ASSISTED SUICIDE AND THE SUICIDE STIGMA

ASSISTED SUICIDE AND THE SUICIDE STIGMA

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ABSTRACT

The purpose of this thesis is to argue for the permissibility of assisted suicide in certain cases. Since the practice of assisted suicide involves the act of suicide, I have chosen to focus my arguments on a defense of the act of suicide in certain cases. I then argue that there is no moral difference between suicide and assisted suicide, so that in most cases if it is permissible for a person to take his or her own life then it ought to be permissible for him or her to receive suicide assistance. I accomplish this first by critically analyzing the psychological view of suicide, which gives rise to the incompetency argument, and by refuting numerous other arguments offered to demonstrate the unconditional moral impermissibility of suicide. I then defend suicide as being morally permissible if 1) the agent is competent; and 2) the suicide does not violate any overriding obligations that would not otherwise be violated. I also defend a notion of 'full permissibility', meaning an action that a person ought to be free to perform without justified paternalistic interference from others. An action, and thus a suicide, is fully permissible if it is morally permissible as well as rational for the person in question. In the final chapter I make the move from defending suicide in certain cases to defending assisted suicide in those same cases. I conclude that in most cases if it is permissible for a person to take his or her own life then it also ought to be permissible for him or her to receive assistance.

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Introduction

'Doctor, the real enemy is not death – the real enemy is inhumanity.'[1] This statement, from an elderly patient in conversation with his physician, sums up the prevailing attitude behind the 'right to die' crusade. Nobody doubts that death is something everybody wishes they could avoid. Unfortunately, however, the avoidance of death is impossible. While some argue that we should still fight to avoid death right to the end, others argue that there comes a point in time when it may be better for the person dying to focus efforts on comfort and autonomy rather than the fight against death. For some people palliative care will suffice but for others a premature death may be the only way of achieving their desired ends. Many of those who want to die can take their own lives without the involvement of another person. Others, however, for various reasons, must ask for help. Perhaps they are bedridden and cannot gain access to means for suicide; perhaps they are simply afraid of failure and want someone to instruct them in proper dosages of medication. Is it permissible for someone in one of the above situations to receive suicide assistance? If the answer is 'sometimes', in what situations would it be permissible for someone to receive suicide assistance? These are the two main questions that I will attempt to answer in this thesis.

One might notice that in the above questions I used the term 'permissible' rather than 'morally permissible'. This is because, as I will argue in chapter 3, moral permissibility does not seem to be enough when we are dealing with the practical questions of whether

[1] Christian Barnard, "The Need for Euthanasia," in Voluntary Euthanasia, ed. A. B. Downing and Barbara Smoker (London: Peter Owen Publishers, 1986), p. 176.

and when it would be 'okay' for someone to take his or her own life. When the risk to the agent is as high as death, as in the case of suicide or assisted suicide, we as a society seem to be at least justified in wanting more than just moral permissibility if we are to grant someone complete freedom to perform an act. We want to make sure that he knows what he is doing and that his decision is not irrational. Thus, I will argue that in the cases of suicide and assisted suicide, when the stakes are so high, the important question is whether suicide can ever be 'fully permissible'. What I mean by an action being fully permissible is an action that an agent is free to perform without justified paternalistic interference from society. In order for a suicide or an assisted suicide to be fully permissible, it must be morally permissible (which I will explain in more detail below) as well as rational.[2]

The progress in medicine over the last several decades has brought the issue of assisted suicide to the forefront of bioethical issues. Few issues have occupied the pages of bioethical literature, as well as the pages of newspapers around the world over the last ten to fifteen years like the issue of assisted suicide. Not too long ago the Netherlands adopted a permissive moral and legal attitude towards assisted suicide, and very recently the state of Oregon in the United States has done similarly. For the most part, however, moral acceptance of assisted suicide has been reluctant to say the least. The reason, I believe, is because 'assisted suicide' contains the word 'suicide'; and since the beginning of human civilization suicide has been viewed as one of the most horrible acts a human being can perform.

For most people the topic of suicide stirs up intensely negative emotions: suicide is seen as the worst kind of sin, as evil, cowardly, and shameful. It is no secret that the act of

[2] Henceforth I will refer to full permissibility as simply 'permissibility' unless otherwise stated. Moral permissibility will be distinguished by continuing to refer to it as 'moral permissibility'.

suicide is highly stigmatized in western culture. Even the verb that always precedes the term 'suicide' in a sentence perpetuates the stigma: to say that someone *commits* or *committed* suicide places the act of suicide in the same category as such negative things as crimes and errors. One commits suicide like one commits a crime.[3] The stigma is no surprise considering the history of opinions on the topic. Throughout the history of North American and European culture, with a few exceptions, suicide has been viewed in the negative ways mentioned above. A major source of the suicide stigma comes from the Catholic condemnation of the act. Since St. Augustine, the Catholic Church has viewed suicide as a horrible sin, as gravely morally wrong except in the case of mental illness.[4] In various countries around the world, the corpses of suicides have historically often been treated much differently from those who died by other means, including a prohibition from burial in regular cemeteries. In France, for example, during the middle ages, "the corpse [of a suicide] was hanged by the feet, dragged through the streets on a hurdle, burned, thrown on the public garbage heap..."[5] Even in ancient Athens, where suicide was supported for people in many situations by Stoic philosophers, the corpse of the suicide was buried outside the city away from the other graves – and the self-murdering hand was cut off and buried separately altogether.[6]

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[3] To avoid personally perpetuating the stigma, throughout my thesis I will avoid using the verb 'commit' and instead refer the act of suicide as 'taking one's own life' or 'killing oneself'.

[4] Margaret Pabst Battin, Ethical Issues in Suicide (New Jersey: Prentice-Hall, Inc., 1982), p. 3. Mental illness was an exception not because it would count as justification but because those who are mentally ill could not be held responsible for their actions.

[5] A. Alvarez, "The Background," in Suicide: The Philosophical Issues, ed. Margaret Pabst Battin and David Mayo (New York: St. Martin's Press, 1980), p. 9.

[6] Alvarez, in Battin and Mayo (1980), p. 9.

It is my contention that this suicide stigma is the major source of the aversion towards the practice of assisted suicide.[7] Public opinion polls in Canada have shown that there has been a continual increase in public support of the practice of assisted suicide and the most recent 1995 Gallup Poll showed a public support of 75 percent for the practice of physician-assisted suicide in the case of an immediately life-threatening terminal illness.[8] So if there is a public support of 75 percent, how can I claim that there is still a general aversion to assisted suicide? My claim is based on the fact that the 75 percent public support for physician-assisted suicide counts only for assisted suicide in cases of immediately life-threatening terminal illnesses. Interestingly, public support for the practice of physician-assisted suicide drops drastically for cases of illnesses that are still incurable but are not *immediately* life-threatening: support in these cases was only 57 percent.[9] What this demonstrates, I believe, is that while public support for assisted suicide has grown over recent years, the increase in public support has been very hesitant. There is not strong public support for assisted suicide *per se*, only for assisted suicide in certain limited cases. The prevailing attitude seems to be that if someone is going to die (very) soon anyway, then it ought to be permissible for him or her to request assisted suicide; but in any other case, it is still wrong. Suicide, and thus assisted suicide, is still morally reprehensible for many people and so it should continue to be avoided at all costs.

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[7] I refer to assisted suicide here as a *practice* rather than an *act* because, as I shall explain in chapter four, assisted suicide technically involves two acts. Therefore, it is not entirely accurate to use the phrase 'the act of assisted suicide'.

[8] Gallup Canada Inc. website: www.web.apc.org/~dwdca/gallup.html. Although the Gallup poll asked Canadians specifically about physician-assisted suicide, I think it is safe to assume that it reflects public opinion about assisted suicide in general.

[9] Gallup Canada Inc. website.

The purpose of this thesis is twofold: first, to subject the suicide stigma to critical scrutiny and to show that there ought not to be a general moral censure of the act of suicide. My goal is not to offer a defense of suicide in general, or to argue that suicide is never impermissible, because this would be just as much of a mistake as the claim that suicide is always and in all circumstances impermissible. My goal is only to defend suicide as permissible in some cases. The second purpose of this thesis is to move from a defense of suicide in some cases to a defense of assisted suicide in those same cases. Once again, I do not intend to argue that assisted suicide ought to be permissible in all cases. But I believe that once suicide has been destigmatized, once it can be shown that suicide in some cases is permissible, then most of the work will be done in order to make the argument that assisted suicide in some cases is permissible.

In the first chapter I will launch an attack on the psychological view of suicide. The psychological view of suicide still dominates western views of suicide and, I think, has largely contributed to the continued stigmatization of suicide. The psychological view of suicide is the view that suicide is essentially the act of a mentally ill person. This view gives rise to a potentially damaging argument against the moral permissibility of suicide, that people who kill themselves are mentally ill, and thus incompetent, and the actions of incompetent people can not be judged as morally permissible.[10] This does not mean, however, that suicides by incompetent people are always morally *wrong*. The significance

[10] However, as Professor Sami Najm has pointed out, my characterization of the incompetency argument may result in a confusion between judging the acts of incompetent people on moral grounds and judging the incompetent person him or herself on moral grounds (i.e. as praiseworthy or blameworthy). In other words, it may be the case that an incompetent person can not be praised or blamed morally for his or her action (suicide) but we can still make the claim that his or her action was itself morally impermissible. However, for the practical purposes of this thesis, I will continue to characterize the incompetency argument as I have done: that suicide can be neither morally permissible nor morally impermissible for incompetent people.

of the argument is that the actions of incompetent people can not be judged on moral grounds at all because an agent must be competent in order for his or her actions to be judged as morally permissible or impermissible. If someone is incompetent we can not be sure that he or she is acting in his or her own best interests, or making a rational decision to take his or her own life; incompetent people are considered to be unable to make decisions for themselves. Therefore we (society) are at liberty to protect incompetent people from doing something drastic and irreversible to themselves by doing what we can to prevent incompetent people from killing themselves. Society becomes the surrogate decision-maker for incompetent people when it comes to suicide, assuming that it is in their best interests to remain alive and acting in these best interests.

The basis for the psychological view of suicide is a type of study known as 'the psychological autopsy'. Psychological autopsy studies have been carried out for nearly forty years in countries all around the world, and they all consistently have shown that there is a significantly high correlation between completed suicides and mental illness. That is, the psychological autopsy studies supposedly show that a very high percentage of people who have killed themselves were in fact suffering from a diagnosable mental illness prior to the suicide. Moreover, depression apparently constitutes a very high percentage of the diagnosable mental illnesses of people who kill themselves. I will begin chapter 1 with a brief description of the psychological autopsy method, with an outline of some of the statistics, followed by an analysis of some of the problems from which the study method suffers. Since depression accounts for most of the mental illnesses found in the studies, I will confine my discussion in chapter 1 to the problems with the studies as they relate to clinical depression. In addition, I will also discuss some of the problems with the

diagnostic criteria used to diagnose depression (not only in the psychological autopsy studies but in general as well), the fourth edition of the *Diagnostic and Statistical Manual of Mental Disorders.* Finally, I will conclude chapter 1 with a discussion of competency, and I will demonstrate that the assumption that a mental illness such as depression automatically renders a person incompetent is contestable. By the end of chapter 1 I will have demonstrated the following: 1) that the psychological view of suicide (that only mentally ill people want to take their own lives) is unjustified; and 2) that it is not necessarily the case that a mental illness renders a person incompetent.

In chapter 2 I will focus on refuting a number of the popular arguments offered against the moral permissibility of suicide. Some of the arguments are religious and are derived from St. Thomas Aquinas' published arguments against suicide. The religious arguments all have to do with the idea that suicide is a form of playing God, and that it is morally wrong to play God. I will examine three of the arguments that fall under the 'playing God' argument and I will show that none of them succeed in establishing that suicide is unconditionally morally impermissible. There are also several secular arguments that are commonly offered against suicide; for example, the argument that suicide is wrong because it is unnatural or that suicide is wrong because it harms others. I will subject these and other arguments to critical analysis and I will show that they also fail to demonstrate the unconditional moral impermissibility of suicide.

Chapter 3 will be the chapter in which I outline those cases in which suicide ought to be fully permissible. My claim will be that there are two conditions for a fully permissible suicide: First, the suicide must be morally permissible. In order for a suicide to be morally permissible, two further conditions must be met: 1) the agent in question must be

competent; and 2) the 'obligation condition': the suicide must not violate any overriding obligations that would not otherwise be violated. The second condition for a fully permissible suicide is that the suicide must be a rational act for the person in question. The reason why the rationality condition is separate from the moral permissibility condition is that it seems inaccurate to say that a person has done something morally wrong simply because his suicide is considered to be an irrational act for him to perform. On the other hand, there does seem to be a societal concern about people being totally free to act irrationally when their irrational actions will result in their deaths. Thus, the irrationality factor gives society the liberty (to a limited extent) to try to prevent irrational suicides from occurring. This argument will be explained in more detail in chapter 3.

Since I maintain that there is a rationality requirement for a suicide to be fully permissible, I will outline in chapter 3 an account of what it means for an action to be rational for an agent. After doing this I will apply the two conditions for a morally permissible suicide as well as the rationality condition to several fictional case examples to demonstrate which types of suicides may be permissible and which types may not. It is important, however, that the reader keep two things in mind: First, by no means do I claim that my case examples exhaust the list of permissible or impermissible suicides. I will only analyze a few examples of each, and I have chosen the examples that I have chosen because I believe that they are some of the more common types of suicides; they are examples that I think can most successfully be applied to the permissibility standard. Yet I fully admit that there may be several other types of suicides that I have not included in my analysis. Second, I also do not claim that all specific examples of each type of suicide will result in the same conclusions. This is the reason why I have chosen to analyze the

examples as cases of specific people, rather than general types of suicides. For instance, when I argue that a specific example of a suicide due to a terminal illness is permissible I do not claim that *all* suicides due to terminal illnesses are necessarily permissible. I only claim that cases of suicide due to terminal illness which match the features of the specific example I discuss will be permissible.

Finally, in chapter 4 I turn to the task of moving from a defense of suicide to a defense of assisted suicide. As I mentioned above, I think that most of the work will be completed for a defense of assisted suicide in some cases if it can be shown that suicide is permissible in those cases. By the end of chapter 3 I will have accomplished this work. Chapter 4 will consist mainly of my responses to the common arguments lodged specifically against assisted suicide. I will respond to three arguments in particular: 1) the argument that assisted suicide is morally impermissible because it involves one person *killing* another; 2) the argument that assisted suicide is morally impermissible because it involves one person *causing the death* of another; and 3) the argument that assisted suicide is morally impermissible because it involves one person *intending the death* of another. In addition, I will also attempt to respond to the slippery slope objections to assisted suicide, as well as arguments related to the corruption of the physician-patient relationship that some argue would result from a legal or policy acceptance of assisted suicide. What I intend to show in chapter 4 is that there is nothing morally special about assisted suicide to justify condemning assisted suicide while accepting the permissibility of suicide in those cases. That is, with one exception that will be discussed at the end of the chapter, if it is permissible for a person to take his or her own life then it also ought to be permissible for him or her to get suicide assistance from another person.

CHAPTER 1
THE RATIONAL SUICIDE

The psychological view of suicide is the dominant view of suicide in western culture. The attitude toward suicide expressed by those who hold this view is that suicide is the act of a mentally ill person, a symptom of mental illness, and that anybody who wants to take his or her own life must be crazy. Consider the following passages:

> Anyone who has given serious scientific consideration to the problem of suicide knows that death...is for the most part chosen under pathological circumstances or under the influence of diseased feelings.[10]

> ...generally suicide is not a rational act of a normal person, but rather intimately connected to depression, panic disorder, substance abuse, schizophrenia, and other emotional disorders.[11]

> Rational suicide is an oxymoronic statement.[12]

The reason why this view dominates western culture is because it is the view that is held and expressed by those who are considered most qualified to make this type of judgment: physicians, psychiatrists, and other mental health professionals. One of the reasons why the majority of mental health professionals hold this view is the existence of forty years of psychological studies that seem to demonstrate a definite connection between suicide and mental illness (most commonly depression).[13] While the statistics vary from study to study, they all point to a significantly high correlation between

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[10] Erwin Ringel, "Suicide Prevention and the Value of Human Life," in Margaret Pabst Battin and David Mayo, eds. Suicide: The Philosophical Issues (New York: St. Martin's Press, 1980), p. 206.

[11] Jay Callahan, "The Ethics of Assisted Suicide," Health and Social Work, 19 (4), Nov. 1994, p. 241.

[12] Kathleen M. Foley, "The Relationship of Pain and Symptom Management to Patient Requests for Physician-Assisted Suicide," Journal of Pain and Symptom Management, 6 (5), 1991, p. 295.

[13] I am ignoring here the debate over the classification of depression as a mental illness; that is, whether depression really is a mental illness and whether it ought to be classified as such. At the present time depression is still classified as a mental illness in the *Diagnostic and Statistical Manual of Mental Disorders*, fourth edition.

completed suicide and mental illness. For example, Barraclough et al. (1974) found that 78 percent of completed suicides exhibited evidence of depression and other diagnosable mental illnesses.[14] Hagnell (1978) and Rorsman (1979) found that 93 percent of completed suicides in the Lundby Study had received prior psychiatric diagnoses.[15] Jay Callahan notes that "in every community psychological autopsy study that has been conducted, more than 90 percent of the subjects who died by suicide had a psychiatric disorder."[16]

The statistics are so overwhelming in favor of the psychological view of suicide that the validity and reliability of the studies that produce the above mentioned statistics are rarely questioned. My purpose in this chapter is to do just that: to examine the statistics more closely and to question the validity and reliability of the studies and the methods on which they are based in order to determine whether the psychological view of suicide is justified. It is my view that there may be some fundamental problems with the studies and the methods on which they are based, which has led to a general exaggeration in the statistical correlation between suicide and mental illness. While I think the studies do demonstrate that there is a significant correlation between suicide and mental illness, and that perhaps most suicides are a result of mental illness, I believe that not enough attention has been given to the percentage of suicides that are carried out by people who are not mentally ill. These people may be mentally healthy at the time of their suicides and may be evidence that there is such a thing as a rational suicide. Moreover, I believe that a close

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[14] Margaret Pabst Battin, Ethical Issues in Suicide (New Jersey: Prentice-Hall, Inc., 1982), p. 5.

[15] David Lester, Why People Kill Themselves: A 1990's Summary of Research Findings on Suicidal Behavior (Springfield: Charley C. Thomas, 1992), p. 272.

[16] Callahan, p. 241.

examination of the suicide studies will reveal that the percentage of non-mentally ill suicides may be significantly larger than what the studies show. My aim in this chapter is to demonstrate that it is conceivable that suicide is a decision that is sometimes made by fully rational agents.

1.1 Irrationality vs. Non-Rationality

At this point I must outline an important distinction that is a source of confusion in the literature on the rationality of suicide. The confusion lies in the fact that there are actually two quite different issues that both tend to be referred to as the rational suicide issue. One issue is whether the decision (choice, desire, etc.) to suicide can be considered a rational decision. This issue focuses on the analysis of individual decisions in order to determine whether a certain decision meets the requirements of rationality. For example, one of the requirements for a rational decision may be that the decision must have a certain high probability of achieving the agent's desired ends or goal. If the decision to suicide meets this requirement, as well as the other appropriate requirements, then the decision to suicide is deemed rational. It is this issue that is discussed most often in the literature on rational suicide, such as in Carlos Prado's The Last Choice[17] and Margaret Battin's Ethical Issues in Suicide[18]. The main question at hand here is whether suicide is rational or *irr*ational.

The second of the two issues is the one with which I shall be concerned in this chapter. This is the issue not of the rationality of the decision to suicide, but of the rationality of the *agent* who makes the decision. As mentioned above, the psychological view of suicide argues that no rational person would ever want to take his own life. Instead of being

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[17] Carlos Prado, The Last Choice: Preemptive Suicide in Advanced Age, 2d ed., (Connecticut: Praeger Publishers, 1998).

concerned with the *irr*ationality of suicide, this issue is concerned with the *non*-rationality of the agent. The difference between the two issues is that a rational agent can (and often does) make perfectly irrational decisions. Moreover, it is possible for a non-rational agent to make what appear to be perfectly rational decisions. To help reduce the confusion surrounding the rationality of suicide, I will henceforth refer to the rationality-of-the-agent issue as the competency issue.

1.2 The Studies and the Statistics

"'Psychological autopsy' studies have documented that up to 90 percent of completed suicides had some psychiatric disorder at the time of death."[19] As noted in this statement, the method by which studies determine a statistical correlation between suicide and mental illness is what is referred to as a 'psychological autopsy'. Since the goal is to study the relationship between *completed* suicide and mental illness, the only way this can be achieved is by a study of the person after the suicide has occurred. However, a medical autopsy will not reveal much about the psychological state of the person in question, especially with respect to such illnesses as depression.[20] The only way that a psychological profile of a deceased person can be put together is by way of a psychological autopsy.

A psychological autopsy is performed by one or more mental health professionals, most often psychiatrists, who interview friends and family of the deceased, and examine

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[18] Margaret Pabst Battin, Ethical Issues in Suicide (New Jersey: Prentice-Hall, Inc., 1982).

[19] Mark D. Sullivan, Linda Ganzini, and Stuart J. Youngner, "Should Psychiatrists Serve as Gatekeepers for Physician-Assisted Suicide?" Hastings Center Report, 28 (4), 1998, p. 25.

[20] Recently there have been a handful of studies published purporting to demonstrate biological indications of depression discovered through medical autopsies, such as certain glands in the brain being larger than average in people who were known to be depressed. However, these kinds of studies are very new and the data have been so inconsistent that the medical community has yet to take them seriously.

personal notes such as journals or diaries, as well as the medical (including psychological) history of the deceased. The process is much like a criminal investigation, with mental health professionals piecing together a psychological profile of the deceased in order to determine whether he or she was mentally ill at the time of the suicide. The psychological autopsy method was developed during the 1950's at the Suicide Prevention Center in Los Angeles.[21] Since then, the method has been used numerous times in studies done all over the world with the same general result: a significantly high statistical correlation between suicide and mental illness, most commonly depression. Since psychological autopsies have demonstrated that a very high percentage of people who killed themselves were mentally ill immediately prior to the suicide, the presumption is often made that only mentally ill people kill themselves.

1.3 Problems with the Studies and Statistics

Many questions immediately come to mind when presented with the psychological view of suicide and the studies that support it. What about the small percentage of suicide agents who are not deemed mentally ill? How valid and reliable is the psychological autopsy method? For example, how precise can the method be if it relies largely on what friends and family say about the suicide agent? Even if someone is mentally ill, does this necessarily mean that he or she is not competent? What diagnostic criterion is used to determine mental illness, and how valid is the criterion? These are questions that are largely left unasked in the literature. In this section, I will attempt to answer them and to

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[21] Jan Beskow, Bo Runeson, and Ulf Asgard, "Psychological Autopsies: Methods and Ethics" Suicide and Life Threatening Behavior, 20 (4), Winter 1990, p. 307.

show that the answers succeed in casting some doubt over the acceptability of the psychological view of suicide.

The status of depression as a clinical mental illness has been a constant source of debate in the mental health field ever since psychiatrists first began to diagnose it. One of the most common debates is how to classify the different types of depression. Since very early on psychiatrists have recognized that there is no one general mental illness called depression; rather, there seem to be different types of depression that differ in degree of severity, types and combinations of symptoms, and length of time that the patient displays or suffers from various symptoms. Although the recognition that there are different types of depression is reflected in the most recent fourth edition of the American Psychiatric Association's *Diagnostic and Statistical Manual of Mental Disorders* (DSM), the most widely used diagnostic criteria for mental illness, the different types of depression are all diagnosed in relation to the symptomatic criteria for Major Depressive Episode.[22] With what type of depression the patient is diagnosed depends on how many depressive episodes the patient has/had experienced, when they were experienced, how long the patient has/had been experiencing the symptoms, and, in some cases, whether any additional required symptoms were experienced.

There is one significant problem with the use of the DSM-IV in the diagnosis of depression that is directly related to the link between suicide and mental illness. The problem is that thoughts of death, suicide attempts, and suicidal ideation is in fact one of the symptoms of Major Depressive Episode according to the DSM-IV criterion.[23] What

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[22] American Psychiatric Association, Diagnostic Criteria from DSM-IV (Washington: American Psychiatric Association, 1994), p. 161. (henceforth referred to as APA)

[23] APA, p. 163.

this means is that people who have killed themselves already have a check-mark beside one of the symptomatic criteria for depression before the psychological autopsy even takes place. They are already one step closer to being diagnosed as depressed *by virtue of the fact* that they killed themselves. This results in a dangerously circular, question-begging argument.

One might respond that the symptom of suicidal thoughts or attempts is only one of numerous symptoms for depression in the DSM-IV and so it is doubtful that it would skew the results in any significant manner. People still must display other symptoms in addition to suicidal thoughts or attempts (for example, insomnia or hypersomnia nearly every day, fatigue or loss of energy nearly every day, etc.).[24] This may be so in the clear-cut cases of depression, in which a patient displays/displayed several of the required symptoms, as well as severe types of depression (such as Major Depressive Disorder, Recurrent[25]) in which the requirements are more strict. However, the inclusion of suicidal thoughts or attempts as a symptom may very well play an important role in borderline cases. Those who "just make it" in terms of a diagnosis of depression may be pushed over the line by the inclusion of suicidal thoughts or attempts as a symptom of depression. Moreover, it may also play a role in the diagnosis of milder forms of depression such as Dysthymic Disorder, which is characterized by a depressed mood for at least two years, no Major Depressive Episode must be present during the first two years, and only two of six symptoms are required for a diagnosis.[26] While suicidal thoughts or attempts is not included on this smaller list of

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[24] APA, p. 162.

[25] For a diagnosis of Major Depressive Disorder, Recurrent, a patient must experience two or more Major Depressive Episodes separated by an interval of at least two consecutive months (APA, p. 168).

[26] APA, p. 170.

symptoms for Dysthymic Disorder, the more general "feelings of hopelessness" is a symptom.[28] This symptom may certainly be fulfilled by the act of suicide. Not only is it unlikely that someone killed him or herself without previously expressing feelings of hopelessness, but most people tend to view suicide as the ultimate expression of hopelessness.

How much of an effect the diagnostic problem discussed above might have on the statistics is debatable. However, a study by Tenoche, Pugh, and MacMahon (1964) revealed an interesting statistic. They noted that all of the studies that produced the highest correlation between suicide and mental illness (47%-94%) were psychological autopsies done *after* the suicide. Yet in different studies in which psychiatrists diagnosed mental illness in people *prior to* their eventual suicide, the correlation between suicide and mental illness was substantially lower (5%-22%).[29] That is, while as many as 94% of completed suicides were diagnosed as mentally ill in *post*-suicide diagnoses, only as many as 22% of completed suicides were diagnosed as mentally ill in *pre*-suicide diagnoses. What this shows is that the act of suicide itself indeed has a significant effect on whether people are diagnosed as mentally ill.

Another problem with the use of the DSM-IV in psychological autopsy studies, as pointed out by Beckham, Leber, and Youll, is that there has always been some confusion in the DSM criteria surrounding the difference between grief and depression.[30] According

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[28] APA, p. 170.

[29] James L. Werth, Jr., Rational Suicide? Implications for Mental Health Professionals (Washington: Taylor and Francis, 1996), p. 28.

[30] E. Edward Beckham, William R. Leber, and Lorraine K. Youll, "The Diagnostic Classification of Depression," in Handbook of Depression, 2d ed., ed. E. Edward Beckham and William R. Leber (New York: The Guilford Press, 1995), p. 54.

to the DSM-IV, someone who is grieving may "present with symptoms characteristic of a Major Depressive Episode."[30] However, the main thing that differentiates the condition of Bereavement from a Major Depressive Episode is if clinical attention is focused on a reaction to the death of a loved one.[31] Since the two conditions are very similar, with the only significant difference being the death of a loved one, it is very possible that some people diagnosed with Major Depressive Episode may simply be grieving. In addition, Beckham, Leber, and Youll point out that someone may grieve for the loss of a loved one without that loved one actually dying. For example, a woman may grieve for the loss of her husband who walked out on her and so she may experience depressive symptoms. If her husband died and she experienced these symptoms, she would probably *not* be diagnosed with a depressive disorder. Yet if her husband leaves her, and she suffers the same depressive symptoms, she *would* be diagnosed with a depressive disorder.[32] With respect to the psychological autopsy studies, this may play a role in the diagnosis of those suicides that are in part reactions to the loss of loved ones. For instance, an adolescent who kills herself because her mother walked out on her family may be more likely to be diagnosed as depressed than the adolescent who kills herself because of the death of her mother, even though the symptoms experienced may be identical.

In addition to the problems discussed above, there are also some rather significant problems with the psychological autopsy method itself, which may affect the validity of suicide studies. One of these problems is that human bias towards a negative view of

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[30] APA, p. 299.

[31] APA, p. 299.

[32] Beckham, Leber, and Youll, p. 54.

suicide, fueled by the psychological view of suicide, will inevitably affect the judgment of those involved. Since the psychological autopsy method relies heavily upon the testimony of the suicidal agent's friends and family, one way this problem can manifest itself is in the testimony given by these people. Because of the stigma that is attached to suicide in western culture, people may be more inclined to think that their friend or loved one would not kill himself unless something was wrong with him, or unless he was 'sick'. The suicide of a friend or loved one may be easier to accept if the suicide agent was suffering from a mental illness, especially if, as is common in suicides, the friends or family feel guilty about the suicide. Survivors often feel that they did something to contribute to the suicide, or that they failed to do something that could have prevented the suicide. The existence of a mental illness would certainly help to alleviate this guilt. "It was not our fault, it was the depression that made him do it." This type of bias, whether conscious or unconscious, may affect the testimony of the interviewees.

Perhaps the more serious way this problem of bias can manifest itself is in the judgment of the interviewer, the person making the diagnosis. In all cases the person performing the interview and making the diagnosis is a mental health professional, usually a psychiatrist. Hence, since most mental health professionals support the psychological view of suicide, the person making the diagnosis is not an objective impartial agent. However hard he or she may try to be objective and impartial, it is more than likely that this bias may still affect his or her judgment. That is, since most mental health professionals already consider suicide to be a symptom of mental illness, those performing the interview and making the diagnosis in the psychological autopsy studies may be more inclined (again whether consciously or unconsciously) to interpret the material to support

this belief. This problem of interviewer bias is made more probable by the fact that in most of the studies the interview and diagnosis was conducted by only *one* mental health professional.[33]

Connected to the problem of interviewee bias is the question of how reliable a study method can be if it relies so heavily on what other people say about the suicide agent. In the psychological autopsy method the mental health professional does not have direct access to the suicide agent him or herself, and so can not observe his or her behavior and make a diagnosis first hand. Therefore, the mental health professional must rely almost entirely on the testimony of friends and family. Not only will bias come into play, but the testimony depends on how well the interviewees knew the suicide agent, how they interpret the suicide agent's behavior, and so on. How friends interpret the behavior of the suicide agent may be very different from how the parents interpret the behavior. Also, parents who did not have a close relationship with a son who took his own life may interpret the son's melancholic mood as "just the way he was," whereas parents who were closer to their son may recognize the melancholic mood as abnormal. Analogously, the psychological autopsy method is like a court case that relies on circumstantial evidence and hearsay testimony.

A third problem with the psychological autopsy method is that diagnoses are made after only one interview with friends and family. This problem may be unavoidable because of the emotional strain that the interview places on friends and family; the emotional strain may be too severe if friends and family were interviewed more than

[33] Beskow, Runeson, and Asgard, pp. 312-313.

once.[34] Although it is an unavoidable problem, it is still nonetheless a problem. Mental health professionals are required to make a diagnosis about the mental health of an individual based, not even on one interview with the *individual*, but on one interview with second parties. A study was recently conducted regarding the views of Oregon psychiatrists toward physician-assisted suicide which showed that only *6 percent* reported confidence in their ability to determine, in the context of a single consultation, whether a mental illness was affecting a person's request for physician-assisted suicide.[35] This number might be even lower if the psychiatrists were required to make this determination by interviewing friends and family rather than the individual, as in the case of psychological autopsy studies.

Finally, the time period in which the psychological autopsy interviews are conducted will have an impact on the testimony that is given by the friends and family of the suicide agent. If the interviews are conducted too soon after the suicide occurs, the emotional distress felt by the friends and family may interfere with their ability to give reliable objective testimony as to the suicide agent's behavior prior to the suicide. For this reason, Beskow, Runeson, and Asgard suggest a waiting period of at least two months after the suicide before initiating the interview process.[36] However, they also point out that in many of the suicide studies cited, the interviews took place before the two-month waiting period; some were conducted a few weeks after the suicide while some were conducted "very soon

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[34] Beskow, Runeson, and Asgard, p. 317.

