

**Ending Life:
Ethics and the Way We Die**

Margaret Pabst Battin

OXFORD UNIVERSITY PRESS

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for Brooke Hopkins

*Season of mists and mellow fruitfulness,
Close bosom-friend of the maturing sun;
Conspiring with him how to load and bless
With fruit the vines that round the thatch-eaves run;
To bend with apples the moss'd cottage-trees,
And fill all fruit with ripeness to the core . . .*

—From John Keats, “To Autumn,” 1819

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ENDING LIFE

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Introduction

Ending Life: The Way We Do It, the Way We *Could* Do It

I want to talk in this collection about dying, about how we do it—and how we *could* do it, if we weren't so caught in conceptual confusion, misleading assumptions, bad argument, and political friction over this issue. How we die, and how we could die, is an issue under sustained debate in the United States and in much of the developed world. The currently visible controversies over voluntary euthanasia in the Netherlands and physician-assisted suicide in Oregon are, I believe, just iceberg-tips of a huge undercurrent of ongoing social ferment. Indeed, the social and political currents now in motion—some of which will be explored in this book—may well determine how we can and must die.

I have to confess that I've been thinking about this issue for twenty-five or thirty years. I go back and forth about it, and although I have a continuously articulated position in print I am still always plagued by the question of whether I should change my mind. You'll see some currents swirling forth, some eddying back, a process of continuing inquiry and reflection that moves like a river, sluggish here, rushing there, heading in one general direction but forever forming backwaters, meanders, waterfalls, and huge deep lakes along the way. How we do and how we could do our dying is still a live issue for me, a troubling one.

The Great Divide Concerning How We Die

To begin to see the theoretical poles that define the scope and central problematic of this issue, think first about Seneca, the Roman Stoic philosopher and statesman

who lived from 4 BC to 65 AD, when Nero ordered him to commit suicide and he opened his veins. In Letter 70 of his *Moral Letters to Lucilius*, Seneca considers “the proper time to slip the cable.” We make many mistakes, Seneca tells us here and in other texts, in thinking about death. Here are four: we assume (1) that death is bad, (2) that death later is better than death earlier, (3) that longer life is better than shorter life, and (4) that death is something that happens to us rather than something we control. All these assumptions seem completely obvious—to us. But here’s what Seneca says:

Living is not the good, but living well. The wise man therefore lives as long as he should, not as long as he can. He will observe where he is to live, with whom, how, and what he is to do. He will always think of life in terms of quality, not quantity. If he encounters many vexations which disturb his tranquillity, he will release himself. He will do this not only in an extreme exigency, but as soon as he begins to suspect Fortune he will look about him carefully to determine whether he ought to have done. He will consider it of no importance whether he causes his end or merely accepts it, whether late or early. He does not shrink as before some great deprivation, for not much can be lost from a trickle. Dying early or late is of no relevance, dying well or ill is. To die well is to escape the danger of living ill . . .

Just as I choose a ship to sail in or a house to live in, so I choose a death for my passage from life. Moreover, whereas a prolonged life is not necessarily better, a prolonged death is necessarily worse. . . . A man’s life should satisfy other people as well, his death only himself, and whatever sort he likes is best.¹

Here’s the core element of the Stoic view: that we—the wise man, in Stoic terms, or, translated into contemporary terms, each thinking, reflective one of us—that we are responsible for the timing and character of the deaths we die. We can’t complain if death goes badly; it is up to us to seize the opportunity to ensure that it goes well. Sometimes this means suicide; sometimes this means dying quietly of old age in our own beds; sometimes this means a dramatic, public act like Cato’s self-sacrifice in preference to slavery or Lucretia’s suicide after she was raped.

There’s an important theoretical point underneath Seneca’s view—one it’s taken me decades to understand. A self-embraced death, a suicide, Seneca argues, is not a premature end to a complete life. It isn’t like a journey cut short, which is incomplete because you don’t get there; rather, Seneca maintains, a life cut short can still be complete if it has been lived well—you do get there, so to speak; you’ve actually lived your whole life. The important thing, Seneca insists, is how well one lives, not how long. That means that the proper time to cut the cable could come at any point.

That’s the Stoic view. But keep in mind all the considerations Seneca doesn’t mention:

1. The impact of suicide on one’s family—spouse, parents, children
2. The effect of suicide on one’s fellows, coworkers, and those involved in joint work, projects, and other cooperative enterprises
3. The invidious role of depression and mental illness

4. The social framing of choices
5. The question of whether such an act, if many did it, would generate pressures on vulnerable persons, including the chronically ill, the elderly, people with disabilities, and others to do likewise, largely for reasons of social cost-saving
6. The question of whether there is some fundamental moral rule that prohibits killing oneself (Seneca certainly didn't think so)
7. The implications for an afterlife, if there is one

These are medieval, modern, and contemporary considerations. Seneca didn't address them, or at least he didn't pursue them much. But *we* have to. This is where the philosophical work begins, to try to sort out whether one form of concern takes priority over another, whether one's own sense of when it has become the proper time to slip the cable (which Seneca thinks you will almost instinctively know) is to be trumped by social and principled concerns, or the other way around.

Seneca and the other Stoic thinkers thought self-willed death, at the right time and for the right reasons, was a good thing—that way lay virtue. The Christian thinkers who followed them thought just the opposite: that issues about impact on society, on others, and especially fundamental religious/ethical law were central—one ought *never* act to deliberately end one's own life. That way lay sin. On the contrary, suffering, acceptance, the willing embrace of martyrdom—these were the ways in which the faithful should meet death: death should come at God's will, not man's. This is St. Thomas Aquinas's view of the morality of suicide, the issue that Seneca had also been addressing:

... to kill oneself is altogether unlawful for three reasons. First, because every thing loves itself, it is thus proper for every thing to keep itself in being and resist decay as far as it can. Therefore, to kill oneself is contrary to natural inclination, and contrary to the charity according to which everyone ought to love himself. Hence self-killing is always a mortal sin, inasmuch as it stands against natural law and charity.

Second, because every thing that is a part belongs to a whole, every man is part of a community, and as such is of the community. Therefore, he who kills himself injures the community . . .

Third, because life is a gift divinely given to man, and subject to the power of Him "who kills and makes to live." Therefore, he who deprives himself of life sins against God . . . To God alone belongs the power over death and life . . .²

You don't have to be religious to have imbibed something of this view; it has become a fundamental part of Western culture, the notion that one ought not end one's own life. The other major monotheist religions have incorporated this view as well: Judaism had developed it (though with exceptions to avoid apostasy) by the time of the Talmudic period, and in Islam, the Prophet biography includes a categorical rejection of suicide, though it is currently under challenge in notions of *jihad*. In Western culture, of these three, it has been Christianity that has most resolutely rejected suicide.

