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LAW & HUMAN DIGNITY

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WHY DIGNITY IS A POOR REASON TO LEGALISE ASSISTED SUICIDE

PETER KURTI*

A growing movement in support of assisted dying is bringing pressure to bear on Australian politicians to enact legislation making it legal for doctors to help people to die. Victoria has already legalised assisted suicide, and now the Western Australian parliament may introduce a similar law. Proponents of assisted suicide argue that the burden of great physical or mental suffering diminishes human dignity and that — in the name of compassion — people should be able to receive assistance to end their lives when they wish to do so.

The word “dignity” is used in equivocal ways, however, and can refer both to an intrinsic dimension of human identity, and to an extrinsic, or social, dimension. Opponents of euthanasia and physician-assisted suicide tend to use dignity in its intrinsic sense whereas proponents use it in its extrinsic sense. There is, however, a response to those who argue that the demands of social dignity require the possibility for assisted suicide. This is the therapeutic option known as ‘dignity therapy’, increasingly used in palliative care to restore the social dignity of the terminally ill patient.

In jurisdictions where assisted suicide is legal, the categories of those eligible for assistance in dying are already expanding to include not only those with physical or mental ailments, but also those who are simply weary of life. Avoidance of suffering is only one factor to be weighed in the debate about legalising assisted suicide. It is also vital to consider the harmful impact on Australian culture and society if laws are enacted that permit doctors to kill their patient when prevailed upon to do so. Is the risk of cultural harm, perpetrated in the name of dignity, really one that we should be willing to run?

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I THE LEGISLATIVE JOURNEY OF ASSISTED SUICIDE IN AUSTRALIA

Until recently, it was an offence everywhere in Australia — punishable by up to five years in prison — to incite, counsel, or assist another to commit suicide or to attempt to commit suicide.¹ The criminal law reflected the social taboo about suicide which held the act to be an offence against humankind; suicide deprived the individual’s family and community of a member prematurely and denied them the opportunity to care for the troubled individual. It was also regarded as ‘self-murder’.²

Criminal codes also reflected Judeo-Christian teaching about the sanctity of human life. According to this teaching, a human being is neither the absolute owner of her life nor its author. Created in the image of God, the life of each human being is ‘entrusted to us by God that it may begin to find its fulfilment in the loving service of God and our fellow human beings. It is not for us to decide for how long it shall be so used.’³ As such, the criminal law imposed sanctions for suicide and attempted suicide both because of key ethical and religious conceptions of humanity and because of the wider impact of each act of suicide on society.

In many places, the law has now changed, and the act of suicide is no longer illegal. An eloquent account of the reasons for this legal development was given by Lord Bingham in a House of Lords judgment:

¹ See, eg, Sir John Vincent Barry, ‘Suicide and the Law’ (1965) 5 Melbourne University Law Review 1, 8–15.

² See, eg, Andreas Bähr, ‘Between “Self-Murder” and “Suicide”: The Modern Etymology of Self-Killing’ (2013) 46(3) *Journal of Social History* 620.

³ John Macquarie and James Childress, *A New Dictionary of Christian Ethics* (Westminster Press, 1st ed, 1967) 609.

Suicide itself (and with it attempted suicide) was decriminalised because recognition of the common law offence was not thought to act as a deterrent, because it cast an unwarranted stigma on innocent members of the suicide's family and because it led to the distasteful result that patients recovering in hospital from a failed suicide attempt were prosecuted, in effect, for their lack of success.⁴

Suicide ceased to be a felony in England in 1961. Reform occurred earlier in all Australian jurisdictions — much earlier in New South Wales ('NSW') where the *Crimes Act 1900* (NSW), passed at the beginning of the 20th century, abolished the offence of suicide. Assisting suicide, however, was another matter. The *Crimes Act 1900* (NSW) indicates clearly that one of the factors according to which an action causing the death of another person can amount to murder is where it has been done with the intent to kill that person.⁵ Accordingly, not only would a person counselling another to commit suicide commit a crime, the provision in any circumstances of the means to commit suicide, such as acceding to an individual's voluntary request for the administration of a drug to bring about death, could also well be construed as an act of murder.

