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Book Review

'NEW DIRECTIONS IN THE ETHICS OF ASSISTED SUICIDE AND EUTHANASIA' BY MICHAEL CHOLBI AND JUKKA VARELIUS (EDS.)

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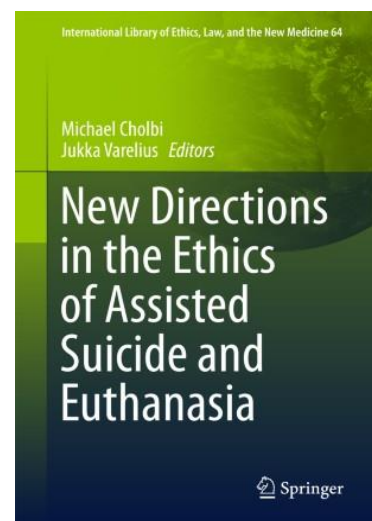
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Euthanasia and physician-assisted suicide are barely fresh subjects on the human agenda. Although the vocation of medicine has long deprecated such practices - all the way back to Hippocrates - and even despite the fact that opposition to them has been endorsed time and again in different epochs and in divergent societies, they have indefatigably sidled behind the scenes. One rationale behind euthanasia debate emerging now in industrialized Western countries than ever before is the recent astonishing medical successes that have prolonged our life span and altered the diseases from acute to chronic ones. For the reason that euthanasia is a theme of debate, it matters how we address that debate. Frequently this debate revolves around what is required to reverence dying people. We have moved from a stage of true simplicity concerning how our societies should handle human death to one of chaos, which is the context of the euthanasia debate. We have shifted to a point where we will appreciate the intricacy and conundrum of death, which precisely echoes the convolution and mystery of human life. Our decisions at this juncture are ones that acknowledges the mystery of



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our humanness, while apprehending the torment of terminally ill and dying people and our most somber obligations to address it.

The present book 'New Directions in the Ethics of Assisted Suicide and Euthanasia' is intended to be appurtenant in terms of comprehending the unfolding history of the euthanasia debate and how advocacy of its legalization shifted from being a "peripheral" issue, even in the early 1980s, to becoming the epicenter of a fundamental ethical and legal debate linking the larger society in most Western democracies by the end of the twentieth century. This is a book series of International Library of Ethics, Law and the New Medicine which encompasses volumes with an international and interdisciplinary focus. The avowed aim of the Series from Springer is to publish books on foundational issues in (bio) ethics, law, international health care and medicine. The book in review has been edited by Michael Cholbi & Jukka Varelius. Michael Cholbi is Professor of Philosophy at California State Polytechnic University, Pomona. He has published widely on the ethics of suicide, as well as on paternalism, Kantian ethics, and death and dying. He is a founding member of the International Association for the Philosophy of Death and Dying (IAPDD). Jukka Varelius is a Research Fellow at the Department of Behavioural Sciences and Philosophy at the University of Turku, Finland. His work focuses on issues of applied ethics.

With an introduction, Cholbi & Varelius have assorted thirteen compelling chapters of diverse intellectual flavours that provide narratives on the ethical tenability of assisted dying. The ethical connotation of euthanasia is inexorably coupled with the way that we recognize the value of life and what it is to espouse and protect that value. In quest to go beyond conventional debates on topics like the value of human life and questions contiguous to intention and causation, this volume has attempted to shift the topography of the ethical debates about assisted dying. It reassesses the position of patient autonomy as well as the part projected for medical professionals and clinical ethics consultation in connection with assisted dying, communicates the debate on assisted dying to questions about organ-donation and progresses in medical technology, and displays the implication of experimental philosophy in evaluating questions of assisted dying. This book can be relevant for advanced courses in bioethics and health care ethics.

Since intensive care and life support technologies facilitated medical professionals to prolong, or even arrest, the process of biological death or in a nutshell being able to 'medicalize' death, these developments tend to put death and dying within the compass of human agency. The current debate about assisted dying predominantly spins around the cardinal enquiry of who may exercise such agency and under what circumstances. Physician-assisted dying therefore became, along with abortion and research abuse, one of the innermost topics driving contemporary bioethics. Medical professionals, philosophers, ethicists, theologians, and legal scholars have engendered a wide assemblage of cerebral literature on assisted dying. In the introductory chapter, the editors have nevertheless identified four central threads in the debates laid out in this enormous array of literature.

