Assisted Suicide: Pro-Choice or Anti-Life?
by Richard Doerflinger

The intrinsic wrongness of directly killing the innocent, even with the victim's consent, is all but axiomatic in the Jewish and Christian worldviews that have shaped the laws and mores of Western civilization and the self-concept of its medical practitioners. This norm grew out of the conviction that human life is sacred because it is created in the image and likeness of God, and called to fulfillment in love of God and neighbor.

With the pervasive secularization of Western culture, norms against euthanasia and suicide have to a great extent been cut loose from their religious roots to fend for themselves. Because these norms seem abstract and unconvincing to many, debate tends to dwell not on the wrongness of the act as such but on what may follow from its acceptance. Such arguments are often described as claims about a "slippery slope," and debate shifts to the validity of slippery slope arguments in general.

Since it is sometimes argued that acceptance of assisted suicide is an outgrowth of respect for personal autonomy, and not lack of respect for the inherent worth of human life, I will outline how autonomy-based arguments in favor of assisting suicide do entail a statement about the value of life. I will also distinguish two kinds of slippery slope argument often confused with each other, and argue that those who favor social and legal acceptance of assisted suicide have not adequately responded to the slippery slope claims of their opponents.

Richard Doerflinger is associate director of the Office for Pro-Life Activities of the National Conference of Catholic Bishops, Washington, DC.

Assisted Suicide versus Respect for Life

Some advocates of socially sanctioned assisted suicide admit (and a few boast) that their proposal is incompatible with the conviction that human life is of intrinsic worth. Attorney Robert Risley has said that he and his allies in the Hemlock Society are "so bold" as to seek to "overturn the sanctity of life principle" in American society. A life of suffering, "racked with pain," is "not the kind of life we cherish."

Others eschew Risley's approach, perhaps recognizing that it creates a slippery slope toward practices almost universally condemned. If society is to help terminally ill patients to commit suicide because it agrees that death is objectively preferable to a life of hardship, it will be difficult to draw the line at the seriously ill or even at circumstances where the victim requests death.

Some advocates of assisted suicide therefore take a different course, arguing that it is precisely respect for the dignity of the human person that demands respect for individual freedom as the noblest feature of that person. On this rationale a decision as to when and how to die deserves the respect and even the assistance of others because it is the ultimate exercise of self-determination—"ultimate" both in the sense that it is the last decision one will ever make and in the sense that through it one takes control of one's entire self. What makes such decisions worthy of respect is not the fact that death is chosen over life but that it is the individual's own free decision about his or her future.

Thus Derek Humphry, director of the Hemlock Society, describes his organization as "pro-choice" on this issue. Such groups favor establishment of a constitutional "right to die" modeled on the right to abortion delineated by the U.S. Supreme Court in 1973. This would be a right to choose whether or not to end one's own life, free of outside government interference. In theory, recognition of such a right would betray no bias toward choosing death.

Life versus Freedom

This autonomy-based approach is more appealing than the straightforward claim that some lives are not worth living, especially to Americans accustomed to valuing individual liberty above virtually all else. But the argument departs from American traditions on liberty in one fundamental respect.

When the Declaration of Independence proclaimed the inalienable human rights to be "life, liberty, and the pursuit of happiness," this order- ing reflected a long-standing judgment about their relative priorities. Life, a human being's very earthly existence, is the most fundamental right because it is the necessary condition for all other worldly goods including freedom; freedom in turn makes it possible to pursue (without guaranteeing that one will attain) happiness. Safeguards against the deliberate destruction of life are thus seen as necessary to protect freedom and all other human goods. This line of thought is not explicitly religious but is endorsed by some modern religious groups:

The first right of the human person is his life. He has other goods and some are more precious, but this one is fundamental—the condition of all the others. Hence it must be protected above all others.8

On this view suicide is not the ultimate exercise of freedom but its ultimate self-contradiction: A free act that by destroying life, destroys all the individual's future earthly freedom. If life is more basic than freedom, society best serves freedom by discouraging rather than assisting self-destruction. Sometimes one must limit particular choices to safeguard
freedom itself, as when American society chose over a century ago to prevent people from selling themselves into slavery even of their own volition.

It may be argued in objection that the person who ends his life has not truly suffered loss of freedom, because unlike the slave he need not continue to exist under the constraints of a loss of freedom. But the slave does have some freedom, including the freedom to seek various means of liberation or at least the freedom to choose what attitude to take regarding his plight. To claim that a slave is worse off than a corpse is to value a situation of limited freedom less than one of no freedom whatsoever, which seems inconsistent with the premise of the "pro-choice" position. Such a claim also seems tantamount to saying that some lives (such as those with less than absolute freedom) are objectively not worth living, a position that "pro-choice" advocates claim not to hold.

