Chapter Thirteen

Physician-Assisted Suicide Is Ethical

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In this chapter, after noting that the typical bioethics case study is too detached from real-world experience, I argue that, if their misery is placing an undue burden on their existence, rational adults may legitimately ask for assistance in ending their lives. If conscious and intelligent enjoyment of life is absent for people—especially individuals suffering near the end of life—and they see their existence as no longer of value, then suicide or assisted suicide (in the event that a person is unable to commit suicide) is a legitimate and morally justified option. I refute some of the standard objections against physician-assisted suicide and offer provisions for the practical application of physician-assisted suicide in our society.

Introduction

A persistent weakness of bioethics discussions is their abstraction. A nameless individual or someone designated by a capitalized letter, without personal background and value commitments, is supposed to have drifted into the emergency room and presents us with a thorny moral problem. The age and gender of the individual are indicated, and his/her condition is described in a neat paragraph. That is all we know of the “case,” and that is supposed to be enough to come to a medically defensible and morally conscientious decision (cf. Yin, 2009).

Physicians in emergency rooms may encounter such cases, but this way of presenting moral problems is ill adapted to getting sound answers. The current condition and future prospects of people cannot be detached from their histories. Treatment appropriate to them is not independent of their beliefs and values. Such abstract principles as “First, do no harm” and “Respect autonomy” lack meaning without an understanding of what, for the person involved, constitutes harm and counts as self-determination (Arras, 1993; Walker et al., 1995).

Magda

I will try to correct such vacuous abstractions by describing in considerable detail the ways and needs of a person seeking relief from existence. Her name was Magda, and she lived a long and rich life. She outlived a series of her physicians, all youngsters by comparison with her. She was massively healthy throughout life. Two broken hips in her 90s did not slow her down, and at 101 she cooked and needed no help to take care of herself.

Her husband died before she turned 70. As she aged, her closest companions also went to the grave. Undaunted, she made new friends and reached out to...
people she had known as a child. Over decades, she saw these buried as well. Eventually, only two or three friends remained, and they lived so far away that she could keep only in telephone contact with them.

Although Magda had no life-threatening illness, her organs began to fail. Macular degeneration robbed her of her sight, and she lost much of her hearing. She learned to walk with a cane, then with a walker, and finally gave up walking altogether, except for a step or two when someone would lift, steady, and support her. Her mind remained clear, which made things more difficult because she saw and understood how her life was closing down.

A vibrant woman who loved life and enjoyed its activities, Magda resisted the closing hour. She employed every mechanical aid available to support her organs. But she had always been fiercely independent and did not find it easy to have to rely on others for help with a growing number of activities. Her tendency was to offer help rather than to seek it, and her disabilities took a heavy toll on her self-image. She said that she was angry because she could no longer even attempt what she used to do without effort.

Magda understood how, as we age, the horizon narrows, and the activities of life become impossible to sustain. But she thought it was an indignity that she could not take care of her own private functions and communicate with others only with great difficulty. At 103, she suffered compression fractures and found that moving caused excruciating pain. Going to bed became torturous, so she learned to live and sleep in a recliner. She had to wear diapers and rely on her son to clean her.

A mild case of pulmonary hypertension did not hold hope of terminating her life quickly. Living longer seemed to her utterly pointless: the pain, the indignity, and the growing communicative isolation overshadowed her native optimism and the joy she had always taken in being alive. She decided that she had had enough, and she was ready to die. She had foreseen this possibility in her younger years and stockpiled sleeping pills so that when the time came she could commit suicide. But the pills disappeared in the chaos of her apartment, and she was, in any case, unable to leave her chair to get them. She decided not to eat or drink, but there was enough love of life left in her to make this a regimen she could not sustain.

This leads us to the moral problem. Is it acceptable to provide her with aid in dying? Here is a more pointed way of putting it: Is it not outrageously wrong to let her shriek in pain and live disgusted with her condition for months and possibly years?

It may be worth mentioning that this was the story of my mother.

The Value of Human Life

In the name of what value past, present, or future could one deny Magda help with finishing her life? Clearly, no past value is at stake: her days of delight and generosity were over and would never return. The past has an integrity all its own, opening itself to grateful memory without ever changing. There is reason to be thankful for lives of kindness and sharing, but what was achieved in the past neither calls for, nor justifies, maintaining an existence after it turns barren.

