

Examination

Living and Dying The State's Way

By Jeffrey A. Schaler

If you think doctor-assisted suicide puts people in charge of their own lives, think again.

It is now fashionable to clamor for “assisted suicide,” sometimes described as “the right to die” or “death with dignity.” But curiously the right to suicide – to kill oneself without harassment or hindrance from the state – is not at all popular. Many of those campaigning for “assisted suicide” are among the most effective opponents of an individual’s right to suicide, that is, death by one’s own hand.

Suicide today is usually construed by society as a symptom of mental illness. As such, the possibility of suicide, or of being “a danger to oneself or others,” which usually refers to being a danger to oneself alone, is grounds for locking someone up and taking active steps to prevent that person from taking his own life. Even though suicide and attempted suicide are no longer criminal offenses, there is no effective right to suicide.

In practice, very few psychiatrists will ever come across a suicide or attempted suicide that they do not believe to be a symptom of mental illness – especially if extreme physical pain or physical disability are absent. If you try to commit suicide

and the authorities catch you and keep you alive, or if you merely talk about suicide, thereby communicating a preoccupation with the idea of suicide, you are likely to be jailed in a mental hospital and supervised to make sure you do not get a chance to kill yourself. You will be coerced into staying alive against your will.

Those who lean towards protecting a “right to die” in cases of physical suffering tend to be silent when it comes to protecting a right to suicide in cases of existential suffering or among those people who want to end their life simply because they have had enough of living, because life seems absurd to them, or for any number of other non-suffering reasons. If one has a right to suicide, one does not have to satisfy anyone else that one's suicide is wise or proper.

In view of this actual persecution of suicide with very little opposition from intellectuals or physicians, how do we account for the popularity in these same quarters of “assisted suicide”? These two positions are totally compatible. “Assisted suicide” does not grant individuals the right to commit suicide at all. It merely sanctions homicide with the state's permission, by giving physicians a legal monopoly on providing the means to die by one's own hand.

And while physician-assisted suicide often refers to giving a patient a lethal dose of medication, at the patient's request, which the patient then administers to himself, many of those favoring “assisted suicide” really seem to want something different: the legalization of euthanasia or “mercy killing.” This may involve killing someone who is unwilling to kill himself or apparently incapable of doing so.

Derek Humphry, founder of the Hemlock movement, president of Euthanasia Research & Guidance Organization (ERGO), and author of two international bestselling books, *Jean's Way* and *Final Exit*, defines euthanasia this way: “Euthanasia is a doctor giving a lethal injection by request.” And what is ERGO's position regarding euthanasia? “ERGO . . . holds that voluntary euthanasia, physician-assisted suicide, and self-deliverance, are all appropriate life endings depending on the individual medical and ethical circumstances.” *

The same people who want the state, through the agency of authorized physicians, to be able to kill people also want the state, through the agency of authorized physicians, to be able to stop people from killing themselves. Their position is thus consistent: individuals do not have any right to kill themselves, whereas the government has every right to kill individuals, if, for example, the

government considers that the individual's life is now too painful or too harrowing. Your body does not belong to you: it belongs to the government.

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This contrasts sharply with the traditional liberal or libertarian view that a person rightfully owns his or her own body, the principle that helps explain why slavery is and should be illegal, while abortion is and should be legal. No grown human is the property of another, whereas a fetus has not yet ceased to be the property of its mother. Just as people who advocate legalizing marijuana for medicinal purposes often oppose the right to drugs as property, people who advocate legalizing "assisted suicide" in the name of compassion often oppose the right to the body as property.

Suicide is a form of homicide. Thomas Szasz, who argues for the right to suicide in his important book, *Fatal Freedom: The Ethics and Politics of Suicide* (Syracuse, N.Y.: Syracuse University Press, 2002), makes the distinction between killing oneself ("autohomicide") and killing someone else ("heterohomicide"). Much talk about "assisted suicide" blurs this distinction by describing as "suicide" cases where a physician kills a patient who has (perhaps) previously signed a consent form.

Often such patients are comatose or otherwise unable to make a decision at the time. Consequently, "assisted suicide" can easily be stretched to include cases where a doctor, faced with a patient who cannot currently decide, or who perhaps at the time even wants to live, will be able to kill that patient.

