

FREEDOM OF CHOICE: A PRAGMATIC ARGUMENT FOR THE PERMISSIBILITY OF  
ASSISTED SUICIDE

BY

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Thesis

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To my Father and Mother

The focus of this thesis will be an argument for the permissibility of assisted suicide as an end-of-life treatment. In parts I and II, I will argue that assisted suicide has similar physical and experiential effects compared to other currently allowed end-of-life treatments. In part III, I will argue that the difference in meaning that can be gained by a patient who elects to take their own life can be very fulfilling and that society currently does certain patients an injustice by forbidding them from taking their own lives. This paper will not argue that assisted suicide will or should be a preferred end of life treatment for any patient; rather it will support the ability to choose assisted suicide for those patients who may glean extra meaning from the act. The paper will extend its pragmatic analysis of the differences between currently allowed acts and assisted suicide to include a discussion of how, in light of work by William James, this added meaning is pragmatically good.

## Part I

In recent years, there has been an explosion in the world of applied ethics. This drive has been furthered by the mixing of cultures due to increased globalization and the difficulty of addressing morally right behavior. The presence of what appears to be pluralism has been challenged by thinkers who desire to

maintain the status quo of western religious-derived moralities. Increasingly, however, these systems fail to appeal to our sense of how best to care for people and respect their personal desires.

At the same time, theorists are taking careful steps to ensure that the new applied ethics do not offend the spiritual sensibilities of the religious population; rather theorists recognize the freedom of the religious to maintain obligations similar to the non-theistic. The result has been the rapid expansion of applied ethics in many fields and a scramble for power between differing schools. One school, pragmatism, maintains an advantage over others because it is already built around the way people actually behave. A product of thinkers in psychology, education, and political science - all with a new found focus on empiricism - pragmatism is uniquely suited for the challenges of modern applications.

In no field may this applicability be more apparent than in the burgeoning field of medical ethics. Here, theistic medical practitioners deal with atheistic patients and hedonistic administrators. The confrontation of perspectives is challenging because of medicine's tendency to defer to expertise. For a long time, the existing and lopsided power structure between patient and physician alienated patients. As questions began to be asked about how to compensate for this unevenness, solutions flowed in

from a wide range of sources. Doctors with an eye toward reform spoke with clergy who were concerned about the way in which people were losing control of their own lives. The mission was not only to balance out the doctor-patient relationship, but also to push further and create a set of common rules and criteria to strengthen the patient's role in his own care. Also into this space came the philosophers, bringing with them their rigid and detailed ethical structures, ready to test them in the clinic. The result, so far, has been a somewhat fragmented map of ethical education that ranges from the utterly practical, in the case of nurses and medical students, to the overly abstract, in the case of traditional philosophers.

The meeting point between these differing approaches involves the recognition of the dissimilar demands placed on the actors in a medical environment. The resulting mixture is practical, a realization of how things have already come together, much like in pragmatism. That this blending has occurred on its own is no surprise. It is similarly not surprising that ethicists are increasingly turning to pragmatism as an ethical system for precisely this reason. Pragmatism offers an applicable system for interrogating difficult questions in medical ethics, such as assisted suicide. The focus of this paper will be on demonstrating the usefulness of pragmatism in recognizing and addressing the issues that

currently occupy the assisted-suicide debate. It will also use a Jamesian approach to argue for the permissibility of assisted suicide in limited cases.

William James's work, as a focus point of this paper, is inspired by the simplicity of this initial formulation of his pragmatic principles: "Whenever a dispute is serious, we ought to be able to show some practical difference that must follow from one side or the other's being right."<sup>1</sup> Assisted suicide and the debate surrounding it are most definitely serious, but as I will argue, there seems to be a grave misconception as to what the differences are between it and currently allowed practices. The differences in how the treatments physically affect patients are small, but the emotional and moral impacts these choices may have on patients are great. Still, as James tells us, for our investigation to prove fruitful, we must make sure to pay attention to all the details and to all the differences. The essential question of pragmatism is, "what difference would it practically make to any one if this notion rather than that notion were true?"<sup>2</sup> In this respect, I will argue that much is at stake in defining the difference between assisted suicide and currently available end-of-life treatments. Furthermore, I believe that the differences between assisted suicide and

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<sup>1</sup> William James. *Pragmatism*. (Indianapolis: Hackett, 1981), 26.

<sup>2</sup> *Ibid.*, 28.

euthanasia have been minimized, severely damaging the idea of assisted suicide as a choice for rational, moral adults.

Pragmatism as a school of thought is particular in not only its Americanness but also in the common sense nature that defines its functionality. Unlike other consequentialist philosophies, pragmatism is not based on an external idea of what is 'good'. Instead, its focus is on what works in the instrumental sense. In ethical discussions, this idea translates into the idea of maximizing the fulfillment of desires. That is to say, James believes that creating maxims that attempt to define what is good is a misdirected project. We should not attempt to determine *a priori* what is good, he argues, but rather base our determinations by measuring "how much more outcry or how much more appeasement comes about," as a result of different choices.<sup>3</sup> What is good or bad, according to James, is not a truth older than time itself, but rather, the terms are defined by their empirically measured effects. In its simplest form, morality is a reflection of the feelings of an individual, "so far as he feels anything to be good, he makes it good."<sup>4</sup> In a complex universe with a multitude of people, however, morality becomes a balance of desires, ease of execution, and the reality of the difference. James states that "if one ideal judgment be

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<sup>3</sup> William James, "The Moral Philosopher and the Moral Life." From *Ethics*, Ed. Steven M. Cahn. (Oxford: Oxford UP, 2006) 361.

<sup>4</sup> *Ibid.*, 363.

objectively better than another, that better-ness must be made flesh by being lodged concretely in someone's actual perception."<sup>5</sup> Simply enough, "the essence of good is simply to satisfy demand," where demands are a desire for outcomes or states.<sup>6</sup> Thanks to this formulation, pragmatism is able to account for the differences between the beliefs of individuals on the edges of our understanding. There is, according to pragmatism, "no common character" that connects the moral ideas of individuals, "apart from the fact that they are ideals."<sup>7</sup> Because of this, the context of situations and the desires of the individuals involved become the ultimate determinations of morality.

James's most famous example of the importance of difference for pragmatism comes from his essay "What Pragmatism Means." In the essay, he tells the story of a camping trip he took with friends during which a debate arose over whether a man passed around a squirrel that was on a tree. While the man would walk in a circle around the tree, the squirrel would constantly move so that its stomach was facing the man, hiding its body from the view of the man. James's response to his friends' questions was to ask them to clarify what it is they meant by going around the squirrel: "'Which party is right,' [James] said, 'depends on what you *practically mean* by 'going round' the

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<sup>5</sup> Ibid., 365.

<sup>6</sup> Ibid., 365.

<sup>7</sup> Ibid., 362.



squirrel.'"<sup>8</sup> If the men meant make a circle around the tree and therefore also the squirrel, then the man did go around the squirrel. On the contrary, if they meant that the man must see all sides of the squirrel, including its back, then the man did not go around the squirrel. James claims that all one must do is, "make the distinction, and there is no occasion for any farther dispute."<sup>9</sup>

The discussion that follows will use this practical difference as a measuring stick to gauge what it is exactly that separates assisted suicide from other currently allowable practices such as Continual Deep Sedation, an accepted and legal palliative therapy. I will argue that the practical difference between assisted suicide and CDS occurs only in name, as both treatments end the lives of the patients who undergo them. Furthermore, I will argue that there is a difference in meaning that can be derived from these acts and that in disallowing one but allowing the other, we do a great disservice to those people who would, if they were allowed, choose assisted suicide.

