



Choosing to Die

ELECTIVE DEATH AND MULTICULTURALISM

C. G. PRADO

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In this book, C. G. Prado addresses the difficult question of when and whether it is rational to end one's life in order to escape devastating terminal illness. He specifically considers this question in light of the impact of multiculturalism on perceptions and judgments about what is right and wrong, permissible and impermissible. Prado introduces the idea of a "coincidental culture" to clarify the variety of values and commitments that influence decisions. He also introduces the idea of a "proxy premise" to deal with reasoning issues that are raised by intractably held beliefs.

Primarily intended for medical ethicists, this book will be of interest to anyone concerned with the ability of modern medicine to keep people alive, thereby forcing people to choose between living and dying. In addition, Prado calls upon medical ethicists and practitioners to appreciate the value of a theoretical basis for their work.

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Elective Death and Multiculturalism

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In memory of
Nancy Sutherland and Rose Candeloro Williams,
who chose to die;

and

Larry Baker, Hugheen Ferguson, Nathan Jaganathan,
Russ Savage, Carolyn Small, George Teves, and Bill White,
who didn't

[A]ble to say a holy No when the time for Yes has passed.

Friedrich Nietzsche, *Zarathustra*

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Preface

Book prefaces often are skipped. This one should be read because it is important for readers to appreciate the intent and nature of what follows and to whom it is addressed.

This book is about the rationality, and so the permissibility, of choosing to die and is addressed to medical ethicists and to those on their way to being medical ethicists. More particularly, the book is addressed to medical ethicists who deal or will deal with terminal patients. And most specifically, the book is addressed to those who deal or will deal with terminal patients considering ending their lives to escape the physical and personal devastation and torment that many terminal conditions produce.

The writing of this Preface was prompted by events at a recent conference on end-of-life issues to which I was invited. I presented some material from the first two of the following chapters, with a view to both sharing my observations with participants and seeking constructive criticism.

The conference participants were mostly clinicians, with a significant number of health-care administrators and some lawyers specializing in terminal-illness issues. I regret that the comments and questions about the material I presented made it clear that few in the audience thought what I had to say was relevant to their work. My commentator ridiculed the abstractness of my presentation and dismissed my concern with the rationality of choosing to die by saying simply that we cannot be rational in terminal suffering.

In his closing remarks, the conference organizer attempted to remedy matters by saying a little about the importance of the questions I raised. His remarks were well intentioned, but he succeeded only in further marginalizing my position when he said I had spoken about a “noble death” achievable only by a very few. However, he summed up by asking a question that has stayed with me and that I return to in Chapter 7. The question he asked was, “After all, how many Socrateses die?”¹

While I was disappointed and frustrated by my commentator’s and the audience’s reactions, I benefited from the experience. It brought home to me how important it is to attempt to narrow an undeniable communicative gulf that exists between theoreticians concerned with end-of-life issues and clinicians and others who must deal directly with those who are dying.

This gulf is precisely the one that medical ethicists must straddle. The gulf has two aspects; one is perceptual. Medical ethicists are usually perceived by theoreticians as clinicians because of their applied work and regular contact with physicians, nurses, medical administrators, and patients. But medical ethicists are seen as theoreticians by clinicians and other practitioners because of their educational backgrounds and contact with academic ethicists, epistemologists, psychologists, and often theologians. The second aspect of the gulf is institutional and has to do with responsibility and defined function. The fact is that medical ethicists are advisors; they advise both clinicians and patients, as well as patient family members and sometimes the clinics and hospitals in which they work. Medical ethicists are not implementers or agents in the treatment of patients and thus are distanced from clinicians in a manner that cannot be changed by remedying misperceptions.

Medical ethicists, then, occupy a unique position, and in order to function effectively they must balance theory and practice. Their main job is to apply ethical theory to clinical situations and on that basis to offer the best guidance they can to those who make the actual treatment decisions. And this means that medical ethicists must reconcile the sort of abstract considerations regarding rationality and permissibility that this book discusses with the actualities of terminal

¹ My thanks to David N. Weisstub for this productively provocative question.

patients' states of mind, pressures exerted by families, and physicians' priorities, responsibilities, and liabilities. Regarding the choice to die, medical ethicists stand between those who, like me, try to formulate standards to govern the surrender of life in dire medical situations, and those whose primary mandate and fiduciary responsibility is to preserve life.

