

Chapter VIII

Dying: Rights and Responsibilities

“They tell us that suicide is the greatest piece of cowardice ... that suicide is wrong; when it is quite obvious that there is nothing in the world to which every man has a more unassailable title than to his own life and person” -- Arthur Schopenhauer

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What is the basic rationale for a right to die? More specifically, in the medical context, the right in question is a right to hasten one's death in such a manner that one dies sooner in order to die better. The qualities that make a death a good death, or at least a better death, are determined by the person's individual conception of good and also broader religious or spiritual imperatives. When the death of person is already imminent, the focus should be on the character of the death, and not simply whether to live or die. Defenders of a right to die insist that hastening death in no way diminishes the value of each person's life. After looking at the basic rationale for a right to die we turn to familiar objections to taking more active means to hasten death, including physician assisted suicide (PAS) and voluntary active euthanasia (VAE). We see that pragmatic considerations, in particular, concerns about protecting the weak, the elderly, and the vulnerable, and not basic principles, provide the primary basis for the remaining objections to actively hastening one's death.

Although, those that object to actively hastening death do not seem to appreciate the scope of these arguments, these practical objections actually apply equally to passively hastening death by letting underlying diseases kill people. It would seem that the appropriate moral and practical response to these practical concerns is not a prohibition on actively hastening death, but instead an expanded right to high quality end of life

health care services. As a corollary, it also follows that high quality end of life care should be an essential part of basic health care services.

First, we focus directly on the moral arguments for allowing natural death and against actively hastening death. Next, we will also consider the experience in the Netherlands with legalized voluntary euthanasia and the German approach of non-physician based assisted suicide. On the basis of these moral arguments, and our reflections on the Dutch and German approaches, there is indeed a right to hasten one's death but that this right should be part of a cluster of rights that include affordable access to a range of end of life care options, including hospice and high quality palliative care. We conclude by looking at Confucian, Islamic, and Buddhist attitudes towards hastening death. It is striking that in otherwise strikingly different cultural contexts as in the West, the central objection to actively hastening death depends in each case on an appeal to the doctrine of double effect which permits actively causing death as an foreseen effect but prohibits intentionally causing death. Despite its wide indeed global appeal, the principle of double effect is itself controversial and it is not at all clear that it even properly applies to the cases at issue.

PART I – Basic Issues

44. Allowing Natural Death

It was not until the 1970s that the issue of the right to die became pressing. With the advances in life-sustaining medical technology, it became possible to sustain life beyond the point where the patient might value his or her continued existence. Indeed, as we saw in the last chapter, patients in persistent vegetative states can be sustained for years without any hope of regaining even minimally conscious awareness. Even if we conclude that such patients are still alive, it is a different question as to whether patients with no hope of any form of meaningful recovery should be kept alive by artificial life support. Although it is now widely accepted that it is permissible to remove life support and allow the patient to die, originally this was sufficiently controversial to lead to court battles and lively debate.¹ Many felt that the conscious decision to remove life support and let the patient die amounted to intentionally causing the patient's death and thus was an act of impermissibly killing the patient. Since it was recognized that patients could refuse life saving medical care, we were faced with the dilemma that a patient could refuse to be put on a respirator, but once on the respirator it could not be removed. It was permissible to withhold care, at the patient's request, but not to withdraw that same care once it had been initiated. Something clearly was wrong with this approach.

If treatment could not be stopped once it was started, patients that are afraid of being trapped on life support and held against their will in a hospital, would be more likely to refuse potentially beneficial care. If a respirator cannot be withdrawn once it is started, many patients with a questionable prognosis are not willing to take the chance

¹ The 1995 Asch Study demonstrates striking shift in the United States medical profession since the 1970s: The study found that 96% of 879 physicians working in intensive care units throughout the country had discontinued life-sustaining treatment with the expectation it would result in the death of the patient. It is also noteworthy that 35% reported acting without the knowledge or formal consent of the patient or surrogate, and 3% reported acting over the objections of the patient or a family member. On the other hand, 34% had refused a request to discontinue life support on some occasion. We thus see both an acceptance of allowing death and that physicians are relying on their own judgment of whether continued life support is appropriate.

and risk being left “hooked up to machines” living in limbo, in a sort of medical purgatory. Some people believe that such a life is an “unnatural,” “artificial,” even “inhuman” existence. Indeed, many people with a reasonably good prognosis would no longer trust hospitals for fear of losing control of their fate. Prohibiting the withdrawal of treatment when withholding care is permitted, or even required in cases where a competent patient or surrogate refuses consent, is clearly bad public policy. It is also conceptually questionable.

If I consent to a treatment, there is no basis for the assumption that I cannot subsequently withdraw my consent. If I start chemotherapy, say, and after several treatments make an informed decision not to continue with the treatments (perhaps because the prognosis turns out not to be as good as I initially hoped, or perhaps because the side effects turn out not to be worth the chance of success), I have the right to “withdraw” and stop the treatments. If I am in a hospital, I do not thereby lose this right. The mere fact that I am incapable of leaving the hospital on my own, perhaps “against medical advice,” does not somehow transfer a prerogative to the hospital that overrides my right to refuse continued treatment. To be sure, in any case where withdrawal of a treatment is likely to lead to the death of the patient, there is an added responsibility to be sure that the decision to withdraw reflects the considered and informed wishes of the patient. But if the considered preference of a patient is clearly known, then continued care of the patient should reflect the patient’s wishes.

It is important to appreciate, however, the added subjective sense of responsibility experienced by the person that must actively do something to withdraw care. If the “act” in question is withdrawing a respirator, the feeling of responsibility may be quite strong. If the act is simply the omission of what was routine care, like regular dialysis, then many will feel less of a sense of responsibility (although still a sense that one should do something, perhaps). In either case, however, the feeling of responsibility does not reflect any culpability for the resulting death. It is indeed the responsibility of health care providers to care for patients, but this care must be constrained by the values and principles of the patient. If life prolonging treatment is contrary to the considered preferences of the patient, then it is contrary to the basic medical duty to care for, and not harm, the patient. Medical interventions that are contrary to the wishes of the patient do not treat the patient as a person at all, and thus they do not really reflect an attitude of care for the person that happens to be a patient. Of course, allowing death, when death is sought, does not preclude continued comfort and palliative care. Medical care involves more than curative medicine or life prolonging interventions.

The same reasoning that justifies withholding or withdrawing life-continuing care also justifies withholding or withdrawing medically administered nutrition and hydration. The withdrawal of “food and water,” however, raises some distinct emotional and symbolic issues. As a matter of principle, the right to refuse medical treatment is simply not contingent on the type of treatment. It does not matter if the care is simple or complex, noninvasive or invasive, routine or heroic, pharmacological or technological. Medically administered nutrition and hydration is indeed medical care, and thus like any other medical treatment it is subject to the right to refuse. Just as patients can refuse respirators which give the breath of life, they can refuse IVs and tubes that provide basic sustenance that sustains life. In various ways, however, withdrawing sustenance is harder than withdrawing a respirator. Providing food and water is the most basic way in which

we care for the young and the sick, and it is thus also a particular symbolic form of caring. Dying in this way is also often a slow process and thus especially difficult on those who must watch and wait. Context, however, is everything. If allowing someone to die is permissible and we are respecting the wishes of the patient, then we care for the patient by honoring his or her wishes. Here too the medical team should do all that it can to insure the comfort of the patient. Although dying in this way is a slow process, it need not involve any pain or suffering for the patient -- and knowing this is also a comfort to all those involved with this most difficult situation.

The biggest objection to allowing natural death in general and especially in the case of withdrawal of sustenance in particular is the “slippery slope” argument to the effect that there is no significant difference between these cases of allowing death and more active means of causing death. Of course, if the reasons offered for allowing death are sound and if there is no relevant difference between these types of cases and the use of more active means, this would simply mean that more active means of hastening death are also permissible. It would not show that allowing death is impermissible. We will return to this issue and approach it from a theological perspective in our discussion of Islam and the divine prerogative over life and death (section 53), and again in our discussion on Buddhist ethics (section 54). The question we now will consider is whether these same arguments do indeed permit hastening death by more active means, for example, by prescribing a lethal dose of drugs to be taken by the patient (that is, physician assisted suicide or PAS) or administering a lethal agent in accordance with the will of the patient (that is, voluntary active euthanasia or VAE). We now turn to this question.

45. Freedom of Conscience, Self-Determination, and the Right to Die

Although reasonable people may disagree about the nature and extent of a right to die, as a matter of public policy in a secular democracy, there is an overwhelming case for a broad and expansive right to die. Clearly, one of the most powerful sources of opposition to a right to die is based in particular religious beliefs and a more general belief that life and death questions are a matter for the divine will or Karmic forces and not human choice (see section 53 and 54). Religious doctrines, and the judgment of religious authorities, are powerful and important determinants of individual moral belief. In a society committed to religious freedom and a doctrine of free faith, however, religious authority does not provide a reasonable basis for public policy or state coercion. Here we can see a deep similarity between an individual’s choice about how to die and the pro-choice position over the decision whether or not to carry a pregnancy to term. The ethics of abortion involves fundamental beliefs about the beginning of life and the value of human life. So too the right to die involves fundamental beliefs about the value of life in the face of death.² We will focus first on arguments that do not appeal to

² In considering the analogy between abortion rights and the right to die, it is noteworthy how easily the US Supreme Courts latest ruling on the constitutionality of abortion applies to the right to die. Below is the fundamental liberty principle governing abortion rights as stated in the *Casey v. Planned Parenthood of Pennsylvania*” US SC 1992), which upheld the courts earlier 1973 (and more famous) *Roe v. Wade* ruling:

“It is a promise of the Constitution that there is a realm of personal liberty which the government may not enter ... Men and women of good conscience can disagree about the profound moral and spiritual implications of *terminating a pregnancy, even in its earliest stage*. Some of us find *abortion* offensive to our most basic principles of morality, but that cannot control our decision.

religious authority. In particular, in examining the right to die, we will focus on the principles of respect for autonomy, compassion and beneficence, and the duty not to harm. Of course, these principles are also central principles of religious ethics, and our discussion here will thus inform our more specific consideration of Islamic and Buddhist approaches to hastening death.

