Physician-Assisted Suicide in Theological Perspective[1]

Andrew Ball[2]

Physician-assisted suicide (PAS) and other forms of euthanasia are commonplace in the conversations and decisions surrounding end-of-life care in the United States. What was once considered a questionable practice "associated with the brutal activities of Adolf Hitler's Nazi Germany,"[3] has in our time become a matter of so-called *right*, *dignity*, *self-interest*, *choice*, and even *compassion* according to some of its most staunch proponents in modern western nations where PAS is legally practiced, such as Belgium and the Netherlands,[4] Luxembourg,[5] Switzerland,[6] Canada,[7] and the United States.[8]

There are many reasons why euthanasia, and in particular PAS, has become accepted as a viable end-of-life option. This essay is an attempt to explain those reasons and offer an assessment of them. It is fair to say that *all* of those reasons in the popular philosophical, public policy, and legal literature all boil down to one simple dictum: *one has the right to exercise one's autonomy and personal choice in order to achieve his or her best interests, no matter what that may mean*.

This has been the mantra of prominent so-called 'right-to-die' advocates, such as Derek Humphry, noted journalist and co-founder of The Hemlock Society (which has in recent years changed its name to *Compassion and Choices*, for obvious reasons), a public advocacy group for suicide. Humphry's widely popular 1991 book, *Final Exit*, was a how-to manual of sorts that instructed readers how to order their affairs and commit suicide – what Humphry called "self-deliverance"[9] – in a quick, efficient, painless, and not too messy way. In a follow-up book published the next year, Humphry laid out what he saw as the many reasons why it would be in one's interest to be euthanized, such as the

[2] Department of Humanities and English, Wallace State College, 801 Main Street NW, Hanceville, Alabama, 35077; email: andrew.ball@wallacestate.edu

[3] Ball 2012: 69; see also W.J. Smith 1997: 69-81 and especially Alexander 1949.

[4] Both formally decriminalized PAS in 2002. And both later approved it for minors with especially dire medical prognoses. See Chambaere 2010:895 and Gorsuch 2006:2.

[5] Pereira 2011: 38.

[6] Ibid.

[7] In 2012 the Supreme Court of Canada struck down laws that prohibited terminally ill patients from seeking physicians' aid in seeking death in, arguing that such laws violated the rights protected by the Canadian Charter of Rights and Freedoms; see *Carter v. Canada* (AG) 2012 SCC 5. Parliament responded with the *Medical Assistance in Dying Act* (S.C., 54-65 Elizabeth II, 2015-16).

[8] This essay will deal with euthanasia and PAS in the United States in detail below.

[9] Humphry 1992: 79.

> Dread of spending one's last days hooked up to equipment, bells, and buzzers while breathing and feeding through tubes, either through natural orifices or surgical slits; Reluctance to risk putting the family through long and draining court battles; Disillusionment with the effectiveness of the Living Will; A fear of losing control one's life and body as medical procedures gradually take over during an illness; A horror of spending one's final years in a nursing home with an unacceptable quality of life; Dread that the physician attending one in their final days is poorly trained in pain control, or has qualms about administering large doses of drugs because they will either cause addiction or indirectly bring about death; Concern that one may be among the 10% of dying people whose terminal pain cannot be managed without their being made zombies by massive doses of narcotics; Suspicion that the medical profession has become purely business and cares more about income than alleviating suffering; Fear that one's health insurance will run out just when one needs it most; *Finally, and probably most important, the desire to be in charge of one's life and the dying process*. Personal autonomy is extremely precious to many people, especially those who have considerable achievements behind them, and consider that they have led a full and useful life.[10]

For these reasons, Humphry claimed that "the right to die in the manner, at the time, and by the means that a competent adult wishes" is the "ultimate personal liberty."[11]

But if Humphrey was really right about this, if suicide were such a valued liberty, then why are we so distressed when we hear that a friend, acquaintance, or coworker has committed suicide? Why do we wish that we'd known they were on the brink of it? Why do we regret not extending at least one more simple word of encouragement that might have influenced their fate differently, wishing that we would have made a visit or phone call? And, of course, why do we not celebrate their autonomous exercise of this choice as a personal achievement on their part in the way we celebrate those who complete marathons or hikes to the summit of Mt. Everest? Rather, we typically mourn the deaths of suicide victims worse that we do the deaths of those who die of other causes, maybe because we tend to feel like we could have done something to stop it. Daniel Callahan puts it well: "it is very hard to feel good about suicide or to rejoice that it was the way chosen to get out of a burdensome life."[12] Popular reaction to recent high-profile suicides in testify to this. No one is celebrating the suicides of celebrities Robin Williams, Anthony Bourdain, or Kate Spade. Our practices reveal what we really think about this. And, truthfully, we don't like it.

But at the same time, we are inconsistent in our dislike of it. A recent Gallup poll, for instance, showed that only 18% of America approved of suicide, yet a majority 57% approved of PAS. [13] This is a remarkable difference. What accounts for it? Is it the white-coats? That is, is there something about suicide that when shrouded in the professional attire of a medical practitioner it now possesses an aura of legitimacy and authority? Furthermore, is it the case that because some states have now legalized its practice, it no longer seems as taboo?

One crucial point to note is the influence of celebrity and mass media. When PAS was a popular social policy topic of conversation in the mid-nineties,[14] popular culture was inundated by pro-euthanasia messages. Wesley Smith wrote in 1997 that

> Television shows often deal with the issue, almost always presenting hastened deaths in a sympathetic light as the "only" choice available to alleviate a desperate patient's suffering. Popular television series such as ER, Homicide, Chicago Hope, Star Trek: Deep Space Nine, Star Trek Voyager (in which we learn that Vulcans like Mr. Spock practice a ritual suicide in old age), and Law and Order, just to name a few, all have aired episodes dealing positively with the theme of hastened death.

[10] Humphry 1992: 32-34 (*emphasis* mine).
[11] Humphry 1992: 22.
[12] Callahan 2005: 181.
[13] Jones 2017.
[14] See Vanderpool 1997 for a good history of the euthanasia explosion of the 1990s.

Today we have moved beyond the 90s prerogative of encouraging its legalization and now support its actual practice and our continual so-called social duty to facilitate such a choice for those who seek it. 2016 saw the release of the William Brothers film *Me Before You*, a lighthearted romantic drama about a twenty-something paraplegic man that closely befriends a young woman who has been hired to help him with routine daily activities. But after a few months he decides that he can no longer bear to live such a limited, confined life and says his goodbyes before heading to Switzerland where he seeks out the services of Dignitas, an actual real-life non-profit euthanasia provider in Switzerland. The moral of the story presented in the movie is that even though you love and care for these people, they live in difficult circumstances and have to make their own decisions and, thus, you have to accept it or else you are not supporting them adequately. In real life, this is exactly what happened in the recent high-profile Oregon PAS case of Brittany Maynard, a 29-year-old California woman who was diagnosed with an aggressive brain tumor and subsequently moved to Oregon to take advantage of its permissive PAS laws. This case is important because her personal story was "widely documented in TV interviews and popular magazines" and had the effect of turning the nation into a bastion of supporters.[15]

In what follows, I will argue for the moral impermissibility of PAS and, really, all forms of euthanasia. First, I define the important terms relevant to the issue. After that, I sketch a very basic history of the cases that have shaped the PAS debate, especially in regard to what the American courts and various states have said about the issu. Next, I'll discuss those various states that have legalized it and how they regulate the practice. After that, I lay out some of the practical problems with its actual practice and then discuss the reasons and rationale that are often put forward in favor it. The rest of the essay will deal with it from a biblical-theological perspective, laying out a theological case for why *all* forms of human *euthanasia* are contrary to biblically-informed moral practice and then why the philosophical arguments in favor of it are wrong. Lastly, I'll discuss how the church should think about two specific issues regarding end of life care: the proper time to refuse treatment and the importance of holistic end-of-life care which has become very common in modern palliative care practices.

Here is a table of contents to help you navigate this paper:

[15] Bever 2014; Personally, I recall people's social media posts at the time expressing things such as, "safe passage, Brittany," "Thank you for a beautiful life," "You are so courageous, Brittany," and other similar sentiments.

1. DEFINING THE TERMS

Before getting into too many details of our topic, several things need to be defined, with one important caveat: the following definitions are not held uniformly by the philosophers, bioethicists, and the physicians who work on these issues. There are varying degrees of nuance to each of them. And, interestingly, this makes some people more apt to hold certain positions rather than others – all due to how they understand and define the concepts and issues that are part of this debate. But the following best represents my own preferred way of defining the concepts.

Euthanasia literally means a "good death." Modernly construed, it is the practice of killing a person whose life is not worth living and would thus be "better off dead than alive,"[16] not out of spite or malice, but "for merciful reasons."[17] Many pet owners have had the unfortunate experience of having to euthanize Fido out of mercy for him in times of intense pain and suffering. The important question for us is whether or not we should treat Fred and Fran like Fido.

Voluntary Euthanasia. This is a euthanasia where the person to be euthanized requests death for him or herself.[18] They volunteered for it in such a way that explicitly conveyed their *consent* to being euthanized.

Nonvoluntary Euthanasia. This happens when the person being euthanized "is unable to indicate whether or not he or she wants to undergo euthanasia."[19] This may be due to a coma, or a persistent vegetative state (PVS), or some other malady that has caused an absence of consciousness. This particular category has caused a lot of concern for the courts, especially in regard to whether or not someone else may make such a choice on a patient's behalf.

Involuntary Euthanasia. This is a euthanasia forced on a patient who does not want to be euthanized, but "wants to go on living."[20] Here, the patient "explicitly refuses to be killed, and his or her request is not honored."[21]

Active and Passive Euthanasia. These two categories are controversial and problematic. Most experts will define *passive* euthanasia as a death that is brought about by the refusal or withdrawal of life-saving or -sustaining treatment, such removing a patient's ventilator, feeding tube, hydration, or medication. I would argue, however, that such a passive killing is still a *killing* since it is an "intentionally fatal withholding"[22] in order that the patient may "die naturally"[23] from "whatever ills already afflict him."[24] *Active* euthanasia, on the other hand, is also an intentional killing but differs from the former in that the *act* itself of killing, not the underlying disease or ailment, is the cause of death.[25] The best way to distinguish active and passive euthanasia is to imagine what the cause of death would be on the death certificate of the deceased. A PVS patient who dies after his or her ventilator is shut off, or feeding tube removed, would be declared dead as a result of the underlying physical maladies that required the use of those treatments to begin with. They were euthanized *passively*. The same patient, however, who died after an injection of potassium chloride was inserted into the intravenous therapy (IV) tube connected to her arm would, seemingly, be declared dead as a result of poisoning. This is a clear case of active euthanasia.

[16] Tooley: 2005: 161.
[17] Pence 2015: 31.
[18] Dyck 2002: 32.
[19] Tooley 2005: 161.
[20] Ibid.
[21] Stewart et al 1998: 25.
[22] Ibid., 24
[23] Dyck 2002: 32
[24] Rachels 1986: 107.
[25] See Ibid; Dyck 2002: 32; Stewart et al 1998: 22.

There are at least three problems with the 'active' and 'passive' categories. For one, it is not clear that all instances of passive euthanasia are merely *passive*. For our purposes, let's call this the *classification problem*. Judith Jarvis Thomson puts this problem well in what she calls "disconnecting cases"[26] where "the doctor who disconnects does not stand by, doing nothing, [but] positively intervenes – she shuts off, or removes the patient from, the equipment that is keeping [the patient] alive."[27] As Thomson argues, there's nothing "passive" about this at all. The physician here *actively does something* that brings about the patient's death.

> No doubt the patient who is disconnected dies of the disease because of which he needed life-saving equipment, but does the doctor who disconnects him merely *let* this happen? Does she merely "let nature take its course"? If the patient is currently being kept alive by (as it might be) a respirator, then nature's taking its course is currently being prevented by the respirator. The doctor who disconnects him from the respirator removes what is preventing nature from taking its course. She intervenes – and seems to be most plausibly seen as not merely letting nature take its course but rather causing it to. If I knock out the main beam that is currently preventing the fall of a roof, I do not merely let gravity take its course and the roof therefore fall on those locked in the house. I intervene – I cause gravity to take its course. Plainly, if the doctor disconnects the patient, the patient dies sooner than he otherwise would, just as if I knock out the main beam, those locked in the house die sooner than they otherwise would.[28]

Secondly, a problem arises for the one who thinks that the *moral* difference between active and passive euthanasia is parasitic on what is thought to be the *metaphysical* difference between *killing* and *letting die*, respectively. James Rachels argues that such a metaphysical difference between killing and letting die makes no moral difference at all, but rather, implies a moral "equivalence" such that "if one is permissible (or objectionable), then so is the other, and to the same degree."[29] Consider his famous two cases:

> In the first, Smith stands to gain a large inheritance if anything should happen to his six-year-old cousin. One evening while the child is taking his bath, Smith sneaks into the bathroom and drowns the child, and then arranges things so that it will look like an accident. In the second, Jones also stands to gain if anything should happen to his six-year-old cousin. Like Smith, Jones sneaks in planning to drown the child in his bath. However, just as he enters the bathroom Jones sees the child slip and hit his head, and fall face down in the water. Jones is delighted; he stands by, ready to push the child's head back under if necessary, but it is not necessary. With only a little thrashing about, the child drowns all by himself, "accidentally," as Jones watches and does nothing.[30]

Rachels thinks that your reaction to these two different cases will be that Jones and Smith are both morally culpable. Smith *killed* his cousin, Jones *let his cousin die* by refusing to offer life-saving help, and so both have blood on their hands. And if both are morally blameworthy for the death of their cousins, then there can be no inherent moral difference between killing and letting die.[31] (Rachels will use this point to argue that since there is no moral difference tied to the manner of killing, but there is moral blameworthiness attributed to those who cause or refuse to ameliorate

[26] Thomson 1999: 498.
[27] Ibid., 501.
[28] Ibid.
[29] Rachels 1986: 111.
[30] Rachels 1975: 79.
[31] In a famous response to Rachels, Philippa Foot 1977: 101-2 agrees that there is no moral distinction between the actions of Smith and Jones. They are both morally egregious. But what makes them both culpable is that while Smith fails to exercise the virtue of justice (because murder is an injustice; this cousin did not deserve it), Jones fails to exercise charity (because failing to help in a time of need is a failure of being charitable to the one in need). Their collective failure, then, is a failure of virtue.

intense pain and suffering on others, then we are morally culpable for passively letting people die a slow and painful death when we should be actively euthanizing them for their own sake. In some situations, then, Rachels argues the moral thing to do is to actively terminate lives instead of letting them die). Rachels is correct about these cases. There is no moral difference because, as Michael Tooley puts it very well, there is no such difference "between intentionally killing and intentionally letting die."[32] Smith and Jones *intend* the deaths of their respective cousins, such intentions are what drive their actions, and this is what makes their actions morally reprehensible.

(Much more will said about this issue later on in this essay. But right now, it is helpful to note that Rachels and Tooley will downplay the significance of intentions regarding morality because, for them, moral differences are determined by whether the consequences of actions achieve the best *interests*. Tooley claims that the intentional-killing and intentional-letting-die distinction is problematic because it "reflects [...] a moral point of view unrelated to the interests of individuals."[33] And for Rachels, "a person's intention is relevant to an assessment of his character [...] but the intention is not relevant to determining whether the act itself is morally right."[34] However, other ethicists will argue that intentions do matter.[35] John Kilner, for instance, argues that stopping a patient's life-sustaining treatment will be morally different from giving that patient an injection of potassium chloride when the former is motivated, not by achieving death, but rather to protect the patient from harmful invasive, futile, life diminishing treatment.[36] In such a case death may be reasonably foreseeable, but it's not what is intended. Giving potassium chloride injections, however, cannot be done except with an intent to kill unless, I suppose, it is some horrible accident. This raises a host of issues that will be discussed in much more detail in §9 and §10 of this essay).

This leads to a third problem regarding and active and passive distinction specifically and their connection to the definition of "euthanasia" more generally. Given that *euthanasia* is an *intended killing* for a specific medical reason (as the above definitions show), there are some (most?) cases where patients are disconnected from life-sustaining treatment and subsequently die but should not be classified as euthanasia at all. As Bonnie Steinbock puts it, "the termination of life-prolonging treatment cannot be identified with the intentional termination of the life of one human being by another."[37] That a patient has a right to refuse treatment, for example, "is not the same as, nor does it entail, a right to voluntary euthanasia" since the reason for this action is "protect[ion]from the unwanted interference of others," especially where such treatment "has little chance of improving the patient's condition and bring greater discomfort than relief."[38] When someone refuses or requests the withdrawal of life-saving treatment for the purposes (or intent) of lessening discomfort and/or making the most out of one's life in the later stages of a terminal illness (because it is thought that treatment itself is actually lessening the quality of living), the death that results is not a case of passive euthanasia because *it's not a euthanasia at all* – death was not intended. More will be said about this later.

Suicide. Just as the active/passive distinction is controversial, so is the definition of suicide. It's not helpful to define it as a self-killing, or even an intentional self-killing, because it's possible that

[32] Tooley 1994: 103.

[33] Ibid.

[34] Rachels 1994: 143.

[35] See Kilner 1992: 96-7; Sullivan 1994: 135-6; Kilner 1996: 77-81; Stewart et al 1998: 40; Kilner 1998: 135; Dyck 2002: 35-9; Kass 2002: 37; Cohn & Lynn 2002: 247-8; Kilner & Mitchell 2003: 89-94; Gorsuch 2006: 66.

[36] John Kilner 1992: 125-6, "In fact, treatment may on balance be harmful. When death is drawing near and can no longer be avoided, continued treatment may inflict terrible pain and suffering on a patient that never would have occurred apart from the treatment. [...] A God-centered, reality-bounded, love-impelled outlook provides ways to distinguish the proper and improper use of medical technology."

[37] Steinbock 1994: 122.

[38] Ibid. 123

one could intend one's own death due to coercion by someone else, such as a torturer in a military prison camp.[39] There seem to be very clear cases of suicide – the depressed nearly-bankrupt businessperson who hangs him- or herself in a hotel room; she who consumes an overdose of sleeping pills and alcohol after her spouse has absconded with a lover; the rare case of a defendant who slips a cyanide pill into his mouth after a judge sentences him to life imprisonment. But what about the cases of truck drivers who veer their massive rigs off the sides of mountains to avoid hitting runaway school buses, or fast-thinking bystanders that put themselves in harm's way in order to save someone from a burning house or car – are their deaths truly cases of suicide? Maybe some of the difficulty here lies in our attempt to define suicide in a morally *thick* way, that is, one that is both descriptive and evaluative.[40] For my purposes in this paper, however, I'll use Tom Beauchamp's definition which avoids some of the difficulties just noted. A suicide is "an act or omission [where] a person intentionally brings about his or her death, unless the death (a) is coerced or (b) is caused by conditions that are not specifically arranged by the agent for the purposes of bringing about the death."[41] J.P. Moreland offers the additional insight that for a suicide to obtain, it must be that the person "intentionally and/or directly causes his or her own death as an ultimate end in itself or as a means to another end,"[42] such as when someone intentionally seeks death itself as the goal to achieve in escaping life, or as a means to be free from pain and suffering.

Assisted Suicide. Assisted suicide is the suicide of a person who "lacks the knowledge, courage, or physical capacity to achieve the desired end"[43] and thus solicits the help of another. Consider the many instances of people who killed themselves with the assistance of Jack Kevorkian, the notorious Michigan pathologist who would connect a lethal-drug-dispensing machine intravenously to his clients who would activate the machine themselves. In the few states that have legalized PAS, a physician "assists" by prescribing lethal barbiturates to the patient that will ingest it whenever they want (more on these two cases in §2). For these reasons, *PAS* is a kind of *euthanasia*, that is, it is a kind of death brought about because it's thought to be best for the patient. However, in the common parlance of *practice* they are two very different actions – PAS is a suicide with the assistance of a physician; *euthanasia* is primarily understood as a death that is brought about completely by the actions of the physician.

2. THE CASES THAT SHAPED THE HISTORY

The public policy fight to achieve the legalization of PAS has never solely been theoretical, political, or philosophical. It has been raised because of real cases of real people. This section will outline some of the most important ones that have influenced the public policy, court decisions, and legislation regarding PAS in the United States today.

Karen Ann Quinlan

The best case to start with is the one that first brought the issue of euthanasia to the public front, that of Karen Ann Quinlan. In 1975, the vivacious 21-year-old slipped into an irreversible coma after ingesting a combination of alcohol and anti-anxiety drugs.[44] The drugs stopped her ability to breath and intake oxygen for several minutes, ultimately causing the destruction of her

[39] See Beauchamp 1993: 69-83 for an excellent review of the relevant issues here.
[40] See Moreland 1998: 183-4.
[41] Beauchamp 1993: 79.
[42] Moreland 1998: 186.
[43] Orr 1998: 62
[44] Pence 2015: 59.

"higher brain" before she could be connected to a ventilator that breathed for her. Physicians assessed her condition and determined that she was in a persistent vegetative state[45] (PVS), a condition of "prolonged unconsciousness"[46] where even though the patient may move her eyes, limbs, and mouth, she is totally unaware of her surroundings and of herself.[47] Gregory Pence notes that although in times past such patients would eventually starve to death due to the inability to be fed either by themselves or others, Quinlan had been given an intravenous feeding tube that was eventually replaced with a nasogastric feeding tube.[48] As a result, she was being kept alive through artificial feeding and breathing mechanisms.

Six months after her accident, her parents, Joe and Julie Quinlan, decided that the ventilator keeping Karen alive should be stopped and that she should be allowed to die a natural death instead of being artificially kept alive given the severity and hopelessness of her prognosis. The aftermath of this decision, however, would be a public firestorm that caught the attention of local and national media, culminating in a landmark decision by the New Jersey State Supreme Court[49] and a primetime TV movie on NBC.[50] Joe and Julie Quinlan told the doctors that, even though Karen had never explicitly documented her preference about end-of-life care should she ever become incapacitated, she had nonetheless conveyed to them on two occasions prior to her accident that "if anything terrible happened to her, she did not want to be kept alive as a vegetable on machines."[51] Karen's doctors and hospital administrators balked at Joe and Julie's request to shut off the ventilator and the matter ultimately ended up in the New Jersey Supreme Court, which ruled in March 1976 upon the basis set by previous judicial decisions regarding the right to privacy,[52] that a PVS patient's family could legitimately make surrogate judgments on the patient's behalf and ultimately "let her die" if they so choose.[53] Karen was subsequently weaned off of the ventilator over the course of the next few months, but to everyone's amazement she was able to breath on her own for an additional 10 years, and died in June 1986 of pneumonia.[54] The New Jersey judicial decision was the very first "right-to-refuse" case and since then "virtually every state in the nation has recognized a right, belonging at least to competent adults, to refuse basic, life-sustaining medical care, including tubes supplying food and water."[55] It is not a stretch, then, to say that this particular case served as something of a national model and even catalyst for considering the practical morality of euthanasia as an end-of-life care option.

[45] Ibid. It is important to note that the language used by Pence here is typical of those who make a distinction between a person and her body, often identifying the former as identical to one's "higher brain" which is understood as the arena or organ of *consciousness*, and identifying the latter as identified as crucial for the *physiological* function of one's body. Although more will be said about this below, one should keep in mind that for many proponents of euthanasia and PAS, they will argue that even though Quinlan's *body* was alive, *she* was actually dead.

[46] Ashwal et al 1994:1499.

[47] Ibid: "The vegetative state is a clinical condition of complete unawareness of the self and the environment, accompanied by sleep-wake cycles, with either complete or partial preservation of hypothalamic and brain-stem autonomic functions. In addition, patients in a vegetative state show no evidence of sustained, reproducible, purposeful, or voluntary behavioral responses to visual, auditory, tactile, or noxious stimuli; show no evidence of language comprehension or expression; have bowel and bladder incontinence; and have variably preserved cranial-nerve and spinal reflexes. We define persistent vegetative state as a vegetative state present one month after acute traumatic or nontraumatic brain injury or lasting for at least one month in patients with degenerative or metabolic disorders or developmental malformations."

[48] Pence 2015: 60.

[49] *In Re Quinlan* 70 N.J. 10; 355 A.2d 647 (1976)

[50] *In The Matter of Karen Ann Quinlan*, September 26, 1977 (https://www.imdb.com/title/tt0076188/)

[51] Pence 2015: 61.

[52] Namely, *Griswold v. Connecticut* (1967) and *Roe v. Wade* (1973).

[53] Pence 2015: 62-3.

[54] Ibid.

[55] Gorsuch 2006: 49.

Three crucial points about this case stand out. First, given that Karen Quinlan had become incompetent as a result of her tragic injury, the thorny issue about her case is that *she would never be able to make her own decisions* about her own life ever again. Because she could not indicate whether or not she wanted continued treatment and had never given explicit instructions regarding her own preferences for end-of-life care, the court ruled that the next best option was to honor the Quinlan parents' rendering of Karen's previously casually-made statements about the kind of end-of-life care that she would *not* want. Second, her parents sought only to remove the ventilator that kept her breathing, not her feeding tube. Third, the New Jersey Supreme Court decision was just that – a decision for New Jersey. However, it would inform other decisions to come, especially the landmark Supreme Court cases that would ultimately rule that even though a person had a constitutionally protected right to refuse medical treatment, this did not include an equivalent right to assisted suicide.

Nancy Cruzan

One case that directly influenced the first U.S. Supreme Court decision of its kind was that of the 24-year-old Nancy Cruzan who was irreparably injured in a single-car accident in January 1983 on a remote icy rural road in rural Missouri. After losing control of her vehicle, she was ejected into a nearby ditch where paramedics found her lifeless.[56] Although they were able to medicinally stimulate her heart back to a normal rhythm, she had tragically succumbed to a state similar to Karen Quinlan's – her brain had went so long without oxygen that despite having a beating heart again, she was PVS, she couldn't swallow, and would never again be conscious.[57] Cruzan's parents argued that Nancy would not want to be artificially kept alive in the way that she was, via the feeding tube, and so after nearly five years of Nancy's persisting in a PVS, they petitioned the courts to have the feeding tube removed.[58] The Cruzans won their case in a local probate court, but the Missouri Supreme Court reversed that lower court's decision. In their judgment, the lack of Nancy Cruzan's explicitly stated wishes forced the court to "err on the side of life."[59] As far as that court was concerned,

> only when guardians produce documentary evidence reliable enough to meet Missouri's 'clear and convincing evidence' standard ('the most rigid of formalities') for withdrawal of life-sustaining medical care from an incompetent individual could the state's protection of Nancy Cruzan end. In the absence of such evidence, the 'substituted judgment' of Nancy's parents acting in her best interest, a key factor in the *Quinlan* decision, would not be the basis of termination of medical care for incompetent patients in Missouri.[60]

On one hand, the state's opinion rejecting "substituted judgment" made sense since its vagueness could legitimate any sort of evidence used to justify an incapacitated person's preference to die.[61] But on the other hand, many argued that maintaining the "clear and convincing" evidentiary standard "would place an enormous [financial] burden on society" by forcing people to stay alive in the kinds of conditions that "no one in their right mind would ever want to be in."[62] Having lost their case at the state level, Cruzan's parents took it to the U.S.

[56] Pence 2015: 64.
[57] Ibid.
[58] Pence 2015: 64; Ball 2012: 37.
[59] Ball 2012: 40.
[60] Ibid.
[61] Pence 2015: 65.
[62] Ibid.