Some later thinkers in the West, like Hume, sided with the Stoics; others, like Kant, argued for categorical prohibitions. Mme. de Staël, writing at the end of the

18th century, argued ardently for the liberty of suicide; she then changed her mind and, writing at the beginning of the 19th century, argued vehemently against suicide on essentially religious grounds. Nietzsche was for; Schopenhauer's view was guarded; Durkheim claimed it was an issue of social organization and not a moral issue at all. The rest, in a sense, is history—that descent from high theory to the knotty legacy of tension over right-to-die issues that is boiling up now in Oregon, in the Netherlands, in Switzerland, Canada, Germany, England, Belgium, Australia, Japan, everywhere in the developed world where death in the grasp of high-tech medicine is often seen as the unfortunate alternative.

Underlying this debate is what I think of as the Stoic/Christian divide about the individual's role in his or her own death: whether one's role should be as far as possible active, self-assertive, and responsible and may include ending one's own life—or, on the other hand, acceptant, obedient, and passive in the sense of being patient, where “allowing to die” is the most active step that should be taken. In the contemporary world we're still battling around the edges of this divide. When by a 51–49% majority and then again 60–40% Oregon legalizes physician-assisted suicide for people who are terminally ill; when Canada's Supreme Court rules 5–4 that physician-assisted suicide cannot be allowed for someone pleading for it in the final stages of ALS; when the Australian government reverses the Northern Territory's law permitting physician-assisted suicide and euthanasia in less than a year; when the Dutch Supreme Court rules that intolerable suffering can be mental as well as physical and thus an adequate basis for requesting euthanasia; when Britain's High Court and House of Lords reject a plea from a woman dying of ALS and the European Court of Human Rights in Strasbourg—where she travels in an ambulance—rules that her human rights are not being violated if she cannot be helped to die; when the U.S. Supreme Court rules 9–0 against a right to assistance in suicide but in effect leaves the matter up to the states; when the U.S. Attorney General moves to undercut Oregon's law with a reinterpretation of the Controlled Substances Act, the Ninth Circuit rules against this move, and the Attorney General files against just before he resigns, we should see these as just a few more skirmishes among the ongoing battles in this continuing conflict—part of the ongoing tension that results from the tectonic-plate collision of essentially Stoic and essentially Christian bodies of thought about a person's appropriate role in his or her own dying.

As members of contemporary culture, at least in the West, we almost all have deep-rooted allegiances to both, regardless of our surface affiliations and whether we're the slightest bit religious or not, and that's why this issue strikes such painful nerves. Not only does this tectonic-plate collision of deep-rooted bodies of thought affect our thinking about suicide, but it colors our attitudes toward all the other modern medical practices that come into play in treating (or not treating) the dying: do-not-resuscitate orders, withholding and withdrawing of life-prolonging treatment such as dialysis and respiratory support, the use of escalating levels of opioids, the withdrawal of artificial nutrition and hydration (especially in the practice known as terminal sedation), “letting die” in general, and many forms of “comfort care,” as well as physician-assisted suicide and euthanasia. I've focused to a considerable extent on the various forms of assisted dying because that's where the issues are

most vivid, but the Stoic/Christian divide underlies issues in all the ways we die—and *could* die.

In exploring these tensions in this collection of writings, I have at least five purposes in mind: to challenge assumptions about how we can and should die; to illuminate the structure of arguments for and against physician-assisted dying; to explore the morality of suicide (the deepest issue underlying the death-and-dying controversies that are visible in public debate); to speculate a bit about how the future might look and what we should be prepared for; and to look for possibilities of resolution in these ancient, yet new, debates. This collection is thoroughly diverse: it offers systematic essays, practical notes, historical explorations, policy analyses, cross-cultural comparisons, pieces with political implications, fiction, creative nonfiction, and essays on matters as varied as clinical suicide prevention, suicide bombing, serpent-handling, and the development of high-tech methods for non-drug-aided death. While this collection takes the argument over physician-assisted suicide as a central framework, many of these pieces are used here in a way that triangulates into this issue, so to speak, from comparatively unconventional vantage-points. Nearly everything in this collection has real relevance to the issues in physician-assisted suicide (though that may sometimes be difficult to see), but it also addresses the larger, tectonic-plate issue of the role a person may play in his or her own dying.

Most of these pieces have been written over the last dozen years, roughly since the publication of my earlier volume of essays *The Least Worst Death*—or, if you include “Roebeck” and “Terminal Procedure,” one fiction, the other creative nonfiction, they stretch back almost thirty years. Some of the pieces, like “Euthanasia: The Way We Do It, the Way They Do It,” have been continuously revised and updated, while others, like “Going Early, Going Late,” “High-Risk Religion,” and the creative pieces, remain deliberately unrevised, despite on the one hand huge advances in medicine or on the other considerable social change that has occurred since the original publication of those pieces. My general strategy has been to preserve insights where they remain relevant, and some of the earliest pieces I believe still offer insight in a way that more contemporary work no longer can. Still other pieces in this collection are quite new, written for this collection as it has taken shape—the piece puzzling over possible explanations for the same-day deaths of John Adams and Thomas Jefferson, for example. But despite its diversity in type and in time of composition, the pieces in this collection all nevertheless revolve around the central arguments in the death-and-dying debates.

On the Structure of the Argument over Physician-Assisted Dying

The death-and-dying debates, especially where they focus on physician-assisted dying—euthanasia and suicide—involve five central arguments—two pro, three con. These include two arguments for moral acceptance and/or legalization, the argument from autonomy or self-determination and the argument from the relief of

pain and suffering, sometimes also called the argument from mercy. On the other side, the principal arguments against assisted dying include the argument from the intrinsic wrongness of killing, the argument concerning the integrity of the medical profession, and the argument about the potential for abuse, the so-called slippery-slope argument. The first of the pieces in this collection, “Euthanasia and Physician-Assisted Suicide,” sketches an introduction to the overall issues of assisted dying; this exploration of the ethical framework is continued in “Is a Physician Ever Obligated to Help a Patient Die?”

The pieces in this volume, as well as those in *The Least Worst Death*, explore this overall argument, bit by bit. Some—indeed many—focus on or touch on issues of autonomy: for example, “Going Early, Going Late: The Rationality of Decisions about Physician-Assisted Suicide in AIDS,” the case study “Scott Ames,” the short novella “Robeck,” the lengthy analysis of challenges to autonomy in religious contexts in “High-Risk Religion,” and the future-oriented pieces “Genetic Information and Knowing When You Will Die,” “Extra Long Life: Ethical Aspects of Increased Lifespan,” and the closing piece, “Safe, Legal, Rare.” Is autonomy central? How is it threatened? Should autonomy be recognized as central in public policy and law? Does the requirement of “informed consent” actually protect autonomy? Is autonomy even possible in the first place? Does religion enhance autonomy or get in the way? What are the implications in practice of recognizing autonomy at a theoretical level? The concept of autonomy has been on the ropes in philosophical discussion in recent years, but I still think it is crucial to the death-and-dying issues.