The first of these, centers on the ethical norms that administer the behavior of medical professionals and the reconcilability of those norms with physician-assisted death. Given that, medicine has been traditionally defined by an unequivocal moral norm against doctors killing their patients or facilitating their patients to kill themselves, this view necessitates that whatsoever the other intrinsic worth of assisted dying, sanctioning physicians either to assist in their patients' deaths or to kill their patients is too great a departure from this norm. Adherents of physician-assisted death maintain that this interpretation of medical morality is a gross misrepresentation. Appropriate ethical norms for medical professionals involve, campaigners of physician-assisted death assert, that when a patient's suffering is intolerable to him and there is no way of

satisfactorily allaying it other than ending his life a doctors are required to stick on to the patient's appeal to be helped to die.

A second thread in this debate pertains to the nature of a person's participation in bringing about another person's death. Here antagonists of physician-assisted dying call upon quite a few diverse distinctions. One is the distinction between killing and letting die. Antagonists of physician-assisted dying assert that doctors may let a patient die, but may not kill a patient. Physician-assisted dying is thus ruled out, but mechanisms through which a patient dies due to the progress of her illness are not. A second seemingly pertinent distinction is between acts and omissions: When a doctor lends a hand to the patient to die, the death results from the doctor's direct act, whereas for example when a doctor does not administer potentially life prolonging treatment to a patient who knowledgeably declines the treatment, the death results from the doctor's omission, that is, from the doctor from abstaining from acting. The former, it is argued, is ethically impermissible, the latter ethically permissible. A third distinction is associated with the Doctrine of Double Effect, is between death being intended as a result of one's actions and death's being simply a foreseen outcome of one's actions. All three of these distinctions engage various ways in which an exercise of agency can bring about another person's death.

The third thread in debates about assisted dying pertains to how respect for patient autonomy and beneficence shape the ethical and lawful acceptability of physician-assisted death. Just as with the preceding two threads, the third thread of the modern debate remains debatable. For supporters of physician-assisted death, the validation of physician-assisted dying that has already occurred within some jurisdictions appears as the 'victory of autonomy' in bioethics and public policy. Yet challengers of physician-assisted death maintain that the two principles are far too esoteric and too little in number to effectively account for all the involvedness, shades and vagueness related to palpable end-of-life decision-making. With respect to autonomy, they clash on whether the conditions for informed, cogent consent to one's own death can be achieved and whether the worth of autonomy should be accorded predominantly in medical decision making. With respect to beneficence, antagonists of physician-assisted dying question whether, given the value characteristically tied to human life, ending a person's life can in actuality be a beneficent act! Moreover, they argue that much more research concerning the principles, potential alternative starting points for evaluating questions allied to physician-assisted death, and the particular features of the kinds of cases in which end-of-life choices would be made is required for it to be possible to sufficiently assess the ethical and legal suitability of physician-assisted death. For proponents of physician-assisted death, more research is basically a plan by which opponents of physician-assisted death try to hold on to the status quo in which the measures remain illegitimate in most jurisdictions. In this view, the purpose of opponents of physician-assisted death is to guarantee that the ethical and legal adequacy of such procedures remains under incessant inquiry.

A final thread in these debates is less about physician-assisted dying per se than about the envisaged consequences of its legalization or approval. Opponents of physician-assisted dying may forfeit that euthanasia or assisted suicide are ethically permissible if carried out voluntarily, etc., but nonetheless argue that the recognition of such practices would weaken our common respect for human life and the proscription on killing. As a result, other more ethically offensive practices, like involuntary euthanasia or the murder of the disabled, would emerge. Such slippery slope qualms mirror anxieties about societies' capacity to put into practice physician-assisted dying without inviting maltreatment or deterioration of ethical standards. While the claims that allowing physician-assisted death would have distressing societal consequences were once tricky to appraise, the legalization of the trials within some jurisdictions has enabled the possibility of conducting empirical studies by which to evaluate such assertions.

