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PHYSICIAN-ASSISTED SUICIDE: *A CONSERVATIVE CRITIQUE OF INTERVENTION*

By Daniel E. Lee

In the course of the years, my views with respect to the morality of physician-assisted suicide have not wavered one bit. I'm opposed to it. Strongly opposed to it. I agree with Karl Barth that "it is for God and God alone to make an end of life" and that God gives life to us "as an inalienable loan."⁽¹⁾ I believe that meaning and hope are possible in all of life's situations, even in the midst of suffering. I am very uncomfortable with the idea of physicians, who are trained to preserve life, dispensing lethal drugs to be used to end life.

In recent years, however, as Oregon has legalized physician-assisted suicide and other states have considered doing so, I have found myself wrestling with a very difficult question. Do those of us with deep moral reservations about the morality of physician-assisted suicide have any business using the coercive power of government to try to prevent those who disagree with us from doing what they believe is right? Are there any compelling arguments to justify placing legal roadblocks in the way of terminally ill individuals who wish to end their suffering by ending their lives, provided such decisions are made only after thoughtful, careful deliberation in an environment devoid of social pressure?

When what some might do poses a significant risk to the health and well-being of others, a strong case can be made for intervention. But does rationale based on protection of those who might be harmed work in the case of physician-assisted suicide? Protecting vulnerable individuals from threats posed by others is one matter. But what if the consequences of the act are born primarily by the perpetrator of the act?

One of the most frequent arguments made by those opposed to legalization—an argument with strong overtones of paternalism—holds that we always ought to intervene to prevent self-destructive behavior. But do we have either the right or the wisdom to decide what is best for other people in situations in which they are perfectly capable of making their own decisions? In *On Liberty*, John Stuart Mill cautions, "A person should be free to do as he likes in his own concerns, but he ought not be free to do as he likes in acting for another, under the pretext that the affairs of the other are his own affairs."⁽²⁾

A distinction is often made between hard (or strong) paternalism, which would permit intervening because of a belief that those doing the intervening know what is best for others, and soft (or weak) paternalism, which would permit intervening

to secure an outcome consistent with the values held by those who are being coerced. Because of deficiencies in our decision making processes or failures of the will, we sometimes act in ways at odds with our own deeply held values and desires, or fail to do things mandated by these values. In such cases, coercive intervention can have the salutary effect of forcing us to do what in fact we really want to do.

In a thoughtful little book published three decades ago, Joel Feinberg, commenting on John Stuart Mill's strong defense of individual liberty, observes, "Nevertheless, there are some actions that create a powerful presumption that an actor in his right mind would not choose them." The stronger the presumption, "the more elaborate and fastidious should be the legal paraphernalia required, and the stricter the standards of evidence," if that presumption is to be overridden. And what of suicide? Feinberg comments, "The desire to commit suicide must always be presumed to be both nonvoluntary and harmful to others until shown otherwise. (Of course, in some cases it can be shown otherwise.)" (3)

There is a good deal of wisdom in Feinberg's approach. Suicide and attempted suicide often are acts of desperation by individuals who, as a result of mental illness or other distorting factors, are not in full command of their senses. In such cases, an ethic that values life and affirms the dignity of each person mandates intervention to prevent self-destruction.

But as Feinberg allows, it is also possible that in some cases suicide really is a freely chosen course of action by individuals in full command of their senses. In advocating "elaborate and fastidious" legal procedures to assess situations such as these, he emphasizes that "the point of the procedure would not be to evaluate the wisdom or worthiness of a person's choice, but rather to determine whether the choice really is his."

Oregon's Experience

The Oregon Death With Dignity Act specifies an elaborate procedure consistent with the most rigorous standards of voluntariness. Requirements include two oral requests for lethal medication separated by at least fifteen days, a written request witnessed by two people followed by a fifteen-day waiting period, a determination that the patient is capable of making health care decisions, and the opportunity to rescind the request at any time. Before prescribing lethal medications, the prescribing physician must inform the terminally ill individual of alternatives to suicide and explicitly give the terminally ill individual an opportunity to rescind the request at the end of the fifteen-day waiting period.

Some fear that allowing physician-assisted suicide could result in social pressures compelling the aged and the infirmed to exercise this option. In an article that appeared in Christianity Today shortly after Oregon legalized physician-assisted suicide, Peter J. Bernardi warned that "the right to die may become the duty to die." He argued, "Radical autonomy is a deadly deception. Proponents of mercy

killing argue for the right of deception. Proponents of mercy killings argue for the right of mentally competent, terminally-ill adults to receive a physician's assistance to commit suicide. The reality is that such autonomous requests will be subtly or not so subtly influenced by others." (4)

But is this necessarily the case? Various provisions of the Oregon law are intended to make it very clear to those contemplating ending their lives that they are under no pressure to do so. For example, the requirements that physicians, prior to prescribing lethal medications, must inform terminally ill individuals requesting such medications about hospice care and other alternatives is a way of saying, "Look, you don't have to do this. There are other options." And the requirement that there be multiple opportunities to rescind the request, including an explicitly stated opportunity at the end of the fifteen-day waiting period, is a way of saying, "Are you sure you really want to do this?" In short, if physician-assisted suicide is presented as an option that no one need exercise, it remains a matter of individual choice, rather than a decision forced or helped along social pressure.