[35] Linda Ganzini and Melinda A. Lee, "Psychiatry and Assisted Suicide in the United States," The New England Journal of Medicine, 336 (25), p. 1825.

[36] Beskow, Runeson, and Asgard, p. 316.

after the act" or "as soon as suicide was confirmed."[37] It is possible that in these studies the interviews were conducted too close to the time of the suicide for the testimony to be considered reliable. Although this may not be a serious problem, and may only affect a handful of the studies, it may be enough to add more skepticism to the case for the psychological view of suicide.

1.4 Competency

In the above section I attempted to outline some problems with the often-cited psychological autopsy studies, and the method on which they are based, in order to demonstrate the possibility that the statistics may be exaggerated or even unreliable. Aside from the problems with the studies themselves, however, there is still one crucial question that has remained unanswered. It has the potential to be more damaging to the psychological view of suicide than any of the problems discussed thus far and yet it is a question that has remained largely unexamined in the literature until recent years. This question is: Even if it is true that most people who have killed themselves were mentally ill at the time of the suicide, does that necessarily mean they were incompetent?

It is important to review why this question is so significant and so potentially damaging. The implication of the various psychological autopsy studies and, hence, the psychological view of suicide, is that if someone who killed him or herself was mentally ill then he or she was not competent to make the decision to take his or her own life. If the person was incompetent at the time of the suicide, then the suicide can not be considered morally permissible or impermissible because the person can not be held responsible for the suicide; the suicide was something that happened to her, through no fault or choice of

[37] Beskow, Runeson, and Asgard, pp. 312-313.

her own. In other words, an agent must be competent in order for his or her actions to be judged as either morally permissible or impermissible. This is why the psychological view of suicide is so powerful: the question of whether suicide is morally acceptable or permissible is blocked before it can be asked *if* it can be determined that suicide is the act of an incompetent person. The question asked above arises because this line of reasoning is grounded in one major assumption: that a mental illness necessarily renders a person incompetent. In order to investigate this question, the notion of competence must first be examined.

Much has been written in the psychiatric, medical, and bioethical literature on the subject of competency. Since it is such a complex concept, and so many different theories and interpretations of competency have been offered, there is no room here for a full and detailed account of the concept. What I will do is briefly discuss what I believe to be the main important features of competency in order to give the reader a basic idea as to what the concept is about.

In a 1977 issue of the American Journal of Psychiatry, Loren Roth, Alan Meisel, and Charles Lidz offered an account of competency that I think perfectly captures the basic features of the concept. Although there has been much written on the subject more recently than 1977, all theories of competency tend to base themselves on the same basic idea as outlined by Roth, Meisel, and Lidz. In general, competency involves the ability "to comprehend the nature of the particular conduct in question and to understand its quality and its consequences."[38] Though this view, as with most others, focuses on competency in the context of consent to treatment, it can just as easily be applied to a person considering

[38] Loren H. Roth, Alan Meisel, and Charles W. Lidz, "Tests for Competency to Consent to Treatment," American Journal of Psychiatry, 134 (3), March 1977, p. 279.

suicide. In this case, the conduct in question is the act of suicide. If a person considering suicide is unable to comprehend the nature of the act of suicide, and/or is unable to understand the quality and consequences of suicide, then the person would be incompetent. So what exactly does it mean to be able to understand the nature, quality, and consequences of a certain action?

It is imperative that this ability to understand the nature, quality, and consequences of an action not be the ability to understand purely in the abstract. This is because it is possible for a person to comprehend the nature, quality, and consequences of an action without an understanding of how the information relates to her actual life. In this sense, she understands the relevant information abstractly, as if she was studying for an exam, but she has no concept of how the information applies to *her*. Since we are concerned with whether *she* understands the nature and consequences of suicide, namely that she will be dead if she chooses to take her own life, it is important that she understand how suicide will affect *her* life. Hence, Drane argues that competency "requires an understanding that is both technical and personal, intellectual and emotional."[39]

In order to achieve this kind of understanding, more elements are required in addition to the basic capacity to understand.[40] According to Allen Buchanan and Dan Brock, these elements are the capacity for reasoning and deliberation, and the possession of a set of

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[39] James F. Drane, "The Many Faces of Competency," Hastings Center Report, 15, April 1985, p. 20.

[40] It must be pointed out that this capacity to understand inherently includes the capacity for communication. Without the existence of communication between the patient (or the agent in question) and the mental health professional performing the evaluation, a test to determine competency would be impossible. Since in the case of the psychological autopsy method, however, the agent in question is deceased, communication is impossible. Therefore, the communication element must be waived and so I will ignore it in this discussion.

values or a conception of the good.[41] The first of these elements, the capacity for reasoning and deliberation, may even be required for the capacity of understanding itself. The existence of this capacity allows the agent to reach conclusions, on her own, as opposed to simply memorizing and reciting what the physician or mental health professional tells her. What is required (not only of the agent but of the test design itself) is that the agent be able to demonstrate, upon receiving only the minimally required information, that she can draw her own conclusions as to the quality and consequences of the conduct in question. This involves, according to Buchanan and Brock, the capacity "to draw inferences about the consequences of making a certain choice and to compare alternative outcomes based on how they further one's good or promote one's ends."[42]

The latter of the two above elements, the possession of a set of values or a conception of the good, is required for this capacity of reasoning and for the intimate personal understanding discussed above. This is obvious with respect to the type of reasoning described by Buchanan and Brock; in order for one to be able to draw inferences and compare alternatives based on how they further one's conception of the good, one must first possess a conception of what is good (or a set of values). Similarly, in order for one to be able to understand how a certain action may affect one's own life, one must possess an idea of what one considers important or valuable. That is, if one is to understand the consequences of suicide to be good or evil, to use Buchanan and Brock's terminology[43], one must first have a conception of what one considers to be good and evil. Without a set

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[41] Allen E. Buchanan and Dan W. Brock, Deciding for Others: The Ethics of Surrogate Decision Making (Cambridge: Cambridge University Press, 1989), p. 23.

[42] Buchanan and Brock, pp. 24-25.

[43] Buchanan and Brock, p. 25.

of values, one would not be able to formulate ends and goals; without ends or goals, an action such as suicide would have no purpose. Someone who is contemplating suicide without any specific end or goal in mind should not be viewed as competent.

Now that I have outlined a basic conception of competency, I can turn to the question of whether or not mental illness necessarily renders one incompetent. In order for this question to be answered in the affirmative, a mental illness would have to block or disable at least one of the above mentioned elements of competency. Is this the case? The answer may be somewhat obvious with respect to some severe mental illnesses; a paranoid schizophrenic comes to mind as someone who might be clearly incompetent. Someone suffering from a severe, psychotic level depression may also be clearly incompetent. Arieti and Bemporad (1977) suggested that one of the symptoms typically displayed by severe psychotic level depressives is disordered and disturbed cognitive processes, "in which thinking is slowed, blunted, and blocked, and is marked by idiosyncratic and distorted content."[44] Blunted and blocked thinking would certainly obstruct one's capacity for reasoning and deliberation. Along the same lines, Jerold Gold noted that in psychotic level depressions,

> Attention and concentration are disrupted and impaired, as is the person's ability to direct, guide, and focus his or her thinking. Reading, writing, thinking, and speaking often become cumbersome, slowed, or blocked entirely...[45]

Again, this type of cognitive impairment characteristic of psychotic level depressions would obstruct the capacity for reasoning and deliberation that is required for competency. However, psychotic level depressions make up the extremely small minority of total

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[44] Jerold R. Gold, "Levels of Depression," in Depressive Disorders: Facts, Theories, and Treatment Methods, ed. Benjamin B. Wolman and George Stricker (New York: John Wiley and Sons, 1990), p. 215.

[45] Wolman and Stricker, p. 217.

depressions. The most common types of depression fall within the mild-medium range, and it is these mild-medium depressions that constitute the majority of mental illnesses diagnosed in the psychological autopsy studies. And there is little if any concrete evidence that mild or medium depression obstructs any of the elements of competency.

Before analyzing the symptomatic criteria for mild depression, I will first briefly discuss one of the more general problems with the assumed connection between mental illness and incompetence. This problem stems from the view discussed in the psychiatric and bioethical literature in recent years that competency is decision-relative, as well as time-relative, rather than a general phenomenon. Instead of viewing people as either competent or incompetent in general, some argue that people are only competent or incompetent to make certain decisions at certain times. In other words, someone may be competent to make a certain decision at a certain time, but incompetent to make another decision at that same time, or incompetent to make the same decision at another time.[46] Hence, a terminally ill patient may be incompetent to make the decision to withdraw life support at a certain time but competent to make a different decision several days later. One of the reasons for this view is that, depending on the person, many of the symptoms of mental illness (or factors that may affect competency) often vary in presence and severity over time. The effects of dementia, for example, may cause mental confusion to come and go, and so periods of confusion may be followed by periods of clarity.[47] However, if a hospitalized patient were to be diagnosed with a mental illness he would be deemed *generally* incompetent. Yet he may have only been experiencing the symptoms that led to

[46] Buchanan and Brock, p. 18.

[47] Buchanan and Brock, p. 19.

the diagnosis, and thus the symptoms that impair his competency, at that specific time. Or, perhaps, he may have been experiencing the symptoms at their strongest level of severity at that time. It is possible that a second psychiatric consultation two days later might declare him perfectly competent. Therefore, the general conclusion that mental illness renders people incompetent may not be justified. It may be the case that mental illness renders people incompetent to make certain decisions at certain times, but this does not mean that they cannot make other decisions at other times.

As for the symptomatic criteria, difficulty in thinking and making decisions has always been one of the standard symptoms of a depressive episode. In older versions of the DSM, this symptom was referred to as "slow thinking", or "retardation". However, slow thinking does not necessarily affect one's competence. It may mean that a depressed person requires more time to make decisions, and may reason and deliberate at a slower pace than a non-depressed person, but this does not mean the depressed person is incompetent. More will be said about this below. What is interesting about this symptom of depression (as well as all the other symptoms) in the DSM is that not all depressed people experience, or at least display, this symptom. In a 1971 study of hospitalized depressive patients, only 67 percent showed the symptom of slow thinking.[48] Therefore, even if slow thinking did render a depressed person incompetent (which it very well may not), this is a symptom that only affects a certain percentage of depressed people.

While the terminology has undergone a slight change in the DSM-IV, the basic idea remains the same. The eighth of the nine symptoms listed for a Major Depressive Episode

[48] George Winokur, Depression: The Facts (Oxford: Oxford University Press, 1981), p. 6.

in the DSM-IV is "diminished ability to think or concentrate, or indecisiveness."[49] The problem mentioned above, however, is also the same. Diminished ability to think or concentrate does not necessarily mean a depressed person is incompetent. Someone suffering from a Major Depressive Episode may still have the capacity for understanding, for reasoning and deliberation; it is just that this capacity might be diminished. This person may have trouble thinking and concentrating, and trouble making decisions, but she still has the capacity to think and make decisions; as mentioned above, it just may take longer for her to reach her conclusions.

The wording of the symptom of slow or difficult thinking is vitally important. There is a significant difference between the meanings and implications of the statements "depressed people *have difficulty* thinking and making decisions," and "depressed people are *unable* to think and make decisions." In order to reach the conclusion that depressed people are incompetent, the latter of these two statements would have to be true. Unfortunately, it is only the former that is true. And this is not just the case in the symptomatic criteria of the DSM; the wording is the same throughout the psychiatric literature on depression. Consider, for example, the following: "Depression also alters intellectual functioning and impairs concentration, memory, and decision-making."[50] Depression may alter or impair thinking and decision-making, *in those who actually suffer from this symptom*, but this does not mean they are not competent to make the decision to take their own lives.

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[49] APA, p. 162.

[50] Ian H. Gottlib and Constance L. Hammen, Psychological Aspects of Depression (Chinchester: John Wiley and Sons, 1992), p. 3.

Since depression may not render one incompetent by blocking one's ability to reason and make decisions, the only question left to answer is whether depression necessarily interferes with one's value system. This is doubtless the most problematic condition of competency because it is more likely that depression would affect one's value system rather than the cognitive requirements for competency. It must be certain that in at least some cases a person suffering from depression may retain his or her "valuational competence."[51]

In order to demonstrate that she is competent an individual must be able to give reasons for the choice/desire in question, in order to show not only that she understands and can reason through the information but also that the information has been related to her personal value system.[52] If her reasoning conflicts with her personal value system, she should be considered incompetent. For instance, suppose a patient is known to be religious and places a high value on suffering, believing that it is God's will to challenge us in this manner, and she expresses the desire to die. If the reason for her desire to die is that she does not want to suffer, and also expresses that she values suffering, she should be considered incompetent because her reasoning contradicts her personal values. Also, a patient should be considered incompetent if the values she holds contradict each other or conflict with reality. An example of a value that conflicts with reality would be if someone valued and sought after immortality.[53] Kluge combines these factors into a concept of valuational competence based on three conditions: 1) the values adopted must be in

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[51] Eike-Henner Kluge, Biomedical Ethics: In a Canadian Context (Scarborough: Prentice-Hall Canada, Inc., 1992), p. 96.

[52] Drane, p. 20.

[53] Kluge, p. 96.

keeping with the facts of reality; 2) the values adopted must be consistent with the nature of the individual as a person; and 3) the valuationally incompetent person is one who, in spite of the evidence of the valuational unreasonableness of a position, continues to adhere to it because she is unable to change.[55] Therefore, the question at hand is: does depression *necessarily* violate any of these conditions of valuational competence?

With respect to the reality requirement, I think that the most severe psychotic level mental illnesses, such as paranoid schizophrenia characterized by hallucinations or delusions, would necessarily render one valuationally incompetent. Since this kind of severe mental illness seriously alters one's view of reality, it is more than likely that one's value system would be affected in the same manner. However, although a person's view of reality does become altered by more severe types of depression, I think it is unlikely that depression in most cases would alter one's values to the point that the values come into conflict with reality. Depression alters one's view of reality only by making one's reality seem more negative than it may actually be. For instance, studies have concluded that "depressed individuals perceive and interpret aspects of their environments more negatively than do nondepressed persons and recall these negative aspects more easily."[56] Depression would not cause the middle-aged man who lost his job and whose wife left him to value such things as immortality or the ability to fly, as schizophrenia might. Depression would simply cause this man to think his job or romance prospects are less numerous than they might actually be. There is no reason to believe that depression would alter one's values to the point that they conflict with reality.

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[55] Kluge, p. 96.

[56] Gottlib and Hammen, p. 115.

The second requirement, that the values must be consistent with the nature of the individual as a person, is the most problematic. This requirement is necessary to protect those individuals who express values (which have been altered by a mental illness) that contradict the values he or she may *really* hold. For instance, a common scenario might be that a person values certain things before a mental illness but the person expresses different values now, while he or she is suffering from the mental illness. If the old value system is the one the person really holds, that is, would continue to hold if he or she was not mentally ill, then the person ought to be considered valuationally incompetent. This is because the new value system would not be viewed as being consistent with the nature of him or herself as a person. Of course there exist empirical difficulties with this view. For one, it would be extremely difficult in practice to be able to determine which value system is really consistent with the nature of the person for the reason I will discuss below. Unfortunately, there is no room in this thesis to examine or try to solve these empirical difficulties.

The distinction between values that are consistent with the nature of the individual as a person and values that are inconsistent is tricky because it is not uncommon for people to autonomously alter their value system. This may especially be the case when people have experiences that force them to reevaluate their values. For instance, many people may value the sanctity of life over quality of life until they encounter an experience, such as a relative suffering from a debilitating terminal illness, that might cause them to alter their values. Mental illness may also be an example. The mental illness may lead a person to alter his or her value system in the same way that an experience with a life-threatening disease might. But this does not mean that the new value system is necessarily

inconsistent with the real person just because he or she is suffering from a mental illness. Hence, the claim can not be made that depression necessarily causes one's values to conflict with the nature of oneself as an individual.

The third requirement of valuational competence is needed to distinguish between those who are morally responsible for their choices and those who are not; as Kluge states, "to distinguish between individuals who are self-destructive because they want to be, and those who cannot help themselves."[56] The point is not whether the person's position is valuationally unreasonable because this would open the door to the dangerous "reasonable person" standard for competency.[57] Rather, the point is whether the position held is voluntarily or autonomously unreasonable (meaning unreasonable by way of autonomy, or unreasonable by choice). If the person's position is not unreasonable by choice (that is, if the person is holding the valuationally unreasonable position simply because she is unable to alter her position) then she ought to be considered valuationally incompetent. However, there is again little reason to believe that depression would necessarily render one valuationally incompetent in this fashion. Certainly in some cases, if not most, depressed people are unable to see that their life prospects are more positive than they believe. Many depressed people who think, for example, that their lives are not worth living because they will never find love again may hold on to this belief because they are unable to alter it; they just can not comprehend the valuational unreasonableness of this position and so it

[56] Kluge, p. 97.

[57] The "reasonable person" standard is dangerous because it allows the individual making the diagnosis to label a person as incompetent based on the fact that the person's values conflict with those that would be held by the average reasonable person. On this basis, one is incompetent if one's values differ from the norm. (see Buchanan and Brock, pp. 69-70 and Mark D. Sullivan and Stuart J. Youngner, "Depression, Competence, and the Right to Refuse Lifesaving Medical Treatment," American Journal of Psychiatry, 151 (7), July 1994, p. 975 for discussions of this danger.)

can not be said to be an unreasonable position by choice. Nevertheless, this is not the case in all depressions. Especially in those cases in which the depression has not impaired the person's capacity for reasoning and deliberation, it is perfectly conceivable that some people can autonomously hold on to a valuationally unreasonable position. As Kluge states in an endnote, "this [third requirement] allows us to say that not all suicides are incompetent."[58]

My examination of the concept of competency has shown that it is not the case that depression *necessarily* renders one incompetent. None of the three requirements for competency, the capacity for understanding, the capacity for reasoning and deliberation, and valuational competence, are necessarily impaired by depression. Again, this is not to say that depression does not affect competency; it is only to say that we must accept that the decision to take one's own life is sometimes made by competent individuals, even if the decision itself seems irrational.

> It is very easy to grant that some, perhaps even most, suicides do reason in fallacious ways...But although we may readily grant this point, this is not to establish that all suicides commit these errors. In the absence of any compelling evidence to the contrary, we must simply leave open the possibility that some persons do choose suicide in preference to continuing life on the basis of reasoning which is by all usual standards adequate.[59]

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[58] Kluge, p. 108.

[59] Margaret Pabst Battin, "The Concept of Rational Suicide," in Death: Current Perspectives, ed. Edwin S. Shneidman (California: Mayfield Publishing Company, 1984), p. 301.

CHAPTER 2
OTHER ARGUMENTS AGAINST SUICIDE

The first chapter of my thesis was devoted to a critical examination of the psychological view of suicide because it gives rise to the most compelling, and one of the most popular arguments against suicide: that suicide cannot be morally permissible because suicide is only performed by incompetent people. It is also the argument against suicide that has remained the least challenged. However, there are several other arguments that are commonly offered against suicide; some are secular in nature and some are religious. The most common secular arguments that I have chosen to discuss are the "suicide is unnatural" argument, the argument that suicide violates the sanctity of life principle, the "suicide harms others" argument, the slippery slope, and the more specific "a cure may be found" and "pain can be managed" arguments. The most common religious arguments, which I group together under the "suicide is playing God" argument, include the argument that our lives are God's and only he/she can decide when they are to end, the argument that suffering is God's will, and the argument that suicide destroys a gift (life) from God. My aim in this chapter is to critically examine these arguments and to show that they do not succeed in demonstrating that suicide is always morally wrong.

2.1 The Secular Arguments

2.11 "Suicide is Unnatural"

The argument that suicide is wrong because it is unnatural was first expressed by Aquinas in his *Summa Theologiae*. The crux of this argument, which is still often expressed today, is that suicide is wrong because it is contrary to the human instinct for

self-preservation. People who offer this argument against suicide sometimes make reference to the animal kingdom to support the view that suicide is unnatural. All animals have an instinct for self-preservation and no animals are known to ever commit suicide. Therefore, humans who desire to commit suicide are deviations from nature. Although this argument has been quite popular since Aquinas first offered it, the argument is not very compelling.

The first thing that can be said in response to this argument is that it may not be quite true that suicide is necessarily contrary to the natural instinct for self-preservation. With respect to the animal kingdom, there have been documented cases, though they may not be common, of animals performing actions that result in their own deaths. Cats (both wild and domestic), for example, apparently take steps to hasten their deaths when they become aware that they are dying. Once the cat becomes aware that it is dying, it will forego all nourishment in the attempt to avoid suffering by hastening its death. Whether one wants to refer to this behavior as cat suicide or cat passive euthanasia, it clearly shows that there is no unconditional natural instinct for self-preservation.

Since examples of animal 'suicide' can be found to show that there is no unconditional natural instinct for self-preservation, the same reasoning can be applied to human behavior. That is, one would only have to find cases in human behavior that run contrary to the supposed instinct for self-preservation to show that this instinct does not exist unconditionally. These cases are obviously not hard to find, as suicide is prevalent in western society. If suicide really were contrary to human inclination, it would not occur as often as it does. The most that can be said is that suicide is contrary to *some* human

inclination for self-preservation; but this is not enough to show that suicide is contrary to *human* nature and, therefore, that it is wrong in itself.[61]

The above, however, is not a very strong argument against the 'suicide is unnatural' argument because counterexamples do not actually succeed in showing that there is no instinct for self-preservation. One can have an instinct to do a certain thing without always doing that thing because, for one thing, instincts may compete with each other or instincts may compete with other desires.[62] Just because some animals, or some people, kill themselves, this does not mean there is no natural instinct for self-preservation. Therefore, a stronger argument must be found to refute the 'suicide is unnatural' argument.

Whether suicide is or is not contrary to a human inclination for self-preservation turns out to be irrelevant because there is a more serious objection to the 'suicide is unnatural' argument. Even if it could be demonstrated that suicide is contrary to the human instinct for self-preservation, this argument is a textbook example of a mistaken appeal to nature. In other words, it commits what might be referred to as the "is-ought fallacy"; it moves from what is to what ought to be. What this argument claims is that since it *is* the case that humans tend to remain alive rather than taking their own lives, they therefore *ought* to remain alive rather than take their own lives.[63] Yet this move from is to ought is erroneous; even if it is true that something is a certain way in nature, it can still be asked whether that is the way it should be, or whether there might be a better way. Moving directly from the fact that suicide may be contrary to a human instinct for self-preservation

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[61] Karen Lebacqz and H. Tristram Engelhardt, Jr., "Suicide," in Death Dying, and Euthanasia, ed. Dennis J. Horan and David Mall (Washington: University Publications of America, Inc., 1977), p. 681.

[62] Professor Wil Waluchow, personal email communication, April 28, 1999.

[63] Battin (1982), p. 55.

to the conclusion that it is therefore morally wrong disregards a step in between; the step that *demonstrates* that what is natural is what ought to be. Moreover, as Battin points out, there are numerous cases of "natural" behavior that our moral system condemns and "unnatural" behavior that our moral system permits.[63] For example, since all animals including humans have a natural instinct to promote their species by reproduction, it could be said that monogamy is unnatural in this sense. Yet monogamy is something that is not only permitted but is encouraged by our moral system. Therefore, for the reasons noted above, the argument that it is unnatural does not succeed in demonstrating that suicide is always morally wrong.

2.12 "Suicide Violates the Sanctity of Life"

The idea behind the argument that suicide violates the sanctity of life principle is that life is intrinsically valuable and since suicide destroys life, suicide is morally wrong. Advocates of this argument place suicide in the same group with any other type of killing. Since we hold that other forms of killing are morally wrong because they destroy life, it is said, so must suicide be wrong. Noticeably, however, this argument rests on one major assumption: that life itself is intrinsically valuable.

Since this argument rests entirely on the acceptance of the sanctity of life principle, the easiest way to refute the argument is by attacking the idea of life as intrinsically valuable. Before I do this, however, I will point out that the argument is problematic right from the start. Even if one were to initially accept the sanctity of life principle, one would not necessarily have to be committed to the view that suicide is morally wrong. Similarly, one would also not have to be committed to the view that killing in general is wrong. This is

[63] Battin (1982), p. 55.

because it is generally accepted that there are always exceptions to the principle of the sanctity of life. That is, few would argue that *all* types of killing are wrong. Self-defense, for example, is commonly accepted as a type of justifiable killing. Some would also argue that capital punishment or killing in the pursuit of a just war are also exceptions to the rule that killing is wrong because it violates the sanctity of life principle.[64] Therefore, it is not the case that all acts that violate the sanctity of life principle are morally wrong. Suicide may be another one of these exceptions.

Many philosophers have argued against the sanctity of life principle. They opt instead for a quality of life principle: the view that what is valuable is life of a certain quality rather than mere life itself. The justification for this view, although it is articulated differently by different authors, is that life is only valuable as a means to an end. It is valuable because it allows us to achieve certain things: happiness, autonomy, success, and so on. Since life is only valuable as a means to whatever ends we choose to pursue, life becomes valueless once it drops below a certain quality as to make the achievement of our ends impossible. Rachels makes a distinction between *being alive* (in the biological sense) and *having a life* (in the biographical sense); and death is a misfortune because it puts an end to one's having a life, not because it puts an end to one's being alive.[65]

Life can not be intrinsically valuable because if it were, *all* life would have to be protected by the sanctity of life principle. If being alive (biologically) were intrinsically valuable, then moral opposition to destroying life based on the sanctity of life principle would have to apply equally to all animals, plants, insects, and any other variety of

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[64] P. R. Baelz, "Suicide: Some Theological Reflections," in Battin and Mayo (1980), p. 73.

[65] James Rachels, The End of Life (Oxford: Oxford University Press, 1986), p. 50.

biological life on our planet. Although some people do morally oppose the destruction of any life, most would agree that someone who picks a flower has not committed an act that is morally equivalent to the murder of another human being. The fact that we do draw a line and exclude most other forms of biological life from the moral realm supports the view that it is not biological life per se that we consider valuable, but it is human (or at least advanced) life that is valuable.[66]

One might respond to the above argument in the following manner: although someone who picks a flower has not committed an act that is morally *equivalent* to murdering a human being, she has nonetheless committed a morally wrong act. The life of a flower may not be *as* valuable as the life of a human but it is still valuable. In this sense, all life is valuable but there are degrees of value. Thus, some might place the value of life along a sentience spectrum: beings with higher degrees of sentience (such as humans, apes and monkeys, dolphins) are of a higher value than beings with lower degrees of sentience (such as insects). Yet no matter how low a being is on the value scale, all life is still valuable.

Though this argument is initially plausible, it suffers from a serious problem. Once we distinguish between different levels of value, whether the distinction is made along the lines of sentience or some other characteristic, one must then ask why the distinction is made based on that characteristic. That is, why might we value the life of beings with strong sentience, for instance, more than beings with weak sentience? If the characteristic is sentience, one might say that beings with higher levels of sentience will be able to experience pain and suffering, and it is wrong to bring about pain and suffering unless there are excellent reasons for doing so. But once the reason is given, a line (though it may

[66] Baelz, in Battin and Mayo (1980), p. 72.

be blurred) is automatically drawn which will inevitably separate those beings which have the necessary characteristic from those that do not. Plants, for instance, would be exempt from the category of beings that are valued because of sentience. No matter what characteristic is chosen, some forms of life will always be excluded.

The same will be true within the realm of human life. That is, whatever characteristic is chosen, some humans will inevitably be left out of the valued group. Even if the characteristic were sentience, which would at first glance seem to include all humans, some humans would be excluded. For example, anencephalic infants and comatose patients without higher brain activity would be left out and their lives would not be considered valuable.[67] If we are not satisfied with this implication, then a new characteristic for valuable life must be developed. But then the task becomes arbitrary: we search for a characteristic to delineate what is valuable about life simply because we want it to include certain kinds of life, not because it is really what we consider valuable. Either the criterion for valuable life must be weakened to the point at which all life is included, which is impossible without naming biological life as the characteristic, or we admit that certain kinds of life are valuable and certain kinds are not. The former is unacceptable as it does not represent how we actually view, nor how we ought to view, the value of life. Simply put, the act of turning off the life support machine of a 'brain dead' human, who has no chance of recovery, is not morally equivalent to the act of turning off the life support machine for a comatose person who has a good chance of a full recovery. Nor should it be. The latter of the above two alternatives is also unacceptable because it is

[67] It is no coincidence that similar reasoning is used to make the argument that anencephalic infants and other 'brain dead' humans are 'dead', making them viable organ donors. In this sense, they are biologically alive but are considered dead in Rachels' sense of not having a life.

incompatible with the sanctity of life principle. Therefore, I think that an appeal to the sanctity of life principle to show that suicide is morally wrong is a dead end.

2.13 "Suicide Harms Others"

The argument that suicide is wrong because it harms others takes many different forms. One argument is that suicide is wrong because of the emotional trauma that it causes for family and friends of the suicide[68]; another is that suicide is wrong because it deprives loved ones of services, perhaps financial, that the person may have provided if he or she had lived longer.[69] Still another form of the argument is that our relationships carry with them covenantal obligations and suicide violates these obligations.[70] Finally, perhaps the oldest form of the argument, offered first by Aristotle, is that suicide is wrong because it harms the community as a whole by removing valuable skills from the community.[71] Though the argument takes different forms, many of the same basic objections can be made to each.

First, Lebacqz and Engelhardt point out that the most obvious question that arises in response to the harming others argument in the first three forms noted above is: What if the suicide agent has no family and friends?[72] If suicide is wrong because it harms family and friends, regardless of in what form this harm occurs, then suicide would not be wrong for those who have no family and friends. The same would also apply for people who are

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[68] Lebacqz and Engelhardt, Jr., in Horan and Mall (1977), p. 675.

[69] Anthony Flew, "The Principle of Euthanasia," in Downing and Smoker (1986), p. 52.

[70] Karen Lebacqz and H. Tristram Engelhardt, Jr., "Suicide and Covenant," in Battin and Mayo (1980), p. 85.

[71] George Howe Colt, The Enigma of Suicide (New York: Summit Books, 1991), pp. 159-160.

[72] Lebacqz and Engelhardt, Jr., in Horan and Mall (1977), p. 675.

estranged from their families. Consider a homeless man or a hermit with no personal relationships. If his death would not cause any emotional or financial harm, or would not break any covenantal obligations, then there would be nothing morally wrong with his suicide. One may respond by claiming that this does not apply to the argument in the fourth form above: people who do not have family and friends are still a valuable part of the community and still have skills and services to offer. Suicide would be wrong for these people because their suicides would harm the community. However, this argument fails because we can still think of members of the community who unfortunately have no skills to contribute. For instance, some people are simply beyond the point in life at which they can contribute their skills to society, such as elderly people in the late stages of Alzheimer's.[74] One could surely think of numerous other examples. Suicide for these people would still not be wrong according to the harming others argument.

There is another argument that could be made in response to the harming others argument, yet it only applies to the emotional trauma form. Though it does not apply to the others, I think it is interesting enough to warrant a brief remark. Werth suggests, and this relates back to the discussion of interviewee bias in chapter 1, that much of the emotional trauma caused to family by a suicide may be accounted for by the stigma that is attached to suicide. For most people a suicide would be more emotionally painful for the survivors than a natural death. As discussed in chapter 1, a contributing factor in this emotional trauma is the guilt that many survivors feel when a loved one has taken his or

[74] In ancient Greece, suicide was thought to be morally permissible for people who could no longer contribute to the community.

her own life. Perhaps if society's views toward suicide changed positively, the emotional effects on survivors may not be as bad.[74]

Clearly the most serious objection to the harming others argument is what follows if it is accepted. As numerous authors have pointed out, if we accept the argument that suicide is wrong because it harms others, then what seems to follow is that suicide may be right or even obligatory in cases in which suicide may be of a benefit to others.[75] Talk of positive obligations is tricky in this case, however, but I think the point can be made in a less controversial manner. If suicide is wrong because it harms others, then what is implied is that the alternative (remaining alive) is morally preferable. The important question is: What happens when the alternative is more harmful than the suicide would be? The implication would seem to be that the alternative would be morally impermissible, since it is more harmful, and the suicide would be the preferable course of action. Consider, for example, a man who physically, sexually, and emotionally abuses his wife and two daughters. Suppose this man has no other family or friends and is despised by all who know him (including his wife and children). This man's suicide would not only not harm others, but in many ways the alternative of remaining alive would be more harmful. Although his death may create a financial burden for the wife and children, the emotional and psychological benefit of his death may override this burden. If it is harm to others that makes suicide wrong, then remaining alive would be the morally wrong action when the harm of remaining alive would outweigh the harm of suicide (assuming of course that the abusive man is unable or unwilling to cease or get help for his abusive behavior). Once

[74] Werth, p. 35. This is probably unlikely, however, as it is doubtful that the grief and guilt that survivors feel is society-driven. (Professor Elisabeth Boetzkes, personal communication).

again, one may respond that potential suicides in these cases (like the horrible abusive man) may still contribute to society and the harm to society may override the benefits to family. However, we can again think of examples in which a suicide that would benefit others might also benefit the community. Suppose the evil man above was diagnosed with cancer and required numerous hospital visits, some involving lengthy stays, numerous tests, radiation and chemotherapy treatments, and so on. His remaining alive would not only be more harmful to his family but would also be harmful to society by increasing the financial burden on the (Canadian) health care system. In this case as well, suicide would not be morally impermissible. The above argument may still seem controversial, and somewhat unpersuasive, but I think it succeeds in showing that if suicide is *always* wrong it must be something other than the harm to others that makes it so.

