

Dying at the Right Time: Reflections on (Un)Assisted Suicide

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Let us begin with two observations about chronic illness and death:

- 1 Death does not always come at the right time. We are all aware of the tragedies involved when death comes too soon. We are afraid that it might come too soon for us. By contrast, we may sometimes be tempted to deny that death can come too late – wouldn't everyone want to live longer? But in our more sober moments, most of us know perfectly well that death can come too late.
- 2 Discussions of death and dying usually proceed as if death came only to hermits – or others who are all alone. But most of the time, death is a death in the family. We are connected to family and loved ones. We are sustained by these connections. They are a major part of what makes life worth living for most of us.

Because of these connections, when death comes too soon, the tragedy is often two-fold: a tragedy both for the person who is now dead and for those of us to whom she was connected. We grieve both for our loved one who is gone and for ourselves who have lost her. On one hand, there is the unrealized good that life would have been for the dead person herself – what she could have become, what she could have experienced, what she wanted for herself. On the other, there is the contribution she would have made to others and the ways *their* lives would have been enriched by her.

We are less familiar with the idea that death can come too late. But here, too, the tragedy can be two-fold. Death

can come too late because of what living on means to the person herself. There are times when someone does not (or would not) want to live like this, times when she believes she would be better off dead. At times like these, suicide or assisted suicide becomes a perfectly rational choice, perhaps even the best available option for her. We are then forced to ask, "Does someone have a right to die?" Assisted suicide may then be an act of compassion, no more than relieving her misery.

There are also, sadly, times when death comes too late because *others* – family and loved ones – would be better off if someone were dead. (Better off overall, despite the loss of a loved one.) Since lives are deeply intertwined, the lives of the rest of the family can be dragged down, impoverished, compromised, perhaps even ruined because of what they must go through if she lives on. When death comes too late because of the effect of someone's life on her loved ones, we are, I think, forced to ask, "Can someone have a duty to die?" Suicide may then be an attempt to do what is right; it may be the only loving thing to do. Assisted suicide would then be helping someone do the right thing.

Most professional ethicists – philosophers, theologians, and bioethicists – react with horror at the very idea of a duty to die. Many of them even argue that euthanasia and physician-assisted suicide should not be legalized because then some people might somehow get the idea that they have a duty to die. To this way of thinking, someone who got that idea could only be the victim of vicious social pressure or perverse moral reasoning. But when I ask my classes for examples of times when death

would come too late, one of the first conditions students always mention is: "When I become a burden to my family." I think there is more moral wisdom here than in the dismay of these ethicists.

Death does not always come at the right time. I believe there are conditions under which I would prefer not to live, situations in which I would be better off dead. But I am also absolutely convinced that I may one day face a duty or responsibility to die. In fact, as I will explain later, I think many of us will one day have this duty.

To my way of thinking, the really serious questions relating to euthanasia and assisted suicide are: Who would be better off dead? Who has a duty to die? *When* is the right time to die? And if my life should be over, who should kill me?¹ However, I know that others find much of what I have said here surprising, shocking, even morally offensive. So before turning to these questions that I want us to think about, I need to explain why I think someone can be better off dead and why someone can have a duty to die. (The explanation of the latter will have to be longer, since it is by far the less familiar and more controversial idea.)

I When Someone Would be Better Off Dead

Others have discussed euthanasia or physician-assisted suicide when the patient would be better off dead.² Here I wish to emphasize two points often omitted from discussion: (1) Unrelieved pain is not the only reason someone would be better off dead; and (2) Someone can be better off dead even if she has no terminal illness.

(1) If we think about it for even a little while, most of us can come up with a list of conditions under which we believe we would rather be dead than continue to live. Severe and unrelieved pain is one item on that list. Permanent unconsciousness may be another. Dementia so severe that we no longer recognize ourselves or our loved ones is yet another. There are some people who prefer not to live with quadriplegia. A future shaped by severe deterioration (such as that which accompanies MS, ALS, AIDS, or Huntington's chorea) is a future that some people prefer not to live out.

(Our lists would be different because our lives and values are different. The fact that some people would not or do not want to live with quadriplegia or AIDS, for example, does not mean that others should not want to live like

that, much less that their lives are not worth living. That is very important. The point here is that almost all of us can make a list of conditions under which we would rather not live, and that uncontrolled pain is not the only item on most of our lists.)

