Christian Bioethics, 24(1), 17–37 2018
doi:10.1093/cb/cbx017

Institutionalizing Inequality: The Physical Criterion of Assisted Suicide

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The recent legalization of assisted dying in California, along with similar bills before other states, returned assisted suicide to the national spotlight. In Anglo-American dying bills, two criteria restrict eligibility for assisted suicide: (1) the uncoerced request to die (roughly, the "autonomy" criterion) and (2) severely deteriorated health of a certain kind (roughly, the "physical" criterion) from a six-month terminal illness (US jurisdictions) to severe and irreversible conditions (the Netherlands, Belgium). I argue that the physical criterion in any form violates the equality of respect and moral status of a large class of people, thereby degrading them, and I supplement this with theological considerations drawn from Thomas Aquinas. Even if the slope were not slippery and the autonomy firewall prevented Dutch-style mission creep, the physical criterion itself degrades tens of thousands of sick, disabled, and dying people by insinuating that their lives—but crucially, not other people's—are "objectively" the sort of thing they might reasonably want to dispose of.

Keywords: *Aquinas, assisted suicide, disability, dying, end-of-life, equality, respect*

I. INTRODUCTION

Assisted suicide has in recent years become legal in Oregon, Washington, Montana, Vermont, California, and Canada. Last November it was legalized in Colorado, and further bills are in preparation. The procedure puts in tension competing moral intuitions. On the one hand, there is the wish to help patients who long for relief from appalling agonies and want to contrive a seemly death. Advanced technologies have improved pain control but prolonged life expectancy in ways that multiply tragic scenarios, such as when a spreading and incurable cancer induces constant pain, incontinence, loss of bodily functions, and despair coupled with resentment at a humiliating sense of lost dignity. In such circumstances, to refuse to help kill those who want to die strikes many as needless cruelty and blatant paternalism. Ronald Dworkin went further, calling it a “devastating, odious form of tyranny” to force people to endure “a horrible contradiction” of themselves (Dworkin, 1994, 217).

On the other hand, to imply that some human lives are less worthwhile due to age or sickness is a ruinous thought, and many think assisted suicide insinuates just this. There is also the Hippocratic anxiety, as we might call it, that medicine as a craft will be subverted if our definition of healing becomes elastic enough to include killing. It is also unclear how helping to take people’s lives could affect solidarity within society and between generations. Might it not create a sense of abandonment to signal that we are not altogether committed to keeping certain people around? With healthcare and entitlement costs exploding, many note that the patients most costly to the system tend to be exactly those who would be eligible for assisted suicide (see Humphrey and Clement, 2000, 339–53). As fair innings arguments and healthcare rationing become more common, might old tropes about those “useless to society” return in sanitized or disguised forms? (On this question, see: Andre and Velasquez, 1990; Williams, 1999, 47–55; Lamm, 2004, 1; Altman, 2005.) Combined with this are slippery slope worries that critics dismiss as alarmist but that sordid tales from Belgium and the Netherlands help to keep alive.

Yet, advocates of assisted dying insist that if strict safeguards are put in place, a reasonable compromise may be struck between refusing mercy to the desperate and installing a lax suicide regime prone to abuses. They note that no US or UK bill has proposed suicide on demand as a right for any adult, for any reason. In every such jurisdiction, great efforts have been made to show that eligibility for suicide assistance would be strictly limited. Two criteria are proposed to do this in what I will call the “standard model.” First, the request to take one’s life must be made by the patient capably and without coercion. Second, the patient must suffer from severe physical deterioration of a certain kind: typically, a terminal illness in which death is foreseen within six months. For convenience, we may call the first the autonomy criterion and the second the physical criterion. The first tries to disarm slippery slope worries while valorizing patient autonomy. The second puts buffers on autonomy itself by reaffirming our commitment to preserve people’s lives except in the most desperate circumstances. In doing so, the physical criterion salutes the view that suicide generally is tragic and something to be prevented rather than an ordinary treatment.

Many regard this as a reasonable model that shows compassion in extreme circumstances within strict limits. Moreover, such assurances are now being heard by a culture increasingly prepared to strike down religious and conservative taboos that interfere with growing claims to autonomy—especially bodily autonomy. Combine this with a string of recent legislative successes, and a judicious observer might predict that assisted suicide will be widely legal and fairly accepted within a decade or so. But, part of the ethical interest of this issue, I want to suggest, is that its moral complexity eludes our cultural expectations. Partly owing to notable medical and disabled opposition, assisted suicide has suffered its worst defeats in socially liberal contexts such as the United Kingdom.[1] That alone raises interesting questions and suggests that the issue need not map onto the usual left versus right political scripts.

Skirting questions of individual suicide and treading the slippery slope lightly, I argue that the very criteria meant to restrict eligibility and protect the vulnerable would ironically end up violating the equality of all concerned in institutionalized fashion. Whereas much of the debate has addressed issues related to what I call the autonomy criterion, my argument focuses on dangers latent in the physical criterion. The weak link in the chain, I argue, is the physical criterion *in any form*: from the six-month terminally ill (US jurisdictions) to those with a variety of severe conditions (the Netherlands, Belgium). The physical criterion establishes who is eligible for assisted suicide and who is not. The criterion, of course, is not meant to be arbitrary, but judicious. As such, it sifts suicide applicants into two categories: those whose request is judged reasonable and justified, and those whose request is judged unreasonable and unjustified. The latter are targeted for suicide prevention and for them lethal drugs are abusive; the former receive suicide facilitation and for them lethal drugs may be "medicine." The criterion therefore functions as an evaluative basis for the state to judge whether someone who thought his life was not worthwhile was *objectively* justified in that belief, or not. That the state would regard this judgment as "objective" is shown by the fact that it would see your opinion not just as plausible enough to guide your actions, but as evident enough to be irreversibly and lethally action-guiding for the state's own. The criterion will therefore degrade the tens of thousands of very sick and dying people who conform to it by insinuating that their lives—but crucially, *not* other people's—are the sort that may be reasonably thought not worthwhile and disposed of accordingly.