The unavoidable complication is that some terminally ill patients *do* choose to die, that some physicians *do* assist in suicide, and that a few even perform euthanasia for compassionate reasons. It is of paramount importance, therefore, that medical ethicists be provided with standards and especially a rationale on which to ground their advice when patients choose to end their lives, whether by refusing treatment or by taking more direct means. Without standards and an underlying rationale, advising clinicians, patients, and family members regarding terminal patients' choices to end their suffering can only be a more or less happenchance sequence of more and less successful instances of coping with a recurring problem.

What prompted this book, as opposed to a planned third edition of my *The Last Choice*,² is that provision of standards and a rationale for dealing with terminal patients have been greatly complicated by the contemporary rise of multiculturalism and especially the relativism inherent in it. The need to respect cultural values and their influences on assessment standards, and factor them into policy and particular decisions about end-of-life issues, has made dealing with those issues greatly more complex than it was when policy and decisions were made and assessed in the context of a single dominant culture.

The key question, then, is not how many Socrateses die – though I return to this question in Chapter 7. Rather the key question is, How close can we come to emulating Socrates? The criteria I offer here, and the consideration of how relativism and culture impact their formulation and application, are intended to provide medical ethicists, as well as individuals considering ending their lives, with a basis for assessing the rationality of choosing to die for medical reasons.

² Prado, C. G. 1998. *The Last Choice: Preemptive Suicide in Advanced Age*, 2nd edition. New York and Westport, Conn.: Greenwood and Praeger Presses.

Setting the Stage

This book is about the two most fundamental questions underlying current debate about suicide, assisted suicide, and requested euthanasia in medical contexts. Those questions are whether choosing to die rather than endure hopeless torment can be *rational*, and, if so, whether it is *morally permissible*. Only if choosing to die is rational and morally permissible can we go on to consider whether provision of assistance in suicide or of euthanasia should be legalized and allowed by codes of medical ethics.

The questions are hugely complex and cannot be asked without provision of criterial contexts within which they can be answered. If it is rational to choose to die, it is so within philosophical or conceptual parameters. If it is morally permissible to choose to die, it is so within either universal or culturally determined parameters. Moreover, because most cases of choosing to die occur in institutions like hospitals and hospices, institutional cultures – the policies, priorities, and practices of the relevant institutions – need to be considered in establishing the latter parameters.

My original concern with choosing to die or what I call elective death was purely philosophical: I focused on whether choosing to die can be *rational*; that is, whether it can accord with reason and be judged to be for the best. At the time I felt that if my work was applicable in actual dealings with individuals prepared to die rather than face personal and physical devastation, that was all to the good, but that was not my main concern. Further work and especially growing familiarity

with medical ethics made me realize that I had to give a much higher priority to the applicability of my criteria for rational suicide to the cases medical ethicists and clinicians deal with in practice. Though the rationality of choosing to die remains fundamental, I now see that it is insufficient just to establish it. Criteria for rational elective termination of life must be practically applicable. My aim in this book is to provide medical ethicists both with practically applicable criteria for rational and so possibly morally permissible elective death, and with clarification of the grounds of those criteria.

* * *

“Rationality” is defined by the *Oxford Companion to Philosophy* as that “feature of cognitive agents that they exhibit when they adopt beliefs on the basis of appropriate reasons.”¹ This definition captures that to be rational is to rely on sound reasoning and evidence in adopting beliefs and drawing conclusions. The definition, however, is incomplete because it focuses on the cognitive and is silent on the practical. *The Cambridge Dictionary of Philosophy* defines rationality as “a normative concept . . . that, for any action, belief, or desire, if it is rational we ought to choose it.”² The two definitions complement one another, and they jointly capture what is central to assessing choosing to die as rational, which is that *the decision to end life is based on sound reasoning*, and that *the act of ending life is for the best*. This is the sense of “rational” that I have used elsewhere in discussing choosing to die and that I mean in everything that follows.

The question whether it is rational to choose to die is prior to those more commonly asked about whether electing to give up life for avoidance of or relief from great suffering is morally permissible, and whether assistance in doing so should be allowed. If it is not rational to choose to die, then elective death cannot be permissible by any other standard. Only if it is first rational to choose to die do questions legitimately arise about whether it can be morally permissible and

¹ Honderich, Ted, ed. 1995. *The Oxford Companion to Philosophy*. Oxford: Oxford University Press, 744.

² Audi, Robert, ed. 1995. *The Cambridge Dictionary of Philosophy*. Cambridge: Cambridge University Press, 674.

might properly be assisted. The priority of the rationality of choosing to die is bedrock to my claims and arguments.