Before we can begin to address how pragmatism helps us work through the problems of assisted suicide, we must first examine all the different points around the debate. The largest issue will be working through the terminology and technicalities of differing patient states. I will do this with the aid of Mary

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<sup>8</sup> *Pragmatism*, 25.

<sup>9</sup> *Ibid.*, 25.

Moalglan and Micah Hester, as well as with appeals to scientific literature.

Discussions of end-of-life care are filled with loaded and often confused terms: euthanasia, passive or active; assisted suicide, physician or other; palliative or hospice care. The difficulty in this discussion is that because so much has already been attached to these terms, delineating them may prove to be an insurmountable obstacle. Nevertheless, by appealing to strong arguments made by others, I hope to convince the reader of an effective way to view the differences among terms. Mary Mahowald eschews the conventional terminology for a more direct approach in her "On Helping People to Die: a Pragmatic Account":

First, then, what does it mean to kill someone? Among the possible meanings of killing, consider the following:

1. Killing means ending the life of someone
2. Killing means letting someone die when one could have prevented it
3. Killing means helping someone to die <sup>10</sup>

Using these formulations, we can tie our legacy terminology to these more direct definitions. Definition #1 would be what we would call euthanasia or active euthanasia, definition #2 would be passive euthanasia, and #3 would be assisted suicide. Now, of course this is not to say that all cases of definition #1 (that all killing of another) would be euthanasia, but rather that

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<sup>10</sup> Mary B. Mahowald. "On Helping People Die." From *Pragmatic Bioethics*, ed. Glenn McGee. (Cambridge: MIT Press, 2003),109.

euthanasia, as discussed in medical ethics literature, would undoubtedly be thought of as akin to definition #1. Certainly, first-degree murder would also fall under definition #1, as would second-degree murder or the killing of an opposing soldier in war time. However, in the medical realm, definition #1 will most often manifest itself as euthanasia.

Mahowald believes that there are still issues with these definitions in their simple states, and while I agree better work can be done, I disagree with where that revision would take place. Mahowald is worried that none of these definitions tell us if the person wanted to die or not or how the person dies. In regard to the latter concern, for our purposes we must imagine that the patients in #s 2 and 3 would suffer a death not caused by us as an actor. That is, for definition #1, one person kills another directly; and in definition #3, a person is the ultimate cause of his own death. But in case #2, a person may be dying from a self afflicted injury, an injury done to him by another, or any number of other deathly injuries. Not helping a stabbing victim, a patient having a stroke, or a person found overdosed on medication would all count as facets of definition #2. Furthermore, we must maintain this plentitude when examining these cases, as it would be unfair to assume that all instances of letting someone die occur to elderly patients in hospice care.

As to Mahowald's former complaint about the vagueness of a person's will to die , I think that it is clear in definition #3 that the person would have to want to die in order for any contribution to be considered 'helping'. The reason I draw out this point is because I want to make it clear that statement #3 is not saying we help someone by killing them, for this would be a completely different point that would rely on an idea of a higher good that we were achieving by killing them. While #3 may prove to be beneficial, it is not a claim that we help a person in a moral way, but rather just in a mechanical way. That is to say, we provide some part of the essential means required for the person to kill themselves. If there is some sort of moral benefit to be derived from this act, it is completely dependent on the desires of the patient.

These definitions established, we can turn to the analysis of current care protocols, such as do not resuscitate orders or Continual Deep Sedation. Acts like DNR orders seem to fall under definition #2, as the patient asks us to allow him to die when he has reached a certain naturally irreversible state. In this way, not resuscitating a patient could also be construed as falling in line with #3, depending on if this order was well established as the wish of the patient. The difference between numbers 2 and 3 is simply that intention of the patient. In assisted suicide, we see a similar mirroring of effects.

Assisting in suicide is separated from #1 not only by the intention of the patient (the helping) but also by the actor that is the ultimate cause of death. The patient *must* be the one who pulls the proverbial trigger in the case of assisted suicide.

This requirement of patient intention is often touted as a difficult to manage liability of assisted suicide. The argument is that such a practice would risk opening the door further to treatments like active euthanasia. The real practical risk, separate from the anxiety that comes out of fear of a slippery slope, concerns how the consent of the patient can not only be collected, but proven. This is a difficulty in any litigious interaction, and the importance here is amplified by the fact that in these cases, the patient would not be alive to confirm his intention. This problem, however, is not a shortcoming that is absent from other medical treatments. In fact, it would seem that at least with an act like assisted suicide, patients would have more surety about the way in which their wishes were to be enacted, as they are the ones taking the final steps. Contrasted to other treatment complications, such as the intention of a patient's DNR, assisted suicide may actually be a more foolproof system. For example, a patient in cardiac arrest cannot confirm to her caretakers that it was an arrest just like this one for which her orders were intended. There are plenty of cases where

DNR orders fall into confusing traps. Christopher Meyers, in his *A Practical Guide to Clinical Ethics Consulting*, presents just such a case, though it is not intended for this purpose.<sup>11</sup> In Meyers's story, a patient, who previously had been diagnosed with HIV/AIDS has come into a doctor's office. The patient is aware of his impending fate and has drawn up documents detailing his wish not to be resuscitated or be kept alive by extraordinary means when his disease finally takes his life. During a routine treatment, however, the patient goes into anaphylaxis after having a reaction to an antibiotic. The result is that the patient required treatments that he had asked not to receive in order to save his life from a threat that had little to do with the sickness that prompted him to draw up his advanced care directive. This is just one of the many practical issues that arise with advanced directives, but it illustrates a point: that error in intent of execution is a much larger issue when the patient cannot make his intentions clear. Assisted suicide avoids this because it is the patient who must actually commit the life taking act.

It may seem strange to come down in favor of assisted suicide, yet be unsure about euthanasia of incapacitated patients, as those whose diseases have progressed to such an extreme stage may seem to be in even greater need of

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<sup>11</sup> Christopher Meyers, *A Practical Guide to Clinical Ethics Consulting*. (Maryland: Rowman & Littlefield. 2007) 68.

compassionate care. While this may be the case, and while our arguments here may help to sway one toward a position that is more accepting of euthanasia of incapacitated patients, this will not be the focus of our inquiry. There, however, are other states which patients may find themselves in that will be important to our discussion, beginning with what has been called brain death.

With the advent of new cardiac and respiratory technologies in the mid-1900s, patients' bodies could be kept functioning with the help of machines, even after their brains were unable to support these systems on their own.<sup>12</sup> This development left a gap in care standards because previously, the separate brain-heart-lung systems could not operate independently of one another. While only one needed to fail to cause death, due to strokes or heart attacks, all systems quickly failed in unison, due to their interconnectedness. These new technologies meant that patients could be kept alive indefinitely, and this posed a real problem for the medical community. Although it was true that simply removing the support would be enough to cause the death of the patient, the medical tradition had been built up around the 'do no harm' ideology in which everything possible was done to keep patients alive (so long as the resources were there). The solution to this problem came from an ad hoc

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<sup>12</sup> Martin Benjamin, "Pragmatism and the Determination of Death." From *Pragmatic Bioethics*, ed. Glenn McGee. (Cambridge: MIT Press, 2003) 193

committee at the Harvard Medical School that defined a new sort of death—brain death<sup>13</sup>. The truth was, however, that the end result, the state of death, was the same for patients who suffered brain death as it was for those who suffered from a ‘traditional’ death. Nevertheless, the idea of brain death took off and became a real concern for patients and patient groups, as it seemed there was some new type of death to which people were susceptible. The truth was that definition had been given to what was before a sloppy term. This new definition came alongside a new perspective on how we are to define not only death, but also life.