Consider, for example, a recent landmark ruling by the Supreme Court of Victoria, Australia, as reported in the June 7, 2003 issue of the *British Medical Journal*: The court ruled that an elderly woman with severe dementia, kept alive for years by tube feeding, be allowed to die because the food and hydration given constituted a medical procedure rather than palliative care and could thereby be legally refused: "Judge Stuart Morris said that the public advocate Julian Gardner, who was appointed the woman's guardian, would now be able to decide whether it is time for her to 'die with dignity.' . . . 'The court had made it clear everyone has a

right to refuse medical treatment,' said Mr. Gardner. ' This case is about someone who, while they were competent, made their views and wishes about medical treatment clearly known.'" ("Court rules food and hydration are treatment." *British Medical Journal*, 2003; 326:1233 [June 7]). Whose interests are served by keeping this woman alive? Whose interests are served by killing this woman? I cannot see how dignity is within the realm of experience or interest for such a person at this stage of her life. People project their wishes and feelings onto others, and are even more inclined to do so when a person is in a coma, severely demented, or dead, that is, when the person cannot communicate with them.

Some argue that since self-assassination is a right, delegated assassination is equally a right. If someone can decide to kill herself, she can therefore equally decide to make a contract with someone else to kill her, perhaps including in such a contract a stipulation that her being unconscious is to be no barrier to killing, or even that her frantic protests at the time of imminent death are to be disregarded because of the prior contract. People have likely asked others to kill them and their requests have likely been heeded in private. These private and illegal agreements will always continue, and just because they are illegal does not mean they are morally right or wrong. However, these are private agreements and arrangements that the law cannot and should not tolerate in the public domain – especially by empowering certain people, but not others, with the power to kill and not others.

The risks are too great for the principle of freedom of contract to be extended to the engineering of one's own decease. Suicide cannot be delegated via a legally binding contract. The opportunities for abuse, and the costs of abuse, it seems to me, are too great. For example, relatives who do not wish to pay the bills to continue caring for a family member, and who also do not wish to take the responsibility of withdrawing support, can take recourse in an "assisted suicide," which is on paper at the request of the victim, but in fact at the request of the relatives, who communicate their wishes to a compliant physician.

The law does not tolerate and ought not to tolerate consensual, contractual heterohomicide. For one thing, it might be difficult to ascertain whether the killing contract was genuine or fraudulent. The consequence of error can obviously be quite serious. For another, if one of the parties wanted to rescind the contract, there could be problems, especially if the contract included a directive to ignore any attempt on the victim's part to stop the killing.

Assisted suicide, as normally conceived, is also unnecessary. Anyone who wants to die can stop eating or drinking, and can be made comfortable with morphine or

similar drugs. The morphine is not administered to kill the person; it merely stops him from feeling any discomfort as he dies from starvation or disease.

A 91-year-old woman addressed her remarks to me at a recent round-table discussion on euthanasia and assisted suicide, saying she wanted to end her life while she felt good about it, rather than suffer with possible sickness unto death. I asked her if she was willing to commit suicide when the time was right for her. It is a difficult decision, to be sure: most people want to live until they are incapable of committing suicide. The taking of one's life when life is still good is unappealing. This person said no: she wanted someone else to do it for her, because, in her words, she was a "coward."

Unfortunately, many people assume that medical expertise may be relevant to the decision whether to live or die, to kill or let live. However, the decision to commit suicide is an ethical decision, not a medical decision. While doctors may be trained to make ethical decisions, so may non-doctors, and in any case non-doctors may be more knowledgeable about what to consider when making the decision to live or die in any particular case, such as their own.

The principle that doctors should have any say in determining whether individuals be killed or kept alive is itself an ominous one. There is nothing scientific or medical about the decision to end one's life. Ethics pertains to right and wrong conduct. Who is to decide what is right and wrong when it comes to suicide? One can only decide this for oneself.

A priest may or may not be a good person to talk to when considering suicide. The same is true for a psychotherapist, or for one's barber or stockbroker. But really it is an individual's responsibility to decide whom to ask for advice, if one should ask anyone at all. The difference between talking to a priest and talking to a physician about suicide is that the priest is not empowered by the state to assist with killing people.