The first sections argue that the Anglo-American "standard model" of assisted suicide construes some lives as less inherently worthwhile than others, and that the physical criterion degrades those to whom it is applicable, violating the fundamental respect and moral status that all human beings are equally due. Since Western democracies claim to uphold such equality as fundamental, assisted suicide should be viewed by them as wholly incompatible. While much of the argument is philosophical, a section drawing on Aquinas argues that equality in this sense is compatible with Christian theology and greatly enriched by it. This opens up the welcome prospect of joint opposition to assisted suicide from both believers and unbelievers alike. The essay goes on to consider the viewpoint of the degraded themselves and concludes that the physical criterion does frame suicide as reasonable and choiceworthy for anyone sick or frail enough to qualify, degrading them and institutionalizing inequality.

II. THE STANDARD ANGLO-AMERICAN MODEL

One of the remarkable features of assisted suicide bills in the English-speaking world is their general uniformity. From California to Colorado, from the United States to the United Kingdom, assisted dying bills have recycled the same basic formula pioneered in Oregon.[2] Originally ghostwritten and still championed by advocacy groups such as Death with Dignity and Compassion and Choices, I will refer to it as the "standard model" of assisted suicide in the Anglo-American context. It is legal now in six states and has repeatedly been proposed in Britain, Australia, and elsewhere.[3] The standard model proposes the following. To be eligible, patients must be at least 18 and diagnosed with a terminal illness they are reasonably expected to die from within six months. The patient must request, verbally and in writing, to be given medication for ending his or her life; have the capacity to make and communicate healthcare decisions; and must sign the request in the presence of two witnesses. After two weeks, the doctor may prescribe lethal drugs (here termed "medicine") that the patient must self-administer.[4] So, this is what most jurisdictions still call "assisted suicide" as distinct from euthanasia, though advocates seek to detoxify the brand by relabeling it "assisted dying," "death with dignity," or "medical aid in dying."

Everything in the standard model is framed medically, but it is important to ask why. Assisted suicide has not been framed—in fact, it has long been grandiloquently resisted—by the medical establishment. A long list of professional organizations, including the American Medical Association and the British Medical Association, opposes it as corrosive to the doctor-patient relationship, contrary to the Hippocratic oath, contrary to the do no harm principle, and contrary to medicine as essentially a craft of healing and caring.[5]

When looking at the standard model of assisted suicide, the question arises: "why these criteria for assisted dying and not others?" Why, for instance, is a six-month terminal illness required? The medical establishment describes such long-term diagnoses as notoriously inaccurate, leaving the project empirically adrift.[6] It is also unclear why only the terminally ill would be eligible. By what moral consideration does a patient dying fairly painlessly of a tumor have a choice that is refused to a chronic sufferer consigned for decades to the agony of multiple sclerosis or quadriplegia? To the extent compassion and autonomy are meant to inform the debate, the terminal illness criterion rather misses the point. Moreover, what about those who wish to die but cannot physically administer the lethal drugs themselves, and so are left to fester because the state will not take the last step of euthanasia? Once we frame assisted dying as a "benefit," would it not be discriminatory to provide it to patients who can swallow pills by themselves, but withhold that same benefit from a patient so ill she cannot lift her own arm?[7] In my view, such points suffice to show that the standard model is unnervingly arbitrary and indeed incoherent. Simply as a work of practical reason, it has an acutely slapdash scissors-and-paste look to it. Given the steep burden of proof we should expect for justifying new and expanded forms of killing, this is not an encouraging thought.

III. THE UNCERTAINLY WORTHWHILE LIFE

Reflections on suicide with their familiar Hamlet questions are beyond this paper's scope.[8] What motivates the agent and what the agent takes suicide to mean will vary between individuals. Nevertheless, the suicide decision as such, if lucid and deliberate, will share in common the belief that it is preferable for one to die than to live, and that killing oneself (whether with or without assistance) is a well-advised means to that end. Consenting to die obviously differs from trying to. If I take a direct bullet to save someone else, the remote prospect of survival is compatible with my intention. But if I wake up in a hospital vomiting lethal drugs after an assisted suicide attempt, my intention has been frustrated. So whatever the motives may be, the intention of assisted suicide is to be left dead on the table.[9] Since death is supposed to be in the patients' interests (and not, e.g., the state's), it presupposes the patients' belief that life is *not* in their interests: that their lives are no longer worthwhile. Beyond this, the act itself signals despair over their prospects ever mending.

With a few exceptions, current Anglo-American law treats the belief that one's life is no longer worthwhile as powerfully mistaken: to the point where the state actively dissuades from suicide rather than merely registers disapproval. To reverse that policy would empower the state to believe that people in certain circumstances are justified to think their lives are not worthwhile, even while insisting that everyone else's lives are. At that point, some lives would be characterized as less inherently worthwhile than others, however we negotiate that further thought. This conclusion is ratified by the self-reporting of patients who do obtain assisted suicides. According to state records, the top three reasons patients say they elect to die are a loss of physical autonomy, lost enjoyment taken in life, and a lost sense of personal dignity (Oregon Health Authority, 2017). As this suggests, the reasons given to justify assisted suicide do so *precisely by* characterizing a person's life as irremediably wretched, as no longer worthwhile. Given that human beings are necessarily instantiated in human lives, might the belief in equal human worth or dignity thereby be compromised?[10] Might an inegalitarian, undemocratic thought have gotten in the back door, threatening the coherence of our moral taxonomies, and much else besides?

