Introduction

HOW I CAME TO WRITE THIS BOOK: THE END OF MY FATHER'S JOURNEY AND THE BEGINNING OF MY OWN

This is a book about ideas. It was born, however, out of deep emotion. My father was diagnosed with fourth-stage pancreatic cancer in 1975. For the last six weeks of his life, we brought him and my mother home to live with us. While staying at our house, my father asked my sister and me to help him commit suicide. I wouldn't do it. Part of me thought it was wrong. Part of me was afraid to get caught and have to face criminal prosecution. (My sister and I are somewhat bumbling when dealing with very practical things, and I did not wish to involve my exceptionally competent wife, who probably could have gotten away with it.) My father died several weeks later after suffering excruciating pain, which was only intermittently brought under control by the most powerful pain medications available.

My mother had Alzheimer's and Parkinson's diseases. My father had been her life companion and her caretaker during the last portion of her life. After his death, her dementia took over. At some point in 1997, she had to be taken to the hospital to be treated for several extremely painful pressure sores, gaping wounds filled with fetid, rotting flesh. When she arrived by ambulance, she was unconscious. She had a living will and had given me durable power of attorney for health care. When she had not

regained consciousness by the second day, I ordered all artificial feeding and hydration terminated. My mother died within a few days. My decision is documented in the report of the attending physician.

> PLAN: I have discussed quality of life issues with the son, John Mitchell, in detail. He has many concerns about his mother's quality of life. He does not wish to prolong her life in any manner that would require tube feeds or artificial hydration. He states that she would not have wanted that, indeed, she has signed written declaration stating that any procedures that artificially would prolong the dying process should be withheld or withdrawn and she be permitted to die naturally with only the administration of medication with medical procedures deemed necessary to provide her with comfort care or to alleviate pain. Owing to her severe level of dehydration and decreased p.o. intake, as well as no desire for feeding tube and poor quality of life with her severe Alzheimer's disease and her down-going mental status, the son wishes to have a hospice consult and comfort measures only to give his mother quality ending to life other than prolonging her to be in continued pain.
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> I have talked to Dr. —— about this and he agrees totally as I do. We will arrange hospice visit for the patient. In the meanwhile we will provide her with intravenous fluids at 88 cc an hour as well as intravenous antibiotics for infection, also providing her with pain medication as needed. Would expect transfer to an extended care facility for comfort care only in the near future.

After my father died, I did not think too deeply about the request he had made of my sister and me. I missed him terribly, but there was so much to do to take care of Mom, let alone raise two children and handle the rest of the day-to-day life, that I did not engage in much reflection. But, after Mom died, my decision haunted me. Perhaps I should have helped my father to die even though it would have been illegal and I could have gone to prison. What was the real basis of my initial reaction that suicide was immoral and uncourageous? Maybe the truth was that I was a coward.

And so it went: guilt, shame, uncertainty—what had I done? Then a funny thing happened. Without even knowing it, without apparent thought let alone a dramatic moment of decision, I slowly began a journey. This journey eventually would lead me to accept what I had done,

whether good or bad, courageous or cowardly, right or wrong, or possibly somewhere along a spectrum between these absolutes. This book is in large part a chronicle of that journey.

As I said, it began without me even knowing it. I'd be waiting in a doctor's office and a few fragments of some article about dying in America would pop out. *A century ago, people died at home, surrounded by family. Death was a public matter, not something to be feared, or denied.*[1] Or I'd be flipping through the newspaper looking for the sports section and my eyes would rest on another article about dying. *Once death happened at all times; at all ages.*[2] *Now most die when elderly after a long bout with some chronic illness.*[3] Then I'd be browsing in a bookstore. *Death has been transformed from an existential to a medical reality.*[4]

Suddenly, all around me were books, articles, news programs, speaker's series, and such about assisted suicide and euthanasia and particularly about the debate over physician-assisted suicide (PAS). I don't think a psychologist would be surprised at this new framing of my awareness. My mind was taking me where I needed to travel.

Prior to my parents' deaths, I was vaguely aware of assisted suicide movements, the Hemlock Society, and various state initiatives for PAS. But these concepts were no more part of my reality than the suicide practices of the ancient Greeks[5] and Romans,[6] the self-inflicted deaths in the face of dishonor I'd seen in Japanese movies,[7] or the self-sacrificing suicides of the elderly in Eskimo, Samoan, and Crow Indian cultures about which I had once read in college.[8] Those were just tales to me, like the one somewhere in the back of my memory about the villages in ancient Brittany where there was a holy hammer in each village chapel and the oldest living relative would take the hammer and crush the skulls of the dying who were suffering.[9]

But I also began to learn that an openness to the possibility of suicide, and more particularly assisted suicide and euthanasia, was not new to American soil. In the 1930s, there was a serious debate about euthanasia in the United States and England.[10] This debate resurrected an intense interest in euthanasia that had been expressed in American medical journals and meetings in the late 1800s under the sway of social Darwinism[11] and great advances in medicine.[12] The 1930s debate came to a screeching halt after the close of World War II with the discovery of the nightmare that was the Nazi eugenics program.[13]

I did not need to read deeply to come to realize that the idea of assisted suicide for the terminally ill had reemerged as a legitimate topic of discus-

sion in America and many other parts of the world.[14] What I did not realize is that my initial feelings that it would be wrong for my father to kill himself, with or without my aid, likely placed me in the minority in this nation.