At the same time, some pieces focus on or touch on arguments about the other principal case in favor of assistance in dying—pain and suffering, both physical and psychological, what I sometimes like to call the argument from mercy or the argument from compassion. These include some of the same pieces, like “Scott Ames,” and “Going Early, Going Late,” as well as others, including “Is a Physician Ever Obligated to Help a Patient Die?” The futurist piece “Safe, Legal, Rare?” in particular considers whether adequate pain control would obviate any need for physician-assisted dying.

The principal claims on the “con” side of the argument over assisted dying are the claims that killing is intrinsically wrong, that allowing assistance in dying—especially *physician* assistance—would undermine the integrity of the medical profession, and that permitting the deliberate ending of life would pose risks of the so-called slippery slope and the possibility of abuse. This would involve both compromises to the integrity of physicians and direct economic and social pressures that oblige or force patients to choose assisted dying when they would not otherwise do so. A good many pieces here deal directly or indirectly with these issues. For example, “High-Risk Religion” deals with (among other things) expectations within a religiously defined community about risking death, while “Is a Physician Ever Obligated to Help a Patient Die?” deals with (among other things) whether the physician/patient relationship would be altered if assisted dying were allowed. “Euthanasia: The Way We Do It, The Way They Do It” articulates objections to various social policies about how we die, and in doing so argues that the one currently in force in the United States (except in Oregon) may not be the most suitable one, and indeed may be the most risky for patients in vulnerable groups.

Looking at both (or all) sides of the argument over assisted dying is something I've tried to be resolute about doing for years. This hasn't been a systematic effort, and most of these pieces aren't easily categorized under one or the other side of the argument. Rather, I've looked first at one part of the argument, then its opposite, then gone on to something else, then eddied back to the issues I find most deeply troubling and least amenable to resolution. Furthermore, since an interesting view must usually develop over time and rarely springs to life full-blown, many of the pieces in this and in my earlier book *The Least Worst Death* represent repeated and re-repeated attempts to face an issue—return trips often necessitated by something that has come to light in exploring another component of the picture. Despite this seemingly erratic pattern, this collection, together with the earlier one, is intended to examine the underlying philosophical components of the general argument about how we die and how we could die, especially focusing on assistance in dying.

Challenging Assumptions

Many of the pieces in this volume have a faintly Socratic cast, in that they involve challenging assumptions that are held ubiquitously but in a largely unquestioning way. These assumptions include at least four types.

Empirical Assumptions

Among the empirical assumptions challenged in this volume are many that play a substantial but unquestioned role in the discussion of end-of-life issues, such as the claim that there aren't big differences in the way that the advanced industrial nations with well-developed health care systems approach end-of-life issues, or that patients in vulnerable groups are the targets of extra pressure to die.

Values Assumptions

Some of the articles in this book focus on assumptions about values that are hidden, partly obscured, or evident but taken for granted in the public discussion. For example, all the proposals for legalization of physician-assisted suicide, including Oregon's Death with Dignity statute and ballot measures in Washington, California, Michigan, Maine, Hawaii, and elsewhere, have explicitly asserted that a physician is not obligated to provide a patient with assistance in suicide. I agree that this is an appropriate public policy, but in "Is a Physician Ever Obligated to Help a Patient Die?" I've tried to issue a warning for those who assume the answer is *no*.

It is widely assumed that physician-assisted suicide, if it is legalized, should remain rare, a last-resort option where pain and symptom control fail. Indeed, I've joined in arguing this way in other publications.³ I think this too is appropriate as a matter of public policy—that it should be assumed that such cases are comparatively rare. Yet, examining the underlying values assumptions more closely from a philosophical point of view, I do not see the basis for such an assumption. That is the argument pursued in "Safe, Legal, Rare?"

It is widely assumed that religion and deeply held religious belief are “life-affirming” and stand opposed to any form of suicide or self-caused death. In “Primary Texts,” “High-Risk Religion,” and “The ‘Ethics of Self-Sacrifice,’” I try to show that religion is not nearly so simple.

Dichotomizing Assumptions about Practical Strategies

A widespread characteristic of thinking about end-of-life situations involves overly stark dichotomies—either/or dilemmas in which just two choices are offered. A number of the pieces included here challenge such assumptions in practical contexts: for example, “Scott Ames,” which challenges the clinical choices proposed for dealing with a suicidal patient; multiple ways of interpreting the striking fact that John Adams and Thomas Jefferson both died on precisely the 50th anniversary of the signing of the Declaration of Independence; and recommendations for expanding the richness of social observation, in “Empirical Research in Bioethics: The Method of Oppositional Collaboration.” These all combat dichotomizing assumptions about practical policies and reasoning with respect to dying.

Predictive Assumptions

The fourth kind of assumption at work in much of the discourse about end-of-life issues is a bit harder to detect, largely because such assumptions typically play a less conspicuous and less challenged (though just as important) role. These are predictive assumptions about the future. They are partly empirical, in the sense that they trade on projections from current empirical states of affairs; they are also partly value-laden, in that they very, very often reflect the ideological biases of whoever is making the prediction—or, rather, whoever is making the unchallenged, unquestioned predictive assumption that lies behind many sorts of claims about the future. Some of the articles in this volume—for example, “Genetic Information,” “Extra Long Life,” “Global Life Expectancies and International Justice: A Re-emergence of the Duty to Die?” the essay on NuTech, “New Life in the Assisted-Death Debate,” and “Safe, Legal, Rare”—explore issues about the future; they seek to uncover, examine, and challenge both empirical and values assumptions that are typically made about the future in order to reflect on how a future might look different if such assumptions weren’t in place.

Not all of these pieces are about physician-assisted dying or even dying in medical contexts. Some of them address what may seem to be unrelated topics—suicide bombing, laboratory research with dogs, and serpent-handling, for instance—but in fact they are all intended here to provide novel ways of looking at the central issues in the death-and-dying debates. For example, “The Ethics of Self-Sacrifice: What’s Wrong with Suicide Bombing?” examines some of the basic arguments about the wrongness of killing, in this case self-killing for an understandable political purpose. “Terminal Procedure” takes a close-up look at killing in the interests of science. “High-Risk Religion,” examining situations in which faithful adherence to a religious group’s doctrines or practices may mean death, exposes some of the

forms of social construction of choice that underlie fears of the slippery slope. “Robeck” moves beyond the question of self-willed death in terminal illness to pose the same question in the context of old age, where medical concerns are not at issue.

The Uses of Fiction and Creative Nonfiction

One of the serious risks of observation in bioethics—about how people live and how they go about dying—is that observation is easily theory-infected: this happens in accounts of suffering, autonomy, manipulation, pain, the mistreatment of vulnerable patients, and everywhere where we try to look at actual lives of people with whom bioethics is concerned. As “Oppositional Collaboration” points out, theory-infectedness is a real risk in bioethics and social observation generally: we see things that support the academic points we want to make, and overlook the rest.

