

ISSUE 3

*Assuming 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*





## *Utilitarian Arguments against Suicide*



Leaving the world of moral arguments that gave no consideration to circumstances or consequences (called deontological philosophies), such as those provided by religion and cultural philosophies, I next immersed myself in moral claims against suicide specifically based on particular circumstances and consequences (called consequentialist philosophies). Suddenly, I was rummaging through my son's college philosophy books to grapple with utilitarianism.<sup>1</sup>

Not surprisingly, the philosophy of utilitarianism is complex and nuanced, with a number of different "schools" and literature filled with complex responses to complex criticisms.<sup>2</sup> That was all quite challenging and interesting, but when I finished I realized that the ideas and arguments I had acquired were far more than I needed for my purposes. It was a bit like learning calculus to decide how to divide a whole pie evenly among six people.

In fact, for my purposes, one needs only the very basics. For the utilitarian, any meaningful ethical system must yield specific answers. In other words, we must be able to use it in our daily lives.<sup>3</sup> As such, utilitarianism requires that: (1) of every action, one must ask if it is right or wrong; and (2) the answer to this question will always be attained by balancing consequences,<sup>4</sup> which in classic utilitarianism gives the nod to that which does the most good or provides the "greatest happiness."<sup>5</sup>

Roughly speaking, utilitarians then take one of two paths. The first considers the individual, concrete action. This is called *act utilitarianism*, under which one must perform the action that results in the most good. But there are apparent problems if act utilitarianism provides my sole moral guide.

Say I break into the home of a rich person and steal some money he was going to use to put a flat screen television into his third guest bathroom. I use the money to buy food for starving street people. Under act utilitarianism, this would seem to be a moral act when you balance and assess the overall goodness of the consequences. As you can imagine, this type of scenario presents a real problem for act utilitarianism. As a society, we do not believe stealing is a good thing. Is utilitarianism telling us that we must find this theft to be moral? Do we next have to condone the murder of a man who is physically and sexually abusing his children? If so, one might be less inclined to embrace the philosophy.

It is to address such quandaries that a second notion of utilitarianism, *rule utilitarianism*, arose.<sup>6</sup> While this particular act of theft may have good consequences, from our human experience we realize that the aggregate consequences of this type of act (stealing) will have bad consequences for the society if condoned. Thus, this single, perhaps sympathetic theft is wrong. The rule “Do not steal” trumps the individual case, and rule utilitarianism saves the day (although a formal philosopher might question whether a theory based on such projected aggregate consequences is more deontological than consequentialist and thus not truly a form of utilitarianism).<sup>7</sup>

I cannot imagine rule utilitarianism supporting suicide (“Kill yourself if the fancy strikes”); rather, rule utilitarianism would set limits, create a prohibition (“It is wrong to take your own life”). Even if a single act of suicide may achieve good results, the logic of rule utilitarianism is that if the act is one that constitutes part of what is a general practice<sup>8</sup> (and, given 30,000 successful suicides a year,<sup>9</sup> in addition to all the attempted suicides,<sup>10</sup> suicide would seem to qualify as a general practice), and if, at some numerical point, that practice will cross a threshold and cause harm,<sup>11</sup> then the act should be prohibited. So I tried to imagine all the foreseeable bad consequences that could follow from allowing the general practice of suicide. While I found all to merit some concern, they could not convince me that people like my father are committing an immoral act if they engage in suicide or assisted suicide.

COMMITTING SUICIDE WILL INFLUENCE  
OTHERS TO COMMIT SUICIDE

This view claims that if there are enough suicides that suicide becomes a norm for opting out of the difficulties that invariably accompany a life, people will take this path who would not otherwise.<sup>12</sup> Some studies have indicated, however, that suicide does not engender such copycat responses. It is not contagious. On the other hand, studies at their best are just that, studies—random compiling, statistical assumptions, and such. And one surely can imagine someone teetering on the edge for whom hearing about another's suicide might give the last bit of validation needed to tip them over. Also we've seen that once the media show a phenomenon—such as shootings by students at schools—the concept emerges as a possibility when previously it did not even pass through the psyche. One can thus imagine, for example, a chain reaction among that emotionally volatile population we call teenagers triggered by peer suicides.

All that said, there initially is the question of how the copycat phenomenon is affected if the behavioral “image” provided is or is not labeled as immoral, as opposed to tragic, harmful, ill-advised, stupid, or the result of bad judgment. The extreme behavior to which we append the label copycat seems to be conduct in which the perpetrator intentionally stands outside the basic moral precepts of the community and flaunts his or her defiance. The moral label not only fails to deter the perpetrator; it appears to provide the incentive to act.

