

ISSUE I

*Our culture does/does not
subscribe to the notion of the
“absolute sanctity of life”*



*Cultural Arguments That Assisted
Suicide Is Always Wrong*



There are concepts embedded within our culture that would find any attempt to end my father's suffering by ending his life morally wrong. In this regard, I believe certain ideas run through our society that are not proclaimed by formal philosophers but are philosophical nonetheless.¹ These ideas reflect our sense of life and its meaning.² One such idea is at the core of any discussion of suicide or euthanasia: life is sacred and has absolute sanctity.³ Here I should be clear that when I discuss the absolute sanctity of life I do not mean that concept in the sense of vitalism, where life is to be maintained at all costs.⁴ While some may believe that, most who use the sanctity of life as an argument against suicide recognize that although life has incommensurate value it is not the only thing of value. Rather, life does not need to be maintained at all costs. It is, however, inviolable.

This sense of life's sacredness certainly finds support in religion, but it can also reside in the heart of an agnostic or atheist. It is deeply embedded in our culture, and it is deeply embedded in me. It was there the day my father asked my sister and me to help him kill himself. He was suffering, but he was still alive. His life was sacred, inviolable. This idea of absolute sanctity provides the basis for holding suicide, assisted suicide, and euthanasia to be immoral regardless of circumstances or consequences.

Yet we do condone taking lives. We condone war, self-defense, and

capital punishment. In the medical context, we allow lives to be shortened by pulling the plug, not providing “disproportionate” treatment, giving pain medication when we know that there is a substantial risk that the medication will kill the patient, permitting the patient to refuse lifesaving medical treatment, and allowing terminal sedation. My father stopped the provision of food and hydration (other than sponging his lips) to accelerate his death. I requested the same for my mother to achieve the same end. I wanted her to die. So, as I went through this part of the journey, my focus was on whether these seeming exceptions to the absolute sanctity of life could be explained or whether, in fact, we do not really believe in life’s absolute sanctity. If the latter were correct, the notion of the sanctity of life could not provide the basis for an absolute moral claim against suicide, assisted suicide, and euthanasia.

IT IS ALWAYS WRONG TO INTENTIONALLY TAKE A HUMAN LIFE

In our culture, life’s sanctity manifests itself in a moral prohibition against intentionally taking human life.⁵ This serves as a powerful claim against suicide, assisted suicide, and euthanasia. Prior to delving into this aspect of our cultural philosophy, like most of us, I accepted that this belief in the wrongness of taking life could somehow coexist with the acceptance of war, self-defense, and capital punishment. It’s not that I have supported all of this nation’s military adventures. I have not. Nor do I support capital punishment. But my objections have not rested on the notion of the sanctity of life. I was, therefore, curious in my reading about how the proponents of an absolute sanctity of life objection to assisted suicide found war, self-defense, and capital punishment to be legitimate exceptions to the ban against taking life.⁶ I concluded that they do so based on the rationale that the individuals who are killed have somehow forfeited the right to have their lives treated as inviolable. This forfeiture is expressed within what is, in effect, a coded phrase, a term of art—*noninnocent*. But, as I read and thought, it became clear to me that we do condone intentionally taking lives that are “innocent.”⁷ While this may be justifiable from the perspective of a consequentialist moral theory (i.e., one that considers contexts, circumstances, and costs and benefits), it hardly supports an absolute moral claim that it is *always* wrong to take innocent life. To the contrary, our willingness to take innocent life undercuts the use of any claim that it

is “always wrong to kill the innocent” as an absolute moral basis for condemning suicide and assisted suicide in all circumstances.

A Just War

War, which is filled with intentional killing, has been a constant in all recorded history and our own lives over the past century.⁸ Our country has gone to war in World War I, World War II, Korea, Vietnam, Iraq, and Afghanistan. And throughout we have killed civilians; although we call it “collateral damage,”⁹ they are just as dead. Unless we want to say that no one in the enemy population is innocent, including babies, young children, and the elderly infirm, we make the decision to take actions that we know will kill innocents. We may wish it were otherwise and would be happier to just kill official combatants, but the point is that no modern army will forgo a strategically desirable military action just because of the certain knowledge that there will be noncombatant deaths. The very methodology of modern warfare makes killing innocents a necessary (accounting-type) cost of the military enterprise.

