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Daniel Callahan

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When Self-Determination Runs Amok

by Daniel Callahan

The euthanasia debate is not just another moral debate, one in a long list of arguments in our pluralistic society. It is profoundly emblematic of three important turning points in Western thought. The first is that of the legitimate conditions under which one person can kill another. The acceptance of voluntary active euthanasia would morally sanction what can only be called "consenting adult killing." By that term I mean the killing of one person by another in the name of their mutual right to be killer and killed if they freely agree to play those roles. This turn flies in the face of a long-standing effort to limit the circumstances under which one person can take the life of another, from efforts to control the free flow of guns and arms, to abolish capital punishment, and to more tightly control warfare. Euthanasia would add a whole new category of killing to a society that already has too many excuses to indulge itself in that way.

The second turning point lies in the meaning and limits of self-determination. The acceptance of euthanasia would sanction a view of autonomy holding that individuals may, in the name of their own private, idiosyncratic view of the good life, call upon others, including such institutions as medicine, to help them pursue that life, even at the risk of harm to the common good. This works against the idea that the meaning and scope of our own right to lead our own lives must be conditioned by, and be compatible with, the good of the community, which is more than an aggregate of self-directing individuals.

The third turning point is to be found in the claim being made upon medicine: it should be prepared to make its skills available to individuals to help them achieve their private vision of the good life. This puts medicine in the business of promoting the individualistic pursuit of general human happiness and well-being. It would overturn the traditional belief that medicine should limit its domain to promoting and preserving human health, redirecting it instead to the relief of that suffering which stems from life itself, not merely from a sick body.

I believe that, at each of these three turning points, proponents of euthanasia push us in the wrong direction. Arguments in favor of euthanasia fall into four general categories, which I will take up in turn: (1) the moral claim of individual self-determination and well-being; (2) the moral irrelevance of the difference between killing and allowing to die; (3) the supposed paucity of evidence to show likely harmful consequences of legalized euthanasia; and (4) the compatibility of euthanasia and medical practice.

Self-Determination

Central to most arguments for euthanasia is the principle of self-determination. People are presumed to have an interest in deciding for themselves, according to their own beliefs about what makes life good, how they will conduct their lives. That is an important value, but the question in the euthanasia context is, What does it mean and how far should it extend? If it were a question of suicide, where a person takes her own life without assistance from another, that principle might be pertinent, at least for debate. But euthanasia is not that limited a matter. The self-determination in that

case can only be effected by the moral and physical assistance of another. Euthanasia is thus no longer a matter only of self-determination, but of a mutual, social decision between two people, the one to be killed and the other to do the killing.

How are we to make the moral move from my right of self-determination to some doctor's right to kill me—from *my* right to *his* right? Where does the doctor's moral warrant to kill come from? Ought doctors to be able to kill anyone they want as long as permission is given by competent persons? Is our right to life just like a piece of property, to be given away or alienated if the price (happiness, relief of suffering) is right? And then to be destroyed with our permission once alienated?

In answer to all those questions, I will say this: I have yet to hear a plausible argument why it should be permissible for us to put this kind of power in the hands of another, whether a doctor or anyone else. The idea that we can waive our right to life, and then give to another the power to take that life, requires a justification yet to be provided by anyone.

Slavery was long ago outlawed on the ground that one person should not have the right to own another, even with the other's permission. Why? Because it is a fundamental moral wrong for one person to give over his life and fate to another, whatever the good consequences, and no less a wrong for another person to have that kind of total, final power. Like slavery, dueling was long ago banned on similar grounds: even free, competent individuals should not have the power to kill each other, whatever their motives, whatever the circumstances. Consenting adult killing, like consenting adult slavery or degradation, is a strange route to human dignity.

There is another problem as well. If doctors, once sanctioned to carry out euthanasia, are to be themselves responsible moral agents—not simply hired hands with lethal injections at the ready—then they must have their own *independent* moral grounds to kill those who request such services. What do I mean? As those who favor euthanasia are quick to point out, some people want it because their life has become so burdensome it no longer seems worth living.

The doctor will have a difficulty at this point. The degree and intensity to which people suffer from their diseases and their dying, and whether they find life more of a burden than a benefit, has very little directly to do with the nature or extent of their actual physical condition. Three people can have the same condition, but only one will find the suffering unbearable. People suffer, but suffering is as much a function of the values of individuals as it is of the physical causes of that suffering. Inevitably in that circumstance, the doctor will in effect be treating the patient's values. To be responsible, the doctor would have to share those values. The doctor would have to decide, on her own, whether the patient's life was "no longer worth living."