Supreme Court. Their attorneys' strategy focused on the "scope of liberty" in the Due Process Clause[63] of the Fourteenth Amendment and they argued that the state's high evidentiary requirement was inconsistent with that clause.[64] The Supreme Court, however, ruled in favor of the state of Missouri.[65] Although all nine of the Supreme Court justices agreed with the Cruzans that people have a liberty interest under the Fourteenth Amendment to refuse medical treatment if they so choose, the majority opinion argued that this applied only to competent persons.[66] Furthermore, they argued that such a liberty interest is not an absolute right but must be balanced "against the relevant state interests."[67] Since the state has an interest to protect those who cannot protect themselves, the Supreme Court ruled that Missouri's evidentiary standard of requiring "clear and convincing evidence" of a previously-but-no-longer-competent patient's wishes was not too much to require and was a "reasonably designed procedural safeguard" that facilitated the state's legitimate purpose of protecting its residents by making certain that incompetent patients' wishes were respected and followed.[68]

In sum, the Court's decision had three parts to it.[69] First, Missouri law did not violate the U.S. Constitution by requiring that the evidence used to prove what an incompetent patient's wishes are, regarding the withdrawal of life-sustaining treatment, be "clear and convincing." Second, Missouri's Supreme Court did not erroneously conclude that the trial court evidence didn't meet the "clear and convincing" standard regarding Cruzan's wishes to have treatment withdrawn. And, finally, for all the liberties that the Due Process Clause of the Fourteenth Amendment protects,[70] it "does not require a State to accept the 'substituted judgment' of close family members in the absence of substantial proof that their views reflect the patient's." In effect, even though this decision was a response to a legal challenge regarding some of the finer points of Missouri law and judicial procedure, what makes *Cruzan* a "landmark decision" is that it was the "first U.S. Supreme Court declaration that a competent patient could decline all medical treatment to die as his definitive Constitutional right."[71]

How they came to that conclusion is very important. As Chief Justice William Rehnquist would later write, the *Cruzan* court operated under the assumption "that the Constitution granted competent persons a constitutionally protected right to refuse life-saving hydration and nutrition."[72] They based that assumption on two important common law notions. One was the right to not have to endure *battery*, understood as the touching of one person by another without consent and without legal justification."[73] The other was the notion of *informed consent* as

[63] The first section of the amendment reads (the due process clause in *italics*) as follows: "All persons born or naturalized in the United States, and subject to the jurisdiction thereof, are citizens of the United States and of the State wherein they reside. No State shall make or enforce any law which shall abridge the privileges or immunities of citizens of the United States; *nor shall any State deprive any person of life, liberty, or property, without due process of law*; nor deny to any person within its jurisdiction the equal protection of the laws."

[64] Ball 2012:41.

[65] See *Cruzan v. Director, Missouri Department of Health*, 497 U.S. 261 (1990).

[66] Ball 2012: 43; Gorsuch 2006:9 emphatically makes the point that the *Cruzan* Court assumed without deciding that the liberty component of the Fourteenth Amendment embraces the right of a competent adult to refuse life-sustaining treatment."

[67] Ball 2012: 43.

[68] Ibid

[69] See *Cruzan*, 497 U.S. at 261-263

[70] In *Washington v. Glucksberg* 521 U.S at 720, Chief Justice Rehnquist gives a brief history of the various "liberties" recognized by the Court as being protected by the clause, such as the "rights to marry," "to have children," "to direct the education and upbringing of one's children," "to marital privacy," "to use contraception," "to bodily integrity," "and to abortion."

[71] Pence 2015: 63-4.

[72] *Washington v. Glucksberg*, 521 U.S. at 723 (1997)

[73] *Cruzan*, 497 U.S. at 269.

"encompassing the right of a competent individual to refuse medical treatment."[74] As such, to be forced to undergo medical treatment against one's will, especially when one has consented to not be treated, would go against the "traditional rights to bodily integrity and freedom from unwanted touching."[75]

Because the Court upheld Missouri's law regarding the requirements that must be met in order for a withdrawal of treatment to be legally valid,[76] the Cruzans were forced to go back and try again in the Missouri courts. So they did. But this time, in addition to their and another daughter's testimony that was used in the previous cases,[77] they secured additional witnesses[78] that could affirm and attest to what Nancy Cruzan had said in the past about her wishes to not be artificially kept alive if she were to ever become incapacitated. After all testimony was heard, a Missouri judge ruled that the state's evidentiary standards had been meet, and on December 14, 1990 the feeding tube was removed, and 12 days later on December 26 Nancy passed away.[79]

Terri Schaivo

Interestingly, 1990 was an incredibly important year for high-profile cases surrounding end-of-life issues. Not only was the *Cruzan* case decided, but Terri Schaivo, a 27-year-old Florida woman, went into a coma as a result of a massive cardiac arrest which resulted from a severely low level of potassium in her body.[80] Because she went into a PVS without the ability to swallow, she had to be artificially fed through a PEG (percutaneous endoscopic gastronomy) tube that is placed through the wall of stomach so that food could be placed there directly without having to be ingested through the mouth and throat.[81] Eight years later, after being told by physicians that there was no hope for any "meaningful recovery," Schaivo's husband requested the court to allow her feeding tube to be removed, citing that "while watching television many years before, Terri had once remarked that she wouldn't want to live in a vegetative state."[82] Terri's parents, however, retorted that she had intimated the complete opposite to them. What ensued from that point on was complete mayhem in the courts, media, and even the Florida legislature and U.S. House of Representatives. Although Michael Schaivo, Terri's husband, was her legal guardian, and the courts recognized him as such, Terri's parents waged an all-out public effort to keep Terri alive that resulted in special laws being enacted to further their cause, back and forth cases through the

[74] Ibid., at 277

[75] Ibid., at 278

[76] In a concurring opinion, Justice A. Scalia noted, "While I agree with the Court's analysis today, and therefore join in its opinion, I would have preferred that we announce, clearly and promptly, that the federal courts have no business in this field; that American law has always accorded the State the power to prevent, by force if necessary, suicide - including suicide by refusing to take appropriate measures necessary to preserve one's life; that the point at which life becomes "worthless," and the point at which the means necessary to preserve it become "extraordinary" or "inappropriate," are neither set forth in the Constitution nor known to the nine Justices of this Court any better than they are known to nine people picked at random from the Kansas City telephone directory; and hence, that *even when it is demonstrated by clear and convincing evidence that a patient no longer wishes certain measures to be taken to preserve her life, it is up to the citizens of Missouri to decide, through their elected representatives, whether that wish will be honored*. It is quite impossible (because the Constitution says nothing about the matter) that those citizens will decide upon a line less lawful than the one we would choose; and it is unlikely (because we know no more about "life-and-death" than they do) that they will decide upon a line less reasonable" (*Cruzan*, 497 U.S. at 293, *emphasis* mine).

[77] Pence 2015: 64

[78] Ball 2012: 45.

[79] Ball 2012: 45-6.

[80] Pence 2015: 66.

[81] Ibid.

[82] Pence 2015: 67.

appeals process, and even particular congressmen and senators from other states taking it upon themselves to fight for the cause.[83]

Also in 1990, two other extremely important figures for the PAS movement came to the fore: Drs. Jack Kevorkian and Timothy Quill. And these are particularly important because they have to do with patients who actively were requesting to die. Quinlan, Cruzan, and Schaivo were all PVS patients whose final fate were in others' hands.[84] They were incompetent, and so decisions regarding their end of life were being made by others. But now we have instances of people who want to die and are seeking out help, from medical professionals, to make it happen.

Jack Kevorkian

The first instance of this that garnered public spotlight was that of the bombastic Dr. Jack Kevorkian, a Michigan pathologist, may have caused the most controversy regarding PAS from both opponents and other proponents. Kevorkian was a Michigan native who had worked as a physician in the state since his graduation from the University of Michigan Medical School in Ann Arbor in the sixties. Kevorkian was an aggressive advocate for assisted suicide, a "zealot" of sorts, who had taken out newspaper advertisements in the local Detroit-area papers, "offering a dignified death to those who wished to die."[85] In June 1990, Janet Adkins, a 54-year old Oregon sought out his services. Adkins was in the early stages of Alzheimer's disease and was getting frustrated with how the progression of the disease was affecting her ability to remember.[86] Given that assisted suicide was not illegal in Michigan at the time, Kevorkian was not legally restricted in what he was intending to do. He had created a machine, what he called a "Mercitron," that allowed the patient to commit suicide on her own. Kevorkian's contribution was merely that of assisting by connecting the appropriate parts to the patient and making sure the machine would work as the patient herself directed it.[87] When Janet Adkins came to take Kevorkian up on his services, they piled into his Volkswagon van and drove to the Groveland Oaks Park near Holly, Michigan. Greg Pence notes the procedure that was followed on that day.

> In the side of his van, he had Janet, a cot, and a device. The simple device consisted of three intravenous (IV) bottles hung from an aluminum frame; Kevorkian called it the *Mercitron*. At the park, he connected an IV line to Janet Adkins and started a saline solution for fluid volume. Then she pushed a switch that stopped the saline and released thiopental, a powerful sedative. The switch started a six-second timer that activated a drip of potassium chloride. Thiopental rendered Janet Adkins unconscious, and about

[83] Although so much more can be said about the events surrounding the Terri Schaivo controversy, I have only presented it here as a very short summary form for at least four reasons: First, it is an important case in the history of so-called "right to die" movement if only because of its prominence in public view through the mass attention paid to it by the national media and national politicians; Second, the space and scope of this essay does not allow me to go deep into it; Third, there is really nothing redeeming about the Schaivo case, except maybe for how that being in such a prominent national spotlight encouraged a great deal of Americans to draft their own advanced directives should such a tragedy befall them. No important legal cases or legislation was waged in this case. All of the legislation and court decisions were specifically about Terri's case and whether or not the state of Florida could step into that case on behalf of the parents; Fourth, because it was such a high-profile case, it unfortunately became opportunistic for pundits, politicians, and attention-predators to prey upon for their own purposes.

[84] Of course, this is a very controversial statement. Proponents of PAS and other forms of euthanasia would argue that these patients no longer had a fate since they had already lost their lives the moment they entered into a PVS.

[85] Ball 2012: 69, 71.

[86] Pence 2015: 40.

[87] Ball 2012: 70-1; Pence: 2015:40.

a minute later, potassium chloride killed her. Kevorkian said that Janet had in effect "a painless heart attack while in a deep sleep." The whole process took less than six minutes.[88]

Kevorkian was subsequently charged and tried for murder but acquitted due to the lack of specificity in Michigan law regarding assisted suicide. Legally speaking, Kevorkian did not actually kill Adkins. He merely facilitated Adkins death by setting up a machine that would allow Adkins to bring about her own death. He pulled no trigger. He didn't even push any buttons on his so-called "Mercitron" itself. Adkins did that herself. Altogether, from 1990 to 1998, Kevorkian assisted in at least 130 suicides[89] and was brought up and acquitted of homicide charges four times.[90] In 1992 Michigan passed a temporary two-year law[91] that made assisted suicide a felony punishable by a maximum of four years in prison.[92] Kevorkian challenged its constitutionality, but the Michigan Supreme Court ultimately upheld the statute, ruling that it was enacted properly and did not violate the state nor U.S. constitution.[93] Michigan finally passed a permanent statute in 1998 that added assisted suicide to the state penal code as a homicide punishable by a maximum of five years in prison.[94]

1998 was the same year that Kevorkian was convicted of homicide, but not by assisted suicide. The events surrounding his conviction are rather ironic. Kevorkian allowed the CBS network's television show, 60 minutes, to interview him and record the suicide of Thomas Youk, a fifty-two-year-old ALS[95] patient.[96] Because Youk was in an advanced stage of a disease that severely limited his movement and muscle strength, he could not press the buttons that turned on the "Mercitron" machine. What Kevorkian did next is what sealed his fate: as Youk struggled to push the buttons, Kevorkian gave Youk an injection of potassium chloride into his IV line, securing his death within seconds.[97] Kevorkian crossed the line from merely assisting a suicide to actively euthanizing Youk. *60 Minutes* aired all of this on November 22 and Michigan prosecutors subsequently charged him with first-degree premeditated murder on November 25. In April of the next year, Kevorkian was convicted of second-degree murder and handed a ten-to-twenty-year prison sentence in the state penitentiary at Jackson, was paroled after four years, and then spent the rest of his life traveling, writing, and lecturing.[98]

Jack Kevorkian was a controversial figure for both proponents and opponents of the legalization of assisted suicide primarily because he was a brash, bombastic, arrogant, and defiant figure. His eccentricity and antics didn't bode well for other proponents since he and his moniker as "Dr. Death" became the face of assisted suicide in the United States. Nor did his history help. He had spent most of his professional life as the chief pathologist of Detroit's Saratoga Hospital and was known by colleagues and others to be fascinated and even infatuated with death throughout his career.[99]

[88] Pence 2012: 40.

[89] Coleman 2002: 219.

[90] Ball 2012: 72

[91] In effect, the state of Michigan attempted to legislate a moratorium on assisted suicides until its *Commission on Death and Dying* could investigate the matter further and provide recommendations to the legislature for future regulations and policies (See Mich. Compiled Laws 752.1022-1027 1992).

[92] Act 270 MCL 752.1027 1992.

[93] *People of the State of Michigan v. Jack Kevorkian*, 447 Mich. 436, 527 N.W.2nd 714 (1994)

[94] Act 328 MCL 750.329a 1998.

[95] Amyotrophic lateral sclerosis, more commonly referred to as "Lou Gehrig's disease."

[96] Pence 2015: 41; Ball 2012: 72; Coleman 2002: 219-20.

[97] Ibid.

[98] Ibid.

[99] See Nicole and Wylie 2006.

Timothy Quill

If Kevorkian was the brash face of the PAS movement, Timothy Quill was the more reasonable one. Quill was an internist at the University of Rochester Medical Center in New York and in 1990 helped one of his own patients, a 45-year-old female whom he called "Diane," to die after she had entered into an advanced stage of leukemia that caused her severe pain. The public controversy surrounding this began with the publication of an article by Quill in *The New England Journal of Medicine* where he exposed and outlined how and why he helped Diane end her life.[100] This caused a stir in the medical community primarily because, unlike the relationship between Kevorkian and those patients that sought out his services, Diane was long-term patient under Quill's care. As he noted in *NEJM* the article, Diane asked him for a barbiturate to help her sleep, and as he gave it to her, he informed her how much of a dose she would need to sleep well and also the right dosage that would end her life.[101]

As a result, local authorities looked into the case and attempted to prosecute Quill for murder, but a grand jury failed to indict him on the grounds of insufficient evidence that the crime he was being charged with actually violated New York law,[102] even though assisted suicide was considered second-degree manslaughter, a felony in New York.[103] Similar to the Kevorkian cases, it was not clear as to what, if anything, Quill actually did that was in violation of that law that had been in effect since 1965.[104] He did not kill Diane directly, nor did he directly assist in her death in the way that Kevorkian did.[105] What he did was write her a perfectly legitimate prescription for a perfectly legitimate barbiturate and gave her instructions about the dosage that was too much (such that would bring about death) and the lesser dosage that would bring about good sleep. Hence, it was not clear that Quill had actually violated the statute since there is no way he could have known exactly what Diane was going to do with the drugs he prescribed to her.[106]

3. QUILL AND GLUCKSBERG

These cases and the people who made them – Quinlan, Cruzan, Schaivo, Kevorkian, and Quill – are a small sample of all the cases, issues, and people that were instrumental in shaping the way that we have come to think about end-of-life issues today. Arguably, these are the most important ones if only because of the public attention they garnered which shaped the various policies and laws that currently stand as a result of the influence of these cases. *Cruzan* was a crucial Supreme Court decision because the Court did not question the Constitutionality of an intentional withdrawal of life-sustaining treatment, so long as that's what a competent patient wanted. What PAS advocates now wanted to force the Court to declare that same position while also holding that state laws banning assisted-suicide were Constitutionally invalid. PAS proponents argued that since both the withdrawal of medical treatment from a patient and the prescription of life-ending barbiturates have the same goal in mind, namely, a dignified and peaceful death, then there really is no difference between the two actions. If Physician A assists in a patient's suicide and Physician B shuts off a patient's ventilator, both at the request of their respective competent patients, then A and B are in effect doing the exact same thing. If the Court disagreed with this,

[100] See Quill 1991.
[101] Ibid.
[102] Pence 2015: 41.
[103] New York Penal Code 125.15(3).
[104] *Vacco v. Quill*, 521 U.S. at 806 (1997).
[105] Ball 2012: 74.
[106] See Gorsuch 2006:2.

they would have to show why PAS advocates were wrong. If the Court agreed with them, then every state law banning assisted-suicide would be invalidated.

Vacco v. Quill

In 1994 Timothy Quill made headlines again when he and two other New York physicians sued the state of New York on behalf of three patients in the late stages of terminal illnesses who wished to legally seek medical assistance in ending their lives but were legally barred from doing so.[107] They argues that since the state of New York *permitted* competent people to *refuse medical treatment* but *prohibited* them to *seek assistance in suicide*, and also since the refusal of medical treatment is "essentially the same thing"[108] as PAS, New York was violating the Equal Protection Clause of the Fourteenth Amendment[109] in that state was not "treating like cases alike" (which is what the Clause implies),[110] but rather was treating them differently by *allowing* some terminally ill patients to accelerate their deaths by the *withdrawal* of life-sustaining treatments and *disallowing* others from accelerating their deaths by PAS.[111] Their initial suit in U.S. District Court[112] was unsuccessful. However, the Second Circuit Court of Appeals reversed the District Court's decision two years later.[113] But one year after that, the Supreme Court heard the case and sided with the State of New York and the original District Court decision.[114]

In the Supreme Court's majority opinion, Chief Justice Rehnquist argued that the position of the respondents, Quill and his patients, and also of the Second Circuit Court of Appeals, was highly flawed. Basically, Rehnquist noted that even though the Equal Protection Clause does require that like cases be treated alike, it also implies that States "may treat unlike cases accordingly."[115] The Ninth Circuit Court of Appeals said that one's right to refuse life-sustaining medical treatment and the right to employ assistance in ending one's life was "nothing more than subcategories of the same broad right or liberty interest."[116] But the unanimous opinion of the *Quill* Court was that the withdrawal of life-sustaining and life-saving treatment and suicide were *not* alike, but very *different* kinds of actions "widely recognized in the medical profession and in our legal traditions."[117] The Court argued that the distinction is a rational one to make is because "when a patient refuses life-sustaining medical treatment, he died from an underlying fatal disease or pathology; but if a patient ingests lethal medication prescribed by a physician, he is killed by that medication."[118] So, an important factor that makes the two kinds of actions different is what the *cause* of death will be.

But even more important than the cause, is the *intent* of the action that leads to death. Rehnquist argued that when physicians withdraw treatment, their intent is not death, but "only to respect his patient's wishes and to cease doing useless or futile or degrading things to the patient when the patient no longer stands to benefit from them."[119] However, the purpose of PAS is death

[107] *Vacco v. Quill*, 521 U.S. at 797-8 (1997).
[108] Ibid., at 798
[109] The clause says that no state "deny to any person within its jurisdiction the equal protection of the laws" (See fn27 above for the amendment in its entirety).
[110] *Vacco v. Quill*, 521 U.S. at 799 (1997).
[111] Ibid., at 800; see also 80 F. 3d at 729 (2d Cir. 1996).
[112] *Quill v. Koppel*, 870 F. Supp. 78 (SDNY 1994).
[113] *Quill v. Vacco*, 80 F. 3d 716 (2d Cir. 1996).
[114] *Vacco v. Quill*, 521 U.S. 793 (1997).
[115] Ibid., at 799.
[116] Kamisar 2002: 74.
[117] Ibid., at 800.
[118] Ibid., at 801.
[119] Ibid.

– PAS *intends death* as a remedy.[120] Of course, even though the same outcome may be foreseen in both kinds of actions – withdrawing treatment and assisting in suicide – Rehnquist noted that the law already recognizes this distinction and "has long used actors' intent or purpose to distinguish between two acts that may have the same result."[121] For instance, "providing aggressive palliative care" through prescribing "painkilling drugs may hasten a patient's death," but the intent here is not death as is the case with PAS, but "only to ease [the] patient's pain."[122] The latter is morally justifiable, then, because of its *double effect* – taking pain medication has the *intended* effect of easing pain even though it carries a risk of the *non-intended* effect of hastening death.[123] For these reasons, then, the Court thus concluded that New York's law prohibiting assisted suicide did not violate the Equal Protection Clause of the Fourteenth Amendment as alleged. The two actions – PAS and the withdrawal of treatment – are *not* the same kinds of actions, but exhibit "a longstanding and rational distinction."[124]

Washington v. Glucksberg

When the Supreme Court heard arguments for *Quill* on January 8, 1997, they also heard arguments for the other case it was combined with, *Washington v. Glucksberg*.[125] A separate (and much longer) opinion, however, was given for *Glucksberg*. The best way to summarize the difference between the two is that whereas *Quill* challenged the Fourteenth Amendment's Equal Protection Clause in order to argue for the unconstitutionality of laws prohibiting PAS, *Glucksberg* focused its challenge on the Due Process Clause of that same amendment in order to argue the same point. Interestingly, the strategy in *Glucksberg* was precisely the plaintiffs' strategy in *Cruzan* some years before. But whereas the *Cruzan* petitioners argued (unsuccessfully) that the strictness of Missouri's evidentiary standards to prove the informed consent of an incompetent patient violated due process because it unduly limited freedom, the petitioners in *Glucksberg* argued (also unsuccessfully) that Washington's law banning PAS[126] violated due process by limiting the freedom of a competent terminally ill patient seeking help to secure his own death as his best option for remedy.

The original lawsuit against the United States government was brought in 1994 by a team that consisted of some terminally ill patients in Washington state, four physicians that felt their treatment options for those patients were unlawfully limited by the Washington law, and an advocacy group named "Compassion in Dying" that counseled terminally ill patients regarding their end-of-life options.[127] In that first case,[128] the U.S. District Court agreed with the plaintiffs that the state statute was unconstitutional in that it "[placed] an undue burden" on one's liberty.[129] A panel of the Ninth Circuit Court of Appeals, however, reversed the decision upon its initial

[120] Ibid., at 802.
[121] Ibid.
[122] Ibid.
[123] Much more will be said about this below when discussing the moral and theological positions regarding PAS. What's important to note at this point is that the Supreme Court recognized this moral difference as critical for holding a legal difference obtains between prescribing painkillers or refusing medical treatment and committing suicide. According to Yale Kamisar 2002: 81, "the Court's support for the principle of double effect is a victory for everybody" for the simple reason that it implicitly endorsed important palliative care measures for pain control.
[124] Ibid., at 808
[125] *Washington v. Glucksberg*, 521 U.S. 702 (1997).
[126] Wash. Rev. Code 9A.36.060 (1994).
[127] See *Glucksberg*, at 707-08 and Gorsuch 2006: 8.
[128] *Compassion in Dying v. Washington*, 850 F. Supp 1454 (W.D. Wash. 1994).
[129] Ibid., at 1465.

hearing,[130] but when the entire Court heard the case, they upheld the District Court's original decision for roughly the same reasons.[131] The U.S. Supreme Court, however, overturned the Ninth Circuit's decision and upheld the Washington statute. As in *Quill*, Chief Justice William Rehnquist wrote the unanimous opinion of the Court.

The argument of the Glucksberg team, which the Ninth Circuit agreed with, was that since the Due Process Clause[132] guarantees freedom from government intrusion regarding some of the most personal, private, and basic human liberties – that is, it guarantees more than procedural due process but also *substantive* due process[133]– then surely one of those liberties must be "the time and manner of one's death" which included "a liberty to choose how to die and a right to control one's final days."[134] They argued this by appealing to two previous Supreme Court cases, *Cruzan* and *Planned Parenthood v. Casey*.[135] But as Rehnquist noted, the *Cruzan* opinion did not recognize such a liberty interest, but rather, recognized the freedom one has from an unwanted non-consensual touching.[136] Furthermore, in *Casey*, the case that upheld *Roe's*[137] opinion that women had a constitutionally protected right to abortions without government intrusion, the Court (nor *Roe's* Court) never said anything about a right to assistance in death.

The respondents, however, argued that what made the right to an abortion and the right to seek assistance in death *equivalent rights* is that they both are "the most intimate and personal choices a person may make in a lifetime."[138] And given that how one "define[s] one's own concept of existence, of meaning, of the mystery of human life," is "at the heart of liberty," one "could not define the attributes of person were they formed under compulsion of the State."[139] In *Casey*, then, fundamental beliefs and decisions regarding one's life are to be protected from government interference. As Ronald Dworkin and several other philosophers argued in a joint brief of support for the respondents, *Casey* "reiterated that the Constitution protects a *sphere of autonomy* in which individuals must be permitted to make certain decisions for themselves."[140] By implication, then, the sphere must also include beliefs and decision about one's *death*.

But as Rehnquist argued, *Casey* does not imply that *all* of one's beliefs, decisions, and actions regarding their life are constitutionally protected from state intrusion. There is no full and total "self-sovereignty" as far as the Constitution is concerned, especially regarding a so-called right to assistance in death.[141] As Yale Kamisar points out, the PAS proponents' seizure of the *Casey* language was a bad faith attempt in using it for their purposes because when that opinion talked about the "most personal choices a person may make in a lifetime" which "define one's own concept of existence" etc., it had already qualified the scope of those *choices* as regarding "personal decisions relating to marriage, procreation, contraception, family relationships, child rearing, and

[130] *Compassion in Dying v. Washington*, 79 F.3d 790 (9th Cir. 1995), *vacated en banc*.

[131] *Compassion in Dying v. Washington*, 85 F.3d 1440 (9th Cir. 1996).

[132] See fn65 above.

[133] See fn72 above for a summary list of specific substantive liberties articulated by the Court. The reader should be aware that the notion of constitutional due process as implying anything "substantive" and not merely "procedural" is highly controversial, especially since the due process clause says that the government may indeed deprive its citizens of life, liberty, and property, but not without allowing such citizens to seek due process by and under the law; see Ely 1980: 14-20, Bork 1990, Lund & McGinnis 2004: 1556-1573.

[134] *Glucksberg*, at 722.

[135] *Planned Parenthood v. Casey*, 505 U.S. 833 (1992)

[136] *Glucksberg*, at 724

[137] *Roe v. Wade*, 410 U.S. 113 (1973).

[138] *Glucksberg*, at 726 quoting 79 F 3d, at 813-814.

[139] Ibid., at 726-727 quoting 505 U.S. at 851.

[140] Dworkin, Zimroth & Krash 1999: 187 (*emphasis* mine); see also Chemerinsky 2008 for a further argument why a sweeping view of autonomy is what is guaranteed under the Due Process Clause.

[141] *Glucksberg*, at 724.

education,"[142] not just anything and everything. Similar to this point, Gorsuch notes that the object of the *Casey* decision was really quite narrow: "only one person's autonomy interest [is] at risk [...] the woman's."[143] In effect, then, *Casey* does not leave open the possibility to define the constitutional protection of one's own life *tout court*, but only regarding those specified matters within the parameters of the particular issues it actually dealt with.

Rehnquist showed how that the Court has generally employed the use of two criteria as a method for determining whether or not an alleged right in question in a substantive due process case is indeed a constitutionally protected one. First, such a right or liberty will be one that is "deeply rooted in this Nation's history and tradition [...] such that neither liberty nor justice would exist if they were sacrificed."[144] Secondly, Rehnquist noted that the Court has required in such cases "a careful description of the asserted fundamental liberty interest" that the state may not infringe upon "unless the infringement is narrowly tailored to serve a compelling state interest."[145] Regarding the first criterion, Rehnquist noted that the history of the United States is rife with various laws prohibiting assistance in suicide to such an extent that it has been "a consistent and almost universal tradition that has long rejected the asserted right [to assistance in suicide], and continues explicitly to reject it today, even for terminally ill, mentally competent adults."[146] Indeed, even when various states have considered it, the vast majority have repeatedly rejected it.[147] So, the alleged right fails this first criterion.

