

Medicine against Suicide: Sustaining Solidarity with Those Diminished by Illness and Debility

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The medical profession's increasing acceptance of "physician aid-in-dying" indicates the ascendancy of what we call the provider-of-services model for medicine, in which medical "providers" offer services to help patients maximize their "well-being" according to the wishes of the patient. This model contrasts with and contradicts what we call the Way of Medicine, in which medicine is a moral practice oriented to the patient's health. A steadfast refusal intentionally to harm or kill is a touchstone of the Way of Medicine, one unambiguously affirmed by Christians through the centuries. Moreover, physician aid-in-dying contradicts one of the distinctive contributions that the Christian era brought to medicine, namely, a taken-for-granted solidarity between medical practitioners and those suffering illness and disability. Insofar as medical practitioners cooperate in aid-in-dying, they contradict this solidarity and undermine the trust that patients need to allow themselves to be cared for by physicians when they are sick and debilitated.

Keywords: *physician aid-in-dying, physician-assisted suicide, solidarity, trust*

I. INTRODUCTION

What can physicians do for patients who are not only at the end of life but seemingly at the end of hope—patients who are dying and have nothing left to look forward to except debility and decline, pain and misery?

For centuries, physicians in the West have known that whatever they do, they must not intentionally hasten or cause the patient's death. However, physicians today no longer know that. Indeed, many (perhaps most) physicians today are persuaded that to fulfill their professional obligations to patients, they must be willing to offer, or at least to accommodate patients' requests for, "death with dignity"—death brought about by physician-assisted suicide or voluntary euthanasia.¹ In the past few years, several prominent medical associations, including the Royal College of Physicians (Jacobucci, 2019), the American Academy of Family Physicians, and a number of state medical associations (Compassion and Choices, 2021) have dropped their opposition to assisted suicide.

The medical profession's increasing acceptance of what has come to be called euphemistically "physician aid-in-dying" or "medical aid-in-dying" (MAID) indicates that the profession is in a moral crisis. We physicians no longer have a shared public understanding of what medicine is for—of what the *end of medicine* is or should be.

Roughly speaking, there are two visions of medicine that operate today. Most physicians are guided by both of these visions, to greater and lesser extents, but the two visions ultimately contradict one another and cannot be reconciled. The subject of physician aid-in-dying highlights the differences between and the logical consequences of these two visions, and it thereby gives us an opportunity to consider which vision is more fitting for the practice of medicine.²

In answer to the question "What is medicine?" according to what we call the *provider-of-services model*, medicine comprises a set of technical skills that are to be put to work to maximize patient *well-being*. In our consumerist environment, patient well-being is a subjective norm understood principally in terms of satisfying the patient's wishes.³ Healthcare workers provide the services that patients need to bring about the states of affairs they desire. For the provider-of-services model, if an intervention is permitted by law, technologically possible, and autonomously desired by the patient, then medical practitioners should provide the intervention. Indeed, some have argued that physicians are often professionally obligated to do so (Stahl and Emanuel, 2017).

Although the practices of physician aid-in-dying fit the provider-of-services model, they contradict the second vision of medicine. On what we call the *Way of Medicine*, medicine is a paradigmatic moral *practice*—elevated to a profession because of its social importance—that aims at human health. The provider-of-services model also concerns itself with health but, under this model, health is only a subjective and socially constructed concept, and it is only one among a number of goals toward which medicine might reasonably be aimed in pursuit of patient well-being, including the goal of "death with dignity." In contrast, in the Way of Medicine, the good physician orients her practice centrally around the good of health, objectively understood,

pursuing it in ways that are accountable to the broader demands of reason, and steadfastly refusing to intentionally damage or destroy health in any human being.

