# letters

## To Die or Not to Die

**Madam:** John Hardwig's provocative essay ("Is There a Duty to Die?" *HCR,* March-April 1997) begins in a personal vein but steers into the hazardous zone of health and social policy. He says, for example, "I am first of all concerned with my own duty," being careful to say that he will use "duty," "obligation," and "responsibility" interchangeably, and (as he explains in the footnote) avoiding contractual legal obligations and eschewing any right that others may exercise to have such a duty fulfilled.

Yet trouble ensues when he addresses who has a duty to die. While claiming agnosticism, Hardwig goes on to list conditions that would make this duty "more likely." Yet if the reasons for thinking one has such a duty really are "particular and contextual," as he claims, then Hardwig is mistaken to suggest circumstances that would make this duty more compelling. This listing of circumstances sounds ominously like the rudiments of social policymaking, rather than the clarification of a personal virtue. Also, the voice of the essay changes here from a self-descriptive one to an impersonal one, offering general formulations about age, degrees of burden, and past contributions. If Hardwig had said simply, "This is my personal code," I could have viewed him as a paradigm of late Stoicism (which I admire), rather than another effort to turn personal convictions into social policy (which I consider dangerous). I share Hardwig's views almost completely, but I doubt that many others do, and I doubt that any good social policy considerations can come from efforts to apply the teaching of Epictetus and Seneca to late 20th century Americans.

Finally, Hardwig cited me inaccurately. I do not believe that "Christian ethics takes us far beyond" Hardwig's position. When I claimed in *Rationing Health Care in America* that "Christian doctrines of stewardship prohibit the extension of one's own life at a great cost to the neighbor . . . And such a gesture should not appear to us as a sacrifice, but the ordinary virtue entailed by a just, social conscience," I was speaking about efforts to extend life by expensive medical interventions, not about a duty to take one's own life. I, like Hardwig, believe that there are situations in which it would be virtuous and noble to kill oneself, but I know of no Christian doctrine that endorses a duty to kill one's self in order to unburden neighbors or families. Christian theologies I am acquainted with endorse a duty to be proportionate in striving to stay alive when one is terminally ill because death—as much as life—can be thought of as a gift and our finitude seen as a benefit.

**Larry R. Churchill**
University of North Carolina
at Chapel Hill

**Madam:** I was appalled and embarrassed to have John Hardwig cite a book of mine as if it provided some support for his argument about a "duty to die." He said: "To have reached the age of, say, seventy-five or eighty years without being ready to die is itself a moral failing, the sign of a life out of touch with life's basic realities." He then cited—though without a specific page reference—my book *The Troubled Dream of Life.* I do not now, and never did hold such a position, and said nothing even remotely supportive of such a position in my book. I believe it is unwise and unrealistic not to be ready to die by the time one reaches old age, but I see nothing whatever immoral about that; everything unwise is not immoral.

More generally, I reject his thesis that there is, or could be, a duty to die. I believe it trivializes the relationship of family members to each other to act as if their mutual obligations to each other are to be judged by some benefit-burden calculus. Hardwig seems to be saying in effect: "for better or worse, in sickness and in health—well, sort of, it all depends."

By Hardwig's standard, not only would I have a duty to die if, by such a calculus, the burden on another was too great, but they in turn would have the right to demand that I die. Indeed, since they are the ones being burdened, theirs becomes the crucial judgment. Why? Because if there is a real "duty" in some serious sense of that term—that is, a situation transcending a mere *feeling* of duty—then it would be irrelevant that the person imposing the burden on another disagreed with the judgment or simply failed to note how much trouble he was causing. Since the relative weight of the "burden" of one person on another is bound to be highly subjective, there is no way the person with the supposed duty to die could make such a judgment.

In addition, Hardwig's tone of cool rationality in discussing the negotiations among the burdening and burdened partners fails to capture the emotional nightmare they could become—the second guessing, the possible recriminations, and the high potential for self-deception all around. This likelihood seems to me pure ugliness prettied up with moral sensitivity.

Of course Hardwig's duty to die translates into a duty to commit suicide. And that will entail—for efficiency and medical legitimation—the services of a physician. And in order to act as a responsible moral agent, the physician would have to agree with the judgment of a duty to die.