Over the past decade, surveys have consistently shown that approximately 70 percent of Americans believe that the terminally ill should have the assistance of a doctor should they choose to end their lives.[15] A recent survey at Eastern Texas Christian College shows how stable this belief is. Intuitively, you would expect overwhelming disapproval from this pocket of the Christian subculture. Yet the survey came up with the same results as all the others—72 percent approval.[16] It seems that Americans approve of the concept, at least in principle. Indeed, one state—Oregon—has actually passed legislation to legalize physician-assisted suicide.[17] Some, on the other hand, have pointedly argued that the polling method used in the surveys overstates the magnitude of public support for assisted suicide.[18] Perhaps the fact that, other than in Oregon and in California, statewide ballot measures to legalize some forms of assisted suicide have failed reflects a gap between attitudes toward the concept, on the one hand, and adoption of that concept when manifested in a concrete proposal on the other.[19] Nonetheless, whatever one can conclude from these surveys, it is plain that the issue of assisted suicide and euthanasia is in the wind in our culture and hardly my issue alone.

I don't know when, but at some point I acknowledged my journey and commenced it in earnest. In this private journey, I read everything I could get my hands on relating to suicide, assisted suicide, and euthanasia. These works ranged from those expressing religious views to moral and political philosophy, law, and medicine.

Other than my expertise in law, which I have practiced and taught for nearly 35 years, most of my reading involved fields with which I was not very familiar. I was back in school, often struggling to merely comprehend what I was reading. Eventually, I learned the jargon and themes and could grasp what was at the core of each position. From there I slowly began to develop my own critique.

As I journeyed through the literature of so many different fields, I began to see that there was an odd structure to the assisted suicide debate in our culture. While superficially divided into pro and con, the sides were not drawn along single lines. Rather, each side was comprised of a coalition. And the members of the respective coalitions staked out their ground based on their conclusions drawn from one or more of *nine separate, discrete issues.* Moreover, whether in scholarly or popular literature or op-ed

pieces in newspapers, no one relied on more than a few of the nine and often disagreed with a fellow coalition member on an issue that the other person had relied on. For example, the coalitions opposed to assisted suicide are further delineated by the members' beliefs about suicide itself. For some, suicide is immoral, so any discussion of assisted suicide on its own terms is a nonstarter. Others make no moral claim denying individuals the choice of killing themselves but do have moral and/or pragmatic objections to the addition of a third party to the equation, that is, they object to assisted suicide. Further, those arguing opposing positions rarely countered their adversaries' reasoning or data in all but the most superficial or conclusionary manner, rather relying on their conclusions from their own set of debates as determinative.

Therefore, I concluded that to participate in the important cultural discussion of this extraordinarily complex issue, a discussion that will become increasingly significant over the next decade as the baby boomers age and state legislatures consider assisted suicide laws like Oregon's, one must ponder all nine issues.

It is not the casual use of language that leads me to call each of these nine areas contested "issues" rather than "arguments." While plainly employed in argumentation, each of these nine areas possesses its own (often extensive) literature and value structure and is fundamentally self-contained. While I recognize that the various issues borrow pieces from the others to form their arguments, they are nonetheless rhetorically distinct, although the opposing arguments within each issue might be interrelated and logically connected.[20] These nine issues can be fairly characterized as:

Issue 1: Our culture does/does not subscribe to the notion of the "absolute sanctity of life."

Issue 2: Western religion does/does not plainly forbid suicide (and a fortiori assisted suicide or euthanasia).

Issue 3: Assuming that a particular suicide or assisted suicide might be justified, condoning such a suicide or assisted suicide would/would not result in overall harm to the society.

Issue 4: Permitting physician-assisted suicide would/would not result in a "slippery slope," ending in involuntary termination of our most vulnerable and powerless citizens.

Issue 5: Assisted suicide is/is not morally supported by the principle of "autonomy."

Issue 6: Individuals can/cannot be mentally competent and/or rational if they choose suicide (and a fortiori assisted suicide or euthanasia) as the best choice for themselves.

Issue 7: Physician-assisted suicide is/is not morally supported by the combined concepts of "medical autonomy" and "mercy."

Issue 8: One does/does not have a constitutional right to suicide, assisted suicide, or euthanasia.

Issue 9: Legislation permitting physician-assisted suicide would/would not be sound social policy.

As I indicated, there are some interrelationships between the issues, as core elements of one will play a role in another. Thus, culturally based morality (issue 1), carries religious undertones (issue 2) and echoes many of the concerns about risks to the most vulnerable and marginalized, which appear in the discussion of the "slippery slope" (issue 4). Religion (issue 2), on the other hand, adds force to the notion of the absolute sanctity of life found in issue 1 and offers a counterclaim in reliance on one's individual autonomy (issue 5).

