negative utilitarianism, a morally asymmetrical framework, and entails a moral obligation to minimize avoidable suffering for the greatest number (1,3-7). Just as beneficence provides a systematic ethical structure for maximizing overall well-being, DLAS offers a formal and complete theoretical justification for prioritizing the alleviation of suffering over all other considerations.

My aim here is not to argue in favour of the doctrine itself, but rather to introduce and formalize it as a meaningful contribution to the discourse. To illustrate how this doctrine aligns with the goal of minimizing suffering at the end of life, I examine its application in the context of various end-of-life treatments. My analysis demonstrates that DLAS not only provides a structured ethical commitment to reducing suffering but also offers a promising framework for end-of-life decision-making, with important implications for both research and practice. My discussion is primarily theoretical and is not intended to prescribe specific policies; the examples I present are exploratory rather than exhaustive, intended to showcase the doctrine's potential as a guiding ethical framework rather than to dictate its precise implementation.

The structure of this paper is as follows. In the first section, I make mention of those physicians and institutions that favour and even advocate for the position of minimizing unwanted and unnecessary suffering at the end of life. I then argue that neither beneficence nor any other major ethical approach adequately supports minimizing suffering. Following this, I define the doctrine of least avoidable suffering with various considerations and ground it in morally asymmetrical consequentialism. I then apply DLAS to various end-of-life treatments to show that it aligns well with the ethical commitments of end-of-life suffering-minimizers and can serve as a philosophical basis for this view. Finally, in the last section, I respond to various possible objections to DLAS.

## THOSE WHO DESIRE TO MINIMIZE SUFFERING AT THE END OF LIFE

Death is commonly accompanied by significant pain and suffering, and various approaches to end-of-life decision-making prioritize the reduction of this suffering to different degrees. Some scholars, physicians, and institutions prioritize the alleviation of suffering in end-of-life care so strongly that they argue hastening death can be morally justified.

For instance, hospice care was founded in the US in 1967 with the goal of reducing suffering (8). To this day, “the overriding goal of care in the hospice setting is to relieve suffering” (9, p.26). In the 1990s, palliative medicine was introduced, which made the relief of suffering a primary goal. In 2004, the World Health Organization stated that palliative care advances quality of life through the “prevention and relief of suffering” (10). The American Academy of Hospice and Palliative Medicine and The Hospice and Palliative Nurses Association both state that reducing suffering is the goal of their organizations (11). The Oxford Textbook of Palliative Medicine has dedicated every edition to “suffering patients around the world” (12). Some notable figures who endorse a suffering-focused end-of-life approach include Timothy E. Quill from the University of Rochester School of Medicine’s palliative care division and a board member of the American Academy of Hospice and Palliative Medicine, and Robert D. Truog from Harvard Medical School and Boston Children’s Hospital. Another notable figure is Eric Cassell from Weill Cornell Medical Center, who is famous for claiming that the goal of all medicine ought to be the relief of suffering (13).

It might appear uncontroversial that “in the end-of-life context, alleviation of the suffering of a distressed patient is usually seen as a, if not the, central goal for the medical personnel treating her” (14, p.1). However, this view is not held by all and is, in fact, highly contested. Generally, one can presume there is a *pro tanto* obligation to reduce suffering; however, this common moral position still leaves open the chance that some other value might, in certain circumstances, morally compensate for additional unwanted and unnecessary suffering. In contrast, a strict commitment to minimizing suffering means that no other value can ever compensate for additional unwanted and unnecessary suffering.

This debate is especially controversial in end-of-life care, where minimizing suffering often entails sanctioning treatments that deliberately hasten a patient’s demise. These forms of euthanasia include commonly accepted treatments, such as withdrawing life-sustaining treatments, and also more controversial methods like the voluntary stopping of eating and drinking (VSED), proportional palliative sedation (PPS), or medical aid in dying (MAID).<sup>1</sup> Many of these treatments are still illegal in the United States, such as providing MAID before someone is acutely dying, initiating VSED by advanced directive for incompetent people, or administering MAID by advanced directive and which is equivalent to voluntary active euthanasia (VAE). Those who promote minimizing patient suffering at the end of life generally advocate for expanding controlled access to some or all of these treatments.<sup>2</sup>

Some might object to including Dr. Quill and Dr. Truog in this group. The justifications for euthanasia these physicians have published are based on the argument from consistency. They argue that whether a physician withdraws life-sustaining medical treatment or administers lethal drugs, in either case a physician is taking an action that leads to the patient’s demise and so there should be no moral or legal difference between these actions (16-18) not based on the moral demands to minimize suffering. However, one can gather from context that they made the argument from consistency to justify actions that had the goal of minimizing unwanted and unnecessary suffering at the end of life. And so, it is justified to include these physicians in the group of people that desire to minimize suffering at the end of life.

<sup>1</sup> MAID has also commonly been called physician assisted suicide (PAS). MAID is not merely a euphemism for PAS. The term MAID refers to a patient drinking lethal medication, whereas voluntary active euthanasia (VAE) refers to a physician administering a lethal injection. Both of these could be called “physician assisted suicide” so the term MAID provides a valuable distinction.