My focus here is not on teenagers, confused 30-somethings, or even hopeless middle-agers. My concern is with terribly ill, elderly people like my father. The image of a terminally ill, 80-year-old man ending his life presents a narrative that is totally unrelated, totally unconnected to the world of the heartbroken teen or emotionally suffering 35 year old.<sup>13</sup> It is not imaginable that one could affect the other. (In fact, advocates supporting legalization of voluntary termination of life as a tool for physicians dealing with end of life care take the position that this type of medical intervention does not constitute what is meant by the concept of assisting a “suicide” as that term is used in criminal statutes that prohibit helping another to end his or her life.)

From the perspective of risk and consequences, we must balance these for both our young and elderly sick populations. It seems difficult to contend that the number of young people who would kill themselves, if you

do not have a *moral rule* absolutely barring suicide in addition to our society's clear and strong discouragement of suicide as an appropriate problem-solving device, would be significantly greater than the number of elderly sick people who would be deterred from ending their suffering if there were such an absolute moral rule.

#### SUICIDE HAS GREAT SOCIAL COSTS

Suicide can carry with it a range of costs, economic and otherwise. The person committing suicide might have had a number of economic responsibilities, which must now be assumed in some form by others. If the person has young children for whom he or she is solely responsible, the burden might fall on relatives, who may be more or less financially able to shoulder the responsibility. If no such relatives (or even very close friends) are available, the state will have to take on the responsibility for and expenses of relocating and raising the children. There will also be traumatic, emotional effects on the children (even if this were not the sole parent), which will play out in both the short and long term. And suicide generally leaves painful, unresolved, angry, and guilty feelings in those close to the people who are left behind.<sup>14</sup>

Suicide is a sad, awful, tragic event. But again, when considering the justification for an absolute moral prohibition under the philosophy of rule utilitarianism, we face the same dichotomy between our two disparate populations. For the young person who feels hopelessly lost, the middle-aged person suffocating under a blanket of black depression, and such, suicide may well carry serious attendant social costs in dollars, physical and emotional disruption, fragmentation of the remaining family structure, and confusion and pain caused to friends.

But the suicide of the elderly, suffering, terminally ill, like my father, does not bring with it these costs. These people are no longer caretakers, leaving behind their charges for others to watch over. They are the subjects of caretaking. Family members surely will be sad, but they will understand. The sadness is a result of the awful situation the loved one has been placed in, not the means he or she has chosen to end it. No one will think, "If only I'd called more often. . . . I should have seen the signs." Those left behind are neither responsible for nor betrayed and abandoned by the person's decision to end the suffering.

PEOPLE CONTEMPLATING SUICIDE ARE  
DEPRESSED AND COULD BE HELPED

The idea here is that, if suicide is not morally condemned, people who otherwise could be helped by treatment will too easily opt for suicide rather than seeking the beneficial treatment they need to get well.<sup>15</sup> A moral prohibiting rule, on the other hand, will make them think twice and, in this hesitation, perhaps shift their focus to medical or psychological treatment. In favor of this position is the documented fact that a substantial percentage of people who seriously contemplate suicide are clinically depressed or suffer from some other form of mental illness.

In the first place, I have little faith that such a moral rule would provide a meaningful counterweight to a killing depression. Again, it's not like any of us were raised to think that suicide is a good idea. If this accumulated social wisdom does not take hold, how much more would the articulation of a utilitarian moral rule add? This is particularly so since those committing suicide no longer live by the same logic as you and me.<sup>16</sup> They, in fact, reject the logic of life that we live by, responding to an entirely different world conception.

Further, let's assume it's true that, absent this moral rule, some who would have sought treatment with the rule, and who would have been "cured," will now kill themselves. How does that counterbalance the elderly sick, who with the rule will feel compelled to suffer until the drawn-out end? The common answer is that people suffering from a terminal illness, like my father, are also depressed and with access to proper mental health treatment will no longer wish to kill themselves. After all, suffering is far more than pain. It is an emotional, psychological, spiritual, and existential mix. Also pain is not purely physical. It is inextricably bound to the psyche. So there certainly is some plausibility to this position. It is just not the trump card in the assisted suicide debate its proponents claim.

