

# A FEMINIST CASE AGAINST EUTHANASIA

*Women Should Be Especially Wary  
Of Arguments for "the Freedom to Die"*

Nowadays we hear familiar-sounding clarion calls for choice, autonomy, and the moral right to control one's own body, this time from the movement to legalize physician-assisted suicide and euthanasia. In the United States, dedicated activists, some physicians, and certain respected ethicists are making a moral case for the right to control how and when one dies.<sup>1</sup> Feminists and other concerned members of society must ask themselves whether this new liberty would in fact contribute to general human flourishing and the well-being of women.

Women have for so long been denied full autonomy and respect in our society that it might be tempting for feminists to immediately endorse a social measure purporting to increase women's freedom of choice. Fortunately, however, feminists have learned to exercise a "hermeneutics of suspicion," that is, they will be cautious when new social or medical interventions are on offer.

**Summary** Feminists, among others, should not be too quick to hail assisted suicide and euthanasia as extensions of human freedom. Indeed, there are good reasons why women should be especially suspicious of such "reforms."

First, it is not clear that a person has a moral right to end his or her existence. Feminists understand that suicide and murder are irretrievably linked, and that a person is not a monad. We often hear of suicide attempts in which the person's body—by vomiting up poison, for instance—overrules his or her mind. If there can be such miscommunication between a mind and body, how are we to trust the communication between a person and the physician ready to assist his or her suicide?

Ambivalent motivation and ambiguous meanings have always characterized human relations. In

Proposals for increasing personal choices that initially look positive can result in unforeseen drawbacks and dangerous side effects—especially when medical technologies are involved. As noted feminist philosopher Alison Jagger has noted in a comment on reproductive debates:

Feminist approaches to ethics must understand individual actions in the context of broader social practices, evaluating the symbolic and cumulative implications of any action as well as its immediately observable consequences. They must be equipped to recognize covert as well as overt manifestations of domination, subtle as well as blatant forms of control, and they must develop sophisticated accounts of coercion and consent.<sup>2</sup>

Now the time has come for subtle, sophisticated accounts of the symbolic and cumulative

the past, however, an absolute taboo against suicide or euthanasia cemented a patient's right to expect the care of his or her physician, family, and community. If we were to discard that taboo, we would subtly alter these relationships and make each other more vulnerable. History suggests that women, minorities, the ill, the old, and the handicapped would be most at risk.

Finally, the assisted-suicide debate has even larger social implications. Unconditional respect for the gift of life is eroding in the United States. The suicide rate is already climbing at all levels of society, especially among teenagers. Wouldn't the acceptance of suicide and euthanasia make it even more acceptable for people to check out of all kinds of uncomfortable situations—marriages or life?

BY SYDNEY  
CALLAHAN, PhD



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Vivienne Flesher



implications of instituting assisted suicide and euthanasia. Since feminists differ among themselves, there are many intrafeminist debates on many ethical issues; yet there is also a great deal of consensus on many issues.<sup>3</sup> All forms of feminism critique a status quo in which power is abused by unjust gender discriminations against women.<sup>4</sup> Every critical feminist analysis recognizes and protests gender subordination and exclusion, demanding an end to it; women should no longer be excluded from discourse defining themselves or their roles, or have their voices suppressed in the decision making of male-dominated societies. Feminism is always and everywhere a call for justice and social change on behalf of women's well-being and human flourishing.

**FEMINISM AFFIRMS NURTURING LIFE**

Feminism also affirms the importance of concrete contexts and the different perspectives or standpoints of embodied participants in any encounter. Feminists have rightly attempted to make explicit what too often has been ignored, that is, the

social and dynamic developmental realities of actual human lives. Human beings must be born, nurtured, and reared, and then cared for when they are ill, old, or dying. A unique individual self can be formed only within social matrixes of interpersonal relationships; the self is partly created by ongoing self-other dialogues. Each adult person continues to live within embodied, embedded, and interpersonal relationships. Inevitably, the private and the personal interact with public and political actions because no one can live or work without receiving domestic and emotional support. These hidden tasks of nurturing and maintenance have usually been assigned to women, then denigrated and accorded little recognition or reward.<sup>5</sup>

Most feminists have tried to affirm the value of women's traditional contributions, including care of the ill and dying, while simultaneously working to expand roles and opportunities for women in society. Women's traditional power and powerlessness must both be recognized. Many creative feminist proposals for revising gender roles also reappraise and welcome men's potential contri-

butions to cooperative caretaking in the family. To emphasize only women's victimization by men gives too unbalanced a picture. In old age and at the end of life, for instance, gender roles in families and societies tend to become more flexible, overlapping, and shaped by individual personalities and strengths.