<sup>2</sup> For instance, in 1991 Dr. Quill prescribed MAID for a woman diagnosed with terminal leukemia in violation of the laws of New York state (15). This act resulted in him being made the plaintiff in the 1997 US Supreme Court case *Petitioners v. Timothy E. Quill et al* (16).

## THE LIMITATIONS OF BENEFICENCE AND OTHER ETHICAL THEORIES FOR MINIMIZING SUFFERING

While the imperative to minimize suffering at the end of life may seem self-evident, its ethical foundations require closer examination. At first glance, it appears that the ethical imperative to minimize suffering is equivalent to or wholly contained within the *principle of beneficence*. The principle of beneficence, after all, entails maximizing welfare, which includes both minimizing suffering and maximizing pleasure and happiness (19-22). Since beneficence of this form is derived from utilitarianism, one might assume that developed utilitarian arguments support treatments that minimize suffering, including euthanasia (23).

However, beneficence (and, by extension, utilitarianism) does not prioritize minimizing suffering in every case and so is not a sufficient theoretical basis for the ethical goal of minimizing suffering. Beneficence is *morally symmetrical* — it sanctions increasing unwanted and unnecessary suffering so long as they are outweighed by a larger enough increase in happiness or pleasure. Therefore, both in theory and in practice, there will be cases where an increase in happiness or pleasure will outweigh an increase in suffering. For instance, there are many arguments that the unwanted and unnecessary suffering at the end of life is justified because it is part of a good death and can be meaningful for a person (24,25).

If suffering can be justified by its instrumental value in achieving greater happiness, then it is not an inherent moral wrong but rather a factor that can be weighed and, at times, sacrificed for a perceived greater good. For example, some arguments suggest that unwanted and unnecessary suffering at the end of life can be meaningful or even beneficial — whether by fostering spiritual growth, strengthening familial bonds, or contributing to a good death. From the perspective of those who are genuinely committed to minimizing suffering, such arguments are deeply problematic. They suggest that suffering can be morally instrumentalized — that it can be required, prolonged, or justified based on its potential to contribute to some greater happiness.

Perhaps the strongest evidence that the principle of beneficence does not prioritize suffering minimization is that it has been used to justify arguments *against* euthanasia. One argument is that death cannot possibly constitute a benefit at all (55). Various scholars argue that the unwanted and unnecessary suffering at the end of life is morally justified because it helps people reach greater happiness and fulfillment (25). In other words, many scholars use beneficence to justify requiring people to endure the unwanted and unnecessary suffering at the end of their lives because that suffering is instrumental in potentially gaining a great happiness or pleasure. One could argue that certain religious objections to euthanasia also rely on a form of beneficence, as they justify enduring unwanted and unnecessary suffering at the end of life by appealing to a greater good — whether it be increased holiness, spiritual fulfillment, or the sanctity of life (26,27). In each of these arguments, some greater happiness or superior state of being compensates for suffering — a position directly opposed by those who seek to minimize suffering as much as possible.

Alternative consequentialist frameworks for end-of-life ethics also often subordinate suffering minimization to other values in specific circumstances. Vitalism, whether religious or secular, accepts additional suffering when necessary for life preservation. Pure autonomy-centered approaches that advocate for unrestricted right-to-die policies prioritize self-determination over the suffering potentially involved in suicide or assisted death. Even attempts to balance autonomy with beneficence through combined positions or reflective equilibrium are problematic; these approaches provide no consistent safeguard against increased suffering that might be justified by appeals to either principle, depending on the specific circumstances. The resulting ethical framework remains vulnerable to permitting greater suffering based on whichever principle — autonomy or beneficence—is emphasized in a particular reflective equilibrium.

Among deontological approaches to end-of-life decision-making, there is still no guarantee that one will minimize suffering. One of the most prominent positions is the doctrine of double effect (DDE), which is commonly grouped together with its sister theory, distinguishing between killing and letting die (28). DDE does allow for the voluntary withdrawal of life-sustaining treatment and administering strong pain killers, but, at present, it prevents a physician from deliberately helping a patient to die even as a last resort to avoid irremediable suffering (19,29,30). The argument from consistency is a refutation of DDE and the killing/letting die distinction, but it also does not offer any guarantee to minimize suffering. It only expands physicians' latitude to do what they believe is right (17).

## THE DOCTRINE OF LEAST AVOIDABLE SUFFERING (DLAS)

These ethical trade-offs one encounters with beneficence mean a different ethical basis is needed to defend the substantive ethical commitment to minimizing suffering at the end-of-life. Such a commitment must be *morally asymmetrical*, as it holds that no amount of happiness above contentment can morally compensate for unwanted and unnecessary suffering. The notion of moral asymmetry has gone by various names, including moral asymmetry (2,3,31-33), the compensation principle (34,35), and non-commensurability (35). Despite the differences in nomenclature, the idea is roughly the same: *suffering cannot be compensated for or outweighed by happiness*.