As I was considering war and the killing of innocents, I came across a traditional touchstone for assessing the morality of a particular war that I found useful, the Catholic “just war” doctrine.¹⁰ The doctrine provides norms and criteria that place a moral framework around war. The just war doctrine applies one set of criteria to determine whether a government’s decision to go to war is moral (*ius ad bellum*). Another set of criteria assesses the morality of the conduct of the war (*ius in bello*).

The criteria for the conduct of war consist of “proportionality” and “noncombatant immunity.” *Proportionality* in this context means that military violence should be constrained by what is “necessary” to obtain military objectives. Intentionally destroying nonmilitary infrastructure, with the obvious result being that daily civilian life is severely compromised, violates this principle. *Noncombatant immunity* reflects the church’s overall respect for life and the position of the New Testament of loving one’s enemies. In modern warfare, however, this norm appears to be all but irrelevant.

Beginning with the Vietnam War, however, concerns were also stirred about the rising number of civilian casualties in conventional conflicts. During World War II, civilian casualties amounted to 45

percent of casualties. By the time of Vietnam, they counted for 65 percent of the total. By the 1990s, they constituted more than 90 percent.

Much of the increase in noncombatant, civilian casualties was due to the rise in guerrilla warfare, civil wars, terrorism and counterterrorism, and ethnic cleansing. A significant portion, however, was also attributable to shifts in the war-fighting styles of developed countries' militaries, especially that of the United States. The growing lethality of conventional weapons, strategies like air dominance and the use of overwhelming and decisive force, as well as the practice of force protection (giving primacy to guarding the safety of one's own troops), contributed to this trend in civilian vulnerability.¹¹

When we move our analysis to consider Hiroshima, Nagasaki, and Dresden,¹² can one say anything but that in those three instances the killing of masses of innocents was the precise and intended consequence of the action? Whatever might have been the truth about the enormity of allied casualties that would have resulted from a land invasion of Japan, the point is that our nation made no pretense that it was doing anything other than intentionally killing innocents as a calculated strategy of war. Again, while this surely might be justified by some form of consequentialist morality, it hardly supports an absolute moral claim that it is always wrong to take innocent life and, thus, always wrong to kill yourself.

Self-Defense

When I looked at self-defense, I was on my home turf. I have both practiced and taught in the area of criminal law. In contrast to war, self-defense seems clear. Someone is trying to kill you, and it's you or them. Your life is given priority over your opponent's because, as the aggressor, he or she has forfeited (at least at the moment) the sanctity of his or her life.¹³ By trying to take an innocent life, attackers lose their membership in the universe of the innocent (i.e., those whose lives may not be intentionally taken). The problem is that, under modern notions of self-defense, you can kill an innocent person. You're not supposed to, but it can happen, and under the right circumstances, you'll be absolved.

A person has the right to use deadly force if he or she "reasonably believes" that another person is about to inflict life-threatening harm.

Notice that you only have to reasonably believe that you're in such danger. The danger does not have to be real.¹⁴ Imagine you get into a fender bender. The other driver gets out and starts screaming at you, saying things like "I should kill you." He's huge, covered with prison gang tattoos, and walks to the back of his car muttering "You're a dead man . . . you're a dead man." You're terrified. You reach into your glove compartment for your registered firearm just as he goes into his trunk and pivots, pointing what looks like the barrel of a gun at you. In that instant, you react with your gun, and he falls, dropping the road flare he had in his hand.

If that's how it happened, you have killed an innocent person, albeit an extremely unpleasant one. Admittedly, you did not know he was innocent. But you did intentionally kill someone who, in fact, was innocent, and the law will condone that killing. In casual conversation, we may say that it was the deceased's fault, that he was not innocent in his own death. And I would agree in that type of conversation. But here we are talking within the context of an exception to the general rule against intentionally killing where the moral basis for finding the deceased not to be "innocent," and thus subject to intentional killing, was that, by trying to take another life, he sacrificed the sanctity of his. Here the decedent, awful as he was, did no such thing. In this context, he was innocent. Because you acted reasonably, however, your conduct will be considered justified, even though your reasonable perceptions were wrong.