I have argued elsewhere that choosing to die can be rational.³ Here I recapitulate my arguments and the resulting criteria in order to address the more familiar, and often more pressing, question whether choosing to die may be morally permissible. Doing so requires consideration of a number of issues I was earlier able to avoid, chief among them being issues about how cultural values figure in reasoning about elective death. What mainly prompted me to address the separate question of moral permissibility is the historically recent social development of widespread concern with respecting diverse cultural values in assessment of most acts and practices, including elective death.

The result of needing to deal with questions about the role of diverse cultural values in assessing decisions and their enactment is that consideration of elective death cannot remain at the abstract philosophical level of thought about the pure rationality of choosing to die. The issue of moral permissibility must be addressed. However, that issue can no longer be addressed while presupposing a universal morality. It is now necessary to factor in cultural diversity.

The way I go about determining the rationality and moral permissibility of elective death is by employing what one reviewer of this project called “reflective equilibrium.” This involves venturing criteria, testing them against intuitions and critiques, and revising the criteria to achieve a final version. I employ reflective equilibrium in this and the next two chapters and again in applying the resulting criteria in later chapters. The object of the exercise is to deal as productively as possible with the complexity of the questions about the rationality and moral permissibility of choosing to die. Venturing and revising criteria shed light on the different aspects of

³ Prado, C. G. 1990. *The Last Choice: Preemptive Suicide in Advanced Age*. New York and Westport, Conn.: Greenwood Group; Prado, C. G. 1998; *The Last Choice: Preemptive Suicide in Advanced Age*, 2nd edition. New York and Westport, Conn.: Greenwood and Praeger Presses; Prado, C. G. 2000a. “Ambiguity and Synergism in ‘Assisted Suicide.’” In C. G. Prado, ed., 2000b. *Assisted Suicide: Canadian Perspectives*. Ottawa: University of Ottawa Press, 43–60; Prado, C. G., and S. J. Taylor. 1999. *Assisted Suicide: Theory and Practice in Elective Death*. Amherst, N.Y.: Humanity Books (Prometheus Press). See also Prado, C. G., and Lawrie McFarlane. 2002. *The Best Laid Plans: Health Care’s Problems and Prospects*. Montreal: McGill-Queen’s University Press.

the basic question about rationality and on application of the criteria. I proceed, then, by first applying reflective equilibrium to my own development of criteria for rational elective death, and then segueing into consideration of establishing when elective death is morally permissible. In this way, the basic conceptual issues that concern elective death are illustrated, and I can then consider the more practical issues that concern how cultural values bear on abandoning life rather than enduring the pointless torment of some terminal illnesses.

It merits mention that I realize much of what I recommend in this book is already practiced by many medical ethicists. However, as indicated in the Preface, the point of what follows is to articulate and clarify the theoretical basis of what should be and often is done. There also is the need to provide instruction on the underpinnings of present practices for those new to medical ethics generally, or to the issue of elective death in particular.

* * *

In 1990, when I published *The Last Choice*, my first book on suicide, choosing to die to escape intolerable terminal conditions was beginning to be accepted by medical professionals and in some cases by the public. I agreed with Margaret Battin's comment on the book's dust jacket that suicide would "replace abortion as *the* social issue" of the 1990s. However, choosing to die *in anticipation* of intolerable terminal conditions was still perceived as unacceptable and likely pathological. Contrary to that view, I believed that preemptive or anticipatory suicide is a rational option to avoid the personal and intellectual diminishment and eventual devastation that terminal conditions like Alzheimer's disease and ALS (amyotrophic lateral sclerosis or Lou Gehrig's disease) inflict on those who contract them. I devised criteria for rational preemptive suicide done for medical reasons, and while I thought their provision might be a little ahead of time, I was confident they would soon be acknowledged as important and useful.

Not many agreed with me. Even so ardent a supporter of the right to die as Derek Humphry did not endorse preemptive suicide. Humphry, who at the time was head of the Hemlock Society, made it

clear in his review of *The Last Choice* that his concern was limited to affording terminally ill people the opportunity to end lives that were already irredeemably ruined and increasingly unendurable.⁴ His widely read and debated *Final Exit* exemplified that concern, being a manual devoted to the curtailment of the slow and agonizing process of dying from terminal illness.⁵

As matters worked out over the next eight years, Battin was proven right; suicide did become a major social issue and Humphry's endorsement of suicide as release from pointless suffering came to be shared by many, including legislators in Oregon and Australia. Professional and public debate focused on *surcease* suicide, or on choosing to die to escape present, intolerable circumstances, and especially on *assisted* surcease suicide in medical contexts. The reason for the latter focus is the problematic involvement of others, especially physicians, in the enactment of decisions to die rather than face terrible medical situations. In 1998 I published an extensively revised second edition of *The Last Choice*.⁶ By that time both professionals and laypeople were more familiar with the complex issues of assisted suicide and so-called active and passive euthanasia, and I thought the time had come for preemptive suicide to be taken seriously.