But how could a doctor possibly know that or make such a judgment? Just because the patient said so? I raise this question because, while in Holland at the euthanasia conference reported by Maurice de Wachter elsewhere in this issue, the doctors present agreed that there is no objective way of measuring or judging the claims of patients that their suffering is unbearable. And if it is difficult to measure suffering, how much more difficult to determine the value of a patient's statement that her life is not worth living?

However one might want to answer such questions, the very need to ask them, to inquire into the physician's responsibility and grounds for medical and moral judgment, points out the social nature of the decision. Euthanasia is not a private matter of self-determination. It is an act that requires two people to make it possible, and a complicit society to make it acceptable.

Killing and Allowing to Die

Against common opinion, the argument is sometimes made that there is no moral difference between stopping life-sustaining treatment and more active forms of killing, such as lethal injection. Instead I would contend that the notion that there is no morally significant difference between omission and commission is just wrong. Consider in its broad implications what the eradication of the distinction implies: that death from disease has been banished, leaving only the actions of physicians in terminating treatment as the cause of

death. Biology, which used to bring about death, has apparently been displaced by human agency. Doctors have finally, I suppose, thus genuinely become gods, now doing what nature and the deities once did.

What is the mistake here? It lies in confusing causality and culpability, and in failing to note the way in which human societies have overlaid natural causes with moral rules and interpretations. Causality (by which I mean the direct physical causes of death) and culpability (by which I mean our attribution of moral responsibility to human actions) are confused under three circumstances.

They are confused, first, when the action of a physician in stopping treatment of a patient with an underlying lethal disease is construed as *causing* death. On the contrary, the physician's omission can only bring about death on the condition that the patient's disease will kill him in the absence of treatment. We may hold the physician morally responsible for the death, if we have morally judged such actions wrongful omissions. But it confuses reality and moral judgment to see an omitted action as having the same causal status as one that directly kills. A lethal injection will kill both a healthy person and a sick person. A physician's omitted treatment will have no effect on a healthy person. Turn off the machine on me, a healthy person, and nothing will happen. It will only, in contrast, bring the life of a sick person to an end because of an underlying fatal disease.

Causality and culpability are confused, second, when we fail to note that judgments of moral responsibility and culpability are human constructs. By that I mean that we human beings, after moral reflection, have decided to call some actions right or wrong, and to devise moral rules to deal with them. When physicians could do nothing to stop death, they were not held responsible for it. When, with medical progress, they began to have some power over death—but only its timing and circumstances, not its ultimate inevitability—moral rules were devised to set forth their obligations. Natural causes of death were not thereby banished. They were, instead, overlaid with a medical ethics designed to determine moral culpability in deploying medical power.

To confuse the judgments of this ethics with the physical causes of death—which is the connotation of the word *kill*—is to confuse nature and human action. People will, one way or another, die of some disease; death will have dominion over all of us. To say that a doctor "kills" a patient by allowing this to happen should only be understood as a moral judgment about the licitness of his omission, nothing more. We can, as a fashion of speech only, talk about a doctor *killing* a patient by omitting treatment he should have provided. It is a fashion of speech precisely because it is the underlying disease that brings death when treatment is omitted; that is its cause, not the physician's omission. It is a misuse of the word *killing* to use it when a doctor stops a treatment he believes will no longer benefit the patient—when, that is, he steps aside to allow an eventually inevitable death to occur now rather than later. The only deaths that human beings invented are those that come from direct killing—when, with a lethal injection, we both cause death and are morally responsible for it. In the case of omissions, we do not cause death even if we may be judged morally responsible for it.

This difference between causality and culpability also helps us see why a doctor who has omitted a treatment he should have provided has "killed" that patient while another doctor—performing precisely the same act of omission on another patient in different circumstances—does not kill her, but only allows her to die. The difference is that we have come, by moral convention and conviction, to classify unauthorized or illegitimate omissions as acts of "killing." We call them "killing" in the expanded sense of the term: a culpable action that permits the real cause of death, the underlying disease, to proceed to its lethal conclusion. By contrast, the doctor who, at the patient's request, omits or terminates unwanted treatment does not kill at all. Her underlying disease, not his action, is the physical cause of death; and we have agreed to consider actions of that kind to be morally licit. He thus can truly be said to have "allowed" her to die.

