

WILLIAM F. MAY

*Rising to the Occasion of Our Death*

FOR MANY parents, a Volkswagen van is associated with putting children to sleep on a camping trip. Jack Kevorkian, a Detroit pathologist, has now linked the van with the veterinarian's meaning of "putting to sleep." Kevorkian conducted a dinner interview with Janet Elaine Adkins, a 54-year-old Alzheimer's patient, and her husband and then agreed to help her commit suicide in his VW van. Kevorkian pressed beyond the more generally accepted practice of passive euthanasia (allowing a patient to die by withholding or withdrawing treatment) to active euthanasia (killing for mercy).

Kevorkian, moreover, did not comply with the strict regulations that govern active euthanasia in, for example, the Netherlands. Holland requires that death be imminent (Adkins had beaten her son in tennis just a few days earlier); it demands a more professional review of the medical evidence and the patient's resolution than a dinner interview with a physician (who is a stranger and who does not treat patients) permits; and it calls for the final, endorsing signatures of two doctors.

So Kevorkian-bashing is easy. But the question remains: Should we develop a judicious, regulated social policy permitting voluntary euthanasia for the terminally ill? Some moralists argue that the distinction between allowing to die and killing for mercy is petty quibbling over technique. Since the patient in any event dies—whether by acts of omission or commission—the route to death doesn't really matter. The way modern procedures have made dying at the hands of the experts and their machines such a prolonged and painful business has further fueled the euthanasia movement, which asserts not simply the right to die but the right to be killed.

But other moralists believe that there is an important moral distinction between allowing to die and mercy killing. The euthanasia movement, these critics contend, wants to engineer death rather than face dying. Euthanasia would bypass dying to make one dead as quickly as possible. It aims to relieve suffering by knocking out the interval between life and death. It solves the problem of suffering by eliminating the sufferer.

The impulse behind the euthanasia movement is understandable in an age when dying has become such an inhumanly endless business. But the movement may fail to appreciate our human capacity to rise to the occasion of our death. The best death is not always the sudden death. Those forewarned of death and given time to prepare for it have time to engage in acts of reconciliation. Also, advanced grieving by those about to be bereaved may ease some of their pain. Psychiatrists have observed that those who lose a loved one accidentally have a more difficult time recovering from the loss than those who have suffered through an extended period of illness before the death. Those who have lost a close relative by accident are more likely to experience what

Geoffrey Gorer has called limitless grief. The community, moreover, may need its aged and dependent, its sick and its dying, and the virtues which they sometimes evince—the virtues of humility, courage, and patience—just as much as the community needs the virtues of justice and love manifest in the agents of care.

On the whole, our social policy should allow terminal patients to die but it should not regularize killing for mercy. Such a policy would recognize and respect that moment in illness when it no longer makes sense to bend every effort to cure or to prolong life and when one must allow patients to do their own dying. This policy seems most consonant with the obligations of the community to care and of the patient to finish his or her course.

Advocates of active euthanasia appeal to the principle of patient autonomy—as the use of the phrase “voluntary euthanasia” indicates. But emphasis on the patient’s right to determine his or her destiny often harbors an extremely naïve view of the uncoerced nature of the decision. Patients who plead to be put to death hardly make unforced decisions if the terms and conditions under which they receive care already nudge them in the direction of the exit. If the elderly have stumbled around in their apartments, alone and frightened for years, or if they have spent years warehoused in geriatrics barracks, then the decision to be killed for mercy hardly reflects an uncoerced decision. The alternative may be so wretched as to push patients toward this escape. It is a huge irony and, in some cases, hypocrisy to talk suddenly about a compassionate killing when the aging and dying may have been starved for compassion for many years. To put it bluntly, a country has not earned the moral right to kill for mercy unless it has already sustained and supported life mercifully. Otherwise we kill for compassion only to reduce the demands on our compassion. This statement does not charge a given doctor or family member with impure motives. I am concerned here not with the individual case but with the cumulative impact of a social policy.

I can, to be sure, imagine rare circumstances in which I hope I would have the courage to kill for mercy—when the patient is utterly beyond human care, terminal, and in excruciating pain. A neurosurgeon once showed a group of physicians and an ethicist the picture of a Vietnam casualty who had lost all four limbs in a landmine explosion. The catastrophe had reduced the soldier to a trunk with his face transfixed in horror. On the battlefield I would hope that I would have the courage to kill the sufferer with mercy.