Focusing the discussion of euthanasia and assisted suicide on pain ignores the many other varieties of suffering that often accompany chronic illness and dying: dehumanization, loss of independence, loss of control, a sense of meaninglessness or purposelessness, loss of mental capabilities, loss of mobility, disorientation and confusion, sorrow over the impact of one's illness and death on one's family, loss of ability even to recognize loved ones, and more. Often, these causes of suffering are compounded by the awareness that the future will be even bleaker. Unrelieved pain is simply not the only condition under which death is preferable to life, nor the only legitimate reason for a desire to end one's life.

(2) In cases of terminal illness, death eventually offers the dying person relief from all her suffering. Consequently, things can be even worse when there is *no* terminal illness, for then there is no end in sight. Both pain and suffering are often much worse when they are *not* accompanied by a terminal illness. People with progressive dementia, for example, often suffer much more if they are otherwise quite healthy. I personally know several old people who would be delighted to learn that they have a terminal illness. They feel they have lived long enough – long enough to have outlived all their loved ones and all sense of a purpose for living. For them, even daily existence is much worse because there is no end in sight.

Discussions of euthanasia and physician-assisted suicide cannot, then, be restricted to those with unrelieved pain and terminal illness. We must also consider requests made by those who have no untreatable pain and no terminal illness. Often, their case for relief is even more compelling.

Sometimes, a refusal of medical treatment will be enough to bring relief. Competent adults who are suffering from an illness have a well-established moral and legal right to decline any form of medical treatment, including life-prolonging medical treatment. Family members who must make medical decisions for incompetent people also have the right to refuse any form of medical treatment on their behalf, so long as they are acting in accordance with the known wishes or best interests of their loved one. No form of medical treatment is compulsory when someone would be better off dead.³

But those who would be better off dead do not always have terminal illnesses; they will not always need any form of medical treatment, not even medically-supplied food and water. The right to refuse medical treatment will not help these people. Moreover, death due to untreated illness can be agonizingly slow, dehumanizing, painful, and very costly, both in financial and emotional terms. It is often very hard. Refusing medical treatment simply will not always ensure a dignified, peaceful, timely death. We would not be having a national debate about physician-assisted suicide and euthanasia if refusal of medical treatment were always enough to lead to a reasonably good death. When death comes too late, we may need to do more than refuse medical treatment.

II Religion and Ending a Life

Some people can easily see that there are people who would be better off dead. But they still cannot accept suicide or physician-assisted suicide because they believe we have a duty to God not to take our own lives. For them, human life is a gift from God and it remains a gift no matter how much pain and suffering it may bring. It is a sin or an offense against God, the giver of life, to take your own life or to help someone else end theirs. Such believers may also feel that no one should be allowed to end their lives – every life is a gift from God, even the lives of those who do not believe that this is so.

I do not understand this position for two reasons. First, it involves the assumption that it is possible to take a human life (our own or someone else's) *before* God wants it ended, but we cannot possibly preserve it *after* God wants it ended. For if we do not make that assumption, we face *two* dangers – the danger that we are prolonging human life beyond its divine purpose, as well as the danger that we are ending it too soon. If we can extend life longer than God intends, suicide and physician-assisted suicide may be more in accord with God's wishes than attempts to preserve that life.

I can understand the view that everyone dies at precisely the right time, the moment God intends. If that is so, people who commit suicide or who are intentionally killed by physicians also die at precisely the moment God wants them to die. I can also understand the view that we can take life before God wants it ended but we can also extend life longer than God wants it prolonged. But I cannot make sense of the view that we can end a human

life too soon but not preserve it too long. Surely, God has given us both abilities or neither one.

I also have a second difficulty with this religious objection to suicide, assisted suicide and euthanasia. Suppose there is a right time to die, a divinely-ordained moment when God wants each life to end. Even so, we have no right to assume that God will "take my life" when it's the right time for me to die. In fact, we cannot even assume that God will send a terminal illness that will kill me at the right time. There could be a religious test – God may want me to take my own life and the question is whether I will meet this final challenge. Or a God who loves me might see that I would benefit spiritually from the process of coming to the conclusion that I should end my own life and then preparing to take it. That might be a fitting ending for me, the culminating step in my spiritual growth or development.

In short, a God not totally obsessed with the sheer quantity of our lives may well have purposes for us that are incompatible with longer life – even if we want to live longer. So, I think we should not believe that we always have a duty to God not to take our lives or to assist others in ending theirs. God may want me to step up and assume the responsibility for ending my own life or for seeing that someone else's suffering is ended. This observation leads to our next question: Can there be a responsibility or duty to die?