That did not happen, and it took me some time to understand what should have been obvious from the start, which is that preemptive suicide simply is not a social issue – at least in small numbers. Preemptive suicide really is the concern of the individual and perhaps family and close friends. Professional involvement in preemptive suicide, where there is any, is largely limited to a physician, psychologist, or psychiatrist consulted about the likelihood that a terminal illness will develop and perhaps about the would-be suicidist's competence to make a life-and-death decision. Preemptive suicide is mainly the suicidist's own business, and so neither a social nor professional concern on the order of surcease and assisted surcease suicide considered and committed while under medical care.

⁴ Humphry, Derek. 1992b. "The Last Choice." *Hemlock Quarterly*, October, 4.

⁵ Humphry, Derek. 1992a. *Final Exit: The Practicalities of Self-Deliverance and Assisted Suicide for the Dying*. New York: Dell.

⁶ Prado 1998.

Central to its low professional and public profile is that preemptive suicide does not pose questions about professional and legal conflicts, and consequently draws little media attention and is rarely publicly debated. Contrary to this, surcease and especially assisted surcease suicide pose serious professional predicaments and readily capture media and public attention: witness the extensive coverage given to cases like that of Sue Rodriguez.⁷ What most captures media and public attention is that these cases involve individuals who choose to die to avoid surviving in intolerable circumstances, but who for various reasons are physically unable to take their own lives and must rely on the cooperation of their physicians or other caretakers to help them die. These cases, then, essentially are about the conflict between compassion and respect for professional ethics and the law; they are about physicians' conflicts between doing the best they can for patients who are in hopeless situations and having to adhere to legal and ethical requirements.⁸

My concern with preemptive suicide as a rational way of avoiding insupportable personal destruction has not changed. I still see it as a rational and advisable way of avoiding survival as a tormented and much lessened shadow of oneself. However, I came to appreciate that surcease suicide, assisted surcease suicide, and requested euthanasia definitely constitute the social issue meriting primary attention. In 1999 and 2000 I published work on assisted suicide, and that has been the focus of my thinking and research for the last several years.⁹ I still think that consideration of the rationality of preemptive suicide is fundamental to better understanding of the rationality and moral permissibility of surcease and assisted surcease suicide and of requested euthanasia. The reason is that contemplation of preemptive suicide is conducted in the best possible circumstances: that is, when the potential suicidist is not yet affected by the pressures and

⁷ Mullens, Anne. 1996. *Timely Death: Considering Our Last Rights*. New York: Alfred A. Knopf.

⁸ Quill, Timothy. 1996. *A Midwife Through the Dying Process: Stories of Healing and Hard Choices at the End of Life*. Baltimore and London: Johns Hopkins University Press; Quill, Timothy. 2001. *Caring for Patients at the End of Life: Facing an Uncertain Future Together*. New York: Oxford University Press.

⁹ Prado and Taylor 1999; Prado 2000a, 2000b.

uncertainties that inevitably accompany any terminal illness dire enough to prompt thoughts of self-destruction. I believe that keeping in mind how preemptive suicide can be a rational option for someone can help clarify much about elective death that becomes murky with the introduction of a pressing need for release from a punishing condition. Nonetheless, I recognize that surcease suicide, assisted surcease suicide, and requested euthanasia pose the pressing questions.

This new book, then, differs from my earlier ones in terms of focus. But it also differs from earlier ones in other important ways. A second way it differs is that it is written from a perspective reshaped by what I have learned and thought about since publication of *The Last Choice*. Thirdly, the book is written in light of the sea change in health-care professionals' and the public's attitude toward suicide in terminal illness. Briefly put, in the past ten years there has been remarkably quick growth of acceptance of elective death in hopeless medical situations. This growth of acceptance is surprisingly due less to greater willingness to allow avoidance of pointless suffering than to the placing of a higher value on the preservation of personal autonomy and dignity. Perhaps as a legacy of the 1960s, or simply as a result of maturing values, more and more people have come to appreciate the critical difference between living and merely surviving. The idea of preserving life at all costs has waned in importance, and there has been growing recognition that life is not of ultimate and unquestionable value. Given this appreciation, someone's choosing to die rather than bear great suffering is now seen as wise and heroic, when not long ago it was seen as cowardly and immoral, if not pathological.