Capital Punishment

This is historically the third exception to the moral rule against intentional killing. To begin with, there are certainly those who do not find this a legitimate exception and hold the death penalty immoral no matter what its subject.¹⁵ I share that view but will take a different tack, one that brings me into my world of law.

To begin with, we know that currently we likely are mistakenly executing some unidentified innocent persons and but for DNA testing and the Innocence Project we would be killing even more.¹⁶ This is unavoidable. In carrying out any program of state-sponsored executions, those innocent of the capital crimes for which they were convicted have been, and will continue to be, killed due to the inevitable vagaries of jury trials.¹⁷ We would like to have a system that would not allow this to happen, but we never will. Eyewitnesses will make mistakes, witnesses will lie, jurors will have their biases, and incredible coincidences will occur. Our society

knowingly accepts this “collateral damage,” an acceptance that is not consistent with an absolute moral stance in contrast to a consequentialist position.

Assuming we are executing the right person, the justifying moral argument is that the condemned person has sacrificed the right to have his or her life treated as sacred by intentionally taking an innocent life. There are, however, a few problems with this rationale. Initially, throughout history the death penalty has been carried out in cases other than murder. Stealing would earn you the gallows in Merry Olde England. In the United States, at the time the Constitution was drafted in 1787, the death penalty was a common punishment in the various states for a wide variety of personal offenses, including murder, rape, fraud, and theft.¹⁸

Further, here the state is the one taking the life, not someone avenging a death as part of some blood feud. Of course, that’s the point. By entering the picture in the form of law, the state can break the endless cycle of a blood feud in which a family avenges the death of one of its own, the other family responds in kind, and on and on.¹⁹ This is a practical use of power, but is the state’s disruption of this cycle of revenge by killing a person morally justified by the concept of noninnocence? The condemned is not now a direct threat to the state or any of its citizens. Whatever the prisoner did, he or she can’t do it now. Why, now that he or she is helpless and no longer a threat, is the prisoner not again innocent for purposes of being protected from an intentional killing? If all lives are inviolable, if all lives have equal worth, it is hard to see how one can be said to forfeit this innate quality by any particular act no matter how vile.

At the end of my thinking about war, self-defense, and the death penalty, I saw a society committed to protecting life. But that society was also willing to permit exceptions to the absolute sanctity of life when those exceptions both had consequentialist benefits and could be circumscribed and cabined so that the exceptions did not permit a moral rationale that could be further expanded into other aspects of our lives. What all three exceptions have in common is that they maintain their boundaries, thereby ostensibly not permitting any moral rationale for allowing intentional killing to further intrude into our lives in the broader society, by means of spatial narratives. The boundaries are constructed in our cultural imaginations out of narratives that are confined to very narrow *physical spaces*.²⁰ War is on the battlefield. Self-defense takes place within the space of a person-to-person encounter (inches, feet, yards at most). The death penalty is carried out in a room in a prison. Again, this is in our imagina-

tion. Wars today are not confined to battlefields such as Gettysburg or the Somme. Nonetheless, the story remains.

What does this mean for assisted suicide? On the one hand, it cannot be limited by any spatial narrative because it can be done at any place, any time. On the other hand, when I think of all the circumstances under which we condone the killing of an innocent, the thought of an old, sick person like my father taking his own life seems by far among the least troubling or tragic.

THE ABSOLUTE SANCTITY OF LIFE: ALL LIFE HAS
EQUAL WORTH, WHICH MAY NOT BE BALANCED
AGAINST THE “QUALITY” OF THAT LIFE

Unlike the broader cultural arena in which the moral bar against killing innocents provides the articulation for the sanctity of life principle, in the medical context, the sanctity of life principle is articulated in terms of not considering “quality” of life in medical decisions. If one starts with the idea that life is sacred, it seems to follow that, while among us mortals there may be better or worse individuals, no one’s life is more or less sacred than any other’s.²¹ Sacredness does not work in increments. This notion is deeply embedded in our culture: “All men are created equal.” Sometimes when I would see prisoners brought into court in their orange jumpsuits or pass persons sitting in a doorway with their life’s belongings beside them in a trash bag I would be struck by the idea that we were all once children and wonder what had happened to them. Because, in essence, we all are the same.

