A Feminist Case Against Self-Determined Dying in Assisted Suicide and Euthanasia

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Sep 22, 1995 in *Studies in Prolife Feminism*
Link to article at thefreelibrary.com

Familiar clarion calls for choice, autonomy, and the moral right to control one's own body ring forth in current movements to legalize physician-assisted suicide and euthanasia. In the United States dedicated activists, some physicians and certain respected ethicists make a moral case for the right to assisted suicide and euthanasia in order to control how and when one dies. (1) Feminists and other members of society must now confront the dilemma of whether this new liberty would contribute to human flourishing and well-being. More specifically, would women in particular benefit from more choices at the end of life?

Women have for so long been denied full autonomy and respect in our society that it might be tempting for feminists to immediately endorse a social measure purporting to increase women's freedom of choice. But at the same time feminists have learned to exercise a "hermeneutics of suspicion" and be cautious when new social or medical interventions are on offer. Proposals for increasing personal choices which initially look positive can result in unforeseen drawbacks and dangerous side effects--especially when medical technologies are involved. One only has to think of recent intra-feminist debates surrounding reproductive technologies, hormonal therapies, abortion, surrogate motherhood, no-fault divorce, pornography, prostitution, alimony, child custody and employment practices, to name but a few. (2) In the face of so much controversy the valid question arises as to whether there is any consensus to be found among feminists, and if so what would characterize a feminist critique of assisted suicide and euthanasia?

Pluralism and Consensus in Feminism

While there has as not yet been a feminist debate over euthanasia, it is easy to point out an ever increasing pluralism in the feminist movement over many other issues, including the nature of feminism. Turning to collections of feminist writings in many disciplines one finds diversity on display. In a comprehensive compilation of essays devoted to feminism and philosophy, for instance, there are sections devoted to perspectives on feminism described as liberal, Marxist, radical, psychoanalytic, socialist, ecological, phenomenological and postmodern. (3) In religious and theologically oriented feminism one finds another wide-ranging variety of feminist approaches growing out of different theological and faith traditions. A recent review of Christian theological literature even includes a sampling of post-Christian feminism work. (4) Different ethnic and geographical groups of women, such as Hispanic or Asian women, also have developed their own specific approaches to feminism. (5)

Can any consensus or commonality in all of these diverse manifestations of feminism be found? Yes, I think it can be said that while a thousand flowers bloom, feminism is not self-destructing through fragmentation, but enjoying a dynamic pluralism. All forms of feminism are constituted by a critique of a status quo in which power is abused by unjust gender discriminations against women. (6) A critical feminist analysis will recognize, protest and

demand an end to gender subordination and exclusion; women should no longer be excluded from discourse defining themselves or their roles, or have their voices suppressed in the decision-making of male-dominated societies. Feminism is always and everywhere a call for justice and social change on behalf of women's well-being and human flourishing.

But when it comes to a more detailed analysis of what has contributed to women's oppression, or to ideals of human flourishing, or to recommendations for strategic policies to effect social change, then pluralism and disagreements emerge. A general critique held in common and an agreed-upon global goal can be supported by a variety of fundamental principles, analyses and assumptions, especially when it comes to proposals for reform. After all, feminist thinkers come to feminism historically formed by a plethora of subcultures, ideologies and belief systems, as well as from different intellectual disciplines. Those affirming psychoanalytic thought, for instance, will focus on different variables and recommend different social strategies for change than feminists employing a neo-Marxist class analysis. Obviously, different feminists will appropriate different dimensions of several sets of complex traditions and create different intellectual configurations of argument when confronting any new challenge. My own arguments here against assisted suicide and euthanasia will represent a personal synthesis of my experiences as an aging, white, middle-class, married, American woman and mother, educated as a social psychologist.

