

Assisted Suicide and Unassisted Suicide: What's the Difference?

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Introductionⁱ

Discussions about whether or not to legalize assisted suicide often do not take into account the fact that unassisted suicide is already legal.ⁱⁱ Failure to consider this fact may be problematic: unless there is a significant difference between assisted suicide (AS) and unassisted suicide (US) that justifies prohibiting the former while permitting the latter, one must either accept an inconsistent position or reconsider that position.ⁱⁱⁱ

I shall begin by considering three reasons often given for prohibiting AS: the tragic death; preferred alternatives; the social good. I argue that these reasons are equally applicable to US; therefore, one must either also argue for prohibiting US or accept inconsistency.

(1) The Tragic Death

Some argue against legalizing AS on the grounds that people will die, tragically, acting on a decision made in a despairing moment: "The likelihood of confusion, distortion or vacillation would appear to be serious drawbacks to any voluntary plan" (Kamisar 119).

But this is as true for US--as far as consequences are concerned, there are no significant differences between AS and US: in both cases, a death results--a death that may be considered sad, premature, avoidable, perhaps even the regrettable result of a 'bad' decision.

However, we have already decided that a person has the legal right to decide, despairingly or not, whether or not to end his/her life. Proponents of this argument against legalizing AS must therefore either accept the resulting inconsistency or must further argue to illegalize US as well.

(2) Preferred Alternatives

Others argue against legalizing AS on the grounds that the better solution is to improve the standard of care for the terminally ill and the severely disabled so they won't want to choose death; counselling is another often mentioned preference. Speaking specifically of palliative care, Dudgeon says that "Although there are many problems when it comes to pain control, I submit that euthanasia is not the answer. ... What is called for are the following: improving medical and public education that pain is treatable; increasing access to teams of professionals with expertise in symptom management; and increasing funds for research in pain and symptom management" (Dudgeon 84).

But again, this is as true for US: there are alternatives, such as psychological or philosophical counselling, or even employment, which may be preferable to suicide.

And again, however, we permit US despite the same availability of alternatives. Surely even the person committing unassisted suicide may be better off with psychological or philosophical counselling, a rehabilitation program, or a good job, but we don't therefore prohibit US. So once again, advocates of this argument against legalizing AS must, to be consistent, argue as well to prohibit US.

(3) The Social Good

There are many variants of this argument, but all conclude that AS is not to be legalized on the grounds of some social good that transcends personal autonomy. Some claim that no one should have the right to unilaterally make a decision that will affect others: "We are individuals living in a society, a community and the community has rights when it comes to an individual member's behaviour. Our whole society is based on this, and one person's actions can set off emotions or consequences for his family and his immediate neighbours in the community" (Dionne 13:12, Senate Report 56).

Making a slightly different case, some claim that legalizing AS contradicts the social value of respect for life and on that ground argue for prohibiting AS: "Euthanasia and assisted suicide are contrary to the basic respect for human life which is at the core of societal values" (McGregor 4:55, Senate Report 55).

Not only does legalizing AS contradict respect for life, it also contradicts the sanctity of life, another societal value; again, the argument goes, AS should therefore be prohibited.

Again, all advocates of some social good seem to have forgotten that by allowing US, we already allow personal autonomy to override the social good, however it may be defined. To prohibit AS on this ground requires, then, reconsidering the permissibility of US or accepting an inconsistency.

I next explore two possible distinctions between AS and US that may justify illegalizing the one while legalizing the other: assistance (immediacy, foreknowledge, directness) and voluntariness. However, in both cases, I find the difference too weak or too problematic to support legal differentiation.

(1) Assistance

At first glance, it seems that AS requires the assistance of another person while US does not, and perhaps it is this difference that justifies prohibiting the one while permitting the other.

However, depending on the method used for the US, the difference of assistance is often merely a matter of degree. For example, the person who uses an overdose of sleeping pills or morphine needs someone to provide those sleeping pills or that morphine. The same applies to the gun, the razor blade, the car and pipe, etc. Perhaps the only truly US would be something like jumping off a cliff (a bridge would need to be provided) or breathing in water. What exactly constitutes the matter of degree seems to be either the immediacy (an element of time), the

directness (an element of space), or the knowledge (an element of consciousness).