**Double Standards Affect Women** Yet we must also recognize that women are going to be more affected by the euthanasia debate than men, simply because women live longer than men and in their old age command fewer financial and social resources. In a sexist society that also suffers from ageism (prejudice and discrimination against the old), more women will end up living alone as fragile persons in need of care. As families become smaller and more dispersed, many women—particularly single, childless women—will not have nearby kin who can care for them or serve as their advocates within increasingly complex healthcare systems.

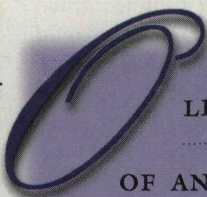
By and large women have been socialized to be less assertive than men and have less of a sense of entitlement when dealing with mostly male authority systems. And, in their turn, authority systems are more likely to discount women's voices. According to some disturbing studies of gender disparities in the legal and medical system, women's medical treatment preferences were more often ignored because the courts "treated prior evidence of women's values and choices as immature, emotional, or uninformed, but considered men's prior statements and lifestyle decisions to be mature and rational."<sup>6</sup> In other words, old women will bear the brunt of any inadequacies in the system our society devises for the fragile old at the end of life. Feminists have long recognized the double standard in aging and worry that there may be a double standard in dying as well.

In reaction to double standards, abuses of power, and overt and covert coercion by elites, feminists have endorsed the adoption of nonhierarchical modes of collaborative problem solving. Although some feminists would see these cooperative methods as an outgrowth of innate biologically based differences in nurturance between men and women, others like myself would give more credit to women's traditional socialization into a female subculture of familial caretaking. In practicing the "maternal thinking" needed to nurture children and dependents, women have learned a great deal about encouraging human potential and creating effective communities that work through dialogue and persuasion.<sup>7</sup> They have embraced a form of power that need not, and should not, be exercised by the "logic of

domination," where the strong employ violence and coercion over the weak. Many feminists have affirmed the importance of "actualizing power," or creative enabling power, which eschews the violence of the jungle and seeks to solve problems in a more fundamental, dialogical, collaborative way.<sup>8</sup> I argue here that instituting self-determined dying by approving either assisted suicide or euthanasia would be a return to the logic of domination and a grievously wrong and harmful step for our society to take.

### EFFECTS OF INDIVIDUAL DECISIONS

Does a person have a moral right to a self-determined death by suicide or euthanasia? Implicit in the claim is the assumption that an individual owns his or her personal body so completely that he or she can kill or extinguish life at will. This concept of absolute human ownership or property right appears morally misguided. Women, along with other formerly owned groups such as blacks, must protest that no body should be owned or destroyed by a unilateral individual decision, even one's own. Whence would come such an individualistic moral right or assumption of absolutely dominant power? After all, each person's self-consciousness, like each individual's body, has been created and received from the person's parents and forebears, and nourished by the community and culture in which the person's life is organically embedded. A human life and identity is a gift from evolutionary biology, natural ecological conditions, parental procreative child rearing, and collective cultural socialization—all transcending the individual power of self-determining will claiming unilateral life-or-death powers.



OLD WOMEN WILL BEAR THE BRUNT  
OF ANY INADEQUACIES IN OUR SYSTEM  
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**Valid Moral Prohibitions** Feminists understand that individuals cannot be treated or treat others as though they are alienated monads cut off from all bonds with one another. Having received the gift of life and social identity, one has a moral obligation to preserve and respect each human life and refrain from suppressing, killing, or destroying self or others. That which one is permitted to do to one's self and that which others are permitted to do to one—these can-

not be morally or psychologically separated. Murder and suicide are irretrievably linked. In ancient cultures such as Rome, where suicide was honored, it was also accepted that powerful elites could unilaterally kill slaves, children, or troublesome women. To be a valid protective principle, the moral prohibition against killing a human being must have no exceptions—either for the self or for physicians.