In my reading of feminism, it appropriates and affirms the importance of concrete contexts and the different perspectives or standpoints of embodied participants in any encounter. Feminists have rightly attempted to make explicit what has too often been ignored-- i.e., the social and dynamic developmental realities of actual human lives. Human beings must be born, nurtured, reared, domestically maintained and cared for when they are ill, old or dying. A unique individual self can only be formed within social matrixes of interpersonal relationships; the self is partly created by ongoing self-other dialogues. Each adult person continues to live within embodied, embedded and interpersonal relationships. Inevitably, the private and the personal interact with public and political actions because no one can live or work without receiving domestic and emotional support. These hidden tasks of nurturing and maintenance have usually been assigned to women, then denigrated and accorded little recognition or reward. (7)

Most feminists have tried to affirm the value of the traditional contributions of women, including care of the ill and dying, while simultaneously working to open up expanded roles and new opportunities for women in society. Women's traditional power and powerlessness must both be recognized. In many creative feminist proposals for revising gender roles, men's potential contributions to cooperative caretaking in the family are also reappraised and welcomed. To emphasize only women's victimization by men gives too unbalanced a picture. In old age and at the end of life, for instance, gender roles in families and societies tend to become more flexible, overlapping and shaped by the unique characteristics of individual personalities and strengths.

Yet it must also be recognized that women are going to be more affected by the euthanasia debate than men, simply by virtue of the fact that women live longer than men, and in their old age command fewer financial and social resources. In a sexist society that also suffers from ageism or prejudice and discrimination against the old, more women will

end up living alone as fragile persons in need of care. As families become smaller and more dispersed, many women, particularly single childless women, will not have nearby kin who can care for them or serve as their advocates within increasingly complex health-care systems.

By and large, women still have been socialized to be less assertive than men, and have less of a sense of entitlement when dealing with mostly male authority systems. And in their turn, authority systems are more likely to discount women's voices. According to some disturbing studies of gender disparities in the legal and medical system, women's medical treatment preferences were more often ignored because the courts "treated prior evidence of women's values and choices as immature, emotional, or uninformed, but considered men's prior statements and lifestyle decisions to be mature and rational." (8) In other words, old women will bear the brunt of any inadequacies in the system our society devises for the fragile old at the end of life. Feminists have long recognized the double standard of aging and are open to the worry that there may be a double standard of dying.

Another valuable contribution of feminist thought has been its questioning of rigid methods of inquiry and narrow forms of abstract logic which limit discourse and restrict reasonable argumentation. (9) Feminism has been an interdisciplinary undertaking. By making explicit a social system's implicit private power arrangements, feminism challenges the methodologies, conventions and acceptable limits of the analysis adopted by the status quo. The idea, for instance, that one's own arguments are completely value-free, neutral, impersonal and rationally objective, is always an illusion. More realistically, feminists have championed a wholistic interconnected analysis of phenomena which recognizes personal commitments and denies the split of affect from cognition or emotion from reason.

When concrete human embodiment is taken seriously, affect and emotions, whether positive or negative, will be seen to play as large a role in life and decision-making as supposedly detached instrumental rationality. Feminists have also done well to point out the power of symbolic rationality. Symbols, imagery and language work to shape individual and collective consciousness. Words are never mere words. (10) Thus, feminists have been alert to the way a male-oriented language functions to ensure women s conformity to the system; subtle forms of communication and euphemisms implicitly shore up the power of dominant elites.

As feminists emphasize symbolic reasoning and the ecological interconnectedness of events, their ethical analysis of a social problem can become subtle and penetrating. As noted feminist philosopher Alison Jagger has noted in a comment on reproductive debates:

Feminist approaches to ethics must understand individual actions in the context of broader social practices, evaluating the symbolic and cumulative implications of any action as well as its immediately observable consequences. They must be equipped to recognize covert as well as overt manifestations of domination, subtle as well as blatant forms of control and they must develop sophisticated accounts of coercion and consent. (11)