This concept explains many common moral intuitions. Consider how one might intuitively feel a moral obligation to make sacrifices to feed people who are starving or malnourished, but there is no such obligation to make sacrifices to feed people who are well-endowed or well-nourished. Similarly, one might consider it acceptable to torture a terrorist bomber who has

hidden a bomb that will explode tomorrow somewhere in an unknown, but heavily populated, city. However, arguably, one would not consider it acceptable to torture someone so that some large number of people could enjoy more convenience in their lives (e.g., slavery). Moral asymmetry sanctions trading a lesser suffering to avoid a greater suffering but rejects trading suffering — even a relatively small amount — to increase happiness above contentedness, no matter how much that happiness may be.

As an alternative to the principle of beneficence, I propose here *the doctrine of least avoidable suffering (DLAS)*, which may be stated succinctly as follows:

*Always choose that action that will minimize unwanted and unnecessary suffering for the greatest number.*

Like the principle of beneficence, DLAS is consequentialist. In other words, someone applying it will judge the moral worth of an action according to the outcome of that action. However, traditional forms of consequentialism are virtually all morally symmetrical since they sanction trading suffering for sufficiently large increases in happiness. DLAS, however, is morally asymmetrical and does not allow trading any amount of suffering to increase happiness beyond contentment and prioritizes minimizing suffering above all else. The most prominent form of morally asymmetrical consequentialism is called “negative utilitarianism” (1,37). While there is an important and ongoing philosophical discourse on the theoretical strengths and weaknesses of negative utilitarianism, here, I set many of the elements of this theoretical debate to one side and focus entirely on exploring how it might relate to the issue of end-of-life decision-making.

DLAS is applied to scenarios in much the same way as other consequentialist approaches. First, one separately evaluates the potential suffering and potential happiness that each course of action would produce. The morally preferable action is the one that results in the least suffering. For example, stealing a loaf of bread to feed a starving family might be justified, as the baker’s minor loss is outweighed by the family’s severe hunger. In cases where the suffering caused by different actions is equal, the amount of happiness produced serves as a tiebreaker (39). Further below I will apply DLAS to various end-of-life treatments.

The distinction between unwanted and unnecessary suffering may not be immediately clear. Would not those committed to minimizing suffering seek to eliminate all suffering entirely? Perhaps counterintuitively, some forms of suffering, while regrettable and tragic, are nonetheless morally tolerable. For instance, one would not object to someone voluntarily getting a tattoo or to the amputation of a gangrenous foot when medically necessary. Given that certain types of suffering are morally permissible, a structured, rules-based distinction between *morally tolerable* and *morally intolerable* suffering is essential to formalizing DLAS and avoiding arbitrariness. To that end, I propose the following three key factors for distinguishing between these categories. These factors will play a crucial role when evaluating how DLAS applies to end-of-life treatments. To judge if suffering is morally tolerable or intolerable, one must first consider the following:

1. **Consent:** For suffering to be morally tolerable, it must be voluntarily chosen. If an individual willingly undertakes distress or discomfort, it does not necessarily constitute suffering in the relevant moral sense. Since such experiences align with personal desires and preferences, they may even contribute to well-being, at least subjectively. This idea is captured in the principle of *volenti non fit injuria* (“to a willing person, no injury is done”). A clear distinction emerges when comparing consensual and nonconsensual suffering. While suffering imposed against one’s will is morally intolerable, suffering that is freely chosen is either not suffering at all or is at least morally permissible. For example, one would not equate a consensual boxing match with an unprovoked beating, a voluntary donation with theft, or rough sex with sexual assault. In each case, consent changes the ethical nature of the experience and shows that suffering — when freely chosen — does not necessarily require intervention.

There are two other conditions of morally intolerable suffering, which I label *capacity* and *exacerbation*.

2. **Capacity:** For suffering to be morally tolerable, it must be impossible for one to alleviate the suffering. It would be irrational for someone to have the moral obligation to do something out of their power, e.g., demanding one’s 90-year-old neighbour bring about peace in the Middle East. This intuition follows roughly the principle of *ad impossibilia nemo tenetur* or “ought implies can.” A good example from the end of life is when someone enters hospice care. One accepts that the suffering that must accompany the person’s death is now unavoidable and therefore must be tolerated even if it is regrettable and tragic.
3. **Exacerbation:** For suffering to be morally tolerable, any action meant to alleviate it must only cause greater suffering. It would be irrational to take actions that reduced a small suffering but caused a larger one, e.g., removing all your furniture to avoid stubbing your toe. As illustrated above by the gangrenous foot case, not amputating the foot will predictably only lead to greater suffering. And so, it is obligatory to endure lesser suffering that is instrumental in alleviating a greater one.

I accept that not everyone might agree with the importance of consent, capacity, and exacerbation in determining if suffering is morally tolerable or intolerable. There are, no doubt, edge cases that challenge the completeness of these three factors. Nevertheless, when applying DLAS to practical cases in end-of-life care, these three factors are important for understanding how DLAS works and aligns with the commitment to minimize suffering at the end of life.