Brain death was centered on the idea that so long as there was not a certain amount of activity in particular parts of the brain, the patient could not be expected either to survive on her own, or to regain the ability to do so. The limits were technically defined, and the tests were laid out with care. The decision on brain death did not have to be made quickly; the body was being kept alive in some way, and the tests could be administered to ensure the fate of the patient was certain. But the guidelines for brain death brought to issue another question: At what level must we have brain function to ensure life? Two different standards exist medically, however, as we

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<sup>13</sup> Ibid., 194.



will see, for the patient there is practically little difference between these states.

Micah Hester lumps these two states together as 'Permanently Incapacitated,' though much can be realized by noting the differences between them. The first, whole brain death, is exactly the case that it sounds like; higher functions and lower functions are lost, meaning that, "neither conscious activity nor reflexive motor response occurs."<sup>14</sup> It was cases like this that the Harvard Committee on brain death had in mind when it laid out its criteria. But in testing for total brain death, another, more difficult type of patient was discovered—those in a permanent or persistent vegetative state (PVS). Patients in a PVS lack higher brain function, meaning that those patients are incapable of "awareness and consciousness."<sup>15</sup> PVS patients do have functioning brain stems. The stem "controls vegetative functions, such as respiration, and primitive stereotyped reflexes, such as the pupillary response to light."<sup>16</sup> These patients, when removed from respiratory devices, can continue to live on their own but still require feeding tubes and fluids. The difficulty of these cases is, of course, that while patients in this state still respond to some stimuli and are often able to survive on their own for surprisingly long

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<sup>14</sup> D. Micah Hester "Progressive Acts of Euthanasia and Assisted Suicide" *Journal of Medical Humanities*. Vol. 19 No. 4, 1998

<sup>15</sup> *Ibid.*, 285.

<sup>16</sup> *Ibid.*, 285.

periods of time, they are totally unconscious beings. I do agree with Hester that a patient in a PVS, "is no longer a being, however, which embodies experienceable and expressible emotions, values, interests, ideals, and virtues."<sup>17</sup> Because of this agreement I also feel comfortable agreeing with Hester, who concurs with H. Tristram Engelhardt that "it will not be possible generally to justify holding higher-brain-centers-dead-but-otherwise-alive human bodies to be persons. They are not persons. If one kills such an entity, one does not take the life of a person."<sup>18</sup> While this is a controversial perspective, it certainly can be seen as an increasingly practical view because when PVS is accurately diagnosed, it appears to be irreversible.

By defining PVS as similar to whole brain death, we are better able to understand the alternatives that are currently used in place of assisted suicide for patients with terminal diseases. Since current protocols forbid assisted suicide and euthanasia, the only acceptable end-of-life care is palliative pain management. This is accomplished in a variety of ways, depending on the state of the patient and his pain level. In its simplest form, palliative pain management can be oral pain medication in a home hospice scenario. But because options such as assisted suicide and euthanasia are not permissible, there exist some rather extreme treatments designed to deal with

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<sup>17</sup> Ibid., 286.

<sup>18</sup> Ibid., 286. Quoting Tristram Engelhardt from *Euthanasia and the Newborn*.

patients whose deaths come both slowly and painfully. Many of these treatments have sharp mental effects due to their use of potent pain killers, which can also make it difficult for patients to stay awake or move on their own.

## Part II

Among the most severe of treatments is continual deep sedation (CDS). CDS is used for patients who are in such excessive pain that all other methods of relief have failed to offer substantive results. CDS is an extreme form of the normal practice of sedation. Often, patients are sedated during difficult treatments so that they can be free of pain and so that their body does not react adversely to any treatments. CDS, however, is not part of regular pain treatment, but rather is one very far end of the scale. It differs from other sorts of sedation because it is not focused on protecting the body from overreaction to treatment, but rather is used to free a patient from pain until death. CDS is an end-of-life treatment that effectively kills the consciousness of an individual while maintaining the biological organism.

Ideally, CDS would not hasten the dying process; it would merely render the patient unconscious until death. In 2008, the Council on Ethical and Judicial Affairs of the American Medical Association released a report titled "Sedation to

Unconsciousness in End-of-Life Care.”<sup>19</sup> In the report, the AMA details the ongoing discussion about deep sedation, addressing the legal and ethical ramifications. What is so particular about this report and others which come down in favor of CDS is that they draw a strong distinction between CDS and euthanasia (and assisted suicide) that is inexplicably tied to the idea of a natural death. This notion of death relies too extensively on the western idea of dying a natural death. Dying ‘naturally’ is a rather poor term for the uses we apply it to, as all causes of death can be explained naturally. A bullet in the body alone does not cause death; it is the tear in the aorta, the loss of blood, and the lack of oxygen transport that does in a gunshot victim. On the other hand, a heart attack is the result of the natural build up of plaque in the arteries of the heart, but this build up may be accelerated by human behaviors such as dietary preferences or factors that cause heightened blood pressure. The causes of death are in many ways equally natural and unnatural.

Furthermore, it would seem that undue reverence has been given to this idea of natural death, as modern medicine is designed to prevent death, no matter how natural the cause may be. Emergency rooms are not only filled with assault victims, but also with patients who have suffered from strokes or heart

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<sup>19</sup> Council on Ethical and Judicial Affairs of the American Medical Association. “Report: Sedation to Unconsciousness in End-of-Life Care.” CEJA Report 5-A-08. 2008.

failure. Ultimately, putting so much weight on death that comes as natural fate seems a rather antiquated notion, given that, at least proximally, all death can be understood in terms of a natural cause. This is not to say that murder is acceptable because the act of killing interrupts normal biological processes akin to the way more 'natural' deaths also end lives. It would be more appropriate to say that there seems to be a false dichotomy here between natural and unnatural deaths, especially when it comes to the actual actions that lead to a loss of a life. Patients who choose to go into CDS and wait to die unconsciously are not suffering any more natural a death than those who are allowed to commit assisted suicide. In fact, both are choosing the point at which they lose consciousness (that part which may define human life). The difference is that for the CDS patient, the organism that supported her body continues to live for an unsettled amount of time.

Susan Wolf, noted pragmatist and legal scholar, takes up the issue of this difference between assisted suicide and other end-of-life treatments in her article "Pragmatism in the Face of Death: The Role of Facts in the Assisted Suicide debate." Wolf is want to suggest that there is actually a greater difference between assisted suicide and the other well-known end-of-life treatments. Wolf is largely correct in her essay to point out the lack of surety in predicting outcomes of patients; end-of-

life estimations are purely that--estimations. Wolf also recognizes the difficulty inherent in the use of advanced directives; the author acknowledges not only that they often are not held by many patients, but also that many patients may write that they "want physicians to make treatment decisions for them."<sup>20</sup> Even when such demands are not written explicitly into an advanced directive, patients will still rely upon physicians to decide when certain parts of the directive are to be triggered. No matter what, patients are left relying upon the imperfect expertise of their physicians.