Magda’s life near its end has no present value. If we added up the positive aspects of her painful existence in the recliner and deducted her anguish, embarrassment, sorrow, and frustration, the sum would come in as a high negative number. Further deducting her sense that she is a burden on everyone and that her will is violated if she cannot die, we get an overwhelming indication that nothing in her present justifies continued life.

There are occasions when the hope of future good makes it appropriate to grit our teeth and fight through painful times. Cancer patients have reason to subject themselves to surgery, radiation, and chemotherapy. Husbands and wives divorcing suffer through dark days in anticipation of a better life. Soldiers endure the pains of basic training and young doctors the sleepless exhaustion of internship, expecting something better at the end of such torture. Nothing like this relates even vaguely to Magda. She had no future; all she could anticipate was release whenever it would come “naturally,” that is, without the help of any human being.

She made it clear to me and to others that receiving no help in dying amounted, in her view, to abandonment. “Don’t let me live like this,” she pleaded, “No human being should be made to endure such a fate.” I cannot think that in this assessment, she
was wrong. With pity in our hearts, we do not permit our animal companions to suffer: we ease them out of life with sorrow, painlessly. By contrast, we seem to take no pity on human beings, forcing them to live to the end, no matter how miserable they are. Visitors from another planet would find this a baffling and indefensible cruelty.

Animal life is cheap, but human life is sacred, some might be tempted to say. Just exactly what is it that makes for this difference? The usual answer is that animals are valuable only as instruments, adding to our comfort and enjoyment, but humans represent an intrinsic and perhaps infinite value (Kant, 1785/1998; Haezrabi, 1961/1962; Pullman, 1996, 2002; CCC, 1994; Baron, 1999; Schaeffer, 2005, p. 69). As ends in themselves, possibly the only ones this side of God and the angels, humans deserve respect: we are not to shorten their lives or interfere with their fortunes. This is a hugely improbable position, a theory we may embrace in words but never honor in practice.

If we are to do nothing to extend human life, we have no business going to the doctor, taking medicines, driving cautiously, and even eating. And if we must not shorten our existence, hundreds of activities, including smoking, eating beef, overwork, and worry, become morally unacceptable. The human race has pronounced judgment on this theory long ago by happily taking control of human life, extending and shortening it according to what seems sensible and good at any given time. If slow and long-term self-destruction escapes moral censure, the immediate termination of life in suicide cannot be morally condemned.

This argument aside, however, we can ask what confers intrinsic value on human life. The idea that humans claim extraordinary status for humanity is immediately suspect (Singer, 1979, Ch. 10; Dunayer, 2004). Does it not sound like special pleading or species-ist foolishness? Cats maintain that humans are there to serve them and lions affirm their superiority by killing and eating everything in sight. If we could converse with chimpanzees and porpoises, would they not instruct us to view our existence as of no special concern because they are merely instrumental to their good? Those who do not spend time observing animals make the mistake of thinking that they lack value systems and intelligence.

The supposed intrinsic value of humans must be due either to some relationship or to a special feature of their lives. The prime candidate for the relation is the Deity who is supposed to have created us and placed us in a privileged position above the beasts (CCC, 1994; Schaeffer, 2005, p. 69; Soulen & Woodhead, 2006; USCCB, 2011). Without reference to something identifiably special in our experience, this relationship remains a theological supposition in need of evidence. That leaves the claim that there is something unique in human experience, something whose extinction would represent a momentous loss. The uniqueness of any feature of human experience is questionable, but let us make the best case for the view and say that the characteristic we are looking for is the conscious and intelligent enjoyment of life.

One can readily see that such enjoyment is of great value. In fact, it may be the only genuine good in the world (Mill, 1863/2001; Singer, 1979). But if this is what constitutes the intrinsic value of human beings, what becomes of that value when conscious and intelligent enjoyment is no longer possible? This was Magda’s problem: her days of delight were over, and she could no longer perform the activities that make life worthwhile. She faced only suffering, and if the source of the intrinsic value of human existence consists of intelligent joy, then toward the end, her life was without value.