For that matter, many feminists and others in society today are beginning to seriously question the claim that human beings can have property rights that morally allow them to kill members of endangered animal species or destroy rain forests.<sup>9</sup> With the growth of ecological consciousness, human beings are beginning to recognize that they exist in an interconnected life-sustaining environment that they must respect and care for if human life is to be preserved. Arrogant and destructive impositions of human will must be forsworn. Surely the moral prohibition against willfully destroying a human life must become universal.

**T**HE DIFFICULTY OF ASCERTAINING A PERSON'S CONSENT TO SUICIDE OR EUTHANASIA CANNOT BE OVERESTIMATED.

**Objectifying the Self** We must also focus on the intractable problem of obtaining fully informed consent from individuals. Even those who would prohibit killing another person claim that one *can* kill one's self because of the certainty of obtaining informed consent—because, that is, the executioner and executed are identical. To use the term for suicide found in the Hemlock Society's literature, in "self-deliverance" the deliverer and the delivered are one and the same.

Unfortunately, in this vision one's own body must be objectified, alienated, and viewed as a target somehow split off from the mind in a dualistic manner. Bodily life becomes the enemy, or the obstacle, which must be dominated and extinguished by technological means that will not fail. In many suicides, the embodied self resists being killed. The person vomits pills, or claws off the plastic bag, or lunges for air. Therefore the more violent or technologically certain the assault, the better. Experts or helpers also need to

stand in readiness to complete the job. Better yet, physicians who will actively commit euthanasia can employ a highly lethal chemical technology that can bring a certain, swift death.

It is viewing the body as a target to be dominated and killed that differentiates an act of suicide or euthanasia from the morally acceptable practice of withdrawing futile medical treatments. Letting a dying person die without prolonging his or her death allows us to give up useless and burdensome interventions. In a naturally occurring inevitable death, a whole person as an embodied self dies from an irremedial medical condition. If a treatment is withdrawn and death is not imminent, then the person continues to live. There is no danger of misreading signals.

**Ascertaining True Consent** The difficulty of ascertaining a person's consent to suicide or euthanasia cannot be overestimated. Persons have difficulty comprehending internal self-self communications and dealing with external self-other signals. Self-knowledge is difficult because the ongoing stream of consciousness is so complex and multi-dimensional. We now know that many different modal subsystems contribute to our unified experiential sense of a conscious self and identity. Arousal, memory, perception, affect, cognition, and other factors play a part in an ever-changing continuous flow of conscious experience. Individuals constantly revise interpretations of their experiences as they respond to the ways their different systems are functioning. Not only can biochemical imbalances and impairments create fears and depressions; temporary disjunctions of impulse, illusions, imagery, and false inferences can create erroneous and dysfunctional judgments.

Individual choices, preferences, plans, and decisions are never simple or unitary, but exist as ongoing processes. Consciousness is constantly being self-created and recreated; and these individual inner processes are constantly affected by ongoing interpersonal and environmental interactions. To complicate the picture further, persons experience many nonconscious cognitive processes, such as implicit memories, that contribute to functioning. An explicit, self-aware, accessible event in consciousness is not all that is operating within a person's mind-body organism.

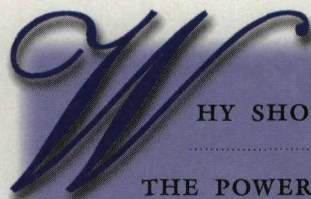
Therefore, when one makes a conscious decision, or choice, or plan to kill one's self, not only must one violently subdue one's body, but one must also extinguish all the other implicit stored dimensions of complex personal identity. These dimensions may resist dying and, like the resisting body, call for help in the midst of a suicide

attempt. When people survive such attempts or their requests for euthanasia are denied, they often report that they have now "changed their minds." They no longer identify with the dimension of self that wanted to die.