Research has shown that mental health treatment has no effect on the suicidal wishes of those with mild to moderate depression.<sup>17</sup> To the extent it provides some benefits to those with major depression, it is not so much that it addresses the depression per se as that it helps alleviate a sense of *hopelessness*. It is not depression but hopelessness, the feeling that there is no end to the suffering, that is most strongly associated with suicidal ideation in very sick patients.<sup>18</sup> In fact, in some studies it was found that,

far from wishing to terminate their lives, depressed patients wanted more care than similarly ill nondepressed patients. (If the suffering is principally from the pain of clinical depression, however, the distinction between hopelessness and depression becomes less clear, as one of the features of this magnitude of depression is the sense that the crippling psychic pain will never end.)

Significantly, studies of patients with bad prognoses (e.g., terminal cancer) who had seriously expressed the wish to end their lives, through either assisted suicide or refusal of lifesaving treatment, indicate that these patients were no more likely to be depressed than not.<sup>19</sup>

Also it is not clear what kind of treatment the proponents of this view have in mind for people like my father. My dad died less than two and a half weeks after he asked us to kill him, and I have no basis on which to judge whether this time frame among the dying seeking release was idiosyncratic with my father. Was he to be dragged from his bed to counseling or forced to find a therapist who makes house calls? Or was he to be prescribed some form of antidepressant, even the newest of which take 10 to 12 days to have any real effect? Moreover, such drugs have significant side effects, which would have included interactions with the legion of other powerful drugs coursing through his body.

My father, of course, is only one case. There are likely other terminal patients who seek death at a far earlier stage of diagnosis and degeneration. Those patients, in turn, may be responding to controllable depression as much as any impetus from the consequences of the disease. For them, the availability of therapy is no doubt a good idea. But the fact that there are some such cases does not carry the day for an *absolute* utilitarian rule barring suicide.

#### THERE COULD BE A MISDIAGNOSIS

This certainly happens.<sup>20</sup> A close relative of mine who was first diagnosed as having surgically treatable prostate cancer was then told that further tests established that the cancer had metastasized throughout his body. Translation: he was a dead man. A subsequent test showed that the diagnosis of metastasized cancer was incorrect (“sorry”). Surgery followed, and he remains cancer free. Yes, misdiagnosis happens. I would have no problem with a rule that stipulated, “Never kill yourself within— weeks of any medical diagnosis.” But, if one is contending that the mass of

people diagnosed with a terminal illness, and who are already suffering its pathology, have somehow been misdiagnosed, I'd say that's utter nonsense.

#### THERE COULD BE A CURE ON THE HORIZON

This book is not about people in a persistent vegetative state (PVS) since I am dealing with conscious individuals making conscious choices.<sup>21</sup> Nonetheless, it is worth noting that one of the implications of this argument is that no one should ever be taken off life support (i.e., pulling the plug), and, if one fully follows this implication, everyone should be cryogenically frozen prior to the moment of death to await future cure.

Moving back to reality and people like my father, this argument, while invoking our need for hope in life, seems totally unrealistic. Cures don't suddenly happen. There are years of clinical trials, protocols, and cohorts. Particularly with computer information systems, competent oncologists (and likely their patients) are aware of available and experimental treatments. Even if an experimental treatment suddenly emerged, it is extraordinarily unlikely that an elderly ill person would qualify for experimental trials. A friend of mine underwent experimental cancer treatment, early stem cell research. He was in his late thirties. He almost died during the experiment; my father never would have made it through.

As for a treatment that moves from experimental to generally available, what we're talking about is timing. The proponents of this stance imagine a scenario in which the day after you kill yourself the Food and Drug Administration (FDA) announces that a cure is available to the general patient population (or, more likely, that insurance companies will cover the treatment). But, again, it seems implausible within the modern world of medical information that this announcement would come as a bolt out of the blue. Even if we assume such a deeply improbable scenario, the treatment will not magically become instantaneously available to all who want it.<sup>22</sup> There will be limited supplies of the drugs and limited facilities in which to carry out the new treatment. People like my father (79 years old and already very ill) would be placed near the bottom of the list. Finally, like others in the last stages of a terminal illness, his disease was so far progressed that realistically it would have been too late for any treatment which suddenly became available to save him.

## THERE COULD BE A “MIRACLE”

If, by a miracle, you mean that, after years of unconsciousness, people have come out of comas feeling fine,<sup>23</sup> or that our bodies are miracles and can sometimes fool science and heal themselves, I completely agree. So we're back to balancing alternative rules and consequences between the elderly terminally ill and others in the population who are physically and/or psychologically suffering. In one pan of the scale are people like my father, who an absolute moral rule would tell to continue to suffer in their dying even though they are beyond any hope of getting better. In the other pan are those individuals who, if there were not an absolute moral rule, would kill themselves when, had they just persevered, they would have “miraculously” recovered. I certainly do not have the information, knowledge, and wisdom to maintain this balance, and I sincerely doubt that anyone else does, or even would, given that I cannot see how the admittedly realistic possibility of miracle recoveries could lead to an absolute prohibition (i.e., no exceptions or excusing conditions) of suicide.