Confusing Essence with Existence

Opponents of suicide may here respond that intrinsic value can never be lost. That which is valuable in and of itself relies on nothing beyond itself for its value. For this reason, it is immune to changes in its surroundings: since nothing external gave it value, nothing external can take it away (Sulmasy, 2002).

Unfortunately, this argument is flawed. It confuses essence with existence, the characteristic of an object or experience with its presence. Certain experiences are valuable in and of themselves, and it may well be impossible to separate them from their value. But that does not mean that such events must happen or always do. Being special on account of a unique brand of intelligent enjoyment does not guarantee that that enjoyment will always be available to humans. So long

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as it is at hand, it may well be wrong to hasten death. But in Magda's case and in many others, the enjoyment is unavailable, eliminating the special status of humans and the obligations that go with it.

Opponents of suicide can attempt to reformulate their view by insisting that what makes humans special, and imposes restrictions on hastening their death, is not a set of events or experiences but the very constitution of human nature. Followers of Kant (1785/1996, 1785/1998) maintain that our uniqueness is due to our rationality or to the spontaneity of the human mind. It is notoriously difficult to give a precise account of what it means to possess reason, especially if this single factor is to be responsible for separating humans from all other animals.

The fact is that many species of animals show themselves capable of reasoning (Watanabe & Huber, 2006; Pearce, 2008). Their behavior reveals that they seem to understand what counts as evidence and can move unhesitatingly from premises to conclusions. In the sphere of morality, Kant believes that reason enables us to decide on our actions totally independently of desires and external pressure. But if such performances serve as conditions of being human, the large majority of our fellows belong to a different species. We cannot be sure that anyone in the human race has ever reached a level of purity of intention to satisfy Kant. Moreover, how can we maintain that reason is the hallmark of the human in the teeth of all the irrationality that surrounds us? Thinking of reason as a faculty present in all of us, if only potentially, amounts to embracing an unwarranted opinion.

**Social and Political Reasons**

Obviously, arguments on the basis of the quality of life and the constitution of human nature do not prevail against suicide. But many people who object to the practice do so for social or political reasons. On the social side, they think that permitting it sets a dangerous example: they fear mass suicides and the possibility that, not understanding what they do, children will join adults in terminating their lives. Politically, they maintain that the state has a legitimate interest in the protection of human life. They imagine that without legislation banning the practice, older people, the sick, the disabled, and the poor will likely be forced to end their days (Moreland & Geisler, 1990; Siegler, 1996).

The fear of mass suicides is altogether groundless. We do not have to outlaw starvation to get people to eat; living is sufficiently joyous and the alternative sufficiently frightening to motivate people to hang on with all their might. The way to reduce child suicides is by parental love and caring, and not by laws of whose existence the young are in any case unaware. Unavoidably, some young, jilted romantics will kill themselves under any regime, but here, too, the best hope of reducing their number is social vigilance and the investment of time to help them over their despair, rather than legislation and threats of punishment.

From the standpoint of justice and the protection of human life, there is nothing to fear from morally accepting and legally permitting suicide. In 1994, Oregon passed the Oregon Death with Dignity Act (ORS 127.800-995). The Oregon experience of legalization yielded significantly fewer suicides than had been anticipated (OHD, 1999; Werth & Wineberg, 2004). It is possible, of course, that heartless people will exert pressure on the old, the sick, and the less fortunate to remove themselves before their time, but this can occur whether suicide is legal or not. If there is evidence of it, laws can be introduced to control the unfeeling, and in any case, adequate safeguards can be developed against abuse when suicide is aided by physicians.

The state's interest in protecting life raises a troubling issue concerning the range of its power. Sometimes, this is expressed by the question of who owns our persons or our lives. The metaphor of ownership can be misleading, but it is useful because it points to social arrangements of which slavery was an integral part. The great historical development of banning slavery established the untouchable independence of human individuals. If no other person can own us, no group of people—such as the state—can either.

That God, having created us, has lost or ceded ownership control was clear as early as the Garden of Eden. He can order us about, but whether we obey him is a question for us to decide. The idea that we are somehow God's "children" and therefore lack the right to mired on commitmen adult, with credit. The myth of the of one's individual variety of consenlizations is can hardly be benefit ever. The state of others who legitimate and every sensehps in particular in matters of the bed can only be" the prospect to the com"
right to make decisions about our lives confers no credit on religion. One would want to make the commitment to a faith and its God as a responsible adult, with an understanding of the prospects and the costs. Acting like a child in such matters of the gravest import does not give moral credit to individuals and can hardly be acceptable to God.