If so, then in a roundabout way, assisted suicide would unwittingly threaten belief in human equality. Those like Peter Singer who distinguish human *beings* from human *persons* are generally happy to accept this (see Singer, 1994, 132–58). That distinction rests on a strict utilitarian anthropology (which I have criticized elsewhere, see Elliot, 2017, 33–8) whose outright rejection of human equality and human rights is sternly opposed anyway by the overwhelming majority of assisted suicide advocates.[11] Since human beings are inseparable from human lives, the consequence is that if I believe my life is not worth living, then I implicate and devalue the ongoing worth of me. Those who collude in that judgment performatively characterize some lives and people as less worthwhile than others, however unintentionally and however motivated by compassion.

IV. THE STATE AS ARBITER OF MORAL STATUS

It is one thing for private persons to think some lives are less worthwhile, but quite another for the state to traffic in such judgments armed with new lethal powers. Understandably, then, the standard model tries to make the state stay neutral about the value of my life in deliberating about my death. According to the standard model, only I would decide whether my life was worth living any more. The state would take a "no comment" approach here, honoring my decision to die but saying nothing about whether the government thinks my lethal choice well-advised. This would "save the appearances" for the state, allowing it to say that all human lives have equal value, while helping some people end a life for which *they* see no further value.

State agnosticism might hold up if autonomy pulled all the levers. However, no US or UK bill proposes assisted suicide on demand for any and all autonomous agents.[12] As previously noted, two criteria govern the standard model. The *autonomy criterion*, with its medical checks, I discussed already. I also touched on the *physical criterion*, according to which lethal eligibility requires some kind of physical deterioration. To be eligible for assisted dying, one would need a diagnosis that the state could then treat as an objective way of measuring whether one's life had sufficient disvalue for death to be in one's own interests. This judgment would grant the state an epistemic space licensing severe evaluative intrusions into our lives. Whether a six-month terminal illness or something else, the physical criterion establishes who is eligible for assisted suicide and who is not. This would empower the state through medical delegates to play the role of meta-ethical epistemologist, judging which patients were more or less correct, more or less accurate, to believe themselves better off dead. With notable irony, assisted suicide would in this respect be the apotheosis of state paternalism, giving it the God's-eye view into what—apart from what we think—our lives are really worth.

To get around this concern, some propose dropping the physical criterion altogether, leaving autonomy the sole determinant for eligibility.[13] But, all legislators and advocacy groups behind assisted suicide insist that buffers be put on autonomy and reject the suggestion that they are pushing toward suicide on demand—to a situation in which anyone from roughly age 18 could get a lethal dose of secobarbital, no questions asked. The autonomy criterion, if unconstrained, would permit appalling scenarios: such as a depressed teenager discarding his life after romantic heartbreak or a raped woman facilitated to die out of persistent trauma or shame. Few would accept such horrors, and so the physical criterion as a constraint on autonomy will not go away unless our attitudes about life and death change so drastically that we become almost unrecognizable to ourselves (see Raz, 2013).

The physical criterion gives the appearance of objectivity to the procedure, and the standard model shores this up by calling lethal drugs "medicine" and assisted dying "health care." The "medical" label also makes clear what many doctors resent: that they will be pressured into this scheme as part of their job description. The substantive work this medical language does is to define death as a benefit rather than harm for certain patients and so to provide a fig leaf for the "do no harm" principle. By construing lethal drugs as medicine for me but poison for others, the state would lay its cards on the table and commit to the belief that death was a "benefit" for me after all: that it was good for me to die.[14]

It may help to consider how this could concretely look. Suppose A is an octogenarian dying of cancer who wants to take his life after another round of failed chemotherapy. In the same hospital room is B, a thirty-something who survived a botched suicide attempt with life-long maiming. A and B talk and find solidarity in the notion of dying with dignity on their own terms. Each calls the doctor round to hear their assisted dying requests. Now what happens? We find out that the state views the comparative value of their lives very differently. The doctor tells the non-dying B that he is not eligible for assisted dying. Instead, he is referred for suicide prevention to a group like the Samaritans who provide counseling and say things like "you have reasons for living, there is hope, your life is worthwhile, don't give in to despair, we will help you get through this." By contrast, when A asks for assisted dying, he is not referred to the Samaritans. Instead, after a consultation about options such as counseling, the doctor returns with something rather like a death warrant and gestures to where A should sign. He gets not suicide prevention, but suicide facilitation, however understated; and later receives what Baroness Finlay calls "the medical equivalent of a loaded gun" (BMA, 2016). Any claim to value neutrality subsequently rings false. The state takes a clear *stance* about the comparative inequality of human lives when it insists to some people that their lives are worth living, even if those people think otherwise, while treating other people as justified to think they are better off dead, even if the state does not press the point.

V. INSTITUTIONAL INEQUALITY AND DEGRADATION

Plainly, we undermine the equality of a group of people when (as with the physical criterion) we cast doubt on the equal and ongoing value of their lives relative to other people. Discussions of equality are notoriously complex and fraught with questions of need, merit, opportunity, distribution, and so forth. But, these are not my focus. The sense of equality with which I am concerned here is widely shared and importantly basic: specifically, the view that all of us are owed a certain respect equally and simply as human beings and that we enjoy equal moral status.[15] This is why people's skin color or age, for instance, could never be justified as a *reason* for treating them as less deserving of respect and regard. Bernard Williams argued that instead of a reason, it would be "a purely arbitrary assertion . . . like that of some Caligulan ruler who decided to execute everyone whose name contained three 'R's" (Williams, 2005, 100).[16] That shared equality of respect and moral status is the only aspect of equality I wish to address, and it plainly differs from the personal esteem we may enjoy owing to talent, rank, admirability, and desert; all of which may be unequal between individuals (see Angier, 2015, 169). Notwithstanding outliers such as Peter Singer, equality in this sense of fundamental respect for a shared humanity is widely accepted as a minimal moral standard by the laws and institutions of Western ethical and political culture.[17] Such respect minimally requires us to respond to people not only in terms of their usefulness or status but also with regard for their agency and dignity; and it rules out practices that would exploit or degrade them.[18] The concept is often associated with Kant's injunction to "treat each person as an end in himself, and never as a means only," but it certainly predates eighteenth-century moral theories, a point to which I shall return.