The analysis based on utilitarianism (issue 3) offers a "cousin" in form to the slippery slope (issue 4) and a counter to the claims of individual autonomy (issue 5). The slippery slope (issue 4) in turn looks back to utilitarian balancing (issue 3) and depends heavily on the concerns underlying the fear of moving away from the position that life has absolute sanctity (issue 1).

Autonomy (issue 5) plays a central role in legal arguments (issue 8) and finds that its ultimate benefits are utilitarian (issue 3) in nature. The debate about whether one can choose some form of suicide and still possess mental competency (issue 6) weaves through debates about the slippery slope (issue 4), concerns that underlie abandonment of the absolute sanctity of life (issue 1), and questions about whether autonomy is possible under these circumstances (issue 5).

The combination of medical autonomy and mercy (issue 7) finds a place in discussions of the legal rights to assisted suicide (issue 8) along with autonomy (issue 5) and the slippery slope (issue 4). Finally, autonomy (issue 4), mercy (issue 7), and the slippery slope (issue 4) appear throughout the discussion of the advisability of legislation (issue 9) permitting assisted suicide.

Rhetorically, however, the nine issues do not blur into one another, even though they may share common elements or building blocks. Obviously there are many ways to organize and conceptualize this complex, overarching metaissue of assisted suicide of which the "nine issues" are subcomponents. Standing back, I can imagine viewing the issue as one that is principally moral (though not necessarily religious) and concerned with the tension between maintaining lines, on the one hand, and alleviating recognizable human suffering on the other. I can then imagine an author who chooses to organize a book around these concepts. Yet that is not how people—whether in buses, restaurants, family kitchens, or classrooms—discuss the issue. They select among the nine issues and align themselves with coalitions constructed of them. Structuring this book to reflect how people actually talk and argue thus seemed to be most useful for those who seek to understand, and perhaps even enter the public discussion about, assisted suicide.

While there certainly are strong emotional commitments in the substrata of this issue, at bottom its acknowledged complexity is a function of the fact that we are dealing with nine separate, sophisticated issues that appear, disappear, and reappear in the rhetoric. What follows is organized around these nine issues and offers my analysis and conclusions as to each.

One last point: In our culture of expertise, there are people who have devoted a lifetime to studying a single passage of Genesis or the philosophies of John Stuart Mill. In fact, an expert on Mill might stake his or her career on a single one of the philosopher's works. It's therefore likely that there does not exist a single person who is an expert in all the fields discussed in this book. With that in mind, I am offering my best understanding, based on my own analysis and personal experience, of the vast spectrum of theories, ideas, and information about assisted suicide.

A BRIEF NOTE ON THE CHOSEN ORDER FOR DISCUSSION OF THE NINE ISSUES

The order in which I treat the nine issues reflects the sequence of my personal and intellectual journey. Although there was some back and forth, my reading progressed in a relatively straight line. Interestingly, although my life's work has been in the law, I did not really focus on this aspect of assisted suicide until the last part of the journey. Rather, what occupied me were questions of morality: is or is not assisted suicide immoral? I guess,

under the circumstances, my priorities made sense. My anguish did not result from some legal interpretation; my pain resided in issues of right and wrong.

I began by exploring moral systems that purportedly justified an absolute moral bar against suicide, assisted suicide, and euthanasia, regardless of specific circumstances, situations, or consequences (formal philosophers call these *deontological* moral theories). Obviously, had I been convinced by any of the following it would have been the end of my journey:

1. the cultural philosophy that it is always wrong to kill an innocent person
2. religion, specifically the Judeo-Christian tradition
3. the cultural philosophy that lives perceived to be of less "quality" nonetheless must be perceived as of equal value with all other lives

I next considered moral systems that purportedly justified an absolute moral bar against assisted suicide based on specific circumstances, situations, or consequences (formal philosophers call these *consequentialist* moral theories). I should note here that from the perspective of an academic philosopher my small distinction between moral theories that consider consequences and those that only focus on abstract principles would appear simplistic. Obviously, at some point deontological principles are formed based on some conception of the consequences of adhering to those principles. A deontological system that routinely leads to consequences a society would not wish to experience would not likely find many followers. For my purposes, however, my admittedly oversimplified distinction provides a clarity for this discussion that is beneficial.

1. utilitarian balancing
2. the "slippery slope," including the experiences of the Netherlands and Oregon

From there, I considered the principal moral theory from which one could deduce that suicide, assisted suicide, and euthanasia are affirmatively moral.

1. autonomy

And from there I progressed through other theories from which one could purportedly deduce that suicide, assisted suicide, and euthanasia are moral under the appropriate circumstances.

1. utilitarian balancing
2. the combination of autonomy and mercy

Only after all my thoughts on these debates in moral philosophy and bioethics took shape did I at last look at law—first at assisted suicide and the courts and then at whether assisted suicide should be legalized through legislation.