III The Duty to Die

I may well one day have a duty to die, a duty most likely to arise out of my connections with my family and loved ones.⁴ Sometimes preserving my life can only devastate the lives of those who care about me. I do not believe I am idiosyncratic, morbid, or morally perverse in believing this. I am trying to take steps to prepare myself mentally and spiritually to make sure that I will be able to take my life if I should one day have such a duty. I need to prepare myself; it might be a very difficult thing for me to do.

Our individualistic fantasy about ourselves sometimes leads us to imagine that lives are separate and unconnected, or that they could be so if we chose. If lives were unconnected, then things that happen in my life would not or need not affect others. And if others were not (much) affected by my life, I would have no duty to consider the impact of my life on others. I would then be morally free to choose whatever life and death I prefer

for myself. I certainly would have no duty to die when I would prefer to live.

Most discussions of assisted suicide and euthanasia implicitly share this individualistic fantasy: they just ignore the fact that people are connected and lives intertwined. As a result, they approach issues of life or death as if the only person affected is the one who lives or dies. They mistakenly assume the pivotal issue is simply whether the person *herself* prefers not to live like this and whether *she herself* would be better off dead.⁵

But this is morally obtuse. The fact is we are not a race of hermits – most of us are connected to family and loved ones. We prefer it that way. We would not want to be all alone, especially when we are seriously ill, as we age, and when we are dying. But being with others is not all benefits and pleasures; it brings responsibilities, as well. For then what happens to us and the choices we make can dramatically affect the lives of our loved ones. It is these connections that can, tragically, generate obligations to die, as continuing to live takes too much of a toll on the lives of those connected to us.⁶

The lives of our loved ones can, we know, be seriously compromised by caring for us. The burdens of providing care or even just supervision 24 hours a day, 7 days a week, are often overwhelming.⁷ But it can also be emotionally devastating simply to be married to a spouse who is increasingly distant, uncommunicative, unresponsive, foreign, and unreachable. A local newspaper tells the story of a woman with Alzheimer's who came running into her den screaming: "That man's trying to have sex with me! He's trying to have sex with me! Who *IS* that man?!" That man was her loving husband of more than 40 years who had devoted the past 10 years of his life to caring for her (Smith, 1995). How terrible that experience must have been for her. But how terrible those years must be for him, too.

We must also acknowledge that the lives of our loved ones can also be devastated just by having to *pay* for health care for us. A recent study documented the financial aspects of caring for a dying member of a family. Only those who had illnesses severe enough to give them less than a 50 percent chance to live six more months were included in this study. When these patients survived their initial hospitalization and were discharged, about one-third required considerable caregiving from their families; in 20 percent of cases a family member had to quit work or make some other major lifestyle change; almost one-third of these families lost all of their savings, and just under 30 percent lost a major source of income (Covinsky et al., 1994).

A chronic illness or debilitating injury in a family is a misfortune. It is, most often, nobody's fault; no one is responsible for this illness or injury. But then we face choices about how we will respond to this misfortune. That is where the responsibility comes in and fault can arise. Those of us with families and loved ones always have a responsibility not to make selfish or self-centered decisions about our lives. We should not do just what we want or just what is best for *us*. Often, we should choose in light of what is best for all concerned.

Our families and loved ones have obligations to stand by us and to support us through debilitating illness and death. They must be prepared to make sacrifices to respond to an illness in the family. We are well aware of this responsibility and most families meet it rather well. In fact, families deliver more than 80 percent of the long-term care in the US, almost always at great personal cost.

But responsibility in a family is not a one-way street. When we become seriously ill or debilitated, we too may have to make sacrifices. There are limits to what we can ask our loved ones to do to support us, even in sickness. There are limits to what they should be prepared to do for us – only rarely and for a limited period of time should they do all they can for us.

Somehow we forget that sick, infirm, and dying adults also have obligations to their families and loved ones: a responsibility, for example, to try to protect the lives of loved ones from serious threats or greatly impoverished quality, or an obligation to avoid making choices that will jeopardize or seriously compromise their futures. Our obligations to our loved ones must be taken into consideration in making decisions about the end of life. It is out of these responsibilities that a duty to die can develop.

Tragically, sometimes the best thing you can do for your loved ones is to remove yourself from their lives. And the only way you can do that may be to remove yourself from existence. This is not a happy thought. Yet we must recognize that suicides and requests for assisted suicide may be motivated by love. Sometimes, it's simply the only loving thing to do.

IV Who Has a Duty to Die?