Finally, there is one more thing that can be said in response to the harm to others argument. It unfortunately opens up a whole new set of problems that I cannot attempt to solve here, but I think it is worth mentioning. When appealing to the harm that suicide might cause I think it is imperative that the harm to the person considering suicide be given some weight. That is, suicide may harm others but the reason why most people choose to take their own lives is because they are suffering harm by simply being alive. Although it may be morally wrong to always place one's self interests ahead of the interests of others, it also can not be required by a moral system that one always place the interests of others ahead of one's own interests. If a person is faced with a choice between two actions, one that will harm others and one that will harm himself, why must he always choose the action that will harm himself in order to avoid harming others? Why is their harm more

[76] See Lebacqz and Engelhardt, Jr., in Horan and Mall (1977), p. 675; Baelz, in Battin and Mayo (1980), p. 77; and Flew, p. 52.

worthy of concern than his own harm? Nevertheless, for the reasons discussed above, the argument that it harms others does not succeed in establishing the moral wrongness of suicide.

2.14 The Slippery Slope

One of the most popular and often used arguments against suicide, and countless other ethical standpoints, is the slippery slope argument. In the case of suicide, the argument can take many specific forms; but the general thrust of the argument is that suicide is wrong (or, more accurately, that legal or public acceptance of suicide is wrong) because a permissive attitude toward suicide would lead to permissive attitudes to many other issues surrounding death. For instance, a slippery slope arguer may claim that a permissive attitude toward suicide would diminish respect for life in general, which in turn would lead to a more permissive attitude toward euthanasia and other forms of killing, which would eventually lead to a permissive attitude toward ethnic cleansing and other Nazi ideals. This is, however, the extreme form of the slippery slope argument as it applies to suicide. Some authors point out that while the slope may actually be much shorter, the end result is still disagreeable. Battin, for instance, argues that acceptance of suicide (specifically the acceptance of the idea of rational suicide) may lead to the manipulated suicide of vulnerable members of society.[76] Before discussing some of the specific slippery slope arguments, I will first discuss some of the problems of the use of the slippery slope argument in general.

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[76] Margaret Pabst Battin, "Manipulated Suicide," ch. 10 in Battin, The Least Worst Death (New York: Oxford University Press, 1994).

One problem I have with the slippery slope argument is that I question the force of the argument itself in many cases. What the slippery slope argument states is, essentially, that an action is morally wrong because negative or disagreeable consequences might occur as a result of the action (or acceptance of the action). The argument would be much more forceful and damaging if it could be demonstrated that the negative consequences *will* occur. For instance, if it could be demonstrated that acceptance of suicide would, in all likelihood, lead to widespread manipulated suicide of the vulnerable members of society, then this would certainly be a powerful argument against moral acceptance of suicide. Yet in some cases the disagreeable consequences are merely hypothetical, conceivable situations. If X occurs, it is possible that Y could conceivably occur as a result; therefore, X is wrong. If we were to let this type of reasoning guide our behavior generally, we would rarely accomplish (or even attempt to accomplish) anything. Every kind of action has certain possible, conceivable disagreeable consequences; but this in itself does not mean that the action should not be taken. The possible benefits must always be weighed against the possible harms, and it is this ratio that often guides our behavior. It is not enough to say that an action is wrong simply because possible harms may result.

Recognizing that arguments from possibilities are not strong enough, most slippery slope arguments make the stronger claim that the occurrence of the undesirable consequences is probable rather than possible. This raises a new problem for the slippery slope argument, however, because an argument from probability ought to be supported with evidence to support the probability claim. That is, if one is going to argue that the occurrence of a certain state of affairs is probable, one must be willing to demonstrate this fact. Moreover, since the argument needs to be stronger than the argument from

possibility, the strength of the slippery slope argument will depend on the strength of the claim of probability.[77] In other words, it is not enough just to make the claim that the occurrence of a certain undesirable state of affairs is probable; one must be able to demonstrate that it is probable in order to give any strength to the slippery slope argument. This does not mean that slippery slope proponents must 'prove beyond a reasonable doubt' that the undesirable state of affairs will occur, only that they must at least be able to support their claim with facts, statistics, and logical arguments. The challenge for slippery slope proponents, then, will be to demonstrate satisfactorily the probability of the occurrence of the undesirable consequences. Hence, this will also be the preferred target for those who wish to refute the slippery slope arguments: to show that the occurrence of the undesirable consequences is not in fact as probable as the slippery slope arguer has claimed.

One might respond that an argument based on probability is not always required. If the proposed consequences are bad enough, as in the case of future human deaths, it might be sufficient to make a claim based on possibility.[78] This would parallel the argument made by Drane and others with respect to competency: the more serious the consequences, the more strict the test for competency that should be used.[79] This is a worthy objection and one to which I cannot attempt to respond without engaging in a lengthy discussion of risk-benefit analysis. And there is simply no room for that here. One thing I can say is that the strength of the objection will depend on how bad the consequences are considered to be, and whether there might be any positive consequences that can at least partially

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[77] Professor Wil Waluchow, personal email communication, April 28, 1999.

[78] Professor Elisabeth Boetzkes, personal communication.

offset the negative consequences. In the case of suicide, it might seem that only bad consequences (human deaths) are possible. But, as I will explain below, I think positive consequences could also result from the acceptance of the moral permissibility of suicide.

Another problem I have with the slippery slope argument is that the step from the slippery slope to the conclusion that the action is wrong is not a necessary step. As Werth has argued, even if one were to accept that the slope might exist, one could still argue that "whatever slope might exist will not necessarily lead to an inability to set limits."[80] In other words, even if the slope might exist there is still the possibility that policy decisions could be made in order to halt any possible slide down the slope. For example, the slippery slope argument is often used as an argument against the legalization of active voluntary euthanasia. Some argue that legalization of active voluntary euthanasia will lead to the involuntary euthanazing of various vulnerable members of society, eventually leading down the slope to Nazi ideals of euthanazing the mentally and physically challenged as well as minorities. However, we can accept that this slope may exist while still deciding in favor of the legalization of active voluntary euthanasia. We can attempt to guard against the slide down the slope by instituting policies and amending laws to protect the vulnerable members of society. This may be achieved, for instance, by making the policy requirements for a euthanasia request stringent enough so that it would be unlikely that doctors would start performing involuntary euthanasia. Whether this is realistic in this particular case or not is not the point. The point is that the slippery slope argument by

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[79] See Drane (1985).

[80] Werth, p. 36.

itself is not necessarily a decisive argument against a certain action. Even if the slope does exist, we may still be able to set limits to ensure that the slide will not occur.

Lebacqz and Engelhardt point out that there are two types of slippery slope arguments. The first type is the more common type: arguments that predict that certain undesirable consequences will follow if a position is accepted. Battin's argument is an example of this type. Her argument is that acceptance of the concept of rational suicide will lead to the undesirable consequence of manipulated suicide. The other type, which Lebacqz and Engelhardt refer to as the "argument from precedent," claims not that certain events will occur but that the acceptance of a position will create a precedent such that certain other undesirable events could logically occur.[81] The undesirable consequence in this type of slippery slope is the precedent rather than the events that may follow. Of course, the precedent would only be considered undesirable if it may eventually lead to other undesirable consequences, so it would seem that the consequences are still what is undesirable. Lebacqz and Engelhardt are not exactly clear on the difference between the two types of argument. It is likely that they are trying to make a distinction between slippery slope arguments based on the causal effects of a decision and the logical consequences of the principle underlying the decision.[82] Since the latter type is not as common, I will deal with it first.

The idea of a precedent implies that a certain decision would be used as guidance for any future similar decisions that have to be made. The important aspect of the precedent analogy is that the original decision would be used as guidance on all future cases that are

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[81] Lebacqz and Engelhardt, Jr., in Horan and Mall (1977), p. 678.

[82] Professor Wil Waluchow, personal email communication, April 28, 1999.

similar in relevant ways. Applied to suicide, the argument would claim that the moral acceptance of suicide would be used as a precedent for deciding on the moral status of any future issue that is similar in morally relevant ways. Since suicide is a form of killing human life, it is similar in morally relevant ways to all other forms of killing human life: infanticide, voluntary and involuntary euthanasia, etc.[83] This is not a very strong argument, however, because one only has to demonstrate that other forms of killing human life are not similar in morally relevant ways to suicide.

Infanticide, for instance, is very different from suicide because suicide is the *voluntary* taking of *one's own* life whereas infanticide is the *involuntary* taking of *another's* life. The differences here between the two are significant enough to conclude that suicide would not establish a precedent for the moral acceptance of infanticide.[84] There may be similarities in the justification for the taking of life; for example, both suicide and infanticide could be carried out because of a judgment about quality of life. However, one similarity would not be enough to justify the slippery slope argument from precedent as long as there are other significant differences. So even though one may kill oneself or kill an infant because of a judgment about quality of life, the issue of consent and the difference between taking one's own life and taking the life of another are enough to allow the conclusion that acceptance of suicide would not establish a precedent for the moral acceptance of infanticide. Some might argue, as Lebaqz and Engelhardt point out, that moral acceptance of some suicides would establish a general precedent for suicide, which would open the door to undesirable suicides such as manipulated suicide. Are all suicides

[83] Lebacqz and Engelhardt, Jr., in Horan and Mall (1977), p. 678.

[84] Lebacqz and Engelhardt, Jr., in Horan and Mall (1977), p. 679.

similar in morally relevant ways? Only if the morally relevant feature is that all suicides are suicides. However, there are other morally relevant features that allow us to differentiate between types of suicides. For example, the reasons why people suicide and the circumstances surrounding the suicides are morally relevant features.[85] The person who killed himself because he believed aliens were hunting him in order to steal his secrets of the universe would be viewed very differently from the person who killed herself because she was suffering from ALS. Since suicides can be differentiated in morally relevant ways, moral acceptance of some suicides would not necessarily establish a precedent for the moral acceptance of suicide in general. Therefore, since it is unlikely that the moral acceptance of suicide would establish a precedent that would lead to the moral acceptance of all other forms of killing, the slippery slope argument from precedent does not succeed in establishing the wrongness of a moral acceptance of suicide.

The second type of slippery slope argument, that moral acceptance of an action will likely lead to certain undesirable consequences, has been offered in many different forms with regard to suicide. As already mentioned, Battin argues that moral acceptance of suicide may lead to widespread manipulated suicide of vulnerable members of society. Callahan argues that the stigma that is attached to suicide is valuable in that it makes it more 'difficult' for people to suicide. The decreased stigma that will result from the moral acceptance of suicide "will, in all likelihood, make it easier for a depressed teenage girl who has just lost her boyfriend or for an alcoholic middle-aged man who has just lost his job to commit suicide."[86] The idea here is that the moral acceptance of suicide in some

[85] Lebacqz and Engelhardt, Jr., in Horan and Mall (1977), p. 679.

[86] Jay Callahan, "The Ethics of Assisted Suicide," Health and Social Work, 19 (4), Nov. 1994, p. 242.

cases will inevitably lead to an increase in suicide in general, including those that are still considered morally unacceptable. Once again, the onus should be on these authors to provide sufficient evidence in favor of their slippery slope arguments. However, since they have not done so, the only way to combat these arguments is either to demonstrate that the unacceptable consequences would not likely follow or that the unacceptable consequences are not sufficient to make the argument succeed as an argument against suicide.

Presumably the reasoning behind Callahan's argument is that the moral acceptance of some suicides would make it easier for other people to suicide because one of the major barriers that keep people from killing themselves would be eliminated. The barrier in this case is the stigma that is attached to suicide. What Callahan is assuming, then, is that a significant number of potentially unacceptable suicides choose not to suicide *because* of the suicide stigma. To use his example, the depressed teenage girl who just lost her boyfriend contemplates suicide but chooses not to only because suicide is considered 'bad'. The same is true of the alcoholic middle aged man who just lost his job. I, however, would disagree with this claim. I think it is highly unlikely that the suicide stigma is what stops people from taking their own lives. If someone is driven to the point at which he seriously wishes to end his life, I highly doubt that the suicide stigma would stop him from killing himself. Edwin Shneidman has found that there are ten 'psychological commonalities' of suicide; psychological aspects of suicide that are present in at least 95 percent of completed suicides. Two of them are especially applicable here. First, Shneidman points out that the common purpose of suicide is to seek a solution to a problem, crisis, or an unbearable situation. "Suicide becomes *the* answer – seemingly the

only available answer to a real puzzler: How can I get out of this?"[87] Second, the common action in suicide is to escape, to depart from a region of distress.[88] The point is that most people who take their own lives are stuck in a situation of unbearable suffering (whether it be physical, emotional, psychological) and suicide is, for them, the only way out of the situation. The only people who would be affected by the suicide stigma would probably be those who are uncertain about suicide, those who have not really decided to take their own lives. But for most people who do kill themselves, they have made the decision that suicide is the only way out of their situation. And I find it implausible to suggest that the suicide stigma would keep them from realizing their goal. Hence, I disagree that the elimination of the suicide stigma would necessarily make it easier for unacceptable suicides to occur.

Interestingly, though, the elimination of the suicide stigma could be defended as a positive result of the moral acceptance of suicide for those potentially acceptable suicides who might be stopped by the suicide stigma. Most of those who are suicidal but choose not to suicide because of the suicide stigma are probably people who are not in a position to be able to take their own lives, such as the hospitalized terminal patient who wishes to die. The suicide stigma may result in the hospitalized terminal patient refraining from expressing the death desire to her family and her physician because she would have reason to care about their reactions. Unlike the person who kills him or herself, the hospitalized patient does have to deal with the reactions of her loved ones when she expresses the desire to die. Fearing that her loved ones may view her as a coward, or as a sinner, and fearing

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[87] Edwin S. Shneidman, The Suicidal Mind (New York: Oxford University Press, 1996), p. 130.

[88] Shneidman, p. 134.

that her physician may recommend psychiatric treatment, the terminal patient may keep her desire secret and instead continue to endure the pain and suffering. Without the stigma that is attached to suicide, patients like this would be more free to express their desire to die. So even if Callahan were correct that the moral acceptance of suicide would lead to the elimination of the suicide stigma, it is not so evident that this would necessarily be a negative result.

According to Battin, the acceptance of the notion of rational suicide "first gives rise to the possibility of large-scale manipulation of suicide, and the maneuvering of persons into choosing suicide when they would not otherwise have done so."[89] She describes two different kinds of manipulation: *circumstantial manipulation* and *ideological manipulation.* In circumstantial manipulation, the manipulator alters "the victim's immediate and/or long range circumstances in such a way that the victim chooses death as preferable to continued life."[90] For example, an abusive parent may distort the circumstances of an adolescent child so that the child believes suicide is the only way to escape. Ideological manipulation occurs when a person's values and beliefs are altered to include, for instance, the belief that suicide is the best thing to do for a particular person in a particular situation. This can take the form of subtle manipulation by corporations and agencies through advertising or the direct "programming" by religious and political groups.[91]

Is it likely that this type of widespread manipulated suicide would take place if the notion of rational suicide were to be accepted? Battin certainly paints a grim picture of

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[89] Battin (1994), p. 196.

[90] Battin (1994), p. 196.

what might result from the acceptance of the notion of rational suicide but I think it is also a very extreme picture. Abusive parents manipulating their adolescent children into killing themselves seems like an extremely unlikely occurrence regardless of whether or not suicide is stigmatized. However, one could think of more likely examples. Someone with little emotional attachment to his elderly and sick mother may try to manipulate her into taking her own life to ease him of the burden of having her live with him. Yet I do not see how the occurrence of such cases would increase in any significant manner from the acceptance of the notion of rational suicide. Battin argues that in such cases, "suicide may be the only rational choice for the victim."[92] Again, as with Callahan's argument above, she is assuming that the only thing that stops these people from killing themselves is that suicide is seen as irrational. I doubt that in the case of the elderly mother, once her son has made her life extremely uncomfortable to the point where he has successfully manipulated her into wanting to suicide, she would think 'it's a good thing suicide can be rational, otherwise I would not be able to kill myself.' It could be argued that, all other things being equal, an acceptance of rational suicide might make it easier for the son to manipulate his elderly mother into taking her own life. But just because it is possible, all other things being equal, this does not mean it is probable. Like many of those who offer the slippery slope argument, Battin's claims are speculation only. Moreover, it is important to note that in real situations all other things are never equal. There are many other factors that must come into play and which would affect the context of each particular situation. So while I am willing to concede that, all other things being equal, it is possible that the acceptance of

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[91] Battin (1994), p. 197.

[92] Battin (1994), p. 197.

rational suicide might make it easier for some people to manipulate others into suicide, I think the claim is not strong enough to warrant fear of the slippery slope.

Moreover, I think it is even more unlikely that someone who previously did not want to suicide would be manipulated into suicide simply because suicide is now seen as rational in some situations. In the case of ideological manipulation, even if religious or political groups are successful in 'brainwashing' people into believing that suicide can be rational, I do not think this in itself is going to significantly increase the occurrence of suicide. Cult groups, for instance, are often successful in manipulating their members into killing themselves, but this has nothing to do with public acceptance of the notion of rational suicide. Acceptance of the notion of rational suicide is not going to increase the number of cult or religious suicides. Related to the idea of ideological manipulation, David Phillips published a study originally in 1974 on the effect of suggestion on national suicide rates. Spefically, the purpose of the study was to determine whether suicide rates increased after suicides were published on the front page of a major newspaper (in this case, the *New York Times*). Using a technique in which the estimated number of expected suicides per month was compared to actual suicides per month during which a suicide was reported on the front page, Phillips found that between the years of 1947 and 1967 there was an estimated total increase of approximately 1300 suicides after a suicide was reported on the front page.[93] Although this sounds like a high number, it is a nationwide figure over a period of twenty years. On average, therefore, after a suicide was reported on the front page of the *New York Times*, there was only an increase of approximately 65 suicides per

[93] David P. Phillips, "The Influence of Suggestion on Suicide: Substantive and Theoretical Implications of the Werther Effect," in Essential Papers on Suicide, ed. John T. Maltsberger and Mark J. Goldblatt (New York: New York University Press, 1996), p. 297.

year in the entire U.S. While this may show that suggestion does have an impact on the suicide rate, the impact is hardly significant enough to be used as evidence of a possible slippery slope. As with the general moral acceptance of suicide, I think it is unlikely that the acceptance of the notion of rational suicide will have any significant effect on the occurrence of suicide in general. I am not claiming that the acceptance of the notion of rational suicide, or the moral acceptance of suicide, would have *no* effect on the occurrence of suicide; only that the effect would not be significant enough to warrant a slippery slope argument against suicide.

One might respond at this point by referring to the effect moral acceptance has actually had on the occurrence of certain practices to show that the general slippery slope concern is realistic. Perhaps coercion or manipulation may be unlikely but it is likely that the moral acceptance of suicide would lead to large increase in the number of suicides; and this is certainly an undesirable consequence. This type of slippery slope concern has become a reality with the moral acceptance of such practices as divorce or abortion, for example.[94] When divorce was taboo, it was very rare. But once divorce started to become acceptable (even, perhaps, rational), the divorce rate skyrocketed. Currently, it is commonly reported that the divorce rate in the U.S. is approximately 50 percent. If it could happen with divorce, it could happen with suicide. Of course, one must look at why the occurrence of the practice of divorce increased after acceptance of the practice. The reason is because for many people, in many situations, divorce is a good thing. Many people were trapped in doomed marriages simply because society, and even their own families, would shun them if they tried to divorce. For many of these people, and people

[94] Professor Elisabeth Boetzkes, personal communication.

in the same situations after them, the moral acceptance of divorce meant freedom. So while it is true that the divorce rate has skyrocketed since the moral acceptance of divorce, many of these divorces are positive rather than negative consequences. A similar argument can be made about suicide. As mentioned above, if there were to be an increase in the suicide rate after the moral acceptance of suicide, it is not necessarily the case that this is a bad thing. I believe that the increase, if there were to be one, would consist largely of people who want to kill themselves but are prevented from doing so because of the fear of societal and familial shame. People dying in hospitals, for instance, who are afraid to mention their death desire may be granted freedom by the moral acceptance of suicide. No longer would they be forced to endure a terrible situation, as with people who desperately want to divorce, but they would be free to take their own lives (or express the desire to do so) without fear of public shame and disgrace. However, since I believe that this would only constitute a very small percentage of suicides, I think the potential increase in the suicide rate is not worthy of the title 'slippery slope'.

2.15 "A Cure May be Found" / "Pain Can be Managed"

Two more popular secular arguments against suicide are 1) Suicide is wrong because a cure (in the case of terminal/chronic illness) may be just around the corner; and 2) Suicide is wrong because pain and suffering (also in the case of illness) can be properly managed. I have chosen to group these two arguments together because they are both 'medical' arguments against suicide. Moreover, neither of the two arguments is compelling enough to warrant a separate discussion for each. Although it is important to realize that these two arguments are not arguments against the *morality* of suicide, they are still arguments against the rationality of the decision to suicide. I will deal with each argument in turn.

The first argument, that suicide is wrong because a cure may soon be discovered, is very weak and so I will only consider it briefly. This argument applies to those who suffer from terminal or chronic illnesses, such as cancer, AIDS, or ALS. Those who would offer this argument would say that medicine is progressing at a surprising rate, and a cure for any terminal or chronic illness may be just around the corner. Since there is even just a remote possibility of a cure being discovered, this is enough to make the suicide decision irrational. This argument, however, is grounded more in pure hope than in medical fact. While medicine is progressing at a surprising rate, it is simply unrealistic to believe that any 'miracle cure' is just around the corner. The cure for cancer, for instance, is not just going to appear tomorrow. Even if it did it would not be publicly available until all the tests have been run and it has passed the tests of the appropriate government agencies, which could take several years. Nevertheless, the argument also ignores the major issue that underlies this objection to suicide: some may argue that, even if there was a miracle cure just around the corner, the decision to wait for the cure depends on the individual and the particular circumstances. This will be dealt with more in chapter three.

The second argument, that pain can be properly managed, is slightly stronger than the above argument because it is more realistic. This argument says that with the advances in palliative care and pain management, the pain that drives many sufferers of terminal and chronic illness to suicide could in fact be properly managed. If we can abolish the pain, and many believe we can, then we can abolish one of the significant factors contributing to suicide. As Herbert Hendin states, "Few doctors realize that it is possible to relieve all pain by adequate palliative care if it includes sedation for those who require it."[95] There

[95] Herbert Hendin, Seduced by Death: Doctors, Patients, and Assisted Suicide (New York: W. W. Norton and Company, 1998), p. 259.

are two questions that arise in response to this statement: 1) If it is possible to relieve all pain by adequate palliative care, why do so many patients of diseases like cancer continue to suffer during the late stages of their illnesses? and 2) If adequate palliative care requires sedation, how is terminal sedation any better than being dead?

Before answering the above questions, it is worth noting that there is one serious problem with the 'pain can be managed' argument. The problem is that the argument assumes that pain is only physical, and that it is only physical pain that leads people suffering from illnesses to suicide. However, pain is only one part of suffering.

> Pain is not the main reason that most people ask to die. Degredation and loss of dignity at the end of life because of incontinence, the inability to swallow or speak, the need to have 24-hour-a-day care, not being mobile, or not enjoying any quality of life are conditions that motivate patients to want help in dying.[96]

The point is that even if it were true that pain can be managed, this does not solve the problem. There are still all the other aspects of suffering that need to be addressed.

In answer to the first of the above questions, it is an unfortunate fact that many people suffering from terminal illnesses do experience uncontrollable pain during the late stages of their diseases. It may be true that all pain, or at least virtually all pain, can theoretically be relieved by adequate palliative care. Yet practically and realistically, this is not happening. In a study at the National Cancer Institute in Milan in 1990, of 115 cancer patients, 35% reported uncontrolled pain during their palliative care.[97] Similarly, in another 1990 study at Memorial Sloan-Kettering Cancer Center, of 165 patients, 27%

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[96] Fay J. Girsh, "Physician Aid in Dying: What Physicians Say, What Patients Say," Western Journal of Medicine, 157 (2), Aug. 1992, p. 188.

[97] Gregg Kasting, "The Nonnecessity of Euthanasia," in Biomedical Ethics Reviews 1993: Physician-Assisted Death, ed. James Humber, Robert Almeder, and Gregg Kasting (New Jersey: Humana Press, 1994), p. 33.

reported "a poor outcome" with regard to their palliative care.[98] Brock suggests that there are a number of reasons for the failure of palliative care to manage physical pain, including the discomfort that some physicians feel with prescribing large doses of medication for fear of hastening death, as well as the simple difficulty of accessible means to assess patients' pain.[99] So it does not seem to matter that all pain is relievable with adequate palliative care because this adequate palliative care does not seem to be readily available.

It is interesting that in the above quote by Hendin, "adequate palliative care" involves sedation. Often the patient's pain is so severe that the patient must be sedated essentially to the point of unconsciousness: "Specialists...argue that there are very few patients whose pain could not be adequately controlled, though sometimes at the cost of so sedating them that they are effectively unable to interact with other people or their environment."[100] The point of palliative care is to make terminal patients as comfortable as possible during the late stages of their diseases, not to relieve their pain by putting them to sleep for the remainder of their diseases. What is the point in requiring that patients remain alive rather than be allowed to die if the only way to remain alive is by being put to sleep? Realistically, terminal sedation is no better than death; and it seems silly to say that suicide is irrational because there is a better alternative if that alternative is a comatose existence.

2.2 The Religious Arguments

2.21 "Suicide is Playing God"

The most popular religious argument against suicide is that suicide is wrong because it is an act of playing God. That is, death is to be determined solely by God so any human

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[98] Kasting, pp. 33-34.

[99] Dan W. Brock, "Physician-Assisted Suicide is Sometimes Morally Justified," in Physician-Assisted Suicide, ed. Robert F. Weir (Bloomington: Indiana University Press, 1997), p. 98.

[100] Brock, in Weir (1997), p. 98.

act that ends life prematurely is interfering with God's plan. Though the 'suicide is playing God' argument is in itself a general argument offered against suicide, it also encompasses several other more specific arguments that can be viewed as examples of how suicide interferes with God's plan. The three main specific religious arguments against suicide are 1) we (humans) are God's property and so our life is not ours to do with as we please; 2) suffering is part of God's plan, i.e. God wants us to suffer in order to test us so it is wrong to escape this suffering by suicide; and 3) life is a gift from God and should be treasured – it is wrong to destroy a gift. I will respond to the three specific arguments first and then to the general playing God argument.

The argument that suicide is wrong because we are God's property is quite straightforward. The idea is simply that since God created human life, we are literally God's property. Since we are God's property, only God can determine what is to happen to each of us. God decides how long each of us will live and when he/she has determined that our time is up, he/she will take us from the earth. Suicide is an act of the human destruction of God's property. Suicide is wrong for the same reason that it would be wrong for someone to deliberately vandalize my car. However, this argument is very weak for the simple reason that its logical implications are unacceptable. If we are God's property, and only he/she can determine how long we shall live, then this would imply that it would be wrong to interfere with God's plan in *any* way. Not only would it be wrong to end our own lives but it would be equally wrong to prolong our lives.[101] Since only God is to determine how long we shall live, then one would have to be committed to the view that the entire practice of medicine is also morally wrong. If I pass by a man on the street

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[101] Rachels, pp. 163-164.

apparently suffering a heart attack, I must let him die because God has chosen to destroy that particular piece of his/her property.

Moreover, one could also argue that suicide is an act controlled by God rather than a human act that interferes with God's plan. If God determines when we die, he/she must also determine the circumstances that surround our deaths. That is, if God decides that person J will die at a certain point in time, God must also bring about certain events to result in J's death; otherwise, God is merely predicting J's death rather than determining it. Yet not all deaths are 'natural' events like heart attacks. Many people die in car accidents with drunk drivers, engage in activities that result in their deaths (such as drug use, bungee jumping, etc.), and get murdered. If God controls the circumstances that result in these types of deaths, then one could say that perhaps he/she also controls the circumstances that result in a person's suicide. Maybe suicide is just another method God uses to destroy his property, like the other examples above. Though it appears that suicide is a human act that interferes with God's plan, it is equally conceivable that suicide is actually part of God's plan.

The argument that suicide is wrong because it is an attempt to escape suffering that God wishes us to endure is most often aimed at those who suffer from terminal illnesses. The pain one experiences when suffering from cancer, for instance, is itself part of God's plan; God wishes us to suffer in order to test us or in order to make us stronger. Whatever the reason for the suffering, the point is that God never intended that life should be constantly pleasurable. Since suffering is part of God's plan, any attempt to escape it or interfere with it is morally wrong.[102] Although the argument is mainly aimed at cases of

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[102] Rachels, p. 164.

terminal illness, the argument could be used against any suicide as everybody who attempts or completes suicide is or was suffering in some way.

This argument suffers from a worse fate than the first argument above for two reasons. First, as with the 'we are God's possessions' argument, the logical implications of the 'God wants us to suffer' argument are unacceptable and, second, the content of the argument itself is distressing. The content of the argument is distressing because many people would have trouble accepting the idea that their God actually wants them to suffer. The dominant Judeo-Christian-Islamic concept of God is a being that is omnibenevolent, among other things. God is supposed to love his/her people; why would a benevolent God who loves his/her people want his/her people to suffer? Moreover, even if one could accept that God requires us to suffer a little bit in order to test us, it is difficult to accept that he/she would require us to endure any level of pain indefinitely without allowing us to take any measures to alleviate the pain.[104] In my view, any God that not only wants but also *requires* his/her people to endure agony and suffering is not a God worthy of my worship.

The most problematic aspect of the suffering argument is that it leads to unacceptable implications. One of these implications is very similar to the implication of the possession argument. If suicide is morally wrong because it interferes with the suffering that is ordained by God, then *any* interference with suffering is equally wrong.[105] A large component of the practice of medicine would be considered morally wrong, from antibiotics for an ear infection to palliative care for terminal illnesses. Few if any would be

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[104] Werth, p. 27.

[105] Rachels, p. 165.

willing to accept this extreme implication. The other unacceptable implication is that suffering is seen as something positive rather than something that one wants to avoid. This implication arises from the idea that suffering is ordained by God for a specific reason: to test us, to make us stronger, or perhaps simply because a life without a little adversity is incomplete in some sense. Whatever the reason, suffering becomes valuable as a means to this end.

Finally, the third common religious argument against suicide is that suicide is wrong because life is a gift from God and "to reject it is to reject Him and frustrate His will."[106] The strength of the gift argument lies in the fact that there is a sense in which it is disrespectful to destroy or dispose of a gift that one is given by someone else. Everybody has been in the situation in which one is forced to keep a gift one does not like simply because it would be rude to return it, throw it away, or give it to someone else. Since life is a gift from God, the one gift giver nobody wants to disrespect, it would be morally wrong to dispose of it by taking one's own life. Yet while the argument does draw strength from the gift analogy, there are several problems with it.

The problems with the gift argument lie in the same source from which it draws strength: the gift analogy. If one is to make the gift analogy, and describe life as a gift from God, then one must carry the analogy to its full extent. Once this is achieved, one will see that it is not necessarily wrong to destroy or dispose of a gift that one is given by someone. First, as Battin points out, when one is given a gift the gift becomes the property of the recipient and the donor relinquishes his or her rights to and control over the gift.[107]

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[106] A. Alvarez, "The Background," in Battin and Mayo (1980), p. 13.

[107] Battin (1982), p. 42.

When someone gives me a gift, that gift becomes my property and I can do with it as I choose. I have no obligation to the donor to treat it a certain way. Hence, if life is a gift from God, life then becomes the property of the recipient and the recipient can dispose of it or destroy it if he or she chooses to do so.