While I agree with Wolf on these introductory points, I do not feel that these issues will prove as damning to the argument for assisted suicide as she desires. The track of her argument severely diverges from mine in a few ways, with the largest deviation being her assertion that there are a great number of ways to alter a patient's pain load without resorting to assisting with suicide. While it may be true that there are a multitude of differing pain solutions available to skilled clinicians, this does not mean that all of these choices will leave the patient fully cognizant or in a state that she prefers to the pain she may have been in. Strong pain relievers, even without separate sedative treatments, typically cause strong reactions in patients, leaving them feeling tired, easily

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<sup>20</sup> Susan Wolf. "Pragmatism in the Face of Death: The Role of Facts in the Assisted Suicide Debate." *Minnesota Law Review*, 82 Minn. L. Rev. 1063. 1988. \*1076.

fatigued, and hazy. This also ignores the fact that a pain-treatment program is not just a single pain reliever, but is instead a cocktail including anti-nausea drugs, sedatives, and other relaxers. While legal arguments seem to have failed to note the similarities between strong pain treatments and assisted suicide, these ideas should remain alive in the moral realm. Wolf claims that even "sedation to unconsciousness" can be used to "relieve terrible pain without causing death."<sup>21</sup> But such a claim ignores the different applications of sedation in pain relief. CDS is not used without the intent of death; it relies on a fallacy that there is something acceptable about destroying the conscious portion of an individual while protecting the vegetative body. A study in the Netherlands stated that 94% of patients who received CDS passed away within a week of being sedated, with none exiting the treatment in that period.<sup>22</sup> Wolf is correct to point out the availability of alternative treatments, but she fails to define why these are preferable to assisted suicide, especially in those cases in which patients are being sedated with the intention of death. In those cases, it would seem that assisted suicide may, in fact, have more in common with these treatments than she is willing to admit.

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<sup>21</sup> Ibid., \*1080.

<sup>22</sup> Judith Rietjens, et. al. "Continuous Deep Sedation for Patients Nearing Death in the Netherlands: Descriptive Study." *British Medical Journal*, Published online March 14 2008. Last accessed on may 26th, 2011 at: <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2292332/>

Wolf wants to make sure to avoid the dichotomy of "intolerable agony and death" because she feels that these have been unfairly drawn as the only two options. The problem is that framing them merely as pain and death is not specific enough to the cases in which assisted suicide would most likely be used. The choices really are intolerable agony and death or death alone. The end of these treatments will be death, no matter if a patient is treated with CDS or assisted suicide. Wolf is right to assert that "a patient who is unconscious will not experience anything as degrading and undignified"<sup>23</sup>, but the truth of this assessment dives deeper into the conflict at hand. We are not merely dealing with the treating of pain; we are dealing with the ending of a life. Neither the patient put into CDS until death nor the patient who is assisted in suicide will continue to experience anything as degrading or undignified, but this is merely because he will fail to experience anything at all. Patients who elect to enter CDS are choosing to lose the conscious nature that we identify with human life. Patients who choose assisted suicide are making the same choice, but they are also adding the loss of the biological life as well. That biological death (as opposed to the death of the conscious person, as mentioned above in the comment from Engelhardt) is held out for fate, rather than the individual, to take, seems to

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<sup>23</sup> Wolf, \*1080.



be a vestigial feature of a morality that all patients may no longer identify with.

Wolf also stresses a sort of either/or that seems strange, given her insistence on avoiding similar errors of thinking. Often, she addresses whether or not a patient in a particular state would be in the position to make the choice of assisted suicide, in the sense that he would be acting from a normalized position. That is, she talks about a "depressed and dependent patient with inadequately treated symptoms."<sup>24</sup> As has been echoed before, many times, in the discussion of end-of-life care, it should not be unexpected to have patients near death demonstrating signs similar to depression. In a study from *The Journal of the American Medical Association* that addressed the preferences and feelings of patients with advanced chronic illnesses, researchers found that less than a third of patients reported being "Not at all depressed."<sup>25</sup> More than half of the subjects called themselves "slightly" or "moderately" depressed, and about 10% were "quite" or "extremely" depressed. It is not surprising that patients, particularly non spiritual ones<sup>26</sup>, would feel something like what would otherwise be called depression when death is looming. Attaching a normalized emotion

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<sup>24</sup> Wolf, \*1081.

<sup>25</sup> Karen E. Steinhauser, et al. "Factors Considered Important at the End of Life by Patients, Family, Physicians, and Other Care Providers." *The Journal of The American Medical Association*. Vol. 284, No. 19, 2000. 2476.

<sup>26</sup> Colleen McClain, Barry Rosenfeld, William Breitbart. "Effects of Spiritual Well-Being on end-of-life Despair in Terminally ill Cancer Patients." *The Lancet*. Vol. 361, 2003. 1603.

to this time in a patient's life is damaging, and it fails to recognize the different ways that different individuals deal with death. Furthermore, it also fails to fairly account for the way in which the period at the end of life is inherently unique. To expect these patients to demonstrate the same desire for living as young healthy men and women ignores the precarious nature of their state.

It should also be emphasized, in order to address the concerns of Wolf and those who share her opinion, that assisted suicide would not be the only treatment offered to patients. We do not want this to become a discussion of limiting the use of resources on those about to die. Rather, a patient may be kept comfortable, to the maximum extent that this is possible, until he makes his own choice about the end of his life. The real difficulty, as Wolf mentions, is that often patients are in a state of pain that seems to be incurable. While Wolf wants us to avoid drawing lines here, it seems that we must in the case of this pain that she speaks of. If it is possible for a patient's pain to be managed to the extent that she feels comfortable, it would seem that at this point, she would be in a fair position to make a determination about whether she would like to continue her life. Wolf fears that patients may choose death because their physician has been unable to relieve their pain. Pain relief, to the extent that it can be accomplished, should remain a primary

goal in patient care. If, however, this pain cannot be managed in any appreciable way, meaning that we cannot get the patient into a position to make a decision uninfluenced by pain about how to continue her treatment, then it seems that Wolf has failed to account for such a case. That is to say, in all cases where pain can be managed while maintaining a comfortably-conscious patient, we would think that this patient would be in some shape to make determinations about her own life.

Contrarily, if a patient's physician is unable to alleviate the pain, despite following his best intentions and practices, then it would seem that Wolf's critique is dubious at best.

Wolf makes several remarks alluding to the higher instance of involuntary assisted suicide in the Netherlands, but I would disagree with her assumption that the mere permission of assisted suicide is the cause of this. That is, Wolf states that the "Dutch rule firmly requires voluntary patient consent for assisted suicide and euthanasia."<sup>27</sup> Nevertheless, she worries that there are cases in which patients are being subjected to this treatment without their consent. While it does seem that in allowing for doctors, in the correct circumstances, to administer life-ending drugs, these laws may be meeting an injustice half way, it does not suggest that an increase in misused authority will follow. Doctors who want to act counter

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<sup>27</sup> Wolf, \*1083.

to the intentions of their patients or to make false statements about the intentions of their patients are equally able to do so in a country where assisted suicide is illegal. Doctors routinely have access to medication that could kill patients. In fact, even in terms of the alternatives that we have discussed so far, assisted suicide would remain, in this respect, a safer alternative. CDS, like assisted suicide, requires the consent of the patient. But unlike in assisted suicide, in CDS, it is the doctor who actually commits the act that renders the patient unconscious. CDS would then be a more dangerous protocol to allow, because the presence of those medications in the patient is already caused by the hands of the physician. Furthermore, CDS and other protocols are routinely practiced on those patients who are incapacitated to the point where they are unable to consent to such treatment. Simply warning that some formulations of law have failed to “[deal] seriously with the predictable gap between written rules and human behavior”<sup>28</sup> is a shallow concern, as such claims are applicable to nearly all laws.