But hard cases do not always make good laws or wise social policies. Regularized mercy killings would too quickly relieve the community of its obligation to provide good care. Further, we should not always expect the law to provide us with full protection and coverage for what, in rare circumstances, we may morally need to do. Sometimes the moral life calls us out into a no-man’s-land where we cannot expect total security and protection under the law. But no one said that the moral life is easy.

SIDNEY HOOK

*In Defense of Voluntary Euthanasia*

*Sidney Hook (1902–1989) was a philosophy professor at New York University. This essay was originally printed in the New York Times in 1987.*

A FEW short years ago, I lay at the point of death. A congestive heart failure was treated for diagnostic purposes by an angiogram that triggered a stroke. Violent and painful hiccups, uninterrupted for several days and nights, prevented the ingestion of food. My left side and one of my vocal cords became paralyzed. Some form of pleurisy set in, and I felt I was drowning in a sea of slime. At one point, my heart stopped beating; just as I lost consciousness, it was thumped back into action again. In one of my lucid intervals during those days of agony, I asked my physician to discontinue all life-supporting services or show me how to do it. He refused and predicted that someday I would appreciate the unwisdom of my request.

A month later, I was discharged from the hospital. In six months, I regained the use of my limbs, and although my voice still lacks its old resonance and carrying power I no longer croak like a frog. There remain some minor disabilities and I am restricted to a rigorous, low-sodium diet. I have resumed my writing and research.

My experience can be and has been cited as an argument against honoring requests of stricken patients to be gently eased out of their pain and life. I cannot agree. There are two main reasons. As an octogenarian, there is a reasonable likelihood that I may suffer another “cardiovascular accident” or worse. I may not even be in a position to ask for the surcease of pain. It seems to me that I have already paid my dues to death—indeed, although time has softened my memories they are vivid enough to justify my saying that I suffered enough to warrant dying several times over. Why run the risk of more?

Secondly, I dread imposing on my family and friends another grim round of misery similar to the one my first attack occasioned.

My wife and children endured enough for one lifetime. I know that for them the long days and nights of waiting, the disruption of their professional duties and their own familial responsibilities counted for nothing in their anxiety for me. In their joy at my recovery they have been forgotten. Nonetheless, to visit another prolonged spell of helpless suffering on them as my life ebbs away, or even worse, if I linger on into a comatose senility, seems altogether gratuitous.

But what, it may be asked, of the joy and satisfaction of living, of basking in the sunshine, listening to music, watching one’s grandchildren growing into adolescence, following the news about the fate of freedom in a troubled world, playing with ideas, writing one’s testament of wisdom and folly for

posterity? Is not all that one endured, together with the risk of its recurrence, an acceptable price for the multiple satisfactions that are still open even to a person of advanced years?

Apparently those who cling to life no matter what think so. I do not.

The zest and intensity of these experiences are no longer what they used to be. I am not vain enough to delude myself that I can in the few remaining years make an important discovery useful for mankind or can lead a social movement or do anything that will be historically eventful, no less event-making. My autobiography, which describes a record of intellectual and political experiences of some historical value, already much too long, could be posthumously published. I have had my fill of joys and sorrows and am not greedy for more life. I have always thought that a test of whether one had found happiness in one's life is whether one would be willing to relive it—whether, if it were possible, one would accept the opportunity to be born again.

Having lived a full and relatively happy life, I would cheerfully accept the chance to be reborn, but certainly not to be reborn again as an infirm octogenarian. To some extent, my views reflect what I have seen happen to the aged and stricken who have been so unfortunate as to survive crippling paralysis. They suffer, and impose suffering on others, unable even to make a request that their torment be ended.

I am mindful too of the burdens placed upon the community, with its rapidly diminishing resources, to provide the adequate and costly services necessary to sustain the lives of those whose days and nights are spent on mattress graves of pain. A better use could be made of these resources to increase the opportunities and qualities of life for the young. I am not denying the moral obligation the community has to look after its disabled and aged. There are times, however, when an individual may find it pointless to insist on the fulfillment of a legal and moral right.

What is required is no great revolution in morals but an enlargement of imagination and an intelligent evaluation of alternative uses of community resources.

Long ago, Seneca observed that "the wise man will live as long as he ought, not as long as he can."<sup>1</sup> One can envisage hypothetical circumstances in which one has a duty to prolong one's life despite its costs for the sake of others, but such circumstances are far removed from the ordinary prospects we are considering. If wisdom is rooted in knowledge of the alternatives of choice, it must be reliably informed of the state one is in and its likely outcome. Scientific medicine is not infallible, but it is the best we have. Should a rational person be willing to endure acute suffering merely on the chance that a miraculous cure might presently be at hand? Each one should be permitted to make his own choice—especially when no one else is harmed by it.