The myth of a social contract carries a vital message concerning the relationship of citizens to their states. It reminds us that nations are derivative organizations built on the consent and cooperation of individual human beings. The state can impose a variety of demands and limitations on its citizens, though only ones that promote the common good. For example, a system of taxation, setting limits to one's control of one's earnings, is justified so long as the money extracted is used for projects that cannot be undertaken by individuals and that benefit everyone.

The state can and should protect individuals from others who may want to harm them. It exceeds its legitimate power, however, if it sets out to protect sensible people from themselves, interfering in the way they choose to run or end their lives. Specifically, keeping a person such as Magda going beyond the time she reasonably decides to be done with life is an abomination: there is no value in the name of which government officials can insist that she continue to suffer. The existence of people in excruciating pain, hardly capable of moving and without the prospect of improvement, contributes nothing to the common good. Striving to make suicide unavailable to them reminds one of hell where devils torture sinners instead of letting them expire in peace.

Since neither God nor the state owns us, we must learn to be our own masters. This is appropriate in many of the activities that make life interesting and precious, but especially when it comes to decisions concerning the quality and quantity of existence. People who choose to live as drunkards or as deans must be allowed to make their own decisions and bear the consequences. It is especially important for end-of-life choices to be left in the hands of directly affected individuals. Telling others what they should do is for the most part wrong, but making others carry on the burden of a horrible life when they want to be set free is nothing short of wanton cruelty.

Kant and Mill

The followers of Kant and Mill appear to agree in describing freedom as self-determination. The agreement, however, is only verbal because the selves they have in mind differ sharply. For Kant (1785/1996), the self that is to determine itself is what we might call the “higher” or rational element in us. This means that free actions are supposed to be devised solely by reference to duty or other stern moral values, without taking into account the influence of others or what we may desire. A free action is, in this way, inevitably also a moral action, and an immoral act is at once unfree.

Mill (1863/2001, 1863/2008), by contrast, views freedom as the ability to do what we desire. The self that determines our actions is the everyday agent we know, motivated by needs and wants, and seeking its happiness in a changeable, treacherous world. Here, freedom means the absence of external constraint, that is, the ability of people to frame purposes and to carry them out. Free or autonomous actions are, therefore, not necessarily moral: as Adam and Eve in the Garden of Eden, we can succumb to temptation and choose the wrong alternative.

The point of the contrast is not that Kant recommends the righteous path, and Mill is satisfied with the willful search for happiness. Both of them embrace moral standards, but Kant thinks happiness has nothing to do with them. He finds it difficult to identify with the everyday ambitions of ordinary people, restricting morality to the realm of austere duty. Mill, on the other hand, understands the yearning for untrammeled movement that frames the moral life; he attaches high value to being able to do what we want. Morality, for him, is constituted by desires freely formed and actions freely performed or restrained, enabling us to grow into responsible adults.

Kant and Mill represent the two great strands of accounting for moral action. Deontology, growing out of Kant, measures moral performance by its adherence to duty; teleology, perfected by Mill, insists on assessing the consequences of what we do. Oddly, Kant and Mill agree that suicide is impermissible, but
neither has an argument that adequately supports that conclusion. Kant (1785/1996) thinks that suicide constitutes disrespect for human life: when we commit it, we use ourselves as a means to relieving us of some undesirable condition:

To annihilate the subject of morality in one’s person is to root out the existence of morality itself from the world as far as one can, even though morality is an end in itself. Consequently, disposing of oneself as a mere means to some discretionary end is debasing humanity in one’s person. (6:423, p. 177)

Mill (1863/2008) believes that suicide and selling oneself into slavery do not fall within the range of our freedom because they are arguments for choosing to destroy oneself is to put a permanent end to one’s freedom to choose:

He therefore defeats, in his own case, the very purpose which is the justification of allowing him to dispose of himself. He is no longer free; but is thenceforth in a position which has no longer the presumption in its favor, that would be afforded by his voluntarily remaining in it. The principle of freedom cannot require that he should be free not to be free. It is not freedom, to be allowed to alienate his freedom. (pp. 198–199)

Kant’s argument is unconvincing because we use ourselves (and others), unobjectionably, as means in the course of ordinary life. I use myself to acquire the skill of playing the piano when I make myself practice, and I use the pilot to get me to my destination when I take a trip on an airplane. What makes such actions morally acceptable is that when I undertake them, I do not use humans as means only, but respect their freedom by asking for their consent. But that is precisely what happens in suicide. Designed to relieve a horrible situation, it does so with the sufferer’s consent. Further, we can reasonably ask if it does not show greater respect for human life to terminate suffering rather than to let someone like Magda struggle for months with despondency and pain.