## APPLYING DLAS TO END-OF-LIFE CARE

In this section, I will assess the DLAS by applying it to various end-of-life treatments, progressing from the least to the most controversial. My purpose here is not to argue that these treatments ought to be available or that following this doctrine would necessarily constitute a moral improvement. Rather, my focus is on showing that physicians and ethicists who prioritize minimizing suffering at the end of life often advocate for the availability of these treatments — and that it aligns with and can justify controlled versions of them.

Through this analysis, I find that (a) DLAS sanctions voluntary forms of passive and active euthanasia as a last resort in cases of unwanted and irremediable suffering, (b) it maintains a moral distinction between killing and letting die but does not prohibit deliberate killing categorically, and (c) it does not sanction an arbitrary right to die. As such, I conclude that DLAS supports the commitment to minimize suffering at the end of life.

### DNR, Withdrawing Life Sustaining Treatment, and VSED

Let's begin by seeing how one could use DLAS to justify the choice to comply with a DNR (Do Not Resuscitate) order or decision to withdraw life-sustaining treatments such as a ventilator. These two choices are legal and relatively uncontroversial in the US and traditionally have been justified by a patient's right to autonomy and bodily integrity combined with the killing/letting die distinction (40). In other words, the patient has the autonomy to refuse medical treatment, and a medical provider is not blameworthy for complying with these requests because they did not kill the patient but rather let the patient die. DLAS also justifies complying with these requests, but the justification does not require asserting someone's right to die or the killing/letting die distinction. Like the case of the nonconsensual tattoo above, if the patient does not consent to medical treatment, forcing that medical treatment becomes a form of nonconsensual, and therefore morally intolerable, suffering. Meanwhile, the suffering entailed in the patient dying is morally tolerable since it is consented to, and there is no action that one could take to prevent their dying (any life-saving or life-sustaining treatment) that would not only exacerbate unwanted and unnecessary suffering.

The same goes for the slightly more controversial option of a patient voluntary stopping of eating and drinking (VSED) (41). Again, VSED is commonly justified by reference to autonomy and killing/letting die, but VSED can be justified by using DLAS alone. If someone elects VSED to avoid irremediable suffering at the end of life, force feeding them (or even offering them food) would increase their suffering, because they do not consent to be fed. By contrast, force feeding or offering food to someone who is not facing irremediable suffering at the end of life (i.e., an anorexic) would be sanctioned, all things considered. Here, and in other cases, one can see how this doctrine sanctions deliberate forms of dying to avoid irremediable suffering at the end of life, but it does not sanction a right to die for any reason.

### Proportional Palliative Sedation (PPS)

Proportional Palliative Sedation (PPS) is a legal practice of using strong drugs to render a patient unconscious when managing refractory pain at the end of life (42). PPS will usually hasten the death of the patient (especially if artificial hydration and nutrition are withheld, which is very common). Physicians justify PPS using references to autonomy, beneficence, and the doctrine of double effect (DDE) or killing/letting die. Justifications based on DDE or killing/letting die are what require physicians to only sedate patients in proportion to their pain. If the sedation is out of proportion with the patient's pain and hastens their death, then this would constitute active euthanasia and is considered morally wrong by many and illegal in the US and most other jurisdictions.

DLAS sanctions PPS since it consensually minimizes someone's irremediable suffering. But one might object that focusing solely on avoidable suffering would not require proportionality and would make no ethical difference between PPS and Voluntary Active Euthanasia (VAE). In other words, DLAS would not distinguish between (a) sedating a patient until they die of dehydration and (b) sedating a patient so strongly that it kills them outright. This is objectionable because there is a moral difference between killing and letting die. In response to this objection, I would argue that someone applying DLAS would still require using proportional sedation in cases of refractory pain and does still recognize a moral difference between killing and letting die, albeit different than is traditional.

While the patient is usually most at risk of suffering in an end-of-life scenario, someone using DLAS has the obligation to minimize suffering for everyone involved. There is also the suffering of other stakeholders, including a patient's loved ones and the medical providers. In the case of PPS, being very close to deliberately hastening someone's death risks causing moral injury, guilt, and blame for that person — all terrible forms of potentially life-long suffering. Hence killing someone is morally different from letting them die because it carries very real risk of moral injury. Proportional sedation is one way to prevent moral injury from leaking out and spilling onto those around the patient. Thus, DLAS would also advocate for proportionality when doing palliative sedation and maintaining a moral bright line between PPS and VAE (43).

