EUTHANASIA

Tim Chappell explains "Why Euthanasia is in Nobody's Interest"

In *Harry Potter and the Chamber of Secrets*, Chapter 12, Harry is alone in Professor Dumbledore's office, where he finds "a decrepit-looking bird which resemble[s] a half-plucked turkey". Suddenly, to Harry's astonished dismay, the bird bursts into flames and dies. Harry expects Professor Dumbledore, who arrives at this point, to blame him for the spontaneous combustion and demise of his exotic pet. But Dumbledore's response is this: "About time, too… Fawkes is a phoenix, Harry. Phoenixes burst into flame when it is time for them to die and are reborn from the ashes. Watch him…"

Why is Harry dismayed when Fawkes bursts into flame? Because Harry doesn't understand the natural history of the (mythical) species *the phoenix*. Not understanding that, Harry fails to understand what is in the interests of a phoenix. It is a surprising fact about Fawkes that, at the time when Harry sees him, it is in his interest to burst into flame and die. The reason why is because Fawkes is a phoenix, and because periodic combustion and resurrection is part of what well-being is for phoenixes.

Moral: if you want to know what is in a given creature's interest, you need to understand what kind of creature it is, and what well-being is for that kind of creature. This is at least partly a matter of natural history.

Philippa Foot, in her book *Natural Goodness* expresses an idea very much like this, saying: "We invoke the [idea of what is necessary as a means to some crucial good] when we say that it is necessary for plants to have water, for birds to build nests, for wolves to hunt in packs, and for lionesses to teach their cubs to kill. These… necessities depend on what the particular species of plants and animals need, on their natural habitat, and the ways of making out that are in their repertoire. These things together determine what it is for members of a particular species to be as they should be, and to do that which they should do."

So what is in a *person's* interest? By the argument just given, the answer to that depends on what kind of creature a person is. All the persons we know about are *human beings*; a person, then, is a living human body. You might reply, "But there might be persons of other species – intelligent aliens. These persons would not be living *human* bodies." Correct. The right response is to widen the definition of persons: "persons are living human (or intelligent alien) bodies".

"But," you say, "how do we *recognise* persons? The case of intelligent aliens shows that persons are not recognised by their being living bodies, but by their displaying a particular type of psychology. So a person can't be simply a living human (or intelligent alien) body. A person must be at least a living body of some kind *that possesses a particular psychology*."

This doesn't follow. The criteria whereby we *first diagnose* a natural kind – water, say – may include for example wetness. It doesn't follow that water is essentially wet, still less that water *is* wetness. Similarly, the criteria whereby we first diagnose personhood need not be even *part* of the essence of persons. Still less need personhood be identified with the sum of those criteria. (See Saul Kripke's *Naming and Necessity*, pp.116 ff.) An unconscious person, a brain-damaged person, a person in a deep coma, might still be a person despite lacking a particular psychology. So the question becomes: What is in a human being's interest?

The answer is, of course, that human well-being is complex and multifarious. Human beings have such a wide range of different capacities and abilities that they might develop, in ways that would contribute to their well-being, that we hardly know where to start to draw up a list of human interests. But this much I think we can say. Promoting human *well-being* means developing human *nature*; and developing human nature means developing and exercising human *capacities and abilities*.

So should we say that what is in a human being's interest is "whatever develops and exercises human capacities and abilities"? Not quite, because some activities develop one human capacity while wantonly destroying or endangering some other (or others). Becoming a gladiator is very good for your hand/eye co-ordination, but only so long as you still have hands and eyes. So: what is in a human being's interest is whatever develops or exercises *some* human capacity (/capacities) or ability (/abilities) while not wantonly destroying or endangering any *others*. (I have defended this pattern of argument elsewhere – see 'further reading'.)

Now there are plenty of other risky activities besides being a gladiator – mountaineering, scuba diving, extreme skiing, whatever. Moreover, life is short. Whichever capacities or

abilities I choose to develop, there are bound to be others that I *don't* choose to develop. As a result of this neglect, those capacities may well actually perish altogether. (When I was eleven I had quite a nifty cover-drive, but now…) To my proposal that "What is in a human being's interest is whatever develops or exercises *some* human capacity (/capacities) or ability (/abilities) while not wantonly destroying or endangering any others", you might retort that I've begged the question of what counts as the *wanton* destruction, endangering, or neglect of any human capacity.