Subtle sophisticated accounts of the symbolic and cumulative implications of instituting assisted suicide and euthanasia are desperately needed. In reaction to abuses of power and overt and covert coercion by elites, feminists have endorsed nonhierarchical modes of

collaborative problem-solving. While some feminists would see these cooperative methods as arising mostly from innate biologically based differences in nurturance between men and women, others like myself would more credit women's traditional socialization into a female subculture of familial caretaking. In the practices of "maternal thinking" needed to nurture children and dependents, women have learned a great deal about encouraging potential and creating effective communities that work through dialogue and persuasion. (12) A different form of power can be discerned and affirmed. Power need not, and should not, be exercised by the "logic of domination" employing violence and coercion of the weak by the strong. Many feminists have affirmed the importance of "actualizing power" or creative enabling power which eschews the violence of the jungle and seeks to solve problems in a more fundamental dialogical collaborative way. (13)

From the nineteenth century on, many feminists have led or been allied with peaceful, nonviolent approaches to civic reform. The growth of the modern ecology movement has also engaged feminist energies and aspirations. But since the core of the feminist critique is a demand for justice, feminists have espoused an approach to caring which stresses justice as the fundamental basis and starting point of caring, or an ideal of "just care." (14) In a commitment to justice, feminists embark on struggles of nonviolent resistance to evil and endure conflict. The working goal is that both justice and care should inform the lives of interdependent individuals living in mutually nourishing communities of opportunity. Dedicated to inclusive justice for themselves, many feminists have taken up the cause of other vulnerable members of society, particularly children, the handicapped and minorities who have also been excluded from power. The argument between pro-life and pro-choice feminists, for instance, has been over whet her the unborn should be another vulnerable group to be protected. Are not these developing human lives, like their mothers, most in need of advocacy and nurture?

Today, even in affluent democratic America, women have not achieved full equality or overcome obstacles of overt and subtle gender discriminations. Old women end up with a poorer economic status and are more psychosocially depressed than men, because earlier in their lives they have enjoyed fewer opportunities and less structural supports in pursuing education and work, or in combining motherhood and careers. Unfortunately, women also still can confront domination and physical harm from male aggression, sexual abuse, rape and domestic violence. Pro-life feminists would add the prevalence of permissive legalized abortion, even to the point of sex selection for males, to the list of harmful conditions. While women's oppression can be more dire and extreme in other male-dominated repressive societies around the world, the stress upon women in America, particularly upon young adolescent women, needs to be addressed. At every point in the life cycle, from conception and reproduction to death and dying, fundamental moral questions arise and become debated. I argue here that instituting self-determined dying by approving either assisted suicide or euthanasia would be a wrong and harmful step for our society.

Moral and Pragmatic Arguments for Self-Determined Dying

Today's arguments for and against self-determined dying, like most important contested issues, are made up of a network of interrelated claims, assumptions and foundational principles. Moral and pragmatic political considerations become conjoined. Emotional beliefs about the way the world operates, the purpose of life, human nature and the nature of evil, pain, suffering, death and compassion entwine. Practical assessments of the

present and potential functioning of bureaucratic institutions, health systems and medical professionals also become a part of the debate over dying. Subtle and complex philosophical distinctions and ethical judgments are equally important: for instance, is an active lethal medical intervention morally the same as withdrawing a futile or burdensome medical treatment? (I would say no.) Can a patient's right to refuse treatment be extended to a right to demand a treatment, as in the demand for assistance in suicide or euthanasia? (Again, no.)

A complex array of major and minor arguments undergirds the claims of the proponents for self-determined dying. But a core, or gestalt, of the general claims can be discerned which lies at the heart of the pro euthanasia movement, sometimes called "the right to die" movement. These essential moral and pragmatic claims are based upon the belief that the individual person has the moral right to decisively end his or her own life when he or she judges that it is no longer meaningful or has been reduced to an affront to human dignity. Since individuals differ in their understandings of meaningfulness and in their attitudes toward suffering and human dignity, individuals must be allowed to make these decisions. Out of respect for autonomy and compassion, others in the society, particularly physicians, should comply with requests to die. An important pragmatic corollary claim in pro-euthanasia arguments is that adequate institutional safeguards and medical controls can be instituted. In the processes of changing the laws, abuses can also be avoided so that our society need not go down any slippery slope.