II. WHAT ABOUT CHRISTIANITY?

Two brief notes before we proceed further. First, the Way of Medicine is not dependent on any particular religious view, and it has been taken up, contributed to, and developed within Jewish, pagan, Christian, Muslim, and modern secular cultures. At the same time, experience suggests that the Way of Medicine will be more compelling to those who already know, or intuit deeply, that it is always wrong to intentionally kill any innocent human being, much less one's patient. This claim is both obvious and explicit within Christianity and many other religious traditions, whereas, by contrast, the provider-of-services model has a hard time making sense of such a claim. Tom [Beauchamp \(1995\)](#), for example, cites this blanket prohibition against killing one's patient as an example of the deficiencies of traditional approaches to medical ethics.⁴

Second, we would not deny that thought and action carried on from within a theistic, and especially Jewish or Christian or Muslim, framework *differs* from secular thought and action, even where the two substantially overlap. In describing the Way of Medicine, we seek to identify a core tradition that pagans, Jews, Christians, and Muslims have recognized in common, and which has made possible their cooperation with respect to the healing arts. At the same time, as Christians, we are persuaded that all of reality, including the experience of illness and the practice of medicine, is only fully illuminated in light of the story of God's redemptive work in his calling of Israel, his incarnation, suffering, death, and resurrection in Jesus, and his ongoing work in the Church. As such, everything we say here can be helpfully and suitably amplified by bringing on board the insights of Christian tradition.

III. MEDICINE FOR THOSE AT THE END OF HOPE

Consider this case:

Abe Anderson is a 52-year-old father of two, suffering advanced pancreatic cancer. Abe elects to receive hospice care at home. The hospice physician comes to see him at home, and in their conversation, Mr. Anderson says, "I don't want to languish, doc. I want to go out on my own terms. What can I do if I don't want to go on any longer?"

What can Mr. Anderson's physician reasonably offer him?

First, that which is uncontroversial: The physician can of course offer Abe high-quality palliative medicine. Under ethical norms that have guided

medicine for centuries, physicians have good reasons to treat pain and other symptoms in those who are dying, even when doing so means accepting substantial side effects. That is to say that, although physicians may not intentionally damage or destroy the patient's health, it does not follow that physicians must avoid any action that even indirectly injures health. The rule of double effect has for centuries helped clinicians practicing the Way of Medicine to discern when they can accept as side effects harms that they should never intend from health-oriented interventions, including the foreseen harm of hastening the patient's death (Sulmasy and Pellegrino, 1999).

Now some patients want more than palliation of their symptoms. They want to die on their own terms, not to wait for their illness to bring about their death in unwanted and undignified ways. In particular, some experience a state of progressive and irreversible debility and dependence as one that is worse than being dead. What can be done for such patients?

Today, physicians are often urged in such cases to turn to what have come to be called by their proponents "last-resort options" for palliative care (Quill, Lo, and Brock, 1997). These include encouraging the patient to voluntarily stop eating and drinking,⁵ palliative sedation to unconsciousness,⁶ and most prominently, assisted suicide and euthanasia.

Because assisted suicide and euthanasia involve intentionally harming the patient's health, the Way of Medicine rules out such practices from the start. But, such practices clearly are not ruled out under the provider-of-services model that has so much influence today. Rather, under this model, clinicians pursue the goals of minimizing suffering and maximizing quality of life without any absolute prohibitions, including the prohibition against killing one's patient.

At the time of this writing, assisted suicide and euthanasia remain illegal in most US jurisdictions; so, for the moment, in most jurisdictions, such practices are not in the universe of options that physicians must offer patients. Now when that changes—as it has changed in several US states, all of Canada, and several European nations—the provider-of-services model not only permits assisted suicide and euthanasia, but also requires physicians and nurses to accommodate patient requests for these options, at least through referral to an accommodating "provider." This requirement follows from the provider-of-services model's commitment to use medical technologies to bring about *well-being*. After all, how can a patient be said to have well-being if he lives when he wants to die, particularly when he is obviously suffering a degraded and steadily diminishing quality of life?

