Should physician-assisted death (PAD) be decriminalized?
医生协助死亡应否非刑事化？

Hon-Lam Li (李翰林)

Emeritus Professor, Dept. of Philosophy, The Chinese University of Hong Kong

Advisor, CUHK Centre for Bioethics

Affiliate Professor, Dept of Bioethics & Humanities, University of Washington School of Medicine

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Terminology

1. Physician assisted suicide (PAS)
2. physician assisted death (PAD)
3. medically assisted suicide (MAS)
4. medical assistance in dying (MAID)

They all refer to the same thing.

I shall use “physician assisted death (PAD).”

For my talk today:

- Decriminalization (非刑事化）= Legalization（合法化）

Physician-assisted death (PAD) vs. Voluntary euthanasia

- **PAD** (by swallowing a lethal pill) is committed by a patient, with the assistance of a doctor.
- **Euthanasia** (e.g., a lethal injection) is committed by a doctor.
- PAD offers a terminally ill patient ***peace of mind*** (in case the suffering gets too unbearable and he/she wants to die).
- PAD is better, because a patient **may not really want to die**.
- Some patients (e.g., someone **paralyzed** or too feeble to take the lethal pill), however, can resort to only euthanasia.

Gerald Dworkin

Gerald Dworkin:

- Ethical issues in medicine are generally difficult. But assisted suicide is not one of them.

Let us be clear. We are talking about patients who are:

(1) **Terminally ill** (with less than 6 months to live);

(2) **Experiencing unbearable suffering** (for which there is no adequate remedy); and

(3) Competent adults who are **persistent** in wanting **to die**.

David Benatar:

- “To be forced to continue living a life that one deems intolerable when there are doctors who are willing either to end one’s life or to assist one in ending one’s own life, is **an unspeakable violation of an individual’s freedom** to live—and to die—as he or she sees fit.”

- There are **good arguments** for the conclusion that PAD (Physician-Assisted Death) should be allowed by the law (especially if a patient is terminally ill, experiencing unbearable suffering, and is competent and persist in wanting to die).
- Today, I do not have time to talk about these.
- Instead, I will focus on the **objections against PAD**, and explain why these objections are not good ones.

Objection 1:

"If killing is wrong, it must be wrong in all circumstances."

- This objection is highly implausible. The meaning of an act depends on the circumstances (or the **context**) in which it takes place.

Example 1:

- If John **tells a lie** in order to steal money from a beggar, that is clearly wrong.
- But if John **tells a lie** in order to save Mary's life, that is totally different.

Example 2:

- (**Murder**) Intentionally killing an innocent person who wants to live is (morally and legally) wrong.
- (**Self-defense**) To kill a malicious aggressor who is attempting to take your life is morally permissible (and legally justified).

Conclusion:

- Whether or not killing is wrong **depends on the context.** (“**Moral Contextualism**”) Moral contextualism is true.)
- In this case, we are considering a patient who is terminally ill, experiencing unbearable suffering, and persist in wanting to die.
- PAD is--or (at least) can be--in his/her **interest**.

Objection 2: The slippery slope argument (the theoretical version)

- "If there is a right to PAD, why limit it to patients dying in **pointless suffering**?
- Why not extend **active euthanasia** to dying patients who are so feeble or paralyzed that they cannot take the pills themselves but who beg a doctor to kill them by, say, injecting a lethal drug?
- And why not extend PAD to patients who are not dying but face years of **intolerable physical** or **emotional pain**, or **crippling paralysis** or **dependence**?
- Finally, why not extend it to anyone who has formed a desire to die—such as a 17-year old suffering from a severe case of **unrequited love**?" (from Ronald Dworkin, et al., "The Philosophers' Brief")

This argument (the theoretical version) is grounded in (*a priori*) **logic**.

- Suppose an 18-old is deemed an adult. Using the "slippery slope" reasoning, it could be argued that one day does not make any difference, and hence that it is **arbitrary** to say that someone who is 17-year-and-364-day old is not an adult.
- But this argument could go on and say that someone who is 17-year-and-363-day old is also an adult. In fact, this would go all the way to someone who is 7-year old, and he/she is clearly not an adult. So there is no such thing as adulthood!!!
- If the slippery slope argument **were** good, there would be no such thing as adulthood. But this is absurd. The slippery slope argument is not a good one.

This slippery slope argument (the theoretical version) is:

(1) If the law allows PAD, there is **no natural** or ***non-arbitrary*** **line** to draw between cases where PAD should be legalized and those where it should not be.

