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The Hastings Center Report, Vol. 27, No. 2. (Mar. - Apr., 1997), pp. 34-42.

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Is There a Duty to Die?

Many people were outraged when Richard Lamm claimed that old people had a duty to die. Modern medicine and an individualistic culture have seduced many to feel that they have a right to health care and a right to live, despite the burdens and costs to our families and society. But in fact there are circumstances when we have a duty to die. As modern medicine continues to save more of us from acute illness, it also delivers more of us over to chronic illnesses, allowing us to survive far longer than we can take care of ourselves. It may be that our technological sophistication coupled with a commitment to our loved ones generates a fairly widespread duty to die.

John Hardwig, "Is There a Duty to Die?" *Hastings Center Report* 27, no. 2 (1997): 34-42.

by John Hardwig

When Richard Lamm made the statement that old people have a duty to die, it was generally shouted down or ridiculed. The whole idea is just too preposterous to entertain. Or too threatening. In fact, a fairly common argument against legalizing physician-assisted suicide is that if it were legal, some people might somehow get the idea that they have a duty to die. These people could only be the victims of twisted moral reasoning or vicious social pressure. It goes without saying that there is no duty to die.

But for me the question is real and very important. I feel strongly that I may very well some day have a duty to die. I do not believe that I am idiosyncratic, morbid, mentally ill, or morally perverse in thinking this. I think many of us will eventually face precisely this duty. But I am first of all concerned with my own duty. I write partly to clarify my own convictions and to prepare myself. Ending my life might be a very difficult thing for me to do.

This notion of a duty to die raises all sorts of interesting theoretical and metaethical questions. I intend to try to avoid most of them because I hope my argument will be persuasive to those holding a wide variety of ethical views. Also, although the claim that there is a duty to die would ultimately require theoretical underpinning, the discussion needs to begin on the normative level. As is appropriate to my attempt to steer clear of theoretical commitments, I will use "duty," "obligation," and "responsibility" interchangeably, in a pretheoretical or pre-analytic sense.¹

Circumstances and a Duty to Die

Do many of us really believe that no one ever has a duty to die? I suspect not. I think most of us probably believe that there is such a duty, but it is very uncommon. Consider Captain Oates, a member of Admiral Scott's expedition to the South Pole. Oates became too ill to continue. If the rest of the team stayed with him, they would all perish. After this had become clear, Oates left his tent one night, walked out into a raging blizzard, and was never seen again.² That may have been a heroic thing to do, but we might be able to agree that it was also no more than his duty. It would have been wrong for him to urge—or even to allow—the rest to stay and care for him.

This is a very unusual circumstance—a "lifeboat case"—and lifeboat cases make for bad ethics. But I expect that most of us would also agree that there have been cultures in which what we would call a duty to die has been fairly common. These are relatively poor, technologically simple, and especially nomadic cultures. In such societies, everyone knows that if you manage to live

long enough, you will eventually become old and debilitated. Then you will need to take steps to end your life. The old people in these societies regularly did precisely that. Their cultures prepared and supported them in doing so.

Those cultures could be dismissed as irrelevant to contemporary bioethics; their circumstances are so different from ours. But if that is our response, it is instructive. It suggests that we assume a duty to die is irrelevant to us because our wealth and technological sophistication have purchased exemption for us . . . except under very unusual circumstances like Captain Oates's.

But have wealth and technology really exempted us? Or are they, on the contrary, about to make a duty to die common again? We like to think of modern medicine as all triumph with no dark side. Our medicine saves many lives and enables most of us to live longer. That is wonderful, indeed. We are all glad to have access to this medicine. But our medicine also delivers most of us over to chronic illnesses and it enables many of us to survive longer than we can take care of ourselves, longer than we know what to do with ourselves, longer than we even are ourselves.

The costs—and these are not merely monetary—of prolonging our lives when we are no longer able to care for ourselves are often staggering. If further medical advances wipe out many of today's "killer diseases"—cancers, heart attacks, strokes, ALS, AIDS, and the rest—then one day most of us will survive long enough to become demented or debilitated. These developments could generate a fairly widespread duty to die. A fairly common duty to die might turn out to be only the dark side of our life-prolonging medicine and the uses we choose to make of it.

