Choose Not to Live as an “Ultimate Excercise of One’s Right to Privacy”

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I have adhered to the Honor Code for this assignment. - Satoru Uchida

Rights of privacy focus on an individual's freedom to be autonomous[1]. In medical contexts, it is a right that would presumably apply only to competent patients[2]. In the argument for euthanasia, Pence inserted the word from Elizabeth Bouvia when she was appealing to the California Court for her right to conduct euthanasia, "A desire to terminate one's life is probably the ultimate exercise of one's right to privacy." And the Court ruled in her favor[3]. But this case was exceptional, not generalizable.

How about suicide, not euthanasia? In the US, no law prohibits suicide. A few countries prohibit suicide based on historical legacy or religious ethics[4]. I will come back to this perspective later. The fact that many countries do not prohibit suicide implies that society, politics, and courts in those countries may not regard living as an absolute good, and individuals are not obliged to live. It might even insist life is not an absolute good if taking one's life by themselves is legal. One's autonomy can decide whether to live or not. Then what prohibits the choice of not to live, especially under the assumption of life as relative good? Why not legalize active euthanasia for anyone who is suffering physical and psychological pain and seeks to end their life? As Pence mentioned, killing oneself is not easy.[5]

Think about taking human life from different perspectives. Abortion is a somewhat controversial topic in the States, but most European countries have legalized abortion as a woman's control over their body. We consider it ethical to take away the human lives of fetuses

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[1] Britannica, T. Editors of Encyclopaedia. "Rights of Privacy." In Encyclopedia Britannica, 2024.
[2] Gregory E. Pence, *Medical Ethics: Accounts of Ground-Breaking Cases* (McGraw-Hill, 2016), 61.
[3] Gregory E. Pence, *Medical Ethics: Accounts of Ground-Breaking Cases* (McGraw-Hill, 2016), 23.
[4] Ali Hasnain. "Suicide is Not a Crime — Countries must Stop Treating it as One," Al Jazeera, October 10, 2022, Accessed April 29, 2024, https://www.aljazeera.com/opinions/2022/10/10/suicide-is-not-a-crime-countries-must-stop-treating-it-as.
[5] Gregory E. Pence, *Medical Ethics: Accounts of Ground-Breaking Cases* (McGraw-Hill, 2016), 39.

under the autonomy of human beings to whom the life belongs. Then why is it unethical to take away human beings' human lives based on their autonomous choice?

There are many concerns around this topic, and I will not focus on some of them for this paper. For those who have impaired cognitive functions, including people with disability, children and adolescents, older adults, and any other forms of neuropsychological dysfunctions, I would oppose the idea that we should accept their decision not to live based on nonmaleficence. This paper is too short to argue those complex discussions around cognitive capability and respect for autonomy. It is also hard to define who is cognitively capable. Many arguments are going on about how to protect people with impaired or immature cognitive functions, such as old, young, and severely disabled. However, this is also a problem that medical professionals and ethicists argue in various clinical settings, so the same principles and general rules apply here. The age or means to determine one's autonomy varies State by State, so the decision of suicide does.

Pence mentioned cognitive criteria of brain death, which might help to shape a vague definition of who is cognitively capable. This criteria "identifies a philosophical core of properties of persons (commonly includes reason, memory, agency, and self-awareness) and assumes that without such a core, a human body is no longer a person."[6] In other words, a philosophical core of properties consists of a cognitively capable person. It aligns with Exuextive

[6] Gregory E. Pence, *Medical Ethics: Accounts of Ground-Breaking Cases* (McGraw-Hill, 2016), 69.

Cognitive Functions, the prerequisite to any purposeful and goal-directed action[7]. I believe these somewhat clear but vague definitions work fine for this paper.

I have to pay attention to huge debates among the requests to die from those who have disabilities. Batavia, who also has a disability, insists that not recognizing one's right to choose is dehumanizing disabled people[8]. Disability advocates argue people with disabilities are led by society to choose to cease to live, so medical practitioners should not recognize requests to die from people with disabilities. Golden and Zoanni mentioned the considerable problem of legalizing assisted suicide in the US, where insurance companies take a significant role in patient's lives.[9] Again, I will not take my position over this argument in this paper, but we should carefully consider one's relationship with society in the cases of requests to die.

There are multiple reasons not to accept one's request to die. First of all, religious ethics casts a huge concern over this problem. As I mentioned earlier, some countries ban suicide because of religion. One easy circumvention is to reject religious ethics as outdated or conservative thoughts. However, I am constructing my argument over principles of medical ethics, which are deeply connected with religious ethics. Dealing with religious ethics, we are allowed to interpret to some extent. Farley, for example, made a clear point that human life is not absolute good and does not have supreme value for humans. Farley focuses on moral distinctions between active and passive euthanasia and direct and indirect active euthanasia. Her argument is

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[7] Yana Suchy, Rosemary E. Ziemnik, and Madison A. Niermeyer, "Chapter 22 - Assessment of Executive Functions in Clinical Settings." In *Executive Functions in Health and Disease*, edited by Goldberg, Elkhonon (San Diego: Academic Press, 2017), 551-569, doi:10.1016/B978-0-12-803676-1.00022-2.