In an expansive burst, moreover, Hardwig says, "There can be a duty to die before one's illness would cause death . . . In fact, there may be a fairly common responsibility to end one's life in the absence of any terminal illness at all." That passage reminded me that Dr. Kevorkian has argued that we should have a medical specialty call "obitiatrists," doctors who specialize in assisting suicide. If Hardwig's idea of a duty to die is taken seriously, such doctors will surely be needed; all of us are possible candidates.

**Daniel Callahan**
The Hastings Center

**Madam:** John Hardwig admits that his "duty to die" includes a duty to commit suicide if simply refusing further treatment would not result in death in the near future. The rest of his discussion assumes that the difference between these two ways of coming to die is insignificant. By blurring the distinction between killing oneself and refusing life-prolonging treatment, he weakens his argument and misleads the reader.

It is easy to agree with him that since we are interconnected, we have a duty to consider the impact of our decisions on significant others. "Respect for patient autonomy" should never have been interpreted as the sole operative moral principle in life-and-death decisions. That principle can help to guide the caregiver, but it is no help to a patient who asks, "But what decision should I make? What should I consider?" That there could be a duty to forgo further aggressive medical treatment, based on the burden this would create for others, is a supportable claim. It is interesting to note that Hardwig's strongest example, the eighty-seven-year-old woman whose care costs her daughter her savings, her home, her job, and her career, is an example of continually "opting for rehospitalization and the most aggressive life-prolonging treatment possible." It is *not* an example of refusing to commit suicide.

The step from such a case to a duty to remove oneself from the scene by taking positive steps to end one's life is a much larger one than Hardwig suggests. Let me note three kinds of considerations that make this "duty to commit suicide" problematic. They are what I will call "narrowly practical," public policy, and religious. The first two are interrelated.

Hardwig does not make clear whether his "duty" applies whether or not physician-assisted suicide becomes legal. If having this duty requires the availability of the assistance of a physician, then all of the issues connected with this controversy need to be

part of the discussion. I have in mind especially the slippery slope concerns about the possibilities of abuse. If, on the other hand, he means to say that we have this duty *regardless* of the availability of medical assistance, then we must imagine the person acting alone (since aid from anyone is likely to risk criminal prosecution). How will this person go about carrying out her duty? What means will she use and how will she obtain them? What happens if she is not successful in ending her life? What will be the effect on her family, of her attempting suicide? Of her successfully committing suicide? It is true, as Hardwig states, that the family will have to deal with the death of their loved one in the fairly near future anyway, but the emotional burdens of a suicide are quite different from those occasioned simply by a death.

Finally, the often misrepresented religious objections to suicide: The claim is not that death is the ultimate evil, to be avoided at all cost. Nor is it simply that somehow we know that God forbids suicide, a kind of appeal to divine command theory. Hardwig cites one religious writer, Larry Churchill, as claiming that "Christian ethics takes us far beyond my present position." That claim is seriously misleading. The context in Churchill's book, *Rationing Health Care in America,* makes clear that Churchill would distinguish between not pursuing longevity with excessive passion, and directly ending one's life. He cites Leon Kass (well known for his opposition to active euthanasia and physician-assisted suicide): "Man longs not so much for deathlessness as for wholeness, wisdom, and goodness." This statement captures the central religious objection to suicide: that it prematurely forecloses the process of spiritual development that is this life's deepest purpose. Common to many religions is the belief that we have here no lasting city, but we seek a city that is to come. The present life is a kind of probation, a place of challenge, testing, and moral development in which we become fit for our true destiny, the kingdom of God. As St. Iranaeus put it in early Christian times, this is a place of "soul-making." In such a context someone who is no longer able to contribute tangibly to society still may have "work" to do, challenges to meet. Further, all of the major world religions speak about the meaning that can be found in suffering. A competent person, still capable even of *preferring* to live, is presumably able to grow in wisdom and goodness.

The interesting and important question left unresolved both by Hardwig's discussion and by this response is the extent to which family members have a duty to sacrifice to care for each other. Did the daughter in Hardwig's example fulfill a duty? Act in ways that were heroic, supererogatory? Or did she yield to demands she should have reisted, to support her mother's denial of mortality?

**Elizabeth A. Linehan**
St. Joseph's University

**Madam:** It is certainly my hope that your choice to feature John Hardwig's essay was an attempt to be provocative and not an expression of the Center's support for this frightening position. Those of us who oppose the legalization of assisted suicide have long argued that it would be the creation of a social policy that would lead to covert and subtle pressures on those among us with the fewest resources to elect the assisted suicide option. This article would seem to confirm that it would not be too long before those pressures would be overt and direct.