<sup>1</sup>Seneca (4 B.C.E.–65 C.E.) lived in Rome and taught a philosophy known as Stoicism, which advocated duty, self-discipline, and adherence to the natural order of things.

The responsibility for the decision, whether deemed wise or foolish, must be with the chooser.

## MATTHEW E. CONOLLY

### *Euthanasia Is Not the Answer*

*Matthew E. Conolly, a professor of medicine at UCLA, delivered this speech before a 1985 conference sponsored by the Hemlock Society, an organization that advocates voluntary euthanasia.*

FROM THE moment of our conception, each of us is engaged in a personal battle that we must fight alone, a battle whose final outcome is never in any doubt, for, naked, and all too often alone, sooner or later we *all* must die.

We do not all make life's pilgrimage on equal terms. For some the path is strewn with roses, and after a long and healthy life, death comes swiftly and easily; for others it is not so. The bed of roses is supplanted by a bed of nails, with poverty, rejection, deformity, and humiliation the only lasting companions they ever know.

I know that many people here today carry this problem of pain in a personal way, or else it has been the lot of someone close to you. Otherwise you would not be here. So let me say right at the outset, that those of us who have not had to carry such a burden dare not criticize those who have, if they should plead with us for an early end to their dismal sojourn in this world.

## HARD CASES MAKE BAD LAWS

Society in general, and the medical profession in particular, cannot just turn away. We must do *something*; the question is—what?

The “what” we are being asked to consider today, of course, is voluntary euthanasia. So that there be no confusion, let me make it quite clear that to be opposed to the active taking of life, one does not have to be determined to keep the heart beating at all costs.

I believe I speak for all responsible physicians when I say that there clearly comes a time when death can no longer be held at bay, and when we must sue for peace on the enemy's terms. At such a time, attending to the patient's comfort in body, mind, and soul becomes paramount. There is no obligation, indeed no justification, for pressing on at such a time with so-called life-sustaining measures, be they respirators, intravenous fluids, CPR, or whatever. I believe that there is no obligation to continue a treatment once it has been started, if it becomes apparent that it is doing no good. Also,

withholding useless treatment and letting nature take its course is *not* equivalent to active euthanasia. Some people have attempted to blur this distinction by creating the term “passive euthanasia.” The least unkind thing that can be said about this term is that it is very confusing.

Today’s discussion really boils down to the question—do hard and tragic cases warrant legalization of euthanasia? There can be no doubt that hard and tragic cases do occur. However, the very natural tendency to want to alleviate human tragedy by legislative change is fraught with hazard, and I firmly believe that every would-be lawmaker should have tattooed on his or her face, where it can be seen in the mirror each morning, the adage that **HARD CASES MAKE BAD LAWS**.

If we take the superficially humane step of tailoring the law to the supposed wishes of an Elizabeth Bouvia (who, incidentally, later changed her mind),<sup>1</sup> we will not only bring a hornet’s nest of woes about our own ears, but, at a stroke, we will deny many relatives much good that we could have salvaged from a sad situation, while at the same time giving many *more* grief and guilt to contend with. Even worse, we will have denied our patients the best that could have been offered. Worst of all, that soaring of the human spirit to heights of inspiration and courage which only adversity makes possible will be denied, and we will all, from that, grow weaker, and less able to deal with the crisis of tomorrow.

#### UNLEASHING EUTHANASIA

Let’s look at these problems one by one. The first problem is that once we unleash euthanasia, once we take to ourselves the right actively to terminate a human life, we will have no means of controlling it. Adolf Hitler showed with startling clarity that once the dam is breached, the principle somewhere compromised, death in the end comes to be administered equally to all—to the unwanted fetus, to the deformed, the mentally defective, the old and the unproductive, and thence to the politically inconvenient, and finally to the ethnically unacceptable. There is no logical place to stop.

The founders of Hemlock no doubt mean euthanasia only for those who feel they can take no more, but if it is available for one it must be available for all. Then what about those precious people who even to the end put others before themselves? They will now have laid upon them the new and horrible thought that perhaps they ought to do away with themselves to spare their relatives more trouble or expense. What will they feel as they see their 210 days of Medicare hospice payments run out, and still they are alive. Not long ago, Governor Lamm of Colorado suggested that the old and incurable have a *duty* to get out of the way of the next generation. And can you not see where these pressures will be the greatest? It will be amongst the poor

<sup>1</sup>Elizabeth Bouvia, chronically ill with cerebral palsy and crippling arthritis, was well known in the 1980s for her legal battles for the right to starve herself to death while she was hospitalized.

and dispossessed. Watts will have sunk in a sea of euthanasia long before the first ripple laps the shore of Brentwood. Is that what we mean to happen? Is that what we want? Is there nobility of purpose there?