[8] Andrew I Batavia. "Disability and Physician-Assisted Dying." In *Physician-Assisted Dying - the Case for Palliative Care and Patient Choice*, edited by Quill, Timothy E. and Margaret P. Battin (Baltimore, MD: Johns Hopkins University Press, 2004), 55-74.

[9] Marilyn Golden and Tyler Zoanni. "Killing Us Softly: The Dangers of Legalizing Assisted Suicide," *Disability and Health Journal* 3, no. 1 (2010): 18.

aimed at euthanasia and assisted suicide and their moral problems, but it is able to apply her argument to suicide or request to die[10]. It is the choice to reduce physical or psychological pain, and human beings are subjected to die sooner or later in any case.

Bleich took a different approach. He mentioned the idea of "social death" as an individual's capacity to serve as a useful member of society. This is an ethically controversial idea, but it could be an alternative to religious ethics.[11] Rachels focuses on two points while insisting active euthanasia may be humane in some cases: active euthanasia may be more humane in some cases, and not to do something is to do something. Through the article, Rachels reveals that the moral distinction between direct and indirect active euthanasia is vague because indirect euthanasia is the result of the decision not to continue medical treatment.[12] Then, what is the difference between chronic physical pain caused by illness and psychological distress? Why do we allow active euthanasia only in cases with chronic pain caused by illness and exclude psychological chronic illness?

Some advocates for people with disabilities say those who want to die need to learn to live with dignity.[13] Doesn't it violate autonomy? Our society embraces diversity and respects one's thoughts unless it harms someone. The idea that someone doesn't know how to live with dignity itself dehumanizes its targets by teaching them how to live as humans.

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[10] Margaret A Farley. "Issues in Contemporary Christian Ethics: The Choice of Death in a Medical Context." In *Moral Issues and Christian Response*, edited by Paul T. Jersild, Dale A. Johnson, Patricia Beattie Jung and Shannon Jung (Harcourt Brace College Publishers, 1998), 417-429.
[11] J. David Bleich. "The Quinlan Case: A Jewish Perspective." In *Jewish Bioethics*, edited by Fred Rosner and J. David Bleich (KTAV Publishing House, Inc., 2000), 285-296.
[12] James Rachels. "Active and Passive Euthanasia." In *Classic Works in Medical Ethics*, edited by Gregory E Pence. (McGraw-Hill, 1998), 21-26.
[13] Gregory E. Pence, *Medical Ethics: Accounts of Ground-Breaking Cases* (McGraw-Hill, 2016), 21.

Golden and Zoanni insisted that psychological pain caused by physical pain is not enough to request to die by arguing that the attempt to justify active euthanasia is dangerous. They wrote, "most patients requesting death do so not based on physical symptoms such as pain but rather based on depression and other forms of psychological distress." I would argue psychological pain could be a reason to request suicide because there is no pain reliever targeting psychological pain. They quoted the sentence of H. Rex Greene, M.D., "The wish for death is a 'cry for help.'"[14] What if there is no help available?

Quill makes stronger arguments. Quill defined killing as an act with the desire to destroy a person's essence, while physician-assisted suicide is an act to protect dignity.[15] Cease to live may be the protective way to preserve one's essence before it is destroyed.

People against a request to die sometimes say suicidal thoughts are caused by society and that people should wait until society gets better. Historically, it is hope-fraud. Based on the history of the social justice movement, despite some exceptional successes in reducing racial and sexual biases, it is more likely that our society will not solve most of the problems in a generation. Who wants to live without hope? Is it ethical to tell an unrealistic gospel to prevent suicide? If it is not ethical, I would argue there is no reason to force someone to live longer with internal and external negative experiences.

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[14] Marilyn Golden and Tyler Zoanni. "Killing Us Softly: The Dangers of Legalizing Assisted Suicide," *Disability and Health Journal* 3, no. 1 (2010): 23.
[15] Timothy E Quill. "The Ambiguity of Clinical Intentions." *The New England Journal of Medicine* 329, no. 14 (Sep 30, 1993): 1039-1040.

Request to die has been controversial because of the idea that human lives belong to God, country, or someone else who is not themselves. As technology evolves, we are gradually shifting the idea that human life belongs to human beings and that human beings have right to decide whatsoever happens to them, including fatal decisions. If we regard one's autonomy as a superior value, admitting suicide and providing adequate support for that decision is one of the barriers we have to overcome to achieve a highly autonomous society.

Is it a slippery slope to a society where people cease to live before they reach their natural termination? I am not sure. I am not sure what natural death is for human beings with advanced medical technologies. It is possible to interpret that every death is natural regardless of when and how people die because death is natural. So far, I am only focusing on ending one's life, not extending one's life to eternity. I believe, then, ethicists face an actual ethical question when medical technology finds the path to gain eternal life without paying atonement.

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