Obviously, people are born with different social and genetic assets and then make different things of their lives. But all are entitled to be treated according to the same societal standards or principles. They may not have the right to the same treatment, but they have the right to be treated equally under the law. That is the basis for a just society. No matter what your fate in the social lottery, whatever your race or gender, great athlete or physically disabled, genius or mentally challenged, everyone has to stop for you when you’re in the crosswalk.

Those who strongly subscribe to this idea of the absolute sanctity of life are concerned about the establishment of a hierarchy (or “lowerarchy”) in which certain lives have less value than others. They fear for those most vulnerable in our society²² (the elderly, severely disabled,²³ poor, or disadvantaged minorities)²⁴ if we begin to distinguish among lives based on

their quality.²⁵ Floating in front of those committed to this notion of the *absolute* sanctity of life is the specter of the Nazi eugenics program,²⁶ in which the German government began killing the insane, then the mentally disabled, then the “useless feeders” (the elderly infirm and severely disabled), and eventually six million Jews, as well as Gypsies and others.

The risk of this nightmare is seen as inherent in any ethic that considers the subjective quality of individual lives, even if that type of judgment is, to begin with, only made by the individuals themselves. Under this view, once the line is crossed from the absolute sanctity of life to a morality based on individual contextual judgments, the so-called slippery slope toward the Nazi experience is inevitable. I am not unsympathetic to this view. Most of my father’s family died in German death camps during World War II. It’s difficult for me to think about the Holocaust without feeling a tide of rage rise in my body. But when I look closely the fact seems to be that we consistently incorporate “quality of life” decisions in medical care.²⁷

Pulling the Plug

When to stop treatment, when to give up and say goodbye to the person, is as profound and emotion-laden a choice as it is a common, everyday decision in medical care facilities in America.²⁸ That’s what I did with Mom, although I did not agonize over the decision until much later. Within this image of “pulling the plug” are two separate concepts to which those who try to simultaneously maintain both the legitimacy of the procedure and the sanctity of life resort: letting the disease take its natural course and ordinary versus extraordinary treatment.

Letting the Disease Take Its Natural Course

One common rationale is that when we pull the plug the doctor is not killing the patient, the disease is. We’re merely “letting nature take its course.”²⁹ And if the patient is in the dying phase and the machine is interfering with the process, or if the machine alone is moving the patient’s heart or lungs, then I agree. But that wasn’t my mother’s situation, and that’s not what we’re generally talking about. We are generally dealing with situations in which, due to the machine, the person could go on for half a day or days. His or her life, every moment of which in the view we are now considering has absolute sanctity, is being shortened by pulling the plug. Saying that we’re merely stepping aside to let nature (in the guise

of the disease) take its course does not change the reality of what we're doing or the implicit importation of quality of life considerations.

Much of the human endeavor is to mitigate and limit the day-to-day impact that the natural/physical/biological world has on our choices. We dam rivers, create irrigation systems in arid land, develop clothing that allows us to survive in the Arctic, and invent scuba-diving equipment so we can spend time under water. Most of medicine is aimed at curtailing nature—antibiotics, immunizations, cataract surgery. For individual disabilities, we've created glasses, wheelchairs, artificial limbs, and heart pace-makers.

In thinking about this "letting the disease take its natural course," I thought about glasses and people who literally cannot see anything without them but blurred, indistinct shapes. Now let's put one such person in an ice age tribe, of course without his or her glasses. Chances are that person would be dead meat—falling into some ravine or blithely walking into a saber-toothed tiger. That's letting nature take its course.

Back to the twenty-first century. If I am hiking with a bespectacled friend, and, as we are traversing a narrow, extremely precarious ledge, I grab his glasses, knowing that this will result in his taking a false step and plummeting to his death, I will be said to have caused the death and likely be facing homicide charges. In the ensuing trial, I don't believe the jury would be terribly moved if my defense was that I didn't kill him but merely returned him to a natural state in which "his disease [visual infirmity] killed him." The point is that by using a heart or other machine doctors can delay the disease that is killing the person. Their accepted choice to turn off the machine and let the disease ultimately hold sway is only comprehensible within a context in which the value, the quality of the moments that could be gained by continuing to use the machine, is not worth it.