Regarding the second criterion, Rehnquist noted that the State of Washington does indeed have interests in denying its residents the legal right to assistance in suicide. First, this includes "an unqualified interest in the preservation of human life"[148] which includes "all persons' lives, from beginning to end, regardless of physical or mental condition," and not just those "who can still contribute to society and have the potential to enjoy life."[149] The state also has an interest in responding appropriately to the fact that suicide itself is "a serious public health crisis, especially among persons in otherwise vulnerable groups" such as those who, "terminally ill or not, often suffer from depression or other mental disorders."[150] Given the data suggesting that legally permitting assistance in suicide might exacerbate this problem, especially given the inordinate amount of depressed patients who express interest in suicide, Washington has an interest in denying it.[151]

Secondly, according to Rehnquist, Washington "has an interest in protecting the integrity and ethics of the medical profession," and given the controversy surrounding the incongruity of physicians as "healers" being given the power to prescribe death, as well as the potential that PAS would have in "undermin[ing] the trust that is essential to the doctor-patient relationship by blurring the time-honored line between healing and harming," PAS would do serious damage on this front.[152] Third, Rehnquist noted that the State of Washington "has an interest in protecting the vulnerable groups – including the poor, the elderly, and disabled persons – from abuse, neglect, and mistakes."[153] This is especially important given how that being a citizen in one of these

[142] *Casey*, 505 U.S. at 851. See Kamisar 2002: 70-1.
[143] Gorsuch 2006: 82.
[144] *Glucksberg*, at 720-721; see *Snyder v. Massachusetts*, 291 U.S. at 105 (1934) and *Palko v. Connecticut*, 302 U.S. at 325-326 (1937).
[145] *Glucksberg*, at 721; see *Reno v. Flores*, 507 U.S. at 302 (1993).
[146] *Glucksberg*, at 723.
[147] *Glucksberg*, at 728.
[148] Ibid.; See *Cruzan*, at 282.
[149] *Glucksberg*, at 729.
[150] Ibid., at 730.
[151] Ibid.
[152] Ibid., at 731.
[153] Ibid.

categories – poor, disabled, elderly, etc. – already puts one at risk to lots of serious factors including lack of access to quality health care, social stigmas, and an all-around lack of options when it comes to one's ability to care best for themselves. What the state intends in prohibiting PAS, then, is its protection of "disabled and terminally ill people from prejudice, negative and inaccurate stereotypes, and societal indifference."[154]

Fourth and finally, "the State may fear that permitting assisted suicide will start it down the path to voluntary and perhaps even involuntary euthanasia."[155] Here Rehnquist explicitly notes the plausible slippery slope that legal permission of PAS may cause, especially in cases, such as what happened with Jack Kevorkian and Thomas Youk, where the patient may be physically "unable to self-administer the drugs and administration by the physician" or even by "family members and loved ones" might be "the only way the patient may be able to receive them."[156] If assistance in suicide were allowed by law, those who could not participate in the law would not be able to enjoy the law, and hence the law itself would be prejudicial *against* them. If there were ever a legal right to PAS, then that would obligate the rest of us to recognize and even facilitate that right. For this reason, Rehnquist notes that PAS "is likely, in effect, a much broader license, which could prove extremely difficult to police and contain" such as it has been in the Netherlands where its own government study of PAS in 1990 revealed that there had been "1,000 cases of euthanasia without an explicit request" and "an additional 4,941 cases where physicians administered lethal morphine overdoses without the patients' explicit consent."[157] The laws prohibiting PAS in Washington and in the many other states, then, "are not innovations," but "are longstanding expressions of the States' commitment to the protection and preservation of all human life."[158] Those laws "reasonably ensure against the risk[s]" noted above "by banning, rather than regulating, assisted suicide."[159] Rehnquist's opinions in *Quill* and *Glucksberg* deny that the New York and Washington statutes restrict the legitimate freedom of its residents to choose their own preference for end-of-life care. Frankly, it's just that patients aren't entitled to choose just *any* option for end-of-life care. The state has interests for the protection and welfare of its people and its PAS ban, for the reasons given, is more than justified.

However, we must recognize that the *Quill* and *Glucksberg* decisions are contextually limited in scope, resulting in a sort of legal modesty that leaves their precedent-setting effect somewhat in question regarding whether any constitutional right may someday exist to seek assistance in death. For instance, even though Justice O'Connor voiced her agreement in *Glucksberg* "that there is no generalized right to commit suicide," she left it open in her concurring opinion (also joined by Souter, Stevens, Ginsberg, and Breyer) as to whether or not "a mentally competent person who is experiencing great suffering has a constitutionally cognizable interesting in controlling the circumstances of his or her imminent death."[160] For O'Connor, determining this constitutional question needn't be determined "in the context of the facial challenges" to the New York and Washington bans on PAS.[161] Simply put, these cases were not appropriate ones in which to ultimately settle the question. Why she joined the unanimous opinion of the Court in *Quill* and *Glucksberg* was because the New York and Washington prohibitions on PAS were justified because of "the difficulty in defining terminal illness and the risk that a dying patient's request for

[154] *Glucksberg*, at 732; see *Compassion in Dying* 49 F. 3d, at 591-592.
[155] Ibid.
[156] Ibid., at 733.
[157] Ibid, at 733-734.
[158] *Glucksberg*, at 710.
[159] Ibid., at 735.
[160] *Glucksberg*, at 736.
[161] Ibid.

assistance in ending his or her life might not be truly voluntary."[162] O'Connor's position here is representative of her and the other "critical concurring justices"[163] who saw their role in upholding the PAS bans as a way of addressing "only the question whether laws banning assisted suicide are [...] unconstitutional in all possible applications – and specifically reserved for a later case the question whether those laws are unconstitutional as applied to terminally ill adults seeking death."[164] These justices "variously hinted at, suggested, or at least kept the door open to the possibility that prohibitions against [PAS] would be unconstitutional if and when applied to competent, terminally ill adults."[165]

So, in effect, nothing really changed. The Washington and New York laws prohibiting assisted suicide remained on their books. "The immediate consequence of [these] rulings was to return the assisted suicide question to the states and the political process where it remains the subject of active debate."[166] On the flipside, however, while the Court did not recognize a constitutional right to assisted suicide, it did not rule that any state laws that actually permitted PAS were unconstitutional.[167] As a result, the Court left it an open matter for all 50 states to decide for themselves what they wanted to do about PAS.

4. THESE NIFTY FIFTY STATES

As it stands in July 2018, all 50 states have some position on PAS. Most of those states that do not permit it have enacted specific explicit legislation to that effect. For a few others, PAS is prohibited by common law. However, seven states – Oregon, Washington, Montana, Vermont, California, Colorado, Hawaii, and also the District of Columbia – legally allow the practice of PAS. Most of these have done so by passing so-called "Death with Dignity" statues. Montana, however, allows it by a 2009 state Supreme Court ruling which held that an incidence of a physician's aid in helping a patient die does not violate any state homicide law specifically because what separates an instance of PAS from forms of murder is a patient's *consent*.[168]

Through a statewide ballot initiative in November 1994,[169] Oregon became the first state to pass a *Death with Dignity Act*[170] and did so through a state-wide ballot initiative.[171] Although court challenges and injunctions held the law up for a few years,[172] it was implemented in October 1997

[162] *Glucksberg*, at 738;

[163] Including Stevens, Souter, Breyer, and Ginsberg.

[164] Gorsuch 2006: 3.

[165] Gorsuch 2006: 14. For instance, in Justice Stevens' concurring opinion, he noted a historical-legal point that just as some applications of various States' capital punishment laws were constitutional and some were not, there is no reason to think that this could not also be the case regarding laws that regulated the practice of PAS, especially since the question in *Glucksberg* was not about "the application of the statue to a particular set of plaintiffs before it, but the constitutionality of the statute's *categorical* prohibition against aiding another person to attempt suicide;" indeed, for Stevens, one's personal interest in hastening death "not only is [...] sometimes legitimate, I am also convinced that here are times when it is entitled to constitutional protection" (*Glucksberg*, at 740, 742).

[166] Gorsuch 2006: 17.

[167] For instance, Rehnquist recognized that although most of the states banned PAS, Oregon was, at the time, the only state to have enacted legislation that allowed PAS for competent terminally ill persons (*Glucksberg*, at 717).

[168] *Baxter v. Montana*, 2009 MT 449.

[169] Measure 16 (1994).

[170] ORS 127.800-995 (1994) as a result of Ballot Measure 16 (1994).

[171] Oregon Division of Public Health. 2017 Dec. 1. "FAQs about the Death with Dignity Act." [www.oregon.gov/oha]

[172] See Ball 2012: 132-9.

after a ballot repeal effort[173] failed, four months after the U.S. Supreme Court's rulings in *Quill* and *Glucksberg*. Some of the specifics of the Act are as follows.[174]

- Terminally ill residents of the state of Oregon may bring about their own death through self-administering lethal medication prescribed by an Oregon-licensed physician (an M.D. or D.O.).
- Such residents must
  (1) be able to prove Oregon residency which may be done by proof of Oregon driver's license, voter registration, etc., although there is no minimum residency requirement;
  (2) Be competent in making and articulating one's own medical choices;
  (3) Have a terminal illness with a prognosis that estimates one's death to take place in less than six months.
- Oregon physicians and health organizations are not required by law to participate in the Act. They may decline, and then patient's seeking such treatment "must find another M.D. or D.O. licensed to practice in Oregon who is willing to participate."
- If a patient seeks out the lethal prescription, and meets the requirements notes above, the following process must be adhered to:

  (1) After a patient makes an initial oral request to his or her physicians, a minimum of 15 days must pass and then the patient must make a second oral request at which time the physician must offer the patient the opportunity to withdraw the request. The patient must then submit a written request to the physician and the patient must sign that request in the presence of two witnesses (one of which may not be related to the patient).
  (2) The physician must then consult with another physician, and they must determine the patient's eligibility, prognosis, and also if the patient might be suffering from depression or any other mental malady that might be impairing their judgment and, if that is the case, they must refer the patient for a psychological examination.
  (3) The physician must inform the patient of alternatives such as pain control, hospice, etc.
  (4) Physicians are required to report all lethal medication prescriptions to the Oregon Health Authority, as well as information about the patients who participate in this activity.

This last part of the *Act* is an important one in that it gives us a window for looking at how the *Act* has been implemented and who are those that have accessed it. And those statistics show us some very interesting data. Consider the following:

Table 1.[175]

Year	Prescriptions	Deaths
1998	24	16
1999	33	27
2000	39	27
2001	44	21
2002	58	38
2003	68	42
2004	60	37
2005	65	38
2006	65	46
2007	85	49
2008	88	60
2009	95	59
2010	97	65
2011	114	71

[173] Measure 51 (1997).
[174] Oregon Division of Public Health 2017.
[175] Oregon Health Authority, Public Health Division 2018: 12.

2012	116	85
2013	121	73
2014	155	105
2015	218	135
2016	204	138
2017	218	143

Some select specific data regarding the characteristics of the 143 patients that used the act in 2017 is as follows:

Table 2.[176]

Patient Characteristics	**#**
Male	83
Female	60
Age 18-34	0
Age 35-44	2
Age 45-54	3
Age 55-64	23
Age 65-74	46
Age 75-84	43
Age 85+	26
White	135
African American	0
Asian	4
Hispanic	3
Married	75
Widowed	26
Never married	6
Divorced	36
Less than high school	7
High school graduate	36
College graduate	69
Enrolled in Hospice	130
Not enrolled in Hospice	13
Private health insurance	36
Government provided ins.	78
Cancer illness	110
Neurological disease	20
Respiratory disease	2
Heart disease	9
Patient died at home	129
Patient died in long-term facility	13
Concerned with loss of autonomy	125
Concerned with loss of ability to engage in activities that makes life enjoyable	126
Loss of dignity	96
Loss of control of bodily functions	53
Burden on family	79
Inadequate pain management	30
Financial implications of treatment	8
Median duration in weeks between first request and death	52

[176] Ibid: 8-11.

Median minutes between ingestion of drugs and unconsciousness	6
Median minutes between ingestion and death	31

The Oregon data shows several interesting things. For one, there has been a steady increase in the number of people seeking and being prescribed life-ending barbiturates. At the same time, however, only around 50-60% of those who are prescribed the meds actually take them. And the ones that do are overwhelmingly married, white, college educated, financially well off, suffering from cancer, and cite loss of autonomy or at least the fear of the loss off autonomy the main reason for seeking PAS. As two supportive physicians put it, these Oregonians strike back at their loss of autonomy by taking advantage of legislation that allowed them to accomplish the ultimate "exercise [of] their autonomy" by "control[ling] the timing of their death rather than waiting for it to happen to them."[177]

Every other jurisdiction in the United States that practices PAS has taken Oregon's *Death with Dignity Act* as its model.[178] Although there two differences to note, one relatively minor and another more serious. First, Hawaii law[179] requires a 20-day waiting period between requests for PAS rather than 15 days required by the other pro-PAS states. Other than that, in all of the PAS states patients must submit multiple requests to their physician for PAS, they must undergo examinations, a waiting period, consultations between physicians, have diagnosis, prognosis, and residency requirements met, and be informed of the alternatives that are available to them. Second, however, Montana's situation is especially concerning given the lack of oversight as to how PAS is practiced. Since that state's legalization of PAS was the result of a court decision, there have been no guidelines nor any reporting requirements as there are in the other states. This means that Montana is in "a very ambivalent position" such that "in the absence of an authorized protocol for implementing [PAS], such as the OREGON [PAS] guidelines, prudence seems to deter medical practitioners from taking any action regarding PAD."[180] Of course, even if Ball is correct here, no one could possibly know this since there are no reporting requirements required by Montana law.

5. PROBLEMS IN PRACTICE

Now that PAS is being practiced in several countries around the world, including seven U.S. states and the District of Columbia, we have an opportunity to reflect on its practice and get a better sense of what its pitfalls are. Consider the following two problems that have come with the implementation of PAS.

Degrading the Calling

First, PAS has brought serious *challenges to the medical profession* itself. Part of this is the tension due to the profession now starting to consider death as a 'legitimate' treatment option. On the other hand, part of this is due to the challenges of implementing the PAS laws themselves. Consider the practice of PAS and euthanasia in the Netherlands in the late 80s and early 90s. Even

[177] Prokopetz & Lehmann 2012:98.

[178] See *The Washington Death with Dignity Act* 70.245 RCW & 246-978 WAC (2008); Vermont's *Patient Control and Choice at the End of Life Act* Act 39 18 V.S.A. 5283 (2013); California's *End of Life Option Act* AB15 HSC 1.83 443 (2015); *Colorado End of Life Options Act*, CRS 25-48 (2016); *Washington D.C. Death with Dignity Act of 2016*, D.C. Law 21-182; Hawaii's *Our Care, Our Choice Act*, HB 2739 HD1 (2018)..

[179] Hawaii's *Our Care, Our Choice Act*, HB 2739 HD1 (2018).

[180] Ball 2012: 161.

though the Dutch government started requiring physicians to report their cases of euthanasia and PAS, serious problems arose.[181] For instance, the official Dutch guidelines require that a justifiable euthanasia can only be in response to persistent voluntary requests by the patient and also after another physician has supported the decision. Afterward the physician must report the euthanasia to the government, not certifying the death as due to "natural causes" and thus notifying the appropriate local medical examiner who in turn notifies the local prosecutor, who then does an investigation to make sure that the guidelines had been followed.[182] The results of Dutch government studies in 1990 and 1995, however, revealed that the guidelines had failed. For example, "more than 50 percent of physicians considered it appropriate to suggest euthanasia to patients" instead of merely responding to requests for it by the patients themselves.[183] The study also revealed a serious underreporting problem: in 1990, only 18 percent of cases of euthanasia were reported to the proper authorities; in 1995 that figure rose, but only to 41 percent.[184] Most disturbingly, physicians in 1990 admitted to euthanizing over 1000 patients without their consent; in 1995, that figure rose to 1,537 deaths.[185]

What the Dutch studies show is that people, especially the terminally ill, have good reason to be skeptical and distrustful of their physicians. Those physicians are not operating from the assumption of preserving, sustaining, and improving life for their terminally ill patients. This historic mission of medicine embodied in the Hippocratic Oath directs its adherents to never intentionally harm or poison a patient, but to always seek life.[186] But many now consider death as a viable option of medical care since "the proper goals which define medical practice include healing, preventing illness, and helping the dying patient to achieve a peaceful and dignified death," even if the latter means participating in PAS.[187] How might a physician, who has a personal moral conviction against engaging in such an act, get along? Howard Brody suggests that even though they come into the medical profession with their *personal* morality, "we might also imagine them someday reaching consensus about the core moral commitments that make up their *professional* identity,"[188] such as the "moral obligation to use medical means to relieve their patients' suffering, " and the "moral obligation to respect the autonomous choice of patients."[189] In other words, Brody is interested in the possibility of a medical professional ethics that is divorced from one's personal morality such that when a physician puts the white gown on, he is governed by a completely different, and potentially incommensurate, set of moral principles and rules than he is when it's off. This is the complete opposite of the classic Hippocratic physician who practices "no dichotomy between his 'life' and his 'art" but is a "thoroughly integrated individual who is on the inside just what one sees on the outside."[190] The forfeiture of this model, however, if it should become commonplace, will infect popular opinion of the profession with a dearth of trust and surge of paranoia.[191] And it will do so precisely because of the abandonment of Hippocratic medicine which emphasizes the covenant between doctor and patient for a transactional model of healthcare where the customer is "infallible."[192]

[181] The Dutch, as do most other experts and jurisdictions, define euthanasia as the physician killing the patient by lethal injection and PAS as patient death by physician-prescribed lethal drugs, see Buiting et al 1990.
[182] Hendin 2002: 100.
[183] Hendin 2002: 103.
[184] Hendin 2002: 104.
[185] Hendin 2002: 104-5.
[186] Crawshaw et al 2016.
[187] Brody 1996: 141.
[188] Brody 1996: 140.
[189] Brody 1996: 137.
[190] Kilner & Mitchell 2003: 13.
[191] Kass 2002: 28.
[192] See Mitchell 2002: 190-2.

Physicians' Inability to Adequately do PAS

Along these lines, a second problem arises, that of *the kinds of assumptions and judgments that legislators and physicians are ill-equipped with in order to be death practitioners*. This ties in directly with the previous point in the sense that providing death as a professional care option, as the Netherlands studies show, "means that physicians [have] to weigh in their minds whether life or death is best for the patient."[193] For instance, consider the Dutch disaster again. Those physicians, responding to the government survey, who anonymously admitted to performing euthanasia on patients without their explicit consent, cited "low quality of life," "relatives' inability to cope," and "no prospect for improvement" as their reasons for doing so.[194] These are outright chilling cases of doctors making the death determination clearly on their own. But the problem also extends to cases where physicians have to determine a patient's eligibility for PAS when they suffer from the same illness that, say, 35 other patients of that same physicians suffer from, yet this one patient finds that he cannot live any longer with it. Given that people's suffering is so much a "function of [their] values," in cases of PAS "the doctor will in effect be treating the patient's values."[195] "But how could a doctor possibly know that or make such a judgment? Just because the patient said so?"[196]

The problem here is that for a physician "to justify committing an act of PAS and still maintain professional and personal integrity, the doctor must have his or her own independent moral standards," but then the concern is about what those standards will be.[197] When the ubiquitous moral standard for the entire profession is *life* and *health*, the physician needn't appeal to his own moral values or reasoning processes to make judgments for treatment. This is the why, for instance, he can reject my request to have my perfectly healthy arm amputated.[198] But without a common moral standard guiding the profession, and given that PAS "is not a medical but a moral decision" in that it can never be justified "on purely medical grounds," then the doctor will be exercising a medical procedure on purely moral grounds: he or she "must believe that a life of subjectively experienced intense suffering is not worth living in order to feel justified in taking the decisive and ultimate step in killing the patient."[199] As such, it will ultimately come down to "the doctor's moral reason to act, not the patient's reason."[200] Where death is practiced as a legal medical option, this asks something of physicians that they are not prepared to do. They are being asked to form epistemic and ethical judgments about quality, worthiness, dignity, and viability of life. But the classical ideal of the physician is that he or she "pledges not to practice beyond his competence," meaning that he or she would not practice beyond their specialty, that which they are trained and prepared to do, including decisions for death.[201]

On the other hand, maybe physicians do have some sense of the quality of life *qua* physicians. But that life will be the physiologically optimal life, conceived in solely physiological terms, not moral ones, and that would influence how they approach their own definition of a life that's worth living. A study in the early nineties found that of a test group of high-functioning quadriplegics that had suffered spinal cord injuries, 86 percent rated their quality of life as "average or better

[193] Kilner 1998: 133.
[194] Kass 2002: 27.
[195] Callahan 1992: 53.
[196] Ibid.
[197] Callahan 2002: 64.
[198] Callahan 2002: 64.
[199] Callahan 2002: 64.
[200] Callahan 2002: 64.
[201] Kilner & Mitchell 2003: 13.

than average," but only 17 percent of physicians and nurses who were polled rated that same level of the quality of life if *their* lives were similar.[202] This makes sense given their training and practice of working from an operational assumption that identifies less-than-optimum as pathological. This is ingrained as part of their critical thinking and reasoning toolkit. As such, the standards they would use in order to make PAS judgment-calls would not – nor could not – be purely *moral*. One possible solution to this would be to take such decisions out of the hands of physicians altogether. One team of physicians advocates for "the development of a central state or federal mechanism to confirm the authenticity and eligibility of patients' requests [for PAS], dispense medication, and monitor demand and use."[203] But it's not clear that this would alleviate the real problem, because this would make death-decisions legitimate only by bureaucratic process.

PAS is Biased Against 'Less-than' Populations

Given societal stigmatization and bias against mentally ill and disabled persons, *PAS implementation exacerbates the prejudices against vulnerable populations*. If legislators, bureaucrats, and physicians have the authority to wield the definitions and criteria of what counts as low quality of life, it's not clear that they are immune from selecting against the lives of those who suffer from *all* kinds of impairments. Diane Coleman puts the severity of this point well:

> Common social stereotypes appear to have overcome professional objectivity and insight. Studies also show that medical professionals assess the quality of life of disabled people to be dramatically lower than disabled people themselves do. Yet in the face of documented inadequacies in medical knowledge, as well as documented economic pressures in the health care system, these medical professionals are the gatekeepers of the safeguards. These medical professionals determine who is voluntarily choosing assisted suicide.

There are several pertinent examples of this. Consider Elizabeth Bouvia. In 1983, she was a twenty-something California woman who suffered from a physically debilitating cerebral palsy.[204] Her illness was non-terminal, yet she complained of psychiatric pain and told her doctors that she wanted to die.[205] They refused, so she sued in state court and won, the appellate court ruling that "a competent adult patient had a constitutionally guaranteed right to refuse medical treatment that must not be abridged."[206] The question, however, is just how competent Bouvia was, all things considered. Prior to her legal ordeal, Bouvia suffered tremendous professional and personal traumas. She had been a graduate student in social work at San Diego State University but dropped out after a professor told her that her disability made her unemployable such that if his department had actually known just how disabled she was at the time of application, they would have never admitted her to the program.[207] At the same time, she was married and had gotten pregnant, but separated and divorced her husband after suffering a miscarriage after the tragic drowning death of her brother.[208] At her trial, psychologist Faye Girsh gave testimony that Bouvia was competent and rational in her decision to want to refuse medical treatment and die.[209] But as Diane Coleman argues, "a nondisabled woman facing similar traumas would have been found

[202] W. Smith 1997: 191.
[203] Prokopetz et al 2012: 99.
[204] Coleman 2002: 213.
[205] See Pence 2015: 19-25.
[206] Pence 2015: 24.
[207] Coleman 2002: 213-4.
[208] Coleman 2002: 214.
[209] Coleman 2002: 214.

suicidal and therefore 'incompetent'."[210] In other words, given cases of non-disabled terminally ill patients and those of non-terminally-ill disabled patients, people like Girsh and the courts find all their lives to be *equally* not worth living, and thus are better off dead.

This is the sort of idea that motivated the philosophy of the eugenics movement of the late-nineteenth and early-twentieth centuries, and in terms of the PAS movement of the mid-nineties, was epitomized in the writings and work of Jack Kevorkian. Kevorkian had published writings explaining how his "primary goals" for medical practice included "live human experimentation and organ harvesting" and that good subjects for these purposes included death-row inmates, Alzheimer's patients, and infants suffering from spina bifida.[211] And, in a statement he submitted to the court during one of his criminal cases, Kevorkian noted that his work in providing PAS was to "enhance public welfare through the voluntary self-elimination of individual and mortally diseased or crippled lives taken collectively," even though many of his clients, such as Sherry Miller, suffered from multiples sclerosis, a non-terminal disability. [212] So why do such people want to die? As evidenced by the 2017 Oregon data noted above in Table 2 (and discussed a bit more in §5 below), it's not so much from pain, but from indignities that, frankly, are socially constructed, and that for those who have them death looks like the most rational option. In such a society as the one we live in, "disability is feared far more than death," and this is especially the case given the amount of studies showing how people who live with such disabilities cite their main source of unhappiness and suffering, not from the disability itself, but from "societal attitudes" about it.[213]

What this means for the implementation of PAS in states like Oregon, however, is that there are huge gaps in proving the incompetence of patients whose suffering is caused by such attitudes. For instance, although Oregon requires PAS physicians to confirm that a patient did not seek PAS out of "impaired judgment" due to mental illness, "this criterion […] utterly fails to address the more prevalent but subtle forms of social coercion."[214] This is especially disturbing given that as more thorough studies of the first few years of Oregon's implementation of PAS were coming out, it became clear one of the main reasons that patients chose PAS was because of "fear and prejudice about disability."[215] Tragically, what PAS may seem to offer those who suffer from non-terminal disabilities and the 'indignity' stereotypes that accompany them, is the socially acceptable mentality that claims "suicide is the best way to reclaim their dignity," the right way to "make one last contribution" to society.[216] In other words, this mentality holds that such persons have a duty to die; they owe it to the rest of us to free up the financial and medical resources their lives require in order to make society more efficient. A very cynical view of the implementation of PAS, then, is that it helps the majority get what it wants by discriminating against a minority – terminal, disabled, incompetent, etc. – by allowing them to be the only ones with legal access to PAS so long as they can justifiably meet the criteria.[217]

But there is good reason for taking the cynicism seriously. Wesley J. Smith notes the very different public reactions to two tragic child-murders in the nineties. First, there was the 1993 homicide of Saskatchewan Tracy Latimer, a quadriplegic twelve-year-old girl with an advanced form of cerebral palsy who was killed by her father by carbon dioxide poisoning on a Sunday morning as the rest of the family were at church. That next year, Susan Smith intentionally drove

[210] Coleman 2002: 214.
[211] Coleman 2002: 219, citing Kevorkian 1991 and 1998.
[212] Coleman 2002: 219.
[213] Coleman 2002: 221.
[214] Coleman 2002: 224.
[215] Coleman 2002: 225.
[216] Coleman 2002: 228.
[217] See Avila 1998: 56-8.

a car into a Union, South Carolina lake, killing her two young boys who were fastened firmly in their car seats.[218] The public reactions to these tragedies could not have been more different. While "Smith was branded a monster and had to be protected from an angry crowd, Robert Latimer was widely hailed as a loving father."[219] The public support for Latimer included thousands of dollars in unsolicited donations toward his legal expenses and letters sent to the various judges who tried his case through the trial and appeals court process.[220] Latimer was eventually cleared of all charges, however, Susan Smith was convicted and sentenced to life in prison. What accounts for these differences is that "Smith's children were able-bodied and pleasant to look at, and therefore they had a right to their lives. Tracy Latimer was disabled and unphotogenic, and therefore she was seen by many as better off dead."[221]

With such biases informing values that are firmly planted in the modern, western way of thinking, there is real concern about the ability of public policies and medical practitioners to accurately define "competence," "voluntariness," and even "terminal illness" when it comes to not only making laws for the implementation of PAS, but in making the specific decisions for specific patients as well. For instance, as just noted, societal attitudes reveal a prejudice that is highly *coercive*, not only to non-terminal disabled patients, but also to terminal patients who "experience a welter of strong emotions, such as anger, fear, exhilaration, and self-disparagement," and are thus "vulnerable to the suggestions, expectations, and guidance of others."[222] So, it's not clear how voluntary the desire for death really is, or how competently they are making such decisions when in the face of such psychological distress. And even though terminal illness is defined in many state statutes, they all leave room for interpretation that opens the door for a "subjective determination of who is terminally ill,"[223] especially given the biases society maintains regarding the mentally ill, disabled, and even elderly. This would result in "regional and situational variation," arbitrary data-interpretative thresholds that would be "likely to result in many borderline cases," ultimately leading to final judgements in the face of many diseases that "are just too unpredictable."[224]

A further critical issue along these lines is that so many of the state laws legalizing PAS fail to adequately acknowledge the crucial and decisive influence that clinical depression – a psychotic disorder[225] – plays into end-of-life decisions, making the depressed the most vulnerable population for PAS. Oregon especially overlooked this given that they do not require psychiatric evaluations for PAS requests, although it is "the standard of care for suicidal patients."[226] Psychiatrist Gregory Hamilton tells of a 1994 case in Oregon that conveys the real issues here.