It is also important to recognize that different proponents of the need for socially instituted assisted suicide and euthanasia may disagree among themselves as to what is needed. While most proponents of change invoke the general claims above, some take nuanced moral and practical positions. (15) There are persons, for instance, who make distinctions between approving physician-assisted suicide and approving active euthanasia. Others may differ over whether physicians, or some other group, would be the appropriate agents to administer death. There are also some who distinguish between private moral acceptance of suicide and euthanasia by individual physicians but do not wish to see the laws changed.

Another division between groups is between those who approve only of voluntary euthanasia by competent consenting patients and those who accept involuntary euthanasia decisions made by surrogates for neonates or in cases of incompetency. Those who refuse to draw the line at voluntary consent argue that it would be wrong to deny incompetent persons or their families the euthanasia or mercy killings that competent individuals could procure. And as might be expected, there are many disagreements about which legal requirements, social controls, medical safeguards and technical administrative procedures would be necessary to avoid possible abuses and harm. How close to the end of a terminal illness, for instance, must a requested decision to end one's life be allowed? Can severe psychosocial suffering or a resolute desire to die count as a valid reason to receive aid in dying, or must there be a terminal medical disease present? As for the problem of abuse, there are disagreements over what levels of abuse would ensue, and what levels of abuse could be tolerated in order to procure what is judged to be a much needed reform. I cannot here address all of the complex issues involved, and so will only briefly outline my counterarguments to the claims made.

Moral and Pragmatic Arguments against Assisted Suicide and Euthanasia

I do not agree with the proposals for allowing assisted suicide and euthanasia; my position has been developed out of my feminist affirmations. I focus my moral and pragmatic arguments on 1) the individual's decision, 2) interpersonal effects, and 3) harmful outcomes in society.

Individual Decisions

Does an individual have a moral right to a self-determined death by suicide or euthanasia? Implicit in the claim is the assumption that an individual owns his or her personal body-self so completely that he or she can kill or extinguish life at will. This concept of absolute human ownership or property right appears morally misguided. Women, along with other formerly owned groups like Blacks, must protest that no body can be owned or destroyed by unilateral individual decision, even one's own. Whence would such an individualistic moral right or assumption of absolutely dominant power come from? After all, each individual self-consciousness, like each individual's body-self, has been created and received from one's parents and forebears and nourished by the community and culture in which an individual's life is organically embedded. A human life and identity is a gift from evolutionary biology, natural ecological conditions, parental procreative childrearing and collective cultural socialization, all transcending the individual power of a self-determining will claiming unilateral life-or-death powers.

Feminists have understood that individuals cannot be treated or treat others as though persons are alienated nomads cut off from all bonds with one another. Having received the gift of life and social identity, one has moral obligations to preserve and respect each human life and refrain from suppressing, killing or destroying self or others. What is permitted to the self and what is permitted for others to do to a human being cannot be morally or psychologically separated. Murder and suicide are irretrievably linked acts. In ancient cultures such as Rome, where suicide was honored, it was also accepted that powerful elites could unilaterally kill slaves, children or troublesome women. To be a valid protective principle, the moral prohibition against killing a human being must have no exceptions -- neither for the self, nor for physicians.

For that matter, today's society and many feminists are even beginning to seriously question the claim that human beings can have property rights that morally allow them to kill members of endangered animal species or destroy rain forests. (16) With the growth of ecological consciousness, human beings are recognized to be existing in an interconnected life-sustaining environment which has been received from interacting natural patterns and must be respected and cared for, if human life is to be sustained. While no individual has ever given informed consent to become a member of earth's ecosystem, individuals can have moral obligations and duties to protect and exercise care for the earth's environment. Arrogant and destructive impositions of human will must be forsworn. Surely the moral prohibition against willfully destroying a human life must become universal.