Some might object that the presence of or risk of guilt and moral injury to those around the patient is not a strong enough reason to force DLAS to use proportionality.<sup>3</sup> Of course, in an end-of-life scenario, the patient is usually the one facing the greatest suffering — intense pain, debilitation, losing their life, and so on — and so the emphasis is on the patient, but it would

<sup>3</sup> Thanks to the comments from an anonymous reviewer for this objection.

be inconsistent if DLAS entirely ignored the suffering to those around the patient. While in the philosophical literature the discourse on end-of-life care is largely focused on the patient — namely, respecting their autonomous choices and doing them as much benefit as possible — in legal and clinical domains it is the DDE and killing/letting die arguments that hold tremendous sway.<sup>4</sup> These arguments hinge precisely on the risk of blame, guilt, and moral injury for medical providers. Moreover, considering the suffering of all involved ends up not being a weakness of DLAS but a strength. For instance, it is commonly agreed that medical care providers who feel they risk moral injury with a particular treatment ought not to be forced to perform it. If DLAS ignored all suffering except for the patient, it would sanction forcing medical providers to perform procedures they felt violated their conscience, and this is very objectionable. For these reasons, the consideration of the risk of moral injury to providers is a sufficient reason to maintain a moral difference between killing and letting die. However, whereas this moral difference is categorical for DDE (deliberately killing is prohibited), for DLAS, deliberately killing is permissible if it is the last resort for minimizing suffering.

### Medical Aid in Dying (MAID)

Medical Aid in Dying (MAID) generally refers to a physician proscribing a single dose of lethal medication that must be self-administered by drinking by the patient (44). MAID is commonly justified today with arguments based on autonomy, DDE, and killing/letting die. MAID can be justified using DLAS alone without reference to DDE and killing/letting die by the same reasoning as justifying withdrawing life-sustaining treatment. The suffering of the patient is morally intolerable because it is non-consensual, there exists the capability to improve it (the lethal medication), and any other action would only make the suffering worse. Meanwhile, the suffering entailed in the patient dying must be tolerated because the death is consented to and there is no capability to select an alternative that would not exacerbate the suffering.

MAID is a controversial end-of-life treatments that is legal only in a few US states, and a handful of other countries. MAID laws in the US require a patient to have no more than six months to live, but they do not require irremediable suffering (45). In other words, as the laws are currently written, they simply allow people that are provably near the end of their lives the medical means to kill themselves painlessly. By contrast, the MAID laws of Canada, Belgium, and the Netherlands do require the patient to be facing irremediable suffering. As such, one could not defend the laws of the US using DLAS, but one could use DLAS to defend those of the latter countries. Once again, one can see that DLAS does not sanction an arbitrary right to die, even for terminal patients, since it requires irremediable suffering to justify any form of euthanasia.

### Voluntary Active Euthanasia (VAE)

Voluntary active euthanasia (VAE) means treatments that directly bring about the demise of a patient. VAE is a controversial practice and is illegal in the US and in most countries, with notable exceptions being the Netherlands, Belgium, and Switzerland. One can think of VAE as the same as MAID but where a lethal medication is administered by a volunteer or physician. By similar analysis as MAID, one can use DLAS to justify VAE. However, since DLAS still makes a moral distinction between killing and letting die, VAE would only be justified as an absolute last resort and would require a physician or volunteer who agreed to administer the lethal medication, and even then, it would come at considerable moral risk. Both the patient and their physician must agree that there is no other way to minimize suffering. Some examples where VAE might be justified could be, (a) if the patient is competent and committed to taking MAID but there is some risk involved in self-administration (e.g., tremors, paralysis, or poor swallowing) or (b) if the patient is a candidate for MAID, VSED, or PPS but considers these as constituting greater suffering than VAE.

Switzerland's legal regulation of voluntary euthanasia could not be justified by DLAS directly because it does not require a patient to face irremediable suffering. However, one could use DLAS to justify the euthanasia laws of Belgium and the Netherlands since these do make irremediable suffering a requirement.

In conclusion, DLAS generally aligns with the commitments of those who wish to minimize suffering at the end of life, but not with those who advocate for an arbitrary right to die. It offers a middle way between disavowing any sort of euthanasia and allowing for "self-determination run amok" (46). DLAS treats any form of passive or active euthanasia as an absolute last resort against irremediable suffering. Moreover, DLAS treats forms of passive euthanasia (letting die) as morally preferable to forms of active euthanasia (killing), but it does not forbid active euthanasia categorically.

## VARIOUS OBJECTIONS TO DLAS

One might object that DLAS is an absolutist moral approach, and therefore it does not admit of moral pluralism and runs the risk of being culturally colonial, which is objectionable. Many cultures and religious traditions interpret suffering in ways that do not align with a strictly harm-reduction perspective. For instance, some traditions may regard suffering as spiritually meaningful or necessary for personal growth, redemption, or preparation for the afterlife. If DLAS were to be applied without sensitivity to these perspectives, it could be criticized as imposing a Western-centric model of moral reasoning on suffering.