Wolf takes issue with the equivocation of assisted suicide and termination of care, arguing that termination of care does not have complete control over the timing of one’s death, while assisted suicide does. This argument works for Wolf because

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<sup>28</sup> Wolf, \*1085.

despite her claims, she is looking for sweeping applications of rules. In fact, it seems at times as if she thinks that proponents of assisted suicide want the practice to wholly replace other sorts of treatment. Her discussion of these points begins with a claim that falls in line with my own argument: "that physicians' intent in both terminating treatment and assisting suicide is to bring about death."<sup>29</sup> Wolf claims that there is no data to back this claim up, but it seems that there does not have to be data to support the idea that every time physicians remove care, they intend the patient to die. This is not to say that their intentions are in any way nefarious, but since it is the physicians who commit these acts, it is important to ascertain what their intentions may be. While their hypothesis (and belief) will be that the patient will die, that it is also their intent is not a claim that I think is extreme. If it were, we must ask if their intention was for the patient not to die. Since it clearly is not, I do not think that it is a leap to say that doctors intend (act so as to bring about the end) for their patient to die. This point that Wolf brings up also seems to fail to realize the lack of a pragmatic difference between intending to follow a patient's desire to die and intending for death to occur.

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<sup>29</sup> Ibid., 1086.

The mere fact that this discussion centers around the discussion of removing care and end-of-life treatments is indicative enough of the fact that some (if not many) doctors intend that their patients die when treatment is withdrawn. Furthermore, it would seem that all that would really need to be proven is that some doctors have death in mind when they discontinue care for their patients. Her assertion that "physicians remove life-sustaining treatment to honor patients' wishes and their right to be free of unwanted treatment"<sup>30</sup> seems to ignore the reasons why a patient would desire to be free of unwanted treatment. Wolf fails to discuss the extent to which patients make decisions based on avoiding death as opposed to maximizing health.

Wolf's discussion of pain-relieving treatments also seems to miss the mark when it comes to the role that strong medications play in end-of-life care. She is right to question the assumption that high doses of pain relievers will hasten death, as there are plenty of cases where they have failed to do so. But what we must ask is whether or not there is a real difference between using these medications to relieve pain or to cause death. When administered in high-enough doses, pain killers have been known to cause death. That a doctor could feign ignorance about this 'side effect' is not something that

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<sup>30</sup> Ibid, 1086.

should be a tenable position for the pragmatist. Doctors know that pain killers not only relieve pain, but also reduce the functionality of the patient's nervous system. To say that doctors do not mean to cause these 'side effects' (which are just as much 'effects' as pain relief) fails our pragmatic test established by James. The practical difference of intending it or not is the same; the patient will often be compromised by her medication, and the physician knows that this will be the outcome.

Whether or not some doctors have been illegally using medications to kill their patients is not what should dictate the acceptability of a controlled, assisted-suicide practice. As for sedation until death, there are plenty of cases in which CDS has been used not only with the intention of the patient dying while unconscious, but also with the intention that CDS hasten death. In addition, the AMA as well as the U.S. Supreme Court has said that such practice is permissible.<sup>31</sup>

Wolf's argument, though claiming to be pragmatic, puts up barriers between treatments like CDS and assisted suicide that when examined seem to disappear. Furthermore, her brand of pragmatism, as presented in this essay, is overly focused on empiricism in a way that fails to capture the essence of this debate. While we are obliged to pursue all available data, there

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<sup>31</sup> Council on Ethical and Judicial Affairs of the American Medical Association, 3.

may not be a real source that would allow us to approximate a preferable last action, as so much is similar between two of the choices. In essence, we must ask whether CDS, where the intention is sedation until death, is really that different from assisted suicide. While CDS protocols would require the body to continue to receive nutrition (although not all do), there is a strong weight we must attribute to the intention of the practice. Furthermore, Wolf's desire for data seems quite limited. As we have seen, there may not be data that demonstrates a difference in the experience of an individual who undergoes CDS as opposed to assisted suicide, because the experience to them may be very similar. Where data will be important, as I discuss later, is in determining if the meanings of the different end-of-life choices matter to the patients choosing them. In that case, we may have a moral obligation to permit the patients to act according to their desires.

The great difficulty of comparing CDS to assisted suicide is the often-made deceptive claim that CDS is not permanent in the same way as assisted suicide. Jeroen Hasselaar, in his "Palliative Sedation Until Death: an Approach From Kant's Ethics of Virtue" demonstrates this mistake:

To be clear, the argument is not that all sedated patients have rational capacities, but that the intentional lowering of consciousness until death does not in itself destroy those rational capacities of the patient. In contrast, (assisted) suicide involves the immediate and total destruction of all predispositions



of agency. CDS as the intentional reduction of the expression of free action does not necessarily involve the intentional destruction of capacities for free action.<sup>32</sup>

While this quote comes from a Kantian analysis of a subject similar to my own, it nonetheless demonstrates the same sort of errors that permeate much of the discussion of the differences between CDS and assisted suicide. As mentioned before, in 94% of Dutch cases, the patient passed on within a week of being sedated. Patients who have reached the point where CDS is the only viable option are not in the position to rapidly recover while unconscious. Rather, the intention is purely to put patients into this state and wait for death to take them on its own time. Burying someone alive may not kill them instantly, but if you never plan on digging them out, it's the same as killing them. CDS buries the rational personhood of the individual and waits for death to take the body. I realize that this is a strong formulation of what occurs in CDS, but given the data on the use of CDS coupled with the reality of CDS's complete (albeit 'potentially' temporary) destruction of agency, I feel it to be an accurate comparison.

The greatest error with Wolf's perspective, and like it the perspectives of similarly minded pragmatists, is that it fails to recognize the limited extent of the demands that assisted suicide places on others relative to the effect that the

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<sup>32</sup> Jeroen G. J. Hasselaar, "Palliative Sedation Until Death: an Approach From Kant's Ethics of Virtue." *Theoretical Medicine and Bioethics*, Vol 29, Number 6; 2008. 387.

treatment has on the patient. To best maximize the fulfillment of the desires of all parties involved, one would have to recognize that choosing when and where one dies, when death is eminent, will have a much greater effect for the dying individual than it may have on the other stake-holding parties. Wolf, I imagine, would want to see data to reinforce this, and there seems to be enough to help our case. From the earlier mentioned *JAMA* article comes the following data: in the survey, 39% of patients agreed that it was important to know the timing of one's death, and 40% agreed that it was important to control the time and place of one's death.<sup>33</sup> On the other hand, family members agreed 49% with the importance of timing, yet only 38% with the time and place. 40% of Family members neither agreed nor disagreed with the place/time question. The disagreement here is interesting if only for the flop between the two groups when it comes to the difference between timing and controlling the time and place. More critical to our discussion, however, is the fact that 78% of family members either agreed or felt neutral about importance of the patient choosing the time and place of his death. If almost 4 out of 5 people do not take an issue with the patient choosing these parameters of his death, it seems silly not to oblige such desires when he has them. In fact, given our Jamesian attempt to maximize goods, it would be

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<sup>33</sup> Karen E. Steinhauser, et al., 2477.

wrong of us to protest when it would be a net (and easily accomplished) gain.