It may further be argued in objection that assistance in suicide is only being offered to those who can no longer meaningfully exercise other freedoms due to increased suffering and reduced capabilities and lifespan. To be sure, the suffering of terminally ill patients who can no longer pursue the simplest everyday tasks should call for sympathy and support from everyone in contact with them. But even these hardships do not constitute total loss of freedom of choice. If they did, one could hardly claim that the patient is in a position to make the ultimate free choice about suicide. A dying person capable of making a choice of that kind is also capable of making less monumental free choices about coping with his or her condition. This person generally faces a bewildering array of choices regarding the assessment of his or her past life and the resolution of relationships with family and friends. He or she must finally choose at this time what stance to take regarding the eternal questions about God, personal responsibility, and the prospects of a destiny after death.

In short, those who seek to maximize free choice may with consistency reject the idea of assisted suicide, instead facilitating all choices except that one which cuts short all choices.

In fact proponents of assisted suicide do not consistently place freedom of choice as their highest priority. They often defend the moderate nature of their project by stating, with Derek Humphry, that "we do not encourage suicide for any reason except to relieve unremitting suffering." It seems their highest priority is the "pursuit of happiness" (or avoidance of suffering) and not "liberty" as such. Liberty or freedom of choice loses its value if one's choices cannot relieve suffering and lead to happiness; life is of instrumental value insofar as it makes possible choices that can bring happiness.

In this value system, choice as such does not warrant unqualified respect. In difficult circumstances, as when care of a suffering and dying patient is a great burden on family and society, the individual who chooses life despite suffering will not easily be seen as rational, thus will not easily receive understanding and assistance for this choice.

In short, an unqualified "pro-choice" defense of assisted suicide lacks coherence because choices have no choices. A particular choice, that of death, is given priority over all the other choices it makes impossible, so the value of choice as such is not central to the argument.

A restriction of this rationale to cases of terminal illness also lacks logical force. For if ending a brief life of suffering can be good, it would seem that ending a long life of suffering may be better. Surely the approach of the California "Humane and Dignified Death Act"—where consensual killing of a patient expected to die in six months is presumably good medical practice, but killing the same patient a month or two earlier is still punishable as homicide—is completely arbitrary.

**Slippery Slopes, Loose Cannons**

Many arguments against sanctioning assisted suicide concern a different kind of "slippery slope": Contingent factors in the contemporary situation may make it virtually inevitable in practice, if not compelling at the level of abstract theory, that removal of the taboo against assisted suicide will lead to destructive expansions of the right to kill the innocent. Such factors may not be part of euthanasia advocates' own agenda; but if they exist and are beyond the control of these advocates, they must be taken into account in judging the moral and social wisdom of opening what may be a Pandora's box of social evils.

To distinguish this sociological argument from our dissection of the conceptual logic of the rationale for assisted suicide, we might call it a "loose cannon" argument. The basic claim is that socially accepted killing of innocent persons will interact with other social factors to threaten lives that advocates of assisted suicide would agree should be protected. These factors at present include the following:

The psychological vulnerability of elderly and dying patients. Theorists may present voluntary and involuntary euthanasia as polar opposites; in practice there are many steps on the road from dispassionate, autonomous choice to subtle coercion. Elderly and disabled patients are often invited by our achievement-oriented society to see themselves as useless burdens on younger, more vital generations. In this climate, simply offering the option of "self-deliverance" shifts a burden of proof, so that helpless patients must ask themselves why they are not availing themselves of it. Society's offer of death communicates the message to certain patients that they may continue to live if they wish but the rest of us have no strong interest in their survival. Indeed, once the choice of a quick and painless death is officially accepted as rational, resistance to this choice may be seen as eccentric or even selfish.

The crisis in health care costs. The growing incentives for physicians, hospitals, families, and insurance companies to control the cost of health care will bring additional pressures to bear on patients. Curt Garbesi, the Hemlock Society's legal consultant, argues that autonomy-based groups like Hemlock must "control the public debate" so assisted suicide will not be seized upon by public officials as a cost-cutting
device. But simply basing one's own defense of assisted suicide on individual autonomy does not solve the problem. For in the economic sphere also, offering the option of suicide would subtly shift burdens of proof.