> [A] legal action was being brought by a patient with a progressive neuromuscular disorder, along with other plaintiffs. She had previously become depressed and vulnerable to suicidal ideation and with treatment had recovered from those feelings, as most patients do. She pointed out that the assisted suicide law discriminated against her and threatened her life, because once her disorder progressed to the point of meeting the definition of "terminal illness," she would no longer be afforded the same protection against her suicidal impulse that others are granted. If her depression recurred, as it was likely to do, this time she could be given an overdose instead of help. Her challenge raised serious questions about how difficult it is to tell when depression is affecting decisions about assisted suicide and the impossibility of protecting those who are depressed from other mentally ill individuals. A similar

[218] W. Smith 1997: 185.
[219] Ibid.
[220] Ibid.
[221] Ibid.
[222] Cohn & Lynn 2002: 257.
[223] Cohn & Lynn 2002: 252
[224] Cohn & Lynn: 252-3.
[225] See Chocinov & Schwartz 2002: 262-3.
[226] Foley & Hendin 2002b: 151.

> concern would soon be raised by 94 percent of Oregon psychiatrists surveyed, who said they were uncertain they could determine in a single visit when depression or other mental disorder was affecting decisions about assisted suicide.[227]

This is a crucial problem since there is no policy implementation safeguard to accurately distinguish clinically depressed patients from those who are truly competent and voluntary. Even more sobering is the fact that "the most significant predictor of support for PAS [is] depression and psychological distress."[228] This is not too surprising when one considers the data that shows cancer patients to have a suicide risk that's twenty-five times higher than the rest of the population.[229] If such patients' moods and behavior are merely thought to just be reacting normally to their physical ailments and not properly diagnosed with depression, this may make them the most vulnerable population to PAS policies and expectations, especially since clinical depression "is a highly treatable source of suffering" such that those who receive treatment "often recover the ability to enjoy social discourse and may rekindle some prior interests."[230]

What all of this shows is that the actual practice of PAS, at least in terms of it diagnoses, vetting, and exhaustion-of-options aspect, are far from acceptable. There are loopholes, contradictions, and blindspots to the practice that make it a serious public health crisis.

6. WHY PEOPLE REQUEST PHYSICIAN-ASSISTED SUICIDE

Consider the 2017 Oregon PAS report again (Table 2 above). Out of 143 people who died by PAS, 126 said they were concerned with the "loss of ability to engage in activities that makes life enjoyable;" 125 said they were concerned with "loss of autonomy;" 96 said "loss of dignity;" 53 cited "loss of control of bodily functions;" 79 said they were a "burden on family;" 30 said "inadequate pain management;" and eight said that they chose PAS because of the "financial implications of treatment."[231] These, I think, can be narrowed down to two categories of suffering that serve as the reasons why people consider and even follow through on PAS.

Physical Pain

First, there is *pain*. Interestingly, this is the only purely *physical* reason cited by patients (whereas pain is understood as a "physical sensation").[232] One of the problems with particular illnesses, such as late-staged cancers, is that the pain can sometimes be quite unbearable. It is important to note, however, that effective pain-relieving measures are much better than ever before in medical history, partly because the implementation of PAS in some states have upped the ante for its detractors to develop better palliative care, and in the vast majority of cases adequate pain relief is achievable.[233] Success in relieving pain, then, may be why "effective pain management" was the second-least cited reason by those who had undertaken PAS. This point, however, is not meant to disparage the reality of severe pain. Pain indeed is a huge problem for a great number of people, and it is something of a moral failure and malpractice on our part to not "use pain medication optimally" for those who are suffering unbearable pain.[234] Part of the

[227] Hamilton 2002: 176-7.
[228] Chochinov & Schwartz 2002: 263.
[229] Ibid.
[230] Ibid. 270-1.
[231] Oregon Health Authority, Public Health Division 2018: 10.
[232] Kilner 1998: 132.
[233] Kass 2002: 22; also see Byrock 1997: 115-8.
[234] Pellegrino 2002: 50

problem here may be due to the fact that physicians aren't trained well in managing pain effectively, partly because the medical profession tends to give accolades to solutions and cures for acute problems, not chronic ones.[235] Nevertheless, it does not follow that euthanasia is an appropriate response.

Suffering from lack of Self-Worth

Second, and more prominently, there is what I call suffering out of the *struggle for self-worth*. This is a different kind of suffering than physical pain, although pain may be a contributing factor, especially if it's thought that the unbearableness of one's pain destroys one's rational self.[236] Yet, despite that many of the popular pro-PAS arguments have focused on society's obligation of having compassion on those who are suffering from unbearable, untreatable pain as the ultimate reason for having legal PAS, the data above shows something very different. Loss of dignity, autonomy, bodily function, participation in enjoyable activities, and burden to family etc. are the reasons people choose PAS. Hence, the majority of cases of PAS are not a result of objective diagnoses at all, but out of patients' subjective responses to those diagnoses. What this may suggest is that the factors influencing one's decision for PAS has more to do with one's perspective on the value of their life than on objective physical factors themselves. This really shows that *suffering* can be very complex, involving the "emotional, psychological, and even spiritual aspects of the human condition" in that sufferers "[feel] fragmented, unraveled, or violated" to such an extent that "[their] integrity as a person is sometimes assaulted by suffering."[237] However, there is no need to think that one is *less* of a person just because one's family needs to tend to her more, or because she cannot use the restroom alone, or drive herself to the bank, or play tennis like she once could, or use financial resources that could be used elsewhere. As Daniel Callahan puts it, these sorts of things come not just with a terminal illness, but simply with age: "our bodies just give out at some point."[238] Nonetheless, these things are still cited as the primary reason motivating PAS.

In a study that was undertaken by the State of Oregon, PAS patient surveys were compared with those of non-PAS patients who had similar illnesses, and the findings were striking:

> The PAS group was more concerned about autonomy and control than the other group. Even more provocative was the fact that the PAS group was far more able to function physically than the control group: 21 percent of the [PAS] patients, as compared with 84 percent of the [non-PAS] patients were completely disabled. In other words, the PAS group was far better off physically than the [non-PAS] group. It was their personal values that led them in one direction rather than another, not the objective intensity of their incapacities. [...] PAS represents a legitimation of suicide for those who have a particular conception of the optimum life and its management, one of complete control.[239]

What this reveals, then, is that the vast majority of PAS cases in Oregon are motivated by "a particular set of personal (and idiosyncratic) values."[240] These values play into a particular view of *self*, whether right or wrong, justified or unjustified, coerced or voluntary, terminal or temporary, disabled or able-bodied. Many who cannot bear to lose control of their lives, who value such control and estimate their self-worth in terms of it, see PAS as a viable (and even the appropriate)

[235] Kilner 1998: 132
[236] Velleman 1999, 618.
[237] Mitchell 2015: 70.
[238] Callahan 2005: 187.
[239] Callahan 2005: 188, citing Chin et al 1999.
[240] Ibid., 188.

solution. But it's not clear if such subjective values are really those of the patient, or a result of social and cultural values. The determination that "a life is no longer valued" may not so much be one of the person himself, but "by the onlookers," especially given the concerns noted in the previous section.[241] Interestingly, though, where the ideas or values come from doesn't matter as far as PAS-providing states and practitioners are concerned. What matters is that the patient has defined their own sense of *dignity* such that a life that achieves anything less than that is not worth living.

This is why PAS is often called "rational" suicide by proponents: so long as the circumstances are such that one is better off dead than alive, then suicide is the rational thing to do.[242] So, for instance, if one suffers from a condition that does not allow one to live up to one's standard of dignity, or puts a substantial financial or emotional burden on one's family, suicide may be the most rational thing to do. What matters is that the circumstances are such that a patient's quality of life is no longer satisfactory to him or her, or to others (if one takes a pretty strict utilitarian 'lifeboat' perspective on this).[243] A "rational" suicide, then, is one where death "is a better prospect than continuing to live."[244]

Daniel Callahan, however, responds critically to this notion of a "rational" suicide. When intelligent people use the term "rational," they imply "some predictability in behavior."[245] For example, the reason why it is rational for me to assume the truth of claims such as, "the sun will arise tomorrow morning," or "the fuel gauge in my car will move closer to 'empty' the further I drive without refueling," is because these claims' obtainment is very likely. I can predict them with high probability. That people will commit suicide, however, is not this way at all. After all, "people die miserable deaths all the time" without turning to suicide as a way out of their misery.[246] And even though it is more likely for a depressed person to commit suicide, that clinical depression is a mental/emotional disorder would automatically make suicide, much less any decision at all, an irrational choice for that person.

7. PHYSICIAN-ASSISTED SUICIDE AND THE PHILOSOPHERS

As the real-life cases about people like Karen Ann Quinlan and Nancy Cruzan became part of the national conversation, many ethicists turned their attention to it and the amount of scholarship on this issue grew enormously. As one can probably imagine, most of what was put out by professional philosophers were arguments in favor of PAS, some even going further in arguing that nonvoluntary euthanasia would be morally required for someone who is suffering unbearable pain as they are dying.[247]

In philosophical ethics,[248] these arguments represent two of the three major normative approaches that most ethicists take. Consequentialists simply argue that the morally right action is the one that provides the best consequences, although they do not all agree as to what those are. Egoists say that the kinds of consequences that matter are those that affect one's own self-interests. Utilitarian thinkers such as the infamous Peter Singer – influenced by Jeremy Bentham and John Stuart Mill – argue that the consequences which matter are those that benefit the most amount of people, which does include one's self interests (after all, you have to start somewhere), but does

[241] Kass 2002: 23.
[242] See Quill 1991; W. Smith 1997: 8; Dyck 2002: 17-24; Dworkin 1993: 193; Moreland 1998: 187-8.
[243] See Werth & Cobia 1995.
[244] Dyck 2002: 20.
[245] Callahan 2005: 180.
[246] Callahan 2005: 180.
[247] See Rachels 1975.
[248] A very good and accessible primer in moral theory is Vaughn 2015.

not stop there. On the other hand, Kantian thinkers appeal to what they think are universal principles that form the foundation of right ethical reasoning, one of these being Kant's famous second formulation of the categorical imperative: "act as to treat humanity, whether in thine own person or in that of any other, in every case as an end withal, never as means only."[249] Kant's point here is that persons should never merely be treated only as having instrumental value, but as having intrinsic value in and of themselves, and thus should be treated as such. Most of us are in agreement with this point. But the reason why Kant thought this was the case, that is, why we should treat people as *people*, is because of their autonomy – because they can figure out a form of action and follow through on it all by themselves. This gives them a high status. Our freedom to reason, desire, and will is what makes us respectable and deserving of others' respect such that it is never right for someone to interfere with one's moral decision making. That being the case, many who follow this tradition and argue for PAS emphasize this autonomy principle as the core starting point (even though Kant himself argued that suicide is morally wrong due to its inherent logical inconsistency). In what follows, I present the basic arguments from these two normative ethics frameworks: the consequentialist-interests and Kantian-autonomy traditions.

The Consequentialist Argument for PAS

In a §1, I noted James Rachels's criticism of the distinction between active and passive euthanasia. For him, the claims that *allowing* terminally ill patients suffering from unbearable pain to die is morally permissible but actively *killing* them is not, are inconsistent. Why? Because even though the ultimate result of death ends up being the same in both cases, there is a very important sense in which they aren't morally equivalent at all. In the former case you are allowing the patient to suffer for no good reason. He is going to die anyway, and your lack of action is extending his suffering. Euthanizing him in order to minimize his suffering is the better option because it brings about the best consequences.[250] This argument is summarized thus:

1) If an action promotes the best interests of *everyone* concerned, and violates *no one's* rights, then that action is morally acceptable.
2) In at least some cases, active euthanasia promotes the best interests of everyone concerned and violates no one's rights.
3) Therefore, in at least some cases active euthanasia is morally acceptable.[251]

Is this argument sound? Rachels indeed thinks it is. First of all, premise 1 seems to be true because of how generally applicable it is – it's the general principle or rule (what the ancients and mediaevals called the *major premise*) taken to be objectively true. The strategy of this argument, then, is to conjure agreement with this general principle and then identify specific cases that conform to it. But how can you ever prove that the first premise is objectively true? You examine specific cases in order to get a sense of its plausibility. Here's a silly example. There are those (rare) times when I curve my students' exams grade up a bit such that everyone gets more points than what they actually earned by their brute performance alone. This is an example of an action that promotes everyone's interests, even mine (especially when student course evaluations are coming near) and the university's (it contributes to better student outcomes), and indeed no one's rights

[249] Quoted from Vaughn 2015: 124.
[250] See Rachels 1975.
[251] Rachels 1994: 150. See also Rachels 1986: 156-7 and 1993: 48.

are violated in my doing so. So, it seems as though the consequent follows: raising the grades is morally acceptable.

Now, what about the second premise – is it true? Rachels obviously thinks it is on the basis of the generalization in premise 1. If that very general principle is true regarding any such action, and euthanasia is such an action, then at least when an act of euthanasia conforms to the rule set in the generalized principle: it's in everyone's best interests and no one's rights have been violated. Bottom line: everyone's interests matter. For the consequentialist, then, this is why active euthanasia is sometimes morally acceptable as well as sometimes just letting someone die – if that's what they want, and it best serves everyone's interests in some way, then so be it. The basic point here is that the sky is the limit when it comes to determining the right moral action because all that matters is actions that are successful in "maximizing interests" which means "satisfy[ing] as many interests as possible."[252]

Michael Tooley uses this same sort of argument specifically for PAS and voluntary active euthanasia. If the above argument applies to euthanasia, then there is no reason why it couldn't also apply to suicide, and then PAS also. Tooley argues that death may very well be in the best interest of the person suffering from incurable pain. And if that's true, and suicide secures death then committing suicide would be in one's own interest.[253] Of course, being the utilitarian that he is, Tooley thinks that there some further conditions that you should meet before being given the moral green light to go ahead with your demise. First of all, it cannot violate others' rights or wrong them in any way. Second, your suicide cannot end up making the world worse off than it is (this is purposefully vague in order to cover all possible cases). But if all of these conditions obtain, then congratulations, your suicide is morally okay.[254]

Now here's where things get really interesting (if you didn't think so already). Since suicide has been morally justified in this argument thus far, there can be no principled objection to *assisted* suicide. After all, it doesn't matter whether someone helps you commit suicide or not, so long as you *want* to commit suicide. Of course, the assister must also meet the same conditions – they may not assist if the subject's suicide itself was impermissible (for the aforementioned reasons, including not being in his or her interest), or their assisting violated obligations to someone else such as a church, spouse, or professional organization. Barring such justificatory defeaters, assisting someone in suicide is morally permissible.[255] Indeed, it may even be morally obligatory depending on "how expensive it will be to keep the personal alive."[256]

But it doesn't stop here. If the argument so far is sound, the Tooley thinks that it is, then there is no reason to think that it doesn't also follow that voluntary active and voluntary passive euthanasia are morally permissible so long as the subject of either action meets the same conditions: self-interest, no one's rights violated, and world isn't made worse off (and if an active euthanasia, the one performing it is not violating obligations to others). This is the simplicity of utilitarian ethical reasoning: no action is in principle barred from being morally permissible unless it does the opposite of maximizing interests. Because of this, to talk about actions being intrinsically moral or immoral makes no sense. Actions can only be moral or immoral given their consequences. Thus, it's consequences that really matter for morality, no so much the action itself, as Rachels's and Tooley's arguments pointedly show. Moral assessment of an action is parasitic on the achievements of its consequences. It has no moral value apart from it.

This is why utilitarians like Rachels and Tooley have a difficult time dealing directly with the claim, for instance, that killing is always morally wrong because it is an absolute, categorical moral

[252] Rachels 1986: 156.
[253] Tooley 2005: 164.
[254] Tooley 2005: 165-6.
[255] Tooley 2005: 166.
[256] Tooley 1979: 63, 72-5.

evil. For them, morally absolutized evaluations of actions are nonsensical. Indeed, everything is open to the utilitarian so long as it maximizes interests. Nothing is ever morally banished on its own. But why should the rest of us think this is true? Tooley offers some insight into the sort of ethical outlook he rejects.

> Some moral rules that people accept, or have accepted, are clearly such as do not serve the interests of individuals – e.g., various sexual prohibitions, such as that against masturbation. The prohibition of active euthanasia seems to be another case of a moral point of view which does not further the interests of individuals living together in society. Why, then, has this moral point of view been accepted? The answer here, as in the case of the traditional outlook of Western society, is found in the powerful influence of the Christian churches. This historical point deserves to be kept firmly in view when one is reflecting upon the morality of euthanasia Many otherwise thoughtful people somehow lose sight of the fact that what they refer to as "moral intuitions" regarding euthanasia sprang originally from a certain theological outlook, one that is no longer taken seriously by most people who have taken the trouble to examine its credentials carefully and impartially.[257]

Rachels agrees with Tooley here and criticizes the "traditional view" that completely disregards what people's actual interests are and that appeals to "traditions" that have no rational basis.[258] Interestingly, Rachels points out that those who hold the traditional view on Christian grounds are doubly irrational given Christian scripture forbids neither euthanasia nor suicide, and thus provides no Biblical rationale for the "traditions."[259] But Rachels and Tooley can make these accusations and claim that the "traditional" views are wrongheaded, because of their particular view of persons and interests. Although I will discuss a biblical-theological anthropology in §8 below, here I want to outline Rachels's and Tooley's view of personhood.

Personhood for the Consequentialists

Following Jeremy Bentham's footsteps, Peter Singer, the utilitarian par excellence, once argued that the crucial capacity that makes all sentient creatures worthy of moral consideration is the capacity they have to suffer pain.[260] Interests, then, only arise out of the ability that one has to suffer pain (broadly construed). In good utilitarian form, then, Singer argues that the maximization of interests is accomplished only when the least amount of pain is achieved. But this leads to some interesting and controversial implications. For one, it means that morality itself is tied to the ability to experience pain. Further, then, to be a moral agent – one deserving of moral consideration – means that you have to be the kind of thing that can experience pain. But to experience pain means that one has to be cognitively wired or developed in such a way that makes pain a possibility for him. This is why Tooley can ultimately make a distinction, then, between himself as a person or as an organism.[261] It's also why James Rachels can make the similar distinction between his *biographical* life and his *biological* life.[262] And in making these distinctions, what Tooley and Rachels both argue is that the kinds of beings that can have interests, that is the kinds whose interests matter and thus have moral standing/value, are the those with the former, not the latter. Of course, they think that to have a biographical life there must be a biological life

[257] Tooley 1994: 109.
[258] Rachels 1986: 3-5.
[259] Rachels 1993: 52.
[260] Singer 1975: 7.
[261] Tooley 1979: 65.
[262] Rachels 1986: 25.

to support it. But a lump of flesh and bones on a hospital bed in a PVS is not a person. It has no interests. It is a mere organism. As Rachels thus notes,

> The sanctity of life ought to be interpreted as protecting lives in the biographical sense, and not merely in the biological sense. There is a simple, but I think conclusive argument for this. From the point of view of the living individual, there is nothing important about being alive except that it enables one to have a life. In the absence of a conscious life, it is of no consequence to the subject himself whether he lives or dies. Imagine that you are given a choice between dying today and lapsing into a dreamless coma, from which you will never awaken, and then dying ten years from now. You might prefer the former because you find the prospect of a vegetable existence undignified. But in the most important sense, the choice is indifferent. In either case, *your* life will end today, and without that, the mere persistence of your body has no importance. [...] the importance of being alive is only derivative from the more fundamental importance of having a life.[263]

So what does it mean to have a biographical life, or to have personhood? What does it mean to be the kind of thing that merits the status of personhood? For Rachels, it's to have just enough consciousness such that you can actually experience your life, have pleasure and pain, and thus have interests as a result. On Rachels's account, being a human – or other mammal, or amphibian, or reptile – is unimportant – but "the capacity to suffer pain" is the crucial.[264] So when Rachels makes the claim that people have the right to commit suicide because "the life belongs to the individual; no one else has the right to interfere,"[265] the implication here is that it only belongs to those who have biographical life. Tooley agrees. For him, a person can only be the kind of thing that "is a continuing subject of experiences and other mental states that can envisage a future for itself and that can have desires about its own future states."[266] Of course, this implies at least two further points. One is that this needn't be relegated to any particular species of beings. Secondly, since these are the criteria for what it is to have interests, any human being that does not have this going for him or her – the PVS victim, the Alzheimer's patient, the person in a coma, etc. – is not a moral agent or beneficiary of moral concern. Hence, they aren't persons, and so it's not clear that they would be the kinds of things that would need to consent to any form of euthanasia.

The Autonomy Argument for PAS

The argument from autonomy is basically this: since humans are autonomous beings with the right to self-determination – that is, the right to make their own choices for their own reasons – their wishes, desires, and decisions must be respected, and this "encompasses the right to exercise some control over the time and manner of one's death."[267] After all, this is the crucial issue regarding PAS and other end-of-life issues that made law get involved. *In re Quinlan*, *Cruzan*, *Glucksberg*, and *Quill* were all cases that brought questions about autonomy to the courts – does an autonomous, uncoerced patient have a right to refuse treatment? If so, then does that imply she also has the right to seek her own death? When a patient is incapacitated, may others make decisions for her without violating her autonomy? As Timothy Quill himself noted in his infamous 1991 expose, he assisted in Diane's death because that was her wish given the circumstances surrounding her terminal disease, and he felt that he had a moral obligation to respect that autonomous choice by facilitating it.[268]

[263] Rachels 1986: 26-7.
[264] Rachels 1986: 72-3.
[265] Rachels 1993: 59.
[266] Tooley 1979: 91.
[267] Dworkin, Zimroth, and Krash 1999: 196.
[268] See Quill 1991.

Personhood for Modern Kantians

For those who work within from this moral-philosophical tradition, autonomy is a crucial feature of human beings because it is the criterion that instantiates a person's agency. Put differently, a person isn't one without autonomy. It is a necessary and sufficient condition for having moral obligations, which is why we don't hold infants, Alzheimer's patients, or severely cognitively limited people morally blameworthy. But autonomy is also necessary and sufficient for being an agent that is deserving of moral consideration. As Joel Anderson puts it, "knowing to what extent a person is autonomous is necessarily a matter of knowing how it is appropriate to treat her."[269] So what gets this for us? What makes us autonomous? For Anderson, it doesn't come at birth, but "depends on having developed certain capacities" that, once recognized by others, "earns you a certain normative status."[270] Although Anderson does not explicitly name what these are, he footnotes philosopher Robert Brandom who is known for his position regarding the sapience-requirement for personhood.[271] Brandom's conception is that autonomy only manifests itself in our social discursive activity with one another, in what Brandom describes as the "giving and asking for reasons." Taking part in this sort of activity is crucial for our personhood because we can only be persons if others recognize us as such, and they will only recognize us as such by engaging in this activity. So, since personhood depends on autonomy and autonomy depends on discursive activity and such activity depends on being recognized as a player in that activity, one's agency depends on recognition by others that you can play the sapience game of giving and asking reasons – the ultimate activity of rational beings. One's dignity, then, depends on one's discursive capacities.

Not all Kantians, however, go this route and link dignity to others' recognition of it. Philosophers such as David Velleman argue the other way around – we should recognize it in others because it's already there. Instead of social discursive activity being the creator and indicator of value, for Velleman, your dignity is simply already there in you, and is manifested in the activity of the autonomous you determining and securing things that benefit *you*: "things that were good for you would not actually merit concern unless you merited concern," or put differently, "what's good for you wouldn't matter if you didn't matter."[272] For Velleman, such interest-independent value in persons is *dignity*. You treat yourself as having dignity when you appropriate things to yourself because they are good for you, *for your own sake*. After all, every time you do this you implicitly assume there is a valuable *you* to begin with that other goods can *have value for*. Dignity isn't a value "for" someone, but a value that's already "in" someone.[273]

So how would these views approach the issue of PAS? The Brandom view would hold it as the sort of thing that is rational so long as others recognize it as such once vetted through the game of the giving and asking of reasons. Autonomy can only be proven through rational discourse and once it is, it should be respected. For Velleman, PAS is morally permissible so long as the rationale is not that suicide itself would be good for the person. Framing the justification that way is the same thing as saying that a person with interests-independent value/dignity is treating self-destruction as a good for himself. And, following Kant, Velleman claims this is irrational. Rather, suicide makes sense for a person only when their inherent interest-independent dignity is itself

[269] Anderson 2014: 357.

[270] Anderson 2014: 358.

[271] See Brandom 1994. Brandom is a disciple of Richard Rorty, so if you are familiar with Rorty, then you have a sense of where Brandom is coming from.

[272] Velleman 1999: 611.

[273] Velleman 1999: 613.

deteriorating, that is, one's "rational nature" that is the seat of choosing goods for one's self.[274] Unbearable pain, for instance is the sort of thing that can destroy one's rational nature, and thus one's dignity, and thus one's self.[275] In a case like this, then, PAS is morally permissible because it is a death "for the sake of dignity, not for the sake of self-interest."[276]

Ronald Dworkin holds a view of autonomy that is both similar and dissimilar to Brandom's and Velleman's but has been widely more popular in the public debate for PAS. For Dworkin, the right way to think about autonomy is in terms of the *integrity* of one's rational capacities to define one's life as he or she sees fit. Integrity is the "display" of a "self-defining, commitment to a vision of character or achievement that the life as a whole, seen as in integral creative narrative, illustrates and expresses."[277] For Dworkin, one's autonomy is the result of natural evolutionary processes making a "creative investment" into that person, making that person unique in that's person's own way.[278]

> The value of autonomy [...] derives from the capacity it protects: the capacity to express one's own character – values, commitments, convictions, and critical as well as experiential interests – in the life one leads. Recognizing an individual right of autonomy makes self-creation possible. It allows each of us to be responsible for shaping our lives according to our own coherent or incoherent – but, in any case, distinctive – personality. It allows us to lead our own lives rather than be led along them, so that each of us can be, to the extent a scheme of rights can make this possible, what we have made ourselves. We allow someone to choose death over radical amputation or a blood transfusion, if that is his informed wish, because we acknowledge his right to a life structured by his own values.[279]

For Dworkin, *integrity* understood in this way is the *basis* for having dignity,[280] sanctity,[281] and even self-respect.[282] What this necessarily implies, however, are at least two things relevant to PAS and euthanasia. On the one hand, those who are without such integrity do not have inherent dignity, and thus are not deserving of being treated as autonomous. Dworkin admits as much in his point that demented persons of one sort or another, even if they attempt expressions of desires, wishes, or choices, "reflect no coherent sense of self and no discernable [...] aims" having "presumably lost the capacity that it is the point of autonomy to protect," and thus to recognize a "continuing right to autonomy for him would be pointless."[283] The second point is that since treating people with dignity requires us to respect their wishes, given what Dworkin calls their "critical interests" – interests that arise out of someone's autonomous character – then we are obliged to honor their right to that, even if that means honoring their request to be euthanized when that request was made in a past prior-to-becoming-demented state. Indeed, Dworkin claims that our respect for their autonomous (past) self would require this.[284] In sum, then,

> We not only have in common with sensate creatures, experiential interests in the quality of our future experiences, but also critical interests in the character and value of our lives as a whole. These critical interests are connected [...] to our convictions about the intrinsic value – the sanctity or inviolability – of our own lives. A person worries about his critical interests because he believes it important what kind

[274] Velleman 1999: 618.
[275] Ibid.
[276] Ibid.
[277] Dworkin 1993: 205.
[278] See Rae 2017: 97.
[279] Dworkin 1993: 224.
[280] Dworkin 1993: 205.
[281] Dworkin 1993: 215-7.
[282] Dworkin 1993: 221.
[283] Dworkin 1993: 225.
[284] Dworkin 1993: 230, 232.