To disrespect people due to inherent features (for instance, race or disability) is particularly grave. The disrespect then attaches not just to their clothes, their reputation, or their character—things they might conceivably change—but to unchangeable and salient features of themselves. I call reviling of that kind *degradation*. Where degradation is not just transient and occasional, but socially reinforced and institutionally rooted, it will be structural: absorbed into the fabric of social systems and reinforced by countless attitudes, beliefs, decisions, motives, policies, and rhetorical tropes. A slave state or thoroughly racist society is an obvious example. Yet, degradation is often not obvious at all, especially within its own context.[19] The standard Anglo-American model sets the physical criterion at a six-month terminal illness (although Oregon recently proposed expansion to twelve; see OregonLive, 2015). In the Netherlands, the physical criterion now includes some disabled newborns (see Verhagen and Sauer, 2005); in Belgium, it includes patients going blind or intractably depressed, but not dying (see Bendavid, 2013). However defined, my contention is that by taking one group of human beings to be disposable in a way no one else is, assisted suicide degrades them.

It might nevertheless be said that the focus should be on patient autonomy rather than worries about social attitudes, such as a weakening sense of equality. But, my primary argument is not that social attitudes caused by assisted suicide will emerge to threaten equality; it is that the degrading evaluative status conferred by the physical criterion *itself* violates equality. The point turns essentially on the debasement of moral status rather than on the adverse social consequences that may follow, though the latter would aggravate the former. This violation would remain *even if* abuses were rare, social attitudes did not perceptibly worsen, and the slope was not slippery. Analogously, in a society where husbands may abuse their wives, all women are degraded by that very fact; and this would be true even if data showed that few or no men *did* abuse their wives. But since assisted suicide presupposes a patient's request, it may help to look at scenarios where degradation comes packaged as a right.

One example would be an ancient Greco-Roman context where people could sell themselves into slavery *provided they were "barbarians."* Whatever one thought of the right to sell oneself into slavery in extreme circumstances, the idea of restricting it to "barbarians" would single them out for degradation by implying that they were somehow suited for it in a way no one else was—as with Aristotle's "natural slaves." Assisted dying likewise veers toward defining a category of "natural suicides" apt for lethal medicine as distinct from all the "unnatural suicides" who instead get suicide prevention.

Or suppose a future bill proposed giving students the right to drop out of school at age 12 *provided they were racial minorities*. Even if advocates claimed that many racial minorities attended underperforming schools and were desperate to escape, adding that they welcomed the increase of autonomy and would not be pressured to drop out, the degrading double standard would be apparent. There will be a disquieting parallel if we help people kill themselves *provided they are physically debilitated enough*. That criterion will degrade a great many very sick and dying people by insinuating that their lives—but crucially, not other people's—are the sort that may be reasonably thought not worthwhile and voluntarily terminated. The violation of the equal moral status of a whole class of people will occur, even though some members of it will welcome a right to assisted suicide. As the voluntary slavery and other examples show, degrading violations of equality may occur in and through the voluntary pursuit of states of affairs which neither *aim* at such violations nor *obviate* them.[20] This is not, however, to say that by granting terminally ill patients the right to forgo certain treatments we must think of them as likewise degraded.[21]

One possible solution would be to drop the physical criterion and retain autonomy's alone, with the result being suicide on demand. As I have already noted, this is a complete nonstarter in terms of the bills that have been tabled or may reasonably be expected in the Anglo-American context. Of course, patient autonomy is a crucial part of respecting agency and a bulwark against disinformation and coercion. However, patient autonomy already exists within limits. A patient may be refused forms of treatment which are futile or harmful, such as antibiotics for a viral infection or chemotherapy for urinary incontinence. As this indicates, autonomy alone does not suffice as a medical justification, since autonomous claims are subject to rational scrutiny. Mainstream advocates of assisted suicide agree on this point, because they reject suicide on demand and want to restrict autonomy a good deal by stipulating who is eligible and who is not, and by withholding termination from those who request it but are physically incapable of self-administering the lethal dose themselves.[22]

Moreover, assisted suicide is not simply an act of private autonomy but a public act involving state cooperation. As Russell Hittinger (2007, 137) notes, it is incumbent on legislators to frame laws with a view not merely to the private good of individuals but to the common good of the state, with new claims for autonomy balanced with considerations of the common good. Western democracies overwhelmingly claim that acknowledging the equal moral status and worth of all human beings together with their equality before the law is fundamental to justice, to the rule of law, and to the common good.[23] If my overall argument is correct, assisted suicide would violate precisely this core tenet, making it fundamentally incompatible with the laws and practices of any nation that claims to uphold equality.

It may appear that equality simply trumps autonomy in this scale of moral deliberations, but the relationship is more complex. While I do think that the claim to assisted suicide advanced for autonomy (held in an uneasy balance with the physical criterion) is not a justified claim, I also think that falsifying the physical criterion using the standard of equality indirectly reinforces our respect for autonomy as a whole. This is because to a significant degree equality of respect and moral status *grounds* the very importance we assign to autonomy. As Nigel Biggar (2004, 42) notes, the respect owed to the self-assessments and self-dispositions of all patients depends on the prior belief that all patients are equally owed fundamental respect. It is through acknowledging the moral status of others that their claims on us carry important deliberative weight and demand our moral regard in the first place (see Williams, 2009). To seek to expand the claims of autonomy at the expense of equality of respect and moral status would therefore risk a *reductio ad absurdum*. Jean Porter (1995, 113) has observed that equality in this sense is “not just one consideration among others which go to make up our moral concepts; it is a fundamental component of the concept of morality, and, once undermined, the attitudes of mutuality and respect for one another, which are basic to moral judgment, are likewise called into question.”