(a) Immediacy

In the case of AS, the means are usually provided at the moment, whereas in the case of US, the means are perhaps more typically provided long before the moment. However, in the case of the US, they may also be provided within minutes of the moment: the hardware store salesperson who sells me the pipe and the drugstore salesperson who sells me the sleeping pills may be a five-minute walk from my apartment, and I may make the purchase, come home, and suicide right away.

While this difference in immediacy of provision is a difference, it is an unclear difference, a fuzzy line difference, and therefore not, I think, strong enough to support a legal difference. Would we say that provision of the means for suicide within twenty-four hours of the death counts as an assisted suicide--but provision of the means within twenty-five hours does not? Ascertaining the time of death would become unrealistically crucial!

(b) Directness

Perhaps it is the directness of the assistance that makes the significant difference: after all, feeding the pills to a person until s/he dies is a lot different than simply putting them on a shelveshelf.

Yes, but again, it reduces to a matter of degree: putting them on the shelf, putting them on the counter, putting them in the person's hand, putting them on the person's tongue--where one draws the line is not that clear. Certainly it is not clear enough to support the weight of criminal difference.^{iv}

(c) Foreknowledge

Perhaps a stronger difference concerns the knowledge of the provider: in the case of AS,

the person who provides the pills knows they are for the purpose of suicide, but in the case of US, the drugstore salesperson reasonably assumes they're for the purpose of a good night's sleep.

But how can this difference be significant? Why should it matter whether or not the pill provider knows the purpose for which the pills are to be used? Knowingly assisting is a greater degree of assisting, yes, but typically, such foreknowledge is a problem only when the intended purpose is illegal; in such cases, the provider is guilty of conspiring to commit whatever it is that is about to be committed. But committing suicide as legal as getting a good night's sleep. Conspiring to commit suicide, then, should be as unproblematic as 'conspiring' to 'commit' such a good night's sleep. (It is therefore not a little strange that Section 241 of the Canadian Criminal Code exists: assisting a suicide is illegal even though suicide itself is legal.)

(2) Voluntariness

Whether or not another provides the pills, with whatever degree of immediacy, directness, and foreknowledge, it is the person him/herself who swallows them. But what if swallowing is not possible? What if the person is so physically unable that a lethal injection is the means of suicide that's involved? One can choose to swallow, but one has no voluntary control over one's veins--one can't choose to accept (or not) the morphine that is injected into one's arm. What about such methods that are not so voluntary? Certainly this matter of voluntary choice is significant.

Common intuition suggests that when B puts the pills on A's tongue or when B injects A's arm, there is a greater chance that B is coercing A, or at least, that A is not fully consenting.^y That is, greater than if A put the pills on her own tongue or injected himself. Which is why, if A can do so, I think it is reasonable to 'require' A to do so. But this requirement must occur along

with the public availability of 100% effective methods, user-friendly even for the feeble.

However, what about when A cannot do so? Then, without comparison, there are no grounds for assuming that B doing to A is without A's full consent. In fact, such an assumption, which seems to ground the view that AS should be prohibited, entails two difficulties.

(a) The Mind-Body Issue

In both AS and US, an individual chooses to die. However with unassisted suicide, the individual can and does actualize that choice, whereas with assisted suicide, the individual cannot and requires physical assistance from another to actualize her/his choice. So in both cases the mind is willing, but in one case the body is, and in the other case the body is not, able.^{vi}

First, then, legalizing US but not AS seems to give a sort of supremacy to the body over the mind: it doesn't matter what the mind wills--if the body can, it's legal, but if the body can't, it's illegal. This seems to be inconsistent with current social attitudes: we seem to value the mind more than the body ('It doesn't matter what you look like, it's what's inside that counts'). It also contradicts legal principles that excuse actions of the body when the mind wasn't willing: if one is forced to do X against one's will, it doesn't 'count'. Even death itself is determined by the state of the brain rather than the state of the heart or lungs: one is pronounced dead when one is 'brain dead'--until that time, one can be kept alive with pacemakers and respirators.

