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Assisted Suicide: The Moral Equation

by

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One day many years ago, a young idealistic doctor in a small mining town came face to face with unexpected disaster. The local mine had collapsed, trapping some miners for hours before rescue teams could reach them. As the doctor walked among the mangled victims of the disaster, wondering how he could help, one of the miners who was in excruciating pain grabbed his white jacket and screamed: "Doctor, I beg you, let me go quickly! I can't stand it! You can't do anything for me — it's too late. Doctor, I want to die — do you hear me? — I want to die!"

The poor doctor had to force the man's fingers apart to loosen his grip from the cloth of his jacket. Finally the man expired, leaving the young doctor pale and shaken.

In a recent issue of the *New England Journal of Medicine*, highly respected physicians cited emotional stories very much like this one — and without very much reasoned analysis, assumed that assisted suicide is our only answer to such patients and then started working out the ground rules.¹

In doing so, they have skipped a most important step. The question is not whether we should have compassion for the suffering of patients who seem to be beyond the help of modern medicine. The question is how to channel that compassion into actions that will truly be constructive and not destructive of patients, physicians and society as a whole.

We know what happened to the young doctor in the mining town. He became convinced that compassion *did* require abandoning the old Hippocratic injunction against killing one's patient. Finally that doctor, one Karl Brandt by name, agreed to begin a program of euthanasia for the incurably ill at the request of the chancellor of Germany, one Adolf Hitler.²

In citing this bit of history, I am acutely aware that one should not make facile or irresponsible analogies between Nazi Germany and our present time. And it goes without saying that the people who now propose euthanasia are *not* any kind of Nazis. Nor, for that matter, was the young Dr. Brandt at the time of his mining disaster.

And yet, even as we recoil in horror at everything that has to do with the Nazis, we should also keep our eyes open so as not to repeat some mistakes of the past. We — the NEJM authors and the rest of us — are very much in the position of the young Karl Brandt, who looked upon the apparently meaningless suffering of dying patients and wondered whether once — just once — it might be all right to bend law and morality to put a few suffering humans out of their misery. And just like Dr. Brandt, in his closing statement to the Nuremberg tribunal, we want to insist that our only motive is “pity for the incurable.”

In Germany, once people were used to the basic idea of euthanasia, the program expanded to the mentally ill, the retarded, and then to people in certain social, political or racial categories. But as Robert Jay Lifton has written in his book *The Nazi Doctors*, it all started with one important change in morality and law: “At the heart of the Nazi enterprise,” he wrote, “is the destruction of the boundary between healing and killing.”³

In the progressive corruption of the German euthanasia program, one event in 1940 stands out. The program to end the lives of the incurably ill had been going on under Dr. Brandt’s direction for nine months, and a Nazi official suggested that it was time to begin selecting candidates based on their ability to work. Dr. Brandt, who still thought of the program as a humanitarian one, strongly objected to this rating of lives by their social worth to others — but he was overruled. He found he no longer had any compelling arguments as to why this shift in policy should not be made.⁴ He himself had already crossed the truly important boundary — the one between healing and killing.

Today, too, the compassion that leads many of us to consider euthanasia is mixed with less noble motives. We are tempted to see severely debilitated patients as less than fully human, as less than fully alive — some of us even use dehumanizing language, like “vegetable” or “gomer” or “gork,” to describe them. We are uncomfortable with patients who need care but cannot be cured — the disabled, the senile, the persons with AIDS. Our young doctors increasingly do not want to have to care for certain kinds of patients — out of fear, prejudice, or just a feeling of helplessness and frustration, they want them to just go away. In one recent study published in the *Journal of the American Medical Association*, 23% of American medical residents said they “would not care for persons with AIDS if they had a choice.”⁵ In another recent survey, in the *Journal of AIDS*, exactly the same percentage of physicians in San Francisco — 23% — said they would probably comply with an AIDS patient’s *initial* request for assistance in suicide, even though it is illegal and such action would allow for no waiting period so the patient could think over the matter more carefully. This second study found that actual requests for suicide assistance by patients were “surprisingly low,” and the number of requests a physician had actually received did not affect how willing he or she was to give such assistance. The most important factor determining how he or she responded to the question was that *physician’s* personal belief in the ethical rightness of euthanasia for certain kinds of patients.⁶

I do not cite these realities to criticize medical professionals. But before buying into an agenda that is being sold on the basis of a naive sentimentalism about the

gentle death, we need to look unflinchingly at human nature and human motivations and ask whether the power to kill is something we are prepared to handle. If the answer is “no,” it is not because doctors are unusually venal or unethical — it is because, like all the rest of us, they are only human.

Our investigation should include an appreciation of certain facts.