If we fail to maintain the distinction between killing and allowing to die, moreover, there are some disturbing

possibilities. The first would be to confirm many physicians in their already too-powerful belief that, when patients die or when physicians stop treatment because of the futility of continuing it, they are somehow both morally and physically responsible for the deaths that follow. That notion needs to be abolished, not strengthened. It needlessly and wrongly burdens the physician, to whom should not be attributed the powers of the gods. The second possibility would be that, in every case where a doctor judges medical treatment no longer effective in prolonging life, a quick and direct killing of the patient would be seen as the next, most reasonable step, on grounds of both humaneness and economics. I do not see how that logic could easily be rejected.

Calculating the Consequences

When concerns about the adverse social consequences of permitting euthanasia are raised, its advocates tend to dismiss them as unfounded and overly speculative. On the contrary, recent data about the Dutch experience suggests that such concerns are right on target. From my own discussions in Holland, and from the articles on that subject in this issue and elsewhere, I believe we can now fully see most of the *likely* consequences of legal euthanasia.

Three consequences seem almost certain, in this or any other country: the inevitability of some abuse of the law; the difficulty of precisely writing, and then enforcing, the law; and the inherent slipperiness of the moral reasons for legalizing euthanasia in the first place.

Why is abuse inevitable? One reason is that almost all laws on delicate, controversial matters are to some extent abused. This happens because not everyone will agree with the law as written and will bend it, or ignore it, if they can get away with it. From explicit admissions to me by Dutch proponents of euthanasia, and from the corroborating information provided by the Remmelink Report and the outside studies of Carlos Gomez and John Keown, I am convinced that in the Netherlands there are a substantial number of cases of nonvoluntary euthanasia, that is, euthanasia undertaken without the explicit permission of the person being killed. The other rea-

son abuse is inevitable is that the law is likely to have a low enforcement priority in the criminal justice system. Like other laws of similar status, unless there is an unrelenting and harsh willingness to pursue abuse, violations will ordinarily be tolerated. The worst thing to me about my experience in Holland was the casual, seemingly indifferent attitude toward abuse. I think that would happen everywhere.

Why would it be hard to precisely write, and then enforce, the law? The Dutch speak about the requirement of "unbearable" suffering, but admit that such a term is just about indefinable, a highly subjective matter admitting of no objective standards. A requirement for outside opinion is nice, but it is easy to find complaisant colleagues. A requirement that a medical condition be "terminal" will run aground on the notorious difficulties of knowing when an illness is actually terminal.

Apart from those technical problems there is a more profound worry. I see no way, even in principle, to write or enforce a meaningful law that can guarantee effective procedural safeguards. The reason is obvious yet almost always overlooked. The euthanasia transaction will ordinarily take place within the boundaries of the private and confidential doctor-patient relationship. No one can possibly know what takes place in that context unless the doctor chooses to reveal it. In Holland, less than 10 percent of the physicians report their acts of euthanasia and do so with almost complete legal impunity. There is no reason why the situation should be any better elsewhere. Doctors will have their own reasons for keeping euthanasia secret, and some patients will have no less a motive for wanting it concealed.

I would mention, finally, that the moral logic of the motives for euthanasia contain within them the ingredients of abuse. The two standard motives for euthanasia and assisted suicide are said to be our right of self-determination, and our claim upon the mercy of others, especially doctors, to relieve our suffering. These two motives are typically spliced together and presented as a single justification. Yet if they are considered independently—and there is no inherent reason why they must be linked—they reveal serious problems. It is said that a

competent, adult person should have a right to euthanasia for the relief of suffering. But why must the person be suffering? Does not that stipulation already compromise the principle of self-determination? How can self-determination have any limits? Whatever the person's motives may be, why are they not sufficient?

Consider next the person who is suffering but not competent, who is perhaps demented or mentally retarded. The standard argument would deny euthanasia to that person. But why? If a person is suffering but not competent, then it would seem grossly unfair to deny relief solely on the grounds of incompetence. Are the incompetent less entitled to relief from suffering than the competent? Will it only be affluent, middle-class people, mentally fit and savvy about working the medical system, who can qualify? Do the incompetent suffer less because of their incompetence?