Also commonplace is the "slippery slope" argument, which warns that allowing voluntary physician-assisted suicide invites abuses, such as physicians taking it upon themselves to end the lives of terminally ill patients. Daniel Callahan has reported that in the Netherlands, where physician-assisted suicide has been practiced for a number of years, "there are a substantial number of cases of nonvoluntary euthanasia, that is, euthanasia undertaken without the explicit permission of the person being killed." (5)

Like many others, I find nonvoluntary euthanasia morally reprehensible. But does physician-assisted suicide frequently contend that rigorous safeguards, such as those incorporated in the Oregon law, can prevent nonvoluntary euthanasia by ensuring that euthanasia occurs only at the request of the suffering individual. Their arguments have considerable merit.

There is another firewall—one that is also built into the Oregon law—that might be even more significant. This is the requirement that lethal drugs be self-administered, rather than administered by the prescribing physician or anyone else. IF physicians, family members, and others are prohibited from administering lethal drugs to terminally ill patients, and that restriction is rigorously enforced, nonvoluntary euthanasia is precluded.

As for the Dutch experience, it should be noted that until the Dutch Parliament legalized physician-assisted suicide in April 2001, all forms of active euthanasia were technically illegal in the Netherlands, even though legal authorities often looked the other way when physicians prescribed lethal medications for terminally ill patients. A widespread practice that functions outside of the law is by its very nature difficult to regulate and inevitably invites abuse. In short, legalizing physician-assisted suicide and carefully regulating its practice might be more effective way of preventing a slide down a slippery slope leading to nonvoluntary active euthanasia than continuing the legal prohibition on physician-assisted

suicide.

Finally, it is significant that the Oregon experience to date in no way suggests that a slide down a slippery slope is imminent. The option allowed by Oregon's Death With Dignity Act has been used very sparingly. In 2001 (the most recent year for which statistics are available as this article goes to press), twenty-one Oregonians chose to end their lives by ingesting a lethal dose of medication prescribed by a physician, accounting for 0.33 percent of the 6,365 Oregon deaths from similar diseases. During 2000, the number was twenty-seven (0.38 percent) of the 6,964 deaths from similar diseases. The number of Oregonians opting for physician-assisted suicide has remained fairly stable, ranging from sixteen in 1998, the first year the law was in effect, to twenty-seven in both 1999 and 2000. (6) Clearly, there is no landslide in the making.

When all things are considered, the arguments in favor of continued prohibition of physician-assisted suicide are not particularly compelling. This is not to suggest that those of us with deep moral reservations about physician-assisted suicide should swallow our scruples and spearhead legalization campaigns. But it does suggest that we should not stand in the way of thoughtful individuals such as Timothy Quill and Marcia Angell who favor legalization. (7)

Those of us opposed to physician-assisted suicide would do well to focus our efforts on helping others discover the meaning and hope that are possible in life, even in the midst of suffering. We can accomplish far more by reaching out in a loving, caring manner to those experiencing great suffering, instead of sitting around and moralizing about what they should or should not do and threatening physicians with legal penalties if they act in ways at odds with values we hold dear. If we were to do a better job of responding to suffering individuals in a loving, caring manner, physician-assisted suicide would in all likelihood be an option rarely, if ever, chosen.

Notes:

1. K. Barth, *Church Dogmatics*, Vol. III: The Doctrine of Creation, Part 4, ed. B.W. Bromily and T. F. Torrance, tr. A.T. Mackay et al. (Edinburgh: T.&T. Clark, 1961), 404, 425.
2. J.S. Mill, *On Liberty*, ed. C. V. Shields (Indianapolis, Ind.: The Bobbs-Merrill Company, Inc., 1956, 127.
3. J. Feinberg, *Social Philosophy*, (Englewood Cliffs, N.J.: Prentice-Hall, Inc., 1973), 49-51.
4. P.J. Bernardi, "Is Death a Right?" *Christianity Today* 40 (20 May 1996): 29-30.
5. D. Callahan, "When Self-Determination Runs Amok," *Hastings Center Report* 22, no.2 (1992): 52-55. There is some data to back up Callahan's claim. The Rummelink Report, an official Dutch government study of the practice of euthanasia in the Netherlands, indicates that in 1989, doctors actively killed 1,040 patients without their knowledge or consent; www.euthanasia.com/hollchart.html (accessed 25 March 2002).
6. Oregon's Death With Dignity Act Annual Report 2001, www.ohd.hr.state.or.us/chs/pas/ar.htm (accessed 25 March 2002).
7. See T.E. Quill, "Death and Dignity: A Case of Individualized Decision Making," *NEJM* 324

(1991): 691-94; F. G. Miller et al., "Regulating Physician-Assisted Suicide," NEJM 331 (1994): 119-23; and M. Angell, "No Choice but to Die Alone," Washington Post, 24 February 2002.

Daniel E. Lee teaches ethics at Augustana College, Rock Island, Illinois. He is the author of *Navigating Right and Wrong: Ethical Decision Making in a Pluralistic Age* (Rowman & Littlefield Publishers, Inc., 2002).

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