However, one could argue that although one can technically do with a gift what one chooses, one still shows disrespect in disposing of or destroying the gift. This implies, then, that there is something special about a gift; that the significance of a gift is not the object or item but the meaning behind one person giving something to another. Certainly in some cases this might be true. For instance, most parents tend to keep the dreadful popsicle stick and clay creations given to them by their young children as birthday presents even though they have little practical and aesthetic value. Parents hold on to these gifts because it is the 'thought that counts' rather than the item itself that is valued. Yet most gifts one receives in one's lifetime do not possess this special significance. With these gifts there really does not seem to be anything wrong with disposing of them or destroying them. Is there anything seriously wrong with throwing out a birthday gift one has no interest in keeping? Generally, we do not think it is wrong to destroy or dispose of a gift.[108]

Third, even if one does accept that one has some obligation to the gift giver to at least keep the gift, one must also accept that there must be limits on this obligation. For example, what if the gift is clearly defective or damaged? Whether the gift is defective when one receives it or it later becomes defective, it would seem silly to say that one still has an obligation to keep the defective gift. In addition, if someone gives me a gift that he

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[108] Battin (1982), p. 42.

knows is defective or damaged then I should not worry about disrespecting him by disposing of the gift. Giving someone a defective gift is a sign of disrespect itself so one could argue that any obligation to respect the gift is nullified. Also, what if someone gives me a gift that is damaging to my health or values?[109] The answers to these questions are vital to the gift analogy because in most, if not all, cases of suicide the gift of life can be viewed as defective or damaged. People who suicide do so to escape a life that is wrought with suffering (or they are anticipating it will be wrought with suffering), whether it be physical or psychological. If one is to carry out the gift analogy to its full extent, one would have to realize that a life characterized by physical or psychological suffering is a defective gift; and there does not seem to be anything wrong with disposing of or rejecting a gift that is defective or damaged.

As mentioned above, these three arguments are all specific examples of how suicide is an act in which humans attempt to play God. The problem with this argument generally is that humans play God all the time, and this God playing has in most cases led to some very positive results. My physician father recently joked: "What is the difference between God and physicians? God knows he is not a physician." The entire field of medicine is an example of humans playing God. As Fletcher describes, "by their very use of surgical, chemical and mechanical devices they are, in fashion, playing God."[110] Since the argument would lead to the unacceptable conclusion that the entire practice of medicine is morally wrong, the argument that suicide is wrong because it is playing God is not reasonable.

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[109] Battin (1982), p. 43.

[110] Joseph Fletcher, "The Patient's Right to Die," in Downing and Smoker (1986), p. 62.

To further my defense of suicide in some cases, I have shown in this chapter that the most common traditional arguments against suicide do not succeed in establishing the moral wrongness of suicide. The argument that suicide is wrong because it is unnatural is a fallacious appeal to nature. Not only is it philosophically fallacious but it is also based on supposed facts that have not been successfully established. The arguments from the power of medicine, that a cure may be found and that pain is manageable, are based in hope and faith rather than medical fact. It is simply not true that a miracle cure may be just around the corner and it is likewise not true that all pain can be managed, unless you actually consider terminal sedation to be preferable to death. The argument that suicide violates the sanctity of life principle does not work because it is based entirely on the assumption that life is intrinsically valuable. However, since many view life as valuable because of what it allows us to achieve, then life loses its value once it becomes impossible to achieve one's ends or goals. Therefore, the sanctity of life argument fails. The slippery slope argument fails because, with all its problems, it is valuable only as a warning rather than as a moral argument against suicide. Finally, the religious arguments, which fall under the playing God argument, fall short because their implications are unacceptable. In order to complete my defense of suicide in some cases, I must demonstrate in which cases I consider suicide to be morally permissible. It is to this goal that I turn in the next chapter.

CHAPTER 3
PERMISSIBLE SUICIDES

The first two chapters of my thesis were devoted to refuting the popular arguments against suicide. In the first chapter I discussed the dominant psychological view of suicide, which gives rise to one of the most common and powerful arguments against suicide: that suicide *cannot* be morally permissible because suicide is only performed by incompetent people (most commonly people who are clinically depressed), and a person must be competent in order for a moral judgment to be made about his or her actions. By critically examining the assumptions on which this view is based, the studies that support the psychological view, and the diagnostic criteria for various types of depression, I succeeded in raising doubts about the validity of the psychological view of suicide (and thus the incompetency argument). The second chapter was devoted to refuting many of the popular moral and religious arguments against suicide for the purpose of demonstrating that it is not necessarily the case that suicide is always morally wrong. Since I believe that suicide in some cases ought to be permissible, my goal in this chapter will be to spell out those cases in which I think suicide is permissible.

I will argue in this chapter that a suicide is permissible if the following three conditions are met: 1) the agent is competent; 2) the act of suicide does not violate any overriding obligations that would not otherwise be violated. These first two conditions make up the moral permissibility condition of full permissibility. In addition to these two requirements for a morally permissible suicide, there is also one further condition for a suicide to be fully permissible. The third condition is: 3) the suicide be a rational act for

the person in question. This third condition is intended to capture the idea that although a person who kills him or herself has not done something *morally* wrong if the suicide is only irrational for him or her, there is still a sense in which we (society) do not want irrational suicides occurring without someone at least questioning or challenging the decision to perform the irrational act. Although people must remain free to make bad and irrational decisions, when the decision will result in a drastic and irreversible consequence, such as the death of the person in the case of suicide, society deserves the liberty to try to ensure that the person knows what he or she is doing and the decision is really what he or she wants. However, as I will explain in more detail below, society's liberty to try to prevent irrational suicides is limited.

The first step in this chapter will be to explain the two conditions for a morally permissible suicide, the competency and obligation conditions. The second step will then be to outline a theory of act-rationality (henceforth referred to as simply 'rationality') that can be applied to different types of suicide, as well as explain in more detail the reasoning behind the rationality condition. Once these two steps have been accomplished I will then apply the three conditions to several fictitious case examples to determine which kinds of suicide are permissible and which are not. It is important, however, that the reader realize my argument is permissive rather than obligatory in nature. What this means is that when I argue that there are certain cases in which suicide is morally permissible, I am arguing that suicide in these cases is not morally wrong. But I am not arguing that there are cases in which suicide is necessarily the morally right thing to do (even though it may be). The claim that suicide is the morally right thing to do in certain cases is a much stronger claim because it carries with it the implication of obligation. If suicide were the right thing to do

for a person in a particular situation, then that person would have a moral obligation to perform suicide in that situation. In other words, I am arguing that there are cases in which one is morally *permitted* to take one's own life, not that one *ought* to take one's own life. The question of whether people are ever obligated to take their own lives is a question that I must leave unexamined for the purposes of this thesis.

3.1 The competency and obligation conditions

As mentioned above, the two conditions for a morally permissible suicide are that the agent in question must be competent, and that the act of suicide must not violate any overriding obligations that would not otherwise be broken. The reason for the competency condition is quite simply that an agent must be competent in order to act *morally*, whether permissibly or impermissibly. If a person is not competent, he or she is considered unable to make decisions for him or herself and, thus, he or she can not be held responsible for his or her actions. Recall that this is part of the basis for the incompetency argument discussed in chapter 1. On the psychological view of suicide, suicide is something that happens to people rather than something they freely or autonomously decide to do for themselves. If a person can not be held responsible for his or her actions, he or she can not be morally praised or blamed for those actions. Hence, a moral judgment can not be made about the actions of an incompetent person. It is not that incompetency renders actions morally impermissible; incompetency renders them beyond the scope of moral judgment.[111] Therefore, before meeting any other conditions, a person must meet the condition of being competent in order to perform a morally permissible suicide.

[111] Professor Wil Waluchow, personal communication.

The second condition for a morally permissible suicide is that the act of suicide must not violate any overriding obligations that would not otherwise be violated. This condition is needed to add the moral dimension to the analysis; just because a person fulfills the first requirement, and is deemed competent, does not mean his or her suicide is morally permissible. I choose to include the obligation condition because I think it is broad enough to capture what I think is important, morally, for a person to take into account when considering suicide as an option.

First, what exactly do I mean by 'obligations'? I think that every moral agent possesses a set or list of obligations, by which he or she is bound, and the list will consist of certain specific obligations as well as certain general obligations. What I mean by specific obligations is that there are some obligations the possession of which will depend on the agent's individual circumstances. For instance, a person with children will have an obligation to provide (financially and emotionally) for those children, while a single person without children will not have this obligation. A person in a loving relationship will have certain obligations towards his or her significant other, while a single person will not have these obligations. However, although specific obligations will depend on the agent's circumstances, every agent in those same circumstances will be bound by the same obligation. Providing for one's children is a perfect example. The existence of this obligation will depend on whether one has children; but I believe that anybody who has children has an obligation to provide for them.[112] So specific obligations are those obligations that depend on the particular circumstances of the agent.

[112] The obligation to provide for one's children should not to be purely financial. I think the obligation to provide for one's children must also include providing certain emotional and psychological needs, such as an environment free of abuse.

General obligations, on the other hand, are those obligations by which *every* member of the community is bound. That is, simply by virtue of the fact that one is a moral agent and part of a community, one will necessarily be bound by certain obligations. Which and how many obligations ought to count as general obligations is debatable. However, I think there is at least one general obligation to which all would agree: an obligation of non-maleficence. The obligation not to harm others forms the core of morality and is probably the one obligation by which every member of a community is restricted in his or her behavior. Some people may not have an obligation to provide for their children (if they do not have children), but everybody has an obligation to avoid harming others.

The difficulty still remains to elucidate what is meant in the obligation condition by "overriding obligations". The term 'overriding' must be included in the condition for the simple fact that obligations are rarely, if ever, unconditional. Ross brought this to our attention when he asserted that all duties are only prima facie duties; we must abide by them until they are overridden by other stronger obligations. The difficulty then is to determine which duty 'wins' the conflict.[113] My inclusion of 'overriding' is intended to capture this idea. All moral agents possess a list of obligations, which will consist of the general obligation(s) as well as certain specific obligations. An obligation is overriding if it 'trumps' any other obligations the agent has in the particular situation he or she is in. This will be determined by the ranking of the particular person's obligations – the order of importance, so to speak, of the agent's obligations. How these obligations are ranked for each person will depend on a number of factors. First, one's ranking of obligations will depend in part on one's circumstances. For instance, every parent has an obligation to

[113] However, as professor Wil Waluchow has brought to my attention, obligations are not overridden only by other obligations; an obligation can be overridden by a right or even one's self interest, if it is justified.

provide financially for his or her children. Person A has very wealthy extended family members and so his children are largely provided for through monetary birthday gifts, a trust fund, or whatever. Person B, on the other hand, does not have wealthy family members and so his children depend entirely on his financial provisions. Based on their circumstances, person A may rank his financial obligation to his children lower than person B would.[114] Second, the ranking of certain obligations will depend in part on one's values. Although two people may both have an obligation to provide financially for their children, one may consider the financial obligation more important than her emotional obligations to her children, while the other might consider the emotional obligation more important than the financial obligation. These kinds of differences can only be accounted for by recognizing the effect of one's values on one's list of obligations. Moreover, some people may consider themselves to be bound by what might be considered obligations of virtue, such as the obligation to tell the truth or be honest. One's possession of these kinds of obligations will only depend on one's personal values. However, it is important to note that people can be mistaken in their rankings based on their beliefs and values. In other words, there is an objective component to one's list of values: certain obligations should occupy a minimally high position on one's list of values. For instance, one ought to consider one's obligation of non-maleficence to be more important than, say, one's obligation to tell the truth. Thus, if one is in a situation in which the truth would seriously harm someone while lying (or perhaps not saying anything, if that is different from lying) would do no harm to anyone, then one's obligation of non-maleficence should override one's obligation to tell the truth.

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[114] I thank professor Wil Waluchow for bringing this example to my attention.

Finally, I must explain why I include in the obligation condition that the suicide must not violate overriding obligations *that would not otherwise be violated.* If I were to leave the condition as "the suicide must not violate overriding obligations," many suicides that perhaps ought to be morally permissible would be automatically excluded. This is because suicide will inevitably violate some obligations by virtue of the fact that one removes oneself from the world when one takes one's own life. For instance, suicide would seem to be always morally impermissible for someone who considered the obligation to provide financially for his or her family to be an overriding obligation because his or her suicide would inevitably violate this obligation.[115] But in many cases of suicide (such as a terminal or progressive illness) the person is in a situation whereby the obligation has already been diminished or removed, or will be diminished or removed even if he or she remains alive.[116] Someone dying of terminal cancer can not earn a living any more than someone who is already dead. Therefore, there are some situations in which suicide ought not to be necessarily morally impermissible even though it may violate one's overriding obligations if those obligations would be eliminated by remaining alive.

3.2 The Rationality Standard

Before I outline the standard of rationality I will be using for my analysis, I will first explain in more detail my concept of full permissibility as well as the justification for my inclusion of the rationality condition. As mentioned in the introduction, an action that is fully permissible is an action that an agent is free to perform without justified paternalistic

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[115] Although this is not necessarily the case as one can take steps to make sure one's family is provided for financially after one is dead.

[116] Here I have used alternatives to the term 'violate' because it is not accurate to say that one has violated one's obligations if the breaking of those obligations is beyond one's control (as in the case of a terminal illness). Professor Elisabeth Boetzkes and Professor Wil Waluchow, personal communication.

intervention from others (whether the others are individual people or the state). This concept is different from moral permissibility because there are many examples of actions that may not be morally wrong but that we as a society still do not want people to be *entirely* free to perform. These actions would tend to be the kinds of actions in which there is a very high risk of serious harm or death to the agent. Driving without a seat belt is a perfect example. There is nothing morally wrong with driving one's car without wearing a seat belt; but since there is such a high risk of injury or death if one does not wear one's seat belt, society takes certain steps to try to 'persuade' people to wear their seat belts (e.g. instituting seat belt laws resulting in fines for people caught driving without them or aggressive advertising campaigns to raise people's awareness about the risks).

However, there are what might be referred to as different doctrines of paternalism. Feinberg differentiates between weak and strong paternalism: weak paternalism occurs when "the state has the right to prevent self-regarding harmful conduct only when it is substantially nonvoluntary or when temporary intervention is necessary to establish whether it is voluntary or not."[117] Strong paternalism, on the other hand, occurs when the state (or others) completely prohibits someone from engaging in certain behavior for his or her own good, regardless of whether the action is voluntary or not. For instance, suppose someone wanted to go bungee jumping. Weak paternalism would be if I stopped that person from jumping in order to find out whether he really wanted to jump. If I was satisfied that his choice to bungee jump was truly voluntary, then I would let him jump. Strong paternalism would be if the government made the practice of bungee jumping

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[117] Joel Feinberg, "Legal Paternalism," in Rights, Justice, and the Bounds of Liberty (New Jersey: Princeton University Press, 1980), p.

illegal, so that even those people who make voluntary decisions to bungee jump are prohibited from jumping.

The paternalism that I am defending in the case of suicide and assisted suicide with my notion of full permissibility is similar to Feinberg's weak paternalism but slightly stronger. It is a weak form of paternalism because I am claiming that competent people who make an autonomous and rational choice to take their own lives ought to be free to do so without paternalistic interference from others. However, it is slightly stronger than Feinberg's weak paternalism because I maintain that others are justified in interfering with a person's actions, if those actions constitute a high risk of harm or death to the person, not just to establish voluntariness (or autonomy) but also to establish rationality. Hence, I am advocating the following concept of paternalism in the case of suicide or assisted suicide: 1) Others are justified in trying to prevent a suicide when the suicide is clearly nonvoluntary (or nonautonomous) or when temporary intervention is necessary to establish whether the suicide is autonomous or not[118]; 2) If the suicide is autonomous but irrational, others are justified trying to prevent the suicide, but the paternalism in the case of irrational suicides must stop short of outright coercion, physical constraint, or hospitalization against the person's will. If the suicide is clearly nonautonomous, or if the person is clearly incompetent, others are justified in physically detaining the person to protect him. However, if it has been established that the person is competent and the decision is autonomous, he must remain physically and autonomously free to carry out his irrational action. Examples of justified paternalism in the case of autonomous but irrational suicides

[118] Suicides by incompetent people would also be covered by this rule.

might be trying to talk the person out of suicide or recommending counseling, but must not cross the line to forcing the person out of suicide.

The reason why I defend a stronger doctrine of paternalism so as to include rationality is because rationality is what we tend to look for when a person wants to perform an action with a very high risk of serious harm or death to him or herself. As Feinberg describes it, these risky actions create a presumption that nobody in his or her right mind would choose to perform an action that carries with it such a high risk of serious injury or death. Suicide no doubt tops the list of these kinds of risky actions. Thus, when someone desires to take his or her own life others are not satisfied with just the moral permissibility of the suicide. In addition to the moral permissibility (which includes the person being competent) we also want to make sure that the person has given the decision serious thought, weighed the pros and cons, and that the suicide is really what he or she wants to do. In other words, we want to know that the person is acting rationally. If the action is rational, then the suicide is fully permissible and the person must be free to perform the suicide without any further interference from others. If the action is irrational, on the other hand, then others are justified in engaging in paternalistic behavior to try to dissuade the person from performing the suicide. As mentioned above, this may involve, for example, family members attempting to persuade the person into entering therapy or, in the case of assisted suicide, requiring physicians to recommend counseling to their suicidal patients. However, this paternalistic behavior must not result in the person making a *non*autonomous decision *not* to take his or her own life. Once again, people must be free to make bad or irrational decisions. Now that I have explained my notion of full permissibility and my reasoning

behind the rationality condition, I will proceed to outline the standard of rationality I will use in my analysis.

'Rationality' is one of those concepts that people often use on a daily basis even though most of us would find it difficult to define it with anything close to precision. People are often heard to exclaim "What you did was totally irrational" or "You are acting irrationally." But what exactly do we mean when we say that an action is rational or irrational? Many authors have offered theories of rationality and these theories can, of course, be placed along a spectrum. One way to view the spectrum would be to place 'strong' or 'stringent' standards of rationality at one end and 'weak' or 'lenient' standards at the other end. Another way to view the spectrum might be 'ideal' standards at one end and 'practical' standards at the other (though many 'ideal' theorists may object to their views being classified as impractical). Yet a third and perhaps the best way to view the spectrum is to place 'objective' standards at one end and 'subjective' standards at the other. Though it may not be entirely accurate to superimpose the spectra on top of one another, the standard of rationality I will defend would fall within the lenient, practical, subjective end of the spectrum.

A well-known example of a stringent, objective, and, I would argue, impractical standard of rationality is one outlined by Richard Brandt.[119] Two conditions are required for an action to be considered fully rational according to Brandt: First, the action performed must be "what he would have done if all the mechanisms determining action except for his desires and aversions...had been optimal as far as possible."[120] This first

[119] Richard B. Brandt, A Theory of the Good and the Right (Amherst: Prometheus Books) 1998.

[120] Brandt (1998), p. 11.

condition is met if and only if the agent is vividly aware of all the "relevant available information."[121] Second, the agent's desires and aversions that are involved in the action must be rational.[122] The awareness of all available information condition is what gives Brandt's view the strict, objective, impractical label. The idea is that, similar to an externalist objective epistemology, a judgment of rationality is to be made from an abstract objective viewpoint. In deciding whether a person's action was rational, we (those making the judgment) are to ignore his particular point of view and the information he *actually* possessed, and make a judgment based solely on the information that he *could* have possessed. If there was information available that would have altered the person's choice of action, had he come into possession of the information, then the action he did perform was irrational. In other words, the basic formula of objective standards of rationality like Brandt's is that an action is only rational if the agent would have still performed the action if he was in possession of all relevant available information.

What makes theories like Brandt's stringent is the same quality that makes them impractical. They are strict because the requirement that the agent performing the action have access to all relevant available information makes it extremely difficult for a person to ever perform an act that would be considered rational (or in Brandt's terminology, 'fully rational'). To see why this is the case one must understand what Brandt means by 'all relevant information'. According to Brandt, 'all relevant information' is defined as "the propositions accepted by the science of the agent's day, plus factual propositions justified by publicly accessible evidence (including testimony of others about themselves) and the

[121] Brandt (1998), p. 11.

[122] Brandt (1998), p. 11.

principles of logic."[123] This means that an agent must be vividly aware of the entire body of relevant scientific facts, all other publicly accessible evidence, as well as the principles of logic in order to be capable of performing a rational act. This hardly seems practical. For one, few people actually know the principles of logic. Even if this knowledge of the principles of logic required were interpreted in a weak sense, such as the ability simply to use them correctly in one's reasoning rather than the ability to recognize or formulate them, it is still too strong a condition. Some simple principles may be a matter of 'common sense', such as the law of non-contradiction. Most people will usually abide by this principle in their reasoning without needing to learn it formally. However, most people will be oblivious to other simple principles, such as the invalid argument form 'denying the antecedent', unless they take a course in introductory logic (which most people will not do). In fact, Brandt's view does not seem to accurately represent ordinary usage of the term 'rationality' at all. As Allan Gibbard argues, the problem with what he refers to as 'full awareness' accounts like Brandt's is that "rationality, in the ordinary sense, often consists not of using full information, but of making best use of limited information."[124] Moreover, not only do we often (and perhaps always) act with limited information but it would also seem to be impossible to ever obtain full information. As Richard Fumerton points out, there is no end to the amount of information that one could accumulate which would impact on one's decisions. And since it is nonsensical to say that one is required to postpone making decisions until one has accumulated full information, it also makes little sense to label one's actions as irrational based on information one could

[123] Brandt (1998), p. 13.

[124] Allan Gibbard, Wise Choices, Apt Feelings: A Theory of Normative Judgment (Oxford: Clarendon Press, 1990), p. 18.

not have even obtained.[125] On full awareness accounts like Brandt's, one could only perform rational actions by 'rational luck': acting on limited information and getting lucky in performing the action one would perform with full information.[126]

In response to Gibbard's criticisms, David Schmidtz defends an objective conception of rationality. Gibbard used an example of a hiker lost in the woods to draw a distinction between the objectively best action and the rational action. A hiker is lost in the woods and wants to find the best (quickest) way back to town. The best way back to town is a straight line through the trees but, since he is lost, he is oblivious to this route. He decides to follow the river knowing it will eventually get him back to town, although it is a roundabout route. The straight line through the trees is the objectively best path but the river is the rational path based on the information the hiker actually possesses. Schmidtz disagrees with this conclusion and claims that the idea of a subjectively best path presupposes that the hiker has standards of objective success; and it is the idea of objective success that we use to gauge the successes of our actions (and thus rationality).[127] Suppose the hiker's information is erroneous and the river path actually gets him more lost so that he fears freezing to death. Schmidtz asks, "does the hiker review his strategy, find that it

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[125] Richard A. Fumerton, Reason and Morality (Ithaca: Cornell University Press, 1990), pp. 116-117.

[126] Here again we see the parallels between discussions of rationality and epistemology. Epistemic luck works in the same manner as rational luck: if I make an unjustified (or poorly justified) prediction which happens to come true, my claim to possessing knowledge that the event would take place is based on epistemic luck. Similarly, if I act on limited information and happen to perform the rational action, my claim to acting rationally would be based on rational luck, on a full awareness view of rationality.

[127] David Schmidtz, Rational Choice and Moral Agency (New Jersey: Princeton University Press, 1995), p. 17.

was impeccable by subjective standards, and die happy? Not at all. In fact, he has cause for regret, for his subjectively justified strategy is an objective failure."[128]

Although I think Schmidtz is correct that the hiker would probably not take much solace in the conclusion that he acted rationally by following the river, I think his criticism misses the point. Whether the hiker is happy, pleased, or upset with his choice of action is irrelevant. What matters is whether or not it is rational. There is certainly nothing inconsistent in saying that acting rationally may make one unhappy or that acting irrationally may make one happy. So while the lost hiker may not be happy with the fact that his action may result in his freezing to death, this does not succeed in refuting a more subjective standard of rationality. I see nothing implausible in the hiker thinking to himself, 'The river was definitely not the best route to take. But based on what I knew at the time it still was the rational thing to do.' In fact, since the hiker still did not discover a route back to town, he may even declare that if he were in the same position again he would probably still choose to follow the river. This type of reasoning is more subjective than a view such as Brandt's because the rationality of one's actions depends on one's particular subjective viewpoint. Moreover, it more accurately reflects ordinary usage of 'rational'. More will be said about subjective rationality below.

There is another family of objective rationality theories that is quite popular but suffers from serious problems. These theories are often referred to as the 'maximization of expected utility' theories because they all follow the general formula that an action is rational if it maximizes expected utility. One example from this family might be what Fumerton refers to as the 'actual consequence act consequentialist' concept of rational

[128] Schmidtz, p. 17.

action.[129] This type of theory is purely objective because it ignores the individual agent's subjective viewpoint; all that matters is the end result of action and the rational action is the one that will produce the best end results. The problem with this type of theory is that rational luck plays too significant a role. Suppose, Fumerton argues, my neighbor is bored one day and decides that he will alleviate his boredom by going to the mall and shooting the first person he sees. Few would argue that this is a rational action (i.e. as opposed to staying home or going to a movie). However, suppose it turns out that the person he happened to kill, *unbeknownst to him*, was a terrorist who was planning to blow up the shopping mall. Clearly more utility was produced by my neighbor's action than if he had decided to stay home or go to a movie. On an objective actual consequence act consequentialist theory of rationality, we must conclude that my neighbor's action was rational. Yet as Fumerton points out, it does not seem correct to say my neighbor's action was rational unless he had some reason to believe that his action would produce the utility that it did.[130] But since he did not know that the person was a terrorist, and he was only performing the action to alleviate his boredom, his action should not be considered rational. My neighbor's action may be rational for someone else who knew of the terrorist but it is not rational for him.

As I mentioned in the above example of the hiker and at the end of the above paragraph, rationality is normally understood to be agent-relative. That is, when we say that a certain action is rational or irrational we mean it is rational or irrational *for the person performing the action.* Following the river may not have been objectively

[129] Fumerton, p. 102.

[130] Fumerton, p. 102.

successful for the hiker but it was the rational action *for him* to take. This is how rationality tends to be understood. Schmidtz himself even seemed to recognize this fact as he went on to admit, after defending objective standards of rationality, that the hiker was indeed *subjectively* rational. While Schmidtz did defend objective standards of rationality, he did admit that there is such a thing as subjective rationality: "Insofar as a choice is rational if it warrants endorsement as a means to the chooser's ends, we can say a choice is subjectively rational if it is subjectively warranted and objectively rational if it is objectively warranted."[131]

However, simply making a standard of rationality agent-relative will not solve the problem because a theory of rationality can be agent-relative while still being too objective. Instead of the rational action being the one that maximizes utility, we could say that the rational action *for a particular person* is the action that is the best means to *that person's* ends. Richard Foley refers to this as the 'radically objective conception' of rationality: "All else being equal, it is rational for *S* to bring about *Y* if he has a goal *X* and *Y* is an effective means to *X*."[132] Notice that this conception of rationality makes no mention of what kind of information *S* has about *X* and *Y* or about *S*'s beliefs about *X* and *Y*. If *Y* is effective in bringing about *X*, then it is (or was, in hindsight) rational for *S* to perform *Y* regardless of whether *S* even thinks, knows, or believes that *Y* would in fact bring about *X*. But again situations of rational luck arise. What if *S* has very bad reasons for performing *Y* but *Y* ends up bringing about *X* for very different reasons? For instance, suppose I attend the horse races with the goal of winning a large sum of money. There are

[131] Schmidtz, p. 18, footnote 11.

[132] Richard Foley, The Theory of Epistemic Rationality (Cambridge: Harvard University Press, 1987), p. 131.

several actions I could choose from, corresponding to the different kinds of bets I could make. Now suppose I decide to bet five-hundred dollars on the 100-1 long shot (say the horse is notorious for always finishing at the back of the pack) simply because that horse's name was shorter than all the others. My horse happens to win the race and I win a large sum of money. I performed an action for poor reasons yet (by sheer luck) that action happened to effectively bring about my desired goal. Does this mean betting on a pathetic long shot horse is rational? Certainly not; most would agree that the rational action would be to bet more money on one of the favorites because that action has the best chances of achieving my desired goal. The only way betting on the pathetic horse would be rational is if I had in my possession some information that would give me good reason to think the pathetic horse would win. For example, if I found out that the owner of the pathetic horse had bribed the stable-hands into drugging the other horses then I would have good reason to believe that the pathetic horse would effectively bring about my desired goal.

The above thoughts lend support to the view that there is more to rationality than is allowed by objective standards like Brandt's or the 'radically objective standard' described by Foley. One thing most standards of rationality have in common, whether they are objective or subjective in nature, is the view that rationality has to do with choosing the best course of action from a list of alternatives. The different standards diverge, however, on what is meant by the best course of action and how much of a role the agent's subjective epistemic viewpoint should play in rationality. According to Fumerton, one acts rationally in performing an action only when one has more reason to perform that action than any of its alternatives. However, Fumerton also points out that this definition is really only intended to capture an 'ideal' standard of rationality because it is perhaps too strict

and unrealistic to expect people to always be able to choose the action that is better than all of the alternatives. A more ordinary standard "might allow that a person has acted rationally even if there were things that he had even more reason to do, provided that the action he took was among the 'leading contenders' for the most rational action."[133] Since I am after a permissive argument for suicide rather than an obligatory argument, a more ordinary standard of rationality would serve my purposes better than an ideal standard. In order to be permissible a suicide does not have to be *the* rational action (the best of the alternatives), it only has to be *a* rational action (one of the leading contenders). More will be said about this below.

Since he starts with the assumption that an action is rational if the agent has more reason to do it than any of its alternatives, the next step in defining rationality more precisely is to determine what it means to have a reason for doing something. Like many rationality theorists, Fumerton claims that one's personal ends serve as "the ultimate appeal on all questions of rationality."[134] There is no better way to determine the rationality of one's actions than by how well one's actions achieve one's ends. An end, according to Fumerton, is "something that *S wants* or *values* for its own sake."[135] Therefore, Fumerton begins with the most obvious definition: (D1) *S* has a reason for doing *X* if either *X* is an end for *S* or *X* has either a logical or nomological consequence *Y* which is an end for *S*.[136] In other words, I have a reason for performing an action if that action is an end for me or if it will lead to something that is an end for me. For example, if

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[133] Fumerton, p. 93.

[134] Fumerton, p. 95.

[135] Fumerton, p. 94.

[136] Fumerton, p. 96.

intellectual development were an end for me then I would have a reason for studying philosophy (assuming, of course, that studying philosophy is a means to intellectual development). However, (D1) fails to capture a sufficient notion of having a reason for performing a certain action because it is purely objective. What if I am unaware of the fact that studying philosophy is a means to intellectual contentment? If, from my point of view, I do not know that studying philosophy will lead to intellectual contentment, it does not seem correct to say that *I* still have a reason to study philosophy. Moreover, Fumerton indicates that on the above definition, I would have a reason for performing an action even if I have every reason to believe that performing that action will frustrate my ends.[137] For instance, if I had anti-philosophical parents and they informed me that studying philosophy rots the brain, it would seem that I have a reason to believe that studying philosophy will frustrate my goal of intellectual development. Even if my belief is mistaken or misguided, it would seem incorrect to say that I still have a reason to study philosophy even though I think it will frustrate rather than achieve my end.

These problems with a purely objective definition of having a reason for doing something suggest that an accurate definition must take into account the agent's subjective epistemic viewpoint. This leads Fumerton to the following definition: "(D2) *S* has a reason for doing *X* if *S is justified in believing* that either *X* is an end for *S*..." (my emphasis).[138] This gets us closer to a more accurate definition because it solves some of the problems with the purely objective definition by including the agent's subjective epistemic viewpoint. On this view, then, I would not have a reason to study philosophy if I thought

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[137] Fumerton, p. 96.

[138] Fumerton, p. 96.

philosophy rotted the brain because, based on my belief system, I am not justified in believing that studying philosophy will lead to intellectual development. However, someone else with the same end of intellectual development, who has been convinced that studying philosophy does lead to intellectual development, *would* have a reason to study philosophy.

Unfortunately, (D2) still is not an entirely accurate account of what it means to have a reason for doing something because it is too strict. This is because there is a sense in which a person can have a reason for doing something even though he has good evidence indicating that the action will frustrate his ends, and even if it is objectively true that the action will in fact frustrate his ends. In some cases, a person may have a reason for performing a certain action even if it only *might* be the case that the action will achieve his ends.[139] Lotteries, Fumerton argues, are perfect examples. Suppose a $1 lottery ticket will give me a 1/25 chance at winning a $10 million jackpot. Even though the odds are heavily against me (only a 4% chance of winning), the fact that a very small risk gives me any chance at a huge payoff seems enough to give me a reason to buy the lottery ticket. In a situation like this most would say that I have a reason to buy the ticket even though I have good evidence that I will lose my $1. But (D2) does not allow for situations like this because I am not justified in believing that buying the lottery ticket will achieve my end (i.e. financial security). This leads Fumerton to settle on the following definition: "(D3) *S* has a reason for doing *X* if relative to *S*'s evidence, it might be the case that *X* is an end for *S*..."[140]

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[139] Fumerton, p. 96.