I certainly have begged that question. For present purposes, it doesn't matter. We don't need an account of wantonness to understand why *death* is not in any human's interests. I've said: "What is in a human being's interest is whatever develops or exercises *some* human capacity or ability while not wantonly destroying or endangering any others". This immediately implies that whatever does not develop or exercise *any* capacity or ability of a given human being, while destroying (wantonly or not) *all* of that human's capacities and abilities, can't possibly be in that human's interest.

But that's just how it is with death. Death neither exercises nor develops any human capacity or ability. Humans, like other physical objects, are not exempt from the law of entropy. That doesn't mean that humans have a *capacity* to die, or an *ability* that they exercise by dying. (Humans can go blind too, or suffer from collapsed lungs; but humans don't have a capacity for blindness, or an ability to get collapsed lungs.) What death does is destroy the human person. In the process, death destroys all the human person's capacities and abilities. Since a person's interests are all to do with developing and exercising these capacities and abilities, it follows that it is never in anyone's interest to die. In fact, dying is the most extreme possible negation of anyone's interests.

Now the commonest arguments in favour of euthanasia are these two:

(1) "Euthanasia should sometimes be administered, because it is sometimes in a patient's interest to die."

(2) "Euthanasia should sometimes be administered, because some patients choose to die, and we have no business interfering with their choice."

Let's look at these two arguments in turn.

Argument (1) fails simply because it is a mistake to think that it is ever in a patient's interest to die. Obviously, it might be in a patient's interest *to be freed from pain*, or from suffering or indignity. Also obviously, the only way to free the patient from pain (or whatever) might be to do something that causes or hastens her death. But what does that show? It shows that the palliative-care approach to those who are terminally ill and in great pain gets things exactly right, whereas the euthanasiac approach gets things crucially wrong. The palliative carer believes that he has reason to free the patient from pain, and in certain circumstances is prepared to accept the patient's death as a side-effect – possibly an *inevitable* side-effect – of pain relief. What the palliative carer does not think he has reason to do, unlike the euthanasiac, is aim at the patient's death, either as a means to releasing her from pain, or as an end in itself. The thesis that there is a crucial moral distinction between *aiming at* a consequence and *accepting* it (the principle of double effect) is often attacked, but it has not been refuted. My own defence of that principle is in 'Two Distinctions that do make a Difference', *Philosophy* 2002.

If death is never in anyone's interest, indeed is the negation of all interests, we can see why the palliative carer is right to see his reasons this way. There is no reason to do what is not in anyone's interest; and there is positive reason not to do what negates people's interests. So there is no reason to perform any act of euthanasia, and every reason not to perform it.

Meanwhile argument (2) says that "we have no business interfering with the choice" of patients who choose to die. This robust assertion that autonomy is paramount has a grand ring to it. But the grand ring has a hollow echo. We don't *generally* think that autonomy is paramount. We don't think that we are bound to respect people's freedom of choice anywhere and everywhere. If someone's autonomous choice is to rob banks, we think they should be stopped, not allowed to get on with it.

"Suicide Doctor" Philip Nitschke of Exit Australia, recently invented a new suicide machine with which users inhale carbon monoxide through their nostrils.

In short, we think that autonomy is paramount only where people are making choices that we *already* think are not seriously wrong. But I have just argued that the choice to kill a human being – yourself, or someone else – is seriously wrong. Ethics – at least, as it concerns humans – is all about promoting and respecting human interests, and avoiding doing what *negates* human interests; and killing is the ultimate negation of human interests. So if *anything* is wrong, killing humans is wrong. The idea that euthanasia can be justified by appealing to autonomy is no more plausible than the idea that bank-robbery can be justified by appealing to autonomy.