In our attempt to do the most good, we must acknowledge that for some patients, taking control of their death by taking their own lives may be a greater good than the damage it does to other individuals. By limiting a patient's choice to treatments such as CDS, we are refusing to oblige a dying individual with what, for him, may be the greatest possible good at that time. Furthermore, the acceptance of CDS and the realization of its similarity in practice to assisted suicide should demonstrate that the gap between these acts is much smaller than Wolf and Hasselaar admit. The central difference remains who (or what) it is that does the final act of killing the patient.

Realizing that CDS, a currently allowed practice, is very much like assisted suicide is not enough to argue for the moral permissibility of assisted suicide. Rather, so far what we have done is examine the lack of true mechanical difference between CDS and assisted suicide. If we accept that CDS is a morally correct practice, then we must also admit that assisted suicide is one as well. However, the realization of this similarity may cause one to reexamine the permissibility of them both. In part III, I will continue to discuss the similarity of CDS and assisted suicide as therapies, but I will also address the moral

benefits that are achieved when patients are allowed to be assisted in taking their own lives.

### Part III

Mary B. Mahowald formulates the central discussion of the acceptability of assisted suicide as such: how can a doctor balance the obligations that he has to a patient to both minimize pain, while also avoiding death? The problem with making this question a sort of dichotomy is that these considerations do not operate on common scales. That is to say, death is a binary consideration. One either is or is not dead, while pain operates on a scale. Pain can be of differing types and of differing strengths; it can affect different people in different ways. Death, contrarily, does not work in such a way. It is wholly a similar enterprise for all people; it is inescapable and necessary. Trying, then, to balance these two obligations will be futile. On the great scale of determination, pain can be added in the smallest of increments, while death will overwhelm the balance. This combination of binary and scaled concerns is just one of the many factors that make end-of-life care a particularly individual concern.

Medical treatment in general is becoming increasingly centralized, and as this occurs, it has been argued that doctors are less in touch with the needs of their individual patients.

In some cases, this development is an inevitable product of increased medical knowledge. In a world where the totality of practical medical procedures could fit into a doctor's bag, these concerns were minimized; the average patient needed to see only one doctor. Advancements in medical technology and instrumentation, however, have led to a massive shift in the capabilities of the individual physician. Many doctors are forced to become ultra-specialists purely because of the massive amount of information they must know to be considered experts. American doctors face between 3 and 10 years of graduate medical education (in excess of their 4 years of medical school), during which they increasingly focus on highly specific ailments. And once in practice, it is not unheard of for physicians to focus on treating one specific disease or ailment. In light of these developments, it is not surprising that medicine has taken the institutional turn that it has, regardless of the economic pressures that have also taken root. While this development is often seen as alienating, I believe that it can also be viewed as a great advancement in favor of individualized care.

While it is true that patients no longer see the same doctor for all of their ailments, increased specialization signals the recognition of the differentiation of disease. That is to say, specialized medical education is necessary to help physicians identify the possible causes and complications of an

individual patient's concerns. This means that physicians are better prepared to realize the differences between cases than ever before. By realizing this individuality, the debate over end-of-life treatment can begin to take on an entirely more substantive focus.

Returning to the terms discussed above, allow me to analyze the differences between palliative care and assisted patient suicide. But first, what are the practical differences between suicide, assisted suicide, and patient-voluntary euthanasia? Suicide is an act that most people are familiar with in many forms. Performed by an individual, it can be thought of as not involving the assistance of any other person (in so far as the person who provided the tool by which the act is committed was unaware of its eventual use in a suicide). It should not be difficult to absolve the rope maker of guilt in a hanging, or McNeil in the case of a Tylenol overdose. In the next two cases, it can be more difficult to discern culpability, but they are important for our discussion. The distinction between assisting in suicide and what may be called voluntary euthanasia relies on who actually commits the final act. It is this distinction that famously put Dr. Jack Kevorkian behind bars for his mercy killings.<sup>34</sup> Kevorkian had, by his own admission, helped more than 130 patients kill themselves. It was while treating a patient

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<sup>34</sup> The People of the State of Michigan Vs. Jack Kevorkian. 447 Mich 436, 457-459; 527 NW2d 714 (1994).

with ALS (Lou Gehrig's disease) that he crossed a different barrier. That barrier was committing the final act on his own—injecting the patient with the final substances that killed him.

The reason that the discussion of these three differing acts is so frustrating is because, at least on the surface, it seems that a perfectly well person is free to end her life as she pleases. The inverse relationship of her medical status is a puzzling difficulty to this discussion precisely because it would seem that suicide may be a useful respite from pain for those patients who are most unable to commit the act on their own. In this way, assisting a hospitalized patient with suicide is merely giving them back a power that she had when she was healthy and not under medical supervision.

Micah Hester brings out another issue of illness at the end of life that is particularly daunting: the issue of "everydayness."<sup>35</sup> It is true that even a regular illness is "a break in/with our everyday activities."<sup>36</sup> Such a definition does stress medicine's increased focus on the normal day-to-day life of the patient, but it also brings up a problem that is unique to end-of-life care and in particular, assisted suicide. This is the single mark of difference from a habit that permeates every day of a person's life—staying alive. Handling habits in the pragmatic sense is an important duty, as we can shape our moral

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<sup>35</sup> Micah Hester, "Is Pragmatism Well-Suited to Bioethics?". *Journal of Medicine and Philosophy*. Vol 28, 2003. 547.

<sup>36</sup> *Ibid.*, 547.

personality by forming and reinforcing those beneficial habits. The problem with giving in to dying, at least on the surface, is that this seems to be against the largest of habits. That is, in the simplest form, a habit of realizing one's mortality and choosing to end it in a specific way is not a habit at all; it is used only once. This approximation, however, may be misguided. Choices made at the end of one's life may be affected by the uniqueness of dying, but these decisions may be dealt with in line with the other habits a person has cultivated through her life. In this case, we can argue that a person who chooses assisted suicide may be acting in line with a lifelong habit of taking control of her fate.

We should, given the importance of this habituation, allow those people who have lived a life in line with such ideals to end their life in a similar way, so long as no immoral baggage comes attached to their obligations. Hester does not formulate this view in the aforementioned essay, but the author does go on to discuss it in a later piece titled "Significance at the End of Life."<sup>37</sup> Hester's summation of this later article is as such:

Lacking any a priori reasons against aiding the dying and given James's take on 'meaning' as the intelligent development and pursuit of individual ideas communally tested, there are good ethical reasons to believe that at least in some, maybe

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<sup>37</sup> Micah Hester, "Significance at the End of Life." From *Pragmatic Bioethics*, ed. Glenn McGee. (Cambridge: MIT Press, 2003) 121. The conclusion of this essay falls quite in line with our argument here: "The argument in this chapter attempts to make it clear that no legitimate reasons, a priori, exist to condemn all acts of euthanasia and assisted suicide."



very limited, cases, we should aid dying persons in their desire to die on their own terms.<sup>38</sup>

Hester's defense of his position in this subsequent essay demonstrates the more fundamentally pragmatic nature of his claims. If a patient has spent his life acting in line with a habit of taking control of his life, and at every test this habit has proven to be a beneficial moral perspective, then it would seem that we have no right to forbid him from completing his life in line with his ideals.