It is, I think, an especially great risk in fiction, one reason I don’t write fiction anymore. But I did many years ago—before there was a field of bioethics with its steady diet of puzzle cases and its ongoing flirtation with legal decisions and its romance with policymaking and, most important, its elaborate catechism of *autonomy/nonmaleficence/beneficence/justice*. Back in those years, the late 1960s and early 1970s, bioethics wasn’t even a recognized field: journals like the *Hastings Center Report* had barely been established (first issue June 1971), Sam Gorovitz was just bringing together the group that edited the first bioethics text, *Moral Problems in Medicine* (not published until 1976), and graduate programs like that at Georgetown and Penn and Utah didn’t offer specialization in bioethics. There weren’t any big conventions and there weren’t any TV interviews and there wasn’t any “bioethics industry.” But I was writing fiction then, and what would later come to be called “creative nonfiction,” and I’ve included two of these pieces here. This is not just to support bioethics’ comparatively new recognition of narrative as a respected form of investigation—including narrative in both nonfiction first-person accounts and in fictional constructions—but because I think it may preserve certain early intuitions about issues like autonomy, beneficence, paternalism, respect for persons, and ending life that are hard to capture in bioethics’ academic discussions.

Whatever may be assumed in other quarters, fiction and its close cousin creative nonfiction are not irrelevant to theory. On the contrary, fiction and creative nonfiction may do a great deal to measure and assess theory and to force reflection on otherwise easy points. Indeed, it is tempting to see academic prose, creative nonfiction, and fiction as forming a kind of genre-continuum for exploring difficult social issues. For example, the academic essays presented in this collection are in general strongly autonomist, rooted in the view that a person should be free to live his or her life as he or she sees fit, provided, of course, that this does not cause substantial harm to others. But “Robeck” serves to complicate this view by showing that the issue of autonomy is not a simple matter at all—even if the principle should, as the essays in this volume argue or imply, remain unchanged. Similarly, while the essays in this volume also clearly assume that killing is in general wrong

but argue that certain clearly voluntary cases of self-killing in terminal illness and perhaps old age are to be morally respected, “Terminal Procedure” serves to complicate these views by evoking a basic gut reaction about killing itself: it is hard to watch and hard to participate in, even when one’s role is indirect and it happens, so to speak, off-stage.

Because these two pieces, one largely fictional, the other much closer to the genre of creative nonfiction, are “pre-theoretical” in the sense that I’d barely heard of bioethics at the time they were written and had little idea of bioethics’ theoretical constructions, they offer a kind of view that is comparatively innocent of theory but reinforces and challenges later theoretical accounts. For example, the gut reaction on which “Terminal Procedure” trades (known in bioethics as the “yuck” factor) is often used as an argument in public policy discussion; the question this piece serves to raise is whether exploitation of the yuck factor is a legitimate move in rational argumentation or a bogus appeal to the emotions. I might venture a more careful answer to that question now, but I couldn’t revise these pieces without the risk of theory-infection, so here they are, just as they were originally written.

“Terminal Procedure” was written around 1973, while I was taking a graduate class from the now-famous Daniel Dennett, when he was a young philosopher with an interesting theory on the way up—but although the account is influenced by Dennett’s work, it is quite innocent of theory in bioethics. Since there wasn’t any bioethics then, or at least I hadn’t heard of it, I didn’t have any developed views about autonomy, nonmaleficence, justice, all that. I just looked around and wrote about what I saw, what bothered and disturbed me. Desperate for space to work in while I was a graduate student—this was at the University of California at Irvine—I’d borrowed a desk in Michael Cole’s neuropsychology lab. It was just an old, brown wooden desk over in the corner of the lab, where I thought I could get some work done. This happened a long time ago—the lab equipment seems antiquated now and the science being done outdated, long since incorporated in the basic understanding of the field, no longer new. There were people who worked in the lab where I was using that desk. A man I’ve named Boaz ran the lab, and there was a young dark-haired woman named Maia in the lab, nice people to work around, but there were 23 dogs with names like Mustard and Pablo and Francesca who would nuzzle around the base of my desk, let me scratch their heads, play with them when my attention drifted. This isn’t fiction; this is the way it happened. Maia, the lab assistant who ran the experimental trials on these dogs, was absent from work the day of the events described in the piece, and I played her role. That’s how I know something about killing, even if it was just dogs and even if it was indirect and even if it was done for an important scientific cause. I think it is crucial for bioethicists—like me—who talk and write about end-of-life topics like euthanasia and physician-assisted suicide and pulling the plug to keep in mind the unsettling, stomach-disturbing, conscience-trying unease that acquiescing in, or contributing indirectly to, or actively taking part in ending life can produce. This piece doesn’t focus on the theoretical considerations bioethics offers about killing and letting die, life-termination and so on; it is about the way the “yuck” response can well up in one’s throat, even though the ending of life is in the interests of science, even though the conditions are intended as humane, and even though in

the end it involves dogs, not people. There is a lot in this volume of academic essays about how life ends and how we do and could make it end—all part of an extended exploration of the Stoic/Christian divide over the appropriate role of the individual in his or her own dying—but I’ve wanted you to know what killing has felt like to me.

Exploring the Future

Though considerations about the future properly begin with the historical selections like “Collecting the Primary Texts: Sources on the Ethics of Suicide” and “July 4, 1826,” the essay wondering what could have happened to account for the fact that Adams and Jefferson died on the same significant day, it is the final group of selections that more directly explores the future. What will death and dying be like in our future? How will our underlying assumptions change? What technological advances will reshape this most basic fact of our lives? These pieces, especially “Genetic Information,” “Extra Long Life,” “Global Life Expectancies,” and “Scheduled Drugs versus NuTech” explore some of the ways our experience and practice with respect to our own deaths may change. These pieces are speculative, of course, in contrast to the several more empirically constrained pieces earlier in the volume, but it is the sort of speculation we cannot afford not to make if we are to consider not only how we do die but how we *could* be doing our dying. All the practices at issue in this volume are undergoing very rapid evolution—though it is sometimes difficult to foresee in what direction—and we cannot be content with analyses of them just as they are right now. Thus while this volume is partly analytic, in the usual mode of critical philosophers, it must also be partly visionary, in the mode of philosophers who use the analysis of predictive assumptions to speculate openly about the future.

Looking for Resolution

What about resolution? I’ve tried. I’ve been trying for many years; but I think the project of achieving resolution in the death-and-dying debates is overwhelmingly difficult. This is because, in part, the two huge tectonic plates of Stoic and Christian thinking are still in active collision in much of our thinking about these issues—the one a body of thought that insists that the individual be responsible for his or her own dying, the other a view that sees dying as something the individual must in the end accept. One view thinks of dying as something you do; the other sees it as something that happens to you. They’re both partly right, of course; the trick is to capture these partial truths in a workable resolution.