[140] Fumerton, p. 97.

Since we are working with the premise that an action is rational if an agent has more reason to choose it than any of its alternatives, a full definition of rationality will involve weighing the reasons for and against each alternative and then comparing the alternatives to each other. However, there is something missing from (D3) that must be included if it is to serve as the basis for a definition of rationality: a more thorough explanation of what it means to say that an action, or its consequences, "might" be an end for an agent. An elucidation of 'might' will necessarily include a discussion of probability. Clearly whether someone will have a reason for doing something will depend in part on how likely the action is to achieve one's ends. To use the lottery example again, most would agree that the odds of winning the jackpot would have a significant impact on whether or not one has a reason to buy a ticket. While a low risk with a potentially high payoff would probably give someone a reason to buy a ticket regardless of the odds, a 1/10 chance would give someone *more* reason, or a *better* reason, to buy a ticket than if the odds were 1/100. In addition, how much one values a particular end will also impact on one's reasons for doing something. If an action would achieve a lower-ranking end (e.g. emotional satisfaction) but at the same time would frustrate a higher-ranking end (e.g. financial security), this would seem to affect the strength of one's reasons for performing the action. Therefore, a full definition of rationality must also allow for the agent's ranking of ends. Taking all of this into account, Fumerton arrives at the following definition of rationality, which he refers to as the 'value adjusted possible consequence' standard:

> (R3) *S* has more reason to choose *X* than any of its alternatives if the collective weight of *S*'s ends that might (relative to *S*'s evidence) be satisfied...by *X*, when the value of each end is adjusted for the probability (relative to *S*'s evidence) of its occurring, is greater than the collective weight of the ends calculated in a similar fashion that might (relative to *S*'s evidence) be satisfied by any of the alternatives to *X*.[141]

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[141] Fumerton, p. 101.

An example might help to illustrate how this standard would be applied. Suppose, for the sake of simplicity, I have two ends: financial success and personal happiness. I have a desire to be a lawyer because it is my best path to financial success and I also have a desire to be a high school teacher because it would be the career that would make me happier than any other career. As an undergraduate student I have applied to both law schools and faculties of education, and I must make a decision which to attend. Although I do value both financial success and personal happiness, I must admit to myself that I value financial success higher than personal happiness. This leans me toward attending law school. However, my evidence tells me that law school is extremely difficult and only a small percentage of students actually get jobs when they graduate. In addition, I have been told that there is such a huge surplus of lawyers that only a small percentage of those who get jobs actually get good jobs in the fields they want. Even more, those that do get good jobs usually end up working eighty-hour weeks for ten years or so before they start making the really big money. Many of them burn out from the hard work before they even reach the big money. So, after some rough estimates and calculations I decide that I probably have a 15% chance of becoming a wealthy lawyer if I choose to go to law school. On the other hand, my evidence tells me that my chances of becoming a high school teacher are much better, which I estimate at approximately 80%. Therefore, even though I rank financial success higher than personal happiness, I have a much better chance of achieving happiness than financial success (based on my evidence base). This leads me to choose one of the faculties of education and it is the rational thing to do according to the above standard of rationality. Even if I am mistaken about my evidence base (suppose the

number of law school applications has dropped drastically over the last few years so my chances of success would actually be much higher) the faculty of education is still the rational thing to do, from *my* epistemic viewpoint. Another way to apply the standard might be to conclude that attending law school would be the *irrational* of the two actions since it has a much worse chance of achieving even one of my ends (in fact law school would be more likely to frustrate both of my ends).

One might respond at this point that the above standard of rationality makes rationality purely subjective: as long as an action is rational for a person *from his or her point of view*, then the act is rational. But surely there are situations in which an action should not be considered rational even if it is rational from the agent's point of view. For instance, an action should not be considered rational if it is based on absurd beliefs. This is an important criticism but I must point out that the above standard makes rationality relative to the agent's *evidence*, not merely his or her *beliefs*. As Fumerton himself admits, if rationality is based merely on the agent's beliefs then the "morality/rationality of our action will not be affected no matter how much evidence we ignore, no matter how careless we are in the evaluation of that evidence, no matter how *irrational* our beliefs are."[142] One difference is that people often believe one thing even though they 'know' or may be justified in believing something else. A common example might be gambling; people often visit casinos believing they can make money even though they know the odds are strongly in the casino's favor and their belief (that they can make money) is not actually justified. Similarly, in the above lottery example, it makes perfect sense to say that it is rational for me to enter the lottery even if I truly believe (and I am justified in

[142] Fumerton, p. 111.

believing) that I will not win. Also, sometimes people believe things that are simply foolish or nonsensical. There must be a way of distinguishing between beliefs (or experiences) that are worthy of serving as the basis for decisions and those that are not. Making the rationality standard dependent on the agent's evidence rather than merely his beliefs is intended to capture this idea. Moreover, it is intended to help weed out those purely subjective rational actions that are not in fact rational and should not be accepted as rational.

3.3 Evidence

The next important question to answer would be: how do we distinguish between beliefs that are worthy of serving as the basis for decisions and those that are not? Or, more precisely, how do we distinguish between what should count as evidence and what should not? Above I criticized Brandt's view for being too stringent; on his view the requirements for what should count as evidence are so strict that one would be lucky to ever act rationally. On his view, any belief or experience that contradicts any proposition of science or principle of logic should not count as evidence, which may exclude some religious beliefs or experiences, and would certainly exclude beliefs that may be wrong but are not irrational. Therefore, I maintain that one's evidence base is made up of two components. The first component is well-founded propositions of common sense knowledge. The second component is beliefs or experiences, as long as one's beliefs or experiences meet two conditions: 1) the beliefs or experiences must not contradict well-founded common sense knowledge, unless they represent an advance over current knowledge by better accommodating scientific data; and 2) the beliefs or experiences must be shared or accepted by a community which has reflected upon the beliefs and attempted

to integrate the beliefs or experiences into the body of common sense knowledge and scientific understanding.[143] I will deal with each of the two components in turn.

My concept of well-founded common sense knowledge is quite straightforward. What I mean by well-founded common sense knowledge is the body of facts that are well-founded in current scientific understanding, and that every competent person ought to know. One might ask immediately how this differs from the 'all available evidence' views like Brandt's. Remember that Brandt claimed that one's evidence base must include "the propositions accepted by the science of the agent's day plus factual propositions justified by publicly accessible evidence...and the principles of logic."[144] Although Brandt does curiously refer to his evidence base as "common-sense knowledge,"[145] I think it is clear that he is including much, much more than what is considered common sense. The fact that subatomic particles have both particle and wavelength qualities is a proposition accepted by science today (one of the postulates of quantum theory)[146] but I would hardly call it common-sense knowledge. However, there are certain well-founded facts that we do expect competent people to know, such as facts like the earth is round, the sun is the center of our solar system, human beings are mortal, and so on. Well-founded common sense knowledge would be contrasted with a non well-founded fact of common sense knowledge, such as the old belief that the world was flat. This belief was not well-founded, even when it was the prevailing belief, because it was based more on theory and

[143] I thank Professor Elisabeth Boetzkes for helping me clarify the wording of these two conditions.

[144] See footnote 93.

[145] Brandt, p. 12.

[146] Michio Kaku, Visions: How Science will Revolutionize the 21st Century (New York: Doubleday, 1997), pp. 7-8.

conjecture than on actual scientific data (as soon as someone actually tested the belief by trying to sail off the end of the world it was refuted). If someone were to question the facts of well-founded common sense knowledge, we would probably question his competence (or sanity). Exactly which facts and propositions ought to be considered well-founded common sense knowledge is another question for another thesis (in another area of philosophy). But I think quite simply that there are some things that competent people are expected to know.

The second component of evidence is beliefs and experiences as long as they meet the two conditions mentioned above. I think the first condition is obvious. If one's evidence base contains the body of well-founded common sense knowledge, then any beliefs or experiences that contradict well-founded common sense knowledge should not count as part of one's evidence. For instance, if I still held the belief that I could sail off the edge of the world one would not hesitate to call my belief absurd and irrational. However, there will be beliefs that contradict what may be well-founded common sense knowledge by better accommodating the scientific data and thus representing an advance in our knowledge base. When Galileo asserted that the earth in fact revolves around the sun, his belief contradicted what was at the time well-founded common sense knowledge. Yet his belief represented an advance or improvement in the system of knowledge at the time because his experiments were able to make better sense of the scientific data.[147] Hence, beliefs or experiences that contradict common sense knowledge ought not to be considered

[147] Professor Elisabeth Boetzkes, personal email communication, July 25, 1999.

part of one's evidence base, unless the beliefs represent an advance over the current system of knowledge by better accommodating the scientific data.[148]

The second condition, that the beliefs or experiences be shared or accepted by a community which has reflected upon the beliefs and attempted to integrate them into common sense and scientific understanding, is somewhat obscure but important. The inclusion of this condition is meant to capture the idea that there are some beliefs or experiences that are not wrong, do not contradict common sense knowledge, and seem strange or unlikely, but are still not irrational. Likewise, there are some beliefs or experiences that are not wrong, do not contradict common sense knowledge, and are just *too* strange or unlikely to be considered rational. Many religious beliefs are perfect examples of the former. The belief in Creationism, some might argue, may not be wrong and may not contradict well-founded common sense knowledge, but the idea that an omnipotent deity created everything in the universe as it appears now, only six thousand years ago, is quite strange or unlikely. Yet few would argue that the belief in Creationism is irrational. The reason is that religious beliefs are held and shared by many different communities throughout the world, and that religious scholars and leaders have reflected upon these beliefs for centuries (and continue to do so) in order to try to integrate them into current common sense and scientific understanding. For instance, Jewish scholars are continuously reflecting upon their belief in God in order to integrate this belief into current knowledge – knowledge which includes the horrible fact that six million Jews were slaughtered in the Holocaust. Compare any religious belief to, say, the belief held by a

[148] The first part of this sentence is not the same as saying that beliefs that are *wrong* ought not to be part of one's evidence base. I consider beliefs that are wrong to be beliefs that contradict propositions of science; but since people should not be expected to know all the propositions of science, beliefs that are wrong are not necessarily irrational. They are only irrational if they contradict facts that people *ought* to know.

recent cult that on a specific date an alien mother ship, travelling behind the Hale-Bop comet, would pick up the cult members to take them their home world. The cult belief may be no more strange or unlikely than some of the religious beliefs some people hold, yet to the majority of us the cult belief strikes us as too bizarre to be considered rational. I think the only justification for the difference of opinion about the two kinds of beliefs is that cults do not reflect upon their beliefs and attempt to integrate these beliefs into current common sense knowledge and scientific understanding. This is of course an assumption but I think it is a safe assumption.

It is clear that there are practical problems that would have to be ironed out before the above standard could actually be applied for the purpose of determining whether a person's beliefs or experiences ought to count as evidence. For example, what constitutes a community? How long does the community have to reflect upon their beliefs in order to fulfill the reflection requirement? How do we judge whether the strange beliefs have been integrated into the body of common sense knowledge and scientific understanding? These are clearly difficult questions to answer but they are practical questions and are beyond the scope of this thesis. For now I will have to leave them unanswered and move on.

3.4 Impermissible Suicides

3.41 Suicides of people who are not competent

Since suicides by incompetent people are beyond the scope of moral judgment, it would not be correct to classify them as *morally impermissible*. However, they must still be included in the group of impermissible suicides since they are also never morally permissible. An incompetent suicide is impermissible not because it violates the moral permissibility condition of full permissibility but because it *can not* fulfill the moral

permissibility condition. As already mentioned, suicides by incompetent people can not be morally permissible because incompetent people can not be held responsible for their actions. They can not be held responsible because they are considered unable to make decisions for themselves. To explain why this is the case, it might help to briefly review the standard of competency I discussed in chapter 1.

A general definition of the competency standard I defended in the first chapter might be the following: competency is the ability to comprehend, on both a technical and personal level, the nature and consequences of the conduct in question. Also recall that there are two elements required for this type of understanding: 1) the capacity for reasoning and deliberation (the ability to draw inferences about the consequences of a choice and to compare alternative outcomes based on how they further one's ends); and 2) the possession of a set of values or concept of the good. If a person were incompetent, then at least one of the two above requirements would be incapacitated. Either the person would not have the ability to reason and deliberate or the person would not possess, or would not be able to articulate, a set of values. Both of these elements are required in order for a person to be able to make decisions for him or herself.

First, in order to make decisions for oneself one must possess a set of ends or values. One must have something to aim at when making decisions, otherwise decisions would have no purpose. The whole point of making decisions about how one will act is so that one can achieve something. Moreover, one must also be able to rank these ends according to personal value. This element of competency is required in order to make a decision to choose a course of action that will achieve one end or value over a course of action that will achieve another. If one were completely indifferent as to the personal value of one's

ends, then one would be completely indifferent when it comes to making decisions. One would not be able to choose one action over another. Second, a person must be able to reason and draw conclusions about not just the consequences that might occur but also the probability of those consequences occurring, as well as be able to compare alternatives based on how well the alternatives will promote one's ends. Without the ability to reason and draw conclusions, decisions would be impossible. Hence, a person can not make decisions for him or herself if he or she is not competent.

The point of declaring suicides by incompetent people impermissible in the sense of never being morally permissible is that the declaration of incompetency gives society the liberty to act in their best interests by trying to prevent the suicides from occurring. In other words, society is justified in engaging in strong paternalistic behavior. The idea is that since people who are not competent are unable to make decisions for themselves, they must be protected from performing actions that carry with them a high degree of risk to themselves. Even if it may in fact be in an incompetent person's best interest to kill him or herself, society must take the safe route and assume that he or she does not really want to die. With regard to people who are suicidal but not competent, society has the liberty to try to prevent them from killing themselves (since suicide carries with it the highest level of risk to the person in question), even if it requires restraining or hospitalizing them. Thus, suicides by incompetent people are impermissible.

3.42 An irrational suicide – "James"

James is a young man, sixteen years old, whose life has been filled with unhappiness. He was taken away from his birth parents after investigations by the local children's aid organization revealed that he was the target of physical and emotional abuse from both his

parents. For years he moved from foster home to foster home because foster parents had difficulty dealing with his emotional problems as well as his problems in school. He eventually settled down with a set of foster parents who decided the best way to help James would be to instill in him a sense of discipline and responsibility. He was rarely able to be with his new friends as he always had chores to do and a strict curfew. Although he tried, he was unable to succeed in school and he soon realized that he did not have a very bright future. The only time he was ever happy was when he did get to spend time with his friends, and his new girlfriend. However, since he was often stuck at home learning 'discipline' and 'responsibility' and was only able to spend limited time with his girlfriend, he was constantly paranoid that she would find someone better. One weekend his friends, including his girlfriend, decided they would go camping for the weekend and James was invited to go. His foster parents disapproved, however, and he was stuck at home for the weekend while his friends went away. When they returned, his girlfriend informed him that she spent time with another guy on the weekend and wanted to be with him rather than James. She was sorry, but it was inevitable – James was never around.

James was devastated and became angry with his foster parents. If they weren't always so strict, maybe he would have been able to develop a better relationship with his girlfriend. If they had just let him go on the camping trip, this wouldn't have happened. It was all their fault. This latest experience seemed to be the last straw for James. He began to have suicide fantasies, and daydreamed about what it would be like if he killed himself. He pictured his foster parents, his ex-girlfriend, and all his friends, gathered around his coffin crying. He knew his foster parents would be devastated. They may have been strict but he knew they loved him. He became obsessed with the idea of 'looking down' upon

his funeral and seeing everybody crying over his death. The fantasies made him so happy that he decided to make them a reality by killing himself.

James' suicide is an example of an irrational suicide. The main purpose of his suicide is to fulfill his suicide fantasy; to achieve the pleasure derived from watching everybody cry over his death at his funeral. So we can assume that happiness is one of his ends and that happiness is the end he is aiming to achieve by his suicide. He thinks that his suicide will achieve his end of happiness but he is mistaken because his evidence base includes an absurd belief. In fact, the absurd belief forms the basis of his action. Although there is nothing absurd about his suicide fantasies themselves, that is, about the pleasure he derives from picturing everybody crying at his funeral, the absurdity is that the basis for his action is the belief that he will be able to witness the reality of the fantasy. This is not uncommon for people contemplating suicide:

> Would-be suicides often daydream of the guilt and sorrow of others gathered about the coffin, an imaginary spectacle which provides satisfaction. While the contemplation of such a scene is a pleasure in itself, the patient may also consciously entertain the illusion that after the act of suicide he will be present as an unseen observer to enjoy the anguish of those who view his dead body. Such an illusion may be held with such intensity that it supersedes reality in emotional value and forms the basis for action.[149]

James decided to kill himself because he became obsessed with the idea of 'looking down' upon his funeral and witnessing the event. So he believes that the suicide will allow himself to achieve his end of happiness because it will make him happy to see everybody cry over his death. But this is an absurd belief that should not count as part of his evidence base. The reason is that it violates the second of the two conditions for a belief to count as evidence. The belief does not violate the first condition in that it does not contradict common sense knowledge. But it does violate the second condition because the fantasy of

[149] John T. Maltsberger and Dan H. Buie, Jr., "The Devices of Suicide: Revenge, Riddance, and Rebirth," in Maltsberger and Goldblatt (1996), p. 399.

being able to witness the spectacle of his funeral is the kind of belief that, even if it were shared by a community, would not be able to be integrated into the system of common sense knowledge and scientific understanding. The belief in the afterlife per se is not absurd because it is a religious belief shared by probably the majority of the people in this world. However, James' belief is different presumably because it takes the idea of an afterlife too far. Perhaps it could be argued that James' belief makes a mockery of the spiritual and religious meaning behind the belief in the afterlife. While most would share or at least accept the belief that there is something mysterious beyond the physical world, few would share or accept the belief that it includes being able to look down and witness the tears shed at one's funeral with a sense of gratification. Therefore, James' suicide is irrational because the decision to take his own life was based on an absurd belief.

Once again, the fact that James' suicide is irrational does not make it *morally* impermissible. All other things being equal, James has not done something morally wrong by performing an act that is irrational for him to perform. One could argue that he has done something morally wrong because his motivation is to hurt people around him. But for the sake of this example I will assume that this was not his motivation. The point of James' example was to show how a suicide could be impermissible by violating the rationality condition of full permissibility. In James' case, if anybody found out about his suicide fantasies he or she would be justified in interfering by trying to convince James not to kill himself or by trying to get him to see a therapist.

3.43 The revenge suicide – "Howard"

Howard is a twenty-one year old man who has been involved in a serious relationship with Nathalie for more than two years. Their relationship was wonderful and

unproblematic for the first year but soon after that Howard began to display excessively needy and dependent behavior. He would often make remarks to Nathalie about how he could not live without her and that he would not know what to do if she ever left him. For various reasons, Nathalie's feelings toward Howard changed and she began to doubt the future of their relationship. Howard sensed the change in Nathalie and reacted by telling her constantly how much he loved her, needed her, and could not live without her. On more than one occasion, Howard even threatened Nathalie by saying something like, "you better not ever leave me," or "don't you dare leave me." Eventually Nathalie decided that the relationship had to end and she broke up with Howard. Howard was devastated but was as angry as he was sorrowful. His hurt and anger toward Nathalie was so strong that he decided the best way to get revenge would be to kill himself. 'If I kill myself, she will have to live with that guilt for the rest of her life. That will teach her not to hurt me.' Would Howard's suicide be considered permissible?

The first step in determining whether Howard's suicide is permissible is to determine whether he is competent. For the sake of argument I will assume that he is competent, so the first condition for a permissible suicide is met. Next I will examine whether his suicide is rational. In his situation, there are two other alternatives open to Howard. He could *not* kill himself and do nothing to get revenge on Nathalie or he could not kill himself but get revenge on Nathalie in some other way (for example, by spreading nasty rumors). Therefore, Howard has three alternatives open to him: the above two alternatives plus the suicide alternative. For Howard's suicide to be rational, it would have to be more rational than at least one of the other alternatives. Since Howard is a competent human being he probably has a number of ends, some of which may include personal happiness, financial

success, fulfillment of his base urges, contentment, or fame (although many of these could be interpreted as means to happiness). However, since he has the desire to get revenge on someone who has hurt him, he probably also has a strange version of self-respect as an end as well ('nobody hurts me and gets away with it'). For the sake of argument I will assume that Howard ranks his end of self-respect higher than any of his other ends. Would suicide be rational for Howard?

The answer is that it could very well be. From Howard's point of view, suicide would have the highest probability of achieving his end of self-respect because it would be the best way to get revenge on Nathalie. Since she would surely feel extremely guilty if Howard killed himself because of her, suicide would definitely be more likely to get revenge on her than if Howard spread nasty rumors about her or got revenge by some other means. It may seem that the situation is the same here as with James: that it is irrational for Howard to believe that he will experience the satisfaction of his revenge after he is dead. But in this case, the satisfaction from the revenge is not what Howard is after. What he wants (in order to achieve his end of self-respect) is simply to get revenge on Nathalie; and this can be achieved without him experiencing the satisfaction of the revenge.[150] While he may have other ends that will be frustrated by suicide, such as financial success, this need not be the case. For instance, he may only have one other end, which he ranks lower in value than self-respect, so while suicide would frustrate this end it would have a one hundred percent chance of achieving his higher ranking end.

On the other hand, remaining alive and doing nothing to Nathalie would be less rational for Howard than the suicide option. This is because while remaining alive would

[150] Professor Wil Waluchow, personal communication.

allow him to achieve his other end, whatever it is, it would completely frustrate his end of self-respect. He would simply have to take the pain she gave him and live with it. By doing this he would not have any respect for himself, so remaining alive and doing nothing would have a zero percent change of achieving his most valued end. Therefore, since this alternative would have a zero percent chance of achieving his highest ranking end and perhaps a one-hundred percent chance of achieving his lower ranking end, remaining alive and doing nothing to Nathalie would be less rational than suicide (which, we recall, had a one hundred percent chance of achieving his higher ranking end and a zero percent chance of achieving his lower ranking end). Howard's suicide passes the rationality test for permissibility.

Howard's suicide has passed the rationality test but does it pass the obligation condition? I think not, for the action of Howard's suicide is itself the deliberate attempt to harm another person. This means that Howard's suicide would violate Howard's general obligation of non-maleficence. Is his obligation of non-maleficence overriding in this case? I think so, because in Howard's case his obligation of non-maleficence is competing only with his self-interest and this is a case in which Howard would be violating his obligation of non-maleficence in order to pursue his self-interest (in his case his pursuit of self-respect). Sometimes people are justified in pursuing their self-interests at the expense of their obligations. For instance, we do not hold a physician morally responsible for taking a vacation even though her vacation violates her obligation to help people.[151] In Howard's case, however, I think it is clear that he is not justified in violating his obligation of non-maleficence in order to pursue his self-interest. It can not be morally permissible to

[151] Thanks to professor Wil Waluchow for this example.

harm someone in order to boost one's self-respect. Is this a case in which his obligation of non-maleficence would be violated anyway? Certainly not, for he does not have to harm Nathalie by remaining alive. That is, while getting revenge by some other means would also be harming Nathalie, he does have one other alternative open to him: remaining alive and doing nothing to Nathalie. Therefore, Howard's suicide is morally impermissible (and, hence, impermissible) since it would violate an overriding obligation that would not otherwise be violated.

3.44 The selfish suicide – "Bob"

Bob is in his early forties, with a wife and three children. For the past fifteen years he has held a middle-management position at a local company while his wife has remained at home taking care of the house and the children. Bob's life has not turned out like he had hoped. He had dreams for himself and thought he had a very bright future, but these dreams were all but ruined when he got his girlfriend pregnant early in college. She dropped out during her first year because of the pregnancy, and he remained in college to finish his degree while working part-time to help pay for the baby. Since both he and his girlfriend came from very conservative backgrounds, Bob knew he had to marry her. They had only been dating for four months and he saw no future with her – he was just 'having fun'. The pregnancy changed all that.

Bob was unhappy about marrying his girlfriend but he knew that it was what he had to do. As soon as he finished his college degree, he had to look for whatever job he could get. He eventually found a job and began his career, even though he had no interest in the job he got. Due to his lack of real love for his wife, and the fact that he was forced to take a job he did not want, he resented his child and had a very difficult time feeling an

attachment toward him. His wife wanted more children in the years to come and he unhappily obliged. She always loved him far more than he loved her. The years passed, he fathered two more children, slowly worked his way up to a management position, developed an addiction to gambling (which he did not share with his wife and which resulted in large unpaid debts), and constantly wished his life had turned out differently. One day Bob is informed that his company is downsizing and he is let go. After a few days of reviewing his life and pondering his situation, he realizes that he has had enough. His life is going down the toilet and decides there is no point in living anymore. He tells his wife he is going for a drive and ends up shooting himself in the head by the side of the road.

Regardless of whether Bob's suicide is rational, I think his case is a case of an obviously impermissible suicide as it clearly breaches the obligation condition for moral permissibility. Bob's suicide is a selfish suicide because he fails to take anybody else into account in his decision to kill himself. Most importantly, he fails to consider the effect that his suicide will have on his family. Though he does not kill himself in the deliberate attempt to harm his family, his suicide does harm them in many ways: the obvious emotional and psychological pain that accompanies the death of a loved one (especially in the case of suicide); the added harm (the feeling of abandonment) his wife suffers because he did not share his feelings with her; the harm associated with the fact that his wife becomes responsible for his gambling debts even though she does not earn money herself; and so on. This harm would not have been caused had he not killed himself, so the obligation that is violated here (non-maleficence) by his suicide is one that would otherwise not be violated.

In addition to violating the obligation of non-maleficence, Bob's suicide also violates other obligations such as the obligation to provide for his family. Since he has children, he has an obligation to provide for them; but by killing himself without making any financial arrangements, by leaving his jobless wife to provide for his children, and by leaving behind unpaid gambling debts for his wife to pay, he certainly violates his obligation to provide for his children financially. Although he lost his job and would not be able to provide for them temporarily, there would at least be a chance that he could get another job in the near future. Therefore, he has violated the obligation to provide for his children financially and this obligation would not have otherwise been violated. Moreover, there may also be obligations to his wife that he has violated, such as the obligation to take care of her financially (since he comes from a conservative background and his wife left school to raise their first child). This obligation to his wife violated by his suicide would also not otherwise be violated.

Finally, would Bob's obligations above be considered overriding obligations? Since it seems odd in this case to talk about obligations he was trying to fulfill in killing himself, it would make more sense to question whether the obligations that he is violating would override any of his rights, such as his right to avoid pain and suffering (if he has such a right). For Bob the suicide was an attempt to escape the emotional and psychological suffering of his unhappy life. The question then is whether Bob is justified in exercising this right at the expense of his other obligations. The only way, it could be argued, that he would be justified in exercising his right to avoid pain and suffering at the expense of his other obligations is if the pain or suffering was of such a magnitude that he could not be expected to endure it for the sake of his other obligations. Moreover, there would have to

be no way to avoid the pain and suffering other than killing himself (or at least no other action that would violate fewer obligations than suicide). Yet it would seem that this is not the case. He could take measures besides suicide to reduce the suffering in his life: for example, by using the opportunity of the lost job to look for a more fulfilling job, by sharing his feelings with his wife, by entering therapy, even by having an affair. In other words, I think Bob's case is such that suicide is not justified as a solution to his suffering and so his obligations (of non-maleficence and to his family) would override his right to avoid pain and suffering. Therefore, since Bob's suicide does violate overriding obligations that would not otherwise be violated, his suicide is morally impermissible (and, hence, impermissible).

3.5 Permissible Suicides

3.51 Suicides of some people suffering from terminal illnesses – "Sandra"

Sandra is a successful fifty-five year old mother of three who has been diagnosed with bowel cancer. Sandra undergoes radiation and chemotherapy, and the initial prognosis is positive. Things seem to be going well but two years later Sandra visits her doctor complaining of pain and discomfort in her back and shoulders. Some tests are run and it is feared that her bowel cancer has returned. More tests confirm that a new tumor is growing in her bowel so it is decided that she will undergo surgery to remove the new tumor. However, once the surgery begins the surgeons are shocked to find Sandra's body covered with tumors; in addition to the tumor in her bowel, there is also a very large tumor growing on her stomach, as well as numerous small tumors growing along her spine and into her shoulders. Realizing that little can be done for Sandra, the surgeons remove the tumor in her bowel and inform her family of the bad news. Sandra's oncologist tells Sandra and her

family that she has approximately two years to live. She will feel relatively fine for the first year, after which she will begin to experience pain and discomfort on a regular basis. After approximately eighteen months, the massive tumor on her stomach will make eating extremely difficult, then impossible. She will eventually starve to death. Sandra absorbs the bad news but remains hopeful. Her doctor's predictions come very close to true: she feels fine for fourteen months and then begins to feel pain and discomfort intermittently. The pain becomes regular and, due to the tumor on her stomach, she begins to lose weight. After approximately twenty months the pain is almost constant; she has a day of relative comfort followed by several days of debilitating pain. Since eating has become almost impossible, her diet is comprised mostly of liquids and a few soft foods that she does not throw up. After giving it much thought for several weeks, Sandra decides she wants to take her own life. She cannot stand the pain and discomfort, nor the lack of dignity of having to be fed liquids and soft foods, and she realizes that soon there will be no more good days separating the bad. Remembering that the doctor told her she will die by starvation, she fears that her remaining time will be spent racked with pain while she wastes away to nothing. "I don't have much time left anyway," she tells her family. "I at least want to go with a little dignity." She discusses the issue at length with her family and makes sure they understand and support her decision, which they do. She makes sure her will is up to date and her finances are taken care of, says her good-byes to her family, and dies by an overdose of medication. Is Sandra's suicide permissible?

Although some would argue that someone in Sandra's position would not be competent, I will assume that she is. For some people in Sandra's position the pain may interfere with their thinking and reasoning processes, and sometimes a person's defense

mechanism will kick in making the person unable to comprehend the reality of the situation. However, Sandra has remained competent throughout her illness and she has thought through her decision for some time. Is Sandra's suicide rational? In this situation Sandra only has two options: suicide or let nature run its course. Hence, for Sandra's suicide to be rational suicide must be more rational than letting nature run its course. Sandra's ends are the following, ranked in order of importance: dignity, happiness, respect in the eyes of others, and financial success.

Sandra knows that suicide will bring an end to her life, thus making the further achievement of happiness and financial success impossible (zero percent probability). However, she also knows that taking control over her death would give her immediate short-term happiness. So while suicide may have a zero percent probability of achieving future happiness, it would at least have a relatively high probability of producing (very) short-term happiness (which she estimates at sixty percent). Combining the long-term and short-term results, and weighting the long-term as more valuable, she figures that suicide would have approximately a ten percent chance of achieving her end of happiness. The suicide would also allow her to die before she 'wastes away to nothing', which would have a one hundred percent probability of achieving her end of dignity. She also figures that some people would respect her choice to control her death while others may condemn it (e.g. she has religious relatives and friends), so she estimates that suicide would have a fifty percent probability of achieving her end of respect in the eyes of others. Therefore, suicide would have a one hundred percent probability of achieving her highest-ranking end, a ten percent probability of achieving her second highest-ranking end, a fifty percent

probability of achieving her third highest-ranking end, and a zero percent chance of achieving her lowest-ranking end.

The probabilities for the alternative of letting nature run its course would be the following, relative to Sandra's evidence: letting nature run its course would mean her fear of wasting away would be realized, so it would have a zero percent probability of achieving her end of dignity. Although it is very possible that Sandra will remain dignified while she suffers (as many dying people do), from her point of view she believes that she would not retain her dignity. However, suppose her physician informs her that dignity is possible in suffering and she factors this into her calculation. Therefore, she changes the zero percent to fifteen percent. Since letting nature run its course also results in her death, it would have a zero percent probability of achieving long-term happiness. However, she also admits that spending more time with her friends and family, even if it were only a matter of weeks or months, would result in short-term happiness. Of course her lack of control and fear of an agonizing and slow death would produce short-term unhappiness, so she averages out her short-term happiness probability at seventy percent. Averaging this out and weighting the long-term as more important, she estimates the total happiness probability at twenty percent. She also realizes that some people would commend her bravery for facing her illness, thus having respect for her. While some people would understand and respect her choice to take her own life, nobody would *disrespect* her for *not* taking her own life (especially if she remains positive and fights bravely). So she figures that letting nature run its course would have a one hundred percent probability of achieving her end of respect in the eyes of others. Finally, since death is inevitable in the very near future, letting nature run its course would have a zero percent probability of achieving her

end of financial success. To sum up, then, Sandra estimates that letting nature run its course would have the following results: a fifteen percent probability of achieving her highest-ranking end, a twenty percent probability of achieving her second highest-ranking end, a one hundred percent probability of achieving her third highest-ranking end, and a zero percent probability of achieving her lowest-ranking end. Comparing the two alternatives, it is clear that suicide is the more rational action *for Sandra*. Of course the rationality of suicide for a person suffering from a terminal illness would depend entirely on the particular situation, the particular person involved, and his or her particular system of ends and evidence base. One of her religious relatives, who values the sanctity of life, may think 'If I were in Sandra's position I would not consider suicide but I can understand why she would.' The purpose of Sandra's example was to show that it is perfectly conceivable, since the example is by no means unrealistic, that suicide can be a rational action for some people suffering from terminal illnesses.

