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978-0-521-69758-3 - Choosing to Die: Elective Death and Multiculturalism

C. G. Prado

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Choosing to Die

In this book, C. G. Prado addresses the difficult question of when and whether it is rational to end one's life in order to escape devastating terminal illness. He specifically considers this question in light of the impact of multiculturalism on perceptions and judgments about what is right and wrong, permissible and impermissible. Prado introduces the idea of a "coincidental culture" to clarify the variety of values and commitments that influence decisions. He also introduces the idea of a "proxy premise" to deal with reasoning issues that are raised by intractably held beliefs.

Primarily intended for medical ethicists, this book will be of interest to anyone concerned with the ability of modern medicine to keep people alive, thereby forcing people to choose between living and dying. In addition, Prado calls upon medical ethicists and practitioners to appreciate the value of a theoretical basis for their work.

C. G. Prado is Emeritus Professor of Philosophy at Queen's University in Canada. He has published many books, most recently *Searle and Foucault on Truth* and *A House Divided: Comparing Analytic and Continental Philosophy*.

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In memory of
Nancy Sutherland and Rose Candeloro Williams,
who chose to die;
and
Larry Baker, Hugheen Ferguson, Nathan Jaganathan,
Russ Savage, Carolyn Small, George Teves, and Bill White,
who didn't

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Frontmatter

[More information](#)

[A]ble to say a holy No when the time for Yes has passed.

Friedrich Nietzsche, *Zarathustra*

Contents

<i>Preface</i>	<i>page</i> ix
1 Setting the Stage	1
2 Criteria for Rational Suicide	26
3 Clarifying and Revising the Criteria	47
4 Application Issues	65
5 What Standards?	88
6 Relativism and Cross-Cultural Assessment	111
7 The Role of Religion	135
8 Assessment Latitude	158
9 The Realities of Cross-Cultural Assessment	179
<i>Works Cited</i>	205
<i>Index</i>	209

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[More information](#)

Preface

Book prefaces often are skipped. This one should be read because it is important for readers to appreciate the intent and nature of what follows and to whom it is addressed.

This book is about the rationality, and so the permissibility, of choosing to die and is addressed to medical ethicists and to those on their way to being medical ethicists. More particularly, the book is addressed to medical ethicists who deal or will deal with terminal patients. And most specifically, the book is addressed to those who deal or will deal with terminal patients considering ending their lives to escape the physical and personal devastation and torment that many terminal conditions produce.

The writing of this Preface was prompted by events at a recent conference on end-of-life issues to which I was invited. I presented some material from the first two of the following chapters, with a view to both sharing my observations with participants and seeking constructive criticism.

The conference participants were mostly clinicians, with a significant number of health-care administrators and some lawyers specializing in terminal-illness issues. I regret that the comments and questions about the material I presented made it clear that few in the audience thought what I had to say was relevant to their work. My commentator ridiculed the abstractness of my presentation and dismissed my concern with the rationality of choosing to die by saying simply that we cannot be rational in terminal suffering.

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In his closing remarks, the conference organizer attempted to remedy matters by saying a little about the importance of the questions I raised. His remarks were well intentioned, but he succeeded only in further marginalizing my position when he said I had spoken about a “noble death” achievable only by a very few. However, he summed up by asking a question that has stayed with me and that I return to in Chapter 7. The question he asked was, “After all, how many Socrateses die?”¹

While I was disappointed and frustrated by my commentator’s and the audience’s reactions, I benefited from the experience. It brought home to me how important it is to attempt to narrow an undeniable communicative gulf that exists between theoreticians concerned with end-of-life issues and clinicians and others who must deal directly with those who are dying.

This gulf is precisely the one that medical ethicists must straddle. The gulf has two aspects; one is perceptual. Medical ethicists are usually perceived by theoreticians as clinicians because of their applied work and regular contact with physicians, nurses, medical administrators, and patients. But medical ethicists are seen as theoreticians by clinicians and other practitioners because of their educational backgrounds and contact with academic ethicists, epistemologists, psychologists, and often theologians. The second aspect of the gulf is institutional and has to do with responsibility and defined function. The fact is that medical ethicists are advisors; they advise both clinicians and patients, as well as patient family members and sometimes the clinics and hospitals in which they work. Medical ethicists are not implementers or agents in the treatment of patients and thus are distanced from clinicians in a manner that cannot be changed by remedying misperceptions.

Medical ethicists, then, occupy a unique position, and in order to function effectively they must balance theory and practice. Their main job is to apply ethical theory to clinical situations and on that basis to offer the best guidance they can to those who make the actual treatment decisions. And this means that medical ethicists must reconcile the sort of abstract considerations regarding rationality and permissibility that this book discusses with the actualities of terminal

¹ My thanks to David N. Weisstub for this productively provocative question.

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Frontmatter

[More information](#)*Preface*

xi

patients' states of mind, pressures exerted by families, and physicians' priorities, responsibilities, and liabilities. Regarding the choice to die, medical ethicists stand between those who, like me, try to formulate standards to govern the surrender of life in dire medical situations, and those whose primary mandate and fiduciary responsibility is to preserve life.

The unavoidable complication is that some terminally ill patients *do* choose to die, that some physicians *do* assist in suicide, and that a few even perform euthanasia for compassionate reasons. It is of paramount importance, therefore, that medical ethicists be provided with standards and especially a rationale on which to ground their advice when patients choose to end their lives, whether by refusing treatment or by taking more direct means. Without standards and an underlying rationale, advising clinicians, patients, and family members regarding terminal patients' choices to end their suffering can only be a more or less happenchance sequence of more and less successful instances of coping with a recurring problem.

What prompted this book, as opposed to a planned third edition of my *The Last Choice*,² is that provision of standards and a rationale for dealing with terminal patients have been greatly complicated by the contemporary rise of multiculturalism and especially the relativism inherent in it. The need to respect cultural values and their influences on assessment standards, and factor them into policy and particular decisions about end-of-life issues, has made dealing with those issues greatly more complex than it was when policy and decisions were made and assessed in the context of a single dominant culture.

The key question, then, is not how many Socrateses die – though I return to this question in Chapter 7. Rather the key question is, How close can we come to emulating Socrates? The criteria I offer here, and the consideration of how relativism and culture impact their formulation and application, are intended to provide medical ethicists, as well as individuals considering ending their lives, with a basis for assessing the rationality of choosing to die for medical reasons.

² Prado, C. G. 1998. *The Last Choice: Preemptive Suicide in Advanced Age*, 2nd edition. New York and Westport, Conn.: Greenwood and Praeger Presses.