Futile, Disproportionate, Ordinary-Extraordinary Treatment

In the world of medicine, it is accepted that doctors are not required to provide "futile" or "disproportionate" treatment.³⁰ *Futile* means that further medical intervention will not restore the patient's health,³¹ though it could provide a few more days of sacred life.³²

Disproportionate,³³ like the more recently adopted metaphorical dichotomy *ordinary-extraordinary*,³⁴ also is at bottom contextually circumscribed, its context infused with notions of quality of life. Is fighting pneumonia ordinary or extraordinary? For an otherwise healthy 20 year old,

realizing that the likely result of nontreatment for some extremely virulent form of flu would be death, the doctor would be held responsible and playing in the homicide ballpark. But for a very ill, demented, 94-year-old patient who is in constant agony, nontreatment for pneumonia (resulting in the patient's death)³⁵ will be morally acceptable, as it will be labeled extraordinary.³⁶ Plainly, this does not reflect the application of an absolute moral principle exalting the sanctity of life but, rather, a balancing of factors in which subjective quality of life judgments weigh heavily.³⁷

The same type of analysis applied to not providing Mom with feeding or hydrating through tubes. A finding that the procedure need not be done because it is extraordinary or disproportionate will always be tied to a narrative in which the remaining quality of life of the patient is extremely low. For a young person temporarily in a coma following an accident, a feeding tube may be ordinary; for an 81-year-old person, demented, sick, and in pain, it would be extraordinary.

*Giving Pain Medication under Circumstances Such That
There Is a High Risk That It Will Kill the Patient*

Morphine is a wonderful pain controller. All that stopped my father's agony was morphine pumped directly through a surgically implanted shunt. He had a control button, and within certain time frames and regulated dosages, he could push the button whenever he felt the need. I remember him constantly pushing that button, often counting the minutes until the machine would let him have more. Perhaps as much as once a day, true angels, the nurses from Home Care Hospice, would recalibrate the dosage to increase the level. It never seemed to be enough.

Morphine also lowers the respiration rate, which means that at some dosage it will stop the patient's breathing altogether.³⁸ That's what seemed to happen to my father. At one point, a few minutes after the hospice nurses raised his dosage to try to control what had by then become weakly muttered agony, he stopped breathing. I am not saying it was that last dose of morphine that finally gave him peace. I think so, but I can't be certain. Nor am I implying that the hospice nurses were silently practicing euthanasia under the guise of pain control. From discussions I had with medical professionals and from what I've read, I know that happens and not infrequently. But I can't say that's what happened in my father's case.

Assuming the nurses were not trying to kill him, one would ethically

justify my father's death as a paradigm case of the ethical concept called the "principle of double effect" (PDE).³⁹ You give a patient morphine to stop their pain, realizing that there is a real risk that in the process the morphine will kill the patient. You aren't trying to kill the patient. You just want to stop the pain. Of course, you could stop the pain by cutting out the middleman and just directly killing the patient. But that's not the principle of double effect (PDE). Intentionally killing someone is not a legitimate action even if the ends are good (i.e., cessation of pain). Thus, it is not a morally good action under PDE regardless of your good motive.⁴⁰ Giving pain medication under my father's circumstances, on the other hand, is a morally legitimate action.

Thus, PDE gives moral sanction to well-intended, good actions that turn out to have bad effects. This is a familiar concept in medicine. Without surgery, there's a 95 percent chance you'll die, while the chances of surviving the surgery are fifty-fifty. Under PDE, death as the result of choosing this surgery would not be seen as the product of a moral wrong. It would be seen as an intentionally good act (surgery to save a life) that had a bad result. There would be no moral blame.

