

## Kingdom of the Sick: The Ethics of Assisted Suicide

“Switzerland is a country where few things begin, but many things end.”

—F. Scott Fitzgerald

Every year, hundreds of people—the exact number is unknown—travel to Switzerland to die. The country’s great attraction is its law on assisted suicide, the most relaxed in the world. Other governments, if they allow the practice at all, place strict conditions on eligibility: Generally, the dying person must be a permanent resident who suffers from a terminal or incurable illness, as confirmed by two to three physicians. In Switzerland, assistance in ending one’s life is available to people regardless of whether they reside in the country. No doctor, at least in theory, is needed. And the dying need not be sick.

Half Swiss, half American, I moved to Switzerland in early spring of 2018 and lived there for the better part of a year, during which time it was impossible to avoid discussions of assisted suicide. It should be noted that the likelihood of encountering a certain ethical dilemma varies from place to place. One hears, for instance, about water conservation often in Los Angeles, but rarely in New York. The logic holds for Switzerland, too: With its unique laws and aging population, the question of assisted suicide surfaces with far greater frequency than in the United States.

Just a few weeks into my stay, I started to hear reports about David Goodall, a scientist who would be landing soon in Basel, the city where I was living. He, like so many before him, was coming here to die. Because Switzerland has no residency requirement for assisted suicide, it is globally the main destination for *Sterbetourismus*—literally “dying-tourism,” but more commonly called in English “suicide tourism.” It is estimated that between 2008 and 2012, for the city of Zürich alone, 611 foreigners traveled to take advantage of Swiss laws on assisted

suicide. Few suicide tourists make the news anymore. Goodall's case caught reporters' eyes only because it was so extreme, so outside of the norm. He was a 104-year-old scientist of moderate renown and sound health. His only medical problem was that he was old—very old—and no longer wanted to live. He had, at least once, attempted to kill himself back home, where assisted suicide is forbidden. His attempt failed. The only remaining option he could see lay in another hemisphere. Most suicide tourists in Switzerland come from nearby countries, like the U.K. or Germany. He was coming from Australia.

Goodall arrived in Basel on Monday, May 7, 2018. The assisted suicide organization Exit International had arranged a place for him at a local end-of-life care center. The room was hospital-like, sterile except for a few warm decorations. Goodall's grandchildren came to Switzerland, too, and in his final days, they toured the botanical gardens together at the local university. As the appointed hour neared, Goodall ate cheesecake. He listened to Beethoven. And then he died. The final agent of death was an intravenous dose of barbiturates.

For the assisted suicide to be legal, those directly helping Goodall die first had to lack any selfish motive in the act, such as securing an inheritance.<sup>1</sup> Second, Goodall had to start the flow of barbiturates himself, in this case by releasing a valve. (Euthanasia—in which the doctor, rather than the patient, delivers the final blow—is illegal.) Lastly, Goodall had to be capable of decision-making, in the ordinary sense of the competence needed to make a purchase or sign a contract. Assisted suicide organizations like Exit impose additional restrictions on which cases they will help with, but there are no further limitations from the state. Anyone, regardless of whether they have medical training, can help a person die. Anyone, too, can receive help in dying, including the young and the mentally ill, so long as they have the capacity for decision-making. In practice, since barbiturates and other lethal medicines can only be prescribed by doctors, the

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<sup>1</sup> The legality of the action derives from the fact that the Swiss penal code criminalizes assisting someone's suicide for *selfish* reasons, but says nothing of *unselfish* cases. By omission, unselfish assistance is allowed.

dying person generally has some contact with the medical system. For non-medical methods of death, though, anyone can legally help.

During my stay in Switzerland, a few other instances of assisted suicide made the news, such as a prisoner requesting to die, but none touched me quite like Goodall's case. In the articles and interviews I read, his attitude toward Switzerland surprised me. Like a refugee escaping danger, his overwhelming response was *gratitude*. He gave thanks for the Swiss, because they, and no one else, would help him die.