VI. AQUINAS ON DISRESPECT OR REVILING

I believe this argument is fully compatible with Christianity and indeed is deepened by it. The idea that all human beings are equally owed a fundamental respect which rules out degradation and exploitation is often identified with the philosophy of Immanuel Kant. But it received distinctly

Christian expression long before the eighteenth century. One particularly lucid example is found in the theology of Thomas Aquinas. It goes without saying that Aquinas was not an egalitarian or political liberal. He believed in social hierarchy and had no interest in the concerns about equality which preoccupy late modernity. Yet he believed humans were made in the image of God and strongly affirmed what I have called equality of respect and moral status. Moreover, he did so in a theologically charged way which indicates that equality in *this* sense is not just a preoccupation of modern Western rights culture.[24]

Aquinas held that all human beings are equal with respect to the eminent dignity of their rational nature, and are equally owed the fundamental respect which this merits.[25] Among other things, such respect requires speaking of others honorably, in ways commensurate with their personal dignity. It is therefore an injustice when through words or some other communication we are denied social goods owing to us, such as our good name. Aquinas introduces us to a bestiary of verbal sins against justice which detail this, from false witness, detraction, and backbiting, to derision, talebearing, and cursing. Of particular interest here is reviling or disrespecting (*contumelia*), which consists in injurious words that "dishonor another" by detracting from "the respect (*reverentia*) due to him from others" (Aquinas, 1911, II-II 72.1).[26] It would be particularly grave to dishonor people by withholding the fundamental respect owed to them in virtue of their equal human dignity (Aquinas, 1911, II-II 102; Jones, 2015). I have spoken of *degradation* in related terms, and argued that the physical criterion degrades. But how theological are these points? In one sense, not very. Most of us can find fault with disrespecting and insulting others, and we do not need to open our Bibles to think of reasons why. But Christianity, drawing on Judaism, added theological considerations about what it means to be human, and these change our perspective on what it means to revile one.

The New Testament and much Christian tradition are utterly striking in just how indignantly they condemn "sins of the tongue."[27] Matthew's Gospel strikes the characteristic note when Christ declares: "if you insult a brother or sister, you will be liable to the council; and if you say, 'You fool,' you will be liable to the hell of fire" (Matthew 5:22). Aquinas, following the tradition, cites this text to back up his claim that reviling is a mortal sin (Aquinas, 1911, II-II 72.1). The Letter of Jude takes verbal respect to be so paramount that the lesson goes all the way up and applies all the way down: "when the archangel Michael" contended with the devil, "he did not presume to pronounce a reviling judgment upon him, but said 'The Lord rebuke you'" (Jude 1:9). The Letter of James deplores disrespecting so deeply as to claim that "the tongue is a fire" and "is itself set on fire by hell" because "with it we bless the Lord and Father, and with it we curse those who are made in the likeness of God" (James 3:6, 9).

Examples could be multiplied, but as this last quotation suggests, the extravagant wickedness imputed to disrespecting draws on a theology of *imago dei* which exalts human dignity to transcendent heights.[28] That sense of incalculable human worth fuels the corresponding pitch of indignation when we are reviled. John's first letter adds the further point that we cannot truly love God if we despise our neighbor (1 John 4:20). As this suggests, reviling or disrespect in theological terms is therefore not just what we mean by an insult in secular terms. The Christian theology adds that something of sacred value has been degraded in a quasi-blasphemy that subverts our love for God and renders divine praise a contradiction.

While we do not need theology to know that disrespect or reviling is wrong, it deepens our understanding of *who* or *what* has been wronged and makes clear that it injures our relationship with God. Christians may therefore join with unbelievers to oppose reviling or degradation while adding theological premises that further our motivation and nuance what we take ourselves to be doing. Since assisted suicide degrades, I believe both groups have reason to oppose it; by doing so jointly, they will be far more likely to succeed.[29]

VII. THE VIEWPOINT OF THE DEGRADED

Aquinas says that the precise "injury" (*nocumentum*) done by reviling consists in dishonoring agents through words that violate the respect due to them.[30] This section will try to view that degradation in terms familiar to those who would be eligible for assisted suicide. Suppose that lethal aid is possible for me but not others because I meet the physical criterion. Presumably, I will be notified of this healthcare option, and in what context will I hear it? As Jeffrey Bishop notes, most dying patients require extraordinary levels of care.[31] Nurses or family may have to perform the demanding task of washing and wiping patients who cannot control their bladder or bowels. Patients may constantly need caretakers to provide treatments: to move, to dress, and even to feed them. Humiliation at losing physical self-control and guilt at being a burden are rather the rule than the exception. The option to die will not be heard from a space of psychological neutrality, but from a state where patients routinely feel degraded and burdensome, suffer depression and demoralization, and are by the medical establishment's own admission treated far worse than younger, healthier patients (see Shortt, 2001; Dyer, 2012).

It is therefore important to note that assisted dying would introduce not just one new choice, but two. For the first time, patients given the option to die will now have to do something they never had to before—namely, choose *not* to die (Banner, 2016). As the legal scholar Martha Minow trenchantly observed, the "sizable majority" of eligible patients face one or more of depression, ambiguous mental competence, unmanaged pain, burden feelings, and so forth. As a consequence, "the problem is not merely risks of abuse; the problem arises from inauguration of a regime in which people would have to justify continuing to live" (1997, 21).[32] As patients got sicker and more burdensome, they would readily think the burden of proof was shifting.