Respect for autonomy, in the sense of individual self-determination, provides a clear basis for the individual's right to refuse life prolonging medical care, and also for a broader right to hasten one's death so as to make it better. Some, however, have argued that the right to refuse care, which is widely accepted, is based instead on the right to be free from battery and other assaults on one's bodily integrity. The right to bodily integrity is narrower than the autonomy based right of self-determination. This more limited right, it is argued, does not include a right to control the manner and nature of one's death. Persons have a general right to be "let alone" unless they violate the rights of others, and this negative right is the basis for the right to refuse treatment but it is not a sufficient basis, it is claimed, for a positive right to hasten one's death.³

This argument is puzzling. Granted that battery is wrong, but so too is restricting liberty. Persons clearly have a fundamental interest in determining how they die, and this provides a clear basis for a basic right to hasten death.⁴ We need some competing principle to justify actions that aim to restrict this liberty, and this includes attempts to

Our obligation is to define the liberty of all, not to mandate our own moral code ... The *mother who carries a child to full term* is subject to anxieties, to physical constraints, to pain that *only she* must bear. *Her* suffering is too intimate and personal for the state to insist upon its own vision of the *woman's role*, however dominant that vision has been in the course of our history and our culture. The destiny of the *woman* must be shaped ... by *her* own conception of *her* spiritual imperatives."

Here is the same passage with passages in italics altered above so as to apply to the end of life cases:

It is a promise of the Constitution that there is a realm of personal liberty which the government may not enter ... Men and women of good conscience can disagree about the profound moral and spiritual implications of *actively hastening a death or letting a person die, even by withholding treatment*. Some of us find *assisted suicide and euthanasia* offensive to our most basic principles of morality, but that cannot control our decision. Our obligation is to define the liberty of all, not to mandate our own moral code. The *patient facing death* is subject to anxieties, to physical constraints, to pain that only *he or she* must bear. The suffering of *patients* is too intimate and personal for the state to insist upon its own vision of the *end of life*, however dominant that vision has been in the course of our history and our culture. The destiny of *terminal patients* must be shaped by *their* own conception of *their* spiritual imperatives.

Although many constitutional principles are controversial, there is indeed a widespread overlapping consensus embracing the principle of freedom of conscience, especially on fundamentally personal, spiritual, and religious matters. There is thus a strong presumption in favor of a fundamental right of self-determination at the end of one's life. This constitutional argument for the right to hasten death is developed in "The Philosopher's Brief," by Ronald Dworkin, et al., *New York Review of Books*, vol. XLIV no. 5, March 27, 1997.

³ This commonplace argument can be found in the influential New York Task Force on Life and Law, "When Death Is Sought: Assisted Suicide and Euthanasia in the Medical Context," Supplement to Report, April 1997. For a good response to this argument, see G. Dworkin p.69 in *Euthanasia and Physician Assisted Suicide: For and Against*, Gerald Dworkin, R.G. Frey, and Sissela Bok (Cambridge, 1998).

⁴ A fundamental liberties based argument for the right to die is developed in "The Philosopher's Brief," which is an amicus curiae brief of six moral philosophers to the United States Supreme Court pertaining to the cases of the *State of Washington v. Glucksberg* and *Vacco v. Quill*. For the main idea, see Dworkin's "Assisted Suicide: The Philosopher's Brief, Introduction" in *The New York Review of Books*, vol. XLIV, No. 5, March 27, 1997.

restrict the liberty of others who are willing to help me hasten my death. Both sides of this debate over the nature and extent of a right to die recognize the importance and centrality to a person of the manner of their own death. Indeed, the debate is over how to care for dying persons with due respect and compassion. Limits on the right to die need to focus on how these limits protect the dying person's own interest, or alternatively on distinct and assignable harm to others.

46. The Priority of Persons over mere Preferences

First, we need to get clearer about the nature of respect for a dying person. It is argued by some that the intentional destruction of an innocent person is always incompatible with respect for the dignity of that person. Indeed, the argument goes, it is always wrong to kill oneself merely to avoid suffering because one's value and dignity as a person transcends the mere value of pleasure and pain. It is thus never permissible to kill oneself because one's future promises more misery than benefit because doing so violates the fundamental moral requirement to treat oneself as an end and not a means only. Each person has a special value, a dignity that cannot be exchanged for mere benefit or to avoid some harm. Just as it is wrong to sacrifice someone in order to promote the pleasure of others, so too it is wrong to sacrifice oneself merely to avoid pain. The self-destructive act of suicide treats oneself as a thing and thus fails to recognize the inner value and dignity of oneself as a person.⁵

The idea behind this principle of prohibition of all suicides does have some appeal. Consider a case where a person whom one cares about is acting on self-destructive preferences: Normally, if we care about people, then we also care about their happiness and we thus also want them to realize their projects and to live up to their ideals. Our concern for the ends of others, however, is based on our concern for them. When we act in ways that promote the ends of another, it is because we think that that person matters. If not, then their ends would not matter. So there is something incoherent about caring about the subjective ends of another and not caring about that person. In general, the ends of another person matter because the person matters. The value of a person is prior to the value of the person's preferences -- so far so good.

The argument for the prohibition on suicide next assumes that one's continued existence as a person always takes priority over one's conception of one's own good. Here is the idea: My conception of the good matters only if I matter, so my conception of the good cannot provide a justifying basis for destroying myself. Suicide for the sake of benefit is thus never justified. Despite its apparent logic, this just does not seem right. It seems clear that death can be a release and a benefit for a dying person. So what has gone wrong?

We need to distinguish two senses in which we might be concerned for a person, and not simply the preferences of the person. The argument for prohibition assumes that concern for a person necessarily involves concern for the continued existence of a person. Concern for a person, however, involves concern for the person's integrity and character,

⁵ Kant's example of a suicide maxim in the Grounding for the Metaphysics of Morals is often taken to support this type of position. Kant's discussion of maxims of suicide in the Metaphysics of Morals, however, is subtler. Leon Kass asserts this type of position in "Neither for Love or Money: Why Doctors Must Not Kill," *The Public Interest*, no.94, Winter 1989. The best fleshing out of this position is found in David Velleman's article, "A Right to Self Termination," Ethics vol. 109 no. 3, April 1999, pages 606-28.

not the person's mere existence. The object of respect and the basis of human dignity is autonomy: the capacity to set oneself ends and pursue a conception of the good that gives one's life meaning and purpose. We thus respect human dignity by endorsing and following procedures that allow each person to reflectively endorse and to pursue a substantive conception of the good.⁶ We respect the dignity of ourselves by living *and dying* in accordance with the values and principles that we reflectively endorse. Respect for others also involves a similar respect for their values and principles. And, of course, respect for dignity, in this sense, may include assisting them in dying, in a manner that reflects the values and principles that constitute their conception of the good. Helping someone die may be fully consistent with respecting the dignity of that person.⁷

The choice here can be limited to how to die when death (or loss of personhood) is imminent. Controlling the timing and method of one's death in no way compromises the value of life itself. One can continue to view life as a priceless gift and to honor the dignity of all persons, including one's self, and yet also realize that one's life as a person is now done. The acceptance of death is compatible with the valuing of life. After all, it is not as if how long one lives determines the intrinsic value of one's life. Clinging to every minute of life, simply because it is more life, fundamentally misconceives the nature of the intrinsic value of a human life.

47. Limits on the Right to Die: Debbie vs. Diane

Let us pause for a moment and notice that the argument so far does not imply that one should honor all requests to die. The decision to die must be informed and considered and it must actually reflect the values and principles of the person in question. Respect for a person does not require respect for uninformed or reckless or irrational decision. We have seen that the primary object of respect is the person and not simply the person's preferences. We honor preferences because they reflect the character and values of the person. Especially in cases where the consequences are serious and irreversible, it is reasonable to have procedures and policies that help demonstrate that the preference in question is indeed informed and that it reflects the values and principles of the person. The decision to die clearly should be based on a stable and enduring principled preference.

It follows that safeguards that try to insure that the decision to die does indeed reflect the person's values and principles are called for. We want to make sure that a request to die sooner is not simply the result of depression, panic, or coercive social pressure. Procedural safeguards reflect a commitment to respect the person, and not just passing or distorted preferences, and thus these types of safeguards are not unduly paternalistic and disrespectful of the person. The exact nature of the necessary safeguards is open to debate and discussion, but the usual safeguards include:

1. A voluntary request initiated by a competent individual.
2. A deliberative, informed, and shared decision-making process
including an understanding of the reason for the request

⁶ The understanding of respect for persons and human dignity here is, of course, heavily influenced by John Rawls.

⁷ In the quite different context of his defense of the death penalty, Kant recognizes that respect for human dignity does not always require that we preserve life. So in fact he does not unequivocally endorse a substantive interpretation.

3. A critical and probing consideration of all alternatives
including curative possibilities, hospice, comfort and palliative care options
4. Consultation with others
including an independent physician, perhaps also a psychological or psychiatric consult, and perhaps family consultation.
5. A continued, expressed, preference for death
including an explicit written request and a mandatory waiting period before the request is honored
6. An irreversible and intolerable condition which will result in the permanent loss of self - usually terminal illness and perhaps, and more controversially, significant dementia that leads to total loss of oneself

The importance of these conditions and safeguards should not be underestimated.

Consider the following two cases of Debbie and Diane.

"It's Over Debbie"

A gynecology resident rotating through a large private hospital was awakened and called to come see a patient having difficulty sleeping. (The chart provided the details.) The patient was a 20 year old woman, named Debbie, dying of ovarian cancer. She was experiencing unrelenting vomiting from an alcohol drip, which was administered for sedation. The woman was emaciated, weighed eighty pounds, had an intravenous line, was receiving nasal oxygen, and was sitting in bed suffering from severe air hunger. She had not eaten or slept for two days, and she was receiving only supportive care because she had not responded to chemotherapy. The patient's only words were, "Let's get this over with." The resident prepared and administered a lethal injection of potassium chloride. (Anonymous, JAMA 1988)

"Diane"

A 45 year old patient, who had refused a risky, painful, and often unsuccessful treatment for Leukemia, requested that Dr. Quill provide a prescription for a lethal dose of barbiturates. She had been his patient for many years, her diagnosis had been confirmed by other physicians, she was aware of the hospice and palliative care options available to her, and she had made her decision in conjunction with a loving and supportive family. The patient was fully competent, showed no signs of clinical depression, and she had duly considered and rejected all reasonable alternatives for comfort care and the relief of her suffering. Her family agreed that her decision reflected her deeply held values and personal beliefs. Dr. Quill honored her request and wrote her the prescription. At a later date, with her families support, she used the prescription to end her suffering and die peacefully. (Dr. Timothy Quill, JAMA 1993)

In the case of Debbie, the resident "respects" her preference but it is not at all clear that honoring her stated preference shows a deeper respect for her as a person. In the case of Diane, it is clear that her preference respects her deeper values and self. To ignore or dismiss her considered view of what constitutes the best available death for her, I would say, we clearly disregard her equal status and worth as an autonomous person and we thus fail to show her respect as a person. The point of the safeguards and limitation on hastening death are meant to help us distinguish these different types of cases. Indeed,

these two cases differ strikingly when it comes to the common limitations and safeguards on hastening death listed above:

1. A voluntary request initiated by a competent individual: In the case of Debbie, there is no evidence of competence and given her state of mind at the time of the request it is highly unlikely that she is thinking clearly. In the case of Diane, she is clearly competent and the request is clearly voluntary.
2. A deliberative, informed, and shared decision-making process, including an understanding of the reason for the request: The resident in Debbie's case does not know her at all does not know her values or history except for her chart. In Diane's case, Dr Quill is her oncologist and has been her doctor for many years and he knows her and her family well. Indeed, it is not even clear what Debbie means by "Let get this over with" – perhaps she meant that they should move her to change her sheets!
3. A critical and probing consideration of all alternatives including curative possibilities, hospice, comfort and palliative care options: Debbie's care is clearly inadequate. She is not getting sufficient oxygen and the alcohol drip is for sedation but is causing unrelenting vomiting! Her comfort care is so sub-standard that it is near criminal. What she clearly needs first is a palliative care specialist, not an executioner. Debbie, in contrast has fully explored all of her options for curative and palliative care.
4. Consultation with others including an independent physician, perhaps also a psychological or psychiatric consult, and perhaps family consultation. Diane's diagnosis had been confirmed by other physicians and her options had been extensively explored over a long period of time. She was clearly competent, not clinically depressed, and her decision was well reasoned and confirmed by her loving and supportive family. In less clear cases a psychological consult might be appropriate but it is not clear what point it would serve in this particular case. The resident in Debbie's case acts alone and without confirmation from other physicians or support from other family members.
5. A continued, expressed, preference for death including an explicit written request and a mandatory waiting period before the request is honored: "Let's get this over with" obviously does not constitute a stable and durable preference.

The case of Diane is probably the clearest possible case for physician assisted dying. The case of Debbie clearly exhibits the risks of giving tired and over-extended providers a license to kill their patients. The public policy question is in part at least whether permitting Dr Quill to assisted Diane will lead to an anonymous resident killing Debbie. In section 7 below, the efficacy of the safeguards and limits on hastening death will be more fully explored with particular focus on the experience in Oregon with physician assisted-suicide (PAS) and in the Netherlands with legalized voluntary active euthanasia (VAE).

The other obvious and important distinction between these two cases is that the first case of Debbie is a case of **voluntary active euthanasia (VAE)** and the second case of Diane is an example of **physician assisted suicide (PAS)**. PAS is less controversial than VAE because the final act that causes death is performed by the patient not the doctor. This difference in agency clearly helps insure that the final act is truly voluntary and also helps ensure that the context is less likely to be coercive. If the patient also must

initiate the request for the prescription, then the balance of power between the patient and physician is more equal and balanced. Indeed, in the case of active euthanasia the doctor is the direct cause of the death, and in practice can act alone without the clear consent (or for that matter any consent) of the patient. This just is not the case with PAS. In the case of PAS, the doctor participates by writing the prescription but this action does not and can not cause the patient's death. Indeed many patients do not even fill the prescriptions at all, and many that do fill the prescription do not actually ever use it to end their lives. Indeed, for many (perhaps even most) patients, it is simply a comfort to know that they can end their lives if life itself becomes intolerable and unbearable. This sense of control alone is itself a great comfort that eases the stress of dying. Another distinction that is central to debates about the permissibility of actively hastening death, which we will discuss more directly below, is over the distinction between intending death and foreseeing death (sect 49). In the case of VAE, the physician intends the death of the patient. In the case of PAS, the physician need not, even indirectly, intend to help assist the patient's suicide. The physician's intention instead may be to show respect for the patient's right of self-determination and/or to help calm and comfort the patient by giving them a sense of control over their death. The physician may be confident that foreseen the patient will not need to use the prescription at all and also know that most patients do not in fact use their lethal prescriptions. So, that they might actually kill themselves may be a clearly *possible* secondary effect, but it need not be directly intended at all.

48. The Role of the Physician: Compassion in Dying

Many physicians insist that assisting someone to die is totally contrary to their fundamental role as healers. The role of the physician is to save lives, not end them, it is argued.⁸ Some physicians (still) think of death as an enemy, an evil foe to be conquered and defeated and, since this is in the end impossible, to be fought by every means necessary to that bitter end. Of course, few physicians really hold this extreme view (although the above is almost a direct quote from a physician on a medical ethics committee). Patients clearly cannot always be cured and the physician's role includes *caring* for patients who cannot be cured. Indeed, before the great successes of modern medicine, easing the suffering of illness and dying was a *primary focus* of much medical care.

Yet once we acknowledge, as surely one must, that caring for the dying is a constitutive part of the role of a physician, it is unclear why helping someone die cannot be an act of care that is done for the sake of the patient in question. Since the fundamental values and principles of a particular patient determine what a good death is

⁸ This is the position of the American Medical Association and the British Medical Association. It is also defended by Leon Kass in "Neither for Love or Money: Why Doctors Must Not Kill," *The Public Interest*, no.94, Winter 1989, and in "Is There a Right to Die?" *Hastings Center Report*, Jan 1993 pages 34-43. Also see Edmund Pellegrino "Doctors Must Not Kill" in *The Journal of Clinical Ethics*, Summer 1992; pages 95-102. Despite the official position of the medical associations, this does not seem to be the position of many and perhaps most doctors. Many doctors support physician assisted suicide and many who oppose it do so for the more pragmatic policy reasons discussed below. For a quite different view of the role of a compassionate and responsive physician, see Timothy Quill, "Doctor I want to Die. Will you help me?" *Journal of the American Medical Association*, August 1993 pages 870-73, and *Death and Dignity: Making Choices and Taking Charge* (Norton, 1993). Also see Gerald Dworkin and R. G. Frey excellence response to Kass in *Euthanasia and Physician Assisted Suicide: For and Against*, Dworkin, Frey, and Bok (Cambridge, 1998).

for that patient, the patient's values, not the physician's, should be sovereign. Since caring for a person includes respecting their values and perspective, helping a patient to die sooner so that they die better can be a way of caring and showing compassion for the dying. Compassion towards the dying is indeed a medical imperative, and compassion in dying can involve hastening the death of the person. When this is so, there is nothing in the role of the physician that is intrinsically inconsistent with helping a person die in a manner that reflects the dying person's values and perspective.

Furthermore, physicians do let patients die, in a compassionate and caring way, all the time. It is now commonplace to withdraw life-sustaining treatments at the request of patients or their surrogates. Clearly, when such decisions are made, the physician role does not end; it is instead transformed. The standard of reasonable care of the dying includes continuing to care for the patient, to respect the wishes and values of the patient, and striving to make their passing as comfortable and painless as is possible. Why then does this role not also include respecting a terminally ill patient's considered and informed request to hasten death? In short, hastening a patient death is inconsistent with the role of the physician only if it is wrong for some other reason. It is a dodge, and ultimately also disingenuous, to appeal to the "essential healing" role of the physician. Caring for those who cannot be cured is, and ought to be, part of the essential mission of medicine.

The substantive objection behind this misleading appeal to the ends of medicine, I suspect, is the concern that it is always wrong to intentionally end life. What is truly difficult in these controversial cases is quite simply the individual's recognition of the weighty responsibility for helping to actively end a life. This is not a decision or action to be taken lightly. In the Netherlands, whenever possible, physicians always try to ease a patient's death by euthanasia at the end of the day and on a Friday.⁹ It is too hard to go on as usual afterwards. Even with the conviction that the action is compassionate and justified, hastening a death is still a trying and difficult thing to do. It is no wonder that physicians do not seek this weighty responsibility.

49. Intending and Foreseeing Death

At the heart of much opposition to actively hastening death is the assumption that the intentional taking of human life always violates the sanctity of life. This type of concern is not new. Over the past 40 years, the progress of medical science and technology has forced us to continually rethink and consider the meaning of the prohibition on taking human life. First, the ability to keep the body functioning when the brain is dead changed the focus from cardio-respiratory function to brain function in the determination of the death of the person. Next, the New Jersey Supreme Court case that involved Karen Anne Quinlan (in 1976) focused attention on the permissibility of withdrawing life support for persons in a persistent coma with irreversible loss of consciousness. Although at the time the hospital and doctors argued that the act of withdrawing life-sustaining care is an intentional action that causes death and so is an act of wrongful killing, it is now almost universally agreed that such actions are not wrong. It is also argued that, in withdrawing life-preserving treatment, the physician is not killing the patient but is simply letting the patient die. It is the underlying disease, and not the

⁹ Liesbeth (Elisabeth) Kalff, NVVE, The Dutch Voluntary Euthanasia Society, presentation on euthanasia in the Netherlands, Amsterdam, March 2003.

physician, they say, that causes the patient's death. Although this claim is a commonplace, it is curious. As we have just discussed, the opponents of actively hastening death have also argued that curing disease and preserving life is the primary role of the physician. We are thus owed some explanation for why it is ok to just let patients die when life-sustaining care is available. Of course, if the patient is not facing a terminal condition and has not consented, it would be truly surprising if this omission were consistent with the ends of medicine and the role of the physician! It seems clear that what distinguishes permissible and impermissible cases of letting someone die is in part the consent of the patient or a surrogate, or, when the patient's wishes are not known, a judgment that the continued life prolonging treatment is not in the patient's best interest. The patient's consent, fundamental values, and best interest play a crucial role in deciding whether or not continued life-prolonging care is called for.

So, what importance, if any, is there to the fact that the disease is necessary in these cases as the underlying cause of death? The opponents of more active measures to hasten death (even when the death is equally consistent with the patient's wishes, fundamental values, and best interest) must place tremendous importance on whether the underlying disease kills the patient, or whether instead an additional cause is introduced to intentionally cause the death. Clearly many people *feel* that there is a personal responsibility for the death if more active measures are taken, even when the death is just as certain a result in both cases. But what is the morally relevant difference between intentionally withholding or withdrawing care that will result in the death of the patient and intentionally introducing a cause that will result in the patient's death? Why is the former a case of permissibly letting a patient die and the latter a case of (supposedly) impermissibly killing the patient?

The typical, but mistaken, answer to this question appeals to the supposed different intentions in the two types of cases.¹⁰ The moral principle that is supposed to mark the difference here is called the doctrine of double effect. Roughly, this principle distinguishes actions that directly aim at harm from actions that cause, as a foreseeable effect, a similar harm but which do not directly aim to cause harm. Fortunately, we do not need to consider the soundness of this controversial principle, for it simply does not even apply to the types of cases that we are considering.¹¹

The doctrine of double effect prohibits intentionally aiming at evil (or harm to the innocent) so that good may be done. The principle is familiar in discussion of just war theory and terrorism. One way of distinguishing acts of terrorism focuses on the wrongness of directly harming or killing the innocent as a means to even an otherwise legitimate goal. On the other hand when in war, for example, one may foresee that innocents will be killed as a result of an otherwise justified bombing of a military target. Foreseeing that innocent will be killed is morally different than targeting the innocent. It makes a difference if one is aiming at the harm to innocents, that it is part of the plan one might say, or whether it is an unintended result of what one intends. Although the principle itself is controversial, let's assume that it is sound. The problem is that this

¹⁰ See, for example, Edmund D. Pellegrino, "The Place of Intention in the Moral assessment of Assisted Suicide and Active Euthanasia," in *Intending Death: The Ethics of Assisted Suicide and Euthanasia*, edited by Tom L. Beauchamp (Prentice Hall, 1996).