Sometimes it is clear when someone has a duty to die. But more often, not. *who* has a duty to die? And *when* – under what conditions? To my mind, these are the right questions, the questions we should be asking. Many of us may one day badly need answers to just these questions.

But I cannot supply answers here, for two reasons. In the first place, answers will have to be very particular and individualized...to the person, to the situation of her family, to the relationships within the family, and so on. There will not be simple answers that apply to everyone.

Secondly and perhaps even more importantly, those of us with family and loved ones should not define our duties unilaterally. Especially not a decision about a duty to die. It would be isolating and distance-creating for me to decide without consulting them what is too much of a burden for my loved ones to bear. That way of deciding about my moral duties is not only atomistic, it also treats my family and loved ones paternalistically – *they* must be allowed to speak for themselves about the burdens my life imposes on them and how they feel about bearing those burdens.

I believe in family decision making. Important decisions for those whose lives are interwoven should be made *together*, in a family discussion. Granted, a conversation about whether I have a duty to die would often be a tremendously difficult conversation. The temptations to be dishonest in such conversations could be enormous. Nevertheless, if we can, we should have just such an agonizing discussion – partly because it will act as a check on the information, perceptions, and reasoning of all of us; but perhaps even more importantly, because it affirms our connectedness at a critical juncture in our lives. Honest talk about difficult matters almost always strengthens relationships.

But many families seem to be unable to talk about death at all, much less a duty to die. Certainly most families could not have this discussion all at once, in one sitting. It might well take a number of discussions to be able to approach this topic. But even if talking about death is impossible, there are always behavioral clues – about your caregiver's tiredness, physical condition, health, prevailing mood, anxiety, outlook, overall well-being, and so on. And families unable to talk about death can often talk about those clues. There can be conversations about how the caregiver is feeling, about finances, about tensions within the family resulting from the illness, about concerns for the future. Deciding whether you have a duty to die based on these behavioral clues and conversation about them is more relational than deciding on your own about how burdensome this relationship and care must be.⁸

For these two reasons, I cannot say when someone has a duty to die. But I can suggest a few ideas for discussion of this question. I present them here without much elaboration or explanation.

- 1 There is more duty to die when prolonging your life will impose greater burdens – emotional burdens, caregiving, disruption of life plans, and, yes, financial hardship – on your family and loved ones. This is the fundamental insight underlying a duty to die.
- 2 There is greater duty to die if your loved ones' lives have already been difficult or impoverished (not just financially) – if they have had only a small share of the good things that life has to offer.
- 3 There is more duty to die to the extent that your loved ones have already made great contributions – perhaps even sacrifices – to make your life a good one. Especially if you have not made similar sacrifices for their well-being.
- 4 There is more duty to die to the extent that you have *already* lived a full and rich life. You have already had a full share of the good things life offers.
- 5 Even if you have not lived a full and rich life, there is more duty to die as you grow older. As we become older, there is a diminishing chance that we will be able to make the changes that would now be required to turn our lives around. As we age, we will also be giving up less by giving up our lives, if only because we will sacrifice fewer years of life.
- 6 There is less duty to die to the extent that you can make a good adjustment to your illness or handicapping condition, for a good adjustment means that smaller sacrifice will be required of loved ones and there is more compensating interaction for them. (However, we must also recognize that some diseases – Alzheimer's or Huntington's chorea – will eventually take their toll on your loved ones no matter how courageously, resolutely, even cheerfully you manage to face that illness.)
- 7 There is more duty to die to the extent that the part of you that is loved will soon be gone or seriously compromised. There is also more duty to die when you are no longer capable of giving love. Part of the horror of Alzheimer's or Huntington's, again, is that it destroys the person we loved, leaving a stranger and eventually only a shell behind. By contrast, someone can be seriously debilitated and yet clearly still the person we love.

In an old person, "I am not ready to die yet" does not excuse one from a duty to die. To have reached the age of, say, 80 years without being ready to die is itself a moral failing, the sign of a life out of touch with life's basic realities.

A duty to die seems very harsh, and sometimes it is. But if I really do care for my family, a duty to protect their lives will often be accompanied by a deep desire to do so. I will normally *want* to protect those I love. This is not only my duty, it is also my desire. In fact, I can easily imagine wanting to spare my loved ones the burden of my existence more than I want anything else.

V If I Should Be Dead, Who Should Kill Me?

We need to reframe our discussions of euthanasia and physician-assisted suicide. For we must recognize that pleas for assisted suicide are sometimes requests for relief from pain and suffering, sometimes requests for help in fulfilling one's obligations, and sometimes both. If I should be dead for either of these reasons, who should kill me?