These are huge flaws in Mr. Hardwig's ethical and practical reasoning. I will not even attempt to examine the question of who is going to be making the decisions about who should live and who should die, but significant among those flaws is his assumption that the only choice is between ending our lives and becoming a burden on our loved ones and society. While caregiving is often difficult, it has been our experience, in hospice, that with appropriate—and minimal—support, most families take great joy in being able to bring comfort and peace to their loved ones in the last weeks and months of life. For the situations where the physical, financial, or emotional burden is great, perhaps we as a society should be putting our energy into finding better ways of caring for the chronically and terminally ill and in supporting their families rather than killing the patient. The underlying reasoning here seems to be based on Mr. Hardwig's own fear of death and dying and his promulgation of this policy appears to be from the same school that has evolved the assisted-suicide movement as a "knee-jerk" reaction to that fear. Both schools of thought give a strong message that the end of life has no meaning and devalues the days of all among us who are dying. True ethical discussions about the end-of-life must start from a place that holds onto the core value that all of our days have meaning, that death is a natural part of the life cycle, and that we have, indeed, a "duty to live" the last part of our lives as well as we possibly can.

**Anne E. Thal**
Hospice of Hillsborough, Inc.

**Madam:** Having worked nearly a quarter century for the right to die, I found the article by John Hardwig on the possible duty to die very interesting. I believe there is a moral duty to die in circumstances he describes.

I would distinguish between a moral duty and one mandated by law. As a civil liberatarian, I oppose a legal obligation. Our government must not either require or deny fulfillment of a perceived moral duty. Some early colonial governments required church attendance. Our Constitution recognized that to be an individual choice, to be neither forced nor denied. Decisions about the circumstances of our dying must also be ones of personal choice. We differ greatly in our religious beliefs, concepts of duty, perceptions of pain, beliefs about future life, family situations.

Perhaps some who feel there is a moral duty to die when becoming a burden fear few will choose to honor that duty, that the fear of death is too strong. I disagree. By the time one becomes a burden on family and/or society, the patient will usually have become miserable enough to wish release for his own sake. There is nothing wrong about having more than one reason for choosing to die. There is no reason that family, society, and patient cannot benefit from the same action.

Let us compare this proposed duty to the long-accepted duty to face and accept death in military service. Most who are not morally opposed to all war, or the circumstances of the particular war, feel a duty to serve in the military when drafted. When a soldier volunteers for a "suicide mission" he is greatly honored by his family and society, being viewed as a hero. A big difference between the soldier and patient is that the soldier is sacrificing so much more. He is usually from teen- to middle age, in good health, with good life expectancy, and often with young dependents. The disabled, dying patient is usually old, with practically no life expectancy, and no dependents. Perhaps those who laud the soldier and criticize the patient who wants to die, do so because of the patient's double motive, including release from pain, though they approve using pain medication as long as it is effective.

An interesting thing about a duty to die is that it is brought forth while it is still illegal to help a person die, and most patients who want to die have become unable to act without help, being unable to obtain and/or use means. Even if they have kept a gun or hoarded pills for years, such means are not likely to be available at the right time. A few years ago we won the right to refuse life support so in a few cases simply refusing them may be used to hasten death. But that right does nothing for those who are not on life support, but suffering as much, and becoming a burden as much as those who are on life support. While some have advocated just refusing nutrition, that can be slow and hard on the family and patient. Without legalizing assisted suicide, any promotion of a duty to die is unrealistic.

**Frances A. Graves**
Snohomish, Wash.

**Madam:** I am nearly eighty-three-years old and still a functional person (with failing vision). I have no fear of dying, something Hardwig mentions, but I do fear having a stroke and surviving, and being unable to end my life. I fear living in bed, incontinent, unaware of life around me, perhaps with limited or no vision or hearing, etc.

Yet caregivers are the ones who bear the burden, and it is almost always the wife who cares for her dying husband. The wife is then left alone, with no built-in caregiver. Is that wife who is left alone ready to accept caregiving from a daughter (rarely a son) if she becomes an invalid and needs constant care? Or would she then feel it was her duty to die so as not to disrupt the daughter and her family responsibilities. I am not willing to impose upon my daughter for such care.