¹¹ For the best discussion of the doctrine of double effect and its problems, see Shelly Kagan, *The Limits of Morality* (Oxford, 1991). Also see Timothy E. Quill, M.D., "The Ambiguity of Clinical Intentions," in *The New England Journal of Medicine*, vol. 329 no.14, September 1993; pages 1039-40.

principle simply does not apply to the types of cases which we are interested in here.

The doctrine of double effect presupposes that a person (in this case the patient) is being harmed and provides a context in which the foreseen harm is not a wrongful harm. Yet the reason why it is permissible to intentionally let a patient die, in some situations, is that we are respecting the patient's considered preference or fundamental values, and thus the patient is not harmed, all things considered, at all -- or, alternatively, when knowledge of prior preferences is unavailable, that the death in question is judged to be in the patient's best interest and thus again simply is not a harm at all. As these judgments about the permissibility of letting a patient die concede, death is not always an evil or harm to a person. In some cases the body lives on, but the person is already lost, and thus intentionally acting in ways that are meant to let the body die manifests no intention to allow harm at all. In other cases, death can be a release from great suffering and thus something the person legitimately deems good. Indeed, if letting a person die involves foreseeing that the patient will be harmed, it is not clear *why* the physician does not do wrong by letting patients die. At the very least, if the death is a harm, the physician should do all they can to discourage patients from intentionally harming themselves in this way. Clearly, it is hard to see how it could ever be permissible for a proxy to harm a patient in this way. And of course, the best interest standard of proxy decision-making would simply never apply. The point here, however, is that we rightly judge that death is not always a harm. But if the patient is not harmed, then so too actively hastening death also does not intentionally harm the patient.

In point of fact, the doctrine of double effect, as used in these types of cases, illegitimately assumes what is in question — namely, that the act of ending a life in accordance with the considered wishes of the patient is always wrong and thus evil. It assumes what is supposed to be shown and thus does no independent work in distinguishing actively hastening death from letting a person die.

As a last point, we need to briefly consider the case of “terminal sedation.” As a result of Cruzan (1990), in the United States it is permissible to withdraw nutrition and hydration and sedate a patient and let them die. This practice of “terminal sedation” is now also common in the United Kingdom and many other countries. How the doctrine of double effect here applies is especially curious. Although the sedation does indeed often treat pain and suffering, the lack of nutrition and hydration serves no palliative function. The reason for the withdrawal of nutrition and hydration is to let the patient die. This is the end and goal just as clearly as in the case of a lethal injection. No additional causal agent is introduced and thus the process is slow rather than swift, but the end is just as certain. One hopes that this type of decision is not treated lightly; that safeguards would be in place to prevent abuse; and that all other options are first explored. Yet I fear that a possible negative side effect of the comforting use of the idea that it is an underlying disease, and not the physician, causing the death is that decisions to end a patient's life by withdrawal of life prolonging care are not adequately scrutinized and given the attention that they deserve.

50. The Right to Die as a Basis for Health Care Rights

End of life issues in contemporary medical ethics usually focus on how to respect patient autonomy and yet still act with concern for the best interest of the patient; or at least, to act so as not to directly harm the patient. As the ancient Hippocratic Oath says,

above all first do no harm. These are the three core principles of clinical medical ethics: beneficence, non-maleficence, and respect for patient autonomy. The ideal patient-physician relationship must honor and sometimes balance these core principles. The nature of the right to die and the responsibilities of patients and physician involve day to day issues that emerge between a particular patient and physician in a clinical setting. Health care justice, by contrast, focuses on the health care delivery system rather than the clinical setting of the patient-physician relationship. The principles in question here are matters of distributive justice, efficiency, and fairness. This division is, of course, overly simplistic. The health care system is the context in which clinical questions occur, and the system is often a constitutive part of a moral problem or dilemma. Indeed, health care systems may be more or less justified, in part, because of the problems they resolve or cause. In general, if a basic part of the social structure of a society contributes to the violation of fundamental rights, then that is a good (*prima facie*) reason to modify the structure in question.

In the United States, one of the main obstacles to the acceptance of a broader right to control the manner and time of one's death is the combination of unequal access to basic health care services and inadequate access to palliative care, comfort care, and Hospice. Decisions about death may reflect the economic costs of continued care or the inadequacy of palliative and comfort care provided, rather than the deeper values of the patient. Rather than recognizing this as a compelling reason to provide both better end of life care and universal access to this care, irrespective of financial considerations, the inadequacy of medical care has been used as a basis for restricting a patient's right to die as they see fit.

It is now widely recognized that patients facing imminent death (or their surrogates) have a right to refuse life-prolonging treatments so that they can die what they consider to be a better or more dignified death. The decision to withdraw (often very expensive) life-prolonging care is surely as subject to subtle or explicit coercive pressures as the decision to end one's life when one is not dependent on life support and so must do so by more active means. Yet the opponents of a more expansive right to die (including the American Medical Association) seem to ignore the apparent inconsistency in their position. If lack of access to high quality end of life care is grounds for doubting the autonomy of decisions to actively end one's life, it is also equally an argument against the autonomy of decisions to passively end one's life. The inconsistency here reveals, an important problem with the current state of thinking about end of life decision making.

First, the conclusion that follows from concerns about inequalities in access to health care is that we should be fighting for universal access to a basic health care package that includes high quality end of life care. One can only wonder at those who have opposed and continue to oppose universal coverage but who then use the lack of universal coverage to deny people basic rights to self-determination at the end of life. Second, if one is faced with a system that has inadequate end of life care, then it may well be the case that one prefers to die sooner in order to die better. That a person would not have this preference if there were better end of life care available in no way undermines the soundness of the preference given the real life options. Surely one would also not choose to die if presented with a cure for my disease, but fantasy options do not change the reasonableness of a considered preference given the actual situation. Third, why would the fact that a person is denied basic rights to health care services provide a reason

for also infringing on that same persons basic right to control the manner of his or her own death? It is strange logic indeed that uses the violation of one right as the basis for the violation of another right.

The proper response to the inadequacy of health care services is clearly to strive to provide better health care services. Furthermore, as a general principle if right B is necessary to secure a fundamental right of type A, that is a clear basis for protecting right B. For example, the right of free association (right B) is a necessary social precondition for the right to assemble and petition one's government for grievances (right A). Even though only the right of assembly is enumerated in the Constitution, the right of association is also a constitutionally guaranteed right simply because it is necessary to protect the enumerated right of assembly. Since we have a fundamental liberty right of self determination in dying (right A), and if a right to health care services (right B) is a social precondition for the safe exercise of this fundamental liberty right (right A), then we have a social responsibility to provide health care services (right B), especially high quality end of life care. The fundamental right to die is thus itself a basis for recognizing a right of universal access to basic health care services.

Finally, opponents of assisted dying need to explain why the allegedly coercive context of modern medicine does not provide an equally sound argument for prohibiting physicians from withholding and withdrawing care and "letting people die." The economic and social pressures here are as great, and usually in fact much greater, than in the case of patients that are not life-support dependent. Clearly, there will be countless cases where the withdrawal of care from a patient in an ICU is many times more cost effective than the cost of home care or hospice care for a cancer or AIDS patient. The argument from social pressure and economics is relevant to all end of life medical decisions. We should be more concerned with insuring that the decision to die, whether it involves passively letting someone die or more actively hastening death, is fully informed and truly voluntary. Given the clear inequities in our health care system, for millions of people the decision to die must surely be affected by the economic consequences of the decision. So here again we have an overwhelming reason to provide universal access to high quality health care.

The right to die and the right to health care are indeed connected. Contrary to the arguments of many, however, the connection does not provide a basis for limiting the right to die to passive cases of withholding and withdrawing care and thereby letting patients die. First, pragmatic arguments that focus on the coercive force of socio-economic considerations apply equally to all end of life decisions. Second, the proper conclusion is not that there is no right to actively hasten death. Instead, the right to die provides an additional reason (as if we do not already have enough) for universal access to health care services. Finally, as long as millions are denied the right to health care, the less risky practice of physician-assisted suicide increases the self-determination of competent patients facing death without undue risk. If we are to show due respect for patients facing death, we should show them concern and compassion but the final decision about how to die must be theirs.¹²

PART II – Global Perspectives

51. The Dutch and German Approaches

The principles of respect and concern are focused on a person's *informed* preferences that *reflect the person's basic values*. Decisions at the end of life, however, are difficult decisions influenced by fear of suffering, fear of death, and perhaps even clinical depression. Patients also often have unrealistic fears and concerns about loss of independence. It is thus necessary to be cautious in responding to a person's desire to die. We need to know if the expressed preference to die is a considered, informed preference that reflects the person's values or whether it is a suicidal impulse, which simply reflects fear and depression. To overcome these difficulties, yet still respect the right to choose death, assisted dying statutes in Oregon (and proposed statutes in other states) and policies in the Netherlands, include mandatory waiting periods, second opinions, counseling about palliative care and hospice care options, possible psychological evaluation for clinical depression, and a provision to try to include family members in the discussion and thereby get a fuller sense of perspective on the patient's preferences (see discussion of safeguards above, section 3) . If one includes appropriate *safeguards*, then it is reasonable to believe that the benefit of honoring basic rights overrides these otherwise legitimate concerns about hastening death.

These procedural safeguards clearly can have an impact.

In the Netherlands, although about 25,000 patients per year seek assurances of the option of an assisted death and 9,000 patients make an explicit request, only 2,320 result in active euthanasia and 400 choose assisted suicide. In the state of Oregon, palliative care and hospice use has improved significantly since the legalization of assisted suicide.¹³ It is likely that this is the result of a more open system that allows patients to speak more freely with their physicians and thus become better informed about their options. Nonetheless, even with excellent palliative and hospice care, some patients still want the options to hasten their death, if their condition becomes intolerable.