At the moment in the English speaking world, there is a vigorous and extensive publicity campaign "in favour of euthanasia and its legalization". To put it more plainly, there is a campaign in favour of the proposition that doctors should sometimes murder their patients, that wives should sometimes murder their husbands, that fathers should sometimes murder their children, and that no one should be prosecuted for any of these murders. At present most of the discussions of euthanasia that happen under the supposedly neutral aegis of 'analytic philosophy' merely reflect and repeat the slogans of this publicity campaign. Looking through much of the recent literature, or at some of the undergraduate courses in applied ethics that have been made available on the Internet, it would be easy to think that there simply aren't any serious philosophical arguments against euthanasia. Or that if there are arguments against euthanasia, they are only 'indirect' ones (thin end of the wedge, too easy to abuse the policy, etc., etc.), and not arguments that show *directly* that euthanasia is a bad thing. Or that, to be opposed to euthanasia, you have to be –

in the usual vague uncomprehending phrase – "religious or something".

On the contrary, there is at least one serious philosophical argument directly against euthanasia which has nothing whatever necessarily to do with religion, and everything to do with a question that enthusiasts for euthanasia usually skimp. This is the question I've pursued here: "What is in a person's interests?" Part of the right answer to that question, I've argued, is that euthanasia is literally in nobody's interest; indeed, it is the deliberate negation of *all* a person's interests. This makes euthanasia, in itself, seriously immoral. Since it is bad for our characters to spend much time entertaining seriously immoral proposals, please, let's spend no more time considering the very bad idea of legalising euthanasia.

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Other writings by Tim Chappell on this topic:
Understanding Human Goods (Edinburgh UP, 1998), Ch.3; 'The Implications of Incommensurability', *Philosophy* 2001; 'Practical Rationality for Pluralists about the Good', *Ethical Theory and Moral Practice* 2003.

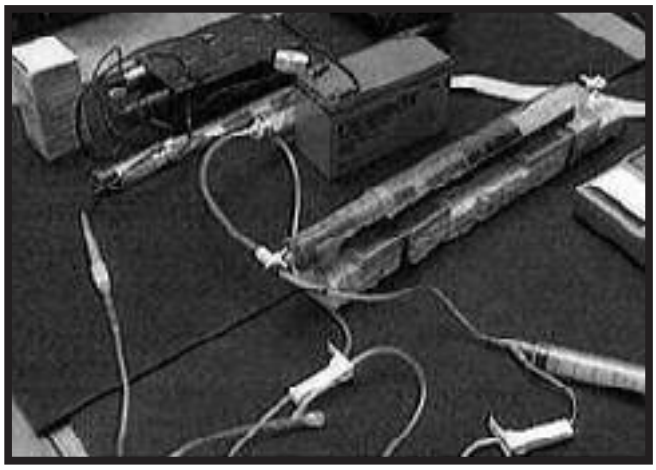
COUNTERPOINT: Jung's Reply to Chappell

Tim Chappell claims: "Since a person's interests are all to do with developing and exercising these capacities and abilities, it follows that it is never in anyone's interest to die. In fact, dying is the most extreme possible negation of anyone's interests." I doubt that one can take such a statement seriously in face of the fact that numerous people end their lives prematurely year after year. In the United States more than 50,000 people take their own lives every year. In Japan 37.9 persons in 100,000 commit suicide annually, in Switzerland it is 40.8, in Russia 74.3. Can one seriously claim that all these people are not in a position to recognize their own interests, and need uninvolved specialists (psychiatrists or philosophers) to enlighten them on their 'real' interests and goals?

I furthermore wonder: what are the life interests of a terminally-ill patient, who suffers from excruciating pain and has become incontinent? What goals and projects can he pursue when he lies in his feces, knowing that he has only a few days or weeks to live? This case is depicted in Sherwin Nuland's treatise *How We Die* (Vintage, 1997, p.231), a book that provides an array of similar instances. It is characteristic of the opponents of euthanasia that they never have the guts to discuss such concrete cases. Instead of condescending to the facts of real life, they argue for maintaining the taboo withwhich assisted suicide is laden, and for ending the debate.

"The thought of suicide is a great source of comfort: with it a calm passage is to be made across many a bad night."

-Frederich Nietzsche



The latest suicide devices are considered by many to be more dignified than the draw-string head bags of the past.

But if Chappell wants to end the debate, why does he join it by writing an article like this one?