Let me be clear. I certainly believe that there is a duty to refuse life-prolonging medical treatment and also a duty to complete advance directives refusing life-prolonging treatment. But a duty to die can go well beyond that. There can be a duty to die before one's illnesses would cause death, even if treated only with palliative measures. In fact, there may be a fairly common responsibility to end one's life in the absence of any terminal illness at all. Finally, there can be a duty to die when one would prefer to live. Granted, many of the conditions that can generate a duty to die also seriously undermine the quality of life. Some prefer not to live under such conditions. But even those who want to live can face a duty to die. These will clearly be the most controversial and troubling cases; I will, accordingly, focus my reflections on them.

The Individualistic Fantasy

Because a duty to die seems such a real possibility to me, I wonder why contemporary bioethics has dismissed it without serious consideration. I believe that most bioethics still shares in one of our deeply embedded American dreams: the individualistic fantasy. This fanta-

sy leads us to imagine that lives are separate and unconnected, or that they could be so if we chose. If lives were unconnected, things that happened in my life would not or need not affect others. And if others were not (much) affected by my life, I would have no duty to consider the impact of my decisions on others. I would then be free morally to live my life however I please, choosing whatever life and death I prefer for myself. The way I live would be nobody's business but my own. I certainly would have no duty to die if I preferred to live.



Within a health care context, the individualistic fantasy leads us to assume that the patient is the only one affected by decisions about her medical treatment. If only the patient were affected, the relevant questions when making treatment decisions would be precisely those we ask: What will benefit the patient? Who can best decide that? The pivotal issue would always be simply whether the patient wants to live like this and whether she would consider herself better off dead.³ "Whose life is it, anyway?" we ask rhetorically.

But this is morally obtuse. We are not a race of hermits. Illness and death do not come only to those who are all alone. Nor is it much better to think in terms of the bald dichotomy between "the interests of the patient" and "the interests of society" (or a third-party payer), as if we were isolated individuals connected only to "society" in the abstract or to the other, faceless members of our health maintenance organization.

*Drawing by
Michael Jacques
from his book
Images of Age.*

The impact of my decisions upon my family and loved ones is the source of many of my strongest obligations and also the most plausible and likeliest basis of a duty to die.

Most of us are affiliated with particular others and most deeply, with family and loved ones. Families and loved ones are bound together by ties of care and affection, by legal relations and obligations, by inhabiting shared spaces and living units, by interlocking finances and economic prospects, by common projects and also commitments to support the different life projects of other family members, by shared histories, by ties of loyalty. This life together of family and loved ones is what defines and sustains us; it is what gives meaning to most of our lives. We would not have it any other way. We would not want to be all alone, especially when we are seriously ill, as we age, and when we are dying.

But the fact of deeply interwoven lives debars us from making exclusively self-regarding decisions, as the decisions of one member of a family may dramatically affect the lives of all the rest. The impact of my decisions upon my family and loved ones is the source of many of my strongest obligations and also the most plausible and likeliest basis of a duty to die. "Society," after all, is only very marginally affected by how I live, or by whether I live or die.

A Burden to My Loved Ones

Many older people report that their one remaining goal in life is not to be a burden to their loved ones. Young people feel this, too: when I ask my undergraduate students to think about whether their death could come too late, one of their very first responses always is, "Yes, when I become a burden to my family or loved ones." Tragically, there are situations in which my loved ones would be much better off—all things considered, the loss of a loved one notwithstanding—if I were dead.

The lives of our loved ones can be seriously compromised by caring for us. The burdens of providing care or even just supervision twenty-four hours a day, seven days a week are often overwhelming.⁴ When this kind of caregiving goes on for years, it leaves the caregiver exhausted, with no time for herself or life of her own. Ultimately, even her health is often destroyed. But it can also be emotionally devastating simply to live with a spouse who is increasingly distant, uncommunicative, unresponsive, foreign, and unreachable. Other family members' needs often go unmet as the caring capacity of the family is exceeded. Social life and friendships evaporate, as there is no opportunity to go out to see friends and the home is no longer a place suitable for having friends in.