While a human being has a body right to self-protection from intrusions and mutilations in order to protect one's life and well-being, these life-affirming rights can hardly be extended to demanding acts of bodily self-execution. Indeed, many proponents of euthanasia appear

to deny the organic unity of an embodied self and believe in some dualistic, even spiritualistic, idea of a ghost in the machine. Typically, one respected physician, writing in Harvard Magazine of his own end-of-life beliefs, says, "It is my credo that assisting people to leave the dwelling place of their body when it is no longer habitable is becoming an obligation of the medical profession. It is part of the doctor's job." (17) He appears to assume that some disembodied person or brain-based mind temporarily dwells in his body and should be able to leave it at will. But where to? Many persons appear to accept another questionable assumption denigrating the body--i.e., that alive brains can somehow, like computers, operate separately from the rest of the bodily machine.

Such dualistic beliefs, from the time of the Stoics' view of the imprisoned soul dragging around a corpse, until today, have helped to justify voluntary suicide and assisted dying. Such dualistic denigrations of the body have also justified less savory killing practices such as offering human sacrifices to the gods or burning heretics for the sake of their souls. Mere bodies can be disposed of in order to send souls on to the next, truly meaningful life. Unfortunately, when embodiment and a wholistic understanding of the human being is denied, then women's bodies too, along with their power to engender and nurture new embodied human beings, become discounted. When an ideological goal strives to dominate and master despised natural bodies at the behest of a higher will or spirit, then women will often find themselves part of the natural order which must be dominated, if not despised.

A dualistic assumption of a mind inhabiting a bodily dwelling place focuses attention on the intractable problem of obtaining fully informed consent. Even those who would prohibit killing another person claim that one can kill one's self because of the certainty of obtaining informed consent -- i.e., when the executioner and executed are identical. Or to use the term for suicide found in the literature of the Hemlock Society, in "self-deliverance" the deliverer and the delivered are one and the same.

Here again, however, the body-self must be objectified, alienated and viewed as a target split off from the mind. Bodily life becomes the enemy, or the obstacle which must be dominated and extinguished by technological means that will not fail. In many suicides, body-selves resist being killed and vomit pills, or claw off plastic bags, or lunge for air; therefore, the more violent or technologically certain the assault, the better. Experts or helpers also need to stand in readiness to complete the job. Better yet, physicians who will actively commit euthanasia can employ a highly lethal chemical technology that can bring a certain, swift death.

Viewing the body-self as a target to be dominated and killed differentiates an act of suicide or euthanasia from the morally acceptable practice of withdrawing futile medical treatments. Allowing a dying person to die without prolonging his or her irreversible death permits giving up useless and burdensome interventions. In a naturally occurring inevitable death, a whole person as a body-self dies from an irremediable medical condition. If a treatment is withdrawn and death is not imminent, then the person continues to live. There is no danger of misread signals.

The difficulty of ascertaining a person’s consent to suicide or euthanasia cannot be overestimated. There are problems with comprehending internal self-self communications and external problems of receiving self-other signals. Self-knowledge is difficult because

the ongoing stream of consciousness is so complex and made up of so many different dimensions. We now know that many different modal subsystems contribute to our unified experiential sense of a conscious self and identity. Arousal, memory, perception, affect, cognition and so on play a part in an ever-changing, ongoing flow of conscious experience. There exists a constant revising of interpretations of self-experience responding to the ways different systems of a person are functioning. Not only can biochemical imbalances and impairments create fears and depressions, but temporary disjunctions of impulse, illusions, imagery and false inferences can create erroneous and dysfunctional judgments.

Individual choices, preferences, plans and decisions are never simple or unitary, but exist as ongoing processes. Consciousness is constantly being self-created and recreated; and these individual inner processes are constantly affected by ongoing interpersonal and environmental interactions. To complicate the picture further, there are many nonconscious cognitive processes, such as implicit memories, outside of full self-awareness which exist and contribute to functioning. An explicit self-aware accessible event in consciousness is not all that is operating within a person's mind-body-organism.