As the dissenting opinions in the Rodriguez case pointed out, this supremacy of the body is also inconsistent with Section 15 of the Charter which guarantees that people with physical limitations are not discriminated against; the converse, the negligibility of the mind, is inconsistent with Section 7 which guarantees the right to life, liberty, and security of the person--security understood to include self-determination.^{vii}

Second, not only is the supremacy of the body over the mind questionable, the very dualism of the mind and body has become suspect. One of the main difficulties with the dualist

view is accounting for the interaction of distinctly different 'stuffs', namely the mental stuff of the mind and the physical stuff of the brain; and yet clearly, they do interact. Materialism, the view that there is only one stuff, physical stuff (and hence the mind is the brain), seems to have 'won out' over dualism.^{viii} It is odd, therefore, for AS to be illegal while US is legal because of a distinction that is no longer accepted.

(b) Consent/Coercion

To assume that AS (the presence of B or B's doing X to A) increases the chance of coercion or to assume that with US (the absence of B or B's doing X to A) there has not been coercion is to assume a very shallow definition of consent (choice, voluntariness).

Coercion need not be immediate nor direct: perhaps B earlier said to A that if she didn't kill herself, he would kill her children; surely A's consequent US could not be considered fully voluntary.

I grant that it seems harder to determine the will of the mind than the act of the body: the latter is subject to simple observation. But we are naive to assume that what we see is 'all there is to it', that the body is indeed acting according to the mind's will, or that the mind has not been somehow coerced.

There are many analyses of consent and coercion and elucidation of a few, below, will illustrate that not only should AS be as legal as US, it should, perhaps, be more legal: with AS, we can be more not less certain that consent is present and coercion absent.

A survey of the medical ethics literature suggests that valid consent is capable (referring to the capacity to understand and so form a judgement), informed (regarding one's condition, the proposed action, its risks, consequences, and alternatives), and voluntary (that is, freely willed by the self).^{ix} The presence of a third party, as is the case with AS and not US, can come closer to guaranteeing that all three conditions are met. First, B can subject A to a test of

mental competence to be sure that the capability condition is met.^x

Second, B can provide A with information, in writing and orally, once or on several occasions, to be sure that A understands not only the proposed course of action (the suicide), but also the alternatives, as well as the consequences (to others). The presence of a third party can also help ensure that the decision is not a tragic, 'bad' decision, but rather one in which respect for life and even sanctity of life is preserved.

The third condition, voluntariness, is difficult to determine, depending as it does on free will. I will assume that free will does exist. I will further propose that, barring coercion, the condition of voluntariness is dependent on the forementioned conditions of capability and informedness. That is, if A is capable and informed, and coercion is not present, we can assume that A's action--whether it is the commission of suicide or the expression of the request for assistance to suicide--is indeed voluntary.

As for coercion, external coercion, usually thought to refer to physical force applied by B to A causing A do X, is relatively easy to establish. Internal coercion, on the other hand, usually referring to one's mental states--fears, desires, beliefs, attitudes--is harder to determine. Indeed, when do our internal states merely cause our behaviour and when do they coerce it?

Johnson notes that in a sense all of our actions are more or less coerced by the reasons for them (Johnson 174), but this is not a useful definition of 'coercion' as it would render all consent invalid.

Katz presents as broad a perspective: when he specifies voluntariness as a condition of consent, he goes on to say that "any informed consent doctrine, to be realistic, must take into account the biological, psychological, intellectual, and social constraints imposed upon thought and action" (Katz 102).^{xi} Of course, one's neurochemicals can affect one's clarity of thought which in turn affects one's beliefs which in turn affect one's attitudes--which are also affected by the society in which one lives. The lines demarcating regions of control of self by self become

fuzzy indeed. One can wonder therefore if anyone is ever "... so situated as to be able to experience free power of choice..." (United States F.D.A.).

One solution is to adopt Cohen's distinction between (i) narrow or tight coercion, where there is a deliberate effort by B to pressure A to do X, which makes consent invalid by making it involuntary, and (ii) general or loose coercion, where one is pressured by the general conditions one finds oneself in or by the desires and needs one has, which does not invalidate consent (Turkington 194). Such a distinction would invalidate the request for assistance made by the disabled person who is being encouraged by next of kin who cannot afford to care for him/her anymore, but it would not invalidate the request made by that same person simply because of the circumstance of disability he/she finds him/herself in. Establishing 'deliberateness' and 'pressure' would not be easy, however; the troubling distinction between 'explicit' and 'implicit' would surely arise.