Like a responsible life, a responsible death requires that we think about our choices in the context of the web of relationships of love and care that surround us. We must be sensitive to the suffering as well as the joys we cause others, to the hardships as well as the benefits we create for them. So, when we ask, "Who should kill me?", we must remember that we are asking for a death that will reduce the suffering of *both* me and my family as much as possible. We are searching for the best ending, not only for me, but for *everyone concerned* – in the preparation for death, the moment of death, and afterwards, in the memory and on-going lives of loved ones and family.

Although we could perhaps define a new profession to assist in suicides – euthanasians?? – there are now really only three answers to the question, "Who should kill me?": (1) I should kill myself; (2) A loved one or family member should kill me; and (3) A physician should kill me. I will consider these three possibilities. I will call these *unassisted* suicide, *family*-assisted suicide, and *physician*-assisted suicide.

V.I Unassisted suicide: I should kill myself

The basic intuition here is that each of us should take responsibility for herself. I am primarily the one who wants relief from my pain and suffering, or it is fundamentally my own duty to die and *I* should be the one to do my duty. Moreover, intentionally ending a life is a very messy business – a heavy, difficult thing for anyone to have to do. If possible, I should not drag others into it.

Often, I think, this is the right idea – I should be the one to kill myself.

But not always. We must remember that some people are physically unable to do so – they are too weak or incapacitated to commit suicide without assistance. Less persuasive perhaps are those who just can't bring themselves to do it. Without the assistance of someone, many lack the know-how or means to end their lives in a peaceful, dignified fashion. Finally, many attempted suicides – even serious attempts at suicide – fail or result in terrible deaths. Those who have worked in hospitals are familiar with suicide attempts that leave people with permanent brain damage or their faces shot off. There are also fairly common stories of people eating their own vomit after throwing up the medicine they hoped would end their lives.

Even more importantly, if I must be the one to kill myself, that may force me to take my life earlier than would otherwise be necessary. I cannot wait until I become physically debilitated or mentally incompetent, for then it will be too late for me to kill myself. I might be able to live quite comfortably for a couple more years, if I could count on someone else to take my life later. But if I cannot count on help from anyone, I will feel pressure to kill myself when unavoidable suffering for myself or my loved ones appears on the horizon, instead of waiting until it actually arrives.

Finally, many suicides are isolating – I can't die with my loved ones around me if I am planning to use carbon monoxide from automobile exhaust to end my life. For most of us, a meaningful end of life requires an affirmation of our connection with loved ones and so we do not want to die alone.

The social taboo against ending your own life promotes another type of isolation. The secrecy preceding many suicides creates conditions for misunderstanding or lack of understanding on the part of loved ones – Why did she do it? Why didn't I see that she was going to kill herself? Why didn't I do something to help? Secrecy and lack of understanding often compound the suffering family and loved ones go through when someone ends their life.

Unassisted suicide – I should kill myself – is not always the answer. Perhaps, then, my loved ones should participate in ending my life.

V.II Family-assisted suicide: A member of my family should kill me

At times, we may have a moral obligation to help others end their lives, especially those close to us, those we love. I can easily imagine myself having an obligation to help a

loved one end her life and I hope my family will come to my assistance if my death does not come at the right time. What should be the role of family and loved ones in ending a life?

They might help me get information about reliable and peaceful methods for ending my life. They might also be able to help me get the drugs I need, if that is the method I choose. Like most people, I would also very much want my loved ones to participate, at least to the extent of being there with me when I die.

For reasons already mentioned, I would hope I could talk over my plans with my loved ones, both to reassure myself and check on my reasoning, and also to help them work through some of the emotional reaction to my death. Some people believe that families should not be involved in decisions about the end of life because they are in the grips of powerful emotions that lead to wildly inappropriate decisions. (A familiar example is the difficulty many families have in deciding to withdraw medical treatment even when their loved one is clearly dying.) Families will always be gripped by powerful emotions over a death in the family. But appropriate decisions are not necessarily unemotional or uninvolved decisions. And I think inappropriate reactions or decisions stem largely from lack of the discussions I advocate or from an attempt to compress them into one, brief, pressure-packed conversation, often in the uncomfortable setting of a hospital.