Another important issue you did not address is how to end one's life. It is not easy and the only accepted method often suggested is forgoing food and fluids. There should be an easier way, but lethal drugs are difficult to obtain. That is why we in the Hemlock Society are trying to pass legislation to make it legal for a physician to write a prescription for a lethal dose of barbiturates. This should be a part of good medical care, to help the dying patient who requests help.

What can we do to help ourselves? We certainly can and should complete an advance directive and appoint a proxy to make decisions should we become incompetent. We might also fill out a do-not-resuscitate order if this option is available in our state. We can refuse antibiotics if we develop pneumonia when we are already dying, as well as ventilators, feedings, dialysis, etc. We can talk to our doctors about treating us the way we want to be treated at the end of life—the way they would want to be treated themselves (and they have the means to do what they choose). For those people who insist upon living as long as possible in any condition, regardless of their dependence on others, they should invest in a long-term care insurance policy to help provide the care they will need.

The SUPPORT study and other sources continue to tell us we must provide better care for the elderly, but so far no one has told us how to do this. The over-eighty-five population is exploding; the budget stands to be cut, not increased for such care; and caring for the elderly is not a job that pays well, so very few licensed health care workers choose this field. Not many physicians are choosing geriatrics either.

So at the end of life we should have a choice—some would consider it a duty. Death is not optional, but the way we die should give us some options.

**Alice V. Prendergast**
Tempe, Arizona

**Madam:** I found the article "Is There a Duty to Die" to be stimulating and timely. As a family practice physician for twenty years I have seen many of my patients refer to a number of points raised in the article. Hardwig, however, discusses these points cogently and in such a manner that the article can be used as a framework for physicians such as myself to be sure that the most relevant issues regarding death and dying are considered.

He also presents an ethical justification of suicide for those who might realize that they are approaching an end to a meaningful, productive life. I find that this aggressive approach usually is not necessary. A more defensible ethical position is to make patients aware of the option of refusing medical care (except relief of pain and suffering) when they have arrived at their "time to die." Allowing "nature to take its course" does not risk breaching many laws and thereby does not increase the turmoil for those family and friends who wish to honor the request of their loved one to be allowed to die.

Prior to the introduction of antibiotics, 50 percent of deaths were from infections. Thus, refusing medical intervention for infections except to relieve pain would allow many people to die from infection. In the elderly population this would most often mean dying from pneumonia or urinary sepsis. Refusing medical care could be extended to the routine outpatient setting and not confined to the hospital or to hospice care. This refusal of available medical care could include no longer receiving yearly influenza vaccinations nor periodic pneumococcal vaccinations and declining antibiotics for all infections. Infections that are painful can be treated with strong analgesics. There is even an ethical benefit to society provided by those who refuse antibiotics. By not using antibiotics as often, there will be a slower spread of bacterial resistance to antibiotics. This resistance is a serious and growing problem.

A more aggressive person might also choose to refuse ordinary care in addition to refusing medical care. This could include refusing to eat or drink. Refusing ordinary care may encounter some legal obstacles in order to assure that family and friends are not charged with elder neglect. This is an area where medical ethicists could help society by providing analyses of related issues that can be a building block for further action by religious leaders, national medical societies, and political leaders.

**Donald G. Flory**
Clinton, Iowa

***John Hardwig replies:***

This is a very helpful set of letters. It moves us toward the discussion we need, which must be personal, familial, and society-wide. Let us begin on the personal level and with a point of clarification. Churchill says that he could share my views if I saw my position as my "personal code," but he worries about an "effort to turn personal convictions into social policy." This paper is my personal code, but if I thought it were only that, I would not have attempted to publish it. I do believe the duty to die is fairly common and that it will probably be much more common twenty years from now. Consequently, I think we all need to reexamine our moral convictions in light of the very real possibility that we will one day be a crushing burden to our loved ones.

I also think that we need to help each other examine our consciences; the best moral reflection comes through dialogue, not monologue. The family needs to be included in these discussions, precisely because they have so much at stake. I agree with Callahan's contention that family discussions about a duty to die could become "emotional nightmares," with "second guessing, . . . possible recriminations, and the high potential for self-deception all around." That is true of virtually all contentious family decisions. But it doesn't follow that such discussions should not take place. The alternative to discussion is superficial—or at least largely unarticulated—relationships and tacit family policies that so often serve to benefit some family members at the expense of others. (Consider, for example, Prendergast's point that it is predominantly women who deliver care and then are reluctant to accept it for themselves.)