Considered from these angles, there are no good moral reasons to limit euthanasia once the principle of taking life for that purpose has been legitimated. If we really believe in self-determination, then any competent person should have a right to be killed by a doctor for any reason that suits him. If we believe in the relief of suffering, then it seems cruel and capricious to deny it to the incompetent. There is, in short, no reasonable or logical stopping point once the turn has been made down the road to euthanasia, which could soon turn into a convenient and commodious expressway.

Euthanasia and Medical Practice

A fourth kind of argument one often hears both in the Netherlands and in this country is that euthanasia and assisted suicide are perfectly compatible with the aims of medicine. I would note at the very outset that a physician who participates in another person's suicide already abuses medicine. Apart from depression (the main statistical cause of suicide), people commit suicide because they find life empty, oppressive, or meaningless. Their judgment is a judgment about the value of continued life, not only about health (even if they are sick). Are doctors now to be given the right to make judgments about the kinds of life worth living and to give

their blessing to suicide for those they judge wanting? What conceivable competence, technical or moral, could doctors claim to play such a role? Are we to medicalize suicide, turning judgments about its worth and value into one more clinical issue? Yes, those are rhetorical questions.

Yet they bring us to the core of the problem of euthanasia and medicine. The great temptation of modern medicine, not always resisted, is to move beyond the promotion and preservation of health into the boundless realm of general human happiness and well-being. The root problem of illness and mortality is both medical and philosophical or religious. "Why must I die?" can be asked as a technical, biological question or as a question about the meaning of life. When medicine tries to respond to the latter, which it is always under pressure to do, it moves beyond its proper role.

It is not medicine's place to lift from us the burden of that suffering which turns on the meaning we assign to the decay of the body and its eventual death. It is not medicine's place to determine when lives are not worth living or when the burden of life is too great to be borne. Doctors have no conceivable way of evaluating such claims on the part of patients, and they should have no right to act in response to them. Medicine should try to relieve human suffering, but only that suffering which is brought on by illness and dying as biological phenomena, not that suffering which comes from anguish or despair at the human condition.

Doctors ought to relieve those forms of suffering that medically accompany serious illness and the threat of death. They should relieve pain, do what they can to allay anxiety and uncertainty, and be a comforting presence. As sensitive human beings, doctors should be prepared to respond to patients who ask why they must die, or die in pain. But

here the doctor and the patient are at the same level. The doctor may have no better an answer to those old questions than anyone else; and certainly no special insight from his training as a physician. It would be terrible for physicians to forget this, and to think that in a swift, lethal injection, medicine has found its own answer to the riddle of life. It would be a false answer, given by the wrong people. It would be no less a false answer for patients. They should

neither ask medicine to put its own vocation at risk to serve their private interests, nor think that the answer to suffering is to be killed by another. The problem is precisely that, too often in human history, killing has seemed the quick, efficient way to put aside that which burdens us. It rarely helps, and too often simply adds to one evil still another. That is what I believe euthanasia would accomplish. It is self-determination run amok.

1992 General Meeting

Medical Ethics and Environmental Ethics: Common Themes, Common Challenges

5-6 June 1992

Beginning with work on the use of animals in biomedical research and on animal biotechnology, the Center has begun to develop a research program in environmental ethics during the past two years. In the course of this work, the Center is exploring many parallels and connections between ethical issues in medicine and those arising in environmental policy and ecological science. Both fields can benefit from an interweaving of their common threads and overlapping ideas. The 1992 General Meeting, which is open to all Associate Members, will explore these connections:

- What does it mean to speak of a "healthy" environment? How do analogies and metaphors of health color debate and policy in both the medical and the environmental arenas?
- What are the limits of technology and our obligations to future generations in the use of scarce resources?
- How does the concept of "nature" and the "natural" function in ethical argument in medicine and the environment? Can nature serve as an ethical standard or norm today, as it has traditionally in ethics?
- How are rights and responsibilities to be balanced in the complex interaction of economic interests, health needs, and environmental concerns?

The meeting will begin in the afternoon of Friday, 5 June and continue through Saturday, 6 June. Meeting sessions and accommodations will be held at Pace University in Pleasantville, New York (approximately 20 miles north of New York City). Complete details will be mailed to all Associate Members in March. For further information now call the Office of Public Information at the Center, (914) 762-8500.