We must also acknowledge that the lives of our loved ones can be devastated just by having to pay for health care for us. One part of the recent SUPPORT study doc-

umented the financial aspects of caring for a dying member of a family. Only those who had illnesses severe enough to give them less than a 50 percent chance to live six more months were included in this study. When these patients survived their initial hospitalization and were discharged about one-third required considerable caregiving from their families; in 20 percent of cases a family member had to quit work or make some other major lifestyle change; almost one-third of these families lost all of their savings; and just under 30 percent lost a major source of income.⁵

If talking about money sounds venal or trivial, remember that much more than money is normally at stake here. When someone has to quit work, she may well lose her career. Savings decimated late in life cannot be recouped in the few remaining years of employability, so the loss compromises the quality of the rest of the caregiver's life. For a young person, the chance to go to college may be lost to the attempt to pay debts due to an illness in the family, and this decisively shapes an entire life.

A serious illness in a family is a misfortune. It is usually nobody's fault; no one is responsible for it. But we face choices about how we will respond to this misfortune. That's where the responsibility comes in and fault can arise. Those of us with families and loved ones always have a duty not to make selfish or self-centered decisions about our lives. We have a responsibility to try to protect the lives of loved ones from serious threats or greatly impoverished quality, certainly an obligation not to make choices that will jeopardize or seriously compromise their futures. Often, it would be wrong to do just what we want or just what is best for ourselves; we should choose in light of what is best for all concerned. That is our duty in sickness as well as in health. It is out of these responsibilities that a duty to die can develop.

I am not advocating a crass, quasi-economic conception of burdens and benefits, nor a shallow, hedonistic view of life. Given a suitably rich understanding of benefits, family members sometimes do benefit from suffering through the long illness of a loved one. Caring for the sick or aged can foster growth, even as it makes daily life immeasurably harder and the prospects for the future much bleaker. Chronic illness or a drawn-out death can also pull a family together, making the care for each other stronger and more evident. If my loved ones are truly benefiting from coping with my illness or debility, I have no duty to die based on burdens to them.

But it would be irresponsible to blithely assume that this always happens, that it will happen in my family, or that it will be the fault of my family if they cannot manage to turn my illness into a positive experience. Perhaps the opposite is more common: a hospital chaplain once told me that he could not think of a single case in which a family was strengthened or brought together by what happened at the hospital.

Our families and loved ones also have obligations, of course—they have the responsibility to stand by us and

to support us through debilitating illness and death. They must be prepared to make significant sacrifices to respond to an illness in the family. I am far from denying that. Most of us are aware of this responsibility and most families meet it rather well. In fact, families deliver more than 80 percent of the long-term care in this country, almost always at great personal cost. Most of us who are a part of a family can expect to be sustained in our time of need by family members and those who love us.

But most discussions of an illness in the family sound as if responsibility were a one-way street. It is not, of course. When we become seriously ill or debilitated, we too may have to make sacrifices. To think that my loved ones must bear whatever burdens my illness, debility, or dying process might impose upon them is to reduce them to means to my well-being. And that would be immoral. Family solidarity, altruism, bearing the burden of a loved one's misfortune, and loyalty are all important virtues of families, as well. But they are all also two-way streets.

Objections to a Duty to Die

To my mind, the most serious objections to the idea of a duty to die lie in the effects on my loved ones of ending my life. But to most others, the important objections have little or nothing to do with family and loved ones. Perhaps the most common objections are: (1) there is a higher duty that always takes precedence over a duty to die; (2) a duty to end one's own life would be incompatible with a recognition of human dignity or the intrinsic value of a person; and (3) seriously ill, debilitated, or dying people are already bearing the harshest burdens and so it would be wrong to ask them to bear the additional burden of ending their own lives.

These are all important objections; all deserve a thorough discussion. Here I will only be able to suggest some moral counterweights—ideas that might provide the basis for an argument that these objections do not always preclude a duty to die.

An example of the first line of argument would be the claim that a duty to God, the giver of life, forbids that anyone take her own life. It could be argued that this duty always supersedes whatever obligations we might have to our families. But what convinces us that we always have such a religious duty in the first place? And what guarantees that it always supersedes our obligations to try to protect our loved ones?

Certainly, the view that death is the ultimate evil cannot be squared with Christian theology. It does not reflect the actions of Jesus or those of his early followers. Nor is it clear that the belief that life is sacred requires that we never take it. There are other theological possibilities.⁶ In any case, most of us—bioethicists, physicians, and patients alike—do not subscribe to the view that we have an obligation to preserve human life as long as possible. But if not, surely we ought to agree that I may legitimately end my life for other-regarding reasons, not just for self-regarding reasons.