A fourth, and perhaps the most noteworthy, way this book differs from my earlier efforts is in its consideration of the impact of contemporary *multiculturalism* on the moral, social, and practical permissibility of elective death. At base, multiculturalism is equitable recognition of diversity of belief and value systems and the imperative to respect and accommodate those differences in the assessment of individual acts and of practices. It is no longer possible, then, to discuss whether suicide, assisted suicide, or requested euthanasia is permissible without taking into account how assessment standards applied in particular cases of elective death are affected, if not determined, by different cultural values.

It is important to appreciate at the outset that my concern with multiculturalism is not political; it does not focus on the rights of indigenous or immigrant minorities, as does so much present-day discussion of and legislation regarding cultural diversity. Generic or specific group-directed recognition or protection of ethnic, religious, or linguistic minority rights is not what is at issue here. What is at issue is that individuals reared and enculturated in diverse cultures have diverse cultural values, and those values influence their perceptions and decisions regarding elective death – just as cultural values influence whether a promiscuous young woman is seen and treated as someone needing counseling and support or as defiled and unmarriageable.

Most important to understanding the role of diverse cultural values in deliberation and assessment of choosing to die is that the multicultural imperative to respect the diversity of cultural values is abandonment of construal of assessment standards as universal, as cross-cultural, and so by intent or by default relativization of standards to culture. In Chapter 5 I consider more carefully how multiculturalism is relativistic; here it suffices to say that preparedness to respect diverse cultural values, and all that entails regarding culture-defining beliefs and doctrines, requires that other cultures' basic beliefs not be merely tolerated as current in those various cultures. Those beliefs must be accepted as *legitimately* held in their respective cultures; that means they cannot be critically compared to beliefs held in other cultures. Multiculturalism precludes judgmental assessment of a given culture's core beliefs from the perspective of another culture. Multiculturalism is inherently relativistic: every culture's defining beliefs are as good as any other culture's defining beliefs.

This relativization poses both a philosophical issue and a practical one. The philosophical issue has to do with the acceptability and scope of the entailed relativism; the practical issue has to do with the inevitable disagreements due to different cultural beliefs and values that arise in assessment of the choice to die. In the chapters that follow it will be necessary to consider both issues to the extent that they affect judgments about the rationality of choosing to die.

It is also important to appreciate that how multiculturalism is considered and treated in what follows has little to do with established, particular, cultural suicidal practices, such as *seppuku* or

sallekhana. What concerns us is the role of cultural values in deliberating and assessing the rationality of choosing to die to avoid the devastation of terminal illness, not specific cultural practices having to do with forfeiture of life to avoid dishonor or demeaning capture, or in the interests of political protest. Most identifiable and fairly cohesive cultures have established notions of suicide, notions often bound up with codes of honor or ritualized practices. But self-inflicted death for honor's sake, as manifestation of loyalty, as fulfillment of obligation, as sacrifice for a greater good, and even as the only avenue open to lovers from incompatible families or castes is not relevant here except to the extent that these practices manifest a culture's general attitude toward elective death.

The first point to note, and one to which I return in Chapters 4 and 5, is that cultural attitudes toward elective death are often based on religious doctrinal beliefs. To the extent that generalizations of this sort are viable, it can be said that in Chinese culture, for instance, attitudes toward elective death are mainly a function of Buddhist and Confucian beliefs. Indian culture's attitudes toward elective death are mainly a function of beliefs rooted in Buddhism, Hinduism, and Sikhism. Islam determines attitudes toward elective death in cultures as different as those of Saudi Arabia and Indonesia. European, North American, and Latin American attitudes toward elective death are determined by Christianity, with perhaps the most negative being those grounded in Catholicism. In these latter belief systems, life is a gift from God and not one's own to dispose of. Christianity, like other religions, venerates its martyrs, but martyrdom, however deliberately entered into, is still not *self*-inflicted death. The notable exception in European culture is, of course, the Netherlands, which has pioneered – if that is the appropriate term – elective death for medical reasons.

In any case, our concern is not with cultural specifics or, for that matter, with whether attitudes toward elective death are religious or secular in origin. Our concern in what follows is not with cultural particulars but with the *differences* that diverse cultural values produce in judgments about the acceptability of elective death. These judgmental differences pose a complication with respect to end-of-life issues in that they are products of the application of varying standards to the assessment of both policy and particular decisions about elective death. But the application of varying standards is now inescapable.