Another solution is to consider consent and coercion to be a matter of degree. Elster defines an action as "the outcome of a choice within constraints" (Elster vii), and perhaps that is the best we can do. Indeed, that is sufficient for my argument: though we may not be able to establish with certainty whether or not the desire for suicide was voluntary, surely we can establish this with greater certainty when there are other people involved to validate or confirm the desire.

Turning back now to consider consent with all of its conditions, AS may in fact be more certainly consented to than US. Since we don't require the US to be competent or informed at all, any proof that these two requirements have been met make the AS more consenting than the US. With respect to the third requirement, great precautions can be taken to ensure voluntariness: not only can there be a superior suicide note (a signed declaration carefully worded), it can be witnessed by disinterested parties.^{xii}

i. I consider unassisted suicide to be the regular kind of suicide involving one person, the person who ends his/her life by actions solely performed by him/herself. I consider assisted suicide to describe a situation in which a person wants to commit suicide, but is physically unable to carry out his/her own wishes and so must ask another to perform the necessary actions; in much of the literature, this is referred to as voluntary euthanasia.

However, voluntary euthanasia is often used to further include situations in which a person wants to commit suicide, is physically able to do so, but nevertheless asks for the assistance of another--whether out of ignorance, cowardice, a desire to ensure that the action is successful, or a desire to ensure a certain kind of suicide (for example, non-messy or quick). I do not consider this situation.

Non-voluntary euthanasia is often used to describe situations in which the wishes of the person are not known for sure, but the 'proxy consent' of another is considered satisfactory justification for yet another party to end the life of that person. I address this situation, briefly, in a subsequent note.

Lastly, involuntary euthanasia is often used to describe situations in which it is known that the person does not wish his/her life to end, and yet another acts to achieve that result. Like many others, I consider this to be indistinguishable from murder and do not consider it at all.

ii. This is the case in Canada, the United Kingdom, and many of the United States.

iii. There is a third possibility: one could argue that there is no point in prohibiting US since the guilty person, being dead, would not be available for punishment. Thus prohibiting one and not the other is not inconsistent, but merely pragmatic. Failing to prohibit US, one would argue, does not necessarily mean it is condoned.

There are two problems with this 'solution'. One, it assumes that the only value of legal prohibition is punishment; perhaps prohibiting US would have deterrence value. Two, attempted suicide is not prohibited either: this increases the inconsistency (since a failed attempt would leave someone to be punished) or naively assumes that all suicides are successful.

iv. It should be noted that the definitions used by the Canadian Senate Committee in its recent report on euthanasia and assisted suicide are so broad that both the problems of immediacy and directness are intensified. Assisted suicide is defined in the Report as "the act of intentionally killing oneself with the assistance of another who provides the knowledge, means, or both" (14). Not only does this definition not restrict assistance to direct physical movement (making an injection, for example), it specifically includes simply providing the means--utilizing those means is not required. In fact, providing the means is not even required; providing the information is sufficient! Conceivably, then, one could be told years prior to suicide that a certain quantity of a certain drug would be an overdose--and the source of that information would be guilty of assisting a suicide. While the current *Criminal Code* prohibits merely 'aiding and abetting' a person to commit suicide,

the interpretation of such aid is, apparently (Senate Report 52), taken to include providing the means of the information to a person who commits suicide. I am surprised then that Derek Humphreys' book *Final Exit* has not been banned.

v. I am substituting 'consenting' for 'voluntary' because at least in cases in which there is not even an action possible, even, for example, that of swallowing, there is no verb for the adverb 'voluntary' to modify.

vi. At this point it might be valuable to review my definitions and compare them with those of the Senate Committee. The Senate Committee's definitions hinge on the physical element of agency--what's crucial is who actually performs the action; my definitions hinge on the mental element of desire--what's crucial is whether or not the person wants to die.