It matters to me that my patients trust me. If they do so, it is because they believe that I will always act in their best interests. How could such trust survive if they could never be sure each time I approached the bed that I had not come to administer some coup de grace when they were not in a state to define their own wishes?

Those whose relatives have committed more conventional forms of suicide are often afterwards assailed by feelings of guilt and remorse. It would be unwise to think that euthanasia would bring any less in its wake.

#### A BETTER WAY

Speaking as a physician, I assert that unrelieved suffering need never occur, and I want to turn to this important area. Proponents of euthanasia make much of the pain and anguish so often linked in people's minds with cancer. I would not dare to pretend that the care we offer is not sometimes abysmal, whether because of the inappropriate use of aggressive technological medicine, the niggardly use of analgesics, some irrational fear of addiction in a dying patient, or a lack of compassion.

However, for many, the process of dying is more a case of gradually losing life's moorings and slipping away. Oftentimes the anguish of dying is felt not by the patient but by the relatives: just as real, just as much in need of compassionate support, but hardly a reason for killing the patient!

But let us consider the patients who do have severe pain, turmoil, and distress, who find their helplessness or incontinence humiliating, for it is these who most engage our sympathies. It is wrong to assert that they must make a stark choice between suicide or suffering.

There is another way.

Experience with hospice care in England and the United States has shown repeatedly that in *every* case, pain and suffering can be overwhelmingly reduced. In many cases it can be abolished altogether. This care, which may (and for financial reasons perhaps must) include home care, is not easy. It demands infinite love and compassion. It must include the latest scientific knowledge of analgesic drugs, nerve blocks, antinausea medication, and so on. But it can be done, it can be done, it can be done!

#### LIFE IS SPECIAL

Time and again our patients have shown us that life, even a deformed, curtailed, and, to us, who are whole, an unimaginable life, can be made noble and worth living. Look at Joni Earickson—paraplegic from the age of seventeen—now a most positive, vibrant and inspirational person who has become world famous for her triumph over adversity. Time and time again, once

symptoms are relieved, patients and relatives share quality time together, when forgiveness can be sought and given—for many a time of great healing.

Man, made in the image of his Creator, is *different* from all other animals. For this reason, his life is special and may not be taken at will.

We do not know why suffering is allowed, but Old and New Testament alike are full of reassurances that we have not been, and will not ever be, abandoned by our God. “Yea, though I walk through the valley of the shadow of death, I will fear no evil *for thou art with me.*” 20

#### CALL TO CHANGE DIRECTION

Our modern tragedy is that man has turned his back on God, who alone can help, and has set himself up as the measure of all things. Gone then is the absolute importance of man, gone the sanctity of his life, and the meaning of it. Gone too the motivation for loving care which is our responsible duty to the sick and dying. Goodbye love. Hello indifference.

With our finite minds, we cannot know fully the meaning of life, but though at times the storms of doubt may rage, I stake my life on the belief that to God we are special, that with Him, murder is unacceptable, and suicide (whatever you call it) becomes unnecessary.

Abandon God, and yes, you can have euthanasia. But a *good* death it can never be, and no subterfuge of law like that before us today can ever make it so.

My plea to the Hemlock Society is: Give up your goal of self-destruction. Instead, lend your energy, your anger, your indignation, your influence and creativity to work with us in the building of such a system of hospice care that death, however it come, need no longer be feared. Is not this a nobler cause? Is not this a better way?

#### A Sample Exploratory Essay

##### *Exploring the Issue of Voluntary Euthanasia*

THE QUESTION I am exploring is whether active euthanasia—assisted suicide—should be legalized as it is in some foreign countries, such as the Netherlands. Debate on this issue has been stirred by the activities of a Michigan pathologist, Jack Kevorkian, who is under criminal indictment for helping several terminally or chronically ill Americans to take their own lives. The arguments that I read are devoted exclusively to the kind of euthanasia in which the patient is conscious and rational enough to make a decision about terminating his or her life. 1

I encountered two basic positions on this issue. Sidney Hook, a philosopher, represents the view that assisted suicide should be a legal option for the patient. After recovering from a life-threatening illness, Hook decided that



each patient must “be permitted to make his own choice” and to ask that his or her suffering be ended (60). The other two writers take the opposing view that legalizing active euthanasia is bad social policy. However, their positions differ slightly. Matthew Conolly, a professor of medicine, argues that even the most extreme and tragic cases do not justify legalizing assisted suicide. His view is that proper medical and hospice care totally eliminates suicide as the only alternative to suffering. William May qualifies his opposition to active euthanasia by adding that in extreme cases it would be moral to break the law and to help someone die.