Secondly, religious considerations aside, the claim could be made that an obligation to end one's own life would be incompatible with human dignity or would embody a failure to recognize the intrinsic value of a person. But I do not see that in thinking I had a duty to die I would necessarily be failing to respect myself or to appreciate my dignity or worth. Nor would I necessarily be failing to respect you in thinking that you had a similar duty. There is surely also a sense in which we fail to respect ourselves if in the face of illness or death, we stoop to choosing just what is best for ourselves. Indeed, Kant held that the very core of human dignity is the ability to act on a self-imposed moral law, regardless of whether it is in our interest to do so.⁷ We shall return to the notion of human dignity.

A third objection appeals to the relative weight of burdens and thus, ultimately, to considerations of fairness or justice. The burdens that an illness creates for the family could not possibly be great enough to justify an obligation to end one's life—the sacrifice of life itself would be a far greater burden than any involved in caring for a chronically ill family member.

But is this true? Consider the following case:

An 87-year-old woman was dying of congestive heart failure. Her APACHE score predicted that she had less than a 50 percent chance to live for another six months. She was lucid, assertive, and terrified of death. She very much wanted to live and kept opting for rehospitalization and the most aggressive life-prolonging treatment possible. That treatment successfully prolonged her life (though with increasing debility) for nearly two years. Her 55-year-old daughter was her only remaining family, her caregiver, and the main source of her financial support. The daughter duly cared for her mother. But before her mother died, her illness had cost the daughter all of her savings, her home, her job, and her career.

This is by no means an uncommon sort of case. Thousands of similar cases occur each year. Now, ask yourself which is the greater burden:

- a) To lose a 50 percent chance of six more months of life at age 87?
- b) To lose all your savings, your home, and your career at age 55?

Which burden would you prefer to bear? Do we really believe the former is the greater burden? Would even the dying mother say that (a) is the greater burden? Or has she been encouraged to believe that the burdens of (b) are somehow morally irrelevant to her choices?

I think most of us would quickly agree that (b) is a greater burden. That is the evil we would more hope to avoid in our lives. If we are tempted to say that the mother's disease and impending death are the greater evil, I believe it is because we are taking a "slice of time" perspective rather than a "lifetime perspective."⁸ But surely the lifetime perspective is the appropriate perspective when

weighing burdens. If (b) is the greater burden, then we must admit that we have been promulgating an ethics that advocates imposing greater burdens on some people in order to provide smaller benefits for others just because they are ill and thus gain our professional attention and advocacy.

A whole range of cases like this one could easily be generated. In some, the answer about which burden is greater will not be clear. But in many it is. Death—or ending your own life—is simply not the greatest evil or the greatest burden.

This point does not depend on a utilitarian calculus. Even if death were the greatest burden (thus disposing of any simple utilitarian argument), serious questions would remain about the moral justifiability of choosing to impose crushing burdens on loved ones in order to avoid having to bear this burden oneself. The fact that I suffer greater burdens than others in my family does not license me simply to choose what I want for myself, nor does it necessarily release me from a responsibility to try to protect the quality of their lives.

I can readily imagine that, through cowardice, rationalization, or failure of resolve, I will fail in this obligation to protect my loved ones. If so, I think I would need to be excused or forgiven for what I did. But I cannot imagine it would be morally permissible for me to ruin the rest of my partner's life to sustain mine or to cut off my sons' careers, impoverish them, or compromise the quality of their children's lives simply because I wish to live a little longer. This is what leads me to believe in a duty to die.

Who Has a Duty to Die?

Suppose, then, that there can be a duty to die. Who has a duty to die? And when? To my mind, these are the right questions, the questions we should be asking. Many of us may one day badly need answers to just these questions.

But I cannot supply answers here, for two reasons. In the first place, answers will have to be very particular and contextual. Our concrete duties are often situated, defined in part by the myriad details of our circumstances, histories, and relationships. Though there may be principles that apply to a wide range of cases and some cases that yield pretty straightforward answers, there will also be many situations in which it is very difficult to discern whether one has a duty to die. If nothing else, it will often be very difficult to predict how one's family will bear up under the weight of the burdens that a protracted illness would impose on them. Momentous decisions will often have to be made under conditions of great uncertainty.