So, a good death for all concerned would usually involve my family – the preparation for taking my life, at least, would be family-assisted. My loved ones should know; they should, if possible, understand. They should not be surprised. Hopefully my loved ones could come to agree with my decision. They should have had time to come to terms with the fact that I plan to end my life. Indeed, I should have helped them begin to deal emotionally with my death. All that would help to ease their suffering and also my concern about how my death will affect them. It would reaffirm our connectedness. It would also comfort me greatly to feel that I am understood and known by my loved ones as I take this important step.

More than this I cannot ask of them, for two related reasons. The first is that actually killing a loved one would usually be extremely difficult. It would be a searing and unforgettable experience that could well prove very hard to live with afterwards. Killing a loved one at her request *might* leave you feeling relieved – it could give you the satisfaction of feeling you had done what

needed to be done. In cases of extreme debility or great suffering, family-assisted suicide might be experienced as a loving act of kindness, compassion, and mercy. It would still be very hard. Much harder would be killing me because I have a duty to die, a duty to die because my life is too great a burden *for the one who now must kill me*. I cannot ask that of someone I love. I fear that they would suffer too much from taking my life.

I might be wrong about this, however. It might be that, though difficult indeed, being killed lovingly and with your consent by your spouse or your child would be a final testimonial to a solid, trusting, and caring relationship. There might be no more powerful reaffirmation of the strength of your relationship, even in the face of death. The traumatic experience for the family members who assist in the suicide might be a healing experience for them, as well. We know so little about family-assisted suicide.

But in any case, there is also a second reason: I cannot ask for family-assisted suicide because it is not legally protected – a loved one who killed me might well be charged with murder. I could not ask my family to subject themselves to such a risk. Moreover, unlike physician-assisted suicide, we would not want to legalize family-assisted suicide. The lives of families are just too complex and too often laced with strong negative emotions – guilt, resentment, hatred, anger, desire for revenge. Family members also often have multiple motives stemming from deeply conflicting interests. As a result, there would be just too many cases in which family-assisted suicide would be indistinguishable from murder.⁹

Finally, family members may also fail. They also may lack know-how or bungle the job. Caught in the compelling emotions of grief and/or guilt, they may be unable to end a life that should be ended.

All this notwithstanding, family-assisted suicide may be the right choice, especially if physician-assisted suicide is unavailable. But should it be unavailable?

V.III Physician-assisted suicide: My doctor should kill me

There are, then, important difficulties with both unassisted suicide and family-assisted suicide. These difficulties are arguments for physician-assisted suicide and euthanasia. If my death comes too late, a physician is often the best candidate to kill me...or at the very least, to help me kill myself.

Perhaps the main argument for physician-assisted suicide grows out of the physician's extensive knowledge of disease and of dying. If it is a medical condition that leads me to contemplate ending my life, a key question for determining *when* or even *whether* I should end my life is: What is the prognosis? To what extent can my illness be treated or at least alleviated? How long do I have to live with my condition? How much worse will it get and how soon? What will life with that condition be like for me and my family? Few besides physicians possess all this critical information. I will be more likely to reach the right decision at the right time if a trusted physician is in on my plans to end my life.

A related point is physicians' knowledge of and access to drugs. Few of us know what drugs to take and in what amounts without the advice of a physician. Often, only a physician will know what to do to ensure that I do not vomit up the "suicide pill" or what to do if it fails. Physicians also have a monopoly on access to drugs. If my physician were more closely involved in the process, I could be more certain – and thus reassured – that my death will be peaceful and dignified, a death that permits reaffirmation of my connections with family and close friends.

A second argument for physician-assisted suicide grows out of physicians' greater experience with death and dying. Physicians know what to expect; those of us outside the health professions often do not. Granted, few physicians nowadays will know *me* and *my* family. For this reason, physicians should seldom make unilateral decisions about assisted suicide. Still, most physicians could provide a rich source of information about death and about strategies to minimize the trauma, suffering, and agony of a death, both for the dying person and for the family.

Thirdly, physician-assisted suicide does not carry the same social stigma that unassisted suicide carries and physicians are not exposed to the legal risks involved in family-assisted suicide. Although many physicians are unwilling to take *any* risks to help someone end her life, there is really very little legal risk in physician-assisted suicide, especially if the family is in agreement. Physicians are also not morally censured the way family members would be for ending a life.

Finally, physicians ought not to abandon their patients, certainly not at the moment of death. Much has been made of the possibility that Americans would lose their trust in physicians if they knew that physicians sometimes kill. But many of us would trust our physicians

more if we knew that we could count on them when death is needed or required (Quill and Cassell, 1995).