The opponents of euthanasia are not vexed by pain or despair but they admonish patients to pull themselves together and "pursue their life interests" even if their state has become hopeless. The adherents of this view arrogate to themselves the right to question the autonomous decision of the patient. Chappell objects that a physician should not comply with every wish a patient voices. To underpin his opinion, he advances the following comparison: "If someone's autonomous choice is to rob banks, we think they should be stopped, not allowed to get on with it." It is clear that nobody is entitled to rob a bank because the bank is not his property. But a patient is certainly entitled to take his own life because it is his possession.

It is deplorable that tradition-oriented philosophers who rate liberty as the paramount value all too often exhaust themselves in lip service. They continuously quote John Stuart Mill and Isaiah Berlin but they shy away from the consequences a really free life involves. I have tried to point out at what conclusions you must necessarily arrive if you take the value of freedom seriously and comprehend humans as autonomous beings who decide on their own in the crucial situations of their lives. I am currently working out a book on this approach, entitled *Individualism: A Theory of Liberty*. (It is due to appear in early 2004.) There I argue that life in itself does not constitute a value because you have always to take its quality into consideration. The meaning of life is not living but being happy. If this goal is obstructed, if a person's life is replete with distress and devoid of any pleasure, and if it can be ruled out that he will ever regain a normal life, then he has the right to turn his back on this world. And I see no reason why, once the decision is made, he should be abandoned by his friends, counsellors and physicians.

Euthanasia Debate

Joachim Jung's "Withdrawing from Life" challenges Tim Chappell

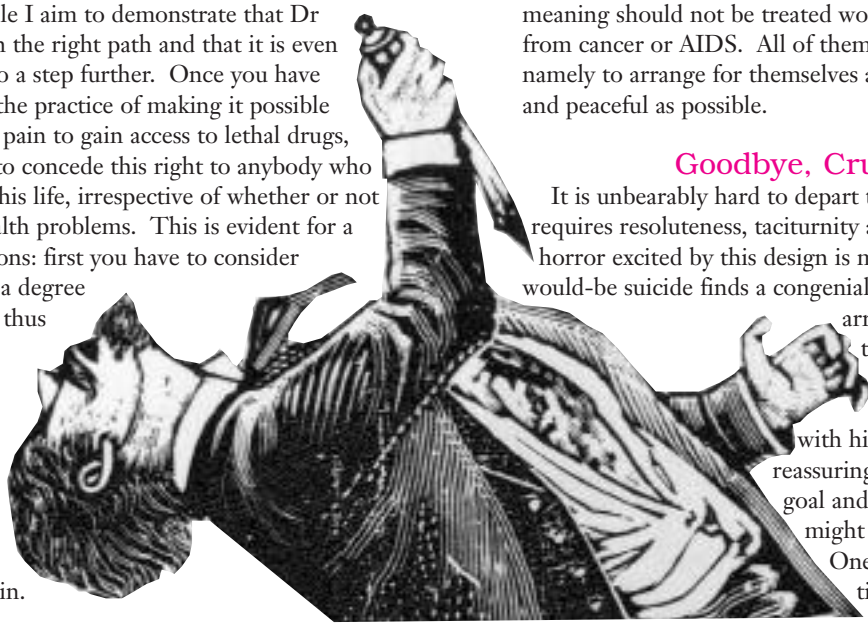
I believe that no man ever threw away life, while it was worth keeping.
David Hume, *On Suicide*

In no country is the application of euthanasia as widely accepted as in the Netherlands. As early as 1984 the Dutch Supreme Court sanctioned individual cases of euthanasia, some of them dating back to the 1970s. The progressive liberalization of assisted suicide culminated in a comprehensive euthanasia law passed by the Dutch Parliament on 10 April 2001. This Act stipulates that physicians can prescribe death-inducing drugs for patients who want to end their lives because they are "facing incurable and unendurable suffering" (*uitzichtloos en ondraaglijk lijden*). A commentary on this law by the Dutch Ministry of Foreign Affairs admits that "the extent to which suffering is unbearable is a highly subjective matter." Although the physician "attempts to assess the patient's suffering objectively," he is not in a position to track down the real motives underlying the patient's suicidal intentions.