It is important to realize that physical pain alone is rarely given as the only reason for wanting the option to hasten one's death. Even with high quality palliative care, many patients still want to control the manner and time of death. Therefore, it is a consequence of a prohibition on assisted dying that we use the force of law in an attempt to compel fully competent informed adults to die in a manner that is contrary to their values and principles. This is not something to be done lightly. Imposing, in a coercive and paternalistic fashion, one's own conception of how one should die on another person is fundamentally disrespectful and a basic affront to the dignity of that person. The opponent of assisted dying chooses to force people to die in a manner that offends the person's preferences and principles.

We can, of course, foresee that, even with safeguards, some people will choose to die for irrational reasons. We must thus decide how we should balance rights of self-determination and duties to prevent unintended and indeterminate harm. In answering this question, the doctrine of double effect provides guidance. Other things equal, it is wrong to intentionally infringe on the rights of some because we foresee that other persons may be harmed. The proper response is instead to honor individual rights and to also strive to minimize any foreseeable harm. Indeed, the procedural safeguards outlined

¹³ Add reference on Oregon experience

above aim to balance respect for individual self-determination with our legitimate concern to protect the vulnerable. There is a big difference, however, between procedures that aim to promote an informed, voluntary choice and outright prohibitions that paternalistically assume that dying patients are uninformed or incompetent.

Can a policy of assisted dying provide adequate safeguards against involuntary euthanasia? The Rummelink study is a comprehensive study of the practice of euthanasia in the Netherlands. This study has suggested to some that legalized euthanasia results in an unacceptable level of misuse. In the Rummelink study, what the Dutch classify as *involuntary euthanasia* occurred in 0.8% of all deaths. Critics of active euthanasia argue forcefully that this study is powerful evidence that significant abuse, including involuntary euthanasia which they take to be the killing of people against their will, is simply impossible to avoid once a policy of allowing euthanasia is set in place. This conclusion, however, is overly hasty.

Voluntary euthanasia in the Netherlands is taken to require an explicit, informed, and persistent request to die. They thus classify all cases that do not involve an explicit request as “involuntary.” This classification combines together two very different types of cases – those in which a person’s prior preferences are unknown and those in which the person has an opposing or contrary expressed or prior preference opposing euthanasia. In the United States, and many other countries, only the last type of case are classified as involuntary euthanasia. Cases of proxy consent based on a substituted judgment of what the patient would want if competent are judged to be what the patient would want and thus still voluntary. In addition cases in which the patient’s preference are unknown (or unknowable) and thus rely on a proxy judgment of the patient’s best interest, are not classified as involuntary in the United States – these are neither voluntary nor involuntary, because the person’s will or volitions are unknown.

All of the cases without an explicit request, in the Rummelink study, involved cognitively incompetent patients. On average, the specialist involved in these cases knew their patients for 2.4 years and the general practitioners for 7.2 years. In 60% of the “involuntary” cases the physician had clear evidence of the patient’s prior preference for death, either from earlier discussions or from family members. In 83% of these controversial cases, the physician had the consent of a relative. In the remaining cases, the patients were incompetent and suffering from uncontrollable convulsions and significant pain and life was probably shortened by a few hours or days at most.¹⁴

The physicians in these cases were attempting to act in the best interest of their patients and agonized over their decisions. This is a far cry from the reports of physicians killing patients against their will that have been reported by overzealous critics. In the United States all such surrogate decision-making is considered a natural extension of autonomy and it is now routine in cases of passive euthanasia. Once we distinguish Voluntary, Non-Voluntary (no explicit request), and Involuntary (contrary to known preferences of the patient) cases, all of the problematic cases are properly classified as voluntary (through substituted judgment) or non-voluntary (but based on the best-interest of the patient) – there is no evidence in any of these cases that the action was contrary to the preferences or principles of the patient. By United States standards, these are all cases of legitimate proxy judgment by a surrogate either acting on a prior directive

¹⁴ L. Pijnenborg, van der Mass, et al., “Life Termination Acts Without Explicit Request of Patient,” *The Lancet* vol. 341, 1993; 1196-99.

(even if not an explicit specific request), or trying to determine the preferences and best interest of the patient.

The Netherlands thus seems to demonstrate that it is indeed possible to practice institutionalized voluntary euthanasia without sliding down a slippery slope to either euthanasia on demand or the involuntary killing of the sick and the elderly. In addition, the healing ethic of the medical profession is alive and well in the Netherlands.

There are clearly conceptual limits on how we think about hastening death. Margaret Battin has pointed out the interesting difference in this respect between attitudes towards hastening death in Germany and the United States.¹⁵ She argues that German cultural history and linguistic resources have given root to a somewhat unique position on physician-assisted "rational suicide." First, the German language, and thus also thought, distinguished different kinds of acts we call suicides with different words which carry distinct denotations and connotations. The German Selbstmord means "self-murder" which connotes a desperate and wrong action; Selbsttötung literally means self-killing and is a neutral scientific term; the Latin construction Suizid is used for a suicide which results from psychiatric pathology; and Freitod means "free death" and connotes a voluntary individual choice which is an expression of deeply held values or ideals. One commits Selbstmord but one chooses Freitod. These distinct linguistic categories have made it comparatively easy for Germans to distinguish a free death from unacceptable suicide. The United States on the other hand, has struggled with the confusion generated by using one word for similar actions motivated by such different contexts and reasons. Second, in Germany, a "freely chosen death" or rational suicide -- that is, a voluntary, reflective choice to end one's life, which is not rooted in despair, clinical depression, or mental illness -- has been decriminalized since 1751. So in addition to a richer linguistic conceptual scheme, the evolution of German practice has been unencumbered by either a legal prohibition, or by an unclear common law tradition.

As a result, medically related (non-physician) assisted "suicide" is quite common in Germany. The German Society for Humane Dying (which is similar to the Hemlock Society) lends out a booklet under control condition on "A Dignified and Responsible Death" which details how to acquire and take drugs so as to produce a painless and nonviolent death. The society reports between 2,000 and 3,000 suicides a year among its more than 50,000 members (as of 1991).

The problem with the German approach is that with no physician involvement or statutory procedural safeguards one is likely to have a significant number of cases where the patient in question is not adequately informed about other medical options. In addition, since initial requests to die are often a result of unwarranted fear or treatable clinical depression, physicians could play an important role in ensuring that patients requesting death are making an informed, reflective, and uncoerced decision. In the modern medical world death is managed by physicians typically in medical centers. Despite the resistance of physicians to participate in actively hastening death, if we are to have active euthanasia or assisted suicide, the patient's physician is the best source of information about the medical options and consequences. It is hard to see how an ideal system of compassionate dying could get by without their wise council and guidance.

¹⁵ Margaret Battin, "Euthanasia: The Way We Do It, The Way They Do It," *Journal of Pain and Symptom Management*, vol. 6 no.5, 1991; pages 298-305).

52. Confucian Ethics and Filial Piety

In China and Confucian cultures generally, the family is the central social unit. Indeed, three generations often live together and children support their parents in old age. We have seen that medical consent usually involves full disclosure to the family first, and the family decides what and how to tell the patient. The relationship is between the physician and the family unit, which represents the patient's interest. As a result, filial piety is at the heart of medical decision-making. In the Confucian tradition, for example, there are 24 models of the dutiful son; many of which require doing everything possible to save one's parents.¹⁶ Although the young owe deference to their parents, elderly and sick parents are in the care of their adult children and thus naturally owe deference to their judgment. The result is that, in end of life care, sons and daughters want to do all that they can to care for and respect their parents, and thus fulfill their filial obligations. In addition the Taoist emphasis on longevity as the goal of medicine and the natural desire to save life create strong pressures to do everything possible to extend life.

For these reasons, it is claimed that in China all necessary life-saving care is always provided and never refused by the patient; the reality is of course quite different. In practice, the standard of necessary care is often quite low and the emphasis is clearly on preventive medicine and comfort care. Despite the authority of the Confucian physician, Chinese doctors are reluctant to make end of life decisions or even recommendations to the family. Some suggest that this attitude of doctors is a legacy of the Cultural Revolution. During the Cultural Revolution many physicians were condemned as murders for letting terminal and suffering patients die. In addition the Chinese courts do not adjudicate "right to refuse" cases because of a belief that these are strictly medical decisions. We thus have a sort of moral vacuum when it comes to a discussion of the ethics of end of life care. All of these factors result in over-treatment of patients at the end of life. In a medical situation where the withdrawal of care may be more appropriate, physicians are reluctant to make end of life decisions, the courts consider these decisions medical and not legal decisions, and the family relies on the normal of ethic of filial piety and preserving life.

In fact, since they lack legal protection, even in cases where the patient or family requests the withdrawal of care, physicians are likely to refuse. In 1986, for example, physicians in Beijing refused to withdraw care despite the persistent demands from three terminal cancer patients. One committed suicide. One attempted suicide and then died when treatment was stopped. The third was suicidal but treatment was continued. As a result of these incidents a survey of public and professional attitudes of voluntary euthanasia was conducted. The results were surprising: 40% favored active euthanasia, 26% passive euthanasia (16% withdrawing all but ordinary care), only 32% supported always doing everything to preserve life, and 2% were undecided. It has been suggested that, despite these attitudes, more aggressive treatment is still common because of the family consensus model of consent. Even a person who favors passive or active euthanasia has great difficulty authorizing the withdrawal of care when they are charged with the care of a loved one. The sense of filial obligation to save one's parent overrides one's sense of what is right. These attitudes and practices are of course slowly changing,

¹⁶ Here and below, I rely on Ren-Zong Qui commentary in *Cases in Bioethics* 3rd edition; edited by Bette-Jane Crigger; p. 133-35.

but without the legal guidance or the guidance of physician in these difficult decisions, a tendency to err on the side of prolonging life is not surprising.

Similar issues arise when it comes to organ donation. Organ transplantation clearly disrupts the natural process of loss and grief at the death of a loved one. The request to transplant an organ shifts the focus away from the deceased and focuses attention on saving the life of a stranger. This shift of attention is difficult in all cultures but it is especially contrary to the focus on the family that we have seen is at the core Confucianism. Additionally, if physicians are reluctant to interfere with the family in end of life decision-making, they will naturally be even more reluctant to intrude and ask for permission to donate the relative's organs. As discussed in Chapter VI, in large part because of these cultural factors, Asian countries have been initially especially cautious in introducing policies of organ transplantation.

In concluding this discussion, however, it is important to appreciate the influence of cultural factors that do not involve basic moral principles. Even if allowing natural death, and even euthanasia, is supported by the general public and is also fully compatible with Taoist and Confucian attitudes toward death, which it obviously is, the ethic of filial piety can lead to a natural reluctance to let family members die. Similarly, even if the virtue of compassion (Ren) strongly supports organ donation, the set rituals (Li) surrounding death and for showing respect for the dead can undermine the willingness to donate organs. Social and family dynamics clearly have important consequences for end of life issues. But these cultural differences do not reflect any deep difference in basic moral principles.