The editors have deciphered three possible conjectures emanating from such ethical dilemmas. In a pessimistic view, the arguments put forth by proponents and opponents of physician-assisted death are in numerous respects so dissimilar from each other that their achieving any concurrence is almost impracticable and hence interminable. A moderate view involves that even though the two parties in the debate will keep on supporting differing points linked to end-of-life questions a realistic conciliation that suits both of them can be brought into being. In the most optimistic view, additional investigation into the relatable questions will eventually lead to a complete cogent resolution of the debate. But it is better to state here that the present collection of different essays takes no stance on which of these three diagnoses is correct. Rather they claim that taking a wider range of perspectives, substantiation, and arguments into account may facilitate us see assisted dying in a new perspective, and more confidently, help to resolve which of the above three positions is tenable. The present volume has reasonably attempted to address the issue with that purpose in mind, to showcase erudition that probes the ethics or legality of physician-assisted dying from unblemished points of view and will refine respective positions accordingly.

Engaging in scholarships of different dimensions, the second three chapters raise defiance to what has become possibly the most widespread resistance of physician-assisted dying, that individuals are autonomous and so have the right to settle on the manner or circumstances of their deaths, counting a right to solicit the help of others to bring about their eventuality. Emma C. Bullock (“Assisted Dying and the Proper Role of Patient Autonomy”) considers the function of patient autonomy in extenuating physician-assisted dying. Bullock warns us that the fact that a patient autonomously decides to die does not necessitate that dying is in her best interests. Conversely, evidence from psychology and behavioral economics indicates that we often fall short to make coherent and autonomous choices. Bullock proposes that the place of autonomy is consequently not to dish up an index of a patient’s concern in dying. Rather, autonomy is better seen as a “side constraint” that allows physician-assisted dying when it is also analytically in the patient’s best interests. Thomas Schramme (“Preventing Assistance to Die: Assessing Indirect Paternalism Regarding Voluntary Active Euthanasia and Assisted Suicide”) deals with a variation of paternalist argument: that there may be “indirect” paternalistic grounds for intruding with aid in some suicides even if there are not justifiable grounds for prying with the suicidal acts themselves. Schramme notes that the overture of a third-party involvement into the equation obscures the principal ethical issues, particularly given the likelihood that suicidal individuals may not have a defensible prerogative to assistance in dying. Eventually, Schramme concludes that the circuitous paternalist argument does not do well in showing that suicidal individuals cannot have a right to the support of others. For such individuals may authentically need such support in order to exercise their right to die and those who provide it are facilitating suicidal persons to pursue the ethically legitimate end of curtailing their own anguish and misery. Julian Savulescu (“Autonomy, Interests, Justice, and Active Euthanasia”) shares Bullock’s cynicism regarding the power of autonomy to substantiate physician-assisted dying in a clear-cut way. In his judgment, appeals to autonomy do not show that those who wish to be assisted to die have a claim to active euthanasia on the part of medical expert. Savulescu also contends that patients who voluntarily endure palliated starvation, supposing that this is in their best interests, have a right to do so on the basis of their respect for autonomy. But in such cases, a person may well die more speedily, and in so doing make use of lesser medical resources, if she were to suffer active euthanasia. The appropriate ethical basis for active euthanasia is consequently respect for autonomy in concert with distributive justice, according to Savulescu.

Chapters 5–7 attempt to expand the existing debate into an exceedingly contentious area, physician-assisted dying for those afflicted with mental illness or suffering. In “Mental Illness, Lack of Autonomy, and Physician-assisted Death,” (Chapter 5) Jukka Varelius argues that