Since the Dutch euthanasia act places high significance on the subjective feelings of the patient, it comes as no surprise that the law does not explicitly rule out the application of assisted suicide in cases of 'psychological suffering'. To date, only one case of this kind has become known. In 1993 the physician Boudewijn Chabot gave lethal medication to his patient Hilly Bosscher, a fifty-year-old woman who had suffered from severe depression for several years. Mrs Bosscher died in the presence of Dr Chabot and two witnesses. The Dutch Supreme Court subsequently disapproved of Chabot's actions but did not impose a penalty.

In this article I aim to demonstrate that Dr Chabot was on the right path and that it is even necessary to go a step further. Once you have acquiesced in the practice of making it possible for patients in pain to gain access to lethal drugs, you will have to concede this right to anybody who wishes to end his life, irrespective of whether or not he has any health problems. This is evident for a variety of reasons: first you have to consider that pain is to a degree subjective and thus isn't precisely measurable by the physician. Second, the hardships of life can cause more anguish and distress than bodily pain. "The most intense suffering can occur in the absence of physical pain – for example, upon the death of a child, the news of a fatal but not painful illness, the sufferings of a loved one, rejection by one's peers, separation or divorce, loss of reputation, or a traumatic lawsuit. The range of possibilities of suffering without physical pain is as broad as the range of untoward events that may affect any human at any time," writes the American bioethicist Edmund Pellegrino. The third reason for challenging undue emphasis on physical pain is that pain abatement has made great strides in the past few decades. According to a report by the World Health Organization, the pain of cancer patients can be sufficiently relieved in over 90 percent of all cases. In fact, pain only ranks second among the motives listed by Dutch patients who want to terminate their lives. The reason cited most frequently in a survey is the loss of dignity. In most cases the emotional stress prevails over the physical. This explains why paralyzed people who do not feel pain at all frequently think of suicide. Their quality of life is extremely reduced because they are divested of any privacy, which is an elementary prerequisite for the preservation of human dignity.

These considerations throw doubt on whether it is defensible to confine physician-assisted suicide to terminally ill patients. I shall argue that assisted suicide should become a civil right, granted to all human beings. Anyone who wants to end his life should be entitled to seek the support of a person who can procure the necessary drugs and accompany him on his last journey. People who, for whatever reasons, have come to the conclusion that their lives have lost all meaning should not be treated worse than patients suffering from cancer or AIDS. All of them have the same interest, namely to arrange for themselves a death that is as painless and peaceful as possible.



Goodbye, Cruel World

It is unbearably hard to depart this life alone. To do so requires resoluteness, taciturnity and iron discipline. The horror excited by this design is markedly alleviated if the would-be suicide finds a congenial partner, someone who has arrived at the same convictions, encourages him in his intention and is willing to depart this life together with him. Suicide pacts aim at reassuring each other in the common goal and dissipating doubts that might frustrate its realization. One such pact aroused international attention when in

February 2000 a young couple plunged from a cliff east of Stavanger in Norway.

The joint suicide was triggered by a twenty-year-old Norwegian whose name was not released. Seeking a partner ready to join him in death, the young man had posted an advertisement on a suicide web site. From among the people who showed interest, the Norwegian selected a woman of his own age from Upper Austria. After they had exchanged several emails, they became convinced that they were destined for each other. The girl travelled to Norway and met her new friend near Stavanger. On 19 February 2000, according to the Oslo daily *Aftenposten*, they headed for the Prekestolen, a projecting rock rising 1000 feet above the Lysefjord. The taxi driver who took them there later recalled that the girl was too lightly clad for the season and that the two of them wanted to camp at the site. Their tent was later found near the summit plateau. How long they stayed there, what they spoke of in their last hours and when exactly they executed their deed, nobody will ever know. Two days later, their corpses were discovered on a rubble field 500 feet beneath the Prekestolen.

When the rescue crew advanced to them, it discovered that they lay 22 yards from each other. This shows how difficult it is to die jointly. Probably the two gripped each other's hands and leaped together into the abyss. But the great shock that must have seized them in this moment and the resistance of the air tore them apart ... Certainly, partner suicides are extreme instances. But they prove that on the brink of death most people do not like to be left alone, particularly if they are to quit life of their own free will. Providing assistance in suicide is a precept of charity, implying advantages for both the perpetrator and society.