When the goal of medicine shifts from helping patients who are dying to helping patients to die, practices that intentionally hasten death no longer seem like last-resort options. Indeed, such practices seem to follow ineluctably from making the relief of suffering—an alternate formulation of *well-being*—medicine's first principle. Medicine aims to minimize suffering and maximize well-being according to the patient's judgment and values.

A patient like Abe is suffering and experiences poor quality of life. The clinician has the tools to make the suffering go away by making the condition that permits the suffering—being alive and conscious—go away. Although intentionally bringing about the patient's death seems to violate the injunction to never intentionally damage or destroy the patient's health, medicine is no longer constrained by this boundary. Therefore, the clinician now may, and is perhaps morally obligated to, offer a patient like Abe various means by which he can bring about the end of his life.

One can see this logic on conspicuous display in the case of Brittany Maynard, the most influential case in making the public argument for *physician aid-in-dying* in our time. Brittany Maynard was diagnosed with brain cancer in January 2014; she was 29 years old. In the remaining 8 months of her life, she became a prominent public advocate for legalization of physician-assisted suicide. She moved from California to Oregon and, per a plan she specified in advance, died on November 1 of that year after ingesting a lethal physician-prescribed drug cocktail. As a young, attractive, and tragic face for the right-to-die movement, Ms. Maynard, as Arthur Caplan (2014) put it, “shifted the optics of the debate.”

IV. WHAT KIND OF SUFFERING DOES AID-IN-DYING RELIEVE?

Ms. Maynard's story illustrates a pattern: those who seek physician aid-in-dying are rarely driven by the direct experience of refractory pain or other symptoms. At the time she committed suicide, Ms. Maynard was not experiencing symptoms beyond the reach of conventional palliative medicine, nor are such symptoms expected from a brain tumor. Rather, as she said, she chose to end her life on her own terms in order to avoid the prospect of further debility and decline, in which she might “suffer personality changes and verbal, cognitive and motor loss of virtually any kind” (Maynard, 2014).

Ms. Maynard's desire to avoid debility and dependence reflects the pattern found in official reports from Oregon (Public Health Division, 2015), where 9 out of 10 patients requesting assisted suicide have reported being concerned about “losing autonomy” (91.5 percent) and being “less able to engage in activities making life enjoyable” (88.7 percent). Only one in four patients (24.7 percent) have reported even “concern about” inadequate pain control, and at no time in history have physicians and patients had greater access to effective tools for treating pain and other distressing symptoms.

A word about suffering and about palliation of symptoms: In his book *Dying Well: Peace and Possibilities at the End of Life* (1997), Ira Byock, a seasoned hospice physician, describes a case in which he finally came intentionally to sedate a dying patient to unconsciousness, until death, because the patient's excruciating pain had proven refractory to every other treatment modality (see Chapter 10). Those who advocate for physician aid-in-dying often invoke cases like the one Dr. Byock described, but these appeals are

red herrings. Dr. Byock noted that the case he described was the only such case he had experienced in more than 15 years of caring for dying patients (1997, 215). One of the authors (Curlin) has practiced hospice and palliative medicine for more than 10 years and has never encountered a patient whose pain or other disabling symptoms could not be relieved under the norms of proportionate palliation. Last-resort options in general, and assisted suicide and euthanasia in particular, are used much more commonly to relieve what has come to be called *existential suffering*.

Such suffering is, to some extent, inevitable in dying, for dying is in its nature an evil—not a moral evil, but a privation of something always and everywhere good: namely, human life and, more specifically, the life of a person. While death is not to be feared above all things, and while Christians profess that hope in eternal life should accompany death, nevertheless, death is not good, and *suffering itself is the experience of that which is not as it should be*.