(2) Therefore, PAD must be either allowed, or disallowed, **for all cases**.

(3) Allowing PAD **for all cases** is worse than disallowing it **for all cases.**

(Conclusion): Therefore, PAD must be disallowed for all cases.

- The theoretical version of the **slippery slope argument** is grounded in logic. It is closely related to the Sorites Paradox (the Paradox of the Heap), which is universally acknowledged to be a fallacious argument.

Premise (2) is problematic.

- (If Premise (2) were correct, the same problem would arise for any law that allows certain conduct for adults, but not for minors, since there is no natural or non-arbitrary line separating those who are adults and who are minors. If one says an 18-year old is an adult, but one who is 17-year-and-340-day old is not, the same logic would lead to the conclusion that such line-drawing is arbitrary.)
- **It is false that, simply because there is no natural or non-arbitrary line (separating cases that should be allowed and those that should not be), the law must either criminalize all cases, or decriminalize all cases.**

- The law does not and cannot make all and only moral wrongs crimes.
- For a variety of perfectly good reasons, the law cannot criminalize all moral wrongs; similarly, the law must forbid some classes of acts that are not wrong at all.
- (In the case of PAD) **The court should try to identify a range of cases where PAD is not wrong.**
- **Although this might be time-consuming, it is preferable that the court do this than to outlaw PAD in a blanket sort of way.**

It is enough:

- (1) that the cases are **clearly marked out**, and
- (2) that the cases marked out are clearly cases where assistance in committing suicide is **desirable**.

It is not necessary that every case where assistance is morally desirable should be included.

Objection 3: Slippery Slope Argument -- the Practical Version

Unlike the theoretical version, the **practical version** of the slippery slope argument is grounded in **empirical** prediction, and not in logic. It goes as follows.

- In a community, if a certain practice (A1) is allowed, A2 will as a matter of fact happen, which will then lead to A3, and perhaps A4 as well.
- Assuming that A2, and especially A3 and A4 are highly undesirable consequences, this argument—**if supported by empirical evidence**—would undermine the attempt to decriminalize A1 in this particular community.

- Proponents for this argument claim that if **PAD** is decriminalized (A1), it will be only a matter of time before **voluntary euthanasia** will be decriminalized (A2) as well.
- **Non-voluntary euthanasia** (A3) and perhaps **involuntary euthanasia** (A4) will eventually be legalized.
- They claim that voluntary euthanasia is bad, but non-voluntary and especially involuntary euthanasia are much worse.
- So they claim that PAD should not be legalized.

- Note that **voluntary euthanasia** for a terminally ill patient, experiencing unbearable suffering, persistent in wanting to die is not wrong but morally permissible.
- Whether or not **nonvoluntary euthanasia** is bad for someone depends on the context. (If someone has been in a **coma for months**, with no chance of regaining consciousness, why should nonvoluntary euthanasia be impermissible?)
- **Involuntary euthanasia** is evil. (**Hilter** ordered involuntary euthanasia of 180,000 psychiatric patients, according to one estimation.)

- Unlike the theoretical version (which is logically suspect), the practical version relies on empirical data, and is not a fallacious argument.
- Therefore, the persuasiveness of the practical slippery slope argument depends on whether there is any empirical evidence to support it.
- Stephen Smith (2005) has looked at the empirical evidence in the Netherlands and in the state of Oregon, and concludes that there is **insufficient evidence** to support the practical slippery slope argument in these places.

- Just because the practical version might **conceivably** be justified in a particular community (which is, say, **corrupt** and bankrupt), it does not mean that it is justified in other communities.
- Should the law prohibit PAD because of the **fear** that the practical version might turn out to apply in our community?

- Tha answer is no. We need substantiated evidence, or real reasons, for thinking that PAD will lead to more than a few cases of **involuntary euthanasia** in our community, and not just the **possibility** that this might happen.
- Just as several cases of dangerous driving should not lead to the banning of driving altogether, so we need more than a few cases of involuntary euthanasia to outlaw PAD -- if indeed PAD does lead to involuntary euthanasia at all. (But there is currently no evidence to suggest that PAD would lead to even one case of involuntary euthanasia.)

Objection 4: Abuse & Other Bad Consequences

- **One problem** is "**psychological anxiety**" – or pressure -- on the part of the **patients** if their physician raises the topic of PAD and euthanasia.

We can resolve this problem in the following way:

- If PAD is legalized, a hospital would need to let eligible patients know of its availability—perhaps in the form of **information sessions** **or** **pamphlets**—because patients have the right to **know** about PAD, and the right **not to opt** for it.