In the *first* place it is an asset for the suicide if a physician or a friend can attend or accompany him without facing legal restrictions. "It is crucial to have a companion with you in self-deliverance to give moral support and prevent mistakes or interruptions ... Having somebody present at this time ... is absolutely essential. Isolation at such a time is an inhuman experience," writes Derek Humphrey in his counselling book *Final Exit*. In most countries it isn't an offence to observe a person committing suicide without interfering. However, if the companion passes a glass of orange juice to the suicidal person to dissolve the death-inducing pills, or turns off the heating in order to accelerate the dying process, then he is *assisting* a suicide, which is a criminal offence in the majority of states. Therefore a suicide can rarely reckon on the support of his friends. They shy away from rendering him the services any dying person badly needs: having his hand held, his temples wiped, and hearing a few comforting words before he loses consciousness. Any act of solidarity with him risks a prison sentence. For this reason the suicidal individual is forced to die in solitude and to steal away from society like a thief.

The introduction of public support for suicidals would *secondly* have the advantage that death could be brought about in a swift and painless manner. Physicians or dependents who had been instructed accordingly would make sure that the suicide departed in a peaceful and decent way. He would be spared any recourse to violent methods which leave his body maimed, crushed or burned. Before somebody exits from life, he ought to consider for a moment the troubles his act might cause to uninvolved persons. Leaping from a cliff with a beloved partner is a romantic deed. Scratching the smashed corpses from the ground is far less romantic. Notwithstanding the numbing agony in which the suicide finds himself he should avoid shocking those who are in charge of salvaging his remains. Carrying out the act in a hospital or at home, under legal protection, would defuse its acuteness and render it a normal procedure, comparable to surgery or a birth.

This practice would *thirdly* make sure that the suicide really succeeds. There is probably nothing worse in the world than a failed suicide attempt that ends up in lasting and irreparable damage. The Austrian physician Eberhard Deisenhammer, who has investigated this issue for several years, records an array of tragic incidents. In one case a girl became a paraplegic when she jumped out of the window. A young woman who leaped in front of a train survived blinded and with severe facial lesions. A woman who sprang from a building endured multiple fractures and has suffered excruciating pain ever since. In all these cases it would have been best to dissuade the victims from their intention in time. Suicide counselling should aim at drawing endangered people back into life. It should imbue them with a new appetite for life. But if this fails, if the suicidal person has made the irrevocable decision to quit this world, it is better to help him carry out his deed perfectly, rather than to expose him to the risk of botching his suicide and surviving in a hopeless, wretched state.

Fourthly: A successfully accomplished suicide is also the least problematic solution for society. The cost of a burial is minimal compared with that of the lifetime care of a person who survives an attempted suicide crippled and incapacitated. Unlike the victim of an accident, the survivor can blame nobody but himself for his mishap. This is a shaming and depressing experience that in the worst case could overshadow the rest of his existence and makes life hell for himself and his loved ones. Professional suicide assistance would ensure that the interests of all parties were equally safeguarded.

The Gentle and Easy Death?

Physician-assisted suicide is nothing to be dreaded, as the practice in the Netherlands shows. Patients whose suffering has become unbearable are administered a potion consisting of pentabarbital, pure alcohol, water, propylene glycol, sugar syrup and a drop of aniseed oil. The bitterness of the liquid is offset by the sweeteners and its fishy taste is reduced by the aniseed oil. Normally the patient dies within thirty minutes, but in some cases the dying process lasts several hours or days, so if the patient is still alive after five hours the doctor administers Pavulon by injection. Pavulon, incidentally, is a derivative of curare, the poison used by South American Indians on the tips of their hunting arrows.

The patients making use of this treatment do not sense more than the bitter-sweet taste of the barbiturates or the prick of the syringe. Their death is swift and painless. There is no reason why this treatment should not be made accessible to any person applying for it. For this purpose public or private counselling boards for euthanasia should be established, which would advice their clients and help them master the technicalities of self-deliverance. The desire to put an end to life should be sufficient to process an application. During this procedure it would not even be necessary to infringe upon privacy by asking the clients for their motives. As the Hume quotation at the start of this article

suggests, anyone with a fixed intention to withdraw from life must have compelling reasons for this step. However, some safeguards should be incorporated into this mechanism.