Sandra's case has passed the rationality test but does it pass the obligation condition? I think the answer is yes. In making sure her will is up to date and her finances are taken care of, she does not violate her obligation to provide financially for her children or her husband.[152] She did (I am assuming) personally feel an obligation to provide an emotionally and psychologically stable environment for her family, and this obligation was also not violated by her suicide. What about her obligation of non-maleficence? By discussing her decision with her family, and by making sure that they understood and supported her decision, she greatly minimized the harm that her suicide inflicted upon them. Although they would still suffer the emotional pain associated with the death of a

[152] Ignoring the fact that at her age her children are probably fully grown adults and so her obligations to provide for them financially may no longer exist.

loved one, the emotional pain is not harm in this case. The emotional pain would be associated with her disease, and her resulting death, but not with her suicide per se. They understood and supported her decision, and so the emotional pain would be directed more at her death from cancer rather than the suicide.

One could take an ethic of care standpoint and argue that Sandra's suicide does violate her obligation to maintain her relationships with her family and friends. By killing herself she is quite simply breaking off all of her relationships. While there is no room here to discuss the problems with the ethic of care and the nature of the obligation to maintain one's relationships, two things can be said in response to the above argument. First, like all other obligations, the obligation to maintain one's relationships (if there is one) is not always an overriding obligation. I think the obligation to maintain one's relationships can be overridden by other obligations, or one's rights. For instance, Sandra may (as all people may) possess the right to avoid pain and suffering. For someone in Sandra's case I think the pain and suffering ought to be considered severe enough to warrant classifying her obligation to maintain her relationships as not overriding. In addition, there is no other way for Sandra to relieve her pain and suffering – death is the only way to end her misery. So while she may violate the obligation to maintain her relationships by taking her own life, she is not violating an *overriding* obligation. Therefore, Sandra's suicide does not violate an overriding obligation that would not otherwise be violated. She is also competent and her suicide is a rational action for her, so her suicide is permissible.

3.52 Preemptive suicides of people diagnosed with fatal progressive illnesses – "Michael"

Michael is a well-known and respected associate-professor of philosophy at a major Canadian university. He is married, without children, and his wife teaches third grade in public school. At forty-one years of age he visits his doctor after experiencing strange twitches in his hands and, his wife tells him, uncharacteristic irritability. Eventually his doctor informs him that he has Huntington's Disease. Michael wants his doctor to be honest with the facts so his doctor tells him the following: the good news is that Michael can expect to live for as long as another twenty years with the disease. However, the symptoms will begin to appear with full force within a few years. He will slowly become emotionally unstable and will lose his intellectual faculties. Eventually he will probably be confined to a wheelchair or a bed, unaware of his surroundings. He discusses the matter with his wife and thinks that before the symptoms progress too far, while he can still make a decision, he would take his own life. He values his intellect highly (especially since his career is based on it) and does not see the point in living once he loses his intellectual faculties. 'I do not want to spend the last years of my life as an emotional and intellectual "vegetable",' he says to his wife. Although his wife does not necessarily agree and thinks he should at least wait to see what happens, she nonetheless understands and supports his decision. Even though she earns a living for herself, he will do his best to make sure she will not struggle financially without him. Would Michael's suicide be permissible?

Based on Michael's personality, I will assume he possesses the following ends (again, in order of importance): happiness (which comes largely from his relationship with his wife), intellectual development, dignity, and occupational success (based more on respect

in the philosophical community than financial success). Like Sandra, Michael is faced with two alternatives: suicide or let nature run its course.

Michael's decision to take is own life is based on a number of reasons. First, he realizes of course that suicide would make it impossible for him to advance further in his career. Specifically, he will not be able to realize his goal of full professorship. So suicide would have a zero percent probability of achieving his end of occupational success. However, he also figures that the disease will make career advancement impossible anyway. Once his intellectual faculties begin to deteriorate, which he is told may happen within a few years, his career is over. So the alternative of letting nature run its course also has a zero percent chance of achieving his end of occupational success. Second, suicide would also eliminate any chance at achieving future happiness, although the feeling that he has an escape route and does not have to experience the progression of the disease will give him some comfort for the next couple of years. This time would not be spent in constant fear of the disease. In addition, he will get to spend quality time with his wife for the time before he kills himself. Therefore, he estimates that suicide would at least give him a twenty percent probability of achieving happiness. Although letting nature run its course will allow him to live for up to twenty years, the majority of this time will be spent in emotional and intellectual deterioration and so he doubts he would be happy. Spending time with his wife would not succeed in making him happy if he is confined to a bed and unaware of his surroundings. However, there is a chance that the symptoms may progress slower than expected which might give him an extra few years with his wife. But he also knows that he will spend much of this time fearing the progression of the disease. So, taking all of this into account, he estimates that the nature alternative would also give him

a twenty percent probability of achieving his end of happiness. Third, suicide would make intellectual development impossible as it would with occupational advancement. As a philosopher, he values not only learning and acquiring knowledge but also use of his intellectual faculties. Death would of course bring this to an end, giving suicide a zero percent probability of achieving his end of intellectual development. Similarly, due to the nature of Huntington's Disease, letting nature run its course will also eventually lead to the end of any intellectual development. Still, he may be able to experience a number of years in which he would still be able to learn and use his intellectual faculties before the rapid deterioration begins. Therefore, he places a twenty-five percent probability on the nature alternative for achieving his end of intellectual growth and utilization. Finally, one of the things he fears most about the disease is the loss of dignity. He has always been a strong, independent, respectable man and he shudders at the thought of becoming entirely dependent on someone else to take care of him. Therefore, he believes that the nature alternative would have a zero percent probability of achieving his end of dignity. By taking his own life before the disease ravages his mind, he will at least never have to suffer the personal humiliation and loss of dignity associated with the disease.[153] People will be able to remember him as the strong and independent man he always was. Hence, he places a one hundred percent probability on the suicide alternative for achieving his end of dignity.

In sum, suicide would have a twenty percent probability of achieving his highest-ranking end, a zero percent probability of achieving his second highest-ranking end, a one

[153] Once again, I am not claiming here that people always lose their dignity when they suffer or when they are dying. Also, some people who think or fear that they might lose their dignity may not end up actually losing it. However, what is important for rationality is that some people, based on their beliefs and evidence, may think that they will lose their dignity.

hundred percent probability of achieving his third highest-ranking end, and a zero percent probability of achieving his lowest-ranking end. The alternative of letting nature run its course would have a twenty percent probability of achieving his highest-ranking end, a twenty-five percent probability of achieving his second highest-ranking end, a zero percent probability of achieving his third highest-ranking end, and a zero percent probability of achieving his lowest-ranking end. Although letting nature run its course would, relative to Michael's evidence, likely achieve ends that are ranked higher than the suicide option, the difference is more than offset by the probabilities of each alternative for achieving dignity. The fact that suicide would allow Michael to retain his dignity while letting nature run its course would not means the collective weight, for Michael, tips the scales in favor of suicide. Once again, someone else who valued the sanctity of life rather than dignity, or someone who did not fear losing his or her dignity, would evaluate the alternatives much differently. Nevertheless, for *Michael* suicide is rational.

As for the obligation condition, I think Michael's situation can be analyzed in a similar fashion to Sandra's. The only difference between the two as I have described them, aside from the fact that Michael does not have children, is that Michael's suicide is preemptive – before he experiences the pain and suffering he is anticipating experiencing. It is safe to assume, then, that the obligations to his wife, as well as the obligation of non-maleficence to others are not violated by his suicide. However, one could again take an ethic of care route and argue that his suicide violates his obligation to maintain his relationships. Moreover, it could be argued that the preemptive feature of his suicide means his right to avoid pain or suffering does not override his obligation to maintain his relationships. The reason is that the mere *anticipation* of pain or suffering is not a good enough reason to

justify prematurely breaking off his relationships with others (specifically his wife). Yet I think this argument fails because the anticipation of pain or suffering would still be covered by the right to avoid pain and suffering. That is, if I have a right to avoid pain and suffering, then I am justified in doing whatever I can to avoid pain or suffering (within limits, of course). But this does not mean that I must wait until I experience pain or suffering before I try to avoid them. If I know (or at least believe) that I will experience pain or suffering in the near future, my right to avoid pain or suffering still justifies me in taking steps to avoid it in advance. Avoiding pain or suffering before they hit is much better than trying to deal with them once they hit. Hence, since Michael anticipates pain and suffering, his attempt to avoid them is still justified by his right to avoid them.

However, one could argue that his right to avoid pain and suffering does not override his obligation to maintain his relationships because there is still another option open to him. Since he is not yet experiencing the pain and suffering, he could choose to wait until he experiences the pain and suffering and this choice would not violate his obligation to maintain his relationships. This argument does not work, though, because I think it is difficult to defend a position that would require people to actually undergo pain and suffering before they are justified in violating their obligations to maintain their relationships. If Michael has a right to avoid pain and suffering, then this right should justify him in taking preemptive steps to avoid the pain and suffering. He should not have to wait until he is suffering, especially since he may not have the cognitive faculties to make the decision by that time, to take the course of action that would help him avoid his suffering. Therefore, since Michael (I assume) is competent, his suicide is rational for him,

and it does not violate any overriding obligations that would not otherwise be violated, his suicide is permissible.

The two cases discussed above obviously do not exhaust the list of permissible suicides. The purpose of discussing the examples I chose was to show how the conditions for the permissibility of suicide can be applied to cases of suicide that may not be so controversial. Even many of those who argue against the rationality/moral permissibility of suicide would be willing to grant that suicide might be permissible for someone in Sandra's position. The second case is a step down on the scale and is certainly more controversial than the first. It is perfectly conceivable that I could continue down the scale and find permissible suicides in even more controversial cases. For example, the next step down might be to discuss the case of someone who suffers a drastically life-changing injury (such as paralysis) and wishes to end her life. Even farther down the scale might be someone who experiences a drastically life-changing event (e.g. a doctor whose medical license is revoked after a malpractice lawsuit). Whether a suicide in one of these cases is permissible will depend on the particular situation, the particular person, the person's evidence base, the person's list and ranking of ends, and the person's list of obligations. The point is that we must remain open-minded and be willing to accept that for some people, in some circumstances, suicide is a permissible action.

3.6 Rebuttals

In response to my analysis, one might argue that most people who desire to take their own lives are not competent because their judgment is always clouded by hopelessness, despair, or pain. Sandra, it might be said, cannot be competent because her pain and suffering are interfering with her thought processes. Or if someone were paralyzed after an

automobile accident and wanted to take his own life, it is likely that his judgment is deeply affected by his feelings of hopelessness. If he could just understand that he could still have a fulfilling life even though he is paralyzed, then he probably would not want to take his own life. Of course the problem with this criticism is that it makes the same major assumption that the psychological view of suicide makes, as I discussed in chapter 1. While it may be true that someone in Sandra's position may be in pain or feeling hopeless, this does not necessarily mean his or her competence has been affected. However, one could argue that even though competence may not be affected the suicide can still not be rational because hopelessness and pain certainly cause people to misunderstand the alternatives and their consequences. That is, if one misunderstands an alternative and its consequences one might misinterpret or misjudge the probabilities of the alternative for achieving one's ends. But one could say that a person in Sandra's position who chooses to let nature run its course may have his or her judgment equally clouded by such positive emotions or states as denial or vain hope. Many people diagnosed with terminal illnesses deny the reality of their situation and remain hopeful right up until the day they die. But emotions like denial and vain hope can affect one's reasoning just as despair or hopelessness can. So if one wants to argue that suicide in a case like Sandra's is irrational because her judgment is clouded by pain or hopelessness, one could equally argue that *not* taking one's own life in Sandra's case would be irrational because one's judgment is probably clouded by denial or vain hope.[154] Though it may seem irrational to think one's life is over when nobody knows what the future holds, it seems just as, if not more irrational to think there is still hope when one is in the late stages of a terminal illness.

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[154] Jay F. Rosenberg, Thinking Clearly About Death, 2ed. (Indianapolis: Hackett Publishing Company, Inc., 1998), p. 290.

Another rebuttal that can be made in response to my argument is what Prado refers to as the "lack-of-contrast" argument. This argument essentially states that suicide can never be rational because one can never really understand what it means to be dead. Weighing alternatives means that one must be able to understand and evaluate each alternative, in order to conclude that one is better than the other. Yet since we have no empirical knowledge of what it is like to be dead, it is impossible to understand death as an alternative. Not only do we not have empirical knowledge of death but conceptually one cannot compare death to another state of being because death is not a state of being; it is a state of non-being or non-existence. Therefore, death can not be evaluated and rationally chosen as preferable to any other alternative.[155] The argument, however, does allow certain exceptions. The main exception is when one is suffering unbearable agony. In this case, Prado explains, 'contextual coercion' forces people to choose suicide as the only sensible alternative. But what about cases of preemptive suicide, like Michael, or even more controversial cases?

In response to the empirical aspect of the argument, it is true that we have no empirical knowledge of what it is like to be dead. This much is obvious. Nevertheless, I do not think this means one can not understand death well enough to evaluate it as an alternative. One thing we do understand about death at this point in our history is that death is non-existence. When one dies, one ceases to exist in the world. Of course it is extremely difficult for us to actually comprehend what it means to not exist but we do know that we will cease to exist. And what is associated with non-existence can be compared to what is associated with existence. For instance, existing in the world means I will be able to fall in

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[155] Prado (1998), pp. 41-42.

love, have a career, make money, have friends, travel, and so on. If I cease to exist I will be unable to do any of these things. So while I do not really know what it feels like to be dead, I do understand what it means to be dead to a certain extent. In fact, the reason why I fear death is not because I fear what it will be like to be dead; I fear death because I enjoy things that are associated with life and I wish to continue to be able to enjoy these things for as long as I can. Hence, I think we do understand death enough to be able to compare it to being alive.

The conceptual argument is slightly trickier. It does seem plausible that death cannot be evaluated because it is a state of non-being, and conceptually one can not compare a state of non-being to a state of being. However, Prado points out that the argument is inconsistent because of the exception that it allows. The reason why the lack-of-contrast argument allows suicide in the case of unbearable agony is because death in this case is seen as the consequence of choosing not to endure something, not itself the objective.[156] Based on double-effect reasoning, the idea is that death in the case of unbearable agony is not the objective being evaluated because death is only a consequence of choosing to escape the unbearable suffering. That is, the point in a case like Sandra's is that one is not actually choosing to die; one is merely choosing to escape the pain and suffering and death is just a consequence of this choice. Therefore, the lack-of-contrast argument does not apply because death (the state of non-being) is not what is being evaluated. Prado argues, however, that the same can be said of preemptive suicide. In a case like Michael's, the double-effect reasoning can be used to justify his suicide (as an exception to the lack-of-contrast argument) in the same way as it can be used to justify Sandra's, even though

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[156] Prado, p. 47.

Michael has decided that he will take his own life before the agony becomes unbearable. This is because the objective for Michael is also not death itself. His objective is the prevention of his personal diminishment; death is just a consequence of this choice.[157] His death is the result of the fact that his goal is to retain his dignity, not because his goal is death itself. Therefore, if the lack-of-contrast argument is going to excuse suicide to escape from unbearable agony on the grounds that death is a consequence of some other objective, then the argument must excuse *any* suicide in which death is a consequence of some other objective.

An interesting question that could be raised in response to the lack-of-contrast argument is what exactly is to count as unbearable agony? Presumably, unbearable agony only includes those cases in which physical pain is so severe that the sufferer cannot stand to live with it anymore. But why should it only be limited to physical pain? Emotional or psychological suffering can be just as severe and unbearable as physical pain. For instance, someone who becomes permanently paralyzed from the neck down after an automobile accident may suffer in many ways other than physical pain. They may suffer from complete loss of dignity and feelings of inadequacy that may accompany total dependence on others. Might this not count as unbearable agony as well? Even someone suffering from depression is suffering greatly even though he or she is not suffering from physical pain. Assuming the depression does not interfere with that person's competency, it is at least arguable that his or her agony should be considered severe enough to excuse his or her suicide from the lack-of-contrast argument.

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[157] Prado, p. 47.

Finally, a popular rebuttal to my argument, which I have discussed in a slightly different form in chapter 2, is that suicide even in a case like Sandra's is not rational because nobody can ever be certain of what the future holds. Even if one's situation seems grim at the present time, one never knows what may happen in the future; therefore, it is irrational to do something as drastic as taking one's own life.[158] An example of this argument might be the miracle cure argument discussed in chapter 2. Even though someone like Sandra may be in the late stages of terminal cancer, a cure could be just around the corner. As I mentioned in chapter 2 this example of the argument is not convincing as it is completely unrealistic. However, the argument may hold more water for someone in Michael's case. While it is virtually impossible that someone in Sandra's position might be saved by a miracle cure, the odds are not as unfavorable for someone suffering from a long-term illness such as Huntington's disease (except for those who are in the late stages, beyond the threshold at which a cure would reverse the disease). Hence, it could be argued that someone like Michael is not justified in taking his own life because it is conceivable that a cure (or at least a more effective treatment) could be discovered several years in the future when he can still be helped. Since this new information would certainly alter Michael's evidence base and probability estimations, it would be more rational for him to wait just in case.

Unfortunately, this argument is not persuasive. One must remember that judgments of rationality must be made from the agent's subjective epistemic viewpoint. One's evidence base only includes evidence that actually exists, not hypothetical evidence that may exist years in the future. As mentioned above in this chapter, it does not make sense to say that

[158] Richard B. Brandt, "The Rationality of Suicide," in Battin and Mayo (1980), p. 122.

one should postpone making decisions until one has obtained all the possible relevant information. When one must make a decision, one can only take into account one's evidence base at the time. While it is true that a cure for Huntington's disease may be found several years in the future, there is currently no cure and so it makes no sense to say that the rationality of Michael's decision should be affected by information that does not yet exist. This may be true, one might respond, but all evidence about the future is not purely hypothetical. While we may not have existing evidence about the development of a cure for diseases like Huntington's or cancer, we do have existing evidence about the development of past cures for other diseases; cures which were at one time thought to be merely hypothetical. Therefore, the evidence we have about future cures is not mere hypothesis, but existing evidence about what might hypothetically occur in the future.[159] However, this objection does not work because every disease is different, and exists within a different context. While we may know, from past experience with other diseases, that unknown and hypothetical diseases sometimes become reality, this is all our past experience tells us. But this is no different from hypothesis: a cure was once found for past disease A, so a cure could be found for present disease B. Thanks to our existing evidence about past cures, and our existing evidence about the progress of medicine, we do know that it is likely that one day cures will be found for Huntington's disease, HIV, most forms of cancer, and so on. Yet this still does not give us any concrete existing evidence about probabilities and time periods. If we could use our existing evidence about past cures to calculate approximately when and how likely it is that a cure will be found for certain present diseases, then this would certainly count as valuable existing evidence.

[159] Professor Wil Waluchow, personal communication.

Unfortunately, this type of evidence is impossible and so we are stuck with mere speculation about future cures, which is not especially valuable for people who want to make decisions now.

Moreover, the argument also circles back on itself. What it claims is that it is wrong to make a decision regarding one's future if one is not certain of what the future holds. In other words, one should only make decisions based on certainties. But if we were to accept this reasoning, then it would seem to *justify* suicide in cases like Michael's, for instance, because what he is certain of is that he has a disease that will soon begin to destroy his mind. It is only a *possibility* that an effective treatment or cure will be found. Therefore, if one ought only to make decisions based on certainties, then suicide is definitely the right decision for someone like Michael. The point is that it is ridiculous to say that decisions should only be based on certainties; we must always make decisions based largely on probabilities.[160]

This chapter brings to a close my defense of suicide. What I had set out to do in the first two chapters is to show that universal arguments against suicide are not convincing. If suicide is not always morally wrong, then this leaves open the possibility that suicide may sometimes be morally justified. I devoted this third chapter to demonstrating that suicide is morally permissible in those cases in which the agent is competent and the act of suicide does not violate overriding obligations that would not otherwise have been violated. Moreover, a suicide is fully permissible if it is morally permissible as well as a rational act for the person in question. However, the main purpose of my thesis is to defend assisted suicide. Since I aim to show that there is no moral difference between

[160] Brandt, in Battin and Mayo (1980), p. 122.

suicide and assisted suicide, assisted suicide should be permissible in those same cases in which suicide is permissible. My aim in the next and final chapter will be to make these arguments.

Chapter 4
From Suicide to Assisted Suicide

My goal in this final chapter will be to demonstrate that there is no moral difference between suicide and assisted suicide. This is not to say that there is no difference between the two, only that the difference is not morally significant. That is, whatever differences there are between suicide and assisted suicide are not significant enough in themselves to make suicide permissible in some situations and assisted suicide impermissible in the same situations. Hence, what I will attempt to show is that in most cases, once it is accepted that suicide in some situations is permissible, assisted suicide in those same situations should also be permissible. The reason why I say "in most cases" is because I think there is a particular case in which a suicide might be permissible while assisting the suicide would not be permissible, and this case will be spelled out at the end of the chapter. But it is my contention that in most cases, assuming it is permissible for a certain person to take his or her own life, it ought also to be permissible for that person to get assistance in his or her suicide.

First, what exactly is assisted suicide? A simple and accurate definition of assisted suicide is "the provision of advice or the means for a patient to commit suicide."[161] The important aspect of assisted suicide, as the terminology suggests, is that it involves two acts: the suicide and the assistance. This is to be distinguished from active euthanasia in which a physician performs an act that directly brings about the death of another person

[161] Douglas M. Sawyer, John R. Williams, and Frederick Lowry, "Canadian Physicians and Euthanasia: 2. Definitions and Distinctions," Canadian Medical Association Journal, 148 (9), 1993, p. 1464).

(e.g. a lethal injection). It is also to be distinguished, at least conceptually, from passive euthanasia in which a physician either withholds or withdraws treatment and lets a patient die.[162] The most well-known example of assisted suicide is Dr. Jack Kevorkian and his 'suicide machine'. However, suicide assistance can occur in many different forms representing the different degrees of involvement for the person assisting. For example, someone may assist a suicide by

> supplying information (e.g., from the Hemlock Society) on the most effective ways of committing suicide, purchasing a weapon of self-destruction, providing a lethal dose of pills or poison, giving the suicidal person encouragement to carry out the lethal deed, or helping in the actual act of killing (e.g., by helping the person take the pills, pull the trigger of a gun, close the garage doors, or turn on the gas).[163]

Jack Kevorkian's suicide machine would fall into the latter of the above categories, and would represent the highest level of involvement for a person assisting a suicide. However, the most common forms of assisted suicide probably fall within the middle range: physicians providing patients with a prescription or supply of medication and instructions on what dosage would result in death. The important thing, however, as we shall see below, is that regardless of the level of involvement for the person assisting, the final act that results in death is still the patient's (or person's who is taking his or her own life).

Initially the argument may not seem to be too problematic. If it is permissible for a person to kill him or herself, how can it not be permissible for him or her to get help? After all, it is still a suicide. It should not matter whether I need someone else to buy me a gun, or provide me with medication, because in the end I still take my own life. This

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[162] For the purpose of this thesis I am ignoring here the arguments that some authors make in favor of a further distinction between cases of withholding treatment and cases of withdrawing treatment.

[163] Robert F. Weir, "The Morality of Physician-Assisted Suicide," Law, Medicine and Health Care, 20 (1-2), 192, p. 117.

seemingly obvious line of reasoning has led James Rachels to make the following claim, which he considers to be a general principle of moral reasoning:

> If it is permissible for a person (or if a person has the right) to do a certain action, or bring about a certain situation, then it is permissible for that person (he or she has the right) to enlist the freely given aid of someone else in doing the act or bringing about the situation, provided that this does not violate the rights of any third parties.[164]

Unfortunately, this is far too simplistic an analysis of the assisted suicide dilemma. The basis for arguments in favor of the permissibility of suicide is autonomy, or self-determination: the right of people to make their own choices and determine the courses of their own lives, as long as they do not infringe on the rights of others. Authors like Rachels carry this reasoning over into the assisted suicide debate. If suicide is justified on the basis of a right to self-determination, and if assisted suicide is still a suicide (with the help of another), then assisted suicide should also be justified on the basis of a right to self-determination. However, what authors like Rachels must realize is that assisted suicide can not be analyzed solely from the point of view of the person desiring suicide because there is another person and, hence, another act involved. Assisted suicide is not just suicide; it is the act of suicide *and* the act of the assistance. As Callahan describes,

> the self-determination in that case [assisted suicide] can only be effected by the moral and physical assistance of another. Assisted suicide is thereby no longer a matter only of self-determination but of a mutual, social decision between two people, the one to commit suicide and the other to technically facilitate it.[165]

Therefore, a proper analysis of the assisted suicide dilemma will include an analysis of both the act of the suicide as well as the act of the assistance. So even if it were obvious that assisted suicide is permissible from the point of view of the person desiring suicide,

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[164] Rachels, p. 86.

[165] Daniel Callahan, "Self Extinction," in Physician-Assisted Suicide, ed. Robert F. Weir (Bloomington: Indiana University Press, 1997), p. 74.

assisted suicide may nonetheless be impermissible if the act of assisting a suicide is not permissible. The challenge, then, is to determine the permissibility of assisting a suicide rather than the permissibility of taking one's own life with the help of another. So the question is: what is it about assisting a suicide that would turn a permissible suicide into an impermissible assisted suicide? Or, more simply, what is wrong with helping someone kill him or herself?

4.1 Assisted suicide involves one person killing another

Although it is not common for opponents of assisted suicide to make this strong a claim, some of them do insist that the person who assists a suicide is actually killing the suicide. The idea is that person A does something that eventually leads to the death of person B, and so person A has, in effect, killed person B. Supporters of this view maintain that there is absolutely no moral difference between assisted suicide and active euthanasia. For instance, the physician who supplies his patient with medication, which the patient takes in the proper dosage and dies, has performed the same moral act as the physician who injects his patient with a deadly drug. Dan Brock makes the argument in a less extreme form when he claims that in assisted suicide "the physician and patient act together to kill the patient."[166] Brock's justification is the following analogy: suppose a physician provides a patient with a deadly dose of medication with both the knowledge and intent that the patient will use it to kill a third party. We would have no problem, Brock argues, in finding the physician equally responsible for the murder of the third party.[167] The problem with this analogy is twofold. First, the analogy fails from a legal standpoint.

[166] Dan W. Brock, "Physician-Assisted Suicide is Sometimes Morally Permissible," in Weir (1997), p. 87.

[167] Brock, in Weir (1997), p. 87.

In Brock's example, the physician is supplying the patient with a drug knowing and intending the patient to use it to perform an illegal act (the killing of the third party). However, in Canada at least, suicide is no longer illegal and so the physician is not legally responsible for working with the patient to perform an illegal act. The physician would only be considered legally responsible for his own act (the supplying of the medication) because it is his own act that is illegal.[168] Second, the analogy fails on a moral level. In Brock's example, the physician is contributing to the patient's performance of an act that is morally wrong (the killing of a third party). But in the assisted suicide case, the use of the medication (the suicide) is assumed to be morally permissible. The point is that if assisted suicide is morally wrong, it must not depend for its moral wrongness on the fact that it is viewed as a contribution to a morally wrong act; there must be some cases in which it is morally wrong because the act of the assistance itself is morally wrong.

Nevertheless, it is simply incorrect to characterize assisting a suicide as one person killing another. Regardless of what form of assistance is offered, the fact is that assisted suicide still ends with a suicide: someone killing him or herself. This is especially evident in the cases toward the lower end of the involvement spectrum. If a patient visits her doctor requesting suicide assistance, and the doctor responds only by providing the patient with a pamphlet from the Hemlock Society, there is no sense in which we could say that the doctor killed the patient (assuming the patient did end up taking her own life); but technically it is an example of assisted suicide.

[168] This immediately raises a very interesting legal question. If suicide is not illegal, then why would it be illegal for the physician to contribute to the suicide? It seems odd that it is illegal to assist a person in performing an act that is perfectly legal. Presumably the answer is the same as is commonly offered to the moral question: that the person assisting is seen as somehow killing or at least causing the death of the suicide.

To characterize the above example as killing would be what Joel Feinberg would call a mistaken translation of causal ascriptions to human agency into ascriptions of causal agency. Translations of this sort work, for example, when someone does something that directly results in certain consequences. To use Feinberg's example, if Peter opens a door, startling Paul who was inside, and Paul has a heart attack and dies, we could either say "that Peter's opening the door caused his [Paul's] death, or that Peter's startling him caused his death, or simply that Peter killed him (by doing those things)."[169] In other words, we could translate the causal ascription to human agency (i.e. Peter did something that caused Paul's death) into an ascription of causal agency (i.e. Peter killed Paul). However, one of the exceptions to the translation rule is in the case of interpersonal causation, in which one person causes another person to act. In cases of interpersonal causation, the translation fails. Again to use Feinberg's example, if Dr. Ortho makes certain comments about the musculature of the forearm causing Humphrey to thoughtfully wiggle his finger, we could say that Dr. Ortho's comments caused Humphrey to move his finger (a causal ascription to human agency). But it would be incorrect to say that Dr. Ortho moved Humphrey's finger (a causal ascription).[170] The point of this digression is that assisted suicide is an example of interpersonal causation; even if we could say that the person assisting caused the other person to kill him or herself (which I will discuss below), it would be incorrect to make the translation and say that the person assisting killed the other person. Therefore, if there is something morally wrong with assisting a suicide, it cannot be that assisting a suicide is a case of one person killing another.

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[169] Joel Feinberg, "Action and Responsibility," in Joel Feinberg, Doing and Deserving: Essays in the Theory of Responsibility (New Jersey: Princeton University Press, 1970), p. 134.

[170] Feinberg, p. 135.

4.2 Assisted suicide involves one person causing the death of another

The argument that assisted suicide is morally impermissible because it involves one person causing the death of another is slightly weaker and much more common than the above 'killing argument'. So maybe the person assisting does not kill the other person, the argument goes, but he or she certainly causes the death of the other person. And it is certainly morally wrong to cause someone's death even if one does not technically kill that person. Supporters of this view admit that the person who kills him or herself is in fact the immediate, or proximate cause of his or her own death, but maintain that the person assisting is a major part of the causal sequence and, therefore, responsible for the death. As Daniel Callahan explains,

> A physician who provides a patient with a deadly drug and instructions about its use to bring about death bears as much responsibility for the death as the patient himself. The doctor is knowingly a part, and a necessary part, of the causal chain leading to the death of the patient.[171]

In the case of assisted suicide, is it accurate to say that the person assisting causes the death of the person who takes his or her own life? I think not, for similar reasons that it is not accurate to call the event killing. To see why, a brief discussion of causation is needed.

In Feinberg's discussion of causal ascriptions above we saw that the addition of a second autonomous agent interferes with the substitutivity of ascriptions of causal agency for causal ascriptions to human agency. Similarly, an action by an autonomous agent seems to break, or at least interrupt, the causal chain from event to consequence. This is because, on a very basic level, causation is commonly understood to involve a kind of direct and necessary connection between an event and the consequence. That is, if event A is the cause of consequence B then B will occur whenever A occurs. Of course the

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[171] D. Callahan, in Weir (1997), p. 71.

necessary connection is only one-way: from event to consequence, not vice-versa. A more accurate way to describe a cause is a condition that is sufficient for a consequence to occur. Or, as Feinberg defines 'cause', "a condition which, when conjoined with circumstances normally present, is *sufficient* to bring about events of the type in question."[172] For example, in active euthanasia the physician causes the death of the patient because an injection of a deadly dose of medication is sufficient, when added to the circumstances normally present, to bring about the death of the patient.

Does the above example describe the situation in assisted suicide? Does the person assisting the suicide cause the other person's death? No, because the introduction of an action by a second autonomous agent (the person who kills him or herself) breaks the necessary progression from event to consequence; the event (the assistance) is no longer sufficient to bring about the death of the other person. The reason is that the decision of the person to take the pill (or use the gun, or whatever) always intervenes between the action of the assistance and the person's death.[173] The assistance is not sufficient to produce death simply because the decision to perform the final act, the act that actually causes the death, still lies with the person who kills him or herself.

One might respond that the reasoning above depends on the level of involvement of the person assisting. In a situation of high involvement, such as Kevorkian's suicide machine, the person assisting may go so far as to hook up the patient to an IV so that all the patient has to do is push a button or turn a key. This seems to take the decision largely away from the patient: the assistance has been taken so far that the only choice the patient

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[172] Joel Feinberg, "Causing Voluntary Actions," in Feinberg (1970), p. 177.