physician-assisted suicide could be ethically allowable for psychiatric patients in front of excruciating and untreatable suffering, even if those patients be deficient in the autonomy to opt for assisted dying. Varelius recommends that lacking autonomy need not be a critical reason to rebut assisted suicide to such individuals, for that autonomy is not to be appreciated for its own sake but because autonomous choices are expected to mirror individuals' idea of how their lives ought to go. He also proposes that the suffering of non-autonomous patients can be ethically more important than that of autonomous patients. In view of that, non-autonomous patients with intolerable and untreatable suffering have convincing reasons to seek to end their lives that an autonomous person would give his support to. Kasper Raus and Sigrid Sterckx ("Euthanasia for Mental Suffering" Chapter 6) consider whether a right to euthanasia can be extended to individuals with physical suffering without also extending a similar right to patients with mental suffering, which they define as suffering that is not caused by any diagnosable physical or psychiatric condition. As they see it, there is no a priori basis for denying the right to euthanasia to individuals in the latter category given that their suffering is not crucially different from the physical suffering often thought to justify euthanasia. That said, Raus and Sterckx are reluctant to endorse euthanasia for mental suffering, in part because if it were administered by medical personnel, it would amount to treating mental suffering as medical in nature. Dementia is another condition where questions about the justifiability of physician-assisted dying have been raised. In chapter 7, Jocelyn Downie and Georgia Lloyd-Smith ("Assisted Dying for Individuals with Dementia: Challenges for Translating Ethical Positions into Law") investigate whether those with dementia would be able to access assisted dying within the various jurisdictions that presently permit it. They find that despite many individuals reporting that they would want access to assisted dying were they to develop dementia, the very features of the laws that license physician-assisted dying for other conditions often preclude its being available for dementia. For example, dementia patients are not terminally ill until late in the progression of their disease, have suffering that is primarily mental or existential rather than straightforwardly physical, often lack competence, and are unable to communicate their wishes. Downie and Lloyd-Smith conclude with a critical examination of a recent legislative proposal in Canada that may provide wider access to physician-assisted dying for those with dementia.

The next three chapters raise novel questions about the ethical responsibilities of clinicians with respect to physician-assisted dying. David M. Adams in Chapter 8 ("Clinical Ethics Consultation and Physician-assisted Suicide") starts from the fact that nowadays, many key care decisions made in medical settings involve professional consulting ethicists. Consulting ethicists typically assist family members, patients, and medical personnel in deliberating about morally complex care decisions. Adams proposes that currently accepted conceptions of the aims and principles meant to guide clinical ethics consultation are deficient when it comes to consultation regarding physician-assisted suicide. According to these conceptions, clinical ethicists are to provide counsel on the basis of current law, institutional policies professional standards, scholarly consensus, and prevailing practices. In the case of assisted suicide, current law and institutional policies are in flux, professional standards do not all align, and no scholarly consensus exists regarding the ethics of physician-assisted dying. In light of the unsettled legal and moral status of assisted suicide, Adams concludes that clinical ethicists must engage the relevant parties in a process of moral inquiry and deliberation aimed at reaching a shared agreement among them as to whether assisted suicide should be permitted in a given case. As noted above, much of the literature on physician-assisted dying is concerned with whether it is compatible with the established norms of the medical profession. In the next chapter, Richard Huxtable and Jonathan Ives ("Licence to Kill: A New Model for Excusing Medically Assisted Dying?") suggest a new way of thinking about this matter. Acknowledging that there are reasonable grounds both for permitting and prohibiting

physician-assisted dying, they propose a compromise or “middle way” that is novel in two respects. First, they suggest that only medical specialists trained in assisted dying (“thanatologists”) be allowed to assist patients to die. Secondly, rather than conferring prospective legal immunity on thanatologists when they participate in assisted dying, Huxtable and Ives suggest that thanatologists may be retrospectively excused for assisting in dying if certain conditions are met. In their estimation, this compromise may satisfy both advocates and opponents of physician-assisted dying insofar as it retains the presumption that physician-assisted dying is wrong but permits thanatologists to rebut this presumption in particular cases. “Medically Enabled Suicides,” in Chapter 10 by Michael Cholbi, considers whether medical professionals have an obligation to involve themselves in patient deaths even when their involvement does not take the form of direct assistance. Cholbi considers a category of suicides wherein individuals both intentionally put themselves in a particular physiological condition (for example, a planned drug overdose) and make use of existing treatment protocols, such as advance directives, that direct medical personnel to withhold or withdraw medical interventions. Such patients intentionally end their lives, and hence engage in suicide, when they die as a result of such protocols being honored. Cholbi proposes that these medically enabled suicides are likely to be attractive to those for whom assisted dying of the usual kind is not legally or practically feasible. He argues that neither the apparent harmfulness of suicide nor medical professionals’ conscientious objection to participating in their patients’ death are sufficient to show that such professionals may refuse to involve themselves in medically enabled suicides. Chapters 11 and 12 relate physician-assisted dying to other medical technologies or techniques. David Shaw in Chapter 11 (“Saving Lives with Assisted Suicide and Euthanasia: Organ Donation After Assisted Dying”) explores the benefits of allowing those who engage in physician-assisted dying to donate their organs and the force that such a possibility has in augmenting the case for legalizing physician-assisted dying. Doing so, Shaw argues, is harmless and would increase the number of organs available for transplant while ensuring that healthy tissues do not go to waste. Donating one’s organs after assisted dying also enables the dying to bear the burdens of death more easily. While Shaw is concerned with the ethical intersection of natural organ donation and end-of-life decisions, Michael Gill (“Implanted Medical Devices and End-of-Life Decisions” Chapter 12) addresses the ethics of deactivating artificial organs and other life-sustaining devices that have already been implanted in individuals. As Gill sees it, deactivating such organs or devices is unsettling because it brings two established tenets of medical ethics into conflict. On the one hand, deactivating such organs or devices seems like an example of withdrawing life-sustaining treatment, which many see (at least when done at the patient’s competent request) as morally equivalent to permissible withholding of medical interventions. On the other hand, deactivating these organs or devices harms patients, in violation of the bioethical principle that doctors may not intentionally harm their patients. Gill argues that the moral equivalence is sufficient to justify doctors deactivating these devices when competent patients refuse it, and the prohibition on harming patients is not sufficient to justify doctors refusing to participate in deactivation.