Firstly, precautions should be taken to rule out any misuse of the fatal drugs. The lethal injection should be administered or at least checked by a person in charge. Secondly, the counselling committee should make sure that the applicant persists in his intention over a specified period. A person suffering from some temporary malady or short-term depression, however intense, should not be eligible for assisted suicide. Support should only be rendered to someone who is imbued with the firm determination to turn his back on this world. Thirdly, universal suicide assistance can only be realized in a welfare state. It is always appalling to hear about people who try to terminate their lives because they are no longer in a position to earn a living. To be sure, no society can provide complete protection against poverty. Debts, unemployment or wretched living conditions can occur even in the most affluent states, but welfare institutions at least minimize the danger of somebody's contemplating suicide for financial reasons. One of the centre-pieces of the welfare state is a system of health insurance that encompasses all citizens. Universal health insurance ensures that no patient is forced into assisted suicide, however lengthy and costly his treatment may be.

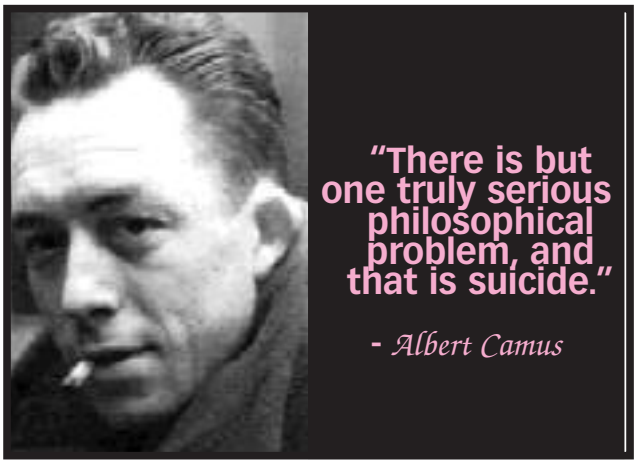
Of course, a comprehensive system of voluntary euthanasia will only be possible when a broad social consensus has been achieved. A person who is tired of life can demand to be put out of his misery, but no physician can be obliged to comply with his wish. The free decision of a doctor must be as much respected as the decision of the patient. Even in Holland a number of physicians steadfastly refuse to be drawn into euthanasia. Universal suicide assistance won't be established from one day to the next. It must be preceded by an extended discussion in the course of which it will become clear whether society is mature enough for this solution. All that is necessary today is to start the debate on this crucial topic and to overcome the taboo that surrounds it.

The Fate of Pioneers

This article shouldn't close without mentioning a man who has fuelled public debate on this issue in an unparalleled way: Dr Jack Kevorkian. From 1990 to 1998 Kevorkian assisted the suicides of some 130 people. According to press reports (Associated Press, 7 Dec 2000) the majority of them were not terminally ill. Five of them only simulated a disease to obtain Kevorkian's help. In September 1998 the retired pathologist induced the death of 52-year-old Tom Youk, who had been diagnosed with Lou Gehrig's disease. This action was recorded on video and broadcast by CBS. The tape showed something that Kevorkian did not deny, namely that it was he himself who administered the lethal injection to the paralyzed patient. This case of active euthanasia was classified as murder by the competent court in Pontiac, Michigan. In March 1999 Kevorkian was convicted of second-degree murder and given a prison sentence of 10-25 years. At present he is serving his term in a Michigan penitentiary, awaiting the first parole opportunity, which is due in 2007.

Jack Kevorkian shares the fate of numerous pioneers who were denigrated and derided when they came up with ways of thinking not in line with the views of their time. Mary Wollstonecraft was ridiculed when she published her *Vindication of the Rights of Women* in 1792. John Stuart Mill fared only marginally better when he claimed the suffrage for women in the middle of the 19th century. His stance was dismissed as a personal whim of an otherwise serious author. When in 1821 the Irishman Richard Martin put forward the idea of drafting a law against the cruel treatment of animals, his proposition was met with guffaws in the British Parliament. Nevertheless Parliament enacted a law on this matter a few months later. Soon afterward the Royal Society for the Prevention of Cruelty to Animals came into being, the first association of its kind in the world.