No one can ever predict how a future self's stream of consciousness will construct or interpret experience. Many human beings can even interpret suffering as meaningful and transcend it, as abundant testimony reveals. A decision to end consciousness forever suppresses a human being's core capacity and essential potential. A voluntary extinction of the meaning-making faculty of persons also signals that nonhealthy bodily life has no meaning; it is a grave violation of human dignity. A steadfast living of each moment to the end not only displays more courage but also gives more meaning to the human condition. Death may forcefully take my life away from me, but why give death an easy victory by an irreversible act of self-extinction?

**Decisions' Intent** Of course, persons sometimes must make irreversible decisions short of death by suicide or euthanasia. And such decisions give rise to inner conflicts in which some part of one's self may dread or shrink from performing a particular act. Undergoing certain therapeutic interventions (e.g., an amputation), or, in a more extreme case, giving up one's life for another or becoming a martyr, may induce ambivalence. Yet these decisions are not the same as choosing death by suicide or euthanasia. In irreversible medical decisions, the goal is to continue to live and thereby retain the ability to experience or shape one's life. In a sacrifice for another person, or in martyrdom, death is really not being chosen but is imposed on a person's altruistic act by external exigencies or persecutors acting beyond the person's control. One is choosing loyalty or love, not death. A mother who chooses to risk a life-threatening pregnancy for the sake of her baby is not committing suicide or choosing death.

There are differences in human actions undertaken even when death as a final outcome can be foreseen. To withdraw futile treatment is not the same as killing. To give a dying person enough medication to relieve pain, which may also hasten death, is not the same as intentionally killing him or her. Human acts are shaped by human intentions and characterized by the means employed. To judge only by ultimate outcomes or consequences is to take the narrowest utilitarian perspective on causation. The bottom-line approach denies human subjectivity and makes no distinction between human beings and inanimate objects. Human beings always act within a world



WHY SHOULD PHYSICIANS BE ACCORDED

THE POWER TO ASSESS THE QUALITY OF

A LIFE'S MEANING?

of willed intentions and affective motivations, using differentiated means within cultural frameworks of meaning. To deny the complexities of human actions would mean denying the very judgments and desires to be merciful and compassionate that inform all the different arguments over what we should do to help each other to a good death.

Obviously all parties agree that we have a duty to provide comfort, care, and pain relief during the dying process. In an era of advanced palliative medicine, no one who is dying should have to die in pain. The increase of chronic illness in our society makes it clear that medicine's caring and palliative function is as important as its heroic feats of cure and rescue. Yet the existential suffering accompanying illness and death can be a psychosocial challenge to individuals and their families. Unfortunately, physicians who become enamored with using dramatic high technologies to fight off death may all too easily arrogate to themselves the duty of relieving existential suffering by deciding when to end a life. In the process they may also foreshorten necessary processes of grieving and farewells.

**Communications in a Crisis** Most worrisome, however, are the problems of communication between the patient and his or her physician. It is very difficult for one to know one's own mind and heart or to internally assess the validity of the ever-changing dynamic processes of decision making—much less read another's heart. Yet physicians in favor of euthanasia appear to have faith that they can tell whether the patient really means it when she or he asks to die.

Feminists and others will be suspicious. Why should physicians be accorded the power or ability to assess the quality of a life's meaning or judge the amount of subjective suffering that is really present? Those physicians who think they would only be responding to a patient's "free" choice are naive about the dynamic processes of interpersonal communication. Healthcare professionals are constantly giving subtle signals and suggestive signs by the phrasing of questions and a host of other nonverbal cues. Ask any woman

who has experienced childbirth for an account of how she scrutinized the physician's facial expressions and gestures, silently asking: Are you telling me the truth about the course of my labor and the health of my baby?