In one sense, I also agree with Callahan that "the relative weight of the 'burden' of one person on another is bound to be highly subjective." If my wife were only barely managing on the edge of chronic depression or a mental breakdown, this fact about her would surely be relevant to deliberation about the appropriate end for my life. By contrast, if members of my family were—like those in Thal's experience—taking "great joy" in providing care for me, I would probably have no duty to die. But it doesn't follow from this kind of "subjectivity" that I can make no judgment about how severe a burden I have become to family members or that I must uncritically accept whatever they say about their burdens. We know that most of us have a tendency either to overstate or to understate the burdens we must bear.

We are nowhere near ready for the legal and policy decisions that worry the authors of most of these letters. Churchill, for example, feels that "the listing of circumstances sounds ominously like the rudiments of social policymaking, rather than the clarification of a personal virtue." But I intend precisely clarification of a personal virtue, not social policy and certainly not a policy of involuntary euthanasia! We do not yet under-

stand a possible duty to die well enough to even begin formulating policy. Indeed, it is far from clear to me that there are any legal or policy implications of a duty to die. There are some duties that each of us must fulfill for and by herself, often even without substantial assistance from others. There are also many duties that we—especially "society"—ought not to attempt to coerce or pressure people into fulfilling.

Callahan, Flory, Graves, Linehan, and Thal all discuss physician-assisted suicide. I believe a duty to die holds whether or not the assistance of a physician is (legally) available. I don't agree that a duty to die would require legalizing physician-assisted suicide. Graves is certainly right that unassisted suicide is often very difficult, even impossible. Those who cannot end their lives have no obligation to do so. But Prendergast and Flory correctly remind us that if we would refuse all medical treatments, we would only rarely have to commit suicide, especially if we refuse food and water. But we still need to consider carefully the effects—on family as well as patient—of a slow death due to deliberate starvation in comparison to the range of other possible deaths.

In any case, without substantial consensus, the threat of social policies that would enforce such a duty to die seems rather unreal. In our present context, who would dare to enact policies enforcing, promoting, or even assisting in a duty to die? I doubt that we will even see policies designed to respect and support the moral convictions of those of us who believe we have a duty to die.

Policies that would shield families from the burdens of care and thus dramatically reduce the incidence of a duty to die also seem very unlikely in the foreseeable future. We do need to weigh carefully possible policies that would change our moral situation. But clearly that must never become a substitute for considering our individual responsibilities in our present social contexts.

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The whole idea of a duty to die may seem far-fetched and out of step with the main body of bioethical thought. For this reason, it may be useful to respond to Callahan's and Churchill's objection that I have miscited them. My claim is not that Callahan and Churchill endorse my view; it is that both (like many others) may well have trouble avoiding it, given the logic of their positions. Is it true that nothing in Callahan's book provides support for my position? There are many things that are only unwise if you have no family or close friends. But they are often wrong as well if they pose a serious threat to the well-being of your family and loved ones.

Churchill is also correct; he was "speaking about efforts to extend life by expensive medical interventions." But what if the same expenses dribble in slowly over a decade rather than suddenly from one high tech rescue attempt? What if the expenses are borne by individuals, not by the health care system? What if the costs are not medical costs at all? And what about the human, nonmonetary costs that are often far more impoverishing than mere monetary costs? (Callahan has written of the loss of identity and of hope.) So if extending my life requires no expensive medical treatment, but is nonetheless extremely costly for the neighbor—my family and loved ones—what would Christian teaching bid me do?

A possible duty to die requires rethinking the appropriate end of life within Christian as well as secular ethics, including the traditional objections to suicide. Linehan and I probably converse across a great metaphysical divide—she expects another city and I do not. Nevertheless, I think I agree with much of what she has in mind when she speaks of "soul-making." But why assume (as Linehan seems to) that when "a man lay down his life for his friends" it is not soul-making? When I try to think about ending my life to save the well-being of my wife or children, I imagine a process that would be soul-making for me . . . and for them, too. Why is such a death "premature," even if the one who lays down her life is still capable of spiritual development? Even if it is premature, is it therefore unjustified? (Consider Graves's point about soldiers.) And why could the process culminating in suicide not be a growth in wisdom and goodness? I certainly believe I would embody more wisdom and goodness by ending my life than by clinging to my life and thereby ruining the lives of my family. Indeed, if I should face dementing disease, this decision may be one of the last serious opportunities for spiritual growth open to me.