So, the experience of illness and the prospect of imminent death usually bring suffering, as they did in the case of Brittany Maynard. This is true whether the patient experiences pain and other symptoms or not. Pain and other symptoms heighten suffering in their direct, noxious effects on conscious experience and also insofar as they disrupt our ability to do what human beings otherwise do when we are healthy. Moreover, patients who are dying often experience alienation from themselves, their friends and family, and even God. All of these bring suffering.

Existential suffering can be described as the cognitive awareness of that which is not as it should be. At the end of life, a patient may experience such suffering through revulsion at the threat of death, regret at missed opportunities and botched choices, sorrow over failed or ruptured relationships, or fear of the divine. These are real problems and real forms of suffering. As such, they require choices, attempts to maintain or restore what harmony is possible at the end of life: acceptance of death, repentance of sin, reconciliation with loved ones, and peace with God.

Physician aid-in-dying cuts short all of these possible responses to existential suffering. Such possibilities can be dramatic: those who have read the novel *Brideshead Revisited* can call to mind Lord Marchmain's literal deathbed conversion, which restored him both to his Christian faith and, in various ways, to his family (Waugh, 1999). Thus, he was restored to the forms of harmony and integrity available to him even at the very end of life. Sometimes treating severe pain will render a patient incapable of pursuing such opportunities to pursue harmony and integrity, but physicians should not accept such losses without proportionate reason.

Brittany Maynard's case makes clear that the primary problem to which aid-in-dying poses a solution is loss of control—the desire to sustain self-determination and autonomy in the face of debilitating illness. In a piece in the *Journal of the American Medical Association*, Timothy Quill, perhaps the foremost physician apologist for aid-in-dying, wrote (with colleagues),

“Patients with serious illness wish to have control over their own bodies, their own lives, and concern about future physical and psychosocial distress” (Back, Quill, and Block, 2016, 245). Brittany Maynard put the point bluntly in her online manifesto: “I want to die on my own terms” (Maynard, 2014). Seen in this light, the movement toward physician aid-in-dying is the culmination of the provider-of-services model’s approach to medicine and medical ethics.

Ms. Maynard then added, “My question is who has the right to tell me that I don’t deserve this choice?” That is a powerful question in our day. The former Hemlock Society is now called “Compassion and Choices” (Brueck and Sulmasy, 2019, emphasis ours). The California law legalizing assisted suicide was called the *End of Life Option Act* (2015). When Governor Jerry Brown signed it, he said he did not know if he would avail himself of assisted suicide, but “I wouldn’t deny that right to others” (Lovett and Pérez-Peña, 2015). Choice looms large.

Now what kind of choice is Ms. Maynard and others like her being denied if physicians refuse to hasten their deaths? Ms. Maynard already had the right to refuse life-sustaining treatment. She had the right to palliation of her symptoms, even if death were hastened as a side effect. She had the means and capacity to cause her death by numerous methods that do not involve physicians and that are equally if not more efficient and effective than ingesting an overdose of pharmaceuticals. Why is it essential that she and others have physicians, in particular, cooperate in helping them kill themselves?

That physicians are being asked, or even required, to cooperate in patients’ deaths shows that “the right to choose” is, as the late Robert Burt noted, “radically incomplete as a justification for physician assisted suicide” (Burt, 1996, 32). The right to choose has been transformed into a positive entitlement to have others help bring about what has been chosen—and not just any others, but medical professionals specifically. The physician aid-in-dying movement portends large-scale changes for the medical profession that will mark the definitive end of the Way of Medicine and the advent of a more authoritarian form of the provider-of-services model.⁷

V. THE END OF MEDICINE AND AID-IN-DYING

The Way of Medicine returns a quick answer to the question of physician aid-in-dying. The end of medicine is health, and the physician professes to seek health in patients. Physician-assisted suicide and voluntary euthanasia involve actions that intend the death of the patient: the first, by means of cooperation with the patient’s suicidal intention; the second, by a direct action of the physician intended to end the patient’s life. Few acts seem more distinctly contrary to the end and the vocational commitment of medicine, and for this reason alone, they have no place in the profession. Nor should physicians be expected, much less required, to aid or facilitate such actions, even by providing referrals.