Therefore, when a conscious decision, or choice, or plan is made to kill one's self, not only must one violently subdue one's body-self, but one must also extinguish all the other implicit stored dimensions of complex personal identity. Other dimensions of personal consciousness may resist dying, and, like the resisting body-self, call for help in the midst of a suicide attempt. When people survive attempts at suicide, or their requests for euthanasia are denied, they often report that they have now "changed their minds." They no longer identify with the dimension of self that wanted to die. No one can ever certainly predict how a future self's stream of consciousness will construct or interpret experience. Even various kinds of suffering can be interpreted as meaningful and transcended by many human beings, as abundant testimony reveals. An irreversible conscious decision to end consciousness forever suppresses a core capacity and essential potential of a human being. A voluntary extinction of the meaning-making faculty of persons also signals the meaninglessness of nonhealthy bodily life; it is a grave violation of human dignity. A steadfast living of each moment to the end not only displays more courage, but gives more meaning to the human condition. Death may forcibly take my life away from me, but why give death an easy victory by an irreversible act of self-extinction?

Of course, many irreversible decisions short of death will have to be made, and inner conflicts exist in some decisions when some part of one's self may dread or shrink from an act. Certain therapeutic medical decisions such as amputation might be cited, or, in an even more extreme case, giving up one's life for another or becoming a martyr may induce ambivalence. Yet these examples are not the same as choosing death by suicide or euthanasia. In irreversible medical decisions, the goal is to be able to continue life and thereby continue to experience or shape one's life. In a sacrifice for another person, or in martyrdom, death is really not being chosen but is imposed upon a person's altruistic act by external exigencies or persecutors acting beyond one's control. One is choosing loyalty or love, not death. A mother who chooses to risk a life-threatening pregnancy for the sake of her baby is not committing suicide or choosing death.

There are differences in human actions undertaken even when death as a final outcome can be foreseen. To withdraw futile treatment is not the same as killing. To give a dying person enough medication to relieve pain, an act that may also result in a less prolonged

death, is not the same as intending to kill a person. Human acts are shaped by human intentions and characterized by the means employed. To judge only by ultimate outcomes or consequences is to take only the narrowest utilitarian perspective on causation. The bottom-line approach denies human subjectivity and makes no distinction between human beings and inanimate objects. Human beings always act within a world of willed intentions, affective motivations, using differentiated means within cultural frameworks of meaning. To deny the complexities of human actions would mean denying the very judgments and desires to be merciful and compassionate which inform all the different arguments over what we should do to help each other to a good death.

Obviously, all parties agree that there is a duty to comfort, care and relieve pain during the dying process. In an era of advanced palliative medicine, no one who is dying should have to die in pain. The increase of chronic illness in our society makes it clear that medicine's caring and palliative function is as important as heroic feats of curing and rescue. Yet the existential suffering accompanying illness and death can be a psychosocial challenge to individuals and their families. Unfortunately, physicians who become enamored with the heroic role of fighting off death with dramatic high technologies may all too easily arrogate to themselves the duty of relieving existential suffering by deciding when to end a life. In the process they may also foreshorten necessary processes of grieving and farewells.

Most worrisome, however, are the problems of communications in a crisis. It is very difficult to know one's own mind and heart or to internally assess the validity of the ever-changing dynamic processes of decision making, much less read another's heart. Yet physicians in favor of euthanasia appear to have faith that they can tell whether the patient really means it when he or she requests to die. Why so? Why should physicians be accorded the power or ability to assess the quality of a life's meaning or judge the amount of subjective suffering that is really present? Those physicians who think that they would only be responding to a patient's "free" choice are naive about the dynamic processes of interpersonal communication. Subtle signals and suggestive signs are constantly being given by the phrasing of questions and a host of other nonverbal channels of communication. Ask any patient, or any woman in childbirth, for an account of how facial expressions, gestures or tones of voice are being scrutinized for social meanings.