Second and perhaps even more importantly, I believe that those of us with family and loved ones should not define our duties unilaterally, especially not a decision about a duty to die. It would be isolating and distancing for me to decide without consulting them what is too

much of a burden for my loved ones to bear. That way of deciding about my moral duties is not only atomistic, it also treats my family and loved ones paternalistically. They must be allowed to speak for themselves about the burdens my life imposes on them and how they feel about bearing those burdens.

Some may object that it would be wrong to put a loved one in a position of having to say, in effect, "You should end your life because caring for you is too hard on me and the rest of the family." Not only will it be almost impossible to say something like that to someone you love, it will carry with it a heavy load of guilt. On this view, you should decide by yourself whether you have a duty to die and approach your loved ones only after you have made up your mind to say good-bye to them. Your family could then try to change your mind, but the tremendous weight of moral decision would be lifted from their shoulders.

Perhaps so. But I believe in family decisions. Important decisions for those whose lives are interwoven should be made together, in a family discussion. Granted, a conversation about whether I have a duty to die would be a tremendously difficult conversation. The temptations to be dishonest could be enormous. Nevertheless, if I am contemplating a duty to die, my family and I should, if possible, have just such an agonizing discussion. It will act as a check on the information, perceptions, and reasoning of all of us. But even more importantly, it affirms our connectedness at a critical juncture in our lives and our life together. Honest talk about difficult matters almost always strengthens relationships.

However, many families seem unable to talk about death at all, much less a duty to die. Certainly most families could not have this discussion all at once, in one sitting. It might well take a number of discussions to be able to approach this topic. But even if talking about death is impossible, there are always behavioral clues—about your caregiver's tiredness, physical condition, health, prevailing mood, anxiety, financial concerns, outlook, overall well-being, and so on. And families unable to talk about death can often talk about how the caregiver is feeling, about finances, about tensions within the family resulting from the illness, about concerns for the future. Deciding whether you have a duty to die based on these behavioral clues and conversation about them honors your relationships better than deciding on your own about how burdensome you and your care must be.

I cannot say when someone has a duty to die. Still, I can suggest a few features of one's illness, history, and circumstances that make it more likely that one has a duty to die. I present them here without much elaboration or explanation.

1) A duty to die is more likely when continuing to live will impose significant burdens—emotional burdens, extensive caregiving, destruction of life plans, and, yes, financial hardship—on your family and loved ones. This is the fundamental insight underlying a duty to die.

2) A duty to die becomes greater as you grow older. As we age, we will be giving up less by giving up our lives, if only because we will sacrifice fewer remaining years of life and a smaller portion of our life plans. After all, it's not as if we would be immortal and live forever if we could just manage to avoid a duty to die. To have reached the age of, say, seventy-five or eighty years without being ready to die is itself a moral failing, the sign of a life out of touch with life's basic realities.⁹

3) A duty to die is more likely when you have already lived a full and rich life. You have already had a full share of the good things life offers.

4) There is greater duty to die if your loved ones' lives have already been difficult or impoverished, if they have had only a small share of the good things that life has to offer (especially if through no fault of their own).

5) A duty to die is more likely when your loved ones have already made great contributions—perhaps even sacrifices—to make your life a good one. Especially if you have not made similar sacrifices for their well-being or for the well-being of other members of your family.

6) To the extent that you can make a good adjustment to your illness or handicapping condition, there is less likely to be a duty to die. A good adjustment means that smaller sacrifices will be required of loved ones and there is more compensating interaction for them. Still, we must also recognize that some diseases—Alzheimer or Huntington chorea—will eventually take their toll on your loved ones no matter how courageously, resolutely, even cheerfully you manage to face that illness.

7) There is less likely to be a duty to die if you can still make significant contributions to the lives of others, especially your family. The burdens to family members are not only or even primarily financial, neither are the contributions to them. However, the old and those who have terminal illnesses must also bear in mind that the loss their family members will feel when they die cannot be avoided, only postponed.

8) A duty to die is more likely when the part of you that is loved will soon be gone or seriously compromised. Or when you soon will no longer be capable of giving love. Part of the horror of dementing disease is that it destroys the capacity to nurture and sustain relationships, taking away a person's agency and the emotions that bind her to others.