- Anyone attempting to **pressure** a patient to choose PAD should commit a **criminal offence**.
- The law should **disallow** physicians to raise the topic of PAD with individual patients, **unless a patient raises it first**.
- Finally, the law should require **two non-attending physicians** to authorize assisted suicide. Part of the function is to **prevent abuse**, whereas another is to **screen off** those who do **not genuinely want to die** from **those who do**. (See Ronald Dworkin, "Assisted Suicide: The Philosophers' Brief.")

- **Another problem** has to do with the suspicion that, although PAD is supposed to be a **“last-ditch” intervention** (justified only after appropriate palliative options are attempted), PAD would be used before **all palliative measures** are utilized.
- This fear has **not materialized** in the **Netherlands**, where two-thirds of requests for PAD or voluntary euthanasia have been **rescinded**, often as the result of **palliative interventions**.

- There is also **little evidence** in Oregon to suggest that vulnerable groups there had been given prescriptions for lethal medication **in lieu of palliative care**.
- On the contrary, physicians' experience with the Oregon Death with Dignity Act (1997) is that **physicians are generally more aware of the patients' need to receive palliative care** and consequently that **patients tend to receive better palliative care**.

- According to one study, “physicians grant **1 in 6** requests for a prescription for a lethal medication, and that **1 in 10** requests actually results in suicide. Substantive palliative interventions lead some—but not all—patients to change their minds about assisted suicide” (Ganzini 2000; Ganzini 2001).

- Third, a reason often used to object to PAD is that terminally ill patients, especially those from poor families, will be under **pressure** to opt for PAD so that their families will be relieved of **financial burden** as well as the **burden to visit them**.
- There are **no accurate studies** of the number of those who would opt for PAD because of family pressure.

- Moreover, one might wonder why, if such pressure exists, should a patient not seek alternative ways to end her life.
- One such option is the **refusal** to be saved at all.
- Another is the option to **withdraw** from life-saving equipment.
- Both of these options are **crueler** than PAD, because the pain associated with the dying process is dragged out.

- (Opponents of PAD might argue that it is more difficult for terminally ill patients to die with life-saving equipment **withdrawn**, than to die by **PAD**.
- If this is correct, it is also fitting to remind such opponents not to say that terminally ill patients can die by **withdrawal** of such equipment -- because the dying process is drawn out and crueler).

- Finally, an opponent of PAD might argue that if PAD is not legalized, one could opt for **terminal sedation**, which is legal (in most countries).
- In reply: many patients would **not** prefer terminal sedation to PAD because one's life is **dragged on** for a longer time, unconsciously, even if painlessly.
- Moreover, one might lose **dignity** in the process.

Objection revisited: Patients would opt for PAD so that they would not burden their families or their adult children

Should we reject PAD because we believe that some patients would opt for it in order **not** to **burden their families or their adult children**?

There are 2 kinds of cases:

- **External pressure** – whether from hospitals, or from one's family or adult children – should be criminalized.
- **Internal pressure** – from one's moral conscience (or sense of duty) that one should die in order not to burden one' family or children – cannot be criminalized.

- We **do not know** how many patients would be **pressured** into accepting PAD, as opposed to those who would **benefit** from PAD.
- If the numbers are equal, surely the benefit of not having to drag through **unbearable**, **meaningless** and **seemingly endless** pain and suffering is much more important than the wishes of those who would **succumb** to family or hospital pressure into accepting PAD.

After all, the remedy to the evil of external pressure lies in:

- (1) the **legal measures** against undue influence on the patients to choose PAD;
- (2) **educational sessions** on patients' rights; and
- (3) **screening measures** to distinguish between those in **genuine need of PAD** and those who simply "feel the heat" from their families or hospitals.

“Moral” patients

- It is conceivable that some patients would opt for PAD in order not to burden their familes or their adult children, if PAD is decriminalized, but not if PAD is banned -- out of a sense of **duty**.
- According to this objection, they would opt for PAD **voluntarily**.

- Suppose patients who would be **pressured** by the own conscience into choosing PAD outnumber those who would benefit from it by a factor of, say, **five to one**.
- Would a ban on PAD be justified?
- The question is whether those who are pressured by their own conscience into choosing PAD could reasonably reject the **decriminalization** of PAD, as well as whether terminally ill patients experiencing unbearable suffering could reasonably reject the **ban on PAD**.

- (I am adopting the contractualist moral framework, according to which an act, policy, or law is morally impermissible if it is disallowed by a principle which no one could reasonably reject.
- For a discussion on contractualism, see Hon-Lam Li, “Contractualism and the Death Penalty.”)