53. Islamic Ethics and the significance of the Divine Will

Allowing Death

At the core of Islamic ethics is the belief that life and death are ultimately in God's hands. More specifically, God determines each person's allotted life span and thus their time of death. In declaring death, we are simply acknowledging that death has occurred. Although we must always recognize and acknowledge Divine Providence, doing so is consistent with striving to overcome disease and using medical technology to preserve life. But it also involves accepting death as part of God's plan. We should not cling to this life as if it is all of human existence. Indeed, after death, a better and higher existence awaits believers. We thus must strike a balance between preserving life and accepting death. Just as we can inappropriately take our lives before the allotted span, so too we can inappropriately attempt to extend life beyond the divinely allotted time. If one accepts the standard of brain-death as marking the death of the person, then we clearly fail to accept death by not letting the body die too (that is, by maintaining mere biological life by wholly artificial means). But one can also fail to accept death by continuing to delay an inevitable death by medical and artificial means.¹⁷ When faced with a terminal disease, or the inevitable decline of old age, switching the medical focus to palliative and comfort care, and allowing natural death may more fully reflect an acceptance of the God's Will than heroic attempts to prevent death. So withholding or withdrawing death-delaying care (when there is little or no hope of meaningful recovery) is compatible with fundamental Islamic attitudes, and it thus should be permissible

¹⁷ Jonathan E Brockopp, "The Good Death in Islamic Theology and Law" in *Islamic Ethics of Life* edited by Jonathan E. Brockopp (University of South Carolina Press, 2003); p. 189.

Islamic ethics officially rejects all forms of “euthanasia,” and when these issues first arose in the 1970s it was common to describe the withdrawal of life support as “passive euthanasia.” Almost immediately, however, allowing natural death was no longer described as euthanasia at all. In cases where it is permissible to withdraw or withhold life support, it became common to claim that it is the underlying disease that kills the patient and not the medical team – and so it is not euthanasia (or mercy killing) at all. In Islam too allowing the natural death of an already terminal patient does not (need not) constitute killing and thus is not euthanasia. When a patient is dying already, the divine will is evident, and thus allowing death to occur is not contrary to the Divine Will. In these cases of withdrawing life-support, the moment of death remains open and indeterminate -- as we learned so clearly with the famous case of Karen Anne Quinlan. When she was removed from artificial life support in 1976 (after extensive legal struggle), with the help of much medical care, IV antibiotics and artificial nutrition and hydration, she lived for another 10 years. But even in cases when death results more immediately from the absence of life support, it is widely accepted that the death is caused by the underlying disease (and not some introduced death causing agent).

In addition to withdrawing life support, active efforts to relieve suffering (for example high doses of morphine that might suppress respiration), even if it might hasten death, do not aim at death and thus do not aim to undermine the Divine prerogative of life and death. Although these issues do give rise to competing opinions (or Fatwas), the basic Islamic principles prohibit intentionally causing the death of the patient. The Islamic position on allowing death is thus very similar to the dominant Western position that prohibits intentionally hastening death. Of course, when it comes to the “right to die,” as I have argued, the autonomy-based Western ethical approach seems to justify a more permissive stance allowing, at least in principle, more active means that hasten the death of the dying. In the West too, however, laws, public policies and the medical professions continue to balk at broadening and extending the right to die so as to permit more active means of hastening death.

We have seen that withdrawing life support that merely delays death (or more controversially when there is no hope of meaningful recovery) is permissible. Should Islamic medical ethics also accept the permissibility of **withdrawing nutrition and hydration**? Removing medically administered nutrition and hydration seems to be an intermediate case between allowing death and aiming at death, and it is thus more controversial than simply withdrawing a respirator. The cases are not, however, as different as they first seem. The obvious differences are that, first, all patients will indeed die without nutrition and hydration and thus the death is always a certain outcome of the action; and, second, that dying from lack of nutrition and hydration is slow, long and drawn-out, and thus intuitively seems uncompassionate, even cruel. Are these differences actually as clear as they seem?

Of course, in the case of respirators patients, it sometimes turns out that they can breathe on their own after all. In many other cases, however, it is clear that they *cannot*, and death then is just as certain without the “breath of life” as it is without nutrition and hydration. In both cases it is the *underlying condition* that is responsible for the inability to breathe or eat, and thus it is common to say “that it is the disease that kills the patient and that we simply allow them to die.” If recovery of significant function is medically impossible, then it is reasonable to discontinue death-delaying care. There is no reason

whatsoever to assume that allowing natural death in either case aims to thwart the Divine Will. Indeed, even withdrawing medically administered nutrition and hydration does not rule out miraculous recovery. In either case, the patient may miraculously recover and be able to breathe or eat unassisted once again. Furthermore, clearly, whatever we may do in the way of allowing natural death, an all-powerful God, capable of raising and resurrecting the dead, can also will the survival and even the full recovery of the patient in these mere medical cases. So the argument that a divine miracle is always possible is neither here nor there. We still must act on probabilities and in many cases the probabilities approach medical certainty. In short, if withdrawing a respirator is consistent with the Divine prerogative to determine each person's life span and time of death, then so too is the more drawn out case of withdrawing nutrition and hydration.

Dying from lack of nutrition and hydration is indeed a drawn-out process in many cases, whereas the patient's inability to breathe results in a more sudden death. In both cases, however, measures can and should be taken to sedate the patient and make the process as painless as possible. If the patient is completely sedated the patient does not experience any discomfort at all. In the case of patients in a persistent vegetative state, where all consciousness is lost, of course there is no experience at all. So death may be certain in other cases of withdrawing care and the patient need not suffer at all. In terms of the suffering of patients, withdrawal of nutrition and hydration is not significantly different from other cases of withdrawing death-delaying care. The practice of withdrawing nutrition and hydration, and sedating the patient is referred to as "terminal sedation." As discussed above, in so far as the patient is dying anyway, or has irreversibly lost the capacity for conscious human life (or perhaps simply meaningful recovery), we do not harm the patient by letting them die. In so far as it is a continuing medical human intervention that prolongs life, there is no reason to believe that terminal sedation is an unjust taking of human life, and thus prohibited by Sharia. Indeed, in letting someone die we acknowledge the inescapable limits on our ability to extend meaningful human life and thus clearly acknowledge that matters of life and death are ultimately not in our hands. It would seem more plausible to maintain that it is the almost desperate attempt to extend human life at all costs that denies the reality of death and aims to thwart the Divine Will.¹⁸

Hastening Death

This brings us to the more controversial cases of actively hastening death by means of ingesting or injecting a lethal dose of some pharmacological agent that causes death. The Sharia (to date) has been near universal in rejecting and prohibiting actively hastening death. It is not clear, however, why this is supposed to be an inevitable conclusion of Sharia interpretation. First, the Sharia principle of choosing the lesser evil, when one is faced with a moral dilemma, suggests that taking life in the case of terminal illness may be permitted in cases where this is the only way to relieve serious and inescapable suffering. Of course, the practice of terminal sedation will usually provide a less active alternative than a lethal injection, and indeed the principle of the lesser evil provides an additional (and perhaps clearer) justification of terminal sedation in cases of otherwise inescapable suffering. However, if terminal sedation is not an option in a particular case, the use of more active measures could be justified.

¹⁸ For additional discussion of this issue, see Brockopp, "The Good Death in Islamic Theology and Law."

Furthermore, the theological basis of the distinction between allowing inevitable death and prohibiting hastening death is itself puzzling. If doing what we can to conquer disease, infirmity, injury, and any other handicap restricting full human functioning and a complete human life, if all of this is consistent with the Divine prerogative over life and death, why would in contrast hastening the death of a terminally ill patient be contrary to the Divine Will? *Why the radical asymmetry? What is the principled basis of the radical disanalogy?* Furthermore, if we are to use our best judgment as to when it is reasonable to prolong life, why are we prohibited from using that same judgment to decide that hastening death is reasonable? On the contrary, since we are told repeatedly in the Quran that God is compassionate and merciful, we must conclude that the Divine will is guided by compassion and mercy. The Quran clearly states that “God desires your well-being not your discomfort” (Q 2:185) Thus why would God prohibit hastening death when death is inevitable, or meaningful human life is no longer possible, and where death has been accepted by the patient, and death is judged to be the most compassionate and merciful alternative? Those who defend euthanasia (and physician assisted “suicide”) require that those eligible are terminal and that they are suffering. It is because of the requirement of a terminal condition that the term hastening death is preferred to euthanasia and suicide. According to the Sharia, these are cases of “lingering life” or “expiring life” and “death sickness” which are intermediate states between life and death (see chapter VI.4) . This intermediate state is based on the assumption that the death has already been caused or ordained, and so the person’s life is essentially over. If hastening death were permitted in Islam, it would probably be restricted to these intermediate terminal states.

Indeed, rather than being contrary to the Divine Will, it would seem instead that whenever we have judge that allowing the death of the dying is consistent with the Divine Will, so too it is reasonable to conclude that hastening that same death is equally justified. That is to say, in any case where it is reasonable to judge that there is no duty to prolong life, we have judged that God has willed the death in question. And this judgment that the death has been willed by God also implies (as a corollary) that hastening the death of the dying is also consistent with God’s Will. More specifically, in any case where we judge that terminal sedation is justified, by clear analogy a lethal injection would seem to be equally justified.

To clarify: the argument here does not justify, and it is not based on, a general right to end one’s life if one so desires (after full and rational reflection). We are assuming no such general right to commit suicide. It is a premise of the argument that the patient in question is in a terminal condition (or that meaningful human life is irreversibly lost). It is on this basis and this basis alone that we conclude that we are not acting contrary to the Divine Will in allowing or hastening death. Indeed, the prohibition on taking one’s own life is out of place when one is already dying anyway. When one hastens death one is choosing between prolonging the dying process and shortening it; and these cases are thus fundamentally different from the suicide of a healthy person or non-terminal patient. Interesting, in many ways the Islamic justification for hastening death, suggested here, clearly justifies the restriction in the Netherlands and in Oregon that limits the right to hasten death to the terminally ill. In a more “Western” pure autonomy based argument, the basis of this restriction is substantially less clear (although, we did offer a justification of it in section 3 above).

At any rate, in both the Islamic tradition and the Western autonomy-based tradition, it has become common to justify allowing natural death but to prohibit actively hastening death. In both traditions, however, we have seen that arguments can be made for a more expansive right to die that includes permitting hastening the death of the dying. Once again despite radically different starting points, reason brings us to the same disputes and positions. In the West we may focus (now) more on respect for persons and in Islam the focus is on submission and deference to God, but in the end we are led to the same arguments and the same range of reasonable positions. The difference at another level, however, is indeed significant. There is a difference between an ethics of submission to the will of God and one based on individual autonomy and the moral standing of the individual. It is thus all the more striking how the two approaches converge in the face of the basic practical issues of life and death. (In considering why this practical convergence occurs and is actually not surprising, we would need to return to the critiques of a extreme Divine Command theory of ethics discussed in chapter II.)