9) There is a greater duty to die to the extent that you have lived a relatively lavish lifestyle instead of saving for illness or old age. Like most upper middle-class Americans, I could easily have saved more. It is a greater wrong to come to your family for assistance if your need is the result of having chosen leisure or a spendthrift lifestyle. I may eventually have to face the moral consequences of decisions I am now making.

These, then, are some of the considerations that give shape and definition to the duty to die. If we can agree that these considerations are all relevant, we can see that the correct course of action will often be difficult to discern. A decision about when I should end my life will

sometimes prove to be every bit as difficult as the decision about whether I want treatment for myself.

Can the Incompetent Have a Duty to Die?

Severe mental deterioration springs readily to mind as one of the situations in which I believe I could have a duty to die. But can incompetent people have duties at all? We can have moral duties we do not recognize or acknowledge, including duties that we never recognized. But can we have duties we are unable to recognize? Duties when we are unable to understand the concept of morality at all? If so, do others have a moral obligation to help us carry out this duty? These are extremely difficult theoretical questions. The reach of moral agency is severely strained by mental incompetence.

I am tempted to simply bypass the entire question by saying that I am talking only about competent persons. But the idea of a duty to die clearly raises the specter of one person claiming that another—who cannot speak for herself—has such a duty. So I need to say that I can make no sense of the claim that someone has a duty to die if the person has never been able to understand moral obligation at all. To my mind, only those who were formerly capable of making moral decisions could have such a duty.

But the case of formerly competent persons is almost as troubling. Perhaps we should simply stipulate that no incompetent person can have a duty to die, not even if she affirmed belief in such a duty in an advance directive. If we take the view that formerly competent people may have such a duty, we should surely exercise extreme caution when claiming a formerly competent person would have acknowledged a duty to die or that any formerly competent person has an unacknowledged duty to die. Moral dangers loom regardless of which way we decide to resolve such issues.

But for me personally, very urgent practical matters turn on their resolution. If a formerly competent person can no longer have a duty to die (or if other people are not likely to help her carry out this duty), I believe that my obligation may be to die while I am still competent, before I become unable to make and carry out that decision for myself. Surely it would be irresponsible to evade my moral duties by temporizing until I escape into incompetence. And so I must die sooner than I otherwise would have to. On the other hand, if I could count on others to end my life after I become incompetent, I might be able to fulfill my responsibilities while also living out all my competent or semi-competent days. Given our society's reluctance to permit physicians, let alone family members, to perform aid-in-

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There is also the very real problem of sudden incompetence—due to a serious stroke or automobile accident, for example. For me, that is the real nightmare. If I suddenly become incompetent, I will fall into the hands of a medical-legal system that will conscientiously disregard my moral beliefs and do what is best for me, regardless of the consequences for my loved ones. And that is not at all what I would have wanted!

Social Policies and a Duty to Die

The claim that there is a duty to die will seem to some a misplaced response to social negligence. If our society were providing for the debilitated, the chronically ill, and the elderly as it should be, there would be only very rare cases of a duty to die. On this view, I am asking the sick and debilitated to step in and accept responsibility because society is derelict in its responsibility to provide for the incapacitated.

This much is surely true: there are a number of social policies we could pursue that would dramatically reduce the incidence of such a duty. Most obviously, we could decide to pay for facilities that provided excellent long-term care (not just health care!) for all chronically ill, debilitated, mentally ill, or demented people in this country. We probably could still afford to do this. If we did, sick, debilitated, and dying people might still be morally required to make sacrifices for their families. I might, for example, have a duty to forgo personal care by a family member who knows me and really does care for me. But these sacrifices would only rarely include the sacrifice of life itself. The duty to die would then be virtually eliminated.

I cannot claim to know whether in some abstract sense a society like ours should provide care for all who are chronically ill or debilitated. But the fact is that we Americans seem to be unwilling to pay for this kind of long-term care, except for ourselves and our own. In fact, we are moving in precisely the opposite direction—we are trying to shift the burdens of caring for the seriously and chronically ill onto families in order to save costs for our health care system. As we shift the burdens of care onto families, we also dramatically increase the number of Americans who will have a duty to die.

I must not, then, live my life and make my plans on the assumption that social institutions will protect my family from my infirmity and debility. To do so would be irresponsible. More likely, it will be up to me to protect my loved ones.