There are hints and sketches everywhere in this volume of a potential resolution, but no official recipe. The last two selections offer differing approaches to the possibilities of resolution: “Oppositional Collaboration” says something about practical procedures in informal research that bear on how to seek resolution, while “Safe, Legal, Rare” says something about the content of resolution and—by going

far beyond it—what it might look like. It’s the closing paragraphs of the very first piece in this collection, the introduction to the death-and-dying debates “Euthanasia and Physician-Assisted Suicide,” that first introduce the possibilities of resolution in proposing a notion of “advance personal policy making,” and the final paragraphs of “Safe, Legal, Rare?” that sketch something of what this might look like in practice, but the full development of such a notion must remain for another day. Instead, in a sense, this volume itself serves as an exercise in advance personal policy making—you can tell what I’d want, what I wouldn’t want, where I’d waffle, and what I’d resolutely seek. Yet I can hardly expect to impose these views on anyone else. In that sense, “advance personal policymaking” appropriately remains in the fullest sense an exercise for the reader.

Notes

1. Seneca, *Letters to Lucilius*, excerpts from Letter 70, in *The Stoic Philosophy of Seneca*, ed. and trans. Moses Hadas (New York: Norton, 1958).
2. Thomas Aquinas, *Summa Theologiae* 2a2ae, question 64, article 5, trans. Michael Rudick, unpublished text.
3. Timothy E. Quill and Margaret P. Battin, eds., *Physician-Assisted Dying: The Case for Palliative Care and Patient Choice* (Baltimore: The Johns Hopkins University Press, 2004).

DILEMMAS ABOUT DYING

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Euthanasia and Physician-Assisted Suicide

Introduction

Something is amiss with the debate over euthanasia and physician-assisted suicide. When it emerged into public consciousness in the mid-1970s, the debate got off to a rousing start, as philosophers, doctors, theologians, public-policy theorists, journalists, social advocates, and private citizens became embroiled in the debate. On the one side were liberals, who thought physician-assisted suicide and perhaps voluntary active euthanasia were ethically acceptable and should be legal; on the other side were conservatives, who believed assisted dying was immoral and/or dangerous to legalize as a matter of public policy. Over the several decades in which this debate has been accelerating it has achieved a lively, florid richness, both as a philosophical dispute and as a broad, international public issue.

That is the good part. In this chapter I want to explore the richness of this debate by showing something of the terrain of the debate and the figures who have inhabited it, both the public figures and the academic ones partly behind the scenes. But I also want to explore the not-so-good part. I am particularly concerned with what has gone wrong in this debate—or, more precisely, what has not gone quite right just yet.

The Development of the Argument in the Assisted-Dying Debate

Although disputes over the moral status of suicide are found as far back as the First Intermediate Period of ancient Egypt, some two millennia BC, the debate about *physician-assisted* suicide and *physician-performed* euthanasia is new, occupying academic and public attention primarily in the late twentieth century and the early twenty-first. The emergence of this issue reflects a basic shift in the epidemiology of human mortality, a shift away from death due to parasitic and infectious disease (ubiquitous among humans in all parts of the globe prior to about 1850) to death in later life of degenerative disease (Olshansky and Ault 1987)—especially heart disease and cancer, which now together account for almost two-thirds of deaths in the developed countries. In earlier periods of human history, physicians could do little to stave off death; now, improvements in public sanitation, the development of immunization, the development of antibiotics, and the many technologies of modern medicine have combined to lengthen the human lifespan, particularly in the developed world. For much of human history, life expectancy hovered between 20 and 40; in the developed countries, at the beginning of the twenty-first century, it is nearing 80 and, unless infectious disease becomes more prevalent again, is expected to increase. The result is that, in the developed world, with its sophisticated health-care systems, the majority of the population in these countries dies at comparatively advanced ages of degenerative diseases with characteristically long down-hill courses, marked by a terminal phase of dying. On average, people die at older ages and in slower, far more predictable ways, and it is this new situation in the history of the world that gives rise to the assisted-dying issues to be explored here.

The debate over euthanasia and physician-assisted suicide pits arguments about autonomy and about relief of pain and suffering on the ‘for’ side, versus arguments about the intrinsic wrongness of killing, threats to the integrity of the medical profession, and potentially damaging social effects on the ‘against’ side.

Principal arguments *for* are:

- the argument from autonomy;
- the argument from relief of pain and suffering.

Principal arguments *against* are:

- the argument from the intrinsic wrongness of killing;
- the argument from the integrity of the profession;
- the argument from potential abuse: the slippery-slope argument.

It is to this overall schema that I will be referring in exploring the five component arguments to be examined below, which I will treat in the order indicated above, for reasons that will become evident later on. It is this overall schema that I will also have in mind in suggesting what seems to have gone wrong with the assisted-dying debate—or, rather, has not gone quite right just yet.

The focused debate over physician-assisted dying began in the wake of the

civil rights movements of the late 1960s and early 1970s, as many formerly disenfranchised or disregarded groups sought recognition of rights or a greater range of rights than had previously been accorded them: blacks, women, people from religious minorities, people with disabilities, and—gradually—medical patients, including patients with terminal illnesses. As in all these groups, the quest for greater respect and a greater range of rights developed with increasing force. With the new availability of antibiotics and technologies like intravenous lines, respirators, and dialysis machines, medicine's capacity to extend the lives of dying patients had begun to increase, but patients themselves were still regarded as 'patients'—comparatively passive subjects of medicine's ministrations. They were rarely understood as agents of autonomous control, but rather as naive and frightened parties appropriately treated in paternalistic ways. In the 1960s, patients with fatal illnesses were rarely (only about 10 percent of the time) told the truth about fatal prognoses. Consent for experimentation was often ignored (as in the infamous Tuskegee syphilis study), and consent for therapeutic treatment—fully informed and fully voluntary consent—comparatively rarely sought. Truth telling and autonomy were hardly central values of medicine; doctors were expected to do what they thought was best for patients, and—believing patients would be harmed if told they were dying—routinely hid fatal diagnoses and urged patients to go on fighting as long as they could.

Gradually, however, it came to be recognized that continuing all-out treatment could be painful, dehumanizing, and pointless. Thanks in large part to Elizabeth Kübler-Ross's influential book *On Death and Dying* (1969), by the mid-1970s it was becoming socially possible to talk openly about death. Kübler-Ross had described a series of five stages through which the person who learns he or she is terminally ill will pass in facing death (denial; anger; bargaining; depression; and a final stage she called detachment but that became popularly known as acceptance); Kübler-Ross held that it was better for patients if the fact that they were dying was openly acknowledged. The California Natural Death Act of 1976 marks one of the earliest legal recognitions of this changing social perception, since it enabled the patient who knew the truth to decline or discontinue treatment that might otherwise prolong the process of dying; the law served to protect their physicians from prosecution for failure to treat. State by state, similar 'living-will' legislation began to permit terminally ill patients to make advance choices about withholding and withdrawing treatment, now that, with increasing frequency, they were being told the truth that they were dying.