Interpersonal Social Dimensions of Self-Determined Death

When you seek or assist a suicide or act of euthanasia, you act to end all human relationships. No more comfort can be given or received; no more companioning or patient watching and waiting with another will take place. A decisive cutting off of interpersonal bonds will be effected. You don't see each other through to the end, you end life. All human dependence and interdependence is actively rejected. Such acts are not without interpersonal consequences because we do not exist alone. Feminists have always emphasized that supposedly abstract decisions are influenced by their pragmatic social context and covert meanings. Cultural scripts, background beliefs, social roles, status, perceived power and emotional histories, along with patterns of speech and symbolic interpersonal communications, will determine outcomes of events.

Ambivalence in motivation and ambiguity in meanings also characterize the human condition. When one decides to actively end one's life or requests euthanasia, the social support that can be counted on from others will be a crucial variable. How much care can

the individual expect? Is it given grudgingly or with love? In the past the absolute fixed tabu against suicide or against euthanasia has served to make a patient's right to expect the care of her family or community fixed and unquestioned. As long as a human being's natural life exists the family and/or institutional caretakers are morally obligated to offer support and care. Whatever ambivalence exists must be suppressed in order to live up to the cultural ideal of helping those who are ill and suffering as their vulnerability increases and their life ebbs away.

When the option or choice to end a life is morally permitted, then the interpersonal situation changes. One must justify his or her choice to go on living and ask why one should voluntarily continue to exact care or be dependent upon others. Subtle internal pressures can all too easily emerge to stop being a burden on others by taking up resources and energy. Women who have been socialized to be self-sacrificing may be the most vulnerable to such pressures. After all, in India it was widows who were required to throw themselves on funeral pyres, not men. And surely in ancient Arctic societies more aged women ended up on those reputed ice flows going out to sea. The majority of Dr. Kevorkian's clients who have used his suicide machine also have been women. People request assisted suicide when they are not yet in pain, but because they fear future debilitation and dependency. Fear of dependency is partly a fear of losing power and self-control, but it can also be a fear that others will not take care of you. It may also mask a displaced fear of death itself.

Unfortunately, the more ill or debilitated a person becomes the more distrusting, depressed or despondent an individual can become. Emotions and thought processes regress in illness and it becomes more difficult to think clearly, much less assert one's claims for care. That is why each old person who goes to the hospital does well to have a family member present to be an advocate in the confusing system of modem American healthcare institutions. The idea that patients have one long-term physician who knows them well and will serve as their discerning protector is more or less a fantasy for most aging Americans. To become ill is to enter the land of vulnerability when what you need above all is an unconditional entitlement to receive appropriate care.

Families and caretakers also will not be unaffected by any new options instituted for assisted suicide or euthanasia. Today most families do take care of their aging and dying members, but they do so supported by tabus against all requests for death. The intergenerational reciprocal cycle of kinship obligations and care should remain undisturbed. Incompetent, vulnerable infants are nurtured, grow up, mature and care for incompetent, vulnerable and dying old persons. If and when possibilities for euthanasia arise as socially approved, there will be a whole new disturbing dimension to caretaking and family communication. Family conflicts can be expected over requests for death. Suicides leave their mark on their families and requests for euthanasia may also engender conflicts, regrets and models for imitation. The situation of dying by request is so emotionally fraught for caretakers that even proponents of euthanasia have recommended that families not be the agents involved. But individuals, families and care takers will not be the only ones affected by social change.

Society and Community Effects of Self-Determined Dying

Arguments over what possible effects approving assisted suicide and euthanasia would have in our society depend a great deal upon assessments of what conditions already exist in our institutions, bureaucracies and professional communities. Feminists will be pessimistic if they look to the way powerless women have been treated in health-care facilities devoted to birth and reproductive health care, or to the way women on welfare have fared. It is instructive also to look at the way abortion moved from being approved of as a tragic choice in exceptional cases to becoming a routinized necessity with only the most perfunctory of counseling or alternatives offered to women. Individual choices have a way of quickly becoming routine procedures in the larger institutions of society. A quick medicalized technological solution to problems can take over. Slippery-slope arguments often do apply when traditional moral prohibitions are breached. Think of the way the Allies began to justify bombing civilians in World War II.