The opposition of many disability rights activists to assisted suicide and euthanasia is sometimes thought to be motivated by slippery slope concerns. But more generally, the disabled sense that the physical criterion degrades them by implication. According to Oregon data, only 24% of those who underwent assisted suicide cited "inadequate pain control" as a motivation for their decision, whereas a full 91% cited "loss of physical autonomy" as a major reason, followed by "losing control of bodily functions" (Oregon Public Health Division, 2014). As Lord Falconer (2012) put it in the UK debate: many would rather die than "face a period of reduced function and (reduced) independence." The disability rights group Not Dead Yet (2017a) noted what should be obvious: "*These are disability issues,*" and they quite rightly resent the implied suggestion that the disabled life may not be worth living (Coleman, 2010, 41).

In a rapidly aging population, there is a bigger social and economic picture. Some time ago the President of Care and Compassion—formerly the Hemlock Society—noted that if assisted dying were available throughout the United States, there would be fewer patients consuming resources: "It is impossible to predict exactly how much money could be saved . . . Conservative estimates, however, place the dollar amount in the tens of billions" (Humphrey and Clement, 2000, 339; see also 340 and 353). Baroness Mary Warnock—fulsomely described in *The Telegraph* as "Britain's foremost moral philosopher"—stated in that paper: "If you're demented, you're wasting people's lives—your family's lives—and you're wasting the resources of the NHS." Such people, she said, had a "duty to die"—this from an influential British parliamentarian (Beckford, 2008). Recently in Japan, the finance minister intervened in their debate by suggesting that the very old and terminally ill should "just hurry up and die" (McCurry, 2013). Such dehumanizing rhetoric may now be read by the old and terminally ill in their morning newspapers. In Aquinas' terms, these not-my-brother's-keeper slurs constitute reviling. They also and obviously mar solidarity. To know that your community is not *invested* in keeping people like you around surely signals an abandonment that reinforces low self-worth and guilt at being a burden. To go by past data, the vast majority of patients will nevertheless decline to kill themselves. Nevertheless, there is no opting out of the structural degradation that the physical criterion, through its social messages and medical practices, will visit upon them.

VIII. CONCLUSION

It would be reckless to behave as though the physical criterion did not inflict a degrading evaluative judgment on those to whom it is applicable. By taking one group of human beings to be disposable in a way no one else is, assisted suicide violates the equal moral status and respect they are owed. The point is not merely academic, since assisted suicide would generate a new politics and a new anthropology: marking the line between those who receive suicide prevention or suicide facilitation, those for whom a lethal dose is poison, and those for whom it is "medicine."

Aquinas sensibly notes that the law teaches (Aquinas, 1911, I-II 92.1). If legalized, the degradation coded in this practice will become increasingly institutional: rationalized by euphemism, enforced by law, practiced in medicine, and reflected in education. The moral hazard is therefore not just with the minority whose choice of suicide may be compromised by lack of good health care, by undiagnosed depression, or by undetected coercion. It is with the tens of thousands who may never seek assisted suicide but whose moral status has now been degraded.[33] That "third party injury" to anyone eligible for assisted suicide is what I am calling attention to.

Far better to oppose assisted dying with an anthropology that insists on equal value for groups in a weaker physical or other position that leaves them vulnerable.[34] Far better to value the broken and dying body than to imply that it is undignified and implicate a whole class of people in the resulting devaluation. The claim is not just philosophical or legal. I observed that Scripture and subsequent Christian tradition object to reviling or degradation in the strongest possible terms, leveraging belief in the *imago dei* to singularly exalt human moral status. Such beliefs led Christians to carve out important space for the sick and dying, from the earliest hospitals to the Christian-inspired hospice movement of Cicely Saunders.

From the work of Stanley Hauerwas and Allen Verhey to that of Jeffrey Bishop, Therese Lysaught, and Lydia Dugdale, a growing and important literature has proposed Christian practices and resources for addressing the problems of medicalized dying today, and for renewing the centuries-old art of dying (*ars moriendi*).[35] Apart from needing such resources, part of our problem is that the culture now lacks the vision to conceive of and practice a hopeful death at all. The rise of assisted suicide is in part an epiphenomenon of despair gone adrift toward old pagan remedies. With the decline of eschatology and traditional Christian practice, death has gone from an inevitability prepared for beforehand and given public liturgical meaning afterward, to a monstrosity we can make no sense of and before which countless people despair. With this problem in view, I have argued elsewhere that we urgently need to devote our efforts to developing the theological virtue of hope rooted in the Resurrection, and have described in some detail what this might look like and help us to achieve.[36]

In this paper, my goal has not been to propose solutions to the wider discontents of which assisted dying is a symptom. It has been the preliminary one of making us see that assisted suicide is a serious problem for reasons that are seldom considered. Ronald Dworkin claimed that opposition to assisted suicide was based on unreflective "conservative revulsion" (1994, 214). Earlier, I noted that, along with a string of successes, assisted dying bills have recently suffered some resounding defeats in mixed social contexts such as the United Kingdom, where doctors and the disabled led the way.[37] This suggests that opposition to assisted suicide can be put in terms that appeal to a wide cultural spectrum. Indeed, part of my goal here has been to propose a formula for doing just that. Those who claim to uphold equality and relieve the plight of victims should naturally see the disabled, the debilitated, and the dying in the same light: as vulnerable groups in danger of being thought unequal to the rest of us. This inequality is just what assisted dying would institutionalize in fact, whatever benign claims are advanced for its motives. Although secular society may lack the resources to solve this problem long-term, I think we can put our case in such a way that it can recognize the problem itself, and potentially interest itself in solutions. It may turn out, as Stanley Hauerwas (1990) has remarked, that in the future Christians will be known as "those peculiar people who don't abort their babies or kill their elderly." But as the example of the late Roman Empire shows, that exemplary witness and way of life often go on to attract conversion to Christianity itself.