Pragmatism avoids a dependence on a presumed a priori prediction of ends which gives great power to the specific circumstances of a patient's life. According to Hester, "pragmatic, intelligent purpose undermines simple categorical logic by transforming experience into something evolutionary."<sup>39</sup> Data, as Wolf points out, is a critical part of formulating our system of beliefs and habits, however, care providers must be cognizant of the fact that what has worked for them may not be something that has worked for their patients. That is to say, patients will enter physicians' care with a history that has come to shape their desires and dispositions. To demand some sort of extra-personal empirical data will only do a disservice to patients who are in the midst of testing out, through living, their own beliefs. Keeping track of all deaths will not tell us

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<sup>38</sup> Hester, *Is Pragmatism Well Suited?*, 548.

<sup>39</sup> *Ibid.*, 549.

about those particularly difficult cases in which assisted suicide may be the most compassionate recourse.

A great difficulty in talking about the acceptability of assisted suicide occurs because as an ethical concept, it exists in a world where things are spoken of as good and bad. Certainly there are contextual aspects to what is good and bad in many ethical systems; hunger can at times be a plus or a minus, but the contextual focus of pragmatism gives greater strength to the determinations reached. The failing of more absolute systems occurs when they make the assumption that a mass rule, or imperative, can be applied to ethical questions such as those that one encounters in end-of-life care. Pragmatism allows for a sort of objectivity in that things can be called goods and bads, but these feelings serve as new standpoints for further questioning. Hester's formulation of this system is as follows: "There are hungry persons and happy persons. The discontented and fulfilled live here and now. These realities, having formed from previous inquires, are retrospective 'givens' for new inquiry."<sup>40</sup> The flow of pragmatic consideration is then evolutionary in that the summation of previous determinations forms the new moral equation. It is not merely an equation that variable life points are plugged into; rather, the equation also evolves with the individual. This makes the question of end-of-

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<sup>40</sup> Ibid., 550.

life care a difficult one because of a number of features. The first is the ability of any person to approximate their future feelings about dying. This long-form pragmatic consideration allows the long-suffering patient to change his wishes for end-of-life care based on the continued experience he has with his disease. It may be that the hypothesis that has guided a patient's life for a long time fails him when he is near death. The evolutionary nature of pragmatism is prepared for these developments because it realizes the limited knowledge with which individuals begin their inquiries.

In recognition of the difficulty of dealing with a patient's changing feelings about her fate and treatment over the term of a disease, medical ethicists and observers have been calling for increased communication with patients. Pragmatism not only demands this increased communication, but also gives the data gleaned from it real power to affect a patient's treatment. Such advantages have been the focus of clinical pragmatism, as detailed in an essay by Joseph Fins, Matthew Bacchetta, and Frank Miller entitled "Clinical Pragmatism: A Method of Moral Problem Solving."<sup>41</sup> Hester details the project: "Clinical pragmatism is democratic, experimental, and fallible, attempting to make decisions in full recognition of the need to

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<sup>41</sup> J. J. Fins, M. Bacchetta, and F. Miller, "Clinical Pragmatism: A Method of Moral Problem Solving." Kennedy Institute of Ethics Journal vol 7. (1992). 129.

act in the face of uncertainty."<sup>42</sup> Acting in the face of uncertainty is exactly what end-of-life decisions are. Choosing how one wants to die is about more than the uncertainty of the act itself; it also deals with the great concern of what it is like not to live. It may be that at the end of a patient's life, he realizes a new set of desires and feelings that overwhelm his previous hypothesis about life. In these cases, pragmatism demonstrates the fallibility of its construction (and of the human intellect) and allows for patients to reformulate their ideals in line with changing desires.

Hester recognizes the misdirected search for empirical data that Wolf has in her "Shifting Paradigms." For pragmatists, the data gathered is only meaningful insofar as it is relevant to the concerns of the investigator. That is, Wolf is mistaken to demand the presence of some universal data in order to show that allowing assisted suicide would be a 'better' state. Rather, the real focus in our discussion should be set on data at the personal level; "Principles must be developed from the features and specifics of the problematic situation that we are attempting to make satisfactory."<sup>43</sup> The data used in this paper can be integrated in a similar way. Studies cited have demonstrated the desire for assisted suicide among certain patients. That we have a large number of unmet desires that

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<sup>42</sup> Hester, *Is Pragmatism Well Suited?*, 552.

<sup>43</sup> *Ibid.*, 554.

could, with relative ease, be fulfilled demonstrates the need for a redesign of our allowed practices. This does not mean that assisted suicide will be an option for all patients, but rather that our data shows that it will be for some.

It is a narrow balance, keeping the idea of consensus in mind while investigating, and for Wolf, the desire to look for a strong statement is overwhelming. Hester describes Wolf's legal pragmatism as needing "only exhibit certain features such as being contextual and instrumental, future-oriented, empirically minded, and eclectic."<sup>44</sup> But the issue is more than this; it is the lack of balance between these trademark features that makes Wolf's pragmatism so difficult to relate to. Hester admits that the movement of what he calls 'freestanding pragmatism' encounters grave problems because it is too willing "to eschew, even denounce, the larger pragmatist context."<sup>45</sup>

Hester gives us a great lesson from the freestanding pragmatists—the reminder that pragmatism does not hang its hat on the authority of any person, not even its founders. While it is important to see that there is support for assisted suicide among some pragmatists, this is merely data in our decision-making process. We may give fair weight to the opinions of our heroes, but we do not depend solely upon them to reach our personal determinations. John Arras's note that "in an important

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<sup>44</sup> Ibid., 556.

<sup>45</sup> Ibid., 557.

way pragmatism and many of its salient features are already constitutive of bioethics as a discipline and practice"<sup>46</sup> demonstrates the great usefulness of pragmatism as a system for the clinical environment. The reality of ethics applied in practice is that axiomatic systems fail to motivate people because there is such difficulty in their wide application. They offend and alienate; they judge without accurate context or understanding. Pragmatism then becomes the perfect system for the clinic because it already reflects the reality and plurality of American life.

Lisa Bellatoni brings this to light as well, as she discusses Miller, Fins, and Bacchetta in her essay "What Good is a Pragmatic Bioethic?" Here, she contends that "Debates among bioethicists [have] become ever more removed from the clinical, cultural and public policy arenas wherein such issues arise."<sup>47</sup> Pragmatism as a system is well-insulated from these types of concerns because of its very nature as an un-insulated process of inquiry. Debates are kept at the bedside, where the context of the question can best be kept in mind. Moving the discussion away to address it more universally is a violation of the very system. In this way, pragmatism also somewhat insulates ethical considerations from academic pressures and trade winds.

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<sup>46</sup> Ibid., 558.

<sup>47</sup> Lisa Bellantoni, "What Good is a Pragmatic Bioethic?" *Journal of Medicine and Philosophy*, vol 28, (2003) 615.

There are problems that any ethical school will encounter in certain aspects of the assisted-suicide debate, such as the discussion of assisted suicides committed by psychiatrists. It is important to note that we will not have to set assisted-suicide guidelines widely; in fact, attempts to formulate principles for dealing with assisted suicide will only violate the specific context of the patient's concerns. That is to say, patients at the end of their lives will demonstrate their troubles differently. To say that no patients who have previously received psychiatric (or any other particular) treatment can be assisted in suicide would set up a system that will certainly fail at recognizing the true goods for their patients.