If, on the other hand, you mean a true biblical-type miracle,<sup>24</sup> parting the Red Sea, loaves and fishes, walking on water, and such (though this is unlikely grist for a utilitarian argument), then we should never bury or cremate anyone because God can later choose to make a miracle and raise the dead. Come to think of it, it doesn't matter whether you bury or cremate someone or even whether he or she chooses to leap from a bridge. If you are relying on miracles wrought by a deity, God can do whatever God wants, including bringing someone back to life. After all, if you're going to rely on miracles, why distinguish between whether God acts to renew the life of a person just as it's about to expire or just afterward.

THIRD-PARTY ASSISTANCE IN SUICIDE AS SEEN  
THROUGH THE LENS OF RULE UTILITARIANISM

I recognize that up until now I've lumped together suicide, assisted suicide, and euthanasia. And for what I've discussed to this point I do not think that matters. But I also recognize that, even if suicide is not immoral, that does not mean it is moral for a third person to help someone kill himself. The reality is that this book was not written because some abstract “third party” faced the question of the morality of helping another kill himself. It is about me; it is about my sister. My father begged, and we refused him. Yet I have no way to pursue my inquiry other than to turn

back to what initially seems so cold, so academic: moral philosophy. Based in real world consequences, however, rule utilitarianism analysis quickly places flesh on its abstract philosophical bones. The rule utilitarianism argument is analogous to the one I just discussed in relationship to suicide; even if a particular assisted suicide is justified, taken as a general practice, the results are so harmful that the practice should be morally banned. Once again, I have tried to imagine all the bad consequences that could follow. Once again, while I take those consequences seriously, singly or collectively they cannot convince me that assisting someone like my father to kill himself is always immoral. In this analysis, I am not considering the assistance of doctors, leaving that for the following chapter.

### *Increases in the Ease of Suicide and Thereby Its Likelihood*

Even if we permit suicide, that does not mean we want to encourage it. Would we want everyone to carry a lethal “poison button” on their wrists? To the extent we allow assistance, or euthanasia, we make suicide easier in several ways. First, assistance helps facilitate the act. When my father first asked us to help him die, he wanted us to put him in the car in the garage, turn on the ignition, and let the carbon monoxide do the rest. In his condition, he might not have been able to even get to the car by himself let alone locate the keys, a hose, something to cut the hose with, and duct tape and then rig this together. Without some help, most very sick people could not kill themselves (unless they use a gun, which means having a gun and not being uncomfortable with leaving a mess). Second, even if they could do it themselves, many people would not do so for fear of botching it and ending up worse off than before. The assistance of another may tend to diminish this concern. Third, the assistance provides emotional support (you are not dying alone) and social acceptance (at least one person seems to approve of what you are doing).

While in most of life’s endeavors assistance makes the task easier, and thus accessible to more people, approving assistance is not likely to lead to an explosion of suicides throughout the population. We’re only talking about those persons who are incapable of committing suicide without assistance. And by “incapable” I mean physically, not emotionally, incapable. If we expanded assistance to the latter group of individuals, then we would expand the reach of assisted suicide to all segments of our population, which is something most of us do not wish to do.

Also we must balance alternative consequences. If we permit assistance,

some people will kill themselves who would not otherwise do so. If we do not, some will not kill themselves who would otherwise do so. So the question revolves around the utilitarian balance between two unknowables. If assisted suicide were seen as moral, would more people kill themselves, who would have been better off not having done so, on the one hand, than people who would not kill themselves (because assistance, being seen as immoral, was not forthcoming), who would then be forced to suffer, on the other?<sup>25</sup> My intuition tells me that there would be far more of the latter, but that is only intuition. Others might see the balance tipping in a different direction. Neither side can claim a firm moral basis for or against assisted suicide based on this single argument.