[173] R. G. Frey, "Distinctions in Death," in Gerald Dworkin, R. G. Frey, and Sissela Bok, Euthanasia and Physician-Assisted Suicide (Cambridge: Cambridge University Press, 1998), p. 25.

really has is to carry out the final act. However, while it is true that a higher level of involvement on the part of the person assisting probably increases the chances of the final act being performed, the assistance is still not sufficient to bring about the death. The person still does have to make the decision to push the button, turn the key, pull the trigger, and so on.[174] There is still an interruption between the assistance and the death. What about coercion? What about cases in which a person is persuaded to carry out the final act so that the choice is not really theirs? This is why the action performed by the second agent (the suicide) must be *autonomous* in order to break the causal chain. A nonautonomous action would not break the causal chain because there would be, in effect, no decision made by the second agent. If the person is coerced (either overtly or covertly) into taking his or her life (with the assistance) then the assistance is sufficient to bring about death because there is no decision that would intervene between the two events. Therefore, if a person offers assistance and this assistance includes coercion so that the final act is not autonomous, then the person assisting has caused the death of the suicide. But in cases of assisted suicide which do not involve coercion, the person assisting does not cause the suicide's death.

In addition to what I have already discussed, there is one significant objection to both the causation argument above and the killing argument in 4.1. The objection is that both of the above arguments, even if they were to be true, ignore the fact that it is not necessarily morally wrong to kill or cause (or even be responsible for) the death of another human being. There are commonly accepted exceptions to the principle that it is morally wrong to

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[174] The issue of control will be discussed in more detail below, when I discuss the slippery slope objections to assisted suicide.

kill or cause the death of another person: self-defense, war, and capital punishment, for example. There is no disagreement over the fact that in the case of self-defense, for instance, one person kills another. It is just that it is accepted that self-defense is a case of justified killing. Even more importantly, over the last several decades we have seen the emergence of exceptions to the principle in the context of medicine. One example is what is referred to as 'terminal sedation', a practice that is generally accepted in the context of palliative care. Not only is terminal sedation accepted in the medical profession but it was also endorsed by the U.S. Supreme Court in 1997 as an alternative to assisted suicide. The practice of terminal sedation involves the patient being "sedated to the point of unconsciousness when necessary to relieve his pain, and then treatments, including nutrition and hydration, are withheld causing the patient's death."[175] Although terminal sedation is usually reserved for patients literally in the last days of a terminal illness, it is still a case of a physician performing an act that brings about death earlier than would have been if the physician did nothing. In effect, the physician knocks the patient out and then starves him to death. How is this not a case of a physician killing or causing the death of a patient? In fact, some authors have even referred to the practice of terminal sedation as 'slow euthanasia', indicating that the only difference between terminal sedation and active euthanasia is that the process of dying is slower. Nevertheless, terminal sedation is an accepted and morally permissible form of killing or causing death.

Perhaps an even better example is the practice that might be called 'overmedicating'. In this practice, which is also morally and legally permissible in the medical profession, physicians treat their patients' pain with such high dosages of medication (usually

[175] Dan W. Brock, "A Critique of Three Objections to Physician-Assisted Suicide," Ethics, 109, April 1999, p. 522.

morphine) that death is likely to ensue. "Sometimes, the dosages of pain medications necessary to relieve adequately a patient's pain...must be raised to levels increasingly likely to cause respiratory depression resulting in the patient's death."[176] There is no doubt that physicians administer the dangerously high dosages of medication deliberately, nor is there any doubt that they are aware that it is likely to cause the patient's death. Yet, once again, this is an example of killing or causing death in the medical profession that is both legally and morally permissible. The question then is, if terminal sedation and overmedicating are morally permissible cases of killing or causing death (i.e. exceptions to the principle that it is morally wrong to kill or cause another's death), then why not assisted suicide? There must be some other reason, besides the killing or causing death arguments, for why assisted suicide ought to be morally impermissible. What is the difference between terminal sedation or overmedication and assisted suicide?

4.3 Assisted suicide involves one person intending the death of another

Some opponents of assisted suicide argue that the important difference between cases of morally permissible killing or causing death (e.g. terminal sedation or overmedication) and assisted suicide is the role of intent. Basing their argument on the principle of double effect, they maintain that assisted suicide violates the most important tenet of the principle: that in order for an action with both good and bad consequences to be morally permissible, the intent of the actor must be to achieve the good consequence and not the bad. Assisted suicide violates this condition because the intent in cases of assisted suicide is always the bad consequence (death of the person), not the good consequence (e.g. relief from suffering). However, in the cases of terminal sedation and overmedication the intent is the

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[176] Brock (1999), pp. 533-534.

good consequence (relief from suffering) and not the bad consequence (death). The intent of physicians is to relieve the patient of his or her suffering and the death of the patient is just a foreseen but unintended side effect.[177] Since it is morally impermissible to intend someone else's death, assisted suicide is morally impermissible; but terminal sedation and overmedication are excused. Is this argument successful at establishing the moral impermissibility of assisted suicide? I think not, for two reasons: first, it is not true that the intention in assisted suicide is always the person's death; and second, it is also not true that the intention in cases of terminal sedation and overmedication is never the person's death.

Consider first the role of intent in assisted suicide. Is it necessarily the case that everybody who assists (or who would assist) is intending the death of the other person? I think this is a huge assumption to make. First, as Brock points out, intentions are very complex; often people will have multiple intentions when performing a certain action.[178] With regard to assisted suicide, I think it is simply a mistake to assume that the death of the person is the only intention that the person assisting could possibly have. For instance, someone who provides medication or buys a gun for a person at her request may carry out the act of assistance with the intention of providing the person in question with the comfort of knowing that she has the means to take her own life *if* she ever wanted to.[179] If the person assisting hopes or truly believes that the potential suicide will *not* carry out the final act, he or she may assist without the intent for the person to die. To make an analogy, teenagers often ask permission from their parents to do things that they may have no

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[177] Brock (1999), p. 534.

[178] Brock (1999), p. 533.

[179] Judith Jarvis Thomson, "Physician-Assisted Suicide: Two Arguments," Ethics, 109, April 1999, p. 505.

intention of actually doing (e.g. to take a very dangerous trip), for the purpose of testing their autonomy or independence. Hence, parents may respond by giving their child permission with the intention merely of relieving the child's anxiety about his or her independence (all the while hoping that the child does not actually take the trip).[180] Therefore, the situation in assisted suicide may not violate the important tenet of the principle of double effect. The intent in assisted suicide may be to relieve the person's anxiety, or to give the person a feeling of control over death, and the actual death may just be a foreseen but unintended consequence.

Consider next the role of intent in situations of terminal sedation and overmedication. Is it likely that physicians in these situations *never* intend the deaths of their patients? Again, I think not. The argument is that in cases of terminal sedation and overmedication the intent of the physician is only to relieve the patient of his or her suffering; physicians know that death may, and will likely ensue, but death is not the goal. This is evident in cases of overmedication, the argument continues, because the pain medication is only administered in a dosage high enough to relieve the pain; it just so happens that in many cases the dosage will also cause death. If the intent really was death, the physicians would just continue increasing the dosage even after pain was relieved to ensure that death occurred. Since they do not do this, it is clear that death is not the intent.[181] This argument fails, however, because it *assumes* that the reason the physician does not continue to increase the dosage is because death is not the intent. As Brock argues, it is more likely that physicians do not increase the dosages of pain medication because hospital policy and

[180] Brock (1999), p. 536.

[181] Brock (1999), p. 534.

the law forbid it. To continue to increase the dosage to the point at which death is certain would constitute active euthanasia; to only administer enough to relieve pain, even if death is likely, is considered acceptable. So the intent may in fact be the death of the patient in cases of overmedication, but physicians only administer medication up to a certain dosage for fear of criminal and civil sanctions.[182] Of course this is also an assumption; but it is just as plausible, if not more plausible, than the assumption that physicians never intend the deaths of their patients in cases of overmedication.

It also seems implausible that physicians who practice terminal sedation never intend the deaths of their patients. As mentioned above, the situation is tantamount to knocking the patient unconscious and then starving him or her (and/or removing other life-sustaining treatments) to death. In the case of terminal sedation, the sedation is not to the same extent that it is in the case of overmedication -- that is, not to the point at which the medication is likely to cause respiratory depression. In the case of terminal sedation the goal of the sedation is simply to knock the patient unconscious so that he or she will no longer experience pain. Up to this point, the argument is at least stronger than the overmedication case that the intent is not to cause death, but to relieve the patient's suffering. However, there is more involved in terminal sedation. Once the patient is rendered unconscious, life-sustaining treatments (including nutrition and hydration) are withdrawn and the patient is allowed to die. If the intent is not the patient's death, then why withdraw life-sustaining treatment, as well as nutrition and hydration? There would seem to be no point to this action unless the intent is to hasten the patient's death.[183]

[182] Brock (1999), p. 534.

[183] Brock (1999), p. 535.

It appears likely that in at least some cases of terminal sedation and overmedication, the intent of the physician may be the death of the patient (even if relief of suffering is also intended). I think that the use of double effect reasoning simply allows physicians to hide their death intentions behind the altruistic intentions of relief of pain and suffering. In fact, in a study cited by Brock, in which physicians who practiced terminal sedation were asked about the nature of their intentions, 39 percent responded that the death of the patient was one of their intentions in practicing terminal sedation.[184] However, Judith Jarvis Thomson asks a very interesting question: is the intention of the physician in such cases really relevant to the moral permissibility of assisted death?[185] Consider a case of active euthanasia, for example. A patient is dying of a terminal illness and wishes to die. He asks his physician to inject him with something to put him out of his misery. All other things being equal, the intent of the physician should be irrelevant. If the only physician available would inject the medication with the intent of causing death, rather than just to relieve the patient's pain, then according to the above argument the injection would be morally impermissible and the patient would have to continue to suffer. "That cannot be right," Thomson concludes.[186] In the context of assisted death (in which the person must consent to the death), what should matter are such things as the wishes of the patient (or person wishing to die), the competency of the patient, the dynamic of the relationship between the patient and the person assisting, the status of the act itself (i.e. whether it is killing, and if so whether it is justified or not), and so on. The intent of the person assisting

[184] Brock (1999), p. 533.

[185] Here I am using the term 'assisted death' to refer to all acts in which someone requests help in dying (i.e. assisted suicide, active/passive euthanasia, terminal sedation, and overmedication).

[186] Thomson, pp. 515-516.

ought not to impact the moral permissibility of the act. This does not mean, however, that intent has no impact on the moral *situation*, only that intent should not affect the status of the *act*. What Thomson is claiming here is that the intent of the agent only affects the moral evaluation of the agent him or herself. Suppose the physician performs voluntary active euthanasia on a patient with malicious intent. The intent of the physician only reveals something morally bad about him or her but does not affect whether the act of voluntary euthanasia is permissible or not.[187] There is more to be said about the role of physician intent but since it will lead me into one of the medical practice objections to assisted suicide I will come back to it at a later point in this chapter.

Thomson raises another interesting objection specifically against the use of the principle of double effect on which the intention argument is based. The principle of double effect is used in situations in which an act will have both good and bad consequences. The idea is that a solution to a moral dilemma is more straightforward in cases in which a proposed action will have only good consequences. But what should one do in cases in which an action will produce both good and bad consequences? The application of this principle to cases of assisted death classifies the good consequence as the relief of pain or suffering and the bad consequence as the death of the person. However, the classification of death as the bad consequence itself can be challenged.[188] The entire basis for the rational suicide argument is that sometimes, for some people, in some circumstances, death might not be such a bad thing. For someone in the late stages of a terminal illness, who endures constant pain and suffering, including a complete loss of

[187] Thomson, p. 516.

[188] Thomson, p. 511.

dignity and control, death may actually be better than the alternative. If it is not the case that death is always a bad consequence, then the principle of double effect can not be applied in order to justify terminal sedation or overmedication while condemning assisted suicide.

There are two more objections that are commonly raised against assisted suicide, both having more to do with the question of whether assisted suicide should be legalized as opposed to the question of the moral permissibility of assisted suicide. The first is the argument against *physician*-assisted suicide (PAS) specifically that a policy or legal acceptance of physician-assisted suicide would be potentially harmful to the physician-patient relationship. The other argument is the slippery slope argument, which claims that a policy or legal acceptance of assisted suicide would likely set us on a slide towards involuntary active euthanasia. Even though the above two arguments are arguments against the legalization (or decriminalization) of assisted suicide rather than the moral permissibility of assisted suicide, a proper defense of the practice of assisted suicide would be incomplete without at least an attempt to deal with these objections. Therefore, the final section of my thesis will be devoted to refuting the above two final objections to assisted suicide.

4.4 Physician-assisted suicide is potentially harmful to the physician-patient relationship

In both the killing and causing death arguments above I raised the objection that both arguments are unpersuasive because it is not necessarily morally wrong to kill someone or cause someone's death, even in the context of medicine. The same objection can be raised in response to the intention argument. That is, the moral impermissibility of intending

someone else's death can be questioned. "Why must a doctor not intend the death of his patient? Why can the doctor not intend to relieve his patient's pain and suffering through having the patient use the means in question to kill himself?"[189] It is a similar line of questioning that leads some authors to make the physician-patient relationship objection to assisted suicide. The objection is that allowing physicians to intend the deaths of their patients, as in assisted suicide, would damage the physician-patient relationship. This would occur, for instance, because the trust patients have in their physicians would be destroyed.

The above argument stems from traditional views of medical practice. Authors who make the argument often appeal to the Hippocratic Oath, claiming that the goal of the practice of medicine, and of the individual physician, is to promote and preserve the patient's health. The primary job of the physician is to do whatever is in his or her power to preserve and restore the health of the patient, no matter what effect the efforts actually have on the patient. Leon Kass is one who defends the traditional view: "The central meaning of physicianship derives not from medicine's powers but from its goal, not from its means but from its end: to benefit the sick by the activity of healing."[190] Not only is the job of the physician simply to heal the patient, so the argument goes, but patients *know* this is the job of the physician and *want* it that way. Thus, when a patient with a medical problem visits a physician, the patient trusts that the physician will do everything in his or her power to fix the problem and restore the patient's health.* Allowing physicians to partake in assisted suicide introduces death as an option into the physician's treatment

[189] Frey, in Dworkin, Frey, and Bok (1998), pp. 21-22.

[190] Leon R. Kass, "Why Doctors must not Kill," in Last Rights? Assisted Suicide and Euthanasia Debated, ed. Michael M. Uhlmann (Washington: Ethics and Public Policy Center, 1998), p. 301.

arsenal, which will result in patients not being able to trust their physicians to do their jobs.[191]

> The patient trusts the physician to do what is in the patient's best interests as it is indicated by the diagnosis, prognosis, and therapeutic possibilities. When patients know that euthanasia is a legitimate choice and that some physicians may see killing as healing, they know they are vulnerable to violations of trust.[192]

It will be useful here to continue the line of argument I originally presented in section 4.3 about the intention of physicians. Recall that Thomson's argument was that the intent of the agent only has an impact on how we judge the agent as a person and does not impact the moral status of the act itself. Thus, voluntary active euthanasia, for example, will be morally permissible or impermissible regardless of the intent of the physicians performing the act. The most that could be said is that the physician with malicious intent is a bad person, a morally bad physician, is performing a good act for bad reasons, and so on. There is, however, one way for the intent to affect the moral status of the act: if the intent of the agent may alter the outcome of the act. In a footnote Thomson quotes Rehnquist, who uses a military example to support the argument.[193] Suppose, Rehnquist says, we are present when Eisenhower orders the D-Day invasion at Omaha Beach. Upon giving the order, Eisenhower whispers to us that his intentions behind the invasion are really just to cause the deaths of a lot of American soldiers. If we believe Eisenhower, we should call Roosevelt and have the orders canceled. The reason is that based on Eisenhower's

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[191] Their jobs being the primary task of doing everything possible to preserve and restore the health of the patient.

[192] Edmund D. Pellegrino, "Distortions of the Healing Relationship," in Ethical Issues in Death and Dying, 2d ed., ed. Tom L. Beauchamp and Robert M. Veatch (New Jersey: Prentice-Hall, Inc., 1996), p. 163. Although Pellegrino is making the argument here with reference to euthanasia, the arguments can equally be interpreted (as many authors do interpret them) to make reference to physician-assisted suicide as well.

[193] Thomson, p. 516, footnote 19.

intentions, we would understandably be concerned about the outcome of the invasion. Eisenhower may not have put serious effort into the planning of the invasion, and so it is likely that there would be far more deaths than are needed to liberate Europe. Therefore, if the intention of the agent will affect the outcome of the act, then the intention *does* affect the moral status of the act as well as our judgment of the agent. However, if our concerns could be proved groundless, if we could be sure that the invasion will proceed exactly as it would if Eisenhower did not have the intention he had, then there would be no reason to cancel the invasion order. We may call him an evil general, or a morally reprehensible general, but if his intention will not affect the outcome of the invasion, then his intention should not bear on whether the invasion should be carried out or not.

The point of the above discussion is to raise in another way the argument that PAS will damage the physician-patient relationship. If we change Rehnquist's example to a physician engaging in PAS instead of Eisenhower and the D-Day invasion, we can see that the exception acknowledged by Thomson and Rehnquist can prove to be a powerful objection to PAS. The exception is that the intention of the agent will affect the moral status of the act only if it is likely that the intention will alter the outcome of the act. Here is where PAS opponents can step in and raise the following objection. Since the intent of the agent can affect the moral status of the act if the agent's intent is likely to alter the outcome of the act, then it can be assumed that an act can be judged morally wrong if the intent of the agent will alter the outcome of the act more negatively than if the agent had a different intent. Hence, all that is needed to demonstrate the moral impermissibility of PAS is to show that it is likely that a physician with a malicious intent will alter the

outcome of PAS more negatively than would otherwise occur.[194] First, opponents of PAS may argue, it is more than likely that some physicians will engage in PAS with malicious, or at least selfish, intentions. Some may argue that Kevorkian, for instance, engaged in PAS not for altruistic reasons but to further his own end of becoming a political champion of the right to die crusade. Second, it is more than likely that the malicious intentions of the physicians will negatively alter the outcome of PAS. For instance, physicians with bad intentions will be untrustworthy and may be more likely, say, to step over the line and involuntarily euthanize patients or coerce patients into assisted suicide. Since it is impossible for any of us to know what our physicians' intentions are, and since it is also impossible to determine whether our physicians' intentions will have an impact on his or her behavior, it will become extremely difficult for any of us to be able to trust our physicians when we seek help for a serious medical problem. Therefore, it is better to be safe and not legalize PAS.

The above argument seems to be a powerful objection to PAS but does the reasoning hold? Is it likely that the legal acceptance of PAS would damage the physician-patient relationship as is described in the argument? The answer to these questions will depend on two things: first, the truth of the assumption that it is never in a patient's best interests for a physician to be legally permitted to engage in PAS; and second, the model on which the physician-patient relationship ought to be based. On a general note, I think there is little reason to believe that a general mistrust in physicians would result if physicians were

[194] There seems to be a problem here because if a physician engages in a PAS, the patient will end up dead regardless of how malicious are the intentions of the physician. One could argue that the intentions may alter the outcome more negatively, say, if the physician deliberately prescribed a lower dosage of medication with the intent of seeing the patient linger and suffer longer. However, I think it would be more advantageous to alter the exception to read: "the intent of the physician affects the moral permissibility of PAS if the intent will alter the outcome of the act *or similar future acts* more negatively than if the physician had other intentions."

legally permitted to engage in PAS. Although there may exist some physicians who possess hidden malicious intentions, or who might be over zealous to push PAS as an option because of political or personal reasons, the fact is that physicians are still professionals whose primary job is to try their best to restore patients' health. Just because physicians would be legally permitted to engage in PAS does not mean that there would be widespread occurrences of physicians as a group trying to push PAS as a treatment option (if it is correct to characterize it as a treatment option). This view is supported by studies that have shown that many physicians who have performed PAS reported being uncomfortable with, and even regretting, assisting a patient's death. Emanuel et al., for instance, found that twenty-five percent of physicians who engaged in PAS regretted their actions.[195] Twenty-five percent may not seem like a significant percentage but one must keep in mind that it is a percentage of physicians *who have performed PAS*; if the study included physicians who *have not* performed PAS, to reflect the opinions of physicians in general, the percentage would surely be substantially higher.

With reference to the first factor stated above, whether the assumption that it is never in a patient's best interests to have a physician who is legally permitted to engage in PAS is true, I would argue that the assumption is clearly wrong. In fact, I think that it would be difficult for many patients to trust their physicians to act in their best interests if is assumed that it is *always* in their best interests for the physician to take all measures possible to try to stave off death and restore the patient's health. The fact that there are such things as the legal right to have life-sustaining treatment withdrawn or withheld, living wills, and DNR

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[195] Ezekiel J. Emanuel, "What is the Great Benefit of Legalizing Euthanasia or Physician-Assisted Suicide?" Ethics, 109, April 1999, p. 636.

('Do Not Resuscitate') orders, is evidence enough that the above assumption is incorrect. While most of us would want the physician to do everything possible to save our lives and restore our health, many people do decide that they do not want extraordinary measures taken to try to save their lives.[196] This decision may take the form of a living will or DNR, or simply a patient telling his or her oncologist that he or she would rather die peacefully at home instead of being subjected to any more radiation or chemotherapy treatments. Even many of us who do want physicians to take every measure possible would probably be willing to draw a line at some point. So it is not necessarily the case that physicians are acting in patients' best interests when they do everything possible to restore health at any cost to the patient.

If the above claims are true, then one could also argue, as some authors have done, that the legalization of PAS might actually lead to a general *increase* in patient trust in physicians. One reason for a possible increase in trust is that patients will know that they will be able to approach their physicians with a request for death assistance *if* they should need it. What this means is that patients will be able to trust that their physicians will help them right to the end rather than desert them when they may need their physicians' help most.[197] If it is in a patient's best interest at some point in time to receive death assistance, the patient will not be able to trust his or her physician to act in his or her best interest if the physician is not permitted to help the patient in the way that he or she requires. As Brody puts it, "since some few patients will experience unbearable suffering and will

[196] I am ignoring here the debate over how 'extraordinary' ought to be defined in the context of treatment decisions.

[197] Margaret Pabst Battin, "Ethical Issues in Physician-Assisted Suicide," in Uhlmann (1998), p. 118.

autonomously request PAS, refusal to even consider the PAS option amounts to a form of patient abandonment."[198]

Another reason why there could be an increase in patient trust in physicians is that allowing physicians to engage in PAS will give patients one more important option when it comes to treatment decisions, thus giving patients more control over their own dying. This may be especially true in cases in which a patient does not have the option of withdrawing or withholding life-sustaining treatment, or when withdrawing or withholding treatment would result in a much worse death for the patient.[199] Patient control, or self-determination, has been a vitally important concept in medical ethics over the last two decades. Even if few patients actually use the new treatment option (PAS), the increase in patient control will at least be symbolic. When patients enter the hospital, or visit a physician, with a serious medical problem, they will know that they have a whole range of treatment options to choose from, including the option to request help in dying. It may indeed be true that some (or even many) people will have a more difficult time trusting their physicians out of a fear that their physicians may have hidden malicious intentions, or may be "trigger happy" in entertaining the PAS option. However, I think it is also likely that this decrease in trust might be offset by the fact that many other people will have an easier time trusting their physicians out of the alleviation of the fear that they will be mercilessly kept alive on machines, forced to die a slow and painful death, or that they will become guinea pigs for their physicians to experiment with every treatment possible.

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[198] Brody, in Weir (1997), p. 137.

[199] Brock, in Weir (1997), p. 101.

The above discussion leads nicely into my discussion of the second factor, the model on which the physician-patient relationship ought to be based. Whether or not one accepts the arguments made above will certainly depend on what model one believes ought to represent the physician-patient relationship. Is the physician an 'employee' or tool of the patient whose job is to carry out the wishes of the patient, no matter what those wishes are? Should we view the physician as an expert whose job should include making important medical decisions for the patient? Is the job of the physician only to heal the patient or might it include other duties as well? How should we view the relationship between physician and patient? I will briefly discuss the four main models of the physician-patient relationship as described by Emanuel and Emanuel: the paternalistic model, the informative model, the interpretive model, and the deliberative model.[200] I will defend the deliberative model as the model that best characterizes the ideal physician-patient relationship.

Historically, the preferred model of the physician-patient relationship was the paternalistic model. The paternalistic model is based on the 'doctor knows best' idea, the view that since the physicians are the experts and the patients are ignorant when it comes to knowledge about medicine, the physicians should have total decision-making control. On the paternalistic model, patients are to have little or no input into the decisions that are made about their own illnesses and treatments. What is important are the medical facts – the diagnosis, prognosis, survival rates, and so on – and based on these facts the physician makes the decision as to how to proceed. The assumption behind this model is that the

[200] Ezekiel Emanuel and Linda Emanuel, "Four Models of the Physician-Patient Relationship," in Health Care Ethics in Canada, ed. Francoise Baylis et al. (Toronto: Harcourt Brace and Company Canada, Ltd., 1995).

physician can make the decisions because he or she knows what is in the patient's best interest.

Although it is still defended mainly by traditional physicians, there are several problems with the paternalistic model, which make it largely inadequate as a model for the physician-patient relationship. One problem is that the paternalistic model assumes that the medical facts are all that are important to making medical decisions and leaves absolutely no room for the patient's personal values. For instance, a single woman diagnosed with breast cancer may choose radiation and chemotherapy (the treatment with a lower success rate) over a mastectomy (the treatment with a higher success rate) because of her fear of being unable to attract a partner when she only has one breast. Another problem is that the paternalistic model assumes that the physician always knows what is in the patient's best interest or, to put it another way, the model assumes that the physician and patient share the same ideas as to what is in the patient's best interest.[201] This assumption is mistaken since, for example, a patient may decide that death is in her best interest while the physician may assume (understandably) that it is in the patient's best interest to try to stay alive as long as possible. Most importantly, however, on the paternalistic model the control over medical decisions lies entirely with the physician; there is no such thing as patient autonomy or self-determination, concepts which have become extremely important in medical ethics over the last two decades.

On the other extreme is the informative model. On the informative model, the job of the physician is simply to provide the patient with the facts and leave the decision entirely

[201] Ezekiel Emanuel and Linda Emanuel, "Four Models of the Physician-Patient Relationship," in Health Care Ethics in Canada, ed. Francoise Baylis et al. (Toronto: Harcourt Brace and Company Canada, Ltd., 1995), p. 164.

up to the patient. The physician then has an obligation to carry out the medical wishes of the patient. On this view, the physician is seen as an employee, or tool[202], of the patient: the patient approaches the physician with a medical problem, and the physician provides the patient with the necessary information and does whatever job the patient wants. The one great advantage of the informative model as opposed to the paternalistic model is that the informative model is centered around patient self-determination, as well as the fact that the patient's values are seen as important components of the decision-making process.

However, as with any extreme view, the informative model has its fair share of problems. First, the informative model assumes that the patient's values are well-defined and known to the patient him or herself, and all that the patient is missing are the facts needed to make a decision.[203] But it is unrealistic to think that all patients (or even most) are consciously aware of what values they hold as well as how they may personally rank their values. As well, there is no 'check' on patient's decisions; patients are free to decide whatever they want and the physicians have an obligation to carry out those decisions. This means that there is no way to protect incompetent patients from making decisions they would not make if they were competent, or to protect competent patients from making irrational decisions. At the very least, we would want physicians to at least question the motives and reasons for the patient's decision. The third main problem is that the informative model completely ignores both the values and the autonomy of the physician. The physician becomes a simple tool of the patient, obligated to do whatever the patient wishes. Yet it is commonly agreed that physicians should be free to refuse to perform

[202] Kluge, p. 79.

[203] Emanuel and Emanuel, in Baylis et al. (1995), p. 164.

medical tasks that seriously conflict with their personal values. For example, a Catholic physician should not be obligated to perform an abortion. The physician must retain some integrity as a professional.[204]

Clearly the ideal model for the physician-patient relationship lies somewhere in between the above two extremes, a form of what is often referred to as a model of 'shared decision making'. In this regard, the interpretive model is a giant step in the right direction. It is a model that lies between the two extremes but closer to the informative end of the spectrum. On the interpretive model the physician is seen as a kind of counselor, working with the patient to elucidate and interpret the patient's values, and the physician provides information on how the different treatment options relate to the patient's values.[205] The physician, however, does not dictate or advise the patient as to the best course of action; the decision still lies completely with the patient. The counseling aspect of the physician's job on the interpretive view helps to solve the first problem with the informative model by the physician helping the patient to clarify his or her values. Also, it goes at least part of the way to solving the second problem with the informative model – by having the physician help the patient elucidate his or her values, the physician has a better chance of detecting when a patient *may* be incompetent or *may* be making irrational decisions.[206] Finally, since the final decision is still the patient's, the interpretive model allows the patient to retain his or her autonomy.

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[204] Kluge, p. 83.

[205] Emanuel and Emanuel, in Baylis et al. (1995), p. 165.

[206] I stress the word 'may' in this statement as it is unrealistic to assume that physicians themselves could successfully determine when a patient actually is incompetent or when a decision is irrational. This kind of task would lie outside a physician's area of expertise. More will be said about this below.

While the interpretive model does solve many of the problems associated with both the paternalistic and informative models, it still has some drawbacks. First, the physician still seems to be relegated to the role of information provider. Although the physician acts as a counselor in the sense of helping the patient elucidate his or her values, the physician's job in the end is still to give the patient the information and let the patient make the decision. Although patient autonomy is extremely important, we must recognize that physicians are experts in medicine and do have something more valuable to contribute than just information: their medical opinions. A second problem is that there are practical concerns. Few physicians have the 'counseling' experience or skills, as well as the time required by the interpretive model. As a result, many physicians may be too impatient with the lengthy process and may, intentionally or not, impose their own values and suggestions on the patient.[207] However, it is conceivable that these practical concerns could be partially mitigated over time by changes in physician training and education. The most serious problem with the interpretive model is that it incorrectly characterizes our ideal of autonomy. We do not want people to be entirely free to do whatever they want, especially when it comes to important medical decisions. When it comes to decisions about life, death, and health, we at least want people to think about and reflect on their values to make sure that they are making decisions based on what they truly want and value (another way of justifying my notion of full permissibility).

> Autonomy requires that individuals critically assess their own values and preferences; determine whether they are desirable; affirm, upon reflection, these values as ones that should justify their actions; and then be free to initiate action to realize the values.[208]

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[207] Emanuel and Emanuel, in Baylis et al. (1995), p. 173.

[208] Emanuel and Emanuel, in Baylis et al. (1995), p. 175.

However, some people may be incompetent and thus unable to reflect on their values, while others may simply be mistaken about their values.[209] A patient can be mistaken about her values if, for instance, she claims to possess values that she would not really hold if she reflected on them. Also, some people may make decisions that are completely irrational for them. Thus, the physician's job should involve more than just providing information and helping the patient to elucidate his or her values. In tune with my notion of full permissibility, the physician ought to be free (to a certain extent) to make judgments about the patient's values and offer advice about what the patient should do. This aspect of the physician-patient relationship is accounted for on the deliberative model.

The deliberative model also lies between the two extremes but is slightly closer to the paternalistic end of the spectrum. The deliberative model is very similar to the interpretive model except that the physician does more than just help the patient interpret his or her own values. On the deliberative model, the physician also helps the patient "determine and choose the best health-related values that can be realized in the clinical situation."[210] Part of the physician's job is to suggest which health-related values are more worthy of aspiration and why, and, at the extreme end, deliberating with the patient as to which health-related values the patient should pursue.[211] However, as Emanuel and Emanuel point out, the physician is confined to only discussing health-related values; he or she must recognize that there may be moral or religious values that are unrelated to the patient's

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[209] Brock argues against the "extreme subjectivism about values", the view that a patient's own ultimate values can not be mistaken. (Dan W. Brock, Life and Death (Cambridge: Cambridge University Press, 1993), p. 56).

[210] Emanuel and Emanuel, in Baylis et al. (1995), p. 166.