A Duty to Die and the Meaning of Life

A duty to die seems very harsh, and often it would be. It is one of the tragedies of our lives that someone who wants very much to live can nevertheless have a duty to die. It is both tragic and ironic that it is pre-

cisely the very real good of family and loved ones that gives rise to this duty. Indeed, the genuine love, closeness, and supportiveness of family members is a major source of this duty: we could not be such a burden if they did not care for us. Finally, there is deep irony in the fact that the very successes of our life-prolonging medicine help to create a widespread duty to die. We do not live in such a happy world that we can avoid such tragedies and ironies. We ought not to close our eyes to this reality or pretend that it just doesn't exist. We ought not to minimize the tragedy in any way.

And yet, a duty to die will not always be as harsh as we might assume. If I love my family, I will want to protect them and their lives. I will want not to make choices that compromise their futures. Indeed, I can easily imagine that I might want to avoid compromising their lives more than I would want anything else. I must also admit that I am not necessarily giving up so much in giving up my life: the conditions that give rise to a duty to die would usually already have compromised the quality of the life I am required to end. In any case, I personally must confess that at age fifty-six, I have already lived a very good life, albeit not yet nearly as long a life as I would like to have.

We fear death too much. Our fear of death has led to a massive assault on it. We still crave after virtually any life-prolonging technology that we might conceivably be able to produce. We still too often feel morally impelled to prolong life—virtually any form of life—as long as possible. As if the best death is the one that can be put off longest.

We do not even ask about meaning in death, so busy are we with trying to postpone it. But we will not conquer death by one day developing a technology so magnificent that no one will have to die. Nor can we conquer death by postponing it ever longer. We can conquer death only by finding meaning in it.

Although the existence of a duty to die does not hinge on this, recognizing such a duty would go some way toward recovering meaning in death. Paradoxically, it would restore dignity to those who are seriously ill or dying. It would also reaffirm the connections required to give life (and death) meaning. I close now with a few words about both of these points.

First, recognizing a duty to die affirms my agency and also my moral agency. I can still do things that make an important difference in the lives of my loved ones. Moreover, the fact that I still have responsibilities keeps me within the community of moral agents. My illness or debility has not reduced me to a mere moral patient (to use the language of the philosophers). Though it may not be the whole story, surely Kant was onto something important when he claimed that human dignity rests on the capacity for moral agency within a community of those who respect the demands of morality.

By contrast, surely there is something deeply insulting in a medicine and an ethic that would ask only what I want (or would have wanted) when I become ill. To treat



me as if I had no moral responsibilities when I am ill or debilitated implies that my condition has rendered me morally incompetent. Only small children, the demented or insane, and those totally lacking in the capacity to act are free from moral duties. There is dignity, then, and a kind of meaning in moral agency, even as it forces extremely difficult decisions upon us.

Second, recovering meaning in death requires an affirmation of connections. If I end my life to spare the futures of my loved ones, I testify in my death that I am connected to them. It is because I love and care for precisely these people (and I know they care for me) that I wish not to be such a burden to them. By contrast, a life in which I am free to choose whatever I want for myself is a life unconnected to others. A bioethics that would treat me as if I had no serious moral responsibilities does what it can to marginalize, weaken, or even destroy my connections with others.

But life without connection is meaningless. The individualistic fantasy, though occasionally liberating, is deeply destructive. When life is good and vitality seems unending, life itself and life lived for yourself may seem

quite sufficient. But if not life, certainly death without connection is meaningless. If you are only for yourself, all you have to care about as your life draws to a close is yourself and your life. Everything you care about will then perish in your death. And that—the end of everything you care about—is precisely the total collapse of meaning. We can, then, find meaning in death only through a sense of connection with something that will survive our death.

This need not be connections with other people. Some people are deeply tied to land (for example, the family farm), to nature, or to a transcendent reality. But for most of us, the connections that sustain us are to other people. In the full bloom of life, we are connected to others in many ways—through work, profession, neighborhood, country, shared faith and worship, common leisure pursuits, friendship. Even the guru meditating in isolation on his mountain top is connected to a long tradition of people united by the same religious quest.