> of life he has led, important for its own sake and not simply for the experiential pleasure that leading a valuable life (or believing it valuable) might or might not have given him. A person's right to be treated with dignity, I now suggest, it the right that others acknowledge his genuine critical interests: that they acknowledge that he is the kind of creature and has the moral standing such that it is intrinsically, objectively important how his life goes. Dignity is a central aspect of the value [of] the intrinsic importance of human life.[285]

8. BIOETHICS AND A BIBLICAL-THEOLOGICAL WORLDVIEW

That Christians should approach the issue of PAS and euthanasia biblically means that we must be honest about what the scriptural teaching is regarding God's purposes for humanity throughout the history of redemption. Indeed, we do this by looking at what specific texts say, but towards a view of understanding them in light of the entire canon. For instance, most Christians would recognize clear-cut ethical precepts in the canon itself, such as the command to not kill[286] which is repeated in various contextual applications throughout.[287] But what about suicide? It is no doubt a form of killing, and so would seemingly fall under the sixth commandment. Yet we also recognize the moral plausibility of other kinds of killing – for example, killing out of defense for self or others,[288] in warfare,[289] and capital punishment.[290] So where does suicide fall into this, especially since there is no outright prohibition in Scripture against suicide as such, although it does present it negatively in certain places,[291] but somewhat positively in other places (such as regarding Samson's death in Judges 16)?[292] To put it mildly, on the surface, it is not clear what, if any, clear and direct scriptural prohibition for suicide exists.

Arthur Holmes accurately identifies the challenge: "the Bible does not answer all our ethical questions, nor does it automatically resolve moral dilemmas. Many things remain for us to work through, not least the agonizing moral decisions which the technology and complexity of today's world require."[293] What we need, then, is a biblical-theological normative framework that will equip us with a method for reasoning morally about difficult cases. This, of course, rests on a fundamental point about Christian moral philosophy that we have been assuming all along, but should go ahead and make very explicit at this point: that the fundamental starting point of our ethical inquiry is our particular view of the world, the conceptual macro-context from which our moral reasoning begins, at the center of which is our conviction that everything in the world is "ultimately rooted in the nature and actions of the Triune God"[294] who through the work of His people[295] in Christ[296] is bringing about the redemption and restoration of all things.[297] Noted bioethicist John Kilner offers sound advice in thinking about what it is to have and exercise such an outlook in our moral reasoning. I quote him at length here because of the relevance and importance this has on our topic of PAS.

[285] Dworkin 1993: 235-6.
[286] Ex. 20:13.
[287] Lev. 24:17; Mt. 5:21-26; 1 Jn. 3:12-15.
[288] Ex. 22:2-3, Ps. 82; Neh. 4.
[289] Dt. 20; 1 Sam. 15; Hos. 13:16; Ecc. 3:8; Mt. 10:34.
[290] Lev. 24; Dt. 17; 2 Chron. 15:13.
[291] Judg. 9; 1 Sam. 31; 2 Sam. 17; 1 Kings 16; Mt. 27.
[292] See Biggar 2004: 7-12.
[293] Holmes 1984:76.
[294] Hollinger 2002: 63.
[295] Gen. 1:26-8; 12:1-3; Ex. 19:5-6; Is. 10:20-2; 11; Mt. 2:15; 2 Cor. 5:17-21; Eph. 2:19-22; 1 Pt. 2:9-12; Rev. 1:5-6.
[296] Gal. 4:6; 5:6; Eph. 1:7-14; 2:15-21; 3:17; Col. 1:27; 2:9-10.
[297] Gen. 1:26 -8; Mt. 28:18-20; Ro. 8:20-22; 2 Cor. 5:19-20; Eph. 1:9-10; Col. 1:15-20; He. 2:8-9.

> Adopting a Christian outlook, since that involves the lordship of Christ, is wonderful in its own right. Moreover [...] it is also the best hope for fostering agreement on ethical issues. The reason is that a person's position on an ethical issue is not determined by the conviction that people matter. Rather, how one reasons or intuits from that conviction to a conclusion about the ethical issue is the key. One's key outlook is what guides that journey. Talking about a person's "way of thinking" or "life outlook" may sound academic and removed from everyday life. However, which outlook one adopts makes a huge difference [...]. Some of the greatest oppression and destruction that individuals, families, communities, and societies have experienced have been due to the prominence of [other outlooks such as utilitarianism, collectivism, individualism, naturalism, and transhumanism]. [...] Christians must be as careful as anyone not to allow any of [these] non-Christian outlooks to shape their thinking. [...] All outlooks have certain faith commitments. Every outlook assumes certain things about the way that people and the world are without being able to prove them to everyone's satisfaction. The challenge, then, is not to adopt a "rational" or "secular" outlook rather than a "religious" or "faith-based" one; those categories are not particularly relevant here. Rather, the task is to adopt an outlook that best conforms to what we know to be true about life. The fact that people matter is one such widely shared core conviction. A Christian outlook can explain and support that conviction whereas the other five outlooks [noted above] cannot. A Christian outlook has a huge advantage over those other outlooks: it has its basis in God, revealed concretely in Jesus Christ. Only when human significance depends not on how great people are (on people's capacities) but on how great God is (on God's capacities) can human significance truly be substantial and secure. [...] In the end, then, God is why people matter.[298]

For the believer, this worldview is given to us in the Holy Scriptures, part of which is the reality of divinely-given law that offers us a glimpse of God's holiness and expectations for his covenant people. These laws are the boundary markers or guideposts for achieving either real human flourishing or its opposite.[299] And those who take this seriously, who form the sort of "lordship of Christ" outlook on the world that Kilner notes above, understand whom such law is intended for – God's people. This is crucial to keep in mind, especially as we look at ethical precepts, casuistic formulas and applications, and how the New Testament informs and extends these even further. Dennis Hollinger is right to note that when we look at the Decalogue, for instance, and are tempted to think that "it forms the foundation of Christian morality," we have to be very careful.

> Clearly, the moral law reveals the broad structure of God's designs, and believers have a responsibility to embody these designs, but they are not the moral foundation. If we start with the commandments themselves, we miss the grounding: God's redemptive act of freeing his people and forming a covenant relationship with them. The preamble to the Decalogue is just as important as the commands themselves: "I am the Lord your God, who brought you out of the land of Egypt" (Ex. 20:2). On the basis of God's actions and his covenant relationship with the people, he then calls them to obedience, and the Ten Commandments give explicit content for following their redeemer. This framework is evidenced again and again throughout divine revelation Moral injunctions are set in a wider context. Thus, they are not mere universals that we are obliged to perform; they are not the heart and essence of the moral life. Indeed, when we divorce them from their ultimate grounding in God and God's act of grace, and when we separate them from the larger Christian story, they become hollow principles with little motivating and sustaining life power.[300]

So again, having a proper outlook that is grounded in a Biblical worldview understanding of the law – that it's set within a framework of relationship between God and His people – is crucial for our task. Having shown our cards, then, I will attempt to lay out the kind of framework we need for thinking about ethics in general, and the issue of suicide in particular. The reason why I'm

[298] Kilner 2017: 214.
[299] See Dt. 28.
[300] Hollinger 2002: 42-3.

concerned with suicide as such is because it's the most basic ethical issue here regarding both PAS and euthanasia. If I can show why suicide is morally impermissible, then it is a short journey to show why PAS is wrong, and an even shorter one to show why euthanasia in general is wrong. So, where do we go for such a framework? If scripture does not directly deal with PAS in the form of a simple, easy prohibition, does it at least provide norms by which we can draw a solution about it?

Arthur Holmes argues that Micah 6:8 does well in capturing the essence of what our overall ethical framework should be. Here, the prophet Micah conveys God's imperative that His people are "to do justice, and to love kindness, and to walk humbly with [their] God."[301] The verse and surrounding context is instructive, primarily because it serves as a warning to its hearers to turn away from their sin and back to God or else they will suffer the punishment promised for breaking their end of the covenant.[302] Simply, what God requires of them, is that they be faithful to God (walk humbly) by exercising justice and love in all they do. For Holmes, the principles of *justice* and *love* are what's crucial here for human action. God expects his covenant people to act justly toward others.[303] God cares about all of those whom he has created in his image and his people are to be ambassadors of his justice towards all of them, treating them in the way that they were meant to be treated in virtue of his creation purposes.[304] A good example of this is the psalmist's criticism of human rulers who have neglected the poor and oppressed and been much too patient with the wicked men that have taken advantage of them. So, he tries to rouse them to what God has called them to in virtue of their covenant relationship with Yahweh: "Give justice to the weak and fatherless; maintain the right of the afflicted and destitute. Rescue the weak and needy; deliver them from the hand of the wicked."[305]

But the flipside of justice is *love*.[306] God has called His people to "selfless devotion to God that issues in sacrificial service to others."[307] In this sense, then, love is not to be understood in the shallow way that it is often used in contemporary western parlance. Rather, it costs something to the one who possesses it because it's the sort of thing that cannot be merely possessed, but is spent for the good of others.[308] When both of these get together – justice and love – you get an overarching map of the "principles of God's kingdom," which for Holmes is "summed up in the Hebrew term *shalom*," understood as the "just peace in which all enjoy the bounty of God and honor him thereby."[309]

With these virtues in our ethical toolkit, they serve as overarching "principles of a Christian ethic, to guide our judgments and our conduct."[310] Of course, one needn't only look to Micah for this framework. Consider four specific ways that the imperative to do *love* and *justice* is presented in scripture:

[301] Holmes 1984: 52.

[302] Cf. Lev. 26, Dt. 28, Dt. 31; Ps. 78; Is. 1; 63; Ezek. 20; Neh. 9; Hos. 7.

[303] Ps. 103; Isa. 9, 11.

[304] Holmes 1984: 52.

[305] Psalm 82:3-4; cf. Dt. 10:12-11:1; Prov. 31:1-9.

[306] It's worth noting ethicist Richard Hays's (1996) criticism of other ethical frameworks such as Holmes's here (and Kilner's below) that see love as a focal point of New Testament ethics. For instance, Hays points out that love makes no sense in the New Testament without that cross: "Jesus's death is consistently interpreted in the NT as an act of self-giving love and the community is consistently called to take up the cross and follow in the way that his death defines" (p. 197 & 200-2; cf. 1 Jn. 3:16; Lk 14:25-35; Heb. 12:5-13). In response, the way Holmes (and Kilner below) present *love* as a crucial foundational concept for biblical ethics is very much in line with the way that Hays understands it, as that which "calls us to repentance, discipline sacrifice, and transformation" (p. 202).

[307] Ibid. 53.

[308] Cf. Jn. 15; 1 Cor. 13.

[309] Ibid. 53.

[310] Ibid. 53.

1) In the first table of the Decalogue in which God instructs His people how to exercise love for Him[311] and in the second table where the instruction turns to exercises love for others in such a way that guarantees just treatment them.[312]
2) In Jesus's summation of the entire law as ultimately requiring utmost love for God from which, however, is derived a true love for others[313]and, when this is cashed out fully, is the catalyst for a robust kingdom ethics.[314]
3) In Paul's admonition that whether you are circumcised or not doesn't really matter. The ultimate thing that matters for the believer is faith in God that results in a specific set of actions that issue from it,[315] specifically, the way we treat other people.[316]
4) John's synopsis of true *love* for God as being the *keeping of His commandments* (see points 1 through 3 again).[317]

What these biblical evidences show is that love and justice are two sides of the same coin, so to say, that results in God's promised *shalom* to those who and exercise them. In these texts, love is not presented as a mere feeling or emotion or desire, but as sacrificial devotion in action – first and foremost to God, and then necessarily flowing out of that to others.

But how does this work in terms of a practical Bioethical outlook? How do we love and do justice specifically in regard to PAS? After all, it may be one thing to apply this to some of the rank and file moral quandaries of every life, but what about when it comes to issues such as stem-cell research, genetic engineering, surrogate pregnancies, and PAS? John Kilner builds on the Holmes' rubric and offers an approach that, more than telling us what to do, it helps us get there by guiding our thinking and moral reasoning from the basis of our basic Biblical-worldview convictions to ethical conclusions. The way he approaches ethical inquiry is best summed up by the following statement: a distinctly biblical way of thinking about any issue, especially answers to moral questions, should be *God-centered*, *reality-bounded*, and *love-impelled*, in that order.[318]

God-centered. The point here is that our thinking begins with the reality of the Triune God who is the ultimately authority on all matters, and that through the Spirit's "enabling power" [319] we respond to his "moral leadership" in faithful obedience to Christ who is the "wisdom and power of God" and whose incarnate work includes embodying and fulfilling the Law.[320] Christ the perfect law keeper is our savior who, out of obedience to the Father, died to atone for and forgive our sin so that we might be redeemed by his perfect righteousness and not left to the futility of the impossible task of trying to keep the law on our own.[321] In this way, then, being God-centered is to be gospel-centered. This Triune God has revealed himself in the entirety the Scriptures[322] through his Spirit[323] such that we come to know him intimately as well as everything about him on its basis.[324] As a result, we do well to know God's thoughts after him, that is, to conform our thoughts to his given his revelation of them.

[311] Ex. 20:1-12; Dt. 5:6-12; Dt. 6-14.
[312] Ex. 20:13-17; Dt. 5:16-21; Dt. 15-25.
[313] Mt. 22:37-39.
[314] Mt. 5-7.
[315] Gal. 5:6; Cf. Jn. 5:41-44; 2 Thes. 2:9-10, 2 Tim. 4:7-8.
[316] Gal. 5:13-6:10.
[317] 1 Jn. 5:3-5.
[318] See Kilner 1992: 15-70; Kilner 1996: 73-5; Kilner & Mitchell 2003: 35-57.
[319] Cf. Ro. 8:14; Gal. 5:18.
[320] Kilner 1992: 18-19; Mt. 5:17-8; Ro. 10:14; 2 Cor. 1:20; Heb. 7-9.
[321] Jn. 14:31; Acts 13:38-9; Ro. 3-4; 8:2; Gal. 6:2; Phil. 2:8.
[322] Jn. 1; Lk. 24; Ro. 3; 2 Pt. 3:14-18; Heb. 1.
[323] 1 Cor. 2; 1 Jn. 2.
[324] 1 Thess. 2; Is. 34:16; Jn. 5; 2 Tim. 3.

Reality-bounded. That our thinking be reality-bounded simply means that we get our facts right about the world we live in, in light of the centricity and sovereignty of the Creator God[325] and redemption history, and then determine what it implies for our moral behavior. Kilner mentions several examples of the kinds of *realities* he has in mind:[326] the "existence of intrinsic good and intrinsic evil" as a result of the fall, and thus the reality of sin and depravity; what "truth" and its contradictions and opposites are;" the "reality of God" as Creator of a world that is "not only ruled by natural physical laws but also by moral laws" that are "in some sense embodied in nature as well as written by God on people's hearts;"[327] that Christians are "members of the body of Christ" and as such have specific responsibilities, obligations, and callings to serve one another and the rest of the world;" that Christians are especially able to think through moral problems because of their renewed minds that allow them to "perceive the world with the mind of Christ," without which people "are bound to reach mistaken conclusions."[328] Indeed, all of these truths are part of the reality of the world that are knowable only because of the first point which assumes the reality of God who has revealed himself and his will to us in the Bible.

But the corollary to this, which is where the hard work begins, is that we have to also get out facts right about our particular situations and circumstances so that we may "discern the realities of life and their implications for *living*."[329] For our topic of PAS, then, we have to get an accurate sense of all of the issues involved in order to bring to bear the reality of God on it. This means that the Christian who is dealing with it will need to understand what patient care is, as well as the nature of the disease in question, various treatment options and their ramifications, the extent of harm or suffering that results from the disease and/or treatment, what it means to stop or withhold treatment, the role and responsibilities of physicians and patients, and so forth. But this will also rest on having a *real*istic view of human persons. We need a robust anthropology that not only explains what persons are (i.e., the criteria that make human persons distinct from everything else), but then on that basis also explains how that important relevant notions such as freedom, autonomy, equality of value and consideration, justice, and rights are to be understood and applied regarding decisions surrounding end-of-life care.[330]

Love-impelled. "Once it has been established no God-given realities are being violated, then the right action is that which is the most loving under the circumstances."[331] Here, all of the definitions and implications of a Biblical notion of love – as noted above in Holmes's schema – apply. As such, real love can never be at odds with the centricity of God's lordship and the realities that make for particular situations. The most loving thing to do for someone else in any situation that calls for it will always be to submit our intentions and putative expression of it to God's. As Kilner puts it, "trusting in God's supreme love for people, Christians believe that acting in accordance with those realities [of God's intentions for the world] is for the ultimate good of all persons, even though such may not appear to be the case at the time."[332] Such love, then, focuses on what God is due and how that that is never at odds with the common good, but rather, the latter is utterly dependent on the former. God has created the world such that he is also the Creator of reality (moral, physical, conceptual, etc.) such that real love is always bound by its norms.

In light of these three guidelines for ethical reasoning, the remaining sections of this essay attempt to follow them as a broad method for assessing whether or not PAS is a morally legitimate

[325] Gen. 1-2; Jn. 1; 1 Cor. 8; Heb. 1.
[326] See Kilner 1994: 21-26.
[327] Ro. 1:18-20; 2:14-5.
[328] Ro. 12:2; Ro. 6:16-18; Gal. 5:13.
[329] Kilner 1992: 23.
[330] Kilner 1992: 23-26.
[331] Kilner 1992: 26.
[332] Kilner 1992: 27.

end-of-life care option. As should be already apparent, the three legs of this approach are not isolated from the others. They necessarily overlap. Indeed, *they are really all the same thing*: the biblical approach to ethics that claims our actions should issue out of *love* for *God* that is bound by the *realities* of this world that He has created. By loosely isolating these three aspects, however, it gives us a helpful framework for thinking about the different issues involved in the PAS debate.

9. GOD AND PHYSICIAN-ASSISTED SUICIDE

What does it mean to consider PAS from the sort of outlook and approach that we have been considering so far? In this section, my concern is to flesh out what the Biblical position is on three of the foundational concepts of PAS in theory and in practice – *death*, *suicide*, and *suffering*. In particular, what is death and what does it mean to kill oneself in order to achieve it? Also, since suffering of one sort or another is *the* reason why people advocate for PAS, what's God's take on it?

Death

The best place to start forming about a theology of death and dying is the first place in scripture where it is mentioned, Genesis 2:16, where God informs Adam of the provisions he has provided him – i.e., the entire garden – with one stipulation: that Adam not eat the fruit of the tree of the knowledge of good and evil or else Adam "shall surely die." Adam and Eve were created and given specific vocational purposes, specifically to take the earth's raw materials, including themselves, and do something productive with it by subjecting it to their vicegerent authority.[333] They were given a context, Eden, in which to carry out this vocation. Yet they tested God's stipulation, to their own detriment. They ate its fruit,[334] and death resulted.[335] At least four things about death can be gleaned from this account: 1) death was *never the divine intention* for Adam and Eve, never part of God's creation plan; 2) death was a direct *consequence of disobedience* to God; 3) death is a *slight against God*, the result of God's image-bearer rebelling against the image, and thus "an insult to the sovereignty of God and a failure of human stewardship over God's gift of life;"[336] 4) After their disobedience, Adam and Eve scramble to make clothes and cover themselves up after they realize what they did,[337] thus instituting and linking the very first historical accounts of *anxiety*, *death*, *shame*, and *judgment*.

This last point is crucial because of how it is repeated throughout Scripture. In response to the chaos and anxiety brought about by sin among God's people, the new covenant promise is one that will deal with it once and for all. God will write his law on the hearts of his people so that they may "know" him who will forgive the sin that causes death[338] and enjoy the "peace" secured by the future Davidic Shepherd-King.[339] Indeed, the message of this new king is that he has the cure to death through new life in him,[340] which he has instantiated with his own blood, [341] by his own

[333] Gen. 1:28.
[334] Gen. 3:6.
[335] Gen. 3:19; 5:5.
[336] Pellegrino 1996: 105.
[337] Gen. 3:7.
[338] Jer. 31:33-34. Cf. Isa. 59 and Heb. 8.
[339] Ezek. 34.
[340] See Mt. 25; Lk. 16; Jn. 3; 10-11.
[341] Lk. 22:19-20; Mt. 26:28; Heb. 9:11-15; Eph. 1:7.

death[342] and resurrection[343] for the entire world,[344] fulfilling God's promise back at the fall that death itself will eventually be seized by a human being, albeit a divine one.[345] For this reason, death as the ultimate enemy has been conquered,[346] its sting has been dulled,[347] and our freedom has been secured from the debilitating fear of it that has been the source of our ultimate angst.[348]

This overarching redemption storyline regarding death shows us a couple things about it.

First of all, *death is never dealt with as a solution to anything*. Even though it is one of the most certain things in the world and will inevitably happen to everyone,[349] it is never presented as a viable option. Indeed, scripture bears out the choice that people are given to choose either life or death, and that they *should* choose life[350] because, after all, death is the wages of *sin*[351] which the scriptures describe as the bondage that only Christ, not death itself, can set us free from.[352]

This is important to point out because there is a small cohort of "Christian" PAS advocates who argue that since death for the believer is nothing, and is only a sort of gateway to the life beyond it, then intending one's death in particular circumstances is morally permissible.[353] Furthermore, philosophers R.M. Hare and James Rachels argue that Christ's command to "do unto others as you would have them do unto you"[354] necessarily requires us to obey each other's request for euthanasia, especially since if any of us suffered from a horrible tragedy that caused us to become PVS or succumb to a debilitating disease that caused unbearable suffering or indignity, we would want others to end it for us.[355] Hence, death cannot always be that bad, and indeed, may be obliged of us if we truly take Jesus's words as authoritative. But these arguments are extremely shallow, primarily because they build a so-called Biblically based argument on the basis of one prooftext while ignoring the entire storyline of the Bible, something that I have been at pains to avoid doing in this section. These thinkers rightly note that being in Christ makes death no longer an enemy and that the "golden rule" does indeed oblige us to consider others needs and desires. But they all *absolutize* these points in their arguments, and for that they should know better.

Second, *death is always presented as a problem, a curse, a kink that thwarts plans*. As Kilner says, "in a pervasive and profound sense, death is an enemy of God and people that it intimately bound up with human disobedience," not only in the Garden but in the everyday affairs of men.[356] The only thing that makes death tolerable is the victory Christ gained over it. In this sense, the consequences of death are good for the believer, and thus death can be talked about as being "swallowed up in victory"[357] since all it means for us is that we become placed in His presence,[358] but the reason for this is because it's a problem that only Christ could triumph over. As already noted, it is the ultimately enemy and the ultimate fear of humanity, and the only reason why it at times is presented in a positive light is because of the Christ who has conquered it for those who

[342] 1 Pt. 3:18; 1 Thes. 5:10; Heb. 2:9; Rom. 14:9.
[343] Jn. 11:25.
[344] Lk. 24:47-9; cf. Mt. 28:18-20.
[345] Gen. 3:15; Heb. 2:14.
[346] 1 Cor. 15:26.
[347] 1 Cor. 15:55-57.
[348] Heb. 2:15.
[349] Heb. 9:27.
[350] Dt. 30:11-20; Jn. 11:25-27.
[351] Ro. 6:23
[352] Jn. 8:34-6; Ro. 6-7; Gal. 5:1.
[353] See Badham 2009.
[354] Mt. 7:12; Lk. 6:31
[355] See Hare 1975; Rachels 1993: 48-50; Rachels 1994: 152-3.
[356] Kilner 1992: 99.
[357] 1 Cor. 15:54.
[358] 2 Cor. 5:1-10.

believe and trust Him.[359] As a result, death itself is a curse for the unbeliever, but something of a tension for the believer: both an "enemy and destiny, both penalty and promise, both cross and resurrection,"[360] both loss and gain.[361]

Good consequences come *in spite* of death for the believer, not *because* of it,[362] and that requires us to prepare for it, not by either plunging into it or staving it off as much as possible such as proponents of vitalism (the position that one should always do what extends one's life as long as possible, no matter what) attempt to do, but "numbering our days" as its inevitability gets nearer to us.[363] What this means, then, is that the Bible distinguishes between the legitimacy of death as an inevitability that we should allow to happen in the right way at the right time, and the illegitimacy of hastening it for the express intent of being dead.

Suicide

If death, in general, is a *bad* thing with tolerable consequences only because Christ prevailed over it, does that mean that death should never be intentionally brought about? The short answer to this is *yes*. After all, the sixth commandment is a pretty clear prohibition of murder in general.[364] But then we face challenges to this, including the fact that scripture records God's endorsement of killing in certain cases, such as capital punishment,[365] but not in other cases.[366] So what can we say about *suicide*? There are seven accounts of suicide in the Bible.

1) Abimelech, the notorious judge over Israel that was known for killing his own brothers as well as civilians out of paranoia.[367] He was severely injured while preparing to set fire to a city when a woman dropped a millstone on Abimelech's head, and out of sexist pride, lest it be told that he was killed by a woman, he ordered his armour-bearer to euthanize him by sword.[368]
2) Samson, Israel's Nazarite-vowed judge that was known for his powerful hair, had lived a life of constant defeat due to anger, disobedience, lust, and trust issues, and as a result of forfeiting the secret of his power to God's enemies, was taken into by them into captivity.[369] Samson could only take so much of their mocking and gloating, and reached a point where he called upon God to give him strength so that he "may be avenged of the Phillistines for [his] two eyes" that had been gouged out.[370] At the right moment, he exclaims "let me die with the Phillistines" and destroys the pillars of the building, which caves in and kills them all, including himself.[371]

[359] Ps. 48:14; Is. 57:2; Lk. 23:42-3; Jn. 3:16; Ro. 14:8; 1 Thess. 4:13-4.

[360] Kilner 1992: 103; See also Cameron 1996: 28.

[361] Phil. 1:20.

[362] See Kilner 1992: 102.

[363] Ps. 90:12; Dennis Hollinger 1998:260 puts it thus: "What does it mean for contemporary ethical issues that death is both friend and foe? Holding the two in creative tension precludes any radical answers to moral issues such as treatment termination or suicide. On the one had it precludes vitalist assumptions, which err on the side of maintaining physical life through burdensome treatment long past the point where there is any real benefit to the dying patient. [...] But the creative tension of detach also precludes active euthanasia and suicide in any form. Euthanasia and suicide advocates have embraced death as a friend but have lost sight of death as enemy."

[364] Ex. 20:13

[365] Ex. 21; Lev. 24; Num. 35; Ro. 13.

[366] Gen. 9; Mt. 5; Jas. 2; Rev. 21:8.

[367] Jud. 9:24, 42-45.

[368] Jud. 9:50-55.

[369] Jud. 14-16:22.

[370] Jud. 16:28.

[371] Jud. 16:29-30; it is somewhat controversial whether or not this is a case of suicide. I think that it meets the conditions for suicide as noted in §1 above.