First, we should appreciate that the real issue here is not personal freedom. If it were, we would have no business saying that *anyone*, sick or healthy, should be prevented from committing suicide. We would have to say that only the individual can decide whether his or her own situation merits death — for that is exactly what *autonomy* means, making the rules for oneself. And yet few people who support assisted suicide favor such an unlimited right. As Professor John Conley of Fordham University has observed: “Supporters of active euthanasia are oddly inconsistent. Their insistence on the right of the terminally ill to kill themselves rarely includes the right to suicide in general. Radical autonomy is valued only in the specific area of terminal illness or severe disability. Few editorials celebrate the right of teenagers to kill themselves after a failed romance, of CEO’s to destroy themselves after a bankruptcy, or of politicians to be euthanized after corruption is revealed Rather than resting upon neutral medical facts, the new enthusiasm for the suicide of the severely ill reflects the growing disvalue placed upon the ill in our society. While we call out the posse to save nephew Frank on the ledge after he broke up with Sue, we are delighted at Granny’s decision to gracefully exit the nursing home thanks to the ‘mercitron’ and sympathetic laws.”⁷

This double standard is not even based on any special agitation by the particular classes of people targeted for suicide assistance. For example, elderly voters rejected California’s euthanasia initiative by a far higher margin than younger voters did,⁸ and terminally ill patients have a suicide rate not markedly different from that of other adults.⁹ Their suicide rate is *slightly* higher than that of the general public, but then so is that of physicians.

A second fact to appreciate: While the class of patients affected by the euthanasia agenda does not include everyone, it is not confined, and cannot be confined, to the terminally ill. It would make little sense to confine it that way. It is true that the terminally ill will “die anyway,” even if we don’t kill them — but that is true of everyone. We will all “die anyway.” And if ending a short life of suffering were good, surely ending a long life of suffering would be better. In fact none of the major players in the current policy debate want to restrict euthanasia to terminal cases. Most of Jack Kevorkian’s clients have had no terminal illness, except by his own definition that “every serious illness is terminal.”¹⁰ The Hemlock Society points with approval to the Netherlands, where assisted suicide has already moved beyond dying patients to the disabled and elderly. This past year, Derek Humphry announced that a great many Hemlock members want to move the American debate to the next logical stage, in which all *elderly* citizens will be encouraged to discuss the circumstances in which they want help committing suicide.¹¹ Recently he described his own book *Final Exit* as a “workshop manual” for anyone needing assistance in suicide “in the cases of terminal illness, terminal old age, or quadriplegia.”¹² And the Washington and

California initiatives offered in recent years by Hemlock and its allies include vague definitions of "terminal illness" that could be construed to include disabilities that are not "terminal" in any ordinary sense of the word. Once the law covered any kind of disability, of course, it might take just one lawsuit under the Americans with Disabilities Act to ensure that *all* disabled people receive equal protection for their right to assisted suicide. Such expansion is not a slippery slope; it is the *present* agenda of those proposing laws on this subject.

A third fact: We should admit that anticipated benefit to ourselves and society, not to the individual patient, is often the primary reason why we are tempted to allow euthanasia and assisted suicide. This is most explicit in recent statements by our euthanasia pioneer, Jack Kevorkian. In one recent interview in the magazine *Free Inquiry*, he was asked whether euthanasia is morally right because it relieves a patient's suffering and the suffering of the family. He said these are "minor benefits" that "do not counter-balance the loss of a human life. But if the patient opts for euthanasia, or if someone is to be executed, and at the same time opts to donate organs, he or she can save anywhere from five to ten lives. Now the death becomes definitely, incalculably positive."¹³ In short, these patients with meaningless lives should be helped to die because they're wasting organs that others with useful lives have a need for.

Even when we are not talking about something as crass as terminating people to get their organs, we often cast an eye toward fiscal bottom line and the burdens and pressures that sick people place on the rest of us. Again, as Professor Conley noted, if the intensity of the individual's own suffering were the determining factor, we would not be talking only about helping the sick and disabled to die. From the individual's own subjective point of view, the source of his or her suffering is not particularly relevant. We are talking about the sick because they place the greatest demands on us.

If this issue is not about personal autonomy, or any factor peculiar to terminal illness, or the relief of the patient's own suffering, what is the issue? It is whether actively inducing death is a morally responsible solution to social and individual problems generally. If we are considering only helping the sick to commit suicide, while continuing to prevent suicide for everyone else, the issue is whether human life has inherent value and dignity — as the authors of our Declaration of Independence believed — or loses that value and dignity in cases of illness and dependency. If the answer is yes, then we seem to have endorsed the key concept that allowed Dr. Brandt and his colleagues to move toward gross violations of human rights — the concept of "lebensunwertes Leben," or life unworthy of life. And then the slope is slippery indeed.

I think we must continue to value all human life — not in the sense that we must always do everything possible to prolong it regardless of the circumstances, but in the sense that we must never actively destroy life and must always treat it with respect. And we must do this even — or especially — in life's final and most vulnerable moments.