In some ways a physician may be the last person one should talk to about ending one's life. While a physician may be skilled in prescribing pain medication and treating disease, he is unnecessary when it comes to suicide. Most people who do commit suicide do so without consulting a doctor.

Belief in "mental illness" adds to confusion about suicide. Psychiatrists, psychotherapists, and the courts hold that persons who are likely to harm themselves may be committed to a mental hospital for "treatment." This is because

people believe that wanting to commit suicide is a symptom of mental illness. While attempting suicide may not be an actual crime, it is treated as if it were: people who talk about or attempt suicide are likely to end up in a jail called a mental hospital. Whether one is behind bars in a mental hospital or behind bars in a prison, one is deprived of liberty by the state. Your physician may not kill you but he can collaborate in depriving you of liberty by putting you in a mental hospital against your will. He may also order that you be given certain drugs that you do not want. He may order that electric shocks be passed through your brain. All this he can do in the name of compassion and medicine.

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Thus, doctors and psychotherapists are key players when it comes to interfering with the right to suicide. On the one hand, people want doctors to assist them with killing people, and on the other hand, they want doctors and psychotherapists to forcibly prevent people from committing suicide, by consigning them to mental hospitals.

At least three barriers to clarity regarding the right to suicide can be removed easily enough: we must differentiate between “assisted suicide” and suicide, that is, death by one’s own hand; we must recognize that the decision to live or die is an ethical decision, not a medical decision; and we must recognize the role physicians and psychotherapists play as agents of the therapeutic state in depriving people of the liberty to live and die.

If we call things by their right names we can eliminate the problems associated with the first two barriers. If we remove the power given by the state to physicians to kill people we can remove the third barrier. Add to this removing the power of physicians and psychotherapists to have people committed to mental institutions and we’ll have come a long way to protecting the sacred right to suicide.

There is one other important issue that is a key part of interfering with the right to suicide: the drugs used to commit suicide are often difficult to obtain because of prescription laws. This, too, is a function of our mental health laws, pharmacracy, and the therapeutic state. A person may want to use any number of drugs to cause a painless death, but because these drugs are only available by prescription, a person

who does not have a prescription must engage in criminal activity in order to purchase them. So, if a person wants to commit suicide he should beware of sharing the intention because he could easily be locked up in a mental hospital. If someone tries to purchase the drugs she wants to kill herself, she can be jailed on illegal drugs charges. If prescription laws were repealed, the right to suicide could be protected.

Imagine the following scenario: you are walking along a bridge with a friend, who suddenly announces his intention to commit suicide by jumping over the bridge. What options do you have?

Since this person is your friend you would likely try to talk him out of suicide. If you fail to persuade him, you could say goodbye and walk away. He does not necessarily have a right to commit suicide – anymore than he does to have sex in public or in the presence of another, unwilling person, so you might report him to the police. The police could arrest him for breaking a no-suicide-in-public law. You could physically try to prevent him from jumping off the bridge. Or you might push him off the bridge – and call it assisted suicide.

Just as people ought to be free to put whatever ideas they want into their minds, they ought to be free to put whatever substances they want into their bodies. People are free to read or not to read any written material. They are free to listen to what they want to listen to. They are free to eat what they want to eat. It follows that a person is free not to eat, that is, a person's right to starve himself is as basic as is the right to satisfy his hunger.

Most of the confusion regarding euthanasia, assisted suicide, physician-assisted suicide, and suicide, can be easily resolved by making sure that heterohomicide is not excused by law, the power to treat people against their will is taken away from doctors, and the prescription laws are repealed.

Freedom rests on the rights to life, liberty, and property. When the state interferes with the right to suicide, it interferes with all three of these fundamental rights.

* <http://www.finalexit.org/about.html>. For more on the confluence of euthanasia and assisted suicide see “Administration and Compounding of Euthanasic Agents,” Royal Dutch Society for the Advancement of Pharmacy. The Hague (1994), at <http://www.wweek.com/html/euthanasics.html>; and Derek

Humphry's views on "Euthanasia in Practice" at
<http://www.finalexit.org/practice.html>

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