Those who favor right-to-die measures claim that surely society can control practices because rational controls and legal supervision of professionals and institutions will work to keep abuses from occurring. Also, they claim, physicians will not be corrupted by becoming "death providers" instead of healers, because part of their role already includes relief of suffering. Providing the means to suicide or giving lethal doses to effect death will only be an extension of their current roles. Families and other caretakers of the dying will not be affected, it is claimed, any more than the current recognition of the patient's right to refuse or withdraw futile treatment has changed the supportive care given to patients.

Most advocates of euthanasia do recognize that there would be a move from voluntary euthanasia to involuntary euthanasia of incompetents, but they are not alarmed. Their reasoning is consistent. If it is a good for competent patients to be able to end a meaningless life that is an affront to human dignity, then why should not those who are incompetent have the same freedom? Surrogates can usually make any decisions which are morally accepted for individuals to make, so this move to involuntary euthanasia would not be seen as a terrible danger. Those demented Alzheimer patients who no longer can recognize their families or even seem fully conscious are the most trying and burdensome patients. Perhaps this group could be most easily judged by surrogate decision makers to have a meaningless unacceptable quality of life.

In these debates the case of Holland's growing acceptance of euthanasia is argued over. Everyone agrees that more and more liberties and laxity in professional requirements for euthanasia have taken place in Holland. Persons have been euthanized only because they claimed to be severely depressed, and family requests for involuntary euthanasia for incompetents and impaired neonates have been met. (18) Proponents of euthanasia may admit some abuses in Holland but also affirm that the extension of the right to die really reveals the need, heretofore suppressed, of increases in personal liberty.

Opponents of euthanasia would, like myself, point to the changes in Holland as an example of how a slippery slope works. Death begins to seem more and more of a seductive way to solve problems. The fuzzy criterion labelled "an acceptable quality of life" becomes ever more elastic. Pressures on older people or AIDS patients to request euthanasia will grow even in a well-organized, fully insured universal health system like Holland's, where no financial pressures are involved in these decisions. Habituation makes each new case easier to carry out. To my surprise, I once heard Timothy Quill, a prominent physician advocate of assisted suicide, proclaim from a podium that a physician's

fourteenth case of assisting a suicide would not be carried through with the same sensitivity as his first case.

In our own disorganized, economically stressed, market-driven American health system, with so many of the poor having inadequate health insurance, many abuses could be expected. Little legal supervision or regulation could really be effective. Physician education, with its technologically driven training, does not prepare doctors to be strong in communication skills or social sensitivity. Certain physicians would undoubtedly become known for the ease with which they approved suicide and euthanasia requests, and perhaps, as with abortion, special for-profit clinics would be set up. Poor and uninsured old persons--particularly women, minorities and the handicapped--would be most at risk.

Another reservation emerges from a consideration of symbolic cumulative effects of assisted suicide on our culture. Is it acceptable to retreat, withdraw or check out of a situation, a marriage or a life when troubles mount and suffering must be endured? Already the adolescent suicide rate has soared and depression rates have increased among the young. No one could look unmoved at the abortion rate or contemplate our homicide statistics without a tremor. Unconditional respect for the gift of life is eroding; nonviolent struggles to patiently overcome a sea of troubles is not validated. Under the banner of increasing technological control and increasing liberty--live free or die--we have opened ourselves up to more and more pressures to die.

Ideals of individual domination and control of life have backfired in our society. Feminists have mounted a critique and reappraisal of our troubles. Feminist ideals of inclusive justice, caretaking and the interconnectedness of all the living require that we struggle against approving assisted suicide and euthanasia. Let there be no more recruits for the armies of domination and death.