On the contrary, DLAS must embrace individual and cultural moral pluralism since failing to take into account cultural differences related to illness, dying, and death have already been identified as being a common cause of avoidable suffering. For instance, ignoring cultural differences causes conflict between medical providers and patients and their families, and can

<sup>4</sup> See the US Supreme Court case *Petitioners v. Timothy E. Quill et al* (16) where DDE, killing and letting die, and the argument from consistency are central.

even lead to physically or psychologically harming a patient or their loved ones (47,48). Consider the issue of a patient choosing their place of death. For many individuals and cultures, planning to die at home causes significantly less suffering than planning to die in a medical facility (49). So, all things being equal, DLAS requires that people have the option to follow their individual and cultural practices in choosing their place of death since this reduces avoidable suffering. While DLAS might run against some cultural practices, these are only practices that deliberately increased unwanted and needless suffering, for instance, female genital mutilation, tortuous human sacrifice, and the like, which are already significantly objectionable and extremely hard to justify solely on the grounds of moral relativism.

Another objection may hold that DLAS would sanction unacceptable violations of people's autonomy and theoretically enable a "slippery slope" from voluntary to involuntary forms of euthanasia (50,51). As it is defined so far, one might still suppose that DLAS *does* sanction involuntary euthanasia, since ostensibly the death of a patient might significantly reduce the suffering of caregivers or the burden on society — perhaps so much so that it could outweigh the suffering of violating someone's wish to live. While it is true that someone's death might reduce suffering for others, there are various reasons why DLAS directly defends people's autonomy (both directly and indirectly), forbids involuntary euthanasia, and therefore makes for a very "sticky slope" towards involuntary euthanasia.

First, as I argue above, suffering reasonably includes the frustrations of preferences, and so violations of autonomy and consent constitute suffering (52). Second, involuntary euthanasia runs the terrible risk of greatly increasing the injury and outrage of family members, loved ones, and concerned members of the public who might feel the person was murdered. This suffering would weigh heavily against the decision to commit involuntary euthanasia. Third, making involuntary euthanasia a legal medical practice would increase suffering greatly by reducing the number of those seeking medical care out of fear of being murdered. Moreover, no one would call a campaign of involuntary euthanasia (as the Nazi's pursued) or legal suicide or consensual homicide as moral acts aimed at minimizing suffering, rather these appear to be a moral scourge or depravity. Finally, if the caregivers of terminally ill people who wish to live are suffering so terribly with their care, the solution that leads to the least avoidable suffering is to provide them with greater support in the form of hospice and palliative care (which is not very costly and causes no additional suffering), not violating the wish of the terminal patient to live.

Another objection to DLAS is that perhaps it could never justify active forms of euthanasia — even though many who prioritize minimizing suffering support such interventions. The reasoning behind this objection is that killing, by definition, must constitute an increase in suffering; otherwise, if death were inherently preferable to suffering, DLAS would lead to pro-mortalism — the absurd conclusion that one be morally obligated to end all lives indiscriminately. In response, I would say that DLAS does not proscribe pro-mortalism. Like DDE or killing/letting die, DLAS offers a precise and non-arbitrary justification for when deliberately increasing suffering (perhaps by killing someone) is morally justifiable and even required. Only if an action leads to less suffering overall, then it is morally justifiable. As mentioned above, the amputation of a gangrenous foot would prevent the loss of the leg or the death of the patient. Similarly, if someone's consensual death is the only possible remedy to suffering at the end of life, DLAS would support this form of euthanasia since it replaces a greater suffering with a lesser.<sup>5</sup>

A final objection is that DLAS does not necessarily limit its application to those at the end of their lives; rather, it would justify intervention for anyone experiencing irremediable suffering, regardless of their life stage. This is true, but rather than a weakness, this is one of the doctrine's strengths. For instance, there are cases where it might be deemed the path of least suffering to withdraw life-sustaining treatments in tragic and hopeless neonatal and pediatric cases (53). Or cases where someone middle aged could continue to live with a ventilator but deems continued living greater suffering than dying (54). If DLAS only allowed for old people with aggressive terminal illnesses to die, then it would require additional unwanted and unnecessary suffering of young people in hopeless situations which is inconsistent and causes greater needless suffering.

## CONCLUSION

In this paper, I introduced the doctrine of least avoidable suffering (DLAS) as a new potential ethical approach for those who desire to minimize suffering at the end of life. There are many people, physicians, and prominent and trusted organizations that are publicly and substantively committed to minimizing suffering at the end of life. I argued that this doctrine cannot be reduced to or contained within beneficence or utilitarianism because of fundamental differences in their moral symmetry. While beneficence and other ethical frameworks in end-of-life care might sometimes permit increases in unwanted and unnecessary suffering for the sake of other values, DLAS will always put the reduction of needless and unwanted suffering above other values.

I also fleshed out this new doctrine, grounding it in morally asymmetrical consequentialism and defining a systematic approach to its application. I highlighted three factors — consent, capacity, and exacerbation — to create a non-arbitrary process for distinguishing between suffering that obliges action and suffering that must be tolerated (even if it pains us). When applied to various end-of-life treatments — from DNR orders and withdrawal of life-sustaining treatment to more controversial interventions like MAID and VAE — DLAS yields positions that align well with the substantive ethical commitments of those who already prioritize suffering reduction. DLAS does not sanction an arbitrary right to die but treats euthanasia as a last resort against otherwise irremediable suffering. Moreover, it makes a moral distinction between killing and letting die but it does not absolutely prohibit killing. It makes the distinction between killing and letting die because deliberate killing can be a cause of

<sup>5</sup> For an excellent discussion of euthanasia for irremediable suffering at the end of life, see Greif, 2018 (20) and his scenario of a man trapped in a burning lorry.

suffering (fear and distress) to others, especially medical providers, friends and loved ones, and the public. In addition, DLAS also withstands various objections, including concerns about moral pluralism, the risk of a slippery slope to involuntary euthanasia, and questions about its scope.