NOTES

1. For contemporary coverage of events as an "overwhelming defeat" for the assisted suicide cause, see Mason (2015); the BBC analysis added that "opinion is not shifting - 74% of MPs voted against this bill [in 2015] compared with 72% back in 1997. The emphatic nature of the result would suggest politicians are unlikely to discuss this again soon" (Gallagher and Roxby, 2015). For the instrumental role of the disabled in the debate, see Grey-Thompson (2015).

2. The Dutch and Belgian approaches, which include euthanasia, differ markedly. See John Keown (2008, 81–150).

3. The Canadian law is a conspicuous exception to the standard Anglo-American model. Not only is it far less restrictive in general, but it permits voluntary euthanasia. In Quebec, euthanasia alone is permitted; in the rest of Canada, assisted suicide is also permitted, but is overwhelmingly declined in favor of euthanasia: that is, from June 2016 to May 2017 there were 504 cases of euthanasia, and only 3 of assisted suicide. See Living and Dying Well (2017).

4. See Oregon Revised Statute § 127.810 s.2.02 (Oregon Health Authority, 2015).

5. See Seale (2009, 205–12). In January 2017, *The New York Times* reported that the AMA was reconsidering its position, but then retracted the claim. See Span (2017). Leon Kass (1989) has argued at length that assisted suicide would harm the doctor-patient relationship by shaking patients' trust in doctors and by undermining doctors' nonnegotiable commitment to heal their patients. The BMA suggested that the practice would harm the doctor-patient relationship by removing doctors' "affirmation of the supreme value of the individual," threatening to weaken doctors' recognition of patient dignity. See Keown (2008, 208–11).

6. See Steinbock (2005, 235–41); and The Royal College of Physicians testimony (TheyWorkForYou, 2015).

7. Jurisdictions such as Belgium no longer limit assisted suicide or euthanasia to patients who are dying or even gravely ill. For instance, in 2013 deaf twins who were going blind but otherwise healthy were euthanized. See Waterfield (2013). As I argue below, the Anglo-American model limits assisted suicide far more strictly using the physical criterion.

8. For a discussion from the literary viewpoint, see Michael MacDonald (1986, 309–17), "Ophelia's Maimèd Rites."

9. If, by contrast, the end were solely to end my pain, incrementally raised doses of morphine to the point where pain is neutralized, or even palliative sedation, could be sought. See American Academy of Hospice and Palliative Medicine (2014).

10. Further on in the paper I touch on both dignity in general and the particular kind of dignity conferred by Christian belief in the *imago dei.*

11. For example, the influential and representative essay "Assisted Suicide: The Philosophers' Brief" (in favor of a change in law) was jointly written by John Rawls, Ronald Dworkin, Thomas Nagel, and other paragons of egalitarian and human rights-based thought. See Dworkin et al. (1997). The same embrace of assisted suicide amid the declared commitment to human equality animates Ronald Dworkin, *Life's Dominion: An Argument About Abortion, Euthanasia, and Individual Freedom* (1994, 179–218) and Martha Nussbaum's essay in favor of assisted suicide for the influential President's Council on Bioethics (Nussbaum, 2008). While I think they misapply the concept, mainstream assisted suicide advocacy groups likewise profess human equality and rights, and reject Singer's human being/person distinction. See, for instance, the Death with Dignity (2017a) statement.

12. In addition to the US Death with Dignity statement, see the UK's Dignity in Dying statement (Campaign for Dignity in Dying, 2017a).

13. Although he thinks it is politically impossible now, Joseph Raz hopes we eventually get to this point. See his (2013) "Death in Our Life." In the Netherlands and Belgium, the separate criterion of "unbearable suffering" has been tried and found wanting. It combines with conceptual vagueness the hopeless effort to quantify highly subjective and complex experiences of suffering with reference to standards of "unbearability" that are never made explicit. See Keown (2008, 136–50).

14. This is compatible with the belief that it might be a different good—but nevertheless a good—for me to continue to live. But, the fact that killing myself is *only* a good for people like me (but no one else) makes quite clear the degrading double standard.

15. Moral status is a contested topic, but for our purposes I mean that all human beings have a fundamental moral claim on our regard and that their needs and interests matter to the extent that it is possible to treat them wrongly. I return to the topic below. For a discussion of the concept, see McMahan (2005) and endnote 16 below.

16. What respect or regard requires of us is a vast topic which cannot be fully treated here, though I devote some space to it below and in endnote 30.

17. This is not to deny that grave failures to observe these commitments are not plentiful. That failure is a matter of hypocrisy, self-deception, weakness of will, and corruption: evils which plague every moral system. On Western legal-moral commitments to equality, see Vlastos (1975) and Williams (2009). See also endnote 11 above.

18. There is a vast literature arguing for and about the intrinsic dignity of all human beings. Space prevents a discussion here, but for fine philosophical treatments, see Vlastos (1975) and Spaemann (2012). For a bioethical treatment, see Sulmasy (2009). On the concept of human dignity, I agree with Patrick Lee and Robert George that it arises from possessing a rational nature whose particular kinds of excellence merit a high degree of respect and consideration from others, ruling out one's instrumentalization. For a detailed discussion, see their (2008) "The Nature and Basis of Human Dignity."

19. The offenders may not be quite aware of themselves as such because they have mingled much rationalization with some goodwill, and they are not adequately self-critical. Worse still, the victims may not know themselves to be wronged if they have adopted the criteria of their oppressors. Some slave states have done this, and I think assisted suicide does so in a very different way. I also think our society has spectacularly degraded human embryos and prenatal children, but that is a separate topic.

20. I take it that advocates of assisted suicide do not *wish* to degrade anybody, but have in mind compassion and autonomy. Our problem, to borrow the legal phrase, is discrimination by consequence rather than discrimination by intention.