It is the physical distinction that is important to members of the Senate Committee who objected to legalizing voluntary euthanasia: whether oneself or another is the principal agent of death is crucial because, according to them, when another is involved, adequate safeguards could not be established to ensure that consent was given freely and voluntarily. I argue that while this may be so, it is more, not less, difficult to know that the usual US has been committed freely and voluntarily--and yet it is legal.

vii. See Daryl-Lynn Carlson, "Murder or Mercy" in *Canadian Lawyer* (May 1994), p.23 and the Senate Report, pp. A-70-72. Both refer to Sue Rodriguez's application to the Supreme Court of British Columbia for an order to declare s.241(b) of the *Criminal Code* invalid (Rodriguez v. British Columbia 3SCR (1993) 519).

viii. See Ryle, Searle, and many others.

ix. See, for example, the statement of the Royal College of Physicians and Surgeons of Canada, Katz, Kieffer, and Kluge.

x. A reminder may be in order at this point that I define AS to exclude what many refer to as non-voluntary euthanasia, cases in which the person is unconscious, comatose, infantile, or otherwise unable to actually request assistance.

I believe it is possible to argue for proxy consent, however; indeed, I suggest that valid proxy consent is what distinguishes euthanasia from homicide.

As one might guess, proxy consent is even more slippery than consent. But again, that has not been, in our legal past, sufficient reason to disallow actions based on proxy consent: parent guardians give consent on behalf of their young children all the time; significant others give consent on behalf of unconscious adults.

The first important question is 'When is proxy consent sufficient?' That is, in which cases do we say consent by the individual concerned is inadmissible and/or impossible? I think we can simply apply the criteria of valid consent under discussion: if the person is capable, informed, and

voluntary, then proxy consent is unnecessary. At the extremes, application of this test will be easy: an unconscious or comatose person is clearly incapable of giving/withholding consent; we're also pretty sure about infants and severely retarded people; the line gets fuzzy with older children and less retarded people. Perhaps a test of mental competence would keep the line clear--but it had better be a very good test.

The second important question has to be 'What constitutes valid proxy consent?' Certainly it must have the attributes of direct consent: it must be capable, informed, and voluntary. Additionally, well, there are a few possibilities. One is to apply the 'reasonable standard' criterion and say that the decision must be what any reasonable person would make. But what is 'reasonable' and who decides?

Another is to say that the decision must be in the best interests of the individual concerned. But this has problems similar to the reasonable standard solution--what is 'best' and who decides?

A third answer to the question of what constitutes valid proxy consent is to say that the decision must be what that individual would make if s/he were able (if s/he were capable, informed, and voluntary). This depends on guesswork, unless a living will exists--though a living will essentially changes euthanasia to assisted suicide.

A fourth answer might be that since personal autonomy is clearly impossible, a decision should be made on the basis of social utility: why should at least three people sacrifice their lives to save one person? Is that one person worth three? (Round the clock care equals three eight-hour shifts, hence three people. However, since that just accounts for labour and not for food, shelter, and the specialized technology usually required, the 'people equivalent' figure would probably be greater than that.)

Lastly, we could decide on the basis of actual and/or potential quality of life--not its value to others, but its value to the individual. This may translate into specific criteria such as the presence of continual (?) severe (?) pain and/or (?) chance of recovery.

xi. Vandervort suggests that economic coercion also be considered.

xii. We would, of course, need to eliminate Section 14 of the *Criminal Code* which states that "No person is entitled to consent to have death inflicted on him [sic]." I believe this section was intended to disallow the defence of consent in murder charges. If we eliminate it, and allow such a defence, will we be able to separate murder from AS? I think so.

First, the dead person needed to have been so disabled s/he could not have committed US (as I explained earlier, if one is physically able to suicide, one should not be allowed the assistance of another--but one should, then, have access to effective methods). Surely that decreases considerably the number of those accused of murder who could even consider using the defence of consent.

Second, the consent requirements could be, should be, too rigorous for a murderer to meet. For example, we could require that (i) on three separate occasions, (ii) in the presence of three completely separate and disinterested sets of people--to include medical, police, legal, and governmental representatives, as well as next of kin, (iii) the person freely and fully expressed consent, (iv) documented with audiotape, videotape, and signed transcript. Could even a corrupt physician, let alone the murderer, meet these conditions? It's unlikely.

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