We have come, then, by a very round-about route to another argument for *physician*-assisted suicide. Often it is simply better – safer, more secure, more peaceful, less emotionally-damaging for others – than unassisted suicide or family-assisted suicide. If physicians refuse to assist or are not permitted to do so, families and seriously ill people will be forced back on their own resources. And many deaths will be much worse than they need to be. When death comes too late, a physician will often be the best candidate to kill me.

And yet, physician-assisted suicide is not always the answer, either. Many physicians take themselves to be sworn to preserve human life in all its forms. Also, many people want doctors who are sworn not to kill, for fear that physicians might start making presumptuous, single-handed decisions about when death comes too late. Moreover, in a time when most people lack a significant personal relationship with their physicians, physician-assisted suicide is often a death that is remote, isolated, disconnected from the relationships that gave meaning to life. It is not always the best death. At times, then, family-assisted suicide and unassisted suicide remain the best answers.

VI Conclusion

We have a long cultural tradition of attempts to deal with the problems of death that comes too soon. Modern medicine, with its dramatic high-tech rescue attempts in the emergency room and the intensive care unit, is our society's attempt to prevent death from coming too soon. On a more personal level, we are bombarded with advice about ways to avoid a death that would be too soon – sooner than we wished, before we were ready for it.

We have much less cultural wisdom about the problems of a death that comes too late. It is almost as if we had spent all our cultural resources trying to avoid deaths that come too soon, only to find that we then had no resources left to help us when death comes too late.

Deaths that come too soon usually raise no difficult moral problems, however difficult they may be in other ways. Such deaths normally occur despite our best attempts to prevent them. "There's nothing more we can do," we say to the dying person, her family, and ourselves. And there is ethical solace in this, despite the tragedy of the death itself. We admit our failure. But our failure is not a moral failure – we did what we could.

Deaths that come too late are ethically much more troubling. They call on us to assume responsibility – to make difficult decisions and to do difficult things. We can try to hide from this responsibility by claiming that we should always try to prolong life, no matter what. Or by not deciding anything. But we know that not to decide is to decide. And it is very often just not clear what we should do. The weight of life-or-death decision pushes down upon us.

The recognition that the lives of members of families are intertwined makes the moral problems of a death that comes too late even more difficult. For they deprive us of our easiest and most comfortable answers – “it’s up to the individual,” “whatever the patient wants.” But we do know that measures to improve or lengthen one life often compromise the quality of the lives of those to whom that person is connected.

So, we are morally troubled by deaths that come too late. We don’t know what to do. Beyond that, the whole idea is unfamiliar to us. But in other societies – primarily technologically primitive and especially nomadic societies – almost everyone knew that death could come too late. People in those cultures knew that if they managed to live long enough, death would come too late and they would have to do something about it. They were prepared by their cultural traditions to find meaning in death and to do what needed to be done.

We have largely lost those traditions. Perhaps we have supposed that our wealth and technological sophistication have purchased exemption for us from any need to worry about living too long, from any need to live less than every minute we enjoy living. For a while it looked that way. But we must now face the fact: Deaths that come too late are only the other side of our miraculous life-prolonging modern medicine.

We have so far avoided looking at this dark side of our medical triumphs. Our modern medicine saves many lives and enables us to live longer. That is wonderful, indeed. But it thereby also enables more of us to survive longer than we are able to care for ourselves, longer than we know what to do with ourselves, longer than we even *are* ourselves. Moreover, if further medical advances

wipe out many of today’s “killer diseases” – cancers, AIDS, heart attacks, and so on – then most of us will one day find that death is coming too late. And there will be a very common duty to die.

Our political system and health-care reform (in the USA) are also moving in a direction that will put many more of us in the position of having a duty to die. Measures designed to control costs (for the government, and for employers who pay for retirement benefits and health insurance) often switch the burdens of care onto families. We are dismantling our welfare system and attempting to shift the costs of long-term health care onto families. One important consequence of these measures is that more of us will one day find ourselves a burden to our families and loved ones.¹⁰

Finally, we ourselves make choices that increase the odds that death will come too late. Patient autonomy gives us the right to make choices about our own medical treatment. We use that right to opt again and again for life-prolonging treatment – even when we have chronic illnesses, when we are debilitated, and as we begin to die. Despite this autonomy, we may feel we really have no choice, perhaps because we are unable to find meaning in death or to bring our lives to a meaningful close. But if we repeatedly opt for life-prolonging treatment, we thereby also increase the chances that death will come too late. This is the cost of patient autonomy, combined with powerful life-prolonging medical technology and inability to give meaning to death or even to accept it.