While I have attempted to make a compelling ethical case for DLAS, my goal has not been to argue for the ethical superiority of DLAS over other approaches, but to help systematize an existing substantive ethical position. Many people, institutions, and healthcare professionals — particularly in palliative and hospice settings — already operate with an implicit or explicit commitment to enable the minimization of suffering at the end of life. What has been missing, however, is a philosophical account that fully, formally, and coherently justifies this substantive ethical position. DLAS provides this missing theoretical foundation and practical justification for a substantive ethical commitment that is already critically important and actively in use in end-of-life care practices in the United States and around the world.

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## REFERENCES

1. Wolf C. O repugnance, where is thy sting? In: Tännsjö T, Ryberg J, editors. *The Repugnant Conclusion: Essays on Population Ethics*. Dordrecht: Springer; 2004. p. 61-80.
2. Mayerfeld J. [The moral asymmetry of happiness and suffering](#). *Southern Journal of Philosophy*. 1996;34(3):317-38.
3. Popper KR. *The Open Society and Its Enemies*. Ryan A, Gombrich EH, editors. Princeton: Routledge; 1945.
4. Häyry M. [Exit duty generator](#). *Cambridge Quarterly of Healthcare Ethics*. 2024;33(2):217-31.
5. Scarre G. *Utilitarianism*. New York: Routledge; 2020.
6. Smart JJC. Negative utilitarianism. In: D'Agostino F, Jarvie I, editors. *Freedom and Rationality: Essays in Honor of John Watkins From his Colleagues and Friends*. Dordrecht: Springer Netherlands; 1989. p. 35-46.
7. Smart RN. [Negative utilitarianism](#). *Mind*. 1958;67(268):542-43.
8. Krisman-Scott MA. [Origins of hospice in the United States: The care of the dying, 1945–1975](#). *Journal of Hospice & Palliative Nursing*. 2003;5(4):205-10.
9. Quill TE, Miller FG, editors. *Palliative Care and Ethics*. Oxford: Oxford University Press; 2014.
10. Davies E, Higginson IJ. [Better palliative care for older people](#). Copenhagen: World Health Organization, Regional Office for Europe; 2004.
11. Dy SM, Kiley KB, Ast K et al. [Measuring what matters: Top-ranked quality indicators for hospice and palliative care from the American Academy of Hospice and Palliative Medicine and Hospice and Palliative Nurses Association](#). *Journal of Pain and Symptom Management*. 2015;49(4):773-81.
12. Hanks GW, editor. *Oxford Textbook of Palliative Medicine*. New York: Oxford University Press; 2011.
13. Cassell EJ. [The nature of suffering and the goals of medicine](#). *Loss, Grief & Care*. 1998;8(1-2):129-42.
14. Varelus J. [Suffering at the end of life](#). *Bioethics*. 2019;33(1):195-200.
15. Quill TE. Death and dignity. In: Battin MP, Francis LP, Landsman BM, eds. *Death, Dying and the Ending of Life*, Vol. I–II. London: Routledge; 2019. p. 245-48.
16. Rehnquist WH; Supreme Court of the United States. [U.S. Reports: Vacco v. Quill, 521 U.S. 793](#). Washington, DC: U.S. Supreme Court; 1996.
17. Miller FG, Truog RD, Brock DW. [Moral fictions and medical ethics](#). *Bioethics*. 2010;24(9):453-60.
18. Bronner B. [Two ways to kill a patient](#). *Journal of Medicine and Philosophy*. 2018;43(1):44-63.
19. Beauchamp TL, Childress JF. *Principles of Biomedical Ethics*. New York: Oxford University Press; 1979/2001.
20. Greif A. [The morality of euthanasia](#). *Organon F*. 2019;26(4):612-34.
21. Rigby B, Symons X. [Abortion, euthanasia, and the limits of principlism](#). *Medicine, Health Care and Philosophy*. 2023;26(4):549-56.