*It Will Increase the Chance for Disguised Murder*

The greedy relative, the rich elderly aunt who simply won't die—we've all seen the movie. To the extent you permit third parties to be legitimately involved with poisoning others, you certainly provide another way in which someone can try to get away with murder, this time under the guise of assisting a suicide. I have no question that there is a genuine risk, although the pool of potential victims is limited to those physically incapable of carrying out the act themselves. It is also a risk that seems greater with euthanasia than assisted suicide because the latter requires that the deceased take the lethal dose themselves. On the other hand, if someone committed murder he or she would lie about it. In other words, the killer could sneak the poison into some otherwise flavored drink (which is a basic method in the world of poisoning) and later lie, saying the deceased knowingly took the poison.

On the other hand, committing murder carries its own, substantial risks. Again, balancing the risk that moral approval of assisted suicide could facilitate homicide against the risk that moral disapproval could lead to needless suffering, I come to the conclusion that, while our society should generally disapprove of assisting suicide, excusing conditions that morally overcome that presumption, such as when the person being helped is suffering and dying, like my father, must be allowed. In other words, there should be no absolute moral bar.

*People Will Be Coerced into Committing Suicide*

This is a recurrent and real concern,<sup>26</sup> which appears anywhere there is a discussion of assisted suicide. Very sick people are extremely vulnerable.<sup>27</sup>

They are exhausted from fighting the disease and pain and often depressed by what is happening to them. In this state, they are often ambivalent about suicide,<sup>28</sup> changing their minds back and forth in relatively short periods of time.<sup>29</sup> America has such a strong culture of independence and self-reliance<sup>30</sup> that dependence becomes a source of shame.<sup>31</sup> And very sick people are extremely dependent; yet, ironically, this culture of self-reliance leads them to distance themselves from others at the very time they most need others.<sup>32</sup> I know it bothered my father, though he never said so. They are also extremely sensitive about being a financial and emotional burden on their loved ones. Under these circumstances, they are susceptible to pressure from those close to them conveying the message that it is time for them to die,<sup>33</sup> especially since they might already feel they have a “duty” to die.<sup>34</sup>

There is a wide range of motives for someone close to a sick person to consciously or unconsciously apply such pressure. It could be the best of reasons. Family members might think sick persons are only holding on and suffering because they, in turn, think the family would be upset if they seemed to give up or even expressed an interest in suicide. In this psychological form of rock, paper, scissors, a family member may merely be trying to give the suffering person the freedom to choose to end it all. It could also be the worst of reasons. Family members might not want to see their inheritance diminished by further health care costs or they might find the obligation of visiting and caring for the person too great an intrusion into their busy schedules. Most likely the motivations are a far more complicated mix of factors, including the pain of watching a loved one suffer, the exhaustion from being involved in caretaking, and such.

Even with the constant help of hospice, it was a 24-hour-a-day task caring for my father in the last weeks of his life. We got so tired, and it was so hard to watch him suffer, we just wanted it to end. We were good people, but we just wanted it to end, truthfully, as much for us as him. At the same time, I wanted him to live on and on. He was confused and slept most of the time at the very end. But he was still there. I could touch him, talk to him, listen to his breathing. I still had a father. It's not simple, not black and white, not even gray. It's something else that is its own world. Within that world, who can say what one's “real motives” are?

At this point, one might point out that the risk of coercion is equally great when decisions are made to refuse treatment (although many of these are not made by the patient, who often is unconscious, but by the family and/or physician). That, however, is not an answer to this concern. That

we risk coercion in the realm of refusing treatment does not mean we must also risk it here. The fact that we allow the opportunity for behavior that has the risk of negative consequences (e.g., by letting people drink, knowing some will drink too much alcohol), does not mean we are committed to accepting that risk in areas where there could be even greater harm (e.g., by legalizing dangerous drugs). Withdrawing treatment takes place in an extremely circumscribed environment (in a hospital surrounded by life-support technology). In contrast, assisted suicide can take place anytime, anywhere.<sup>35</sup> So, again, the fact that we risk coercion in withdrawing life-saving treatment does not mean we can dismiss that concern when it is raised in the broader context of assisted suicide.

All that said, the question remains whether this very real risk justifies an absolute rule that assisted suicide is morally wrong. Like the proverbial broken record, we come back to our competing alternative consequences. Here the balance of consequences is between people who don't really wish to die but are coerced into suicide versus those who must suffer because, although they wish to die, they cannot get assistance because it is labeled immoral (and they hesitate to engage in or ask another to engage in an immoral act). Again this is simply not enough to justify an absolute prohibition. I have no way to guess what the numbers in these groups would be. Even if I knew the numbers, I have no criteria with which to compare them: how much difference has moral significance? For I have no criteria to tell me whether it is worse to have, for example, a month unnecessarily taken from my life or worse to be forced to suffer unnecessarily for an additional month.