During this long process of transformation, several central figures emerged to argue in favour of physician-assisted suicide. British journalist Derek Humphry, widely recognized as the founder of the right-to-die movement, published *Jean's Way* (1978), describing in heart-rending detail his assistance in the suicide of his first wife, dying of cancer. By 1980, then in Los Angeles, Humphry founded the Hemlock Society, a grassroots organization committed to the legalization of physician-assisted suicide. The first philosophical voices in the new debate began to be heard as well: philosophers like Tom Beauchamp, Ray Frey, Dan Brock, David Mayo, and myself, in the United States, and those like John Harris and Jonathan Glover in the United Kingdom, Carlos Prado in Canada, and Helga Kuhse

and Peter Singer in Australia all began to weigh in, largely supporting an autonomy-based view. Although they developed their views in somewhat different ways and responded quite differently to the various objections raised, they all subscribed to what might be called the argument from self-determination or autonomy. And, of course, they all faced the same objections from opponents.

The argument from autonomy is the first of the five components of the overall debate outlined above, one of the two principal arguments on the ‘for’ side. Because even this one component is too complex to examine fully here, I present it just as a schematic outline and will discuss only the more significant parts; it should be evident that its sequences of argument/objection/counter-objection could be extended in great detail through many more sub-arguments and counter-counter-objections.

Components of the Assisted-Dying Argument

The Argument from Autonomy (For)

Just as a person has the right to determine as much as possible the course of his or her own life, a person also has the right to determine as much as possible the course of his or her own dying. If a terminally ill person seeks assistance in suicide from a physician freely and rationally, the physician ought to be permitted to provide it.

- *Objection.* True autonomy is rarely possible, especially for someone who is dying. Not only are most choices socially formed, but in terminal illness depression and other psychiatric disturbances are likely to be a factor.
 - *Counter-objection.* Even if many choices are socially shaped, they must be respected as real choices.
 - *Counter-objection.* Rational suicide is possible, and it is possible for patients to make choices about dying without distortion by depression.
- *Objection.* One cannot impose on another an obligation to do what is morally wrong, even if one’s own choice is made freely and rationally. Since suicide is wrong, the physician can have no obligation to assist in it.
 - *Counter-objection.* This merely assumes, but does not prove, that suicide in circumstances of terminal illness is morally wrong.
 - *Counter-objection.* The physician is not obligated to provide assistance in dying, but should be free to do so if he or she wishes.

Autonomy, involving both freedom from restriction (liberty) and the capacity to act intentionally (agency), is the central value to which this argument appeals, and respect for a person’s autonomous choice the social principle it entails. In the context of end-of-life medical care, respecting autonomy for the dying patient not only means honouring as far as possible that person’s choices concerning therapeutic and palliative care, including life-prolonging care if it is desired, but could also mean refraining from intervening to prevent that person’s informed, voluntary, self-willed choice of suicide in preference to a slow, painful death, or even provid-

ing assistance in realizing that choice. Certainly, respect for autonomous choice had been understood (most fully by Kant) to involve respect for rational self-governance, and to be limited (as Mill had pointed out) by the harm principle: respect for a person's autonomous choice does not license just any old act—not crazed acts and not acts that harm others. But the principle does insist that free, considered, individual choice, where one is the architect of one's own life and the chooser of one's own deepest values, must be respected—including, at least as proponents interpret the principle, choices of physician-assisted suicide.

The early theorists were particularly concerned with what was called the issue of 'rational suicide'. The question was whether a person could rationally choose to die or whether such a choice was always a product of depression, a frequent concomitant of terminal illness that narrows one's view of the range of alternative futures, when the irrationality of the choice is compounded by the fact that the person making this choice can have no objectively confirmable belief about what might happen to him after suicide, at least assuming an agnostic view about whether there is or is not an afterlife. Certainly, such issues had been discussed as early as the time of Lucretius, but they took a new, more psychiatrically informed focus in the light of twentieth-century clinical theories of depression and other mental illness, as well as postmodernist claims that seemingly autonomous choices are actually socially formed. Could suicide be rational and rationally chosen? Could it be the product of a fully autonomous choice? Advocates of physician-assisted suicide said yes, taking this as a mainstay of their position.

The most direct, immediate response to the concept of 'rational suicide' was an objection to suicide itself on religious and ethical grounds, an objection most forcefully pursued by Catholic thinkers. This is the opening argument of the 'against' side in the schema above.

The Argument from the Intrinsic Wrongness of Killing (Against)

The taking of a human life is simply wrong (witness the commandment 'Thou shalt not kill'); since suicide is killing, suicide is also wrong.

- *Objection.* But killing is socially and legally accepted in self-defence, war, capital punishment, and other situations; if it can be accepted there it could be accepted where it is the voluntary, informed choice of the person who would be killed.
- *Counter-objection.* In self-defence, war, and capital punishment, the person killed is guilty; in assisted suicide, the person killed is innocent.

Killing is understood as morally wrong in virtually all cultures and religious systems. Judaism, Christianity, Islam, Hinduism, Buddhism, Confucianism, and many other religious traditions prohibit killing; so do the moral and legal codes of virtually all social systems. Since suicide is a form of killing, this argument observes, suicide—and with it assisted suicide—is wrong ('sinful', 'taboo', 'reviled by God', and so on) as well. However, although this view is shared by all the major world

traditions, it has been Roman Catholicism that has been most active in the political debate over physician-assisted suicide in Europe and the USA.

According to the teachings of Catholicism, suicide violates the biblical commandment 'Thou shalt not kill.' Self-killing can never be permitted, even in painful terminal illness, although if it is caused by depression or other psychopathology, it may be excused from ecclesiastical penalties like denial of funeral rites. It was Augustine in the early fifth century who first interpreted the commandment as a prohibition of suicide. Aquinas, in the thirteenth century, developed an extensive argument against suicide, arguing that because 'everything loves itself' and seeks to remain in being, suicide is unnatural; that suicide injures the community; and that suicide rejects God's gift of life. From Aquinas on, the position of the Catholic Church has been quite uniform: unless someone is driven by insanity and hence excused from blame, suicide is always wrong. (In practice, the Catholic Church has often assumed that suicide victims were emotionally disturbed or mentally ill, and on that ground has withheld blame and permitted church rites to be performed.) Catholic contributors to the contemporary debate over physician-assisted suicide in terminal illness, like Kevin Wildes (1993), John Finnis (1995), and John Noonan (1998), held this view; physician-assisted suicide, even if it could be 'rational', would still, in this view, be gravely wrong.

Proponents of physician-assisted suicide pointed out that, while killing is morally and legally regarded as wrong in general, in some exceptional circumstances—for instance, in war, self-defence, and (though now more controversially) capital punishment—it is accepted as morally permissible. Other religious traditions have different ranges of exceptions, though most accept killing in (legitimate) war and in self-defence. But, the objection goes, if killing could be morally acceptable in some or all of these circumstances like war, self-defence, and capital punishment, why not self-killing or self-directed killing in painful terminal illness, when the killing would be for good reason and any assistance offered in performing it occurs at the express request of the 'victim'?