When I fly to Europe, I leave the U.S. on my navy American passport and arrive on the red *Schweizer Pass*. On this particular arrival in March, though, I felt that I was undergoing more than one journey, that I was entering both Switzerland and another realm. I was sick. I got off the plane woozy, went to my great-aunt's house, and slept the day through. I vomited. I later learned that I had acquired *giardia* while traveling elsewhere in Europe, but there were larger problems, unrelated to the parasite. My legs were giving in. I could hardly walk through the airport terminal, let alone set up life in a new city. Along with a full physical exam, I underwent a battery of tests—blood, enzymes, a host of things I could not recognize in German. Nothing was found, which meant that little could be done.

Later that spring, resting in bed and capable of walking only a few blocks at a time, I remembered a famous Susan Sontag line about how we all hold dual citizenship, in the kingdom of the well and in the kingdom of the sick. "Although we all prefer to use only the good passport," she wrote, "sooner or later each of us is obliged, at least for a spell, to identify ourselves as citizens of that other place." This sojourn of mine, I realized, was to take place not only in Switzerland, but in the kingdom of the sick. I would be breaking in two passports at once.

Switzerland has been associated with illness for a long time. In the 19th century, consumptives traveled to alpine sanatoria, convinced that the mountain air would heal them. In

the 20th century, patients sought out the country's psychiatric hospitals, the most advanced in the world. Suicide tourism is only the latest iteration of Switzerland's role as the place where things reach their inevitable halt. Yet in each stage of this roughly sketched medical history, there has been, alongside the bleak facts of illness, a great deal of compassion. Switzerland may be, as Fitzgerald has it, a country where many things end, but it is because the end one faces there is better than the end found anywhere else. Goodall told the press in his last days, "I am happy to have this chance, although I would have preferred to have it in Australia." Dying in some Basel-area apartment was not the end he had wished for, but it was the best he could get.

In Switzerland as in America, the argument of autonomy plays well. Like the U.S., the country retains something of its history as a confederation; privacy and self-determination are axiomatic in value. To shape your own life, to be free from the interference of others—that is the Swiss ideal.

Patient autonomy—respecting the patient's right to self-determination—is also the main argument behind medically assisted suicide. It is one of the three principles that generally guide physicians' conduct, the other two being beneficence (acting in the patient's interest) and non-maleficence (not harming the patient). Those who defend assisted suicide emphasize patient autonomy and are likely to call the practice "medical assistance in dying" to stress that it is fundamentally the patient's wish and action. They argue that since patients already have the right to refuse or stop care in a terminal case, it is only logical for them to also receive help in dying. If a doctor must allow patients to forgo ventilators if they choose, how is prescribing a lethal medication any different? Opponents, in response, argue that when a doctor withdraws treatment, there is the important distinction of *intention*. While death is a foreseen consequence of moving a patient off a ventilator, it is not intended. In contrast, in assisted suicide, death is

both foreseen and intended. The distinction may be legally important, but to the dying such debates are likely to appear academic.

While the argument for assisted suicide rests on patient autonomy, the opposition rests on non-maleficence. One hears again and again the famous formulation of *primum non nocere*: First, do no harm. It is the doctor's most binding duty. Still, trying to understand suicide in relation to non-maleficence is like dividing by zero: logic founders in the face of unknown nullity. How should doctors approach a treatment that cures all but ends all? Is suicide ultimate relief or ultimate harm?

Because physicians have ethical duties that non-physicians do not have, some believe that assisted suicide, if legal, should be separate from the medical system. How dangerous it would be, they argue, if doctors could stop treatment and instead recommend death. Physicians—those citizens whom we have trained to heal us—are not the ones who should have assisted suicide as a tool in their toolbox. When it comes to euthanasia, some people even fear that doctors will terminate the lives of those who wish to keep living.