**INTERPERSONAL DIMENSIONS OF SELF-DETERMINED DEATH**

When a person seeks or assists a suicide or act of euthanasia, he or she acts to end all human relationships. No more comfort can be given or received; no more befriending or watching and waiting with another will take place. Interpersonal bonds will be decisively cut off, all human dependence and interdependence rejected. Such acts are not without interpersonal con-

a choice to go on living and ask why one should voluntarily continue to exact care or be dependent on others. Subtle internal pressures may tell the sick person to stop being a burden on others by taking up resources and energy. Women who have been socialized to be self-sacrificing may be the most vulnerable to such pressures. After all, in India it was widows, not the widowers, who were required to throw themselves on funeral pyres. The majority of Dr. Jack Kevorkian's clients who have used his suicide machine have been women. People sometimes request assisted suicide when they are not yet in pain, but because they fear future debilitation and dependency. Fear of dependency is partly a fear of losing power and self-control, but it can also be a fear that others will not take care of you. It may also mask a displaced fear of death itself.<sup>10</sup>

Unfortunately, the more ill or debilitated a person becomes, the more likely he or she is to be distrusting, depressed, or despondent. Emotions and thought processes regress in illness, and it becomes more difficult to think clearly, much less assert one's claims to care. That is why each old person who goes to the hospital does well to have a family member present to be an advocate in the confusing system of modern American healthcare institutions. The idea that patients have one long-term physician who knows them well and will serve as their discerning protector is more or less a fantasy for most aging Americans. To become ill is to enter the land of vulnerability, when what you need above all is an unconditional entitlement to appropriate care.

Families and caretakers also will be affected by any new options instituted for assisted suicide or euthanasia. Today most families still take care of their aging and dying members, but they do so supported by taboos against all requests for death. This intergenerational reciprocal cycle of kinship obligations and care should remain undisturbed. Incompetent, vulnerable infants are nurtured, grow up, mature, and care for incompetent, vulnerable, and dying old persons. But if euthanasia should become socially approved, there would be a whole new disturbing dimension to caretaking and family communication. Suicides leave their mark on their families, and requests for euthanasia may also engender conflicts, regrets, and models for imitation. The situation of dying by request is so emotionally charged for caretakers that even proponents of euthanasia have recommended that families not be the agents involved. But individuals, families, and caretakers will not be the only ones affected by social change.

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sequences because we do not exist alone. Feminists have always emphasized that supposedly abstract decisions are influenced by their pragmatic social context and covert meanings. Cultural scripts, background beliefs, social roles, status, perceived power, emotional histories, patterns of speech, and symbolic interpersonal communications—all of these will influence outcomes of events.

Ambivalent motivation and ambiguous meanings also characterize the human condition. In a decision to actively end one's life or seek euthanasia, the social support one can count on from others will be a crucial variable. How much care can the person expect? Is it given grudgingly or with love? In the past the fixed taboo against suicide or euthanasia cemented a patient's right to expect the care of her family or community. As long as a human being is alive, the family and/or institutional caretakers are morally obligated to offer support and care. Whatever ambivalence they feel must be suppressed so they can live up to the cultural ideal of helping those who are ill and suffering as their vulnerability increases and their life ebbs away.

**Options Change Interpersonal Dynamics** When the choice to end a life is morally permitted, then the interpersonal situation changes. One must justify

## SOCIAL EFFECTS OF SELF-DETERMINED DEATH

Arguments over the possible effects that approving assisted suicide and euthanasia would have on our society depend a great deal on assessments of the conditions already present in our institutions, bureaucracies, and professional communities. Feminists must be pessimistic if they look to the way powerless women have been treated in facilities devoted to birth and reproductive healthcare, or to the way women on welfare have fared. It is instructive also to note how abortion, once approved of only as a tragic choice in exceptional cases, became a routinized necessity, with women being offered only the most perfunctory of counseling or discussion of alternatives. Individual choices have a way of quickly becoming routine procedures in the larger institutions of society. A quick, medicalized, technological solution to problems can take over. Slippery slope arguments often do apply when traditional moral prohibitions are breached. Think of the way the Allies began to justify bombing civilians in World War II.

Those who favor right-to-die measures argue that rational controls and legal supervisions by professionals and institutions will work to keep abuses from occurring. Also, they claim, physicians will not be corrupted by becoming "death providers" instead of healers, because their work already includes relieving suffering. Providing the means to suicide or giving lethal doses to effect death will be but an extension of their current roles. Assisted suicide will not affect families and other caretakers—or, at least, no more than the patient's current right to refuse futile treatment affects the quality of his or her supportive care.