A Catholic response, employed by a number of writers, seeks to distinguish between killing of the 'innocent' and killing of those who, guilty of aggressive or immoral actions, are not. Proponents of physician-assisted suicide point out that this gives a curious result: on this reasoning, 'innocent' patients who are terminally ill could not have physician-assisted suicide no matter how fervently they wanted it, but 'guilty' ones presumably could. Catholic thinkers appear to have found this response trivializing of the religious concept of innocence, and have made little response.

While the Catholic Church opposed directly caused dying even in painful terminal illness and had always held that suffering can be of redemptive value, the Church did not ignore the issue about pain. In 1958, Pope Pius XII issued his famous statement to anaesthesiologists 'The Prolongation of Life', in which he employed the traditional Principle of Double Effect to argue that, while death must never be intentionally caused, the physician may licitly use drugs for the control of pain even though foreseeing—though not intending—that this will cause an earlier death. The Pope was referring in particular to the use of opiates, especially morphine, which, it was widely understood, could depress respiration and so cause

death. The principle of double effect rests on the observation that an act may have two ('double') or more effects, both an intended effect and a foreseen but unintended effect (as when a child is given castor oil: the intended effect is preservation of health; the foreseen but unintended effect is the bad taste of the medicine). Rigorously stated, the principle of double effect requires that four conditions be met: (1) the action must not be intrinsically wrong; (2) the agent must intend only the good effect, not the bad one; (3) the bad effect must not be the means of achieving the good effect; and (4) the good effect must be 'proportional' to the bad one—that is, outweigh it. The principle was used to argue that a dying patient could always be assured of an easy death, if given morphine with the intent to relieve his or her suffering, even if that were to mean that the death might occur earlier; this would still be to intend the good effect only—relieving the suffering—while the bad effect, death, was merely foreseen, not intended. Whether this was a tenable distinction was a subject of considerable dispute, but its role in the argument was clear: to deflect claims that death hastened with pain-killing drugs involved killing a human being.

Meanwhile, during the period in which this stage of the argument over assisted dying was being most forcefully argued, social expectations regarding terminal illness shifted from the earlier view that the dying patient ought to fight on as long as possible to the new view that forgoing treatment and discontinuing treatment were permissible, indeed acceptable and even normal. The 1976 case of Karen Ann Quinlan raised the issue of discontinuing the respirator for a permanently comatose patient; within a decade or so, discontinuation of respiratory support was to become routine. Over the years, not starting treatment, or, having once started, stopping treatment of all sorts became more common. While the earliest technologies to be regarded in this way were the conspicuous, highly invasive ones like dialyzers and respirators ('tubes and machines'), the practice gradually came to include withholding and withdrawing of all forms of life-sustaining treatment. Once it had become possible to recognize terminal illness as terminal, to discuss the approach of death with the patient, and to recognize that continuing treatment might prolong the process of dying but not stave off death altogether, it became increasingly possible to plan to 'negotiate' death. Respirators could be unplugged, dialysis discontinued, chemotherapy avoided, antibiotics and pressors simply not used. Most controversially, artificial nutrition and hydration could fail to be started, or discontinued once it was already in use.

Such practices were often referred to as 'letting die', not 'killing'. Though the principle of double effect that was held to draw an adequately bright line between them was inherited from Catholic thought, it was widely embraced in secular bioethics. Letting die seemed sharply distinguished from killing: to turn off the respirator was not to kill the patient, but simply to let the patient die of the underlying disease. The killing/letting-die distinction was supposed to draw an important line, to which virtually all conservatives in the debate subscribed; patients must never be deliberately, intentionally killed, but, if treatment were withheld or withdrawn, they could be allowed to die of natural causes—namely, the underlying disease.

However, early on in the debate, James Rachels had attacked this view in a short but highly influential paper that appeared in the *New England Journal of*

Medicine (1975). Imagine, he wrote in this now-famous paper, Smith and Jones, both of whom stand to inherit a sizeable fortune from their respective 6-year-old cousins, should the cousins die. One evening, while his cousin is taking his bath, Smith sneaks into the bathroom and drowns him. Meanwhile, Jones is also planning to drown his own cousin, who is also taking a bath, but, as Jones sneaks into the bathroom, the child hits his head and slips under the water. Jones does nothing to save him. Now both children are dead. Smith has killed his cousin; Jones has merely allowed his cousin to die. But both are seriously, equally wrong. Hence it cannot be, Rachels argued, that the distinction between killing and letting die is adequate to discriminate between ethically unacceptable and ethically acceptable cases, and indeed in some cases killing may be ethically more defensible than letting die.

Among such cases, proponents of legalization chorused, could be cases of painful terminal illness. In some such cases, they argued, the voluntary, deliberate termination of life involved in physician-assisted suicide or active voluntary euthanasia—even though they involve killing—could be ethically better than simply withdrawing treatment and thus consigning a pain-racked patient to a miserable end by letting the underlying disease cause death.

Opponents of assisted dying, religious and secular, have had little success in answering Rachels's point, especially as it has been developed more fully by later proponents, except to reaffirm the killing/letting-die distinction and to insist that pain can always be controlled (for a number of analyses, see Steinbock and Norcross 1994). They have turned instead to other points of opposition, particularly two closely related concerns about the consequences of legalization. The first of these, the argument concerning the integrity of the medical profession, is the second of the principal arguments against physician-assisted suicide; it has played a major role in the public opposition of physicians' groups like the AMA in opposing legalization.

The Argument from the Integrity of the Profession (Against)

Doctors should not kill; this is prohibited by the Hippocratic Oath. The physician is bound to save life, not take it.

- *Objection.* In its original version the Hippocratic Oath also prohibits doctors from performing surgery, providing abortifacients, and taking fees for teaching medicine. If the Oath can be modified to permit these practices, why not assistance in suicide, where the patient is dying anyway and seeks the physician's help?
- *Counter-objection.* To permit physicians to kill patients would undermine the patient's trust in the physician.
 - *Counter-counter-objection.* Patients trust their physicians more when they know that their physicians will help them, not desert them as they die.

Doctors should not kill! thundered physicians like Willard Gaylin, Leon Kass, Edmund Pellegrino, and Mark Siegler (1988). For some opponents of assisted dying, this reflects a religiously based moral judgment about the intrinsic wrongness of

killing; for others, it is the underlying axiom of medical practice to which the Hippocratic Oath alludes in stipulating that the physician shall give no deadly drug, not even when asked for it. For still others, it reflects concerns about the pressures under which physicians operate and the kinds of incentives to which they are subject. For example, Diane Meier, MD, a former proponent, changed her position to oppose legalization on the grounds that the conditions of medical practice in modern urban hospitals—immense time pressures, financial incentives against expensive treatment, little ongoing relationship with patients, and so on—could so severely compromise physician judgment in the matter of assisting a patient in dying that medical integrity would be sacrificed. For example, she noted, some 25 per cent of people in New York City have no health insurance. Many other physicians have made similar points, aware as they are of the circumstances in which they now practise. Although the argument concerning the integrity of the medical profession is closely related to the slippery-slope argument about the potential for abuse, since it intimates that doctors will become more callous in their treatment of patients, it is also an argument focused on the nature of trust. Patients will be unable to trust their physicians, the argument about integrity claims, since the nature of the physician's role will have changed to permit killing; this is to disrupt something essential to the bond that is established in the physician-patient relationship. Not only will it undermine trust, but it will change the physician as well, from healer to killer, from trusted helper to untrustworthy threat. On this argument, assisting in suicide or performing euthanasia will not only cause physicians personal anguish, as is sometimes observed in the Netherlands, but it will also lead to the corruption of their very nature as physicians.