Death is very difficult for us. I have tried here to speak about it in plain language; I have used hard words and harsh tones to try to make us attend to troubling realities. We may question the arguments and conclusions of this essay. We should do so. But this questioning must not be fueled by denial or lead to evasion. For one thing seems very clear: We had better start learning how to deal with the problems of a death that comes too late. Some day, many of us will find that we should be dead or that one of our loved ones should be dead. What should we do then? We had better prepare ourselves – mentally, morally, culturally, spiritually, and socially. For many of us, if we are to die at the right time, it will be up to us.

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versions of this essay. And more: these friends have been my companions and guides throughout my attempt to think through the meaning of love and family in our lives.

Notes

- 1 A note about language: I will be using “responsibility,” “obligation,” and “duty” interchangeably, despite significant differences in meaning. I generally use the word “duty” because it strikes me as a hard word for what can be a hard reality. (It also echoes Richard Lamm’s famous statement: “Old people have a duty to die and get out of the way to give the next generation a chance.”) Similarly, I use “kill” despite its connotations of destruction because I think we should not attempt to soften what we are doing. War and capital punishment have already taught us too much about how to talk in sweet and attractive ways about what we do. So I have resisted talking about “bringing my life to a close” and similar expressions. I have tried to use the plain, hard words.
- 2 There are many articles on this topic. Perhaps the classic article is Rachels (1975). It has been widely reprinted. A good collection of articles can be found in the *Journal of Medicine and Philosophy* (June 1993), which was devoted to the topic, “Legal Euthanasia: Ethical Issues in an Era of Legalized Aid in Dying.” Recent anthologies include Beauchamp (1996) and Moreno (1995).
- 3 A few states in the US – currently (January 1996) New York, Missouri, Delaware, and Michigan – do require that family members be able to supply “clear and convincing evidence” that withdrawal of treatment is what their loved one would have wanted. This can be hard to prove. So it is especially important for those who live in these states to put their wishes about the kind of treatment they would want (if they become unable to decide for themselves) in writing. For information about the laws that apply in your state, write to Choice in Dying, 200 Varick Street, New York, NY 10014, or call them at 212–366–5540.
- 4 I believe we may also have a duty to ourselves to die, or a duty to the environment or a duty to the next generation to die. But I think for most of us, the strongest duty to die comes from our connections to family and loved ones, and this is the only source of a duty to die that I will consider here.
- 5 Most bioethicists advocate a “patient-centered ethics” – an ethics which claims only the patient’s interests should be considered in making medical treatment decisions. Most health-care professionals have been trained to accept this ethic and to see themselves as patient advocates. I have argued elsewhere that a patient-centered ethic is deeply mistaken. See Hardwig (1989, 1993).
- 6 I am considering only mentally competent adults. I do not think those who have never been competent – young children and those with severe retardation – can have moral duties. I do not know whether formerly competent people – e.g., those who have become severely demented – can still have moral duties. But if they cannot, I think some of us may face a duty to die even sooner – before we lose our moral agency.
- 7 A good account of the burdens of caregiving can be found in Brody (1990). To a large extent, care of the elderly is a women’s issue. Most people who live to be 75 or older are women. But care for the elderly is almost always provided by women, as well – even when the person who needs care is the husband’s parent.
- 8 Ultimately, in cases of deep and unresolvable disagreement between yourself and your loved ones, you may have to act on *your own* conception of your duty and your own conception of the burdens on them. But that is a fall-back position to resort to when the better, more relational ways of arriving at a belief in a duty to die fail or are unavailable.
- 9 Although this is true, we also need to rethink our reactions to the motives of the family. Because lives are intertwined, if someone “wants Dad to be dead” and is relieved when he dies, this does not necessarily mean that she did not genuinely love him. Or that she is greedy, selfish, or self-centered. Her relief may stem from awareness of his suffering. It could also grow out of recognition of the sad fact that his life was destroying the lives of other family members whom she also loved.
- 10 Perhaps a more generous political system and a more equitable health-care system could counteract the trend toward a more and more common duty to die. For now, at least, we could pay for the care of those who would otherwise be a burden on their families. If we were prepared to do so, far fewer would face a duty to die. But we (in the US, at least) are not prepared to pay. Moreover, as medical advances enable more people to live longer (though also in various states of disability), it may be that the costs would overwhelm any society. Even if we could afford it, we should not continue to try to buy our way out of the problems of deaths that come too late. We would be foolish to devote all our resources to creating a society dedicated solely to helping all of us live just as long as we want.

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