21. Here, I think the extraordinary/ordinary and intended/foreseen distinctions used in the Catholic tradition and more broadly do real work. Suppose a patient wishes to forgo or withdraw a ventilator as "extraordinary" treatment since he has no reasonable hope of recovery. Even if the likelihood of death is foreseen, the intention should be to forgo or withdraw unduly burdensome or useless treatment, not

to aim at the patient's death. Hence if the patient unexpectedly continued to breathe after the ventilator was removed, it would not be permissible or in any way a continuation of withdrawal to give him a lethal injection as though to "finish the job." Death was not the "job" in question, and in that respect the phrase "die naturally" muddles an important distinction. Such a right does not aim to cause death in the belief that a patient's life in X conditions has a net disvalue; it merely recognizes that available forms of treatment may be unduly burdensome or without hope of cure, and so not obligatory. Unlike assisted suicide, the evaluation and intention only concern the efficacy of *treatment*; they do not question the worthwhileness of *lives*. I am grateful to an anonymous reviewer for calling my attention to this issue. See Panicola (2001). For related arguments from a Protestant perspective, see Meilaender (1987).

22. For instance, the American pro-assisted suicide organization, Death with Dignity, and its British equivalent, Dignity in Dying, both state their opposition to euthanasia and suicide on demand, and say they want to exclude from the practice anyone who lacks a six-month terminal diagnosis. See Death with Dignity (2017b), and Campaign for Dignity in Dying (2017b).

23. The American Declaration of Independence famously asserts that "all men are created equal" and "endowed by their Creator with certain unalienable Rights." The UN's Universal Declaration of Human Rights—written in the wake of the Holocaust and aiming to prevent future atrocities—begins by stating that "recognition of the inherent dignity and of the equal and inalienable rights of all members of the human family is the foundation of freedom, justice and peace in the world." See United Nations (1948). It goes without saying that Western democracies often fail to observe these commitments, but by acknowledging them they can at least see the obligation to do so.

24. On Aquinas and social hierarchy, see Keys (2007, 223–6); on the particular equality claims of late modernity and postmodernity, see MacIntyre (2007, 6–22), and Taylor (1989, 393–418). On Aquinas and what I have called equality of respect, see Hittinger (2009, esp. 794–9).

25. On the dignity of persons in Aquinas, see Aquinas (1911, I 29.3) and Pinckaers (2005). On the nature of respect in Aquinas, see Aquinas (1911, II-II 102.2) and Jones (2015).

26. See Aquinas (1911, II-II 72.1). More generally, see Aquinas (1911, II-II 72–76). All translations from the Fathers of the English Dominican Province (Westminster, MD: Christian Classics, 1911).

27. For an illuminating treatment of this subject, see Webster (2015).

28. See "The Human Person as Image of God," Lars Thunberg, "Eastern Christianity" (291–311), and Bernard McGinn, "Western Christianity" (312–20) in McGinn (1985).

29. As happened to a significant extent in the 2015 UK debate, where the BMA along with a large spectrum of medical societies, secular disability rights activist groups, and others, made common cause with bishops from the Church of England, the Catholic Church of England and Wales, and a wide spectrum of religious leaders. The impression given was that secular social justice liberals who opposed assisted suicide took the moral high ground away from libertarian liberals who favored it. Combined with traditional and religious opposition, this led to an appreciable consensus against a change in law, and did so without the appearance of a calcified left/right or secular/religious culture war. In that respect, it mirrored certain trends in the American civil rights movement. See references in endnote 1.

30. In general, respect is shown in every form of interacting with people that acknowledges and honors their dignity, from giving directions to a stranger to refraining from degrading characterizations. But more specifically, Aquinas says that it is not just a subjective regard for others, but inclines us to *manifest* esteem for others through "public expressions, visible honours, signs or tokens of regard" (Aquinas, 1911, II-II 72.1; see also 103.1. See Jones, 2015).

31. My discussion of dying patients' perspectives here is indebted to Bishop (2016), "Arts of Dying and the Statecraft of Killing."

32. Jeffrey Bishop has forcefully argued that "in the efficiency of the medico-legal social apparatus, death is the focal point of the picture" and therefore framed in advance as "rational" and choiceworthy for the patient (Bishop, 2016, 262). For a full treatment, see his (2011) *The Anticipatory Corpse: Medicine, Power, and the Care of the Dying*, especially chapter 4.

33. They will also be encouraged toward it, and this aggravates the degradation. I am grateful to an anonymous reviewer for noting this point.

34. Ideally, this will be a Christian anthropology where and so far as possible; but in the absence of Christian convictions, anthropologies committed to the equality of the debilitated are far preferable to those that are not. A good example of the latter is found in the work of secular disability rights activists. See Golden and Zoanni (2010). More generally, see the approach adopted by Not Dead Yet (2017b).

35. See, for example, Verhey (2011), the essays by Bishop, Lysaught, and others in Dugdale (2015), Hauerwas (1990), and Vogt (2004). See also the recent special issue on Death and Christianity in *Christian Bioethics* (April 2017), engaging with Jeffrey Bishop's question "whether only theology can save medicine?"

36. See my *Hope and Christian Ethics* (2017). Retrieving the theological virtue of hope is also important to diagnosing the vice of presumption, a false and bloated counterfeit of hope which presumes upon "glory without merits, and forgiveness without repentance" (Aquinas, 1911, II-II 21.1). By encouraging the view that heaven is all but guaranteed and forgetting the possibility of damnation, presumption removes a strong traditional safeguard against suicide. The Atlantic Bishops document, "Pastoral Reflection on Medical Assistance in Dying," is in this respect acutely unhelpful. See my discussion in *Hope and Christian Ethics* (2017, 124–38).

37. I experienced this first-hand through working in 2015 with the chief advisor to the then leader of the Labour Party and cross-party parliamentarians in crafting the case against assisted dying. In the event, the September 2015 bill to legalize it was overwhelming defeated across party lines in British Parliament. See endnote 1, and Mason (2015).

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