3) Saul, first king of Israel, who had lost legitimate claim to the throne because of perpetual disobedience to God and was in a sort of civil war against God's newly chosen king David, is wounded by a Philistine arrow.[372] and after his armour-bearer refused to follow his request and kill him, Saul kills himself by falling on his own sword.[373]
4) Saul's armour-bearer, apparently out of great fear given what was going on and what had just happened, followed his master's example and fell on his own sword also.[374]
5) Ahithophel, a wise counselor of King David's that had abandoned David in order to join Absalom's rebellion against him.[375] After Absalom rejected a particularly strong piece of strategic advice that Ahithophel offered to him, he evidently assumed that the rebellion would fail. So, "he saddled his donkey and went off home to his own city. He set his house in order and hanged himself, and he died."[376]
6) Zimri, the seven-day king of Israel who became king by killing King Elah, and subsequently killing the rest of his family too.[377] Once the army heard what happened, they set themselves against Zimri and destroyed the city he was in, provoking Zimri to burn down his own house with himself inside.[378]
7) Judas, one of the disciples called out by Christ to follow Him,[379] who betrays him by selling information of His whereabouts to those conspiring to have Jesus arrested and executed,[380] kills himself out of guilt for what he had done.[381]

Interestingly, in all these accounts there is never a distinct prohibition made against suicide as such. It is neither encouraged, nor is there any commentary on the act itself that would suggest it as being sin. As Dónal O'Mathúna argues, however, such ethical ambiguity is our fault, not the scriptures. If we come to the conclusion that scripture is ambiguous about suicide given these accounts, then this reveals our "unfamiliarity with the ways of the Bible" in our failure to understand how "biblical narratives show us ethics in action in people's character."[382] O'Mathúna argues that the problem is with us – we are so influenced by abstract philosophical ethics that focuses on actions themselves that we fail to grasp how the Bible's narratives convey moral instruction by exposing people's character. For instance, consider the account of Saul's death. The narrative of *1 Samuel* exquisitely details the life of David and Saul, but the way it does so is by highlighting the bad choices Saul makes and the gradual decline of his reign, and the favour David has which reveals his ascendancy to the throne. Throughout the narrative, Saul becomes more disrespectful of others' lives, he "drifts further and further away from God," and all of his relationships suffer greatly until he comes to what seems to him to be his best option: his own death.[383]

O'Mathúna claims that the death of Saul in this narrative has all the markings of a *tragedy*. The narrator is presenting the final scene on the battlefield as "the tragic conclusion to a literary masterpiece soaked in moral comment."[384] What is the comment? Since "tragedy implies that

[372] 1 Sam. 31:1-3.
[373] 1 Sam. 31:4.
[374] 1 Sam. 31:4-5.
[375] 2 Sam. 15:12.
[376] 2 Sam. 17:23.
[377] 1 Kgs. 16:10-13.
[378] 1 Kgs. 16: 18-19.
[379] Lk. 6:16.
[380] Lk. 22:3-4, 47-53.
[381] Mt. 27:3-10; Ac. 1:18-19.
[382] O'Mathúna 1998: 351.
[383] Ibid. 358-9.
[384] Ibid. 359.

what 'is' is not what 'ought' to be […] it is a tragic conclusion that should never have happened."[385] Although I won't take the time to go through the other accounts, it's very plausible on the surface that very similar issues are going on in those as well (a good case in point in the book of *Judges* where the narrative progresses into moral chaos). After all, what all of these suicide accounts have in common is that they all result from severe distress that is brought on from sin, evil, and disobedience to God. The suicide is the crescendo to lives that were known more for their disobedience to God then for anything else.

However, it may just be that the reason why the narratives present the suicides as tragedies is because of the moral condemnation of suicide working as a background assumption in the authors. Eugene Merrill argues that even though there is no particular direct prohibition of suicide in the Old Testament, for instance, it is nonetheless pretty clear about what constitutes a murder understood as an "unqualified manslaughter."[386] Relying on Numbers 35, Merrill notes that a murder is distinguished these conditions: "(1) by previous hostility on the part of a person who (2) schemes (3) with malice aforethought to (4) waylay another and (5) strike him or her with an object to do harm."[387] Merrill's conclusion is that the Old Testament accounts of suicide fall in line with this. They are committed "(1) premeditatively by one who (2) schemes to do so (3) with malice aforethought by (4) a stratagem or means (5) designed to do harm."[388] The different instances vary by degree with each of these conditions, but they nonetheless meet them.

Suffering

The main reason why people request PAS is to end their suffering, whether it be the result of physical pain, psychological instability, dashed expectations about quality of life, or a combination of all three (see §5 above). But given the argument thus far that suicide is not morally legitimate, nor is the choosing of death over life, what are God's thoughts about suffering? On the one hand, suffering has a lot in common with death when it comes to the Biblical account in the sense that both never appeared until sin did. The anxiety of Adam and Eve in the midst of their shame was a sort of suffering, as well the judgment declared to them that childbirth and work would be full of pain and misery.[389] On the other hand, also like death, there is a tension between the reality of it and its redeeming features. There is both good and bad with it. Like death, it's not the sort of thing that one should desire for its own sake or ever rejoice because of the suffering itself, but rather, because of the good that may shine in the midst of it.[390]

Kilner notes that many people consider suffering itself to be "an unqualified evil" that "should be removed at all costs."[391] It has no redeeming value and whatever can be done to inhibit it is the right thing to do. But as Kilner rightly notes, this is not the Biblical view of suffering. For instance, the suffering that we endure today is doing several things: it is preparing us for the future glory that we cannot just yet comprehend;[392] reveals the power of Christ in the midst of our weakness;[393] builds our character which in turn cultivates our ultimate hope through the power of the Spirit;[394] tests our character so that our faith in Christ might be refined to an even greater purity and

[385] Ibid. 359.
[386] Ibid. 322.
[387] Ibid. 322.
[388] Ibid. 323.
[389] Gen. 3:16-19.
[390] 2 Cor. 12; 1 Pt. 4:13; Jas. 1:2-4.
[391] Kilner 1992: 103.
[392] 2 Cor. 4:17; Ro. 8:18.
[393] 2 Cor. 12:10; 4:8-10; Phil. 4:11-12.
[394] Ro. 5:3-5; Jas. 1:2-4; Heb. 5:7-9.

potency;[395] is a guaranteed reality, especially in the life of the believer at some point who, however, can rest upon the power of Christ in the midst of it; [396] and through the experience of allows us to receive Christ's comfort, so that in turn we may learn from the experience and in turn comfort those who are suffering.[397]

Job and Jesus are exemplary biblical examples responding to suffering. Job is the man who suffered every imaginable loss up to the point of death,[398] complains about his suffering,[399] all the while in a real struggle of faith[400] and bad theology from so-called friends.[401] However, through it all, the Lord had not left him, and in the end, Job repents of his lack of faith and submits to the wisdom and sovereignty of God.[402] The example of Jesus is also telling. He did not seek out his own death, nor the agonizing way that it was brought about. This is important to note because some have claimed that Jesus's suffering and death was a sort of masochistic exercise in which he wanted to commit suicide in the most public way to make his point. This couldn't be further from the truth. Scripture, for instance, reveals his anxiety-ridden prayer to the Father in Gethsemane that if there could be some other way to accomplish God's purposes in redemption, then may the cup of death pass from him.[403] However, he was unwilling to succumb to his own will, but only to the Father's.[404] This is a crucial point to ponder about suffering. Jesus wanted to avoid it. His desire was to stay away from it. But not at any cost. Jesus modeled to us that "suffering per se does not justify every effort to eliminate it" especially since he saw it as part of the Lord's larger purposes for Him.[405]

The mantra of the secularist is that the most compassionate thing to for someone who is suffering is to extinguish them.[406] Hence, suffering ends by ending the sufferer. But this is a step too far because, as Kilner points out, "relief of suffering, by its very nature, belongs in the service of life rather than the service of death."[407] After all, pain medications, vaccines, antibiotics, kidney dialysis, and a score of other medical treatments have been developed to respond to current and future suffering by improving the quality of life, not ending it. In a way, then, intentional death as a response to suffering is a cheap escape. It's an unwillingness to persevere at the time in life when all of their life's virtue cultivation, experience, and maturity can really come to bear on the dire situation at hand. However, many think that since we put down the family dog or cat when there's no hope for them, we can just do the same thing for ourselves.

But as John Dunlop points out, human beings are *not* to be treated *humanely*, but *humanly*. What he means is that the reason why we have no qualms about ending the suffering of injured and diseased dogs, cats, horses, and cows, is because suffering has no meaning for them.[408] Suffering for them is just the raw, brute pain. But persons have the "potential to develop through the suffering," especially those who are near death and able to reflect on life, relationships, and God as they near their end.[409] And for the Christian who is suffering, the meaning in that is

[395] 1 Pt. 1:6-9; Ps. 119:71.
[396] 2 Tim. 3:12; 1 Pt. 4:12-19; Phil. 1:29.
[397] 2 Cor. 1:3-4; Gal. 6:2; Ps. 119:50.
[398] Job 1:13-2:10.
[399] Job 3, 6-7, 12.
[400] Job 17, 19, 21, 23
[401] Job 18, 20, 22.
[402] Job 42:1-6.
[403] Lk. 22:42.
[404] Ibid.
[405] Kilner 1998: 137.
[406] Pellegrino 1996: 105
[407] Kilner 1992: 109.
[408] Dunlop 1996: 40.
[409] Ibid.

massive. As Pellegrino puts it well, "Christianity gives meaning to suffering because it is linked to the sufferings of God Incarnate, who willingly suffered and died for our redemption," and so "in suffering, we humans follow in his ways, the way of the Cross."[410] The Bible speaks of believers' status of being in Christ in terms of the imagery of suffering: we are crucified with Christ;[411] we share in His sufferings;[412] our baptism is one into death, but then raised again to new life;[413] in following Christ we take up the cross and follow Him,[414] and so forth. And because we suffer with Christ, in Christ, we can suffer *with each other.* "we are called on to suffer with another, to be a supportive presence,"[415] doing what we can to truly love others through sharing their burdens.[416] After all, "suffering is the price we pay for being human" and through our suffering we become "more sensitive and compassionate people, more aware of the needs and anxieties of others."[417]

There is an objection, however, that we need to consider. And that's whether or not all kinds of suffering has such redemptive meaning. Nigel Biggar, for instance, argues that

> Our suffering can help to redeem others, insofar as our lives, reordered and liberated by hindrance, can become a prophetic statement to them. After all, human lives are socially valuable not only for what they build, but also for what they say. So there are some kinds of physical suffering that can be regarded as redemptive. [...] [But] not all suffering it redemptive, and some suffering can be so intense and relentless as to make responding to anything other than pain – including a vocation – inconceivable. Furthermore, severe brain damage can rob a human being even of the very capacity for consciousness that is the precondition of response. Therefore, [I] think it fitting to discriminate between human biological or bodily life that is able to support biographical, or better, responsible – life, and that which is not; and to ascribe 'sanctity' to the former but not that latter.[418]

For Biggar, then, there can be a state of suffering so intense that it has no redemptive value. He's not alone in having such a view.[419] It is fair to say that even our practices admit this, which is why we try to minimize pain as much as possible through drugs and other measures that are geared towards helping pain-sufferers improve the quality of their lives. But the difference between Biggar, a theologian at Oxford University, and the rest of us who admit that not all suffering is redemptive, is that he thinks he can identify exactly what that is instead of accepting it as the "mystery" that it actually is.[420] Indeed, Biggar buys into the framework of James Rachels and Ronald Dworkin, that a beating heart and breathing lungs are not reliable signs of life. Rather, what matters is having a functioning consciousness that makes one a person and gives one their dignity and sanctity.[421] Without such high-cognitive function, Biggar claims we may "help them escape," but because they do not, and will never attain, a life of "responsibility."[422] So, of course Biggar can endorse PAS and euthanasia for PVS patients because on the particular death-definition grounds he gives because he is able to meticulously define cases of living homo sapiens that are not persons. But this makes Biggar's position confusing. If he's right, and one's personhood depends on higher cognitive functioning, and if a PVS patient or another who is

[410] Pellegrino 1996: 111.
[411] Gal. 2:20.
[412] Jn. 15-16; 1 Pt. 4:13
[413] Ro. 6:4-6.
[414] Mt. 16:24-6.
[415] Callahan 2002: 56; Gal. 6:1.
[416] Gal. 6:1; 5:13-4.
[417] McGrath 1998: 141.
[418] Biggar 2004: 54-6.
[419] For instance, see Pellegrino 1996:111 and Orr 1996: 69-70.
[420] See Pellegrino 1996: 112.
[421] Biggar 2004: 47, 166-171.
[422] Biggar 2004:148.

suffering intense pain doesn't have the higher cognitive capacities to have a consciousness that processes it, then why does he advocate for helping them escape to begin with? He has already defined them out of personhood.

Biggar's view is not the Biblical view of death and suffering. Suffering does not remove one's dignity or sanctity. That's a stamp on us that is unremovable (as the next section will outline). But as we have already noted, suffering has the potential to make us better, not for ourselves, but ultimately for others. As Marsha Fowler aptly puts it, we "define ourselves in suffering both as individuals and as participants in a shared human condition."[423] But the problem in or culture is that, for the most part, we have taken the Rachels-Dworkin-Biggar view of suffering and see it as a lessening of the person who experiences is. As Fowler notes, "we have neglected suffering through the avoidance techniques of medicalization, isolation, flawed symptom control, platitudes and evasion, or theologization [like Job's friends did]."[424] But the answer to suffering,

> resides not in the ethics or practice of doing, but in the ethics and practice of *being*, specifically in being present to, with and for the one who suffers. The answer is not in the mastery of suffering, as we have attempted with our medicine and its technology. The answer is not in the avoidance of suffering, as we have attempted with our bioethics. The answer is not in solving the problem of suffering, as we have attempted in our theology. Rather, the answer is in facing the experience of suffering.[425]

10. REALITY AND PHYSICIAN-ASSISTED SUICIDE

I have argued what I think the proper Biblical-theological perspective is on three of the core issues in the PAS debate – death, suicide, and suffering. Pro-PAS advocates argue that the former two are proper goals for a person because of the latter. But given that what God thinks about these things is quite the contrary, we now need to consider the reality of some other issues, specifically those regarding the human person itself. The PAS debate assumes a lot about the human person – what it is, what it deserves, and what its proper activities are. In this section I will discuss everything human. We need to get a *real*istic picture of what humanity is and the kinds of things that can be properly predicated of it.

Human Personhood & Dignity

Having an understanding about the reality of human personhood is another crucial factor for understanding why PAS and euthanasia are not morally permissible because it will help us get a sense not only of why humans have a value distinct from animals, but how that human persons also have a dignity or sacredness that is higher than any other created thing. If humans have such objective intrinsic value at every point of their existence merely in virtue of being *homo sapien*, then the case is much harder to make for the "right" to intentionally destroy such a being. For the Christian, the natural place to start is at the creation account in Genesis where we get the doctrine of the imago Dei. After having created everything else on earth, "God said, 'Let us make man in our image, after our likeness.'"[426] So here, we see that humanity is made in God's image, after his likeness. What does such an image and likeness consist of? Theologians have discussed and argued over this for centuries. Many have thought that if certain characteristics about humans can be discovered and conceptually isolated as distinctly theirs, not shared by any other creature, then it must be that those characteristics themselves *are* the essence of humanity.

[423] Fowler 1996: 49.
[424] Fowler 1996: 49.
[425] Fowler 1996: 50.
[426] Gen. 1:26-7.

In this line of thinking, some have argued that human *reason* is the image. After all, just think of the technological advances of the last few hundred years that have been brought about by the exercise of human reasoning capacities. The massive intelligence of human beings, then, seems like the sort of thing that's a good contender for being the essence of *image*. But there are problems with this. For one, not everyone is able to exercise the same level of reason and rationality, especially those with traumatic brain injuries, cognitively disabilities, Alzheimer's patients, infants, and anyone deemed to be feebleminded. So, does this mean they contain less of God's image? This doesn't seem plausible according to the Bible, although some of the proponents of the eugenics movement of the nineteenth and twentieth centuries, for instance, used this point to rationalize that people had the image to one degree or another.[427] Another problem is that by focusing on the reasoning capacities, this identifies the image with the mental aspects of humanity, perpetuating a "mind-body or spiritual-physical dichotomy that is foreign to the Bible" which actually speaks of the "whole person."[428]

A second aspect of humans that has often been cited as the essence of image is the human reality of *relationships*. For instance, humans have relationship with God, whether healthy or unhealthy, good or bad, in a way that is unlike the rest of creation. Also, humans have relationships among themselves, and even with themselves, in a way that is distinct and ordered. The reality of business, education, our political structures, and even our medical institutions, for instance, all bear witness to the complexities of the human capacity for relationships. But Kilner notes that there are problems with this conception of *image* also. For one, there is simply no textual support for it. Second, relationships seem to be the sort of thing that can be degree-bearing as well. If Al has better, healthier relationships than Bob, then would this mean that Al has more of God's image than Bob? Yes, if you think that the capacity for relationships is what the *image* is.

We see, then, the trouble with identifying human capacities like reason and relationship (and a plethora of other attributes) as the crucial ingredients that make for the image of God in people. If we go that route, and apply them strictly, we can very well end up making judgments about certain people as not even being persons at all because of their severe lack of these capacities which, interestingly, is what pro-PAS and euthanasia advocates such as Rachels, Dworkin, Tooley, and Biggar do. For them, rationality that confers personhood is bound by a threshold such that any being that doesn't reach it isn't a person. Those who advocate reason or rationality as being the image of God are logically committed to this position.

There is a more important reason, however, why both *reason* and *relationships* are problematic criteria for the *image*, and this is because Scripture is very clear that even though humans were created in the image and likeness of God and through their rebellion brought about sin and the cataclysmic fall, *sin has not affected the image per se*. Scripture never says that the image has been lost through sin. Frankly, it does quite the opposite. As Kilner points out, the covenant with Noah is a good example of this.[429] Although sin had been rampaging through generations of people up to the time of Noah, God instructs Noah and his family that disrespecting life by murdering others is absolutely prohibited because "God made man in his own image."[430] So, the image-likeness is still there, despite sin. However, sin has indeed affected our reason and our relationships, as actions such as committing insurance fraud and divorce, respectively, exemplify. But "just because sin has damaged humanity does not logically require that it has damaged God's image."[431] As a

[427] Kilner 2015: 188.
[428] Kilner 2015: 186.
[429] See Kilner 2015:113-116.
[430] Gen. 9:6; cf. Gen. 5:1-2 and Jas. 3:7-10.
[431] Kilner 2015: 45.

result, the doctrine of the imago Dei "says more about who people are than it does about who are people."[432]

So what is the image? For Kilner, Scripture clearly identifies the actual "image" [433] or "imprint"[434] of God as being Jesus Christ himself.[435] And this would make sense given the Trinitarian reality of Jesus Christ as an equal part of the Godhead,[436] along with the Father and Holy Spirit. But when the relationship of human beings to the image is discussed, it is more in terms of reflecting or being a copy of it. People are not the image themselves, but those who are in Christ are being "conformed" to it,[437] "renewed"[438] in it, or "transformed"[439] to it, all because this was God's intention from the very beginning.[440] What this suggests for Kilner, then, is that "creation in God's image is God's expressed *intention* that people evidence the special connection they have with God through a meaningful reflection of God."[441] In other words, this means that Adam and Eve and all their progeny were patterned "according to" the *image*,[442] who is Christ, and it was God's intent even then that they develop into that image before the Fall.[443] Post-fall, however, although it God's intention remains the same that those created in His image indeed conform to that image, it now requires renewal, transformation,[444] and will only take its fullest form as a result of final glorification.[445] As Kilner summarizes,

> People are not God's image now the way that Christ is; however they are intimately connected with God because God's image is the very blueprint for humanity. […] The basic idea here is that God has a likeness-image, and God had created people with that in view. It is a standard for what God intends humanity ultimately to be. It is the goal toward which humanity is to develop. As the New Testament clarifies, sin prevents people from developing as God intends – in fact, it damages people so badly that they are much farther from God's standard after their "fall" into sin than they were before it. However, Christ as both the standard and the course of humanity's renewal, breaks the power of sin and liberates people to resume their God-intended development to become fully conformed to Christ – to God's image who is Christ.[446]

What does this say, then, about the sacredness or dignity of human beings? One ramification should be obvious at this point: since to be created in the Image literally means to be patterned after Christ, this implies something very sacred and dignifying about the human form itself, of whose creation Christ was a party to[447] and thus had a hand in, knowing that He would take that incarnate form someday.[448] In other words, the human form itself was created by the One who would become it. At every point in his life he affirmed the created goodness of humanity not only in his being made of human flesh, but also in his work as a healer of human *bodies*[449] and an agent

[432] Kilner 1992: 52.
[433] 2 Cor. 4:4; Col. 1:15.
[434] Heb. 1:3.
[435] Kilner 2015: 59-60.
[436] Col. 1:19.
[437] Ro. 8:29
[438] Col. 3:10; Eph. 4:20-24.
[439] 2 Cor. 3:18
[440] Ro. 8:29
[441] Kilner 2015: 79 (emphasis mine).
[442] Jas. 3:9.
[443] Kilner 2015:89.
[444] 2 Cor. 3:18;
[445] 1 Cor. 15:49.
[446] Kilner 2015: 92; also see p. 132 for an extended summary.
[447] Jn. 1:1-3; Heb. 1:1-2; 1 Cor. 8:6.
[448] Eph. 1:3-10; Ro. 8:29.
[449] For example, see Mark 1:21-2:12.

of *bodily* resurrection.[450] As such, it is a sign of God's initiative to come to us, be among us, show us what it really is to be a person as God intended, both in body and spirit, and then die for us, but rise again in bodily triumph. As Dyck notes, quoting Oliver O'Donovan, "the resurrection grounds the eternal value of the individual."[451] Consider David Gushee's perspective on this:

> The paradox of the incarnation is that when divinity stooped low and took on humanity, humanity revealed its desperate debasement and yet was elevated through God's mercy. [...] if God became human, the status of human changes. No human can be seen as worthless. No human life can be treated cruelly or destroyed capriciously. Human dignity can never again be rejected or confined to only a few groups or individuals of supposedly higher rank. The incarnation elevates the status of every human being everywhere on the planet at any time in human history. It elevates the worth of every human being at every stage of their lives, because the arc of Jesus's own life included every stage of existence including resurrection, which is human destiny.[452]

But this is completely at odds with the notion of dignity that thinkers like Dworkin, Rachels, Tooley and others have in mind, as I discussed in §6 above. Dworkin conceives of personhood, and its resulting dignity, as evidenced by the capacities people have to desire, create, believe things, intend things, and so forth – their "critical interests," as he puts it – which is to live a reasoned, goal-oriented, and coherent life. More explicitly, he says that a person's dignity is tied to his "capacity for self-respect"[453] which is realized when the life "goes well," making good on its "investment."[454] So, as long as I can respect myself through the exercise of my critical interests, then I have a right to dignity. But if there ever comes a point at which I no longer can do this, then I no longer have it. Biggar has a similar take as Dworkin, but instead of casting the issue in terms of "creative interests" and capacities for one's self-assessment of the progress their life is making, Biggar casts it in terms of being "irreparably bereft of the capacity to engage in responsible life"[455] which he defines in vocational terms as "being dignified by the opportunity and obligation to respond to a call of God to play an inimitable part in the maintaining and promotion of the welfare of the world."[456] For Biggar, intentionally taking the life of a being that cannot do this because of cognitive limitation or injury is "morally permissible" since that life has "lost its unique preciousness – its sacred value."[457]

Rachels and Tooley have similar notions about what the human person is. For Rachels, so long as you have interests and can fulfill them, you are a person. But when you have neither, you are nothing more than mere biological matter. Tooley's view extends this a bit more. "Nonpersons" are those that may have been human but "can no longer be so characterized due to extensive brain damage" or are those that "due to a defective brain, never has been, and never can be, a person."[458] And the reason for this is because a person is only that being which "is a continuing subject of experiences and other mental states that can envisage a future for itself and that can have desires about its own future states."[459] Having these kinds of assumptions about personhood is an important reason why PAS advocates are adamant about their so-called right to make whatever end-of-life decision they deem best when faced with all but certain deterioration and death. Once

[450] See Jn. 11:38-44; 20.
[451] Dyck 2002: 84
[452] Gushee 2017: 179.
[453] Dworkin 1993: 221.
[454] Dworkin 1993: 215.
[455] Biggar 2004: 102.
[456] Biggar 2004: 166; also see pp. 44-5.
[457] Biggar 2014: 114.
[458] Tooley 1979: 66.
[459] Tooley 1979: 91.

personhood is defined in any way according to functional capacities, then humanity has no intrinsic value, sanctity, or dignity. As Edmund Pellegrino puts it well, for these people, "dignity consists in retaining absolute control over one's own dying process. It means choosing death rather than a life marked by dependence on others, pain, wasting, or loss of physical powers."[460] But what this attitude reveals is just more *idolatry of the self*, the same root evil that caused humanity's fall and marred our reflection of the Image.

Jesus, as both God and man – simultaneously Image (like God) as well as image bearer (like you and me) – reveals to us that our personhood, and its dignity and sacredness, are all wrapped up in God's intentions at creation. This means that human sacredness is universal across all humanity, that is, for all homo sapiens.[461] One' disability, incapacity, infirmity, injury, deficiency, impairment, disease, mutilation, frailty, sickness, ailment, malady, disorder, illness, syndrome, debility, or condition of any kind does not diminish their dignity, just as it didn't diminish the dignity of the God-man who carried the cross through the streets of Jerusalem and was later nailed to it for the public to view. This is because one's dignity does not ebb and flow along with their physical or psychological abilities, but is concretely tied to their bodily existence, no matter what condition it is in.[462] Sin may have marred it, making it difficult to develop according to the image, but it hasn't marred the image, nor the fact that the human was crated after the pattern of that image. The source of one's dignity, thus, is "God's special connection with people" evidenced by His use of that pattern when He made you and me.[463]

Real Autonomy and Rights

One of the reasons why the autonomy arguments fail (as I will discuss in more detail below) is because they have a nonrealistic view of human autonomy. Indeed, they elevate it beyond what it actually is and, as a result, enters into moral chaos. As had already been noted, the underlying thing driving the improper view of autonomy is an inaccurate view of persons compounded by the idolization of human control in all areas of life, especially death.

Real autonomy, however, is not really autonomy as such. Autonomy doesn't actually exist (this is what Adam and Even found out the hard way). And, hence, arguing for a "right to die" on the basis of human autonomy is something of a non sequitur. Since God is the giver and taker of life,[464] it is up to Him when either of those events happen. Real freedom, however, is not taking upon ourselves the authority to create our own morality, but is what "enables [us] to live as God has created and intended [us] to live."[465] Indeed, Scripture speaks of real freedom as that which is found in the Lord's removing the binds of sin and the impossibility of achieving God's holiness

[460] Pellegrino 1996: 112.

[461] Cameron 2004: 27.

[462] Although scripture clearly suggests persons to be substantially *dualistic* – both a body and soul/spirit (e.g., Ecc. 12:7, Mt. 10:28, Lk. 16, Acts 7:59, 2 Cor. 5:6-8), it does *not* go so far as to identify either the body or the soul/spirit as the real or essential me (such as philosophers like Rene Descartes or Richard Swinburne do). Rather, the biblical writers treat the human person as a "functional holism and dualism" or "holistic dualism" (see Cooper 1989: 70, 230). That humans are dualistic means that they are *comprised* of the material and immaterial, the body and the soul/spirit. But they *function* holistically, both in terms of body and soul/spirit. Despite the temporary separation from the body (2 Cor. 5:8) prior to the general resurrection which is linked to the events surrounding Christ's consummation of His kingdom (Jn. 5:28-9; Acts 24:15; 1 Cor. 15:52; Rev. 20:12), this resurrection of those in Christ will be a resurrection of the same body, albeit renewed and re-formed closer to Christ's (bearing His Image, after all) for all eternity with Him, as part of His ultimate goal of a renewed creation (Isa. 65:17-8; Phil. 3:20-1; cf. 1 Cor. 15:42). What his shows is that a human being is "neither pure self-transcending spirit no simply finite body – but somehow a union of both," akin to the example of being neither a horse nor a man but a "centaur' (see Meilaender 2017: 22).

[463] Kilner 2015: 233.

[464] 1 Sam. 2:6; Job 1:21.