While there has been evidence of abuse of euthanasia in the Netherlands, with some patients being euthanized without expressly desiring it, there are no grounds for similar concern about assisted suicide in Switzerland. Tight controls are in place, for if the assisted suicide were selfishly motivated, then it would be a criminal act. After each assisted suicide, prosecutors open a criminal investigation. Assisted suicide organizations film each patient's death to prove that the dying person committed the final act himself, aware of his decision and under no external pressure. Switzerland's example does not prove that the practice of assisted suicide is necessarily ethical, but it does demonstrate that one can make it safe. Independent of whether assisted suicide helps or harms patients, it undoubtedly gives them more control.

In the heat of summer in Basel, on a day that my legs were more or less immobile, I picked up the writer Julian Barnes' memoir *Nothing to Be Frightened Of*. At one point in the book, which is largely a meditation on death and dying, Barnes recounts the story of a famous ancient Roman:

When Atticus fell ill, and medical attempts to prolong his existence merely prolonged his pain, he decided that the best solution was to starve himself to death. No need to petition a court in those days, citing the terminal deterioration in your 'quality of life': Atticus, being a Free Ancient, merely informed his friends and family of his intention, then refused food and waited for the end.

The point is not that Atticus had a perfect death—his death sounds, in fact, fairly miserable—but rather that he did not need anyone's permission. He wanted to die, and so he died. There was no bureaucracy, no psychiatric evaluation, no government impeding his wishes. He could just go.

I googled Barnes after reading the book. It turns out he belongs to a British group called Dignity in Dying, which advocates for legalizing assisted suicide for the terminally ill in Britain. Every eight days, according to the group, a Briton travels to the assisted suicide organization Dignitas, in Zürich, to die. Assisting a suicide remains punishable in Britain by up to 14 years' prison, creating risks even for those who help the ill escape to Switzerland. As Barnes told the *New Statesman*: "people with terminal illnesses find themselves obliged to head off to some God-awful Swiss industrial estate to make away with themselves—and in the process potentially criminalize those [in Britain] who help them." Barnes' advocacy group believes that people should, if terminally ill, be allowed to die in their own country, on their own terms.

Appeals for assisted suicide tend to invoke ancient precedent, a nostalgia for when dying involved fewer wires and tubes. Organizations take on Latin words for their names, cite Cato and Socrates as examples, and have even tried to rehabilitate the connotations of "euthanasia," which in Greek only means "good death." The basic contrast at work is of Atticus dying in bed vs.

Britons dying in “some God-awful Swiss industrial estate.” Modernity seems to have afforded us only a more alienated death.

A bad death, as Barnes notes, is easy to define: long and drawn-out. A good death proves more difficult to articulate. Generally, though, we think it is better to die in our home than in a hospital, better to die surrounded by loved ones than alone, better to die in a dignified condition than in a depleted one. Assisted suicide scores well on all of those measures. It offers a modicum of control at the end of life: about the timing, the place, the conditions. And the fact is that when we talk about death, we are always talking about control. The one thing that everyone in the kingdom of the sick wants but that none really has.

In the Swiss Alps that summer, hiking with my aunt and cousin, I retold a story that my mother had once told me. When my grandmother was dying of lung cancer, my grandfather’s new wife had, apparently, suggested euthanizing her. I had inherited my mother’s indignation at the suggestion, but my cousin, when I finished the story, was just confused. “What’s euthanasia?” she asked. I realized my error. One does not speak of death, neither to the elderly nor to the young. My aunt, in an effort to soften the subject for her teenage daughter, replied: “In Switzerland we call it Exit.” When someone is near the end of their life, she went on, they could choose when to say their goodbyes.

The refusal to think about death clearly—unsentimentally—is a privilege found in the kingdom of the well, but it costs those in the kingdom of the sick. The more we look away from death, the more we accept, implicitly, the reality of how people today die. The more we accept, too, the options that we ourselves will be offered at the end.