Mills’ argument against suicide is equally weak. The irreversibility of the choice of self-destruction is shared by every decision. When I marry, I change my life permanently; choices that were once open disappear. In deciding to settle in one part of the country, I surrender a host of possibilities, and in choosing a profession I disable myself to practice many others. Admittedly, these choices close off many activities but not all, whereas killing oneself is, presumably, an end to everything. But this distinction is irrelevant in Magda’s case. She was able to do very little and nothing that satisfied, so the loss of all is a net gain because it ends the suffering.

Another way to look at this is to examine duties and consequences more systematically. In taking my life, do I violate a duty? The language of obligation is not well adapted to capture the relation of individuals to themselves. We commit ourselves to values, formulate plans, undertake projects, and engage in activities as a result of what we want and what we think is good. We do not believe that we owe it to ourselves to do these things or that we are duty-bound to perform them. We do have obligations to others: parents, for example, have a duty to stay alive so they may take care of their underaged children. But no such obligation existed in Magda’s case. Her husband and her close friends had died long ago, her son had grown old, and her grandchildren were busy with their lives. No duty held her attached to existence.

Utilitarian or teleological calculation of the consequences of Magda’s committing suicide yields a similar result. She had little on the positive side of the ledger. A few distant friends had the pleasure of occasional conversations with her, and her son and daughter-in-law took delight in bringing her food she particularly liked. For the most part, she ate only a few morsels. Her days were indistinguishable from her nights: her pain medication left her without knowledge of who or where she was, and when she awoke to a moment of lucidity, all she could call for was an end to it. Sadly, much as she would be missed, her suicide would have reduced the misery and thereby added to the net sum of good in the world.

The Morality of Suicide and Physician-Assisted Suicide

The first stage in arguing that physician-assisted suicide is morally permissible consists in showing that committing suicide is not always wrong. If we can find even one case in which the intentional termination
termination of life by a human being is clearly justi-
ified, the abstract claim that it is always wrong is rou-
dantly defeated. The logic of the argument is that a single
counter-example destroys a general theory. Magda’s
case is just such an example: no good could emerge
from forcing her to continue to suffer. This establishes
the legitimacy of suicide at least in some cases.

The next task is to show that it is morally accept-
able for doctors to aid people when they wish legiti-
mately to terminate their existence. The modern
world values life and makes it difficult for people to
end it. People who want to kill themselves by jumping
from high places find it difficult to identify a suitable
venue. The windows of skyscrapers do not open, and
high fences protect the walkways on bridges. Slitting
one’s arteries is a bloody and distasteful affair. Most
people do not have guns or are not tutored in their use.
In any case, one might miss, as did the German
generals when they tried to commit suicide after their
unsuccessful attempt on Hitler’s life. That leaves pills,
with which everyone today is thoroughly familiar.
They hold the hope of a smooth and rapid transfer,
the painless end to pain and misery.

Unfortunately, however, people do not know the
power of pills: they tend to be ignorant of which ones
end life and which put them in the hospital. In any
case, ordinary people have no access to powerful drugs
without the intervention of doctors, and physicians are
notoriously reluctant to make drugs suitable for
suicide available to their patients. The question of why
doctors should assist in suicides is easy to answer: the
medical profession has monopoly power over drugs
(Light, 2010). Since society conferred this vast and
lucrative power on physicians, they are under an
obligation to help individuals who have a legitimate
reason to hasten their death.