[465] Kilner 1992: 111.

without Christ.[466] Freedom in the fullest sense, then, is secured only in Christ,[467] in the one by whom our every being is patterned after. Sin distorts it, and we often use it for ill, but we all still have it. Whatever rights we have, then, is rooted in the freedom that we have in virtue of our being in the *imago dei*.[468] We have the freedom to choose what we think is best for us in all of life's matters by the direction of the Holy Spirit, while being bound by reality and impelled by love.

So how is such freedom to be exercised regarding PAS and euthanasia? We have already established that intentional killing itself goes against the Biblical prohibition of murder. Image bearers are not to seek death neither as an end nor a means, as PAS advocates argue is morally okay. But we nonetheless have to choose treatment or non-treatment options. John Kilner says that two questions help capture how best to assess whether or not we are using our freedom for good in the rights we have to make our own medical decisions: "is the patient willing?" and "is death intended?"[469]

The first question regarding the patient's willingness has to do with whether or not the patient is actually free in making medical decisions. This is what is meant by the concept of "informed consent."[470] For a patient to truly make their own medical decisions, they need to have access to all of the pertinent information and be able to make the decision without the undue influence of others. Anything less than that is not true informed consent, and hence an immoral restraint on the patient's freedom. Kilner notes four conditions that must be satisfied in order to have true informed consent: "(1) the patient must have the capacity to make the decision; (2) the patient must be able to decide voluntarily; (3) the patient must receive sufficient information to make a good decision; and (4) the patient must come to a genuine understanding of the nature and implications of the proposed treatment."[471] When the conditions have been met, informed consent has been achieved. But we must recognize that sometimes such consent happens before a time when medical decisions have to be made, such as when individuals make their treatment wishes known in *living wills* and *advanced directives* that inform future parties how *not* to treat them if they were to become incapacitated. When patients have made these, it would be disrespectful and a slight against their freedom to not follow through on them. The refusal of treatment, even though it may lead to death, however, is not always immoral. Sometimes it is the appropriate thing to do (which I discuss in §11 below). However, as Kilner notes, documents like living wills or advance directives that include a durable power of attorney "do not expand [our] freedom; they merely affirm it," even if the choice is unwise.[472]

The second question is important because it must directly appeal to God-centered definitions and expectations of life and death in order to choose the best option. A proper use of our freedom does not intentionally seek out death (as I have discussed in §9). All forms of PAS and euthanasia deliberately seeks death as the goal to be achieved in treatment, or as the means to the goal of the cessation of suffering. But there are cases of refusals of treatment that are not purposely seeking death, but rather are seeking to have a better quality of life in one's final days, especially when the treatment itself would be burdensome, painful, and not add to the quality of one's life (I'll discuss this in more detail in the next section below). So when this is the case, refusals of treatment are an appropriate, "responsible" use of freedom.[473]

[466] Ps. 118:5; Lk. 4:18-9; Ro. 8; Gal. 5-6; Jas. 1:5.
[467] Gal. 5:1.
[468] Kilner 1992: 25.
[469] Kilner 1992: 83; 1996: 75-81; Kilner & Mitchell 2003: 89-102.
[470] Kilner 1992: 84.
[471] Kilner 1992: 85.
[472] Kilner 1992: 92.
[473] See Biggar 2004: 49.

False Autonomy

Autonomy, as conceived by those who rely on it as the rationale that justifies PAS, is quite at odds with the moral order of the created world. But it has really caught on. As Martin & Sas note, Western medicine has elevated the notion of "personal autonomy" over other important moral considerations such as non-maleficence, beneficence, and justice, primarily because western "individualism" is so pervasive in our society.[474] Maybe a good example of this is the pervasiveness of pharmaceutical ads on television and other forms of media. The idea is not that you should heed to your doctor's wisdom to direct you to the type of medicine that might be best for you but go to him or her and suggest it yourself. Autonomy is power, especially in medicine.

Russell DiSilvestro notes how this individualism leads to a flaccid view of human significance because its practitioners consider only "their values and preferences in the absence of any objective truths or binding standards."[475] Nigel Biggar concurs. The modern autonomy-mantra that "value resides not in what we decide, but in that we decide" is seriously problematic because of how, over time, it "subverts common moral deliberation, responsible respect, and therefore human community itself,"[476] potentially pushing us closer to "a state of moral alienation" where "sheer incomprehension grows bored and relaxes into utter indifference."[477]

By definition, then, it is a view and practice not bound by reality whatsoever.[478] It is highly seductive, though, for several reasons: it makes me feel good that my desires, preferences, and values "is what makes my life meaningful, enjoyable, or significant;"[479] there is a general moral consensus that in the medical context, for instance, "the shift toward greater respect for the patient's own values has been on balance a morally good one;"[480] the point of governments and other social institutions is to protect individuals;[481] it's easier to defend the significance of one's individual life as having a basis in that individual's "own complex psychological states" such as her "desires, preferences, [and] values;"[482] if you already deny that absolute truth exists, then individualism allows you to define objectivity in terms of what everyone agrees to;[483] the culture, society, or group that the individual is part of can never undermine one's personal values.[484] But there are several problems with this complex view of absolute autonomy rooted in individualism as such.

First of all, *it is false in light of the sovereign omnipotence of God* who is the designer, creator, and owner of all things.[485] The creation account tells us that God created humanity to be stewards over all of the earth and gave us a degree of freedom in order to do this.[486] But the notion of freedom and autonomy just noted "is a distorted sense […] that denies life as a gift of God over which we

[474] Martin & Sas 2015:9. Also, Francis Beckwith 1998: 228 notes how that appeals to autonomy in the modern era are never neutral for they all "assume a view of reality, a view of the person in particular, which is secular, anti-communitarian, and metaphysically libertarian."

[475] DiSilvestro 2017: 66.

[476] Biggar 2004: 40.

[477] Ibid. 41.

[478] According to philosopher Robert P. George, part of the problem is how autonomy is incorrectly viewed as an end in itself, as having *intrinsic* value instead of being realistically understood as having mere *instrumental* value for the person who possess it (See Gorsuch 2006: 93).

[479] DiSilvestro 2017: 71.

[480] Ibid. 71.

[481] Ibid. 72.

[482] Ibid. 73.

[483] Ibid. 73.

[484] Ibid. 73.

[485] See Cameron 1996: 26.

[486] Gen. 1:26-30.

have been given stewardship as with other good things."[487] And as a result of this, it causes us to go derelict on the stewardship we have to protect those who need our protection, those whom our modern notions of freedom and autonomy leave out by "accord[ing] rights only to those who are fully autonomous, putting the demented, the retarded, or the permanently comatose at serious risk."[488]

Second, *absolute autonomy is self-refuting*. For instance, "voluntary slavery is a contradiction" since "one may not use his freedom to give up his freedom; one may not exercise her will in order to eliminate the exercise of her will."[489] Consider, for instance, one's exercise of autonomy in committing suicide:

> Suicide is a self-refuting act, for it is an act of freedom that destroys future acts of freedom; it is an affirmation of being that negates being; it serves a human good (e.g., a painless state) but, as a means to that end, violates other, more basic human goods (e.g., life itself); it is an act of morality that gives up on all other moral responsibilities and rejects the moral way of life.[490]

The bottom line here, then, is that absolute autonomy, in theory, implies all options are on the table. Autonomy is merely just the capacity to do what one wants to do. But it needs to assume itself in order to negate itself, such as in voluntary slavery or suicide.

Third, *there's no such thing as an absolutely autonomous decision*. Indeed, when it comes to medical decisions, informed consent means that others have to be involved to make sure that genuine consent is being given as a result of being properly informed. As this relates to PAS, this means that there is no such thing as a completely *individual* euthanasia. Daniel Callahan notes how inherently social the practice is. After all, suicide itself is a social-legal prohibition, but if we start asking physicians to take part in it, it now adds another level of social involvement since physicians are licensed by states and part of medical licensing boards and associations.[491] In effect, there are social consequences, since its legalization would "say that suicide is a legitimate and reasonable way to of coping with suffering, acceptable to the law and sanctioned by medicine."[492]

But there are other ways of thinking about this particular problem. For instance, Ben Mitchell questions how autonomous patients actually are, given that they are called upon to make decisions *as patients*.

> Patient autonomy is compromised by many factors in the medical setting. First, there is a *dis*-parity of knowledge and clinical judgment. Physicians, nurses, and other caregivers have a great knowledge base than most patients. Second, there is the *dis*-ease of illness, especially terminal illness. After all, the etymology of the word "patient" is from the Latin root for "suffering." By definition, suffering limits autonomy. [...] Furthermore, the evidence shows that caregivers spend less time with dying patients than they did before they were determined to be terminal. This is not to suggest that physicians and nurses are being mean-spirited toward the dying. Rather it is simply true that fewer medical treatments are being offered. A clinician's time is demanded by other cases. Terminal patients often report that they feel they are a burden on family, friends, and other caregivers. They may even feel themselves a burden on the healthcare system itself.[493]

[487] Pellegrino 1996: 109.
[488] Ibid. 109.
[489] Mitchell 2015: 69.
[490] Moreland 1998: 192.
[491] Callahan 2005: 181-2. See also Byock 1997: 119-121.
[492] Callahan 2002: 60.
[493] Mitchell 2015: 69-70.

Another side of this problem is through the sorts of societal ideas about what constitutes legitimate, worthy, or valuable, human lives. After all, autonomy-centered theories like that of Brandom and Dworkin are happy to admit that, for them, a person is to some degree a "social construct" given our shared values on our "cognitive abilities" of being able to "express past experiences and aspirations of the future," or what Dworkin specifically calls *creative interests*.[494] Indeed, if someone wants to undergo PAS, it's probably not because of their own personally arrived-at philosophy of human personhood, but rather, because of societal pressures about what human value consists in. One team of physicians raise this point in the context of three notable cases in the mid 1990s of three PAS seekers with severe, incurable disabilities:

> They all requested assistance from their healthcare providers in some form or other to facilitate their deaths. The critical question is: were these requests an expression of their ultimate autonomy to exercise control over their bodies and medical treatments or were their wishes to die a desire to escape the socially constructed part of disability – the pain of prejudice, the economic deprivation, exclusion from the community, and unnecessarily restricted choices? If the latter scenario is a more accurate approximation of the truth, then their decisions are hardly acts of self-determination, but rather responses to coercive forces that should be opposed.[495]

Nigel Biggar notes that this can be true of anyone since our "autonomous" desires and choices truly are "socially determined" given that "whether or not I want to go on living depends on my self-esteem, and that in turn depends on my perception of how others view me."[496] What this exposes is the arbitrariness involved in the concept of autonomy and especially how it gets applied.[497] Daniel Callahan notes that absolute autonomy is not highly regarded for other kinds of activities, such as slavery and dueling, which have been outlawed long ago.[498] Why don't we allow people to choose those activities, but we want them to choose PAS? Might there be something sinister here going on? Is our "respect" for the autonomous choices of others inconsistent for a reason? Maybe Kilner is right and PAS is our way of ridding ourselves of the undesirables among us, rather than taking our social responsibilities seriously in meeting the needs of those suffering among us.[499] The arbitrariness of it all suggests this to be a possibility:

> It is said that a competent adult has a right to PAS for the relief of suffering. But why must the person be suffering? Does not that stipulation already compromise the right of self-determination? How can self-determination have any limits? Why are not the person's desires or motives, whatever they be, sufficient? How can we justify this arbitrary limitation of self-determination? […] Consider next the person who is suffering but not competent. The standard argument would deny euthanasia and PAS to that person. But why? If a person is suffering, but not competent, then it would seem grossly unfair to deny that person relief simply because he or she lacked competence. Are the incompetent less entitled to relief from suffering than the competent?[500]

[494] Waters 2006: 34.

[495] Kirschner et al 1997: 163.

[496] Biggar 2004: 147.

[497] For instance, philosopher Joel Anderson, relying on a Brandomian conception of personhood, argues that there really aren't and necessary and sufficient conditions for autonomy apart from social construction. Autonomy is a deontic status that is possessed only be those who are recognized as having it. Autonomy is a social practice of bestowing it to one another upon the recognition of capacities that are considered to be autonomy-conferring (see Anderson 2014).

[498] Callahan 1992: 52.

[499] Kilner 1998: 133.

[500] Callahan 2002: 62.

The point, simply, is that our laws, policies, and arguments in favor of PAS and euthanasia are arbitrarily "jerry-rigged" and inconsistent.[501] They truly aren't labors of support for human autonomy as such but are the result of certain kinds of personal values that, as it just so happens, many Americans share.

False Interests

The utilitarianism of Rachels and Tooley, as discussed in §6, is our target here. They think that PAS is justified for a person so long as it best serves everyone's interests, that is, maximizes everyone's happiness. There may be times when this obtains, such as when patients are suffering unbearable pain, or suffering due to major loss of abilities and capacities, inability to pay for life-extending treatment, and so forth. If these phenomena minimize everyone's happiness, the right thing to do is euthanize the patient. This sounds a bit harsh, and though Rachels and Tooley do not put it so bluntly, their ethical frameworks nonetheless of commit them to this. Utilitarianism works from a human-centric view of what are the *interests* that, when realized, benefit all – happiness, pleasure, and the lack of pain (roughly all of these are the same thing for utilitarianism). This might not be so problematic if they assumed a real view of humanity, as I have noted above. But they do not. Hence, none of these are directed toward God, nor towards how he defines what is good for humanity.

This makes determining (1) what is actually in our best interests and (2) how to achieve it for the aggregate good, very difficult tasks. Gilbert Meilander notes how this was a struggle for famed utilitarian philosophy Henry Sidgewick. In a world that has rejected one's individual dignity as being rooted in God, what can one stand on as the ground for one's own dignity if one is a utilitarian and define all good in terms of the aggregate good? All one is left with is an attempt to base it in the welfare of the aggregate good.[502] Hence you take up the mantle to do that which provides the most amount of good to the most amount of people. But this leaves your individual dignity vulnerable, and your self-valuing unsatisfying. If your dignity is grounded in the social good, then what happens when society thinks you are no longer good? These foundational, metaethical issues reveal one of the biggest problems with utilitarianism: how does one go about really calculating consequences? How is that you are able to keep your choices and actions, that are supposed to be for everyone's happiness, from not just "degenerate[ing] into a personal hedonism"?[503] So, this is a problem regarding the internal coherence of the theory itself. But even more problematic is utilitarianism's assumption that there indeed is a precisely correct answer to all moral problems and that person can figure this out on their own.[504] As Meilaender notes,

> [In] the traditional Christian ethic [...] our responsibility to achieve socially useful aggregate goods is always limited. [...] Sometimes individual agents will see more or less clearly how their tasks are related to the overall good. [...] At other times, however, an individual may not be able to see the larger good his assigned duty serves. In such cases, he cannot really be criticized for ignoring the larger good while just minding his own business, for he simply does not know that larger good. We can imagine a world in which the overall good is very important, but also very complex, far too complex for any individual agent always to be sure of how his work helps to produce it.[505]

[501] Callahan 2002: 63.
[502] Meilaender 2017: 19-20.
[503] Kilner 1992: 106.
[504] Meilaender 2017: 28.
[505] Meilaender 2017: 31.

This is why, for the believer, achieving the common good is never a difficult task to figure out. It is always the right thing to do, but not on utilitarian bases. Rather, it consists in a God-centric, reality-bound, and love-impelled ethics. Living according to the creation design and intent is always good for all the people.

So, given the general problem that affects utilitarianism as a theory, utilitarianism in practice is disastrous. Remember, there is no such thing as an absolute moral rule for utilitarianism. All that matters is that consequences maximize aggregate happiness. So, genocide and slavery, for instance, could be justified on this basis. What about PAS? If Rachels and Tooley were more forthright about the implications of their arguments, they would be forced to the position that someone who is near the end of life, suffering from pain, using a vast amount of resources that will not contribute to any "meaningful" remainder of life, should end their lives. After all, if "one is morally obligated to maximize [happiness]" as utilitarians argue, "and if an act of suicide maximizes [happiness], then it would be morally obligatory."[506] Indeed, it would also require that person's physician to help carry it out, given the special obligations that physicians have to their patients in light of our collective notion of good.[507] But why stop there? If your death truly maximized happiness, then the physician should just go ahead and euthanize you. Practically speaking, then, for utilitarianism, the ends always justifies the means so long as the ends truly benefits the aggregate interest.[508] As such, it views the world as a "lifeboat" with room only for those whose happiness can be maximized, telling the sick, diseased, impaired, "disenfranchised and despised to get out of the way."[509]

11. A LOVE-IMPELLED APPROACH TO END-OF-LIFE CARE

Now for the final section of this essay: what does a love impelled ethics do in light of the God-given realities just discussed? It takes them and makes them love in action, through our covenantal obligations to one another. True love is rightly ordered, ultimately to God (God-centricity) and then through that toward others (love-impelled) within the reality of the world we are in (reality-bounded). As noted earlier, this kind of love is sacrificial and unconditional. As Kilner notes, "according to this dimension, as long as no God-given realities are being violated in the process, one is to promote people's well-being as much as possible."[510] So, then, what are our conclusions from the God-centric and reality-bounded approach we took in the previous two sections? Here, I want to suggest at least three as it relates to decisions regarding end-of-life care.

No Obligation to Undergo Extraordinary or Useless Treatment

First, let's get something out of the way. That we should never seek to end life intentionally does not imply that it is always wrong to decline, withdraw, or withhold treatment – let's call these *decisions for nontreatment*. Our God-centered and reality-bounded approach does not lead us to a position of "idolatrous vitalism that justifies absolutely anything that will extend life even the least amount of time."[511] It is the case that such a "technological idolatry" itself offends the dignity of

[506] Moreland 1998: 191.

[507] See Rivera-López 2017.

[508] The implications here are enormous. For instance, not only would your suicide be morally obligatory if it's in the aggregate interest, but also undergoing medical procedures that would also secure that interest. This is where transhumanist issues come to the fore and raise all sorts of ethical questions; see Patrick Smith 2017.

[509] Coleman 2002: 228.

[510] Kilner 1996: 80.

[511] Kilner 1992: 122.

the person because it is an affront to the life-giving and -taking sovereignty of God.[512] No doubt, many Americans already sense this and, along with the very public deaths of people like Karen Quinlan, Nancy Cruzan, and Terri Schaivo, have sought to minimize their chances of becoming in similar situations by crating living wills and advance directives that officially record one's wishes for future care if they should become incapacitated without any hope of recovery. It is worth quoting Kilner at length on this point:

> This never-say-die attitude is particularly problematic in the caregiver, but it may characterize the patient as well. It is radically at odds with a God-centered perspective. God has allowed death to limit physical life – a reality that we must take into account. If we fail to do so, we rebel against God by making an idol of life. Idolatry is subtle: it takes something good and treats it as if it were God. As important as life is, we must remember that it is a gift from God, not a god itself. Accordingly, under certain circumstances withholding or withdrawing treatment can be obeying God, not playing God. We play God when we ascribe absolute significance to life and, derivatively, to the medical technology that sustains it. We play God if we assume the right to make judgments about which lives are worth continuing – if we choose to become the medical cause of death rather than accept another cause that can no longer be stopped. However, truly recognizing that beyond a certain point physical life must end is far from playing God.[513]

What this means, then, is that there is a crucial difference between *intending* and *conceding to* death. Sometimes a decision for nontreatment may be the most appropriate thing to do in the circumstances. It may be that treatment itself would be more burdensome, causing more pain and suffering than not having the treatment, without offering any meaningful benefit to the patient.

Here, however, intentions matter. Kilner, for instance, criticizes the view which says decisions for nontreatment are justified "on the grounds that the patient's quality of life is (or will soon be) too low and there is no significant prospect for improvement" such that death would be better.[514] Such a claim relies on consequentialist views of human significance instead of the Christian view that "life draws its significance from the fact that it is created and sustained by God."[515] It is not up to us to make judgments about what *quality* of life is, especially since our opinions about it are too subjective for having an accurate determination. So, what might make treatment wrong and nontreatment right? Kilner notes that the crucial distinction to make is that "between burdensome treatment and burdensome life."[516] *There is never any such thing as a burdensome life*. However, treatment may be problematic, not because the patient's life itself is becoming worth less as it becomes more burdensome, but because the treatment itself "provides no significant benefit."[517] Another way to define a futile treatment is that it's an "intervention" that "cannot achieve the goals of the intervention, no matter how often it is repeated."[518]

Indeed, treatment may lead to a "prolongation of the dying process" such that the patient's suffering is drawn out longer when it is clear that death is imminent regardless."[519] This is something that the patient has to determine, however. Physician C. Christopher Hook, for instance, notes that doctors tend to undervalue the quality of their patients' lives given their own ideas about living from their perspectives as medical practitioners.[520] Physician John Dunlop notes

[512] Fowler 1996, 46-7.
[513] Kilner 1992: 127.
[514] Kilner 1992: 121.
[515] Kilner 1992: 122.
[516] Kilner 1992: 125.
[517] Kilner 1992: 125.
[518] Hook 1996: 89.
[519] Kilner 1992: 128.
[520] See Hook 1996: 84-88.

that several points need to be very clear for the patient when making such a decision near the end-of-life: knowing the "exact diagnosis;" knowing what the natural prognosis of the condition is without any treatment of it; knowing what treatment is available for the condition and what its success rate and complications are; understanding one's spiritual readiness in the face of death; understanding the emotional health and attitudes of the patient at that point in life, etc.[521] When one is equipped with such knowledge, maybe the best thing to do in such circumstances is be in the comfort and privacy of home, surrounded by family, allowing others to serve in the way that they are being called to do in that very moment, instead of adding or prolonging suffering, especially considering that may cost a lot in terms of resources required.[522] Of course, this requires honest, sobering, and Spirit-led discernment[523] within the context of genuine, God-centered love directed toward the dying patient and patient's family in symbiosis together.

> How does selfless love apply to end of life care? Once all facts of a patient's condition and the likely effectiveness of treatments are known, acting in selflessness can provide a more accurate compass for decision making than making decisions based on selfish autonomy. Love for God would involve sacrificing one's own desires and plans for God's often-mysterious goals. Deference to God's goals and plans could require the family of a terminally ill patient to forego extreme and likely painful measures at attempt to prolong the life of their loved one. Similarly, humble acceptance of God's sovereign plans would require a terminally ill patient to sacrifice illusory autonomy and courageously rests the temptation of PAS. In this way, selflessness would not cling desperately to life regardless of the ethical cost. Love for neighbor would involve sacrificing one's own happiness for the benefit of others. Love for family members might prompt a terminally ill patient to forego expensive treatment options that would bankrupt the family. On the other hand, love for a terminally ill patient would encourage family members to eschew the cost-cutting course of PAS. Although deciding whose needs take priority can be challenging, seldom is there too much love present among sinful human beings. Courageously deferring one's own wishes to the Lord's direction and the needs of others not only provides a clearer standard than autonomy, but also frees us from the burden of demanding our selfish desires in futility. God assures us that he will make our way clear – not free from trial, but sustained by grade – if we trust in him […] (Prov. 3:5-6).[524]

Palliative Care and Hospice

Generally speaking, *palliative care* is a specialty in medicine focusing on end of life care, the broad goals of which "include the alleviation of suffering, the optimization of quality of life until death ensures, and the provision of comfort in death."[525] *Hospice* is a type of palliative care, distinguished by its particular Christian-rooted philosophy of care that is utilized by patients whose prognosis includes a likelihood of imminent death. Although examples of hospice care facilities go back as far as the late nineteenth century, the modern hospice phenomena is rooted in the work of Cicely Saunders, founder of the St. Christopher's Hospice in London in 1967 which started as a facility to take resident patients and help them deal with what Saunders called "total pain, composed of the physical aspects of disease, but as importantly, of the psychological, social, and spiritual dimensions of pain."[526] Kathleen Foley identifies categories of pain that all palliative care attempts to address: physical, psychological, and existential distress.[527]

[521] See Dunlop 1996: 37-41.
[522] See Kilner & Mitchell 2003: 102-114.
[523] See Kilner 1996: 79-81.
[524] Martin & Sas 2015: 118-9.
[525] Foley 2002: 297.
[526] Twaddle 1996: 184-5.
[527] See Foley 2002: 298-302.

Saunders's goal was to provide a place for people to endure their suffering and death with dignity, not with fear, loneliness, and the constant torrent of temptations to escape it all. For this reason, Saunders structured the hospice framework to have what she calls "a complex set of attitudes and skills" in an effort to provide "total continuity of care" for every aspect of the patient.[528] Twaddle describes it as having an "interdisciplinary" approach in that the "team" of people caring for the dying are "composed of nurses, physicians, social workers, chaplains, volunteers, and others" in order to provide for the needs of patients and their families."[529] In this way, relationships are cultivated and nourished not only between the patient and caregiving team, but between that team and the patient's family. It is the concern and efforts of this holistic team of care that is crucial to validating the worth and dignity of the patient who, through their suffering, is most vulnerable to thoughts of worthlessness and indignity.

Table 3.[530]

TOTAL PAIN MODEL	
Physical Well-Being & Associated Symptoms Functional ability Strength/fatigue Sleep/rest Appetite Constipation	**Psychological Well-Being** Anxiety Depression Enjoyment/pleasure Happiness Fear Cognition
Social Well-Being Caregiver burden Roles and relationships Affection/sexual function Appearance	**Spiritual Well-Being** Suffering Meaning of Pain Religiousity

The aim of hospice is to holistically care for the patient who has a prognosis that makes them near the end of life and to do so in such a way that affirms their dignity as a person. Indeed, as Sandol Stoddard points out, a case-in-point of how the assumption that death is the only "merciful release" for severely ill patients is a false one is how hospice has proven that "people who are comfortable, secure, and lovingly cared for do not want to commit suicide."[531] Arthur Dyck agrees with this, noting a 2000 study that found no relevant connection between terminally-ill cancer patients' level of pain and the desire to hasten death. Rather, what it found is that the patients who were open to considering PAS were suffering from depression and, as a result, felt their situation "hopeless."[532] Hospice counters this hopelessness by attending to *all* of the physical, emotional, spiritual, and relational *needs* of the patients in its care.

Affirming the Doctrine of Double-Effect

But there is an argument that has to be reckoned with. Here it is in question form: Since (1) withholding or discontinuing life-sustaining treatment or (2) treating a patient with comfort-only

[528] Saunders 2002: 287.
[529] Twaddle 1996: 186.
[530] Twaddle 1996: 185
[531] Stoddard 2004: 733.
[532] Dyck 2014: 99.

care that utilizes aggressive pain-relieving measures (e.g., morphine) both *hasten death* – that is, they both make death more likely sooner than not doing either of these – *what's really the difference between that and* (3) *PAS or other forms of euthanasia that also result in death*, especially since PAS just speeds up the process and shortens the term of unbearable pain and suffering which would be the more compassionate, merciful thing to allow a patient to do given their circumstances? The point of this argument is that (1), (2), and (3) are somewhat equivalent given their consequences, but there are cases when (3) would in some situations be the morally better thing to do. As briefly noted in §1 and §10, philosophers of all stripes eschew the distinction: if one may legitimately exercise their autonomy in deciding against treatment or for a treatment that may hasten one's death, then one may exercise that autonomy to end their life; if nontreatment or aggressive pain treatment is in everyone's best interests, and both options lead to death, and being euthanized leads to death, then there really is not a moral distinction to be had among all the options. James Rachels and others have made this argument in their attempt to show the moral irrelevancy of the metaphysical distinction between killing and letting-die. Criticizing this distinction was one of the argumentative strategies of the pro-PAS sides in both the *Quill* and *Glucksberg* U.S. Supreme Court cases as well as Chief Justice Rehnquist's majority opinion for the Court noted in §3.