For a medical profession in good order, this point would suffice, but what can be said to those who are concerned to support patients' right to choose—their right to determine how they are going to live and die?

VI. SUSTAINING SOLIDARITY AND TRUST

Robert Burt, quoted earlier, also notes, “The confident assertion of the self-determination right leaves unacknowledged and unanswered a crucial background question: who can be trusted to care for me when I am too vulnerable and fearful to care for myself?” (1996, 32).

His point is well taken. For every Abe Anderson and Brittany Maynard who want a physician to help them end their lives, physicians are called to care for numerous other radically diminished patients who, along with their families, count on physicians to care for them, seeking to preserve and restore the health that remains, insofar as reasonably possible. An example from the practice of one of the authors (Curlin) makes the point:

Not long ago I was asked to see a patient in the emergency room. The patient, whom I will call Mr. Roberts,⁸ had advanced dementia; he had not spoken in 3 years. He was brought to the hospital by his brother and his niece, who for several years had cared for him at home. The emergency physician's initial evaluation made clear that Mr. Roberts had severe pneumonia and was beginning to suffer septic shock and respiratory failure. After I spoke briefly with Mr. Roberts' family members, they agreed with my proposal to give the patient antibiotics, oxygen, and other supportive therapy, but to forgo mechanical ventilation, even if he came to the point of not being able to breathe on his own. I then asked the patient's brother and niece if they had ever considered hospice care for Mr. Roberts. Both shook their heads and said adamantly, “We are not interested in hospice.” “Why is that?” I asked. They responded that what they had seen indicated that hospice too often forgoes any effort to provide medical care for patients, instead focusing only on giving potent drugs like morphine and sedatives, and thereby hastening patients' death.

Mr. Roberts' family members' concern is one that I have heard voiced by numerous other patients and family members in Durham, North Carolina, and on the South Side of Chicago, and it highlights a question that physicians must consider: With respect to physician aid-in-dying, which of the following should physicians care about most: maintaining the trust of those who, like Mr. Roberts and his family, already experience the debility, dependence, and suffering that advanced illness brings; or empowering those who, like Brittany Maynard, seek through assisted suicide to avoid such debility, dependence, and suffering?

That was not a rhetorical question for Mr. Roberts' family. Indeed, like too many others, they had come to the conclusion that some physicians who wield the tools of palliative medicine are not to be trusted, because

such physicians have so prioritized relieving suffering that they fail to do what patients count on physicians to do: use reasonable means to preserve the health and life of the patient. How much less would Mr. Roberts' family entrust him to a physician or group of physicians that is in the habit of practicing assisted suicide or euthanasia.

Physicians cannot practice hastening or causing the death of their patients without undermining the trust on which the practice of medicine depends. This insight is not new. Physicians who care for patients with advanced illness have long known that everyone will at times be tempted to do away with suffering by doing away with the patient. To militate against that temptation, physicians have for more than two millennia sworn in the Hippocratic Oath, "I will neither give a deadly drug to anybody who asks for it, nor will I make a suggestion to this effect" (Edelstein, 1943, 3). This proscription was preserved without qualification in the "The Hippocratic Oath Insofar as a Christian May Swear It," which was promulgated centuries later in the Christian community (Jones, 1924, 23). In the modern era, the American Medical Association has maintained since its founding, "Physician assisted suicide is fundamentally inconsistent with the physician's professional role" (American Medical Association, 2009). The World Medical Association has opposed assisted suicide and euthanasia since the association was formed and issued the Declaration of Geneva just after the Second World War (World Medical Association, 1948). Indeed, insofar as physicians enjoy the trust of patients made vulnerable by illness, it is because, since the Hippocratic reform movement, at least, most physicians have maintained solidarity with those who are sick and disabled, seeking only to heal and refusing to use their skills and powers to do harm. That is why few physicians have been willing to participate in capital punishment, to be active combatants, or to help patients commit suicide.