Opponents, still stung by Rachel's dismantling of the theoretical distinction between killing and letting die, also began to emphasize more fully the second element of this counter-argument, an issue present in the debate from the start. This was the 'slippery-slope' claim that to allow even the few sympathetic cases of physician-assisted suicide or euthanasia where the patient fully autonomously chose it and would be spared great pain—these are the most compelling cases—would lead by gradual degrees down a slippery slope toward widespread abuse. Patients would be pressured by overwrought family members, callous physicians, or cost-conscious insurers into choosing an assisted death when they did not really want to die at all. They would be made to feel superfluous, burdensome, as if they *ought* to make such a request, or they might be forced into it by greedy heirs or circumstances deliberately made intolerable. This component of the overall argument, the third of the principal arguments against physician-assisted suicide, is a complex argument containing a variety of sub-arguments. It is the weightiest in the opposition's case—and, I believe, the one to be taken with greatest earnestness by all.

The Argument from Potential Abuse: The Slippery-Slope Argument (Against)

Permitting physicians to assist in suicide, even in sympathetic cases, may lead to situations in which patients are killed against their will.

- *Objection.* A basis for these predictions must be demonstrated before they can be used to suppress personal choices and individual rights.
 - *Counter-objection.* The bases for these predictions are increasing cost pressures, as well as greed, laziness, insensitivity, prejudice, and other factors affecting physicians, family members, health-care institutions, and society.
 - *Counter-counter-objection.* It is possible, with careful design, to erect effective protections against abuse by doctors, families, institutions, or society.
 - *Counter-objection.* Vulnerable patients will be socially programmed to think of themselves as unworthy to remain alive, and the elderly, the chronically ill, the disabled, and others will be manoeuvred into choosing to end their lives.
 - *Counter-counter-objection.* Only patients with documented terminal illnesses would be allowed this option.
 - *Counter-counter-counter-objection.* Restrictions of this sort cannot be enforced; pressures to die would spread beyond the terminally ill.
 - *Counter-counter-counter-counter-objection.* Where these practices are legal, there is no evidence of disparate impact on patients in vulnerable groups.

Slippery-slope arguments involve predictive empirical issues about possible future abuse. *If you let practice A happen now, these arguments hold, consequences B will occur, and they will be very, very bad.* To carry weight, there must be evidence to support such an argument; slope arguments take both causal and precedential forms in their efforts to provide such evidence, insisting either that practice A will cause consequence B, or that permitting practice A will set a precedent in the presence of which other causal forces will produce consequence B. Many versions of slope arguments in the end-of-life context point either to the suggestive character that some acts of assisted dying would have, thus causing more killing to occur, or to the way in which permitting some acts of assisted dying would loosen the barriers against killing and thus permit such forces as greed, impatience, prejudice, and so on to operate to produce killing on a wider scale.

The risks would be particularly great, many have argued, for those in vulnerable groups. For instance, Susan Wolf has sought to show that the impact of legalization would fall particularly heavily on women; Adrienne Asch has worried about the impact on people with disabilities; Leslie Francis has been concerned about the elderly. Still others have pointed to the likely impact of legalization on blacks and other racial minorities, on people with chronic illnesses, on people with mental illnesses, on people with developmental delays, and so on. To legalize assisted-dying practices at all would start the slide down this very treacherous slope, they have argued, particularly affecting vulnerable groups.

Patients need not even be members of vulnerable categories to be at risk of pressures from family, physicians, institutions, or social expectations in general. John Hardwig's well-known piece 'Is There a Duty to Die?' (1997) explored the

way in which a person might come to think it appropriate to choose to end his life rather than constitute a 'burden' to his family. Were physician-assisted suicide a legal possibility, opponents argued, the pattern of reasoning Hardwig explores in his own case would also become expected of others in general. One would come to believe one had a 'duty to die.'

Virtually all opponents of assisted dying have employed some form of slippery-slope argument. For some, like Dan Callahan, Sissela Bok, and Yale Kamisar, the slippery-slope argument is a supplement to the view that intentionally causing death is morally wrong. For others, like Art Caplan, it is the central one: Caplan says that he would not object to physician aid-in-dying were it not for the risks of abuse. Much the same view characterized *When Death is Sought*, the report of the New York State Task Force on Life and the Law (1994), which took the risk of abuse as its primary reason for recommending against legalization of physician-assisted suicide. Similarly, the Canadian Supreme Court held in the 1993 case *Rodriguez v. British Columbia* that, although ALS patient Sue Rodriguez had good reason to want to end her life, the court could not permit her to do so because of the risks for others this would entail.

Even some proponents of physician-assisted suicide have been alert to the risks of the slippery slope. For instance, in an early paper titled 'Manipulated Suicide', I outlined the various mechanisms of potential abuse, including domestic abuse by families, professional abuse by physicians, and institutional abuse by health-care institutions, insurers, and government agencies, though I did not draw the conclusion that assisted dying ought therefore to be prohibited (Battin 1994: 195–204). Indeed, like many other proponents, I believe legalization and the openness it brings are the best protection against such abuse.

In the early days of the physician-assisted suicide debate, fuel was fed to the fire by data emerging from abroad: the Netherlands was beginning to recognize the legitimacy of voluntary active euthanasia and physician-assisted suicide. In a series of cases, euthanasia was increasingly legally tolerated, even though technically illegal, provided it met the guidelines for 'due care' established by the courts and the Royal Dutch Medical Association. The guidelines required that the patient's choice be voluntary and enduring; that the patient be undergoing or about to undergo intolerable suffering; that the patient have full information about his or her condition and prognosis; that all alternatives for relieving the suffering that are acceptable to the patient have been tried; that a second, independent physician be consulted; and that the physician report the action to the appropriate authorities. The physician who was faced with a conflict of duties between the obligation to prolong life and the obligation to relieve suffering would not be prosecuted for ending or helping end the patient's life under these guidelines, provided he or she acted with due care.

As news from the Netherlands began to reach the rest of the world, so did rumour. Opponents reacted to the developments in Holland with horror and also with distortion. Some, like Richard Fenigsen, a Dutch cardiologist, intimated that 20,000 people a year were being killed against their will; such grossly distorted claims were entertained or repeated by detractors around the world—for example, John Keown in England and a wide network of right-to-life writers in the USA.