Adequate health care is now seen by at least some policymakers as a human right, as something a society owes to all its members. Acceptance of assisted suicide as an option for those requiring expensive care would not only offer health care providers an incentive to make that option seem attractive—it would also denote all other options to the status of strictly private choices by the individual. As such they may lose their moral and legal claim to public support—in much the same way that the U.S. Supreme Court, having protected abortion under a constitutional “right of privacy,” has quite logically denied any government obligation to provide public funds for this strictly private choice. As life-extending care of the terminally ill is increasingly seen as strictly elective, society may become less willing to appropriate funds for such care, and economic pressures to choose death will grow accordingly.

Legal doctrines on “substituted judgment.” American courts recognizing a fundamental right to refuse life-sustaining treatment have concluded that it is unjust to deny this right to the mentally incompetent. In such cases the right is exercised on the patient’s behalf by others, who seek either to interpret what the patient’s own wishes might have been or to serve his or her best interests. Once assisted suicide is established as a fundamental right, courts will almost certainly find that it is unjust not to extend this right to those unable to express their wishes. Hemlock’s political arm, Americans Against Human Suffering, has underscored continuity between “passive” and “active” euthanasia by offering the Humane and Dignified Death Act as an amendment to California’s “living will” law, and by including a provision for appointment of a proxy to choose the time and manner of the patient’s death. By such extensions our legal system would accommodate nonvoluntary, if not involuntary, active euthanasia.

Expanded definitions of terminal illness. The Hemlock Society wishes to offer assisted suicide only to those suffering from terminal illnesses. But some Hemlock officials have in mind a rather broad definition of “terminal illness.” Derek Humphry says “two and a half million people alone are dying of Alzheimer’s disease.” At Hemlock’s 1986 conference, Dutch physician Pieter Admiraal boasted that he had recently broadened the meaning of terminal illness in his country by giving a lethal injection to a young quadriplegic woman—a Dutch court found that he acted within judicial guidelines allowing euthanasia for the terminally ill, because paralyzed patients have difficulty swallowing and could die from aspirating their food at any time.

The medical and legal meaning of terminal illness has already been expanded in the United States by professional societies, legislatures, and courts in the context of so-called passive euthanasia. A Uniform Rights of the Terminally Ill Act proposed by the National Conference of Commissioners on Uniform State Laws in 1986 defines a terminal illness as one that would cause the patient’s death in a relatively short time if life-preserving treatment is not provided—prompting critics to ask if all diabetics, for example, are “terminal” by definition. Some courts already see comatose and vegetative states as “terminal” because they involve an inability to swallow that will lead to death unless artificial feeding is instituted. In the Hilda Peter case, the New Jersey Supreme Court declared that the traditional state interest in “preserving life” referred only to “cognitive and sapient life” and not to mere “biological” existence, implying that unconscious patients are terminal, or perhaps as good as dead, so far as state interests are concerned. Is there any reason to think that American law would suddenly resurrect the older, narrower meaning of “terminal illness” in the context of active euthanasia?

Prejudice against citizens with disabilities. If definitions of terminal illness expand to encompass states of severe physical or mental disability, another social reality will increase the pressure on patients to choose death: long-standing prejudice, sometimes bordering on revulsion, against people with disabilities. While it is seldom baldly claimed that disabled people have “lives not worth living,” able-bodied people often say they could not live in a severely disabled state or would prefer death. In granting Elizabeth Bouvia a right to refuse a feeding tube that preserved her life, the California Appeals Court bluntly stated that her physical handicaps led her to “consider her existence meaningless” and that “she cannot be faulted for so concluding.” According to disability rights expert Paul Longmore, in a society with such attitudes toward the disabled, “talk of their ‘rational’ or ‘voluntary’ suicide is simply Orwellian newswrap.”

Character of the medical profession. Advocates of assisted suicide realize that most physicians will resist giving lethal injections because they are trained, in Garbasi’s words, to be “enemies of death.” The California Medical Association firmly opposed the Humane and Dignified Death Act, seeing it as an attack on the ethical foundation of the medical profession. Yet California appeals judge Lynn Compton was surely correct in his concurring opinion in the Bouvia case, when he said that a sufficient number of willing physicians can be found once legal sanctions against assisted suicide are dropped. Judge Compton said this had clearly been the case with abortion, despite the fact that the Hippocratic Oath condemns abortion as strongly as it condemns euthanasia. Opinion polls of physicians bear out the judgment that a significant number would perform lethal injections if they were legal.