[211] Emanuel and Emanuel, in Baylis et al. (1995), p. 166.

clinical situation and beyond the scope of the physician-patient relationship. According to Emanuel and Emanuel, the physician on the deliberative model acts as a teacher,

> engaging the patient in dialogue on what course of action would be best. Not only does the physician indicate what the patient could do, but, knowing the patient and wishing what is best, the physician indicates what the patient should do, what decision regarding medical therapy would be admirable...the patient is empowered not simply to follow unexamined preferences or examined values, but to consider, through dialogue, alternative health-related values, their worthiness, and their implications for treatment.[212]

One problem with the deliberative model is that it is plagued by the same practical concerns that plague the interpretive model. If physicians do not have the skills or time required to be counselors, then they certainly will not have the skills or the time to be teachers for their patients. Once again, however, I think these concerns could be diminished through changes in medical training and education (as well as funding). Yet there is one serious theoretical concern with the deliberative model. Allowing physicians to recommend and suggest which values are more worthy of aspiration, as well as recommend the best course of treatment, could take us too far back into paternalism. The problem is how to find the right balance between paternalism and patient autonomy: we want physicians to at least try to ensure that patients are making the best medical decisions but there must be a line beyond which the physicians must not step. Patients still must be free to make their own autonomous decisions, free from coercion and external pressure, even if the decisions may be bad for them.[213] It is evident that Emanuel and Emanuel, who defend the deliberative model as the best model, struggle with this concern: "...the physician aims at no more than moral persuasion; ultimately, coercion is avoided..."[214] The avoidance of coercion is much easier to demonstrate in theory than it is in practice.

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[212] Emanuel and Emanuel, in Baylis et al. (1995), p. 167.

[213] Brock (1993), p. 76.

Also, one could argue that even "moral persuasion" is too strong; it is one thing for a physician to *suggest* or *recommend* something to a patient but it is completely another for a physician to *persuade* a patient to do something.[215]

So how can the line be drawn to protect patients from unjustified physician paternalism? I think a big help in this regard is Brock's potential solution to the problem. According to Brock, there exists a continuum of values and functions that are required for a person to be able to construct a relatively full human life through the exercise of self-determination.[216] On what he calls the objective end of the continuum are the four primary functions, functions which are "normatively objective components of a good life": biologic functions (e.g. well-functioning organs); physical functions (e.g. mobility); mental functions (e.g. reasoning and emotional capabilities; and social functions (e.g. the ability to communicate).[217] In addition to the primary functions, there are agent-specific functions which are required "for a person to pursue successfully the particular purposes and life plan he or she has chosen" (e.g. the capacity for highly abstract mathematical reasoning).[218] As one moves along the continuum, one comes across values or functions that are increasingly more agent-relative, such as the desires that particular people pursue in particular circumstances based on their valued aims.[219] The more a patient's decision

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[214] Emanuel and Emanuel, in Baylis et al. (1995), p. 167.

[215] Of course, due to the inequality in power and knowledge between the physician and patient, especially in the case of a vulnerable patient (e.g. the elderly, minorities, women), mere suggestion or recommendation can lead to coercion just as easily as persuasion.

[216] Brock (1993), p. 67.

[217] Brock (1993), pp. 67-68.

[218] Brock (1993), p. 68.

[219] Brock (1993), p. 69.

appears to interfere with the values and functions at the objective end of the continuum, the more justified is the physician in making a serious attempt to ensure that the patient's decision does not conflict with his or her values and functions. To tie this in with my Feinbergian defense of paternalistic behavior in chapter 3, the more a patient's decision appears to interfere with the values and functions at the objective end of the spectrum, the more powerful the presumption that nobody in his right mind would choose that action. The argument here is similar to the sliding scale view of competency defended by authors like Drane: the more serious the potential consequences to the patient as a result of the decision, the more justified is the physician in trying to protect the patient from making bad decisions. However, in Brock's words, this does not mean "that the physician should ride roughshod over a patient's values and choices if they appear to be in conflict with his or her objective good."[220] The only circumstance in which a physician would be justified in paternalistically making decisions for the patient is when the patient is incompetent and there are no relatives to be named as surrogate decision-makers (or there is no time to wait for a relative to come forth).[221] Otherwise, while the physician is justified in 'investigating' the patient's decision, the final decision must still be left to the patient.

How does PAS fit into the above discussion? On a paternalistic model of the physician-patient relationship, the patient would not have the autonomy to make the decision in favor of PAS. The physician's values or opinions would be the determining (and only) factor in whether a patient would be granted the request for PAS; if the

[220] Brock (1993), p. 69.

[221] I am deliberately excluding the circumstance of emergency medicine, in which a patient's life or well-being often depends on very quick decisions and the physician must make these decisions without input from the patient or surrogates. Thus, any model other than the paternalistic model would not be a practical model on which to base the physician-patient relationship in the context of emergency medicine.

physician disagrees, the patient must abide by the physician's decision. Thus, there might be a real concern about how PAS would damage the trust a patient has for his or her physician. If a patient knows that he or she has no input into the medical decision, and the physician has total control over decision-making, vulnerable patients would have reason to fear being pressured into PAS. Of course, I think the paternalistic model is damaging to the trust a patient has for his or her physician regardless of whether PAS is legalized. On an informative model the patient has too much control. The physician would have an obligation to carry out the request of the patient, regardless of the psychological status of the patient, the values on which the decision is based, and the motives or reasons behind the request. In this sense, the patient will have no trust in the physician because the physician is a nonentity in the decision-making process. Part of the trust we have in our physicians is that they will help us make difficult decisions and let us know when and why they may think we are making poor decisions. On the interpretive model the physician has the freedom to refuse to grant the patient's request for PAS if it conflicts with the physician's strong personal values, but there is still not enough involvement on the part of the physician in terms of exploring the PAS request. Thus, there is the threat to patient trust that exists on the interpretive model. On the deliberative model, however, there is a good mix of patient autonomy and physician paternalism. Not only is the physician not obligated to carry out the wishes of the patient if they conflict with the physician's values but there is also some protection for the patient. Since PAS would obviously threaten the patient's primary functions, the physician's job would require him or her to advocate on behalf of those functions and make a concerted effort to ensure that the patient is competent and not making a completely irrational decision. Once again, this does not

mean that the physician can override the patient's decision if the patient's decision is deemed irrational. Patients must be free to make irrational and bad decisions. What it does mean is that the involvement of the physician on the deliberative model is necessary to help patients recognize when and if their decision to want PAS is irrational. This, in my view, is the ideal notion of patient trust in his or her physician: I trust that my physician will help me make decisions, tell me when he or she thinks I am making a bad decision, recommend what he or she thinks is the best course of action, but leave the ultimate decision to me. Only on the deliberative model will there be the least serious threat to the physician-patient relationship if PAS were to be legalized.

While Brock's proposed solution is certainly helpful, the thin line separating justified physician involvement from unjustified paternalism remains a serious concern. Giving physicians the freedom, and making it part of their job requirements, to question patient decisions and even go as far as to recommend the best course of action means there is the real danger of physician coercion (whether intentional or unintentional). The more force there is behind a suggestion from a physician, the less likely it will be that the patient will disagree. This means that it will be more likely that the patient's choice will not be truly autonomous. As already mentioned, this concern is especially real for vulnerable patients such as the elderly. We certainly do not want patients being pressured or coerced into choosing PAS as a treatment alternative. While I think it would be unlikely, this could occur because of physicians with malicious intentions (e.g. a physician may be an 'ageist' and want to rid the world of elderly people when he has the opportunity). A more likely cause might be a physician with political motives (someone like Kevorkian) or a physician who unwittingly lets her personal beliefs in support of PAS overly influence her treatment

recommendations. If PAS were to be legalized it would probably be impossible to completely prevent the occurrence of patients being manipulated or coerced into choosing PAS. But minor occurrences of patient manipulation or coercion does not justify prohibiting the practice of PAS altogether since the benefits to many people who would want PAS could be shown to outweigh the minor harms of the few who nonautonomously choose PAS. However, what could justify prohibiting PAS as a practice is if it could be shown that coercion and manipulation would be likely to occur on a wide scale. Thus, I now turn to the slippery slope arguments against PAS.

4.5 The slippery slope of assisted suicide

There are two main versions of the slippery slope argument as it applies to assisted suicide, one which refers to the power that is placed in the hands of the person assisting and the other which refers to the threat of social and economic coercion. The concept behind the first version is that a legal or policy acceptance of assisted suicide could lead to acceptance (or at least occurrences) of involuntary active euthanasia because the person assisting a suicide has too much power over the potential suicide. Callahan alludes to this concern with respect to PAS specifically: "In sum, I believe PAS to be wrong in and of itself because of the excessive power it puts in the hands of the physicians..."[222] Although Callahan is not making a claim here of the slippery slope, he is expressing the concern that serves as the basis of the first version of the slippery slope argument. The second version is that acceptance of assisted suicide will inevitably result in people deciding to request help to kill themselves when they otherwise would not have, because of social or economic

[222] Callahan, in Weir (1997), p. 72.

pressures.[223] Both versions of the slippery slope argument center around the issue of control in assisted suicide and the relationship between the control possessed by the potential suicide and the slippery slope concerns is inverse: the more control the potential suicide has over the situation, the less likely are the slippery slope concerns to become reality. In the case of voluntary active euthanasia, for example, slippery slope arguments are a serious concern because the control lies largely in the hands of the physician. However, many authors have taken the route of arguing against assisted suicide by asserting that the slippery slope concerns of active euthanasia apply equally to assisted suicide.[224] I think this conclusion is incorrect as I think the person wishing to die in the case of assisted suicide retains substantially more control over the situation than does the person wishing to die in the case of active euthanasia. Nevertheless, I think it is inevitable that some of the slippery slope concerns would occur following a legal or policy acceptance of assisted suicide. That is, it is unavoidable that some physicians may take things too far and euthanize patients and that some people may be coerced or manipulated into requesting assisted suicide. However, this does not mean that a slide down the slope would occur. I think the slide would not occur for two reasons: first, I think it is unlikely that euthanasia and coerced assisted suicides would occur on a grand enough scale to warrant the fear of the slippery slope. Second, and more importantly, I think there is little reason to believe that safeguards could not be put into place to prevent the slide down the slope.

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[223] Nicholas Dixon, "On the Difference between Physician-Assisted Suicide and Active Euthanasia," Hastings Center Report, 28 (5), 1998, p. 26.

[224] Dixon (1998) and Brock, in Weir (1997), both make this argument.

Dixon argues that the slippery slope objections to active euthanasia apply equally to assisted suicide because the difference in control possessed by the potential suicide between euthanasia and assisted suicide is negligible.[225] His reasoning is the following. In both voluntary active euthanasia and assisted suicide, the final act can not take place without the patient/person's (henceforth, simply 'patient') consent. Moreover, at any time during the process the patient can change his or her mind and decide not to go through with the act; in assisted suicide he or she can decide not to take the pills and in active euthanasia he or she can decide to tell the physician the plans have changed. Dixon concedes that the only difference in control is at the last second, since in active euthanasia once the go-ahead has been given there is no turning back. In assisted suicide the person can decide to take the pills but then stop just before he or she actually ingests them or swallows them. However, Dixon argues that such last second changes of mind are unlikely and so are not significant enough to prefer assisted suicide to voluntary active euthanasia. During the entire process for both euthanasia and assisted suicide, except for the last split second, the patient has enough control to put a stop to the proceedings.[226] Therefore, there is no significant difference in control between assisted suicide and voluntary active euthanasia.

Dixon's argument appeals to both versions of the slippery slope argument. First, he is claiming that in both situations the power the physician/person assisting has over the patient is identical because in neither situation can the final act be carried out without the consent of the patient.[227] Second, he is implying that the lack of difference in control means that the concerns of coercion are also equivalent in both cases. The major problem

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[225] Dixon, p. 26.

[226] Dixon, p. 26.

with Dixon's analysis is with the first of the above claims that both assisted suicide and voluntary active euthanasia depend entirely on the consent of the patient.

What is problematic about his claim is that it completely misses the main issue with regard to the slippery slope. Dixon is correct, of course, that voluntary active euthanasia depends on the patient's consent just as assisted suicide does; that is what makes it *voluntary*. But the main concern of the slippery slope with respect to voluntary active euthanasia is not that people who might want to change their minds would not be able to, but that people who never wanted euthanasia would be euthanized. In other words, the concern is that acceptance of voluntary active euthanasia would lead to occurrences of *involuntary* active euthanasia. And this is where the likelihood of the slippery slope concerns of voluntary active euthanasia and assisted suicide diverge: it is far less likely that acceptance of assisted suicide would lead to involuntary assisted suicide than for voluntary active euthanasia to lead to involuntary active euthanasia.

The reason for the divergence is the issue of control. Not control over changes of mind, however, but control over who actually carries out the final act. While some authors such as Dixon argue that this difference is insignificant, it actually has a significant impact on the slippery slope argument. The simple truth is that the control over the final act lies largely with the person who will actually administer the medication, place the pills in the mouth, pull the trigger, and so on. Even in high-level involvement assisted suicide such as the suicide machine, the actual act that brings about death still lies in the hands of the patient. Why is this significant? It is significant because if this control over the final act

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[227] Brock also makes this argument in Weir (1997).

lies with the patient, regardless of how much assistance the person assisting gives, then assisted suicide can never become involuntary (that is, without patient consent).[228]

Of course, even though assisted suicide could never result in occurrences of involuntary assisted suicide, one could argue that there is the possibility that patients may be euthanized involuntarily as a result of the legal acceptance of assisted suicide. Once the legal acceptance of assisted suicide is justified on the basis of patient control and autonomy, some will inevitably believe that the same ideals can justify euthanasia. 'As long as it is the patient who has requested death, why should it matter who does it?' Thus, physicians may begin to put patients out of their miseries and justify their actions by claiming patient control and autonomy. It would only be one more step, the argument goes, to end up with an acceptance of involuntary euthanasia.

To this argument I must concede that it is probably likely that some physicians may resort to active euthanasia and justify their actions by citing the same ideals that would be used to justify the legal acceptance of assisted suicide. Yet this is one case in which I also think it is likely that safeguards could be put in place to greatly reduce the chance of this occurrence. The most simple safeguard would be to make it clear in the legislation that while assisted suicide is legalized, the act of euthanasia is to remain illegal. This would have to be supported by promises of stiff penalties for those who cross the line from assisted suicide into the territory of euthanasia. There is already evidence that the legal system takes this kind of stand with respect to assisted suicide and euthanasia: Kevorkian was never convicted of assisted suicide even though there was no doubt that he did commit

[228] I am making a distinction here between *involuntary* (without consent) assisted suicides and *nonautonomous* (not freely chosen) assisted suicides. Coercion and manipulation can render an assisted suicide request nonautonomous but not involuntary; there is no such thing as non-consentual assisted suicide.

the crime (of assisting a suicide). Yet he was convicted and sentenced to prison for his most recent "60-Minutes" exploits because he did step over the line and administer the injection himself.

Even if the safeguards could not succeed in keeping physicians from performing active euthanasia, however, this would beg the question of whether this consequence would in fact be negative. That is, it would have to be established that voluntary active euthanasia itself is an unwanted consequence. What would more obviously be an unwanted consequence is if the legal acceptance of assisted suicide led to widespread occurrences of *involuntary* active euthanasia. But I think that this consequence is quite unlikely. What makes the transition from assisted suicide to voluntary euthanasia likely, or at least possible, is that voluntary euthanasia can be defended by appealing to the same ideals that justify assisted suicide: patient control and autonomy. Involuntary active euthanasia, though, can not be defended by appealing to these ideals because there is no patient control and autonomy in the act of involuntary euthanasia. Hence, involuntary active euthanasia would have to be justified by some other ideals, such as compassion, which would make its acceptance much less likely. One could argue that assisted suicide could also be defended by appealing to compassion rather than autonomy, and this would make the slide from voluntary to involuntary euthanasia more likely. However, I think it would be morally wrong to justify any type of killing by appealing only to a principle of compassion because this could open the floodgates to wide-scale mercy killing (as in the case of Robert Latimer). This type of slide could be halted simply by requiring autonomous patient consent for legal assisted suicides. With this kind of requirement a

physician could not practice involuntary euthanasia or mercy killing and defend his or her actions by an appeal to compassion.

The concern of coercion is slightly more problematic. Although it is impossible for assisted suicide to become involuntary assisted suicide, it is conceivable that some vulnerable people may be pressured or coerced into requesting assisted suicide when they otherwise would not have (resulting in nonautonomous assisted suicides). This threat would probably be more serious with respect to non-physician assisted suicide than it would be with PAS. For instance, someone may get very tired of the physical, emotional, and financial strain of taking care of an elderly parent. The child may convince the parent that suicide would be the best thing to do, and the child will offer to help. 'I will get you the pills, all you have to do is take them and everything will be better.' Assuming it is possible for people to be coerced into killing themselves the important question is: how likely is it that coerced assisted suicides would occur?

The best way to answer this question is to look at the different scenarios in which a person might request assisted suicide. First, there are those who request PAS by asking their physicians for medication, information, advice, and so on. There are two parties that could conceivably coerce or persuade these people to take their own lives: the physicians and the family of the potential suicide. I doubt that there would be a real threat of physician coercion in this situation because the potential suicide has already made the decision to request the physician's help. There would be no point in the physician coercing the person if the person comes to the physician looking for suicide assistance. That leaves the person's family or friends. It is conceivable that family members may coerce the person into visiting his or her physician to request suicide help, as in a case, for

example, of someone fed up with taking care of his elderly and dying mother. This is where the benefits of the deliberative model of the physician-patient relationship come into play. The physician would be required to discuss the request with the patient, help her elucidate her values, help her figure out the best course of action, recommend which course of action she should take, and even try to convince her to take the course of action the physician thinks is best. This kind of deliberation and physician involvement would surely go a long way towards reducing the occurrences of nonautonomous assisted suicide.[229] However, since physicians are medical experts and not experts on values and counseling, more safeguards would have to be put in place to protect vulnerable patients. One of the best safeguards might be to require those who request assisted suicide to undergo optional or mandatory counseling[230] with a mental health professional, such as a psychotherapist. It is also important that this counseling be

> non-directive, non-paternalistic counseling, not designed to dissuade the patient but to help the patient contemplating suicide to explore what his or her real wishes are...What is required here is counseling that is able to explore not only the patient's feelings and background values but issues of the accuracy of diagnostic and prognostic information, long-shot hopes for cure, possibilities for palliative care, the timing of a suicide, its impact on others, experiences of suffering and pain, and – most important – any perceptions the patient may have of being pushed or manipulated into this choice by family members, institutional policies, or any other factor.[231]

A waiting period could be incorporated into the counseling requirement by perhaps requiring a certain number of mandatory counseling sessions spread over a specified period of time. A psychiatric consultation would also have to be required in order to detect

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[229] This is a strong reason in support of my notion of full permissibility. If we (society, friends, family) do not have the freedom to challenge, question, and investigate suicide requests, there would be no way to detect when people are making nonautonomous decisions to want suicide. One of the reasons why we want to try to prevent people from performing irrational suicides is so we can protect those who were coerced into suicide.

[230] Battin, in Uhlmann (1998), p. 132.

[231] Battin, in Uhlmann (1998), p. 141.

incompetence. While these safeguards, and any others, would not succeed in completely eliminating the chance of nonautonomous requests for assisted suicide, I think they would succeed in alleviating the threat to a very large extent – large enough to no longer warrant fear of the slippery slope.

A second situation in which coercion might play a role is when a physician tries to coerce his or her patient, who has not considered suicide, into considering assisted suicide. For instance, an oncologist may try to persuade certain patients to consider assisted suicide instead of aggressive treatments.[232] Although I think it is conceivable that some physicians may inform their patients of the assisted suicide alternative if it were legally accepted, the idea of physicians *persuading* or *coercing* their patients into assisted suicide seems somewhat implausible. To coerce someone into wanting to kill him or herself is a malicious act, and I find it highly doubtful that there are very many physicians out there who are that malicious. More importantly, though, the assisted part of assisted suicide would be irrelevant. If a physician really did want to coerce his or her patient into taking his or her own life, for whatever reason, the physician probably would not have to be involved in any way that would constitute real assistance. He could just coerce the patient into going home and taking the whole bottle of Tylenol the patient has sitting in the medicine cabinet. Or to sit in the closed garage with the car running. Every person in this situation would have some means to kill him or herself without assistance from the physician. Even if this were not the case, what is to stop the physician from prescribing something for the illness and 'mentioning' the dose that would result in death? Once the

[232] One could think of a number of possible reasons: to conserve resources, to carry out the wishes of family members who want to get rid of the patient, to avoid wasting time on a patient with no chance of survival, etc.

person is dead there would be nobody to testify to the assistance. My point is that the threat of coerced assisted suicide in this situation would be just as likely without legal acceptance of assisted suicide as it would with acceptance.

My argument above does make the assumption that coercion or manipulation is always deliberate and malicious. However, this is not necessarily the case. I do think that it is highly unlikely that there would be widespread deliberate patient coercion by physicians into choosing PAS. Yet there is the real threat of unintentional coercion or manipulation. Physicians who personally support PAS may in limited cases unintentionally make the PAS option sound more appealing than, say, an option that would result in a slow and painful death for the patient. Or the physician may not even do anything on his or her part to constitute pressure or coercion; the simple mentioning of PAS by a physician as an option may carry with it a certain force, for vulnerable patients, that it would not carry if PAS remained illegal.[233] This is another circumstance in which the safeguards, especially the counseling requirement, would help to greatly reduce the occurrences of physician coercion. By involving other professionals in the process, such as psychiatrists and therapists, there would be a good chance that physician coercion would be detected. Also, the requirement of waiting periods may help some patients themselves realize that coercion or manipulation has taken place by forcing them to think about and reflect on their decision over time. Therefore, I think occurrences of physician coercion may also be significantly reduced by effective safeguards.

A third case of assisted suicide in which coercion might have an effect is in the case of a patient confined to the hospital who is perhaps dying of a terminal or progressive illness.

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[233] Professor Elisabeth Boetzkes, personal email communication, June 23, 1999.

For the same possible reasons as in the above case (see footnote 72), a physician may coerce his or her patient into assisted suicide. Coercion in this situation may seem more likely because of the added factor of the patient occupying a valuable hospital bed and precious medical resources. In this case, the person does not have the means to kill him or herself and so assistance would have to play a part. However, once again, I think it is highly unlikely that there would be an increase in coerced assisted suicide in this type of situation for the simple reason that in many cases it would not be necessary. If the physician wants to free up the hospital bed, or carry out the wishes of the family, there are other ways the physician could achieve this goal which are already an accepted part of medical practice, and which would not involve the patient having to take his or her own life. For instance, there is little reason why the physician would try to coerce the patient into assisted suicide when he or she could try to coerce the patient into withdrawing or withholding treatment, terminal sedation, or overmedication.[234] In these cases, at least, the patient would not have to bring about his or her own death; in fact, he or she would not even have to be aware of the fact that he or she is dying. Moreover, Brock points out that there has been no evidence of slippery slope concerns with respect to passive euthanasia, terminal sedation, or overmedication. These acts became legally accepted and yet there is no evidence of patients being coerced into early deaths.[235] If it has not occurred in these cases, why would it occur in the case of assisted suicide?

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[234] Brock (1999), pp. 543-544.

[235] Brock (1999), p. 534. Although Battin disagrees with Brock as she argues that there is already evidence of the slippery slope with respect to coercion and manipulation. However, she still maintains that effective safeguards could be put into place to halt the slide and that the current slippery slope concerns do not justify condemning rational suicide and assisted suicide. See her "Manipulated Suicide," in Battin (1994) and Battin in Uhlmann (1998).

One might argue that time would be one factor that would encourage physicians to coerce or pressure patients into assisted suicide as opposed to withdrawing treatment or terminal sedation. If there is a shortage of hospital beds, for instance, the physician may want to speed up the dying process significantly in order to free up a much needed bed. However, the safeguards discussed above would eliminate time as a factor. By instituting waiting periods and requiring patients to undergo counseling, effectively drawing out the assisted suicide process, the option of assisted suicide would no longer be a quick solution compared to the alternatives. In fact, with the institution of the safeguards it may even take longer for a physician to coerce a patient into assisted suicide than it would to let them die by withdrawing treatment or terminal sedation. Hence, once again, I think the chances of a slide down the slippery slope upon legal acceptance of assisted suicide could be greatly reduced by the institution of effective safeguards.

My goal in this chapter was to bridge the assumed moral chasm between suicide and assisted suicide. What I demonstrated was that if it is permissible for a person to take his or her own life under certain circumstances, then there is nothing about the act of suicide assistance itself that should justify condemning the practice of assisted suicide for the same person under the same circumstances. It might seem from what I have said in this chapter that I am defending the practice of assisted suicide in general; that I am committed to the view that assisted suicide is always permissible. But this is not the case. First, assisted suicide is only permissible if it is permissible for the person in question to kill him or herself. Second, I think there is one exception to my argument that an assisted suicide ought to be permissible if the suicide is permissible.

Jack Kevorkian's actions during the recent years constitute impermissible assisted suicides.[236] The reason for this conclusion is the same reason that many supporters of assisted suicide condemn Kevorkian's actions: his involvement in many cases was a 'no questions asked' policy. He knew his patients for only a brief period of time and made no effort to examine the issue with the patients. In other words, he did not make a serious attempt to ensure (or at least become convinced) that suicide for his patients was in fact permissible. By not discussing the issue seriously with the patients he did not determine whether suicide was rational for them, or whether there was some aspect of the desire to die that would make the suicides morally impermissible. One consequence of this is that if any of the suicides were morally impermissible, then Kevorkian would have contributed to a morally impermissible act.

However, there is more to the issue of the 'no questions asked' policy than whether or not the suicide is permissible for the person. This brings me to the exception to my argument mentioned above. It would seem that someone like Kevorkian has done something wrong by following a 'no questions asked' policy, regardless of whether the suicide is permissible or not. The fact that a suicide might be permissible should not let someone like Kevorkian off the hook since a 'no questions asked' policy appears to be irresponsible in itself. In other words, I would argue that anybody from whom suicide assistance is requested has an obligation to 'ask questions'. Therefore, the one exception to my claim that there is nothing about the act of suicide assistance that would make assisted suicide impermissible, assuming the suicide is permissible, is that an assisted suicide is impermissible if the the person from whom assistance is requested fails to

[236] I am not including his most recent exploits in the famous "60 Minutes" video. His actions in this case constituted active euthanasia, rather than assisted suicide, as he injected the patient himself.

investigate the issue of the suicide and the motives behind the request. In the case of PAS, the deliberative model of the physician-patient relationship, combined with the counseling safeguards I mentioned, would fulfill the investigation requirement. But I would argue that anybody of whom a request for assisted suicide made is also bound by the obligation to investigate. This would involve discussing the request with the person and suggesting that the person visit his or her physician to discuss the request. However, some people may be uncomfortable with requesting PAS from their physicians or may simply wish to take their own lives with the help of a loved one rather than a physician. In this case, the potential assistant would be obligated to suggest that the person visit a therapist or counselor to discuss the request and, perhaps, even refuse to partake in the request until the person does visit a therapist or counselor. The assistant who fails to investigate has violated an important obligation and so has done something morally wrong. Therefore, the assisted suicide would be morally impermissible (also making it impermissible in the full sense).

There are two reasons why the 'no questions asked' policy is unacceptable: first, there needs to be some way of determining whether a suicide in a particular case is morally permissible. For instance, if a person requested assistance to carry out a revenge suicide, with the deliberate attempt to harm someone else, the person assisting would be contributing to this morally impermissible act by assisting the suicide. Second, there needs to be some way of detecting impermissible suicides (due to irrationality). If a person requests assistance for what would be an irrational suicide, it is important for the potential assistant to investigate the issue so that he or she could possibly protect the person from an

irreversible irrational act.[237] Even if these safeguards fail to detect an impermissible suicide, the potential assistant has acted permissibly as long as he or she as made a sufficient attempt to investigate.

Once again, there are some difficult empirical questions that require answers. For one, who or what combination of people would be qualified to perform the investigation? Is a physician and a mental health professional enough, or should the person be required to visit more than one physician or mental health professional? If the person is religious, should he or she also be required to discuss the issue with his or her religious leader? What exactly would constitute a sufficient attempt to investigate? Unfortunately, the answers to these questions are beyond the scope of this thesis. Suffice it to say, though, that a person from whom suicide acceptance is requested has an obligation to investigate the motives behind the suicide. It is certainly possible that there are other examples of assisted suicides, in addition to the ones described above, which ought to be classified as impermissible. However, I believe that, in most cases, as long as the potential assistant has fulfilled his or her investigation obligation, and as long as the suicide is morally permissible, then the assisted suicide also ought to be permissible.

[237] Also to potentially protect an incompetent person from doing something drastic and irreversible that he or she would otherwise not do.

CONCLUSION

The general purpose of this thesis was to argue for the permissibility of assisted suicide in some cases. Since I believe that the public aversion to the practice of assisted suicide is based largely on the public aversion to the act of suicide itself, I decided the best way to defend the practice of assisted suicide was to begin by defending the act of suicide. Once I accomplished a defense of suicide in some cases, I could then focus on making the move from a defense of suicide to a defense of assisted suicide. It was my contention that there is no moral difference between the act of suicide and the practice of assisted suicide.

My first two chapters were focused on refuting the most popular arguments against suicide. In the first chapter I discussed the psychological view of suicide, which gives rise to the incompetency argument against suicide: that suicide can never be judged morally permissible because only mentally ill (mostly depressed) people want to kill themselves. I accomplished two important things in the first chapter. First, I critically analyzed the psychological view of suicide in order to raise doubts about the conclusion that only mentally ill people desire suicide. Second, I outlined a view of competency and argued that mental illness (in this case, depression) does not automatically render a person incompetent. In other words, I demonstrated that some people who want to kill themselves may not be mentally ill and that even people who are mentally ill may still be competent.

In chapter 2 I focused on refuting many of the popular religious and secular arguments against suicide in order to show that there are no arguments that succeed in demonstrating that suicide is always morally wrong. If suicide is not always morally wrong, then there must be some cases in which suicide is morally permissible. In chapter 3 I set out to

outline an account of which suicides are morally permissible. I argued that there are two conditions for a morally permissible suicide: the person in question must be competent and the suicide must not violate any obligations that would not otherwise be violated. Any suicide that meets these two conditions is morally permissible. In addition, however, I defended a notion of full permissibility based on the fact that we as a society tend to want more than just moral permissibility before we allow people to kill themselves unchallenged. Irrational suicides would fall into this category. Although people must remain free to make poor and irrational decisions we (physicians, therapists, friends and family of the person) do have an interest in questioning, investigating, or challenging the irrational suicide decisions. We want to challenge irrational suicide decisions not because we want to paternalistically control people's lives but because we want to make sure that people are truly autonomous, according to my discussion of autonomy in chapter 4. Autonomy is not just the freedom to do whatever one wants to do. Our ideal of autonomy includes the idea that people ought to reflect on their desires and values, to subject them to critical scrutiny, and to make sure that what they think they want is *really* what they want (especially when the proposed action carries with it such a high risk of harm or death for the agent). Often people need help to do this. Therefore, I included a third condition for fully permissible suicides, which are suicides that are permissible in the sense that others are not justified in making serious attempts to prevent the suicides from occurring. The third condition is that the suicide be a rational act for the person in question. In order for a suicide to be fully permissible, it must be morally permissible as well as rational.

After my argument for permissible suicides was complete, I then set to the task of making the move from suicide to assisted suicide. In chapter 4 I argued that there is no

moral difference between suicide and assisted suicide – that there really is nothing about the assistance itself that justifies condemning an assisted suicide in a certain case in which the suicide is morally permissible. What I showed is that it is not correct to classify the practice of assisted suicide either as one person killing another, one person causing the death of another, or even necessarily as one person intending the death of another. I also argued against the two main objections to assisted suicide: the argument that physician-assisted suicide would damage the physician-patient relationship and the slippery slope argument against assisted suicide. In my response to the former, I discussed various models of the physician-patient relationship and I demonstrated that the damage to the physician-patient relationship would be minimized if we were to adopt a deliberative model of the physician-patient relationship. In response to the slippery slope argument, I made and defended two claims: first, that I think it is unlikely that some of the slippery slope concerns would occur on a wide scale; and second, that safeguards could be put in place to halt the slide down the slope before it occurs.

I concluded with a brief discussion of the one exception to my argument that there is no reason to condemn an assisted suicide if suicide in that case is permissible. I argued that any potential assistant, whether a physician, mental health professional, friend, or family member, has an obligation to at least question the motives of the person who desires assisted suicide and to investigate the issue. The justification for this, once again, is our ideal of autonomy: that we do not want to leave people to be free to do whatever they want to do when the risks to themselves are so high. Some people may be incompetent and unable to make the decision and some people may be making an irrational decision (which includes nonautonomous decisions). These people need to be protected from doing

something drastic and irreversible that they may not really want to do. Therefore, the only circumstance in which a permissible suicide becomes an impermissible assisted suicide is if the potential assistant fails to fulfill his or her obligation to investigate. The assisted suicide in this case would be impermissible because, since the potential assistant has done something morally wrong by not investigating, the assisted suicide would violate the moral permissibility condition of full permissibility. Otherwise, if it is permissible for a person to take his or her own life, then it ought to be permissible for that person to get assistance.

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