- If legal measures against **external pressure** are effectively implemented, can a very **“kind”** or **“considerate”** patient who does not want to burden his family, pretending to be entirely willing to choose PAD, reasonably reject the decriminalization of PAD?

- I would think not, because his decision is (at least to a considerable extent) **voluntary**, and hence he is **responsible** for his own choice for PAD.
- It would be **a bad joke** to say that, having pretended to want to die by means of PAD, out of a sense of duty, this person can now reasonably reject PAD.
- On the other hand, terminally ill patients experiencing unbearable suffering **can reasonably reject** **a ban on PAD**, if only because their suffering is unbearable and unavoidable.

- In sum, if adequate measures are in place, a ban on PAD cannot be justified to terminally ill patients in unbearable suffering who have repeatedly asked for their lives to be terminated.
- We owe it them to have PAD decriminalized and make PAD available as an option.

Objection 5: Argument from Hippocratic Oath

- For the reply to the argument from Hippocratic Oath, see Hon-Lam Li, “Replies to Farrell & Tham, and to Fan,” in Hon-Lam Li & Michael Campbell, eds., *Public Reason and Bioethics*, op. cit., 154-156.

Q&A: Objection & Reply: The Slippery Slope Revisited

- **Question**: In some countries, such as the Netherlands, assisted suicide or euthanasia might be granted in cases where the patients suffer from mental illnesses. This is a clear case confirming the presence of a slippery slope. Consequently, the argument in favour of assisted suicide where a patient is terminally ill, experiencing unbearable suffering, and persistent in dying is objectionable because it would or might lead to cases down the slippery slope.

Reply:

- First, as Bernard Williams (1995) points out, although it is illegitimate to slide all the way down a slippery slope (e.g., allowing a 17-year old suffering from a severe case of unrequited love to receive assisted suicide), it is all right to slide a little bit. The slide from the condition of terminal illness to a **severe** mental illness can fall within Williams' conception of sliding a little bit, since this case is not far from the top of the slope.

- Second, whether the law should allow any kind of slide is something that a community should deliberate over, before a decision is reached and sanctioned by law. Communities can legitimately reach different decisions. Thus, while euthanasia can be extended to a case of severe mental illness in the Netherlands, another community (e.g., Germany, which still bears guilt for the the Holocaust) might allow assisted suicide but flatly reject any form of euthanasia.

- Third, what does not follow from the Slippery Slope Argument is that just because (a) it would be absurd to allow a 17-year old falling out of love to have assisted suicide, or just because (b) it would be horrible for a community to witness involuntary euthanasia on a daily basis, assisted suicide (and euthanasia) must be prohibited under all circumstances.

This talk is based on the following published materials:

- Hon-Lam Li, “What we owe to terminally ill patients: the option of physician-assisted suicide,” *Asian Bioethics Review* (Sept 2016), vol. 8, no. 3, pp.224-243.
- Hon-Lam Li, “Rawlsian Political Liberalism, Public Reason, and Bioethics,” in Hon-Lam Li & Michael Campbell, eds., *Public Reason and Bioethics: Three Perspectives* (London: Palgrave Macmillan, 2021), pp. 3-57. See also the following pages for discussions on the Hippocratic Oath and Velleman’s argument from dignity respectively: pp. 154-156; 215-218.

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For discussions on “Moral Contextualism,” see:

- Hon-Lam Li (2021), “Replies to Farrell and Tham,” in Hon-Lam Li, et al., *Public Reason and Bioethics: Three Perspectives* (London: Palgrave Macmillan, 2021), 145-164.
- Hon-Lam Li (2021), “Further Reflections,” in Hon-Lam Li, et al., *Public Reason and Bioethics* (London: Palgrave Macmillan, 2021), 220-232.

For discussions on “Hippocratic Oath,” see:

- Hon-Lam Li (2021), “Replies to Farrell and Tham,” in Hon-Lam Li, et al., *Public Reason and Bioethics* (London: Palgrave Macmillan), 154-156.

For discussions on Velleman’s argument on dignity, see:

- Hon-Lam Li (2021), “Further Reflections,” in Hon-Lam Li, et al., *Public Reason and Bioethics* (London: Palgrave Macmillan), 214-218.

For a discussion on Contractualism, see:

- Hon-Lam Li (2017), “Contractualism and the Death Penalty,” *Criminal Justice Ethics*, 36:2, 159-163. DOI: 10.1080/0731129X.2017.1358912

THANK YOU!