The principle values life. You don't try to kill the person. You take an acceptable risk to stop the screaming pain. My father was almost 80, cancer spread throughout his body, wracked with pain. Give him the morphine. Stop the pain. To do otherwise would be inhuman. But in his place put a 20-year-old man. Having fallen from a rock he was climbing, our young man has broken numerous bones, torn ligaments, and may have damaged his kidneys. When the rescue workers find him, he is in excruciating pain. Because of the terrain, they will have to carry him for four hours to get him to a hospital where they know the doctors will be able to bring his pain under control without using morphine. All they have is morphine. To control his pain using morphine, let's imagine that the required dosage carries the same risk of respiratory shutdown as that given to my father. If they administer the morphine and the young man dies (assuming he would have arrived at the hospital alive had they not given him morphine), I think they could yell PDE to the heavens. Nonetheless, their actions would be seen as wrong, perhaps even falling within the family of homicide, as the result of their having taken an unreasonable risk.

The only difference between the case of the 20-year-old, where giving the required dose of morphine would be "evil," and that of my father, where giving the morphine was "good," is the respective quality of the lives

the patients had and would have in the future: The young man had before him a long life, health, love, a future; my father faced only more suffering and death.⁴¹

Refusing Treatment

As I will discuss in some detail when I consider the arguments supporting assisted suicide, patients are said to have the right to refuse lifesaving medical treatment.⁴² In fact, my father refused food, hydration, and a proposed surgery that would have allowed him to better digest food. In thinking about this concept, I imagined a patient who wakes after surgery to find that the doctors were forced to amputate both his legs. No one would fault the hospital staff if they stopped him from stabbing himself with a nearby pair of scissors. Yet, if before surgery the patient is told that he will die of gangrene if his legs aren't removed and the patient says, "Then I'd rather die . . . no surgery," his request will be honored. While there may be differences in assessing these two situations from a legal perspective, from one espousing the absolute sanctity of life they seem similar. Both patients are taking actions that they know will end their lives.

Certainly, the person with the gangrenous legs would be more than happy to find out that he is going to live after all, even without the surgery. But so would the person who attempted suicide if he could live life without the results of the surgery. The person refusing treatment is killing himself. I believe we only condone his refusal because of quality of life issues. Let me be clear here. I am not saying a double amputee has nothing to live for or cannot have a far better life than me. That would be beyond nonsense. What I am saying is that losing your legs does raise quality of life issues, that our society cannot judge what that means for any particular individual, and that, accordingly, we will not interfere with the individual's decision to refuse the surgery.

More commonly, the decision to refuse treatment is made when the patient has a serious illness and does not have long to live. Sometimes the cure is worse than the disease,⁴³ leaving the patient suffering from a surgery that adds little time to his or her life or violently ill, as can be the result of chemotherapy. While the treatment will extend the quantity of life, it will destroy the quality of the short amount of life that remains. Thus, the line between the concepts of "quality of life" and "burden of treatment" blur in such a case. Given that the person will die soon, this seems like a trade-off

we should respect. Again, quality of life concerns underlie our acceptance of the patient's decision to refuse lifesaving treatment.

Instead of considering a person facing death, let's go back to our 20-year-old man. Imagine that he has an enzyme deficiency that is fatal if not treated. The treatment is a small pill (made in his favorite flavor), which he takes once a week. As long as he takes the pill, he will be a completely healthy 20 year old. The burden of treatment is low; the quality of ensuing life is high. Does anyone really believe that our society would let him refuse to take the pill and die? We would see this as a preventable attempt at suicide.⁴⁴

Terminal Sedation

More recently, hospitals have been using a procedure called "terminal sedation" for dying patients whose pain cannot be brought under control.⁴⁵ The patient is sedated, denied artificial food and hydration, and dies in a few days.⁴⁶ Under this procedure, the patient can be revived for short periods of time to visit with loved ones and again sedated when the pain becomes intolerable.⁴⁷

Again, quality of life considerations are implicit in this procedure. For someone like my father, it may have been an option. If we did it to our healthy 20-year-old, it would be murder.⁴⁸

When someone considers pulling the plug, PDE, refusing treatment, or terminal sedation, I don't see how one could conclude anything other than that, in the medical context, our society has moved the line from absolute sanctity of life to considerations about quality of life. That does not say how far the line has moved or should move or how the balance with quality of life factors should be weighed. But it does show that most who take the absolute sanctity of life stance do not hold that line when dealing with end of life care.