In fairness to the critics, they make a good point. The bare metaphysical distinction between killing and letting-die does not imply the parallel moral distinction that the former is always morally wrong and the latter is always morally permissible. The moral distinction, then, is utterly capricious and the critics are right to call out the arbitrariness of it all. But whereas Rachels and Tooley, for instance, think that best *interests* dictate what the morally required action is for a particular situation, the Biblical position is that *any and all* of the options are morally problematic ones if death is *intended* as a means to the goal that is sought, or the goal itself.[533]

A good way to think about this issue is in terms of what philosophers call the doctrine of double-effect (DDE).[534] Sometimes by intending and doing action *a*, it brings about effect *e*, but may also, unfortunately, bring about effect *f* whereas intending *f* itself would not be morally permissible. Put simply in terms of our topic here, *choosing and causing death as a goal in itself or as a means to some other goal* (e.g., PAS, euthanasia for the purpose of relief of suffering) *is always morally wrong*. At the same time, it may nonetheless be morally permissible, albeit unfortunate, for death to result as a side effect of some other objective, even if that death was somewhat foreseen as a significant possibility.[535]

So, for example, consider a case that is often appealed to in the abortion debate: the removal a malignant ovarian tumour in a pregnant woman. In most cases, women choose to have the tumor removed even though there is a high likelihood that a side effect of the surgery will be the death of the child. Some abortion advocates say that since the results of this procedure and the results of an actual abortion procedure are exactly the same – an aborted fetus –there is no good reason for thinking the two are morally different actions. But those critics are wrong. In the surgery case, the death of the child results, not as an intended outcome, but as an unfortunate side effect of trying to correct a pathology – the tumor.[536] The mother would be especially overjoyed and happy for the child to live because she is not intending death here. She just wants to live too.

Similarly, then, most people that choose to have treatment withheld or withdrawn are not intending to die, they are just intending to not add to the pain and suffering already taking place by unnecessarily attempting to artificially extend their lives. And those that choose to use

[533] See Ro 3:8; Jas. 4:17;

[534] Thomas Aquinas was the first to formulated this in his argument for why self-defense is not an unjustified killing since the one defending himself merely has the intention of doing just that, not killing the assailant (See his *Summa Theologica* II.II Q64 A7).

[535] See Biggar 2004: 71-88 for an excellent defense of the DDE. See also Dyck 2014: 34-44.

[536] See Lee & George 2015.

aggressive pain-relieving measures are not intending to be killed by morphine, but rather that their final days may be lived in relative comfort so they may, as Kilner puts it, spend "their final hours [...] composing themselves for death and drawing to a close important relationships than in a vain struggle against dying,"[537] even though such measure may hasten their death. (As an aside, what doesn't hasten death? Does your lack of exercise or consumption of bacon hasten your death to some degree? If so, and if the DDE scoffers are correct, you are slowly committing suicide). In those cases, those dying loves ones would love to live on, and we would love to have them. So, "the decision to withdraw care [or treat pain aggressively] will, at some level, 'cause' death, and death is the absolutely foreseeable outcome."[538]

But that is completely different from the work of Jack Kevorkian who, although intending to relieve people's suffering, he also "indubitably intended to kill as his means" of relieving their suffering[539] For Kevorkian, suffering was the intended goal, but death was the "instrumental means" to achieving that goal.[540] Thomas Sullivan offers a good example in terms of withholding extraordinary treatment, not to intend death, but for other reasons, even though death will be some potential collateral damage, so to say:

> For example, [the physician] may realize that further treatment may offer little hope of reversing the dying process and/or be excruciating, as in the case when a massively necrotic bowel condition in a neonate is out of control. The doctor who does what he can to comfort the infant but does not submit it to further treatment or surgery may foresee that the decision will hasten death, but it certainly doesn't follow from the fact that he intends to bring about its death. It is, after all, entirely possible to foresee that something will come about as a result of one's conduct without intending the consequence or side effect. If I drive downtown, I can foresee that I'll wear out my tires a little, but I don't drive downtown with the intention of wearing out my tires. And if I choose to forego my exercises for a few days, I may think that as a result my physical condition will deteriorate a little, but I don't omit my exercise with a view to running myself down.[541]

At the end of the day, there are thorny issues to sort out when it comes to determining the appropriate end-of-life treatment options. It may not always *seem* like making an appropriate decision to stop, never start, or use aggressive treatments are the right things to do given their connection to the death of the patient. But what truly separates DDE scoffers from those who see it as helping to account for the moral differences between treatment decisions and PAS, is that the latter "focus on the question of how best to care for patients" while the latter focus on "how to kill them."[542]

[537] Kilner 1992: 128.
[538] Gorsuch 2006: 66.
[539] Gorsuch 2006: 70.
[540] Biggar 2004: 88.
[541] Sullivan 1994: 136.
[542] Gorsuch 2006: 165.

References

Alexander, Leo. 1949. "Medical Science Under Dictatorship." *The New England Journal of Medicine* 241:2(July): 39-47.

Amundsen, Darrel W. 1997. "The Significance of Inaccurate History in Legal Considerations of Physician-Assisted Suicide." In *Physician-Assisted Suicide*, ed. Robert F. Weir, pp. 3-32. Bloomington: Indiana Univ. Press.

Anderson, Joel. 2013. "Regimes of Autonomy." *Ethical Theory and Moral Practice* 17: 355-368.

Ashwal, Stephen et al. 1994. "Medical Aspects of the Persistent Vegetative State." *The New England Journal of Medicine* 330: 1499-1508.

Avila, Daniel. 1998. "Brick walls on the Slippery Slope." In *Suicide: A Christian Response*, eds. Timothy J. Demy & Gary P. Stewart, pp. 53-59. Grand Rapids: Kregel Publications.

Badham, Paul. 2009. *Is There a Christian Case for Assisted Dying: voluntary euthanasia reassessed*. London: Society for Promoting Christian Knowledge.

Ball, Howard. 2012. *At Liberty to Die: the battle for death with dignity in America*. NYU Press.

Beauchamp, Tom L. 1993. "Suicide." In *Matters of Life and Death*, ed. Tom Regan, pp. 69-120. NY: McGraw-Hill.

Beckwith, Francis J. 1998. "Absolute Autonomy and Physician-Assisted Suicide." In *Suicide: A Christian Response*, eds. T. Demy and G. Stewart, pp. 223-233. Grand Rapids: Kregel.

Bever, Lindsey. 2014 Nov. 2. "Brittany Maynard, as promised, ends her life at 29." *The Washington Post*.

Biggar, Nigel. 2004. *Aiming to Kill: the ethics of suicide and euthanasia*. Cleveland: Pilgrim Press

Bork, Robert. 1990. *The Tempting of America: the political seduction of the law*. NY: Touchstone.

Brandom, Robert. 1994. *Making it Explicit*. Harvard Univ. Press.

Brock, Dan W. 2002. "Voluntary Active Euthanasia." In *Social Ethics: morality and social policy*, ed. T. Mappes & J. Zembaty, pp. 76-79. New York: McGraw-Hill.

Brody, Howard. 1997. "Assisting in Patient Suicides is an Acceptable Practice for Physicians." In *Physician-Assisted Suicide*, ed. Robert F. Weir, pp. 136-151. Bloomington: Indiana U. Press.

Buiting, Hilde et al. 2009. "Reporting of Euthanasia and Phyiscian-Assisted Suicide in the Netherlands: descriptive study." *BMC Medical Ethics* 10:18 (Oct.).

Byock, Ira R. 1997. "Physician Assisted Suicide is Not an Acceptable Practice for Physicians." In *Physician-Assisted Suicide*, ed. Robert F. Weir, pp. 107-135. Bloomington: Indiana U. Press.

Callahan, Daniel. 1992. "When Self-Determination Runs Amok." *The Hastings Center Report* 22:2 (Mar.-Apr.): 52-55.

---------- 2002. "Reason, self-determination, and physician-assisted suicide." In *The Case Against Assisted Suicide: for the right to end-of-life-care*, eds. Kathleen Foley and Herbert Hendin, pp. 52-68. Baltimore: The Johns Hopkins University Press.

---------- 2005. "A Case Against Euthanasia." In *Contemporary Debates in Applied Ethics*, eds. Andrew I. Cohen & Christopher Heath Wellman, pp. 179-190. Malden, MA: Blackwell Pub.

Cameron, Nigel M. de S. 1996. "Autonomy and the Right to Die." In *Dignity and Dying: A Christian Appraisal*, eds. John F. Kilner, Arlene B. Miller, and Edmund D. Pellegrino, pp. 23-33. Grand Rapids: Paternoster Press.

---------- 2004. "Christian Vision for the Biotech Century." In *Human Dignity in the Biotech Century*, eds. Charles W. Colson and Nigel M. de S. Cameron, pp. 21-39. Downer's Grove, IL: InterVarsity Press.

Campbell, A.G.M. 1983. "The Right to be Allowed to Die." *Journal of Medical Ethics* 9:3 (Sep): 136-140.

Chambaere, Kenneth et al. 2010. "Physician-Assisted Deaths Under the Euthanasia Law in Belgium: a population-based survey." *Canadian Medical Association Journal* 182(9): 895-901.

Chemerinsky, Erwin. 2008. "Washington v. Glucksberg was Tragically Wrong." *Michigan Law Review 106:8* (June): 1501-1516.
Chin, Arthur E. et al. (1999). "Legalized physician-assisted suicide in Oregon – the first year's experience." *The New England Journal of Medicine* 340: 577-83.
Chochinov, Harvey M. & Leonard Schwartz. 2002. "Depression and the will to live in the psychological landscape of terminally ill patients." In *The Case Against Assisted Suicide: for the right to end-of-life-care*, eds. Kathleen Foley and Herbert Hendin, pp. 261-277. Baltimore: The Johns Hopkins University Press.
Cohn, Felicia & Joanne Lynn. 2002. "Vulnerable people: practical rejoinders to claims in favor of assisted suicide." In *The Case Against Assisted Suicide: for the right to end-of-life-care*, eds. K. Foley and H. Hendin, pp. 238-260. Baltimore: The Johns Hopkins Univ. Press.
Coleman, Diane. 2002. "Not Dead Yet." In *The Case Against Assisted Suicide: for the right to end-of-life-care*, eds. K. Foley and H. Hendin, pp. 213-237. Baltimore: Johns Hopkins Univ. Press.
Compassion in Dying v. Washington, 850 F. Supp. 1454 (W.D. Wash. 1994).
Compassion in Dying v. Washington, 79 F.3d 790 (9th Cir. 1995), *vacated en banc*.
Compassion in Dying v. Washington, 85 F.3d 1440 (9th Cir. 1996).
Cooper, John W. 1989. *Body, Soul, & Life Everlasting: Biblical anthropology and the monism-dualism debate*. Grand Rapids: Eerdmans.
Crawshaw, Ralph S., Byron A. Foster, Matthew Iles-Sheh, and John Stull. 2016. "The uses of medical oaths in the twenty-first century." *The Pharos* 79:2 (Spring): 20-25.
Cruzan v. Director, Missouri Department of Health, 497 U.S. 261 (1990).
DiSilvestro, Russell. 2017. "My life is not my own: individualism and human significance." In *Why People Matter: A Christian engagement with rival views of human significance*, ed. John F. Kilner, pp. 65-86. Grand Rapids: Baker Academic.
Dworkin, Ronald. 1993. *Life's Dominion: an argument about abortion, euthanasia, and individual freedom*. New York: Alfred A. Knopf.
Dworkin, Ronald, Peter L. Zimroth, and Abe Krash. 1999. "Brief of Ronald Dworkin, Thomas Nagel, Robert Nozick, John Rawls, Thomas Scanlon, and Judith Jarvis Thomson as *Amici Curiae* in Support of Respondents." *Issues in Law & Medicine* 15(2): 183-198.
Dunlop, John T. 1996. "Death and Dying." In *Dignity and Dying: A Christian Appraisal*, eds. John F. Kilner, Arlene B. Miller, and Edmund D. Pellegrino, pp. 34-43. Grand Rapids: Paternoster.
Dyck, Arthur J. 2002. *Life's Worth: the case against assisted suicide*. Grand Rapids: Eerdmans.
Ely, John Hart. 1980. *Democracy and Distrust: A Theory of Judicial Review*. Harvard Univ. Press.
Foley, Kathleen. 2002. "Compassionate care, not assisted suicide." In *The Case Against Assisted Suicide: for the right to end-of-life-care*, eds. Kathleen Foley and Herbert Hendin, pp. 293-309. Baltimore: The Johns Hopkins University Press.
Foley, Kathleen & Herbert Hendin. 2002a. "Introduction." In *The Case Against Assisted Suicide: for the right to end-of-life-care*, eds. Kathleen Foley and Herbert Hendin, pp. 1-14. Baltimore: The Johns Hopkins University Press.
---------- 2002b. "The Oregon experiment." In *The Case Against Assisted Suicide: for the right to end-of-life-care*, eds. Kathleen Foley and Herbert Hendin, pp. 144-174. Baltimore: The Johns Hopkins University Press.
Foot, Philippa. 1977. "Euthanasia." *Philosophy & Public Affairs* 6:2 (Wint.): 85-112.
Fowler, Martha D. M. 1996. "Suffering." In *Dignity and Dying: A Christian Appraisal*, eds. John F. Kilner, Arlene B. Miller, and Edmund D. Pellegrino, pp. 44-55. Grand Rapids: Paternoster.
Gentry, Peter J. and Stephen J. Wellum. 2012. *Kingdom through Covenant: a Biblical-Theological understanding of the covenants*. Wheaton, IL: Crossway.
Gorsuch, Neil M. 2006. *The Future of Assisted Suicide and Euthanasia*. Princeton Univ. Press.
Green, Michael B. and Daniel Wikler. 1980. "Brain Death and Personal Identity." *Philosophy &*

Public Affairs 9:2 (Winter): 105-133.
Griswold v. Connecticut,
Gushee, David P. 2017. "Nothing human is merely human: various biblical bases for human significance." In *Why People Matter: A Christian engagement with rival views of human significance*, ed. John F. Kilner, pp. 161-185. Grand Rapids: Baker Academic.
Hamilton, N. Gregory. 2002. "Oregon's culture of silence." In *The Case Against Assisted Suicide: for the right to end-of-life-care*, eds. K. Foley and H. Hendin, pp. 175-191. Baltimore: The Johns Hopkins Univ. Press.
Hare, R.M. 1975. "Euthanasia: A Christian View." *Philosophic Exchange* 6(1): 43-52.
Hayes, Richard B. 1996. *The Moral Vision of the New Testament*. San Francisco: Harper.
Hendin, Herbert. 2002. "The Dutch experience." In *The Case Against Assisted Suicide: for the right to end-of-life-care*, eds. K. Foley and H. Hendin, pp. 97-121. Baltimore: The Johns Hopkins Univ. Press.
Hollinger, Dennis. 1996. "Congregational Care." In *Dignity and Dying: A Christian Appraisal*, eds. John F. Kilner, Arlene B. Miller, and Edmund D. Pellegrino, pp. 232-242. Grand Rapids: Paternoster Press.
---------- 1998. "A Theology of Death." In *Suicide: A Christian Response*, eds. T. Demy & G. Stewart, pp. 257-267. Grand Rapids: Kregel Publications.
---------- 2002. *Choosing the Good*. Grand Rapids: Baker Academic.
Holmes, Arthur. 1984. *Ethics: approaching moral decisions*. Downer's Grove, IL: IVP.
Hook, C. Christopher. 1996. "Medical Futility." In *Dignity and Dying: A Christian Appraisal*, eds. John F. Kilner, Arlene B. Miller, and Edmund D. Pellegrino, pp. 84-95. Grand Rapids: Paternoster Press.
Humphry, Derek. 1990. *Final Exit: the practicalities of self-deliverance and assisted-suicide for the dying*. NY: Dell Publishing.
--------- 1992. *Dying with Dignity: understanding euthanasia*. New York: Birch Lane.
In Re Quinlan 70 N.J. 10; 355 A.2d 647 (1976)
Jones, Jeffrey M. 2017 May 11. "Americans Hold Record Liberal Views on Most Moral Issues." *Gallup*. Retrieved from http://news.gallup.com/poll/210542/americans-hold-record-liberal-views-moral-issues.aspx
Kamisar, Yale. 2002. "The rise and fall of the 'right' to assisted suicide." In *The Case Against Assisted Suicide: for the right to end-of-life-care*, eds. K. Foley and H. Hendin, pp. 69-93. Baltimore: The Johns Hopkins Univ. Press.
Kass, Leon. 2002. "I will give no deadly drug: why doctors must not kill." In *The Case Against Assisted Suicide: for the right to end-of-life-care*, eds. K. Foley and H. Hendin, pp. 17-40. Baltimore: The Johns Hopkins Univ. Press.
Kevorkian, Jack. 1991. *Prescription Medicine*. NY: Prometheus Books.
---------- 1998. "The Last Fearsome Taboo: Medical Aspects of Planned Death." *Medicine and Law* 8: 1-15.
Kilner, John F. 1992. *Life on the Line: ethics, aging, ending patients' lives, and allocating vital resources*. Grand Rapids: Eerdmans.
---------- 1996. "Forgoing Treatment." In *Dignity and Dying: A Christian Appraisal*, eds. John F. Kilner, Arlene B. Miller, and Edmund D. Pellegrino, pp. 69-83. Grand Rapids: Paternoster.
---------- 1998. "Physician-Assisted Suicide: today, yesterday, and tomorrow." In *Suicide: a Christian Response*, ed. T. Demy & G. Stewart, pp. 129-138. Grand Rapids: Kregel Pub.
---------- 2015. *Dignity and Destiny: humanity in the image of God*. Grand Rapids: Eerdmans.
---------- 2017. "Why a Christian Outlook Matters." In *Why People Matter*, ed. John. F. Kilner, pp. 189-214. Grand Rapids: Baker Academic.
Kilner, John & C. Ben Mitchell. 2003. *Does God Need Our Help?: Cloning, Assisted Suicide, &*

Other Challenges in Bioethics. Wheaton, IL: Tyndale House Publishers.
Kirschner, Kristi L., Carol J. Gill, and Christine K. Cassel. 1997. "Physician-Assisted Death in the Context of Disability." In *Physician-Assisted Suicide*, ed. Robert F. Weir, pp. 155-166. Bloomington: Indiana Univ. Press.
Lee, Patrick and Robert P. George. 2005. "The Wrong of Abortion." In *Contemporary Debates in Applied Ethics*, eds. A. Cohen & C. Wellman, pp. 13-26. Malden, MA: Blackwell Pub.
Lund, Nelson and John O. McGinnis. 2004. "*Lawrence v. Texas* and Judicial Hubris." *Michigan Law Review* 102:7 (June): 1555-1614.
Martin, Hannah B. and Daryl F. Sas. 2015. "Autonomy vs. Selflessness at the End of Life." *Ethics & Medicine* 31(2): 109-123.
McGrath, Alister. 1998. "The Price of Life." In *Suicide: A Christian Response*, eds. T. Demy & G. Stewart, pp. 141-144. Grand Rapids: Kregel Publications.
Meilaender, Gilbert. 2017. "Persons are not interchangeable: utilitarianism and human significance." In *Why People Matter: A Christian engagement with rival views of human significance*, ed. John F. Kilner, pp. 17-38. Grand Rapids: Baker Academic.
Merrill, Eugene H. 1998. Suicide and the Concept of Death in the Old Testament." In *Suicide: A Christian Response*, eds. T. Demy & G. Stewart, pp.315-326. Grand Rapids: Kregel Pub.
Mitchell, C. Ben. 1998. "Suicide and the Problem of Evil." In *Suicide: A Christian Response*, eds. T. Demy & G. Stewart, pp. 199-207. Grand Rapids: Kregel Publications.
---------- 2002. "Ethical challenges." In *Cutting-Edge Bioethics: A Christian Exploration of Technologies and Trends*. Eds., J. Kilner, C. Hook, & D. Ustal, pp. 181-193. Grand Rapids: Eerdmans.
---------- 2015. "Why Doctors Must Not Be Complicit in Killing their Patients." *Ethics & Medicine* 31:2 (Summer): 69-71.
Moreland, J.P. 1998. "The Morality of Suicide: issues and opinions." In *Suicide: A Christian Response*, eds. T. Demy & G. Stewart, pp. 183-197. Grand Rapids: Kregel Publications.
Narveson, Jan. 1977. "Animal Rights." *Canadian Journal of Philosophy* 7:1 (Mar.): 161-178.
Nicole, Neal and Harry Wylie. 2006. *Between the Dying and the Dead: Dr. Jack Kevorkian's life and the Battle to Legalize Euthanasia*. Madison: University of Wisconsin Press.
O'Mathúna, Dónal P. 1998. "But the Bible doesn't say they were wrong to commit suicide, does it?" In *Suicide: A Christian Response*, eds. T. Demy & G. Stewart, pp. 349-366. Grand Rapids: Kregel Pub.
Oregon Division of Public Health. "FAQs about the Death with Dignity Act." 2017 Dec. 1. [www.oregon.gov/oha]
Oregon Health Authority, Public Health Division. 2018 Feb. 9. *Oregon Death with Dignity Act: 2017 Data Summary*. Oregon Health Authority.
Orr, Robert D. 1998. "The Physician-Assisted Suicide: Is it ever justified?" In *Suicide: a Christian Response*, eds. T. Demy & G. Stewart, pp. 61-72. Grand Rapids: Kregel Publications.
Palko v. Connecticut, 302 U.S. at 319 (1937).
Pellegrino, Edmund. 1996. "Euthanasia and Assisted Suicide." In *Dignity and Dying: A Christian Appraisal*, eds. John F. Kilner, Arlene B. Miller, and Edmund D. Pellegrino, pp. 105-119. Grand Rapids: Paternoster Press.
---------- 2002. "Compassion is not enough." In *The Case Against Assisted Suicide: for the right to end-of-life-care*, eds. K. Foley and H. Hendin, pp. 41-51. Baltimore: Johns Hopkins U. Press.
Pence, Gregory E. 2015. *Medical Ethics*. New York: McGraw-Hill.
People of the State of Michigan v. Jack Kevorkian, 447 Mich. 436, 527 N.W.2nd 714 (1994)
Pereira, J. 2011. "Legalizing Euthanasia or Assisted Suicide: the illusion of safeguards and controls." *Current Oncology* 18(2): 38-45.
Planned Parenthood v. Casey, 505 U.S. 833 (1992).

Potts, Stephen G. 2002. "Objections to the Institutionalisation of Euthanasia." In *Social Ethics: morality and social policy*, ed. T. Mappes & J. Zembaty, pp. 79-83. New York: McGraw-Hill.
Prokopetz, Julian J.Z. and Lisa Soleymani Lehmann. 2012. "Redefining Physicians' Role in Assisted Dying." *The New England Journal of Medicine* 367(2): 97-99.
Quill, Timothy E. 1991. "Death and Dignity." *The New England Journal of Medicine* 324: 691-694.
Quill v. Koppell, 870 F. Supp. 78 (SDNY 1994).
Quill v. Vacco, 80 F.3d 716 (2d Cir. 1996).
Rachels, James. 1975. "Active and Passive Euthanasia." *New England Journal of Medicine* 292(2): 78-80.
---------- 1983. "Barney Clark's Key." *The Hastings Center Report* 13(2): 17-19.
---------- 1986. The *End of Life: euthanasia and morality*. New York: OUP.
---------- 1993. "Euthanasia." In *Matters of Life and Death*, ed. T. Regan, pp. 30-68. New York: McGraw-Hill.
---------- 1994. "Impertinent Distinctions and Defense of Active Euthanasia." In *Killing and Letting Die*, eds. B. Steinbock and A. Norcross, pp. 139-154. New York: Fordham U. Press.
Rae, Scott. 2017. "More than meets the eye: naturalism and human significance." In *Why People Matter: A Christian engagement with rival views of human significance*, ed. John F. Kilner, pp. 89-108. Grand Rapids: Baker Academic.
Reitman, James S. 1998. "A 'wisdom' perspective on advocacy for the suicidal." In *Suicide: A Christian Response*, eds. T. Demy & G. Stewart, pp. 369-385. Grand Rapids: Kregel Pub.
Rivera-López, Eduardo. 2017. "Is Medically Assisted Death a Special Obligation?" *Journal of Medical Ethics* 43: 401-406.
Reno v. Flores, 507 U.S. 292 (1993).
Roe v. Wade, 410 U.S. 113 (1973).
Saunders, Cicely. 2002. "A Hospice perspective." In *The Case Against Assisted Suicide: for the right to end-of-life-care*, eds. K. Foley and H. Hendin, pp. 282-292. Baltimore: The Johns Hopkins Univ. Press.
Saunders, William L. 2004. "The Human Embryo in Debate." In *Human Dignity in the Biotech Century*, eds., C. Colson and N. Cameron, pp. 115-35. Downer's Grove, IL: IVP.
Singer, Peter. 1975. *Animal Liberation*. New York: HarperCollins.
----------1979. "Unsanctifying Human Life." In *Ethical Issues Relating to Life & Death*, ed. John Ladd, pp. 41-61. Oxford: OUP.
Smith, Patrick T. 2017. "The privilege of being human: transhumanism and human significance." In *Why People Matter: A Christian engagement with rival views of human significance*, ed. John F. Kilner, pp. 109-132. Grand Rapids: Baker Academic.
Smith, Wesley J. 1997. *Forced Exit: the slippery slope from assisted suicide to legalized murder*. NY: Times Books.
Snyder v. Massachusetts, 291 U.S. 97 (1934)
Steinbock, Bonnie. 1994. "The Intentional Termination of Life." In *Killing and Letting Die*, eds. B. Steinbock and A. Norcross, pp. 120-130. New York: Fordham Univ. Press.
Stewart, Gary P., et al. 1998. *Basic questions on Suicide and Euthanasia: are they ever right?* Grand Rapids: Kregel Publications.
Stoddard, Sandol. 2004. "Terminal, but not Hopeless." In *Intervention and Reflection: basic issues in medical ethics*, ed. Ronald Munson, p. 733. Belmont, CA: Thomsen Wadsworth
Sullivan, Thomas D. 1994. "Active and Passive Euthanasia: an impertinent distinction?" In *Killing and Letting Die*, eds. B. Steinbock and A. Norcross, pp. 131-138. New York: Fordham Univ. Press.
Thomson, Judith Jarvis. 1999. "Physician-Assisted Suicide: Two Moral Arguments." *Ethics*

109:3 (Apr.): 497-518.
Tooley, Michael. 1979. "Decisions to Terminate Life and the Concept of a Person." In *Ethical Issues Relating to Life & Death*, ed. John Ladd, pp. 62-93. Oxford: OUP.
---------- 1994. "An Irrelevant Consideration killing versus letting die." In *Killing and Letting Die*, eds. B. Steinbock and A. Norcross, pp. 103-111. New York: Fordham Univ. Press.
---------- 2005. "In Defense of Voluntary Active Euthanasia and Assisted Suicide." In *Contemporary Debates in Applied Ethics*, eds. A. Cohen & C. Wellman, pp. 161-178. Malden, MA: Blackwell Pub.
Twaddle, Martha L. 1996. "Hospice Care." In *Dignity and Dying: A Christian Appraisal*, eds. John F. Kilner, Arlene B. Miller, and Edmund D. Pellegrino, pp. 183-190. Grand Rapids: Paternoster Press.
Vanderpool, Harold Y. 1997. "Doctors and the Dying of Patients in American History." In Physician-Assisted Suicide, ed. Robert Weir, pp. 33-66. Bloomington: Indiana Univ. Press.
Vacco v. Quill. 521 U.S. 793 (1997).
Vaughn, Lewis. 2015. *Beginning Ethics: An Introduction to Moral Philosophy*. NY: Norton.
Velleman, J. David. 1999. "A Right to Self-Termination?" *Ethics* 103(3): 606-628.
Washington v. Glucksberg, 521 U.S. 702 (1997).
Waters, Brent. 2006. *From Human to Posthuman: Christian theology and technology in a postmodern world*. Burlington, VT: Ashgate.
Werth, James L. and Debra C. Cobia. 1995. "Empirically Based Criteria for Rational Suicide: a survey of psychotherapists." *Suicide and Life Threatening Behavior* 25:2 (Sum.): 231-240.
Wilkinson, D. 2006. "Is it in the best interests of an intellectually disabled infant to die?" *Journal of Medical Ethics* 32:8 (Aug.): 454-459.