The standard objection to this consists of remind-
ing us that doctors are supposed to return us to health
rather than aid our demise. “As physicians, we’re not
supposed to be in that role,” many would claim, as
Dr. Andy Harris did when he commented on a case
dealing with a Baltimore doctor who was acquitted of
physician-assisted suicide in 2011 (May, 2011). But
what if health is never to be restored? There was
simply no hope of improvement in Magda’s situation;
at her age, any intervention was like trying to stop the
tides. Would it not be appropriate for her physician to
offer help when she cried out to die? This question
opens a distinction between two conceptions of the
proper function of physicians, one narrow and one
much broader.

The narrow notion is characterized by the claim
that physicians should treat diseases so that their
patients may recover. This tends to be the view of
medical specialists, who arrive on the scene to prac-
tice their marvelous art and depart as soon as the
problem gets resolved. One might think of them as
hired guns employed by the sheriff to help restore
order in town. They have little interest in their patients
as people, asking little about the values and personal
history of the individuals they treat. Such information
is not necessary for the cure and may in fact interfere
with it: doctors are supposed to solve problems by
means of pills or surgery and, when all goes well,
return patients to their normal lives.

The broader conception of the task of medicine
was in complete possession of the field 150 years ago
when many physicians lived in small communities and
cared for their patients from birth to death. Doctors in
those days took an interest not only in the physical
status, but also in the psychological condition and
social relationships of their patients. In the belief that
personal health is inseparable from the flourishing of
society, some went so far as to demonstrate vital
concern for the well-being of the families and
communities of their patients. Family practice physi-
cians come closest to this conception today, though
financial pressures make it difficult even for them to
spend much time with their patients.

Not surprisingly, doctors who subscribe to the
dominant narrow conception of their duties have
difficulty understanding how they could be called on
to aid a patient’s suicide. Their role is to treat the
disease and, when there is nothing further they can
do, to declare the case one of medical futility, making
room for hospice care and palliative measures. The
idea that patients have life histories, purposes, desires,
values, and fervently held beliefs appears irrelevant;
the possibility that they might not want to waste away
waiting for death is given no consideration. The result
is that just when we need good doctors the most, they
become unavailable.

Even if the broad conception of physician duties is
no longer viable, we must insist that doctors help us

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through every stage of life. They need to provide empathy no less than specialist knowledge and learn to view their contributions to our lives as informed suggestions and kindly advice. Most important, they must be there for their patients at the great crises of life, helping in the difficult task of making decisions concerning the dark days. This does not mean that they have to stand ready with pill or syringe to honor every wish of the depressed. But, unless they have personal or religious objections to suicide, they must be on hand to provide, when appropriate, the means to a peaceful and dignified departure.

The original version of the Hippocratic Oath forbids physicians to make deadly drugs available to their patients (North, 2002). It is essential, however, to remember that in the days of Hippocrates people did not live very long. Many died in the prime of life, and virtually no one reached old age in a debilitated condition. Magda would have expired long before she reached her 103rd birthday and hence would not have needed physician help to terminate her life. Enlisting doctors in the quest for a peaceful and dignified death is a need and an activity unique to the contemporary world. It grew out of the success of medicine in keeping people alive and the political decision to control drugs and vest their distribution in the medical profession. The vast and continuing increase in the number of the very old will likely intensify the pressure on physicians until our laws come to reflect the moral acceptability of terminating life.

Does this mean that suicide is morally permissible at any age and under all conditions? Not at all. Here it may be useful to distinguish between what we are free to do and what is good to undertake. A generous reading of human freedom leaves it open for adults to finish the book of life at any time they desire. If they are young and healthy, their doing so is a lamentable error. But they are at liberty to do what is sad and wrong, as Adam and Eve were when they disobeyed God's command. The source of the liberty is the fact that no one has a right to force life on people when they want to die.

Friends and neighbors incur responsibilities when people they know decide to exit life. They must speak with them, stressing the beauty and goodness of life, along with the irreversibility of death. They have to ask them to reconsider or at least to wait until they see more clearly. If they can truthfully say it, they might even indicate how much they mean to their friends and how intensely they will be missed. But just as God did not use His power to stop Adam and Eve, the freedom of individuals blocks us from employing force to prevent their suicide. We cannot be expected to stand idly by while people kill themselves, yet morally we can stop them only by persuasion.