Why should we do so? From a religious viewpoint the answer is clear enough: Life is our first and most precious gift from a loving God, over which we are called to exercise stewardship but not absolute dominion. Responsible

stewardship — especially on the part of physicians — calls us to use our knowledge and skills in reverent humility, recognizing our own finitude and the incompleteness of our wisdom. It means we cannot claim an absolute mandate to prolong life, as though we could actually defeat death by our own puny mortal efforts; but it also means we must never arrogate to ourselves the authority to take life, as though we were its lords and masters. To do either of those things would be to “play God” in the pejorative sense.

The vision of life as a gift of the Creator is shared by Catholics, Protestants, Jews and many others, and is reflected in the founding documents of our nation. But I understand that it is not shared by all. To those who find it unappealing I would say this: If life is not a divine gift, it is at least the most basic and fundamental of the human goods which societies like ours are established to protect. And it is precisely an ethical devotion to this good that makes the physician a member of a *profession*, rather than just another technician with a good-paying job. Life is *basic* because it is the pre-condition for every other human good and human right, even freedom. You cannot enhance someone's freedom by taking his life, because corpses have no freedom. Freely taking your life, like freely selling yourself into slavery, is the ultimate self-contradiction of freedom, not its ultimate triumph.

In fact, if we devalue the lives of the seriously ill we will end up asking ourselves why the freedom of their request is so important. This is because life is not just another good — it is the bodily reality of an individual human *person*. And a human person of little value will surely have freedom that is of little value. Thus do the assumptions behind voluntary euthanasia pave the way for involuntary euthanasia.

Some have asked, “Whose life is it anyway?” My own answer is: “It is God's first of all, and it is mine in trust to respect and care for.” But if my answer is wrong, then the only other answer that makes sense is: “It doesn't *belong* to anyone, not even to me. My life is *me*, not just another piece of property that I own. That is why I can't ethically sell myself into slavery or prostitution or a life of drug addiction — because my life is not just a possession, even to me. And to treat certain kinds of human life as disposable property will be to treat particular classes of people as disposable property.”

Devaluing the life of the sick is not only dangerous — it is also unnecessary for those of us who truly wish to show compassion for the dying. If some patients now die in inhumane, painful and undignified ways, we should not assume that the way to give them a “dignified, painless and humane” death is to have their doctors kill them or help them kill themselves. Why not address this pain, this inhumanity, and these indignities, instead of encouraging the patient to get rid of himself? Euthanasia doesn't solve these problems — it just removes one patient from the environment where the problems will keep arising and increasingly be taken for granted. After all — we will be tempted to say — if you don't like the undignified way we care for the dying, you can always opt to kill yourself.

That would be a cop-out of the most inexcusable sort. Of course there are other and better solutions to the problems dying patients often face — problems like pain, loneliness, and the feeling that one has lost control over one's life. Those

solutions can be summed up in the phrase "comprehensive palliative care" — the kind of care the hospice movement embodies and promotes. Certainly the avenues for improving this approach have not been exhausted, leaving us only with euthanasia — on the contrary, those avenues are just beginning to be opened up as they should.

Proposals for euthanasia and assisted suicide are insidious because they assume there are no real alternatives to suicide for dying patients — and they will ensure that we never have any. While leaving intact the existing laws against assisting suicide for everyone else, they will separate out a class of citizens for whom suicide is *accepted* and even to be *expected*. And at a time when loneliness and alienation are perhaps the most serious problem dying patients face, acceptance of euthanasia will *aggravate* their loneliness. For it is only human nature that many physicians feel uncomfortable spending time with dying patients — because they don't want to get too attached to someone who they know will die soon. How much more cold and distant and impersonal will doctors become when they have to see every dying patient as someone they may be asked to help kill soon? And how much more pressure will that alienation place on the patients themselves to opt for that final exit?

No, we should not be fooled by the myth of neutrality — the myth that by approving euthanasia we will merely be adding to people's free choices. By approving the choice of a physician-assisted death, society would undermine people's ability to make any choice *other* than suicide. We therefore have to make our own choice as a society: to encourage the sick and elderly to make an early exit, to spare the rest of us the burden of caring for them — or to commit ourselves to help dying people to live as well as they can, for as long as they are with us. That second choice is the harder one to follow through on — but for that very reason, it's not something we can do at all, let alone do well, if we're half-hearted about it, if we spend our lives debating whether these people's lives are worth caring for at all.

They *are* worth caring for. And that means we have a lot of work to do. I think we should get to work.

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8. According to a post-election poll of California voters, while the general public voted 54% to 46% against the Hemlock Society's November 1992 ballot initiative, voters aged 65 and over

opposed it 64% to 36% (Tarrance poll conducted November 3-4, 1992).

9. "Among suicides, the number of patients with terminal illness ranges from 2% to 4%, compared to 1.4% in the general population," reports suicidologist David C. Clark, M.D. He notes that depressive episodes in the seriously ill "are not less responsive to medication" than depression in others. Quoted in F. Skelly, "Don't dismiss depression, physicians say," *American Medical News*, September 7, 1992, p. 28. Also see: Conwell and Caine, "Rational Suicide and the Right to Die," 325 *New England Journal of Medicine* (October 10, 1991), 1100-1103.

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