54. Buddhist Ethics: Allowing Death, Hastening Death and Karma

We have seen that Buddhism emphasizes the duty not to kill or harm, and it also emphasizes the virtue of compassion. The value of life and the value of compassion seem to conflict in the case of caring for the dying. What does Buddhist ethics say about allowing death and euthanasia? Is allowing death or hastening death always a violation of the rule against killing? Or can it be a compassionate and loving response to a dying person's decision to end suffering?

Perhaps surprisingly, despite an ethical framework that is very different from Islamic ethics or Western ethics, the standard Buddhist position here is exactly the same as these other traditions: allowing death is acceptable in the case of a dying person or a person in a persistent vegetative state, but actively hastening death is not allowed. In addition the basis of this distinction is once again the doctrine of double effect that distinguishes intending (or aiming at) death from merely foreseeing but not intending death.¹⁹ In addition, the objections to the relevance of this distinction in the context of a dying patient that we have raised in discussing Western views and Islamic views applies equally to the standard Buddhist position. Despite enormous philosophical and cultural differences, the basic ethical issues are the same once again. The moral principles and moral problems are universal despite fundamental cultural differences. In stating this conclusion, we jump ahead. What is the basis of the Buddhist position?

Karmic Causes, Natural Causes, and the Role of Medicine: One might assume that a Buddhist should oppose all forms of euthanasia because we should accept and not pointlessly try to resist our karmic fate, which determines illness, suffering, and death; but this is mistaken. It is, however, a common misunderstanding of karma to interpret it in a fatalist manner.²⁰ The fatalist treats all suffering and benefit as the unavoidable result of one's past karma: It is pointless to try to avoid suffering because suffering is the only way to discharge one's karma. It is either suffering now or suffering later, but the suffering that one is due cannot be avoided. We have already discussed the fundamental

¹⁹ For Buddhist accounts of allowing and hastening death, we are indebted to Damien Keown discussion in *Buddhism & Bioethics* (St, Martin's Press, 1995), pp. 168-87, and to Harvey pp. 286-305.

²⁰ For a discussion of karma and fatalism, see Harvey pp. 23-25

problem with this fatalism in our discussion of Islam and the Divine Will.²¹ Buddhist reject fatalism for similar reasons, but these reasons are now framed by core Buddhist concepts. Karma is *a* cause of one's condition but in addition there are all of the other natural causes and conditions that also have an influence on our mental and physical state. These range from basic biological principles, to external causes like cold or warm weather, and of course to the actions of other persons! A Buddhist can recognize that there are contagious diseases, degenerative diseases and cancers that are the result of natural processes. There are also injuries that are simply physical damage to one's body. So, injury, disease and illness do not necessarily have a karmic cause.

On the other hand, Buddhists also believe that one's attitudes and inner mental state also contribute to disease or good health. Indeed, the idea of maintaining health through an inner calm and changing attitudes and behaviors is a crucial aspect of Tibetan and Chinese medicine. The afflictive emotions affect one's mind and one's body. Stress, anxiety, and tension, for example, are bad for one's health. If one is distracted by anger, hatred, or lust, this lack of awareness causes accidents and injuries. If one expresses anger this might provoke a retaliatory assault and thus injury. Buddhist will thus emphasize these karmic causes.

Disease results from both the agent's karmic state and from natural causes that are not dependent on the agent's inner Karmic state. Contemporary Tibetan medicine, for example, combines principles of modern biomedicine and traditional medicine. In addition to traditional herbal medicines, diet and attitude, effective medicines from aspirin to antibiotics clearly help restore health and are of course widely used by all. Certain conditions are responsive to surgical or pharmacological interventions but others are not and these may be responsive to traditional medicine. The two systems of medicine thus complement and supplement each other. This pragmatic attitude is characteristic of the modern Buddhist approach in combining modern scientific insights with the classical Buddhist worldview. Some things are the karmic fruits of past actions and others things have naturalistic causes. Medicine like all else should be governed by compassion. The role of medicine is thus to cure disease and minimize suffering, in so far as this is possible.²²

Since the karmic causes extend into one's past lives, one can never really know how much of one's fate is in this sense self-inflicted and how much is rooted in other natural causes. After one has done all that one reasonably can to improve one's life in general, including one's health, Buddhists can never really know how much of their fate is the result of bad luck and how much is bad karma. The knowledge that one may

²¹ See chapter II, and sections ???.

²² This information is based in part on an interview with Tibetan physician, Nyi Ma from the Traditional Tibetan Hospital, Out-patient Department (10 Youtok Road, Lhasa, Tibet), June 2005. This hospital of traditional Tibetan medicine also had modern surgical and emergency trauma centers. Nyi Ma was the spokesperson for the hospital, an expert on Tibetan and Chinese medicine. He also had five years experience in contemporary "Western" trauma and emergency medicine. For traditional Tibetan and Chinese medicine see [get references] On Tibetan Buddhist attitudes toward science see The Dalai Lama, Herbert Benson et al. *Mind Science: An East-West Dialogue* (Wisdom Publication, 1991), and *The New Physics and Cosmology: Dialogues with the Dalai Lama*, Arthur Zajonc, editor (Oxford 2005).

oneself be responsible for one's condition can help counteract anger at the seeming "unfairness" of the conditions that befall us all.²³

In addition, the doctrine of karma presupposes that human actions have consequences and that our choices determine these consequences. Negative desires and actions have bad effects and positive desires and actions have good effects. A passive fatalism is thus deeply inconsistent with the very idea of karma. The Buddhist path aims for ever greater wisdom and virtue, and this life produces good karma as an effect. In facing death, as in all else in life, we must do what is right and virtuous and in so doing we will produce some additional good karma that will carry us into the next life.

Actively Hastening Death: So it is a mistake to conclude that actively hastening death is wrong because it mistakenly tries to interfere with the karmic fruit of previous bad actions. There are however two basic Buddhist arguments against hastening death. The first is that the moment of death is an opportunity for great insight and karmic fruitfulness. The second is that the first precept, the prohibition on killing, prohibits actively hastening death.

Buddhists emphasize the importance of the state of mind at the moment of death to one's next rebirth. Why would this be so important? On first glance, the accumulated karma of one's life and past lives could not be significantly changed simply by one's frame of mind in the face of death. One explanation for the importance of the dying moment is based on a particular interpretation of the workings of karma. According to this interpretation, the karmic effects of action do not always express themselves in this or even the next life. Only very bad deeds like killing one's parents have clear immediate effects causing a certain rebirth in a hell for a very long time. On the other hand, those who display great wisdom and compassion are clearly on the path of enlightenment and thus are sure to avoid any subhuman rebirth. The karmic effects of all other more intermediate actions interact and intertwine, amplifying and suppressing karma in a complex and dynamic manner. It is thus claimed that one's next rebirth is underdetermined and the compassion, lucidity, and mindfulness of one's death has a disproportionate influence on one's next rebirth.²⁴ Of course, we may still wonder why this matters, since the bad karma must nonetheless eventually discharge itself. But we can add that an immediate fortunate rebirth as a human allows one to accumulate even more good karma and greater insights into the Dharma, and thus it may in the end

²³ Karma is often used to explain one's social class at birth (Harvey p. 21), but this also seems to us to be a mistake. This view seems to take social classes as fixed independently of human institutions, and to treat it as a fixed condition of one's life. This view of social class fits nicely with the Hindu caste system (or a Western feudal worldview). In Hinduism one's caste was the result of one's past lives and Karma and this was an important part of the justification of the rigid caste system. The Buddha, however, rejected the authority and higher status of the Brahmanical system, and argued that wisdom and virtue are inner features of a person, and not a caste birthright. Anyone can become a monk and study the Dharma. If a high caste Brahman and a low caste servant enter the order of monks, the Sangha, the servant is ordained first so as to always be senior to his previous master. Why should class status (in so far as it limits one's option and quality of one's life) result from previous karma of the subordinate rather than the bad karma of the oppressors? Insofar as Karma is used to explain and justify class status, it is being used as an ideology of social injustice. The tradition of "Engaged Buddhism" takes a more socially progressive stance and seems more plausible and consistent with Buddhist principles. According to this form of Buddhism, social oppression and institutional injustice are human creations that must be overcome. The Vietnamese monk, Thich Nhat Hanh, is the most well known proponent of Engaged Buddhism (see Harvey pp. 112-113).

²⁴ See Harvey p. 24-25.

actually prevent an undesirable rebirth (or series of rebirths) that otherwise would have occurred. With this added element, the moment of death can significantly change the overall course of one's future lives.

Although the above interpretation is interesting it depends (i) on a purely speculative and *ad hoc* claim about the indeterminacy of the workings of karma and also (ii) on the supposed powerful effects of one's mental state on one's next rebirth. Although this view can be found in classical Buddhist texts, it is not clear why karmic causation would work in this causally indeterminate way.

An alternative interpretation of "right dying" – which is not based on the indeterminacy of karma and a simplistic appeal to textual authority – emphasizes the singular significance of the actual moment of death. On this view, dying is an opportunity for great growth and Karmic development that should not be wasted. The impermanence of life and the opportunity for expressing compassion and equanimity are unparalleled when one is facing death. It is thus a unique opportunity for personal insight. Clearly I should be as mindful and as aware as possible as I confront this unique experience.

Dying is also a rare opportunity to comfort others, through one's own strength, in their time of need and loss. This may seem somewhat perverse: "I should be comforting others when I am the one that is dying!" one might exclaim in response. But here we see the very point. This thought is based on a strong assertion of self, and it is the doctrine of no-self and of interdependence that is the key to inner peace and compassion for others. By focusing on loving-kindness to others and focusing on experiencing the fundamental impermanence of life, one both experiences greater inner peace oneself and also comforts others – and this mutual benefit that flows from interdependence is the fundamental moral insight of Buddhist ethics (see chapter IV). Notice that this is an insight even if there is no rebirth at all. Even if there is no rebirth and future karmic effect, this is still a model for a good death for self and others. As a final note, it is also the case that a lack of inner peace and mindfulness in the face of death, is itself a sign or indication of a lack of progress towards Enlightenment, because it manifests both a clinging to life, an assumption of an enduring "I" that will be lost, and thus a failure to appreciate the impermanence of all things.

These insights, however, do not justify a categorical prohibition on actively hastening death. First, in many cases where it is common to think that allowing death is permissible, it is also the case that the patient is no longer capable of mindful awareness or compassionate actions. Substantially incompetent patients, brain damaged patients, patients in minimally conscious states (MCS), and especially patients in persistent vegetative states (PVS) simply cannot experience these benefits of a lucid and compassionate death.²⁵ If it is permissible to withdraw care and let patients in these hopeless conditions die, why is it not also permissible to actively hasten the death of these same patients?