This means that exercising freedom is by no means the same as following moral rules. The freedom to commit suicide gives us more operational leeway than moral principles allow: we have the right to terminate our lives even if it is wrong to do so. But healthy young adults who propose to kill themselves cannot demand aid from others. Helping someone commit an immoral act is itself immoral, so there can be no obligation to provide gun or pills. The situation is altogether different with suicide that is justifiable. As in trying to do what is right or at least permissible, so here also, one can legitimately enlist the aid of friends and physicians. Such a right to ask, if exercised, imposes an obligation on those in a position to help.

Naturally, the duty is dissolved if the request violates the physician's moral commitments. But it is binding if aid is just bothersome or inconvenient. The demand is valid even if meeting it is dangerous or may lead to severe repercussions. This is why Dr. Kevorkian must be seen as a pioneer who was willing to risk criminal censure to affirm in his actions the responsibility of the medical profession for help with suicide. Many found his manner of providing deadly drugs to terminal patients disquieting or even grisly, but he used a parked van only because honest ways of committing suicide are banned in hospitals. The objection to his efforts that the people he aided in dying were not his patients is fatuous; he stepped in only because the attending physicians did not shoulder their responsibility.

Being Careful, Cautious, and Conscientious

How can we tell whether a proposed suicide that requires physician assistance is morally acceptable? There are no easy answers to such questions. In the moral life, everything is a matter of judgment, with no

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A few comments are in order. Even to seek expert help to provide it, approach any pl
it, they might o their friends d. But just as m and Eve, the m employing x be expected elves, yet morn- on. is by no means te freedom to tal leeway than at to terminate o. But healthy selves cannot somehow commit here can be no he situation is justifiable. As permissible, so e aid of friends n, if exercised, sition to help. request violates ut it is binding. The demand or may lead to eevonian must o risk criminal spnsibility of suicide. Many ady drugs to grisly, but he t ways of com-. The objection in dying were only because shoulder their recipe for making them. A careful examination of the facts, conscientious reflection on the values involved, and a savvy understanding of needs and alternatives will still not guaranty the correct result. But it may be helpful to remember Magda’s case and use it as a measure by which other problem situations may be evaluated. Her predicament establishes a standard that other potential cases of physician-assisted suicide must approximate.

First, there must be adequate reasons for terminating life, and they have to be both objective and subjective in nature. On the subjective side, nihilistic mood and temporary despondency do not amount to a justification. We have to begin with objective facts: the patient must be near the end of life and in significant pain or discomfort. The phrase “near the end of life” is vague and requires case-by-case interpretation. No one knew how close Magda was to the end of her life, but it was clear that past her 103rd year, with pulmonary hypertension, she could not live very long. A precise number of days or weeks that would govern universally is impossible to postulate, but we know that, in most cases, a life expectancy of a year or more would be too long.

As important as the amount of time left is the quality of it. People who are likely to be able to operate to the end and then slip away peacefully are not candidates for physician assistance in killing themselves. Sick persons who are not in excruciating pain but experience their debility as a crushing burden, on the other hand, may well be justified in seeking help to get permanent relief. In any case, if people have significant obligations they can discharge only by living on, they forfeit the right to look for help with dying. How significant these duties need to be is another question to which there is no general answer. Having promised someone to go to lunch next month is obviously not weighty enough; earning money to feed one’s children who would otherwise go hungry clearly is.

Provisos

A few common sense provisos need to be added at this point. Even if it is morally acceptable for people to seek expert help in hastening death and for doctors to provide it, patients do not have the right to approach any physician with their request. There must be an established doctor–patient relationship between the parties that makes the call for help legitimate. Furthermore, it is wise for society to establish a variety of safeguards to make abuse of the practice of physician-assisted suicide difficult and improbable. The state may require application to a board, examination of the patient by at least one physician uninvolved in the case, and a waiting period. Regular reassessment of the practice may suggest additional safeguards and procedures (see, for example, OHA, 2012).

It took multiple calls to Magda’s physician to get him to order hospice on the scene. When representatives of this worthy organization arrived, they brought a powerful morphine solution. They assured her caregivers that any dosage necessary to still her pain and any frequency of applying the drug were acceptable. This was essentially, in my view, an invitation to suicide, assisted in this case not by a physician but by benevolent hospice nurses. Hiding behind the double-effect of morphine, they offered pain relief at the price of depressed lung function and accelerated death. Our current laws make it impossible to help needy people die peacefully without this subterfuge.

References