Most euthanasia advocates do recognize that approval of the practice would lead to a shift from voluntary euthanasia to involuntary euthanasia of incompetents, but they are not alarmed. Their reasoning is consistent: If it is a good for competent patients to be able to end a life that is an affront to human dignity, then those who are incompetent should have the same freedom. Surrogates, they say, can usually make any decisions that are morally acceptable for individuals to make, so this move to involuntary euthanasia would not be a terrible danger. Alzheimer's patients who no longer can recognize their families are the most trying and burdensome patients. Surrogate decision makers would perhaps too easily judge such people as having a meaningless, unacceptable quality of life, and such patients could not argue the case for themselves.

Holland's growing acceptance of euthanasia is a subject in debates between advocates and opponents of assisted suicide and euthanasia. Everyone

agrees that more and more liberties and laxity in professional requirements for euthanasia have taken place in Holland. Persons have been euthanized only because they claimed to be severely depressed; family requests for involuntary euthanasia for incompetents and impaired neonates have been met.<sup>11</sup> Proponents of euthanasia may admit some abuses in Holland, but they also claim that this extension of the right to die really reveals a heretofore suppressed need for increases in personal liberty.

**Slippery Slope** Opponents of euthanasia, like myself, point to the changes in Holland as an example of how a slippery slope actually operates. Death seems more and more seductive as a way to solve problems. The fuzzy criterion labeled "an acceptable quality of life" becomes ever more elastic. Pressures on older people or AIDS patients to request euthanasia grow even in a well-organized, fully insured universal health system uninfluenced by financial pressures. Habituation makes each new case easier to carry out. To my surprise, I once heard Timothy Quill, a prominent physician advocate of assisted suicide, admit that no physician's 14th case of assisting a suicide would be carried through with the same sensitivity as his or her first case.



UICIDES LEAVE THEIR MARK ON THEIR

FAMILIES, AND REQUESTS FOR EUTHANASIA

MAY ALSO ENGENDER CONFLICTS, REGRETS,

AND MODELS FOR IMITATION.

In our own disorganized, economically stressed, market-driven American health system, where many poor people have inadequate health insurance, we can expect many abuses. Legal supervision or regulation could not really be effective. Physician education, with its technologically driven training, does not prepare doctors to be strong in communications skills or social sensitivity. Certain physicians would undoubtedly become known for the ease with which they approved suicide and euthanasia requests, and perhaps, as with abortion, special for-profit clinics would be set up. Poor and uninsured old per-

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## AGAINST EUTHANASIA

Continued from page 27

# Unconditional respect for the gift of life is eroding.

sons, particularly women, minorities, and the handicapped, would be most at risk.

**Broader Risks for Society** Listening again to Jagger's warning about "the cumulative implications of any action," we can see other symbolic cultural wounds accruing from the acceptance of self-determined dying. Will it not become ever more acceptable to retreat, withdraw, or check out of situations—marriages or life—when troubles mount and suffering must be endured? Already the adolescent suicide rate has soared, and depression rates have increased among the young. Suicides are increasing at all levels of society. Nor can one look at the abortion rate or homicide statistics without a tremor. Unconditional respect for the gift of life is eroding. Our society does not validate persons' nonviolent struggles to patiently overcome a sea of troubles. Under the banner of increasing technological control and increasing liberty ("Live free or die!"), we have opened ourselves up to more and more pressures to die.

Ideals of individual domination and control of life have backfired in our society. Feminists, among others, have mounted a critique and reappraisal of our troubles. Feminist ideals of inclusive justice, caretaking, and the interconnectedness of all the living require that we struggle against approving assisted suicide and euthanasia. Let there be no more recruits for the armies of domination serving the cause of death. □

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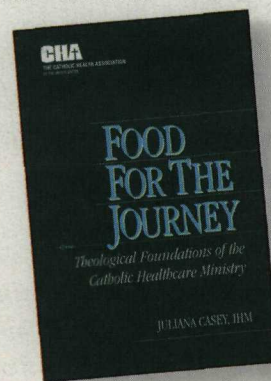
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