But as we age or when we become chronically ill, connections with other people usually become much more

*Drawing by
Michael Jacques
from his book
Images of Age.*

restricted. Often, only ties with family and close friends remain and remain important to us. Moreover, for many of us, other connections just don't go deep enough. As Paul Tsongas has reminded us, "When it comes time to die, no one says, 'I wish I had spent more time at the office.'"

If I am correct, death is so difficult for us partly because our sense of community is so weak. Death seems to wipe out everything when we can't fit it into the lives of those who live on. A death motivated by the desire to spare the futures of my loved ones might well be a better death for me than the one I would get as a result of opting to continue my life as long as there is any pleasure in it for me. Pleasure is nice, but it is meaning that matters.

...

I don't know about others, but these reflections have helped me. I am now more at peace about facing a duty to die. Ending my life if my duty required might still be difficult. But for me, a far greater horror would be dying all alone or stealing the futures of my loved ones in order to buy a little more time for myself. I hope that if the time comes when I have a duty to die, I will recognize it, encourage my loved ones to recognize it too, and carry it out bravely.

ACKNOWLEDGMENTS

I wish to thank Mary English, Hilde Nelson, Jim Bennett, Tom Townsend, the members of the Philosophy Department at East Tennessee State University, and anonymous reviewers of the *Report* for many helpful comments on earlier versions of this paper. In this paper, I draw on material in John Hardwig, "Dying at the Right Time; Reflections on (Un)Assisted Suicide" in *Practical Ethics*, ed. H. LaFollette (London: Blackwell, 1996), with permission.

REFERENCES

1. Given the importance of relationships in my thinking, "responsibility"—rooted as it is in "respond"—would perhaps be the most appropriate word. Nevertheless, I often use "duty" de-

spite its legalistic overtones, because Lamm's famous statement has given the expression "duty to die" a certain familiarity. But I intend no implication that there is a law that grounds this duty, nor that someone has a right corresponding to it.

2. For a discussion of the Oates case, see Tom L. Beauchamp, "What Is Suicide?" in *Ethical Issues in Death and Dying*, ed. Tom L. Beauchamp and Seymour Perlin (Englewood Cliffs, N.J.: Prentice-Hall, 1978).

3. Most bioethicists advocate a "patient-centered ethics"—an ethics which claims only the patient's interests should be considered in making medical treatment decisions. Most health care professionals have been trained to accept this ethic and to see themselves as patient advocates. For arguments that a patient-centered ethics should be replaced by a family-centered ethics see John Hardwig, "What About the Family?" *Hastings Center Report* 20, no. 2 (1990): 5-10; Hilde L. Nelson and James L. Nelson, *The Patient in the Family* (New York: Routledge, 1995).

4. A good account of the burdens of caregiving can be found in Elaine Brody, *Women in the Middle: Their Parent-Care Years* (New York: Springer Publishing Co., 1990). Perhaps the best article-length account of these burdens is Daniel Callahan, "Families as Caregivers; the Limits of Morality" in *Aging and Ethics: Philosophical Problems in Gerontology*, ed. Nancy Jecker (Totowa N.J.: Humana Press, 1991).

5. Kenneth E. Covinsky et al., "The Impact of Serious Illness on Patients' Families," *JAMA* 272 (1994): 1839-44.

6. Larry Churchill, for example, believes that Christian ethics takes us far beyond my present position: "Christian doctrines of stewardship prohibit the extension of one's own life at a great cost to the neighbor . . . And such a gesture should not appear to us a sacrifice, but as the ordinary virtue entailed by a just, social conscience." Larry Churchill, *Rationing Health Care in America* (South Bend, Ind.: Notre Dame University Press, 1988), p. 112.

7. Kant, as is well known, was opposed to suicide. But he was arguing against taking your life out of self-interested motives. It is not clear that Kant would or we should consider taking your life out of a sense of duty to be wrong. See Hilde L. Nelson, "Death with Kantian Dignity," *Journal of Clinical Ethics* 7 (1996): 215-21.

8. Obviously, I owe this distinction to Norman Daniels. Norman Daniels, *Am I My Parents' Keeper? An Essay on Justice Between the Young and the Old* (New York: Oxford University Press, 1988). Just as obviously, Daniels is not committed to my use of it here.

9. Daniel Callahan, *The Troubled Dream of Life* (New York: Simon & Schuster, 1993).