

Response to Jeffrey Bishop

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Abstract

I respond to Jeffrey Bishop's article 'Arts of Dying and the Statecraft of Killing', in this issue, and in particular to his remarks in support of the claim that assisted death should not be legalised.

Let us distinguish between the claim that assisted death should be legalised, and the claim that assisted death 'can become part of a new *Ars moriendi*'. The second claim probably includes and so is stronger than the first; so let's talk about the first claim.

Consider a terminally ill patient who is mentally competent and who has a clear and settled wish to be helped to die. Should it be legally permissible for a physician to help them die, by either prescribing or administering a lethal drug? This question arises against the backdrop of existing legal permission for physicians to take other steps that hasten death. For example, when asked by a mentally competent patient or a proxy, physicians are already legally permitted (and sometimes required) to end or withhold treatment, or withdraw or fail to initiate life support.

You think assisted death should not be legalised. The reason is that you think 'the procedures themselves substantively shape a dying person's desire and decision, reaffirming for the patient that her decision to take her own life is indeed her own choice'. I take it that by 'the procedures', you mean the regulations put in place by a law that permits assisted death, designed to ensure that the law isn't abused. For example, you say that Oregon's legal procedures require, amongst other things, that a patient must make a written request witnessed by two people, that two physicians have to agree on the terminal nature of their condition and the voluntariness of the request, and that the patient has to be referred to a psychiatrist if there is any suspicion of incomplete mental competence.

One way to interpret your line of thought would be as follows. The 'procedures' bring it about that any terminally ill patients wish to be helped to die. But that would be implausible: some terminally ill patients appear to be expressing this wish in places where no such law exists. Certainly some people are expressing the wish for the law in those places (and someone must have pushed for the law in the places where it exists).

Another interpretation is this. In places where the law exists, many of the terminally ill patients who wish to be helped to die are such that they wouldn't have had that wish without the law. For example, in Oregon many are now moved to choose to die, in response to pressure from relatives and health-care professionals. And the same would happen elsewhere.

This would be a serious concern if it was an accurate appraisal of the situation, and hence a trustworthy prediction. But as far as I'm aware, the fears about such abuses of the law have not been confirmed in Oregon.

Any social policy carries with it the potential for abuse. But the question is whether effective controls can be and have been put in place. The evidence seems to suggest that the controls are working.

Note that there is in principle the same potential for abuse through pressure from family members or physicians in the case of decisions to end treatment or life-support. In fact, the controls governing these choices are less stringent than those governing assisted death. It is not clear what could justify safety concerns in the case of assisted death that don't apply equally to these practices.

You say that

while it requires that other options, such as pain control or hospice care, should be discussed with the patient, the law nevertheless frames death as the patient's clearest option. Thus, the social apparatus itself frames the patient's decision to be a rational and moral choice. After all, as many as four professionals—the patient's doctor, a second physician, a counselor or psychiatrist, and the pharmacist ... have said so.

Presenting something as 'the clearest option' is different from presenting it as 'a rational and moral choice'. It is not clear in what sense the health-care professionals involved must present assisted death as 'the clearest option' to any patient who asks for it. But it is true that assisted death will be presented as a rational choice, in the sense that it will (implicitly or explicitly) be presented as a choice that will be respected, and that is in principle open to the patient who is asking for it. The question is why we should

think that that's not how it should be.

You also say that '[t]he option to choose [a medically controlled suicide] will result in subtle changes that exist subliminally—literally beneath a threshold of recognition of all concerned, whether patient, family, doctor or society'. What are these subtle changes?

'Living itself becomes an open question because all will have been radically reframed';

'[a] right to have a physician assist one in suicide makes staying alive a daily choice'.

For those who would need help to bring about their own deaths, such as some terminally ill patients, the law would indeed make staying alive a daily choice. That is, the law would make it the case, when it wasn't the case before, that those people now daily have the choice whether to stay alive or not. The question is why they should not have that choice.

Note that the law doesn't seem to have led to large numbers of terminally ill patients killing themselves. Between 1998 and 2004, 208 terminally ill patients in Oregon took lethal drugs, while 64,706 others were dying of the same diseases.¹

You say the Christian message is about finding hope, and 'ultimate meaning, meaning that overcomes the sting of death and death itself'. I wonder whether it might not also call for a certain epistemic humility. It doesn't seem easy to judge what finding such meaning consists in for another human being, let alone for any terminally ill patient, no matter what their circumstances might be.