Importantly, this boundary against intentionally causing the patient's death not only gives patients a reason to trust physicians, but it also gives physicians the freedom they need to do their work. For example, I was able to tell Mr. Roberts' family members that as a physician I am committed *never* to hasten or cause a patient's death intentionally. This boundary creates a space in which I and other physicians can act decisively to palliate distressing symptoms—for example, by using morphine to alleviate the apparent breathlessness that Mr. Roberts was experiencing, or sedatives to relieve a state of restlessness and agitation in Abe Anderson. Without this boundary, Mr. Roberts' and Mr. Anderson's families have good reason to worry that the morphine or lorazepam that leads to sedation is dosed not at the level reasonably needed to relieve the patient's symptoms but in an effort to hurry along the dying process.

To return to the question we posed above, which should be most important to physicians: maintaining the trust of those who, like Mr. Roberts and his family, already experience the debility, dependence, and suffering that

advanced illness brings; or empowering those who, like Brittany Maynard, seek through physician aid-in-dying to avoid such debility, dependence, and suffering? The witness of physicians and patients through the centuries and into the present has affirmed that we cannot have it both ways. Our answers will determine the practice of medicine into the future.

In April 2017, one of us (Curlin) participated with Timothy Quill in a public debate about physician-assisted suicide, and the night of the event, across town at the Durham Performing Arts Center, Reality Ministries of Durham was having its tenth annual talent show. The performers included dozens of people with developmental disabilities who, to borrow Ms. Maynard's terms, suffer "verbal, cognitive and motor loss of virtually [every] kind." These performers drew an audience of roughly 1,000 persons and, as the organizers promised, "inspire[d], encourage[d], and empower[ed] in a way that no other show can, because somehow this show tells people something about God's presence in our midst" ([Reality Ministries, 2017](#)).

The performers at the Reality talent show displayed a truth that Brittany Maynard could not see: that debility and dependence do not render lives not worth living; that human dignity does not require living (or dying) on one's own terms. This truth is central to Christianity and has been central to Christianity's contributions to the practices of medicine. Historically speaking, the distinctive solidarity of medical professionals with those who are sick and disabled, without respect to their other characteristics—a solidarity we have largely come to take for granted in contemporary medicine in the West—emerged through innovations of Christian communities. It reflects themes central to the gospel narratives and the writings of the Apostle Paul, in continuity with the Old Testament, which emphasize God's own solidarity with those who are suffering and powerless, and his command that his people share in that solidarity.

In a culture that idolizes success and productivity, youthfulness and beauty, and autonomy and control, this truth becomes obscured. The public images of Ms. Maynard made it conspicuously obvious that she possessed all of these when her disease struck, and her public statements made it clear that she saw the loss of success, productivity, youth, beauty, autonomy, and control as a state worse than death. Like Ms. Maynard, those who advocate for and avail themselves of assisted suicide are overwhelmingly white, well-off, and accustomed to being able-bodied. According to official reports, of the 1,083 people who died in Oregon by assisted suicide prior to January 19, 2018, only 1 was African American (statistically, one would have expected at least 20, as 2.1 percent of Oregon's population is African American, according to the US Census) ([Public Health Division, 2018](#)). In Washington State's March 2018 report, fewer than 4 percent of deaths by assisted suicide (from 2015 to 2017) were nonwhites, whereas 20 percent of the population was nonwhite ([Disease Control and Health Statistics Division, 2018](#)). Mr. Roberts' family, like most of my patients in Chicago and Durham, was

African American. A population that already has experienced itself as vulnerable is more likely to see the practice of physician aid-in-dying not as a boon but as a threat.⁹

If “verbal, cognitive, and motor loss” renders life not worth living, you might think that disability groups would welcome physicians hastening or causing the death of those who so choose. The opposite is the case. Disability groups overwhelmingly oppose assisted death. The prominent advocacy group Not Dead Yet speaks for many in arguing that “it cannot be seriously maintained” that legalization of assisted suicide will not lead to “inappropriate pressures from family or society” for people to end their lives. The group contends that “assisted suicide laws ensure legal immunity for physicians who already devalue the lives of older and disabled people and have significant economic incentives to at least agree with their suicides, if not encourage them, or worse” (Coleman, 2010, 48).