The other difficult issue that we are forced to address when we talk about assisted suicide is that we are operating with what is an unknown quantity. Some patients will have ideas of what death may be like, such as a worldly heaven or a sort of non-existing darkness. That we are not sure what death is like does not restrict us from allowing patients to believe that death will be better than being alive. Because we fail to know exactly what it is like, and because there is no data to gather (at least not that we can understand as living beings), pragmatism allows us to leave these determinations up to the patients. The problem with death is that we are making what

sounds like a bold claim: the claim that for some patients, death may be a preferred state, compared to being in pain near death. The issue, of course, is that we do not have enough data to be sure of this in the way we may desire, given the importance of getting such a question correct. However, this determination is really not unlike others that we make while alive. That is to say, the real issue here may be that we have come to overinflate our idea of how well we can predict the future. Beliefs held while alive, for the pragmatist, are mere hypotheses. That what occurs after death is similarly unknown should not pose additional difficulties for our discussion.

Following Hester on James (from *Progressive Dying*), "a life gains significance through its own intellect and fortitude."<sup>48</sup> This means that any life is then determined by the individual who lives that life and not by an external sense of meaning. Arguments against the ability to find meaning in the act of assisted suicide seem to be caught up believing that there is some chance that the sure fate of a terminally-ill patient can be avoided. In many cases, choosing to die while still cogent may be the last and only meaningful act left for the patient to carry out. The counter to this would be that the choice to live on defiantly in the face of impending death could also be meaningful, but this will, of course, depend on the preference

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<sup>48</sup> Hester, *Progressive Dying*, 280.



of the patient. Both continuing to live in the face of sure death and bravely choosing death when at risk of losing control of one's life are acceptable end-of-life perspectives. This should be recognized fairly, and patients should be allowed to make end-of-life decisions that reflect these beliefs.

James's emphasis on desires and their fulfillment gives us an entirely practical system of ethical comparison for the clinic. Hester asserts that end-of-life decisions such as assisted suicide fall well in line with James's idea of morality as a sum of desires, and I tend to agree with him. In the case of a patient who would be eligible for assisted suicide, we see a confluence of different factors that affect what we would call the sum of these desires. An important shift in this process is the affirmation of the meaning of talking one's own life rather than suffering toward a painful and debilitating death. Doctors, patients, and family members can add to this calculation by aligning their desires so as to promote the power of the individual who has reached the end of his life.

Implicit in the above discussion is the idea that sense of life, or at least the life that is most important to this debate, is that of the person and not of the mere biological organism. In this, I largely agree with Martin Benjamin, who says that when it comes to this question of what matters in life, "conceiving the subject of life and death in terms of

personhood will provide a more satisfactory answer to this family of questions than conceiving it in terms of biology alone."<sup>49</sup> It is clear that the medical community has yet to make up its mind about this question, as can be seen from our previous discussion of PVS patients and CDS. PVS patients, though survivable organisms, are clearly viewed as a problem that needs solving, as they fail to display the traits that we treasure in humans. Yet at the same time, CDS is lauded because it does not destroy (even if in name only) the future possibility of these same human traits. It seems clear that as treatments increasingly begin to suppress these capabilities that we so treasure in patients who also are near biological death, that the patients should have the power to decide that they are no longer happy with the treatment they are receiving. To borrow again from Benjamin, "what really matters to us, when we consider our own lives and the lives of others, is continued existence as persons, not continued existence of personless organisms."<sup>50</sup> While this may seem in part like a betrayal of our animal nature, a simple appeal to that which defines others in our minds will prove this assertion correct. I doubt many people would prefer a lengthened, but merely vegetative life for their best friend over a shorter, yet fully cognizant existence.

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<sup>49</sup> Martin Benjamin, *Pragmatism and the Determination of Death*, 204

<sup>50</sup> *Ibid.*, 199.

The problem at hand, of course, comes back to whom these strong formulations affect. While, of course, this serves well our argument for assisted suicide, what about the young who suffer similar but possibly temporary decisions? Or what about the disabled, who are among the largest opponents to assisted-suicide legislation because they fear that it will eventually be used against them? On this topic, I defer to John Lachs, who in his "Dying Old as a Social Problem,"<sup>51</sup> addresses the reality of this problem. I agree with Lachs that those looking to claim to stand for the preservation of all life in all of its forms are misguided. Furthermore, I agree with his assertion that since "we live in a world of relative plenty...economic considerations should not be allowed primacy in such decisions."<sup>52</sup> The largest factors to examine when it comes to assisted suicide should first and foremost be the course of the patient's affliction and the patient's feelings about its progression. The goal of allowing for assisted suicide is to make suicide as real of a choice for those who are near death as it is for the healthy who are free to take their own lives each day. The difference, of course, is that were a young, healthy person to kill himself, there is the potential that the meaning would be lost by giving in to his nihilist tendencies. As for those who are near death already, taking control of their lives with assisted suicide

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<sup>51</sup> John Lachs. "Dying Old as a Social Problem." From *Pragmatic Bioethics*, ed. Glenn McGee. (Cambridge: MIT Press, 2003) 207.

<sup>52</sup> *Ibid.*, 214.

means that they are asserting that life ends with the death of the person and not that of the organism. It is a choice not to be reduced to an organism like mere broccoli, a choice that we otherwise would not treasure had the body not been the previous home of our good friend.

Currently used alternatives, even in places where euthanasia is allowed, are being misused because we have failed to de-emphasize the myth of natural death, leading patients' best intentions to be ignored. That is, where a patient may prefer an act like assisted suicide, social pressures push him to opt for another choice such as CDS. Once unconscious, however, the patient is unaware of the treatment he may or may not continue to receive. In a study of terminal sedation in the Netherlands, researchers found that only 33% of the patients who received CDS had requested the treatment.<sup>53</sup> Furthermore, only 34% of the patients who received CDS discussed with their doctor the idea of forgoing artificial nutrition and hydration. This means that 2 out of every 3 patients were being put into a state where the doctor was unaware of their desires for care. Complicating matters further is the fact that in only 36% of cases was CDS not used with the intent to hasten death.

The desires of patients need to be better understood and explored, and the largest barrier to this is the limiting of

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<sup>53</sup> Judith A.C. Rietjens, et al. "Physician Reports of Terminal Sedation without Hydration or Nutrition for Patients Nearing Death in the Netherlands." *The Annals of Internal Medicine*, Vol. 141, 2004. 178.

choices that pose no grave moral threat to society at large. The question of active euthanasia is a difficult one, but as we see in the Netherlands, just allowing for it does not make it an active choice. In the aforementioned study, only 37% of patients even discussed the idea of euthanasia with their doctor<sup>54</sup>. The problem here is that our social perspective on end-of-life care does not accurately embrace the meaning that death can give to a life even in its waning hours. By emphasizing a pragmatic approach, we can make sure that the most goods are being done for patients who are near death.

The best formulation of this final respect also comes from Lachs, who affirms that when it comes to terminal patients, "Respect for them requires that we permit the last word to be theirs."<sup>55</sup> Assisted suicide should never be a treatment that finds its way to a physician's prescription pad. What it should remain is a choice for care in line with other, similar end-of-life treatments. This respect for final decisions must work in two directions: the ability to refuse to kill oneself and the opportunity to do so. In this, we must support the legal ability to end one's own life, a position fortified by the moral gains that are brought by allowing dying patients to express their final desires. It may be the case for some patients, "that some people at the distant edge of life decide or recognize that it

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<sup>54</sup> Ibid, 178.

<sup>55</sup> Lachs, 217.

is better not to be."<sup>56</sup> It is our responsibility, recognizing their status as moral actors, to allow terminally ill patients to continue to express their moral desires – to affirm their positions as the persons who we value so greatly.

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<sup>56</sup> Ibid., 217.

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