Some might think this division or ambivalence about assisted suicide in the medical profession will restrain broad expansions of the practice. But if anything, Judge Compton’s analogy to our experience with abortion suggests the opposite. Most physicians still have qualms about abortion, and those who perform abortions on a full-time basis are not readily accepted by their colleagues as paragons of the healing art. Consequently they tend to form their own professional societies, bolstering each other’s positive self-image and developing euphemisms to blunt the moral edge of their work.
Once physicians abandon the traditional medical self-image, which rejects direct killing of patients in all circumstances, their new substitute self-image may require ever more aggressive efforts to make this killing more widely practiced and favorably received. To allow killing by physicians in certain circumstances may create a new lobby of physicians in favor of expanding medical killing.

The human will to power. The most deeply buried yet most powerful driving force toward widespread medical killing is a fact of human nature: Human beings are tempted to enjoy exercising power over others; ending another person’s life is the ultimate exercise of that power. Once the taboo against killing has been set aside, it becomes progressively easier to channel one’s aggressive instincts into the destruction of life in other contexts. Or as James Burchaell has said: “There is a sort of virginity about murder; once one has violated it, it is awkward to refuse other invitations by saying, ‘But that would be murder!’”

Some will say assisted suicide for the terminally ill is morally distinguishable from murder and does not logically require termination of life in other circumstances. But my point is that the skill and the instinct to kill are more easily turned to other lethal tasks once they have an opportunity to exercise themselves. Thus Robert Jay Lifton has perceived differences between the German “mercy killings” of the 1930s and the later campaign to annihilate the Jews of Europe, yet still says that “at the heart of the Nazi enterprise...is the destruction of the boundary between healing and killing.” No other boundary separating these two situations was as fundamental as this one, and thus none was effective once it was crossed. As a matter of historical fact, personnel who had conducted the “mercy killing” program were quickly and readily recruited to operate the killing chambers of the death camps.4 While the contemporary United States fortunately lacks the anti-Semitic and totalitarian attitudes that made the Holocaust possible, it has its own trends and pressures that may combine with acceptance of medical killing to produce a distinctively American catastrophe in the name of individual freedom.

These “loose cannon” arguments are not conclusive. All such arguments by their nature rest upon a reading and extrapolation of certain contingent factors in society. But their combined force provides a serious case against taking the irreversible step of sanctioning assisted suicide for any class of persons, so long as those who advocate this step fail to demonstrate why these predictions are wrong. If the strict philosophical case on behalf of “rational suicide” lacks coherence, the pragmatic claim that its acceptance would be a social benefit lacks grounding in history or common sense.

References
1 Presentation at the Hemlock Society’s Third National Voluntary Euthanasia Conference.

The Theologic Ethics of Euthanasia
by Kenneth L. Vaux

As Easter approached, the contrast of the two pronouncements kept going through my mind:

I injected the morphine intravenously...within seconds her breathing slowed to a normal rate. Her eyes closed and her features softened. She seemed restful at last. The older woman stroked the hair of the now-sleeping patient. I waited for the inevitable next effect of depressing the respiratory drive...the breathing slowed...became irregular, then ceased. It’s over, Debbie.1

The strife is o’er, the battle done, the victory o’er death is won. The song of triumph has begun. Hallelujah!2

Debbie’s was one of those epochal cases that seem to engage our whole society in an issue that troubles everyone to the very core of his being. Current practices in Holland and political initiatives in the United States suggest an urgency to debate on euthanasia with implications spanning personal, professional, and legal concerns. How shall we personally meet a good death? How shall physicians act in the face of terminal illness and imminent death? What policy, if any, shall our society promulgate?

A Transcendant Ethic

The questions of deliberate death and euthanasia present issues that move our reflection beyond the customary modes of ethical analysis.

Kenneth L. Vaux is professor of ethics in medicine, The University of Illinois at Chicago.

“A Humane and Dignified Death,” September 25-27, 1986, Washington, DC. All quotations from Hemlock Society officials are from the proceedings of this conference unless otherwise noted.


2 I am indebted for this line of argument to Dr. Eric Cheylin.


5 James T. Burchaell, Rachel Wootton, and Other Essays on Abortion (Kansas City: Andrews & McMeel, 1982), 188.


7 Vitezak Rad, Belzec, Sobibor, Treblinka (Bloomington, IN: Indiana University Press, 1987), 11, 16-17.

This content downloaded from 134.139.29.9 on Tue, 13 May 2014 22:49:05 PM
All use subject to JSTOR Terms and Conditions