The final two chapters bring two recent developments in philosophical methodology to bear on assisted dying. In Chapter 13, Adam Feltz (“Everyday Attitudes about Euthanasia and the Slippery Slope Argument”) applies the methods of experimental philosophy to ascertain some common attitudes toward the ethics of euthanasia. In a pair of studies, Feltz found that describing euthanasia differently (as ‘euthanasia,’ ‘aid in dying,’ etc.) has rather modest effects on experimental subjects’ judgments regarding whether euthanasia is ethically permissible. Feltz also found that subjects’ judgments about its ethical permissibility were significantly influenced by whether the treatment was perceived as voluntary, an influence greater than general demographic differences and differences in more general moral judgments. In other words, test subjects

generally gave little credence to the distinction between active and passive euthanasia, but find euthanasia increasingly problematic the less voluntary it is. Feltz observes that subjects' ability to distinguish among degrees of voluntariness with respect to euthanasia suggests that a premise common in 'slippery slope' arguments against voluntary euthanasia—that individuals struggle to differentiate among voluntary, non-voluntary, and involuntary euthanasia—appears unfounded. In the final chapter, "You Got Me Into This...": Procreative Responsibility and its Implications for Suicide and Euthanasia," Rivka Weinberg mines the emerging field of procreative ethics for insights regarding the ethics of assisted dying. More specifically, Weinberg asks, on the assumption that assisted dying is at least sometimes morally permissible, who has the responsibility to assist a suicidal individual to die? Weinberg advances the thesis that parents may have a special responsibility to assist in light of (a) the risks that parents impose on the children they create (risks of suffering, unhappiness, etc.), risks the children do not agree to be exposed to, and (b) parental responsibilities to meet fundamental needs that children cannot meet at their own. While Weinberg acknowledges that many parents would find assisting a child to die emotionally taxing, she concludes that doing so reasonably falls within the sacrifices that parents are often obligated to make on their children's behalf.

The chapters of this volume cover topics that still leaves many angles on the ethics of assisted dying largely unaddressed, including its relationship to general societal, environmental, and technological questions and developments, such as the aging and growth of the human population, climate change and the sufficiency of food, air, and water, and innovations as regards human enhancement and environmental technology. The most discouraging prospect is that, in the future, an increasingly older, bigger, and sicker population of humans has to make do with a continuously decreasing stock of natural and other resources. Perhaps human enhancement or other technologies will ameliorate these problems. But even so, it is likely that the conceptions we now have about the value of human life and death will undergo some changes. Accordingly, these kinds of questions and developments can also be expected to affect our attitudes toward the moral and legal acceptability of physician-assisted dying. This volume demonstrates that plenty of philosophical and bioethical questions remain about assisted dying. Yet it is an issue that transcends the bounds of 'medical ethics' as it has traditionally been conceived.