One question all three writers address is whether a patient’s suffering justifies giving him or her the right to choose death. Hook argues that suffering can be too horrible to bear, and he supports this reason convincingly with evidence from his own experience with heart failure and stroke. The other writers counter by trying to see some inherent value in suffering. Both argue that it brings out distinctively human virtues, such as courage and patience. I find Hook more convincing on this question; an intelligent man, he did not “soar to heights of inspiration” as Conolly puts it (62), but rather felt he was “drowning in a sea of slime” as pleurisy filled his lungs (59). I agree that humans do have great capacity to carry on in spite of adversity, but that does not mean we should demand that they bear it. Their genuine feelings, from my own observations of dying relatives, are more likely fear and impatience, even self-pity.

The writers on both sides agree that the effects on loved ones of a patient’s suffering are terrible. Hook offers this as the second of his two reasons for active euthanasia, claiming that his family’s life during his illness was “a grim round of misery” (59). Conolly agrees that the family may feel more anguish than the patient (63). However, when he says that this grief does not justify “killing the patient,” he overlooks that the patient would be the one making the choice. And the life the patient is sacrificing for the sake of loved ones is not one he or she finds worth living.

All three writers also touch upon the relationship between the larger community and those within it who are sick and dying. Conolly and May see these people in terms of how they benefit the community, while Hook sees them in terms of what they cost. Conolly and May argue that a civilized society must accept its duty to care for the sick and dying. In this sense, having the sick and dying around gives society a chance to practice a virtue that is in too short supply as it is. Legalizing assisted suicide would make it all too easy for our society to further ignore its duty; as May says, we would “kill for compassion only to reduce the demands on our compassion” (58). He is right that Americans do not have a good record on compassion for the elderly. Typically, ailing grandparents are institutionalized rather than cared for in the homes of family. And as Conolly points out, the poor suffer the most from our society’s indifference (62–63). But to argue as May does that a society needs to have sick and dying members in order to bring forth the virtues of caring and compassion asks too much of the sick and dying. It is like saying

that we need to have the poor around in order to give the rich an opportunity to be charitable.

Hook agrees that the community has a “moral obligation” to “look after its disabled and aged” (60). But he sees these people more as a burden on community resources; caring for them can become costly, reducing the quality of life for the rest, especially the young. I admire the selflessness of this man, but his argument makes me ask, Is it right to let individuals choose to sacrifice themselves for the sake of the rest?

The answer to this question turns upon one other question that all three writers take up: How freely could one make the choice to die? Hook seems to assume that the choice for everyone would be as unpressured as he feels it would be in his case. But he wrote his argument as an old man with a highly successful life behind him—a man who had enjoyed so much he was in a position to be generous with his life. I tend to agree with Conolly that in poor families, guilt may replace generosity as the motive when insurance or Medicare funds run out (62). And May argues that elderly people who have lived alone or in institutions for years may choose death out of sheer despair (58). It is as if the whole society has coerced them into dying.

Hook, Conolly, and May touch on other points in common, but the preceding strike me as the questions most central to the debate. I approached this topic with an inclination to take a position in favor of legalizing assisted suicide. These readings made me see that this policy may bring with it certain dangers.

I agree with Conolly that the medical profession could do more to reduce the suffering of the terminally ill, and I agree with May that society needs to become more compassionate and responsible for quality of life among the aged and terminally ill. However, I do not see either of these desirable goals as alternatives to the option of active euthanasia. Extreme cases of suffering will continue, and they are not as rare as Conolly implies.

However, Conolly and May helped me to see that the apparent individual freedom of choice involved in assisted suicide may be an illusion, so I would want to qualify my position to include a process whereby the courts would be involved to protect the interests of the dying patient. This step may prolong the process of obtaining relief, but I think it ensures justice. Assisted suicide should be a choice, but it must involve more than simply patient, family, and doctor.

## USING INQUIRY BY PEERS IN WRITING AN ARGUMENT

After some research into a topic you are preparing to write about, you will find that inquiry by your peers can help you reach a position you can defend. We will illustrate how inquiry works in class discussion with an ex-