To summarize, under the approach we propose, assisted death is impermissible first because it is never reasonable for anyone to kill the innocent, nor help the innocent to kill themselves. Assisted death is impermissible for physicians *a fortiori*, because killing contradicts the very nature of the practice of medicine and its orientation to the patient’s health. If anyone is to help people take their lives, let it not be physicians. Even if these time-tested reasons have lost their grasp on our moral imaginations, it should be clear that it is unjust to purchase yet another choice for those accustomed to living life on their own terms at the cost of betraying physicians’ distinctive solidarity with those who live under the terms of illness and disability that they have not chosen, but with respect to which they should be able to count on physicians’ care.

Given the deep and abiding importance of medicine—we will *all* be sick, will *all* be vulnerable, and will *all* die—it is imperative that the fundamental virtues of solidarity and trust be sustained within the profession. Now that requires, we might say, a medical-moral ecology that maintains the norm against intentionally harming or killing with all the strictness suggested by the Way of Medicine. That norm, as we have tried to argue here, is the touchstone of medicine.

NOTES

1. In physician-assisted suicide, a physician would prescribe a lethal dose of some medication in order to help a patient take his own life. In voluntary euthanasia, the physician might administer the lethal dose himself, perhaps because the patient is too weak to do so. We refer to both these options as *physician aid-in-dying*.

2. Elements of the arguments in this paper have been presented elsewhere. See Tollefsen and Curlin (2021) and Curlin and Tollefsen (2021). Regarding palliation and the boundary against killing, see Curlin (2015). Regarding assisted suicide, see Yang and Curlin (2016).

3. It is important for us to clarify our use of “well-being” here. Our own moral theory has a substantive account of human flourishing at its foundations, and such flourishing could equally be designated

as a form of well-being. However, throughout this essay, we use the term to designate the thin desire-satisfaction model that many medical ethicists presently use.

4. Beauchamp (1995, 185) critiques approaches to bioethics that include categorical prohibitions, “because society and individual actors are absolutely rather than contingently constrained in many cases in which balancing is justified. A good example is the current absolute prohibition of physician-assisted suicide in physician ethics and social policy, even though a significant percentage of both the physician population and the public believes that at least some cases of physician-assisted suicide are justified. The absence of an appropriate mechanism for balancing patient needs and protection of society has led to serious problems because of an inability to meet the needs of dying patients in these cases.”

5. We recognize that patients can reasonably forego food and even liquids when and if ingesting them poses benefits that are no longer proportionate to the burdens involved. This is sometimes the case with advanced cancers, in particular, and need not involve an intention to cause one’s death. But voluntarily stopping eating and drinking as a “last-resort option” refers specifically to forgoing nutrition for the purpose of hastening one’s death.

6. We have written elsewhere (Curlin, 2018) about the problems of palliative sedation to unconsciousness—which involves intentionally sedating patients to the point of unconsciousness and keeping them unconscious until they die.

7. The authoritarian tendencies of the provider-of-services model is evidenced in arguments that physicians who are unwilling to cooperate in practices like abortion and assisted suicide must leave the profession. See, for example, Stahl and Emanuel (2017) as well as Savulescu and Schuklenk (2017).

8. The patient’s name and some details have been altered to preserve confidentiality.

9. Black Americans are significantly less likely to utilize hospice (Johnson, Kuchibhatla, and Tulsky, 2008; National Hospice and Palliative Care Organization, 2018).

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