Conscious patients present different problems. Although severe pain can be controlled by medication or sedation, these means of controlling pain also diminish or eliminate conscious awareness. The dying patient is thus faced with a choice between sedation that undermines consciousness or mind-numbing suffering. In these all too

²⁵ For a discussion of the nature of minimally conscious states and persistent vegetative states, see Chapter VII, section 39.

common everyday end of life cases, the ideal of the lucid-mindful-death is just not an option. In all of these cases, the ideal of the lucid death does not provide any basis for a distinction between allowing death and hastening death. Furthermore, the ideal of the lucid death provides a justification for hastening death in any case where doing so is likely to result in a more mindful and compassionate death. A deteriorating terminal patient who, after reflection and collaboration with others, decides that it is better to die when one still has one's wits and can do so at home in a way that comforts one's family seems to clearly express the above ideals of the good death.²⁶ Indeed, as discussed above, we learn from patients in Oregon and the Netherlands (where hastening death is legal) that the main reason patients give for requesting assisted suicide or active euthanasia is that they want to avoid the loss of autonomy and control at the end of their life. Similarly, the German ideal of a "free death" also seems compatible with the Buddhist ideal. On the other hand, if one continues to maintain that dying sooner rather than later is still always wrong because there is always more to experience (even when experience is significantly diminished, it is after all still experience), this implausibly applies equally to allowing death when even minimal consciousness can be maintained. It thus seems to prove too much.

The Buddhist story of the suicide of the monk Channa and his subsequent enlightenment recounts just the sort of "free death" in the face of illness that inspires those who defend the legitimacy of hastening one's death so as to die sooner but better. Here is the story:

After describing his intolerable medical condition, Channa declares *I shall use the knife, friend Saariputta, I have no desire to live.*

Saariputta responds: *Let the venerable Channa not use the knife! Let the venerable Channa live -- we want the venerable Channa to live! If you lack suitable food, I will go in search of suitable food. If you lack suitable medicine, I will go in search of medicine. If you lack a proper attendant, I will be your attendant.*

Channa replies: *Friend Saariputta, it is not that I have no suitable food and medicine or no proper attendant. The Teacher has long been served by me with love; for it is proper for the disciple to serve the Teacher with love. Remember this: the monk Channa will use the knife blamelessly (and not be reborn).* Facing intolerable and uncontrollable suffering, Channa cuts his own throat and in the process immediately becomes an Arhat and attains enlightenment.²⁷

In hastening his own death, Channa acts with full mindfulness, transcends suffering, and becomes an enlightened Arhat. Notice also that Channa explicitly recounts that he meets the standard conditions for acceptable hastening of death:

- He faces unacceptable suffering or degradation
- He has exhausted reasonable treatment options
- He has received or has available the best available comfort care
- He has fully satisfied all of his obligations to others
- And he will not learn more from experiencing a worse death

²⁶ For the kind of real case that we here have in mind, see Dr. Timothy Quill ".... The case of Diane" JAMA. [find reference]

²⁷ See Keown <http://urbandharma.org/udharma/suicide.html#53>

In this story of Channa we see that the Buddhist ideal of a mindful death do not exclude hastening death. More generally we conclude that the ideal of the lucid death provides no objection to hastening death (i) in any case where diminished capacity prevents a mindful death, or (ii) in any case where hastening death is likely to result in a more mindful death.

This brings us to the second argument for a Buddhist prohibition on hastening death: the basic precept that forbids killing any living thing. Would this prohibition not include suicide and thus voluntarily and intentionally hastening one's own death? In answering this question it is common to refer to a Buddhist text that recounts a story of the Buddha strongly condemning the suicides of over 60 monks who choose to die to escape their bodily existence.

As the story goes, the Buddha had been instructing the monks on the impermanence of the body and the reasons that is not a suitable object for identification and attachment. The Buddha then leaves the company to go into seclusion, but the monks continue debating and reflecting on the imperfections of their bodies. In their enthusiasm, they decide that they would be better without their bodies and proceed to assist each other in a mass suicide. When the Buddha returns and learns what they have done, he condemns this taking of human life:

*Whatever monk should intentionally deprive a human being of life. Or should look about to be his knife-bringer, he is also one who is defeated and is no more in communion.*²⁸

From this story and the Buddha's reaction, it is concluded that suicide and assisted suicide and thus also euthanasia are all equally a violation of the prohibition on taking human life.

In considering this story, the first thing to note here is that the prohibition is a monastic rule and the rules for monks go beyond the demands of laypersons. Just as monks take a vow of celibacy, they may also be required to take a vow to not commit suicide or help another commit suicide. This monastic rule thus does not settle the question of whether suicide, or assisting in a suicide at the request of the person, is a case of prohibited killing for laypersons.

In addition, and more importantly, the case in question really has nothing to do with euthanasia and assisted suicide of the dying. As we argued, hastening the death of the dying is consistent with refusing to hasten the death or even condone the death of the healthy. The question is whether it is permissible to hasten the death of terminal patient or patients in significantly diminished states that undermine human agency. A prohibition on suicide for the robust and healthy ignores the obvious relevance of the condition of the patient, and thus it simply is not relevant to the question at issue.

Furthermore we have already seen that an autonomy-based ethic should not just promote the expressed preferences of persons. The value of a person is prior to the value of the person's preferences, and so if we value them we may still oppose their preferences when we think that they are confused, wrong, or otherwise misguided (section ?? above). The healthy and robust monks in the above story are clearly confused and misguided. After all, as Buddhists, they must also think that they will simply be reborn in another

²⁸ The quote and the account of this story are from Keown, *Buddhism & Bioethics*, pp. 167-68. Keown argues largely on the basis of this story and an assumption of the doctrine of double effect that Buddhism prohibits intentionally hastening death. Harvey agrees. Although we disagree with their conclusion, our discussion is based on their scholarship and account of the Buddhist texts.

embodied existence. Secondly, they have missed the meaning of the doctrine of impermanence in that they are not a person distinct from their embodied existence. There is no self other than the dynamic of ever changing attributes that make up the person (Chapter IV). Their mind is also subject to the doctrine of impermanence. They can only escape the cycle of rebirth by achieving enlightenment, and the momentary destruction of bodily existence does nothing to advance that cause. So it would be wrong to kill oneself to “escape” bodily existence and it is also wrong to assist another in this misguided project. Even if one is committed to respect for individual autonomy, this is a case that justifies passive paternalism, and perhaps even active interference to stop the person from acting in a way that is so contrary to the person’s own deeper values and principles.

Double Effect Redux: Despite the prohibition on actively hastening death, the Buddhist ethicists typically do allow the withdrawal or withholding of care when this is in the best interest of the patient. Like the Islamic scholar and Western medical ethicists, they argue that this is not euthanasia at all because it is not aiming at the death of the patient. When the physician allows death, they foresee that death will probably occur but they are not intending to cause death. The role of the physician is to restore health if she is able and also to relieve the patient’s suffering. We do not show compassion by imposing treatments that are “futile or too burdensome ... The physician’s role is not to preserve life at all costs but to restore patient health and well-functioning ... It is what is best for the patient that must determine the course of treatment if, indeed, treatment should be given at all.”²⁹ So withdrawing or withholding treatment is permissible when treatment is futile or burdensome or when one cannot restore health. The intention not to treat is not an intention to cause death, it is argued, because the intention is to avoid futile or burdensome care, and death is merely foreseen.

This distinction is made by Western medical ethics too, but despite its wide appeal we think that it is nonetheless mistaken. First, any care that actually prolongs life is *not futile in a physiological sense*. It preserves biological life and the patient will die without it. So the futility claim actually (unintentionally) hides the assumption that there is no benefit to the patient in mere continued biological life. Second, the standard of well-functioning and restoration of health are value judgments about the quality of a patient’s health. A diabetic patient or an HIV patient may be treatment-dependent for the rest of their lives, for example, and thus health and well-functioning cannot be restored. If “health” cannot be restored and the patient is lucid and not terminal, it would be wrong to withdraw care. Obviously, in the above account of allowing death and the role of the physician it is being assumed that *significant* function cannot be restored and that *the death that is foreseen does not harm the patient*. Without this assumption allowing the death that is foreseen would seem to be in conflict with the role of the physician and the basic rule to not harm one’s patients. The Buddhist arguments here are the same as the Western and Islamic objections to hastening death discussed above, and the responses are the same too.

We are left with the bare claim that it is wrong intentionally and actively to cause the patient’s death, but it is not wrong to allow the patient to die from the underlying disease. The problem is that the doctrine of double effect (that is the supposed basis of this claim) is about the permissibility of allowing foreseen harms. The idea is that the prohibition on causing harm does not also prohibit allowing harms that are foreseen --

²⁹ Keown, *Buddhism & Bioethics*, p. 175.

provided that the good intended outweighs the harm that is done. As we have seen, the doctrine of double effect thus presupposes that intended consequence involves serious harm. That is why the same consequence is permitted, when it is foreseen, only if the intended good outweighs the harm done. It is not ok to allow foreseen harm unless more good is done overall.

In the case of actively and intentionally hastening the patient death, the death in question must harm the patient for the prohibition to apply at all. But as we have seen the argument that permits allowing death must concede that the death does not harm all things considered. It follows from this alone that the intended death also does not harm, all things considered. So the prohibition on harming (or injuring living things) also does not apply. If hastening death relieves suffering overall it does not harm and thus it may be permissible. If the patient has lost the capacity for meaningful consciousness or will, then the patient has lost the capacity for karmic fruitfulness, and the hastening as opposed to allowing the death of the patient should make no difference to their rebirth.

At the end of a life, when the opportunities of this life have passed, death itself is not a harm for a Buddhist. Indeed rebirth follows death and life goes on. A Buddhist prohibition on killing the dying, when dying does not harm them, involves a mere bare assertion that intending death is always wrong without *any foundation* in Buddhist ethics. The appeal to the doctrine of double effect masks this bare assertion. The prohibition on killing, however, first presupposes that killing is wrong, and it thus cannot provide the basis for the prohibition. Again the point of double effect is to justify unintended but foreseen killing *that would be wrong if intended*. If the death that is foreseen or intended is not bad all things considered, then the principle simply does not apply.

This is not an objection to Buddhist ethics in particular, however. The view here being criticized is embraced by many Western medical ethicists too. Indeed, it is the position of the American Medical Association. We thus see that the wrongness or permissibility of hastening death turns on substantive issues that transcend mere cultural differences.

[Conclusion: Paternalism Revisited – To be added]