Today the masterminds of the right-to-die movement find themselves in the situation of the spurned pioneers of the past.



In the face of all opposition they are trying to convey the message that every individual is an autonomous being, who may decide on his own on the continuation of his life. The freedom of choice includes the right to give up if the troubles someone has to endure far outweigh the pleasures life normally involves. If the balance of life is negative, suicide is one possible resort. Trapped in this situation, a potential suicide should not be exposed to the incalculable risks of 'going it alone'. He should be granted the right to benefit from the most advanced methods and devices of medicine – a right that is a matter of course for any other dying person.

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Further Reading

• Derek Humphrey and Mary Clement, *Freedom to Die: People, Politics, and the Right-to-Die Movement* (St Martin's Griffin 2000)
• Derek Humphrey, *Final Exit: The Practicalities of Self-Deliverance and Assisted Suicide for the Dying* (Dell Publishing 1996)
• Linda Emanuel (ed.), *Regulating How We Die* (Harvard Univ. Press 1998). See particularly the chapters by Edmund Pellegrino, 'The False Promise of Beneficent Killing',and Paul van der Maas and Linda Emanuel, 'Factual Findings'.

COUNTERPOINT: Chappell's reply to Jung

If the problem is pain, the solution is pain relief. If the problem is depression, the solution is psychotherapy. If the problem is grief, the solution is comfort and support. If the problem is amputation, the solution is prosthesis. If the problem is loss of dignity, the solution is loving and respectful treatment. What is the problem to which death could be a solution? It would have to be life itself. But life is not a *problem*. Life is a gift.

Part of what it means to love other people is to be prepared to help someone with her problems – to act in her interests, as I put it before. Helping her with her problems can include providing pain relief, psychotherapy, prosthesis and so on. It cannot include helping her to die. For being alive is not one of her problems. It is the context of nearly all possible solutions to her problems.

"*Nearly* all" because, sadly, not all problems are soluble. Some terminally ill patients suffer terrible pain. In cases in which someone will die soon no matter what, nothing can be done to protect or promote her interest in being alive. But something *can* be done to promote her interest in freedom from pain. So here the doctor is justified in doing more to prevent pain, and less to preserve life, than he would for other patients. But this is not euthanasia. So long as the doctor's objective is pain relief, it is palliative care.

Why are euthanasia and suicide wrong? Because the worst thing you can do to someone is to violate her interests. According to the argument I put forth in my article, the deepest interest that we all have is our interest in existing. So the deepest violation of someone's interests that you can commit is to kill them.

Dr Jung's article offers no alternative account of interests except an unargued equation of interests and desires. But I say that we can desire what violates our interests; and that in extreme cases – like euthanasia and suicide – we should be legally prevented from pursuing it. Maybe Dr Jung will accuse me of paternalism here. Yet he himself thinks that people should be interviewed before being approved for suicide, to check that they really mean it.

So presumably he intends that those who are *not* approved should, as far as possible, be forcibly prevented from committing suicide. The difference between Dr Jung and me is not, then, the difference between a paternalist and a non-paternalist. So what is the difference? One difference is that Dr Jung apparently accepts what I call the "respectable view of the self." Like many other philosophers, he assumes without argument that individual persons have no value in themselves; they are merely receptacles for the instantiation of value and disvalue.

No wonder, then, that he thinks persons who fail to instantiate positive value are disposable. His way of thinking treats the person as a means to an end, the end of utility maximisation. I call this "the consumerisation of the self," and I reject it. Individual persons are not just possible pleasure-receptors. They are goods in themselves.

Another difference is that Dr Jung is fixated on death. He finds suicide romantic, and advocacy of suicide heroic. In one way, this is just silly. In another, it is sad and disturbing. Any agent who can choose to act at all is always confronted with an indefinite multiplicity of alternative options. That Dr Jung, like too many others, finds our relatively small range of murderous options so hypnotically attractive, and our enormous range of non-murderous alternatives so completely invisible, says something very worrying indeed both about him, and about the society that makes his view seem plausible to him.