22. Young R. [Voluntary euthanasia](#). In: Zalta EN, Nodelman U, editors. The Stanford Encyclopedia of Philosophy, Summer 2024 Edition; 2024.
23. Singer P. [Voluntary euthanasia: A utilitarian perspective](#). Bioethics. 2003;17(5-6):526-41.
24. Kass L. Life, Liberty & the Defense of Dignity: The Challenge for Bioethics. New York: Encounter Books; 2002.
25. van der Haak D. [Death anxiety, immortality projects and happiness: A utilitarian argument against the legalization of euthanasia](#). Conatus – Journal of Philosophy. 2021;6(1):159-74.
26. Dworkin R. Life's Dominion: An Argument About Abortion, Euthanasia, and Individual Freedom. New York: Vintage; 2011.
27. Dyck AJ. Life's Worth: The Case Against Assisted Suicide. Grand Rapids: Wm. B. Eerdmans Publishing; 2002.
28. Norcross A. Killing and letting die. In: Frey RG, Heath Wellman C, editors. A Companion to Applied Ethics. Oxford: Blackwell Publishing; 2007. p. 451-63.
29. Mangan JT. [An historical analysis of the principle of double effect](#). Theological Studies. 1949;10(1):41-61.
30. Bogatyńska-Kucharska A. [The doctrine of double effect: A comparison of the version of Thomas Aquinas and contemporary accounts as formulated by Joseph Mangan and Joseph Boyle](#). Forum Philosophicum. 2020;25(2):273-92.
31. Harnad S. [My orgasms cannot be traded off against others' agony](#). Animal Sentience. 2016;1(7):18.
32. Hurka T. [Asymmetries in value](#). Nous. 2010;44(2):199-223.
33. Mayerfeld J. Suffering and Moral Responsibility. New York: Oxford University Press; 1999.
34. Parfit D. Reasons and Persons. 2<sup>nd</sup> ed. Oxford: Oxford University Press; 1987.
35. Wolf C. Person-affecting utilitarianism and population policy; or, Sissy Jupe's theory of social choice. In: Fotion N, Heller JC, editors. Contingent Future Persons: On the Ethics of Deciding Who Will Live, or Not, in the Future. Dordrecht: Springer; 1997. p. 99-122.
36. Goetz JL, Keltner D, Simon-Thomas E. [Compassion: An evolutionary analysis and empirical review](#). Psychological Bulletin. 2010;136(3):351-74.
37. Ord T. [Why I'm not a negative utilitarian](#). Toby Ord. 28 Feb 2013.
38. Arrhenius G, Bykvist K. [Future generations and interpersonal compensations](#). Uppsala Prints and Preprints in Philosophy; 1995.
39. Truog RD, Campbell ML, Curtis JR, et al. [Recommendations for end-of-life care in the intensive care unit: A consensus statement by the American College of Critical Care Medicine](#). Critical Care Medicine. 2008;36(3):953-63.
40. Quill TE, Ganzini L, Truog RD, Pope TM. [Voluntarily stopping eating and drinking among patients with serious advanced illness—clinical, ethical, and legal aspects](#). JAMA Internal Medicine. 2018;178(1):123-27.
41. Gurschick L, Mayer DK, Hanson LC. [Palliative sedation: An analysis of international guidelines and position statements](#). American Journal of Hospice and Palliative Medicine. 2015;32(6):660-71.
42. Cassell EJ, Rich BA. [Intractable end-of-life suffering and the ethics of palliative sedation](#). Pain Medicine. 2010;11(3):435-38.
43. Treem J. [Medical aid in dying: Ethical and practical issues](#). Journal of the Advanced Practitioner in Oncology. 2023;14(3):207-11.
44. Padubidri JR, Antony Manoj M, Singh T. [Euthanasia: A good death or an act of mercy killing? A global scenario](#). Clinical Ethics. 2022;17(2):118-21.
45. Callahan D. [When self-determination runs amok](#). Hastings Center Report. 1992;22(2):52-5.
46. Crawley LM, Marshall PA, Lo B, Koenig BA. [Strategies for culturally effective end-of-life care](#). Annals of Internal Medicine. 2002;136(9):673-79.
47. Kagawa-Singer M, Blackhall LJ. [Negotiating cross-cultural issues at the end of life: You got to go where he lives](#). JAMA. 2001;286(23):2993-3001.
48. Gomes B, Calanzani N, Curiale V, McCrone P, Higginson IJ. [Effectiveness and cost-effectiveness of home palliative care services for adults with advanced illness and their caregivers](#). Cochrane Database of Systematic Reviews. 2013;6(1):CD007760.
49. Buturovic Z. [Embracing slippery slope on physician-assisted suicide and euthanasia could have significant unintended consequences](#). Journal of Medical Ethics. 2021;47(4):257-58.
50. Meier DE. [The treatment of patients with unbearable suffering—the slippery slope is real](#). JAMA Internal Medicine. 2021;181(2):160-61.
51. Singer P. Practical Ethics. Cambridge: Cambridge University Press; 2011.
52. Chadwick A, Craig F. [Withholding and withdrawing treatment in paediatric intensive care](#). Paediatrics and Child Health. 2024;34(2):69-73.
53. Gaul AL, Wilson SF. [Should a ventilator be removed at a patient's request? An ethical analysis](#). Journal of Neuroscience Nursing. 1990;22(5):326-29.
54. Panayiotou P. [Beneficence cannot justify voluntary euthanasia and physician-assisted suicide](#). Journal of Medical Ethics. 2024;50(6):384-87.