As my sickness progressed that summer, I grappled with the fact that my condition might never improve. What would I do if I never returned to health? Like most residents in the kingdom of the sick, I ruminated on suicide. What surprised me, though, was that the thought of

suicide only made me want to live more. Each time I thought about leaving this world, the more I resolved to stay, at least for now. The same logic, I would later learn, is at work in assisted suicide: When you give people the option to die, many of them use it only to affirm that they want to live. One study records how in Oregon, the first U.S. state to legalize assisted suicide, 1,327 people received prescriptions for lethal doses of medication over two decades, but only 859 used them. The fact of having some control relieved the patients, even if many did not use that control to alter their situation.

I also realized—for this is where one's thoughts go in the kingdom of the sick—that there is a point of degeneration at which I would no longer want to live. If my condition worsened to the point of paraplegia, I would be willing to keep living. But if I became permanently bedridden and quadriplegic, with no possibility of motion at all, I would want to die. At that point, too, I would need help in dying.

The knowledge that others will help us at the end of our life allows us to face dying with some calm. I remember reading many years ago about the case of Percy Bridgman, a Nobel Prize-winning physicist famous in debates about assisted suicide. When Bridgman faced the final stages of an aggressive cancer, he shot himself and left a note: "It is not decent for Society to make a man do this to himself. Probably, this is the last day I will be able to do it myself." Bridgman was afraid of what happened to Goodall, the Australian scientist, who no longer had the physical strength to kill himself and yet whose government would not help him die. Bridgman anticipated that no one would deliver the *coup de grace* that he saw as society's obligation to decency. There were only two options: to kill himself before he grew too weak, or to let the cancer run its full, devastating course.

Bridgman's note reminds us that the question at stake is not the ethics of assisted suicide, precisely, but rather the ethics of banning it. Dying patients do not demand that all doctors participate in the practice. They are not asking *you* to help them die, only that you don't stop

others from doing so. It seems to me, in the balance of things, a small request. It astounds me, too, that it is a request met in only one country on earth.

By the fall, my legs had recuperated somewhat, and I returned to New York for my senior year of college. A few weeks in, I went to the ballet with a friend of mine who, during my sophomore year, had been diagnosed with cancer. We talked on the theater's outdoor balcony, looking out over the fountain in Lincoln Center. I told her I was working on an essay about assisted suicide. She had a lot of thoughts. She knew, for one thing, about Oregon. She told me that when she was preparing for chemotherapy, she promised herself that she would go through treatment once, but no more than that. If the cancer came back, she would kill herself. "That's how my aunt did it," she said. I didn't dare ask: That's how her aunt survived chemo? Or that's why her aunt killed herself? But my friend insisted that there was no other way to get through treatment. She had to know that she was still in control.

The first round of chemo proved enough, and she went into recovery. While I was abroad, though, she had follow-up PET scans that showed the tumor was back. A technician's report indicated a 95 percent probability that the cells were cancerous. My friend was in another part of the country at the time; she rushed back to New York. She did not want more treatment. She remembered a bottle of tranquilizers that she had stashed in her medicine cabinet for exactly this case. At 2 a.m., she reached the door of her apartment and took out her keys, ready to end things. But fate, for the time being, stood in her way: The key would not turn the lock. She endured outside the apartment for twenty minutes, fumbling and fussing with the lock, until finally she collapsed outside the door. She called a friend, who offered her a place to spend the night. It saved her life. A biopsy later proved that the scans were a misdiagnosis.

I wondered, when she told me this story, what I would do if she ever called me and said the cancer had come back for real, confirmed by a biopsy. Would I help her open the door, get to

the pills? If her hand shook opening the bottle, would I unscrew the top? For that is what assisted suicide would be. I knew something of what she felt. I knew that you had to set the terms on which you would or would not live. Hers were honest and fair: *One round of chemo, but not two*. Still, I could not imagine losing her. My private wish that she would keep living collided with my belief in the importance of autonomy. I hold firmly that she has the right to end her life, and the Swiss example has persuaded me that she should receive assistance in doing so. It is a difficult line to toe. All I can say now is that if she ever called me on another dark night—from her apartment, from a hospital, from New York, Oregon, Switzerland—that I would insist on her right to end her life, even as I tried my best to save it.

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