In 2005, the Commonwealth Parliament passed legislation making it illegal to produce, supply, or possess materials intended to promote the committing of suicide.⁶ There have been few prosecutions for assisting another to commit suicide, and when a conviction has been issued, the decision of the court has often been based on the absence of capacity of the deceased to give full consent.⁷

However, the movement to decriminalise the offering of assistance to another to commit suicide continues to gain momentum. In November 2017, the Parliament of Victoria passed the *Voluntary Assisted Dying Act 2017* (Vic). The statute, which will not come into effect until mid-2019, will allow an individual with a terminal illness to obtain a lethal drug within ten days of asking to die, after having complete a three-stage process involving two independent medical assessments. In order to qualify, the individual must be over the age of 18, have been a resident in the state of Victoria for at least twelve months, and be suffering in a way that 'cannot be relieved in a manner the person deems

⁴ *R (Pretty) v Director of Public Prosecutions* [2001] UKHL 61; [2002] 1 AC 800 [35].

⁵ *Crimes Act 1900* (NSW) s 18.

⁶ *Criminal Code Amendment (Suicide Related Material Offences) Act 2005* (Cth).

⁷ See, eg, *Justins v The Queen* [2010] NSWCCA 242.

tolerable'.⁸ The new law was based on the recommendations of an expert panel chaired by a former president of the Australian Medical Association.⁹

A few weeks before the Victorian legislation received Royal Assent, an attempt was made in the NSW Parliament to pass the *Voluntary Assisted Dying Bill 2017*. The Bill, which had been drafted by a cross-party working group and contained provisions similar to those in the Victorian Bill, failed to pass in the State's Upper House by one vote.¹⁰ Attempts to pass similar legislation failed in Tasmania in November 2013 and in South Australia in November 2016. The issues are not likely to come before the Western Australian Parliament in 2019.

Assisted suicide was legal between 1995 and 1997 in the Northern Territory after its Parliament passed the *Rights of the Terminally Ill Act 1995* (NT), which had been prepared by the Country Liberal government led by Marshall Perron. The Commonwealth Parliament responded by passing a private member's Bill promoted by Kevin Andrews MP which became the *Euthanasia Laws Act 1997* (Cth). The Act removed the power of any Australian territory to legalise euthanasia. The 1997 Act specifically repealed the Northern Territory Act — but not before four people had received assistance in committing suicide from Philip Nitschke.¹¹

In mid-2018, however, Senator David Leyonhjelm proposed his own private member's Bill — *Restoring Territory Rights (Assisted Suicide Legislation) Bill 2015* (Cth) — to restore the territories' rights to legislate on assisted suicide which had been set aside in 1997. Although the Bill was subsequently defeated in the Senate in August 2018, it is worth noting the arguments with which it was presented to the Senate. The Bill proposed by Leyonhjelm recognised the territories' rights to legislate without specifying the scope of any legislation that might be passed in the Northern Territory or the ACT. In his second reading speech delivered in the Senate on 3 March 2016, however, Leyonhjelm's principal

⁸ *Voluntary Assisted Dying Act 2017* (Vic); See also Jean Edwards, 'Euthanasia: Victoria Becomes the First Australian State to Legalise Voluntary Assisted Dying', *ABC News* (online, 29 November 2017) <<http://www.abc.net.au/news/2017-11-29/euthanasia-passes-parliament-in-victoria/9205472>>.

⁹ *Ministerial Advisory Panel on Voluntary Assisted Dying* (Final Report, July 2017).

¹⁰ 'Euthanasia Debate: NSW Parliament Rejects Bill on Voluntary Assisted Dying', *ABC News* (online, 17 November 2017) <<https://www.abc.net.au/news/2017-11-16/nsw-parliament-votes-on-euthanasia-bill/9158384>>.

¹¹ Michael Cook, 'Euthanasia Activist Nitschke Loses Legal Battle to Practice as a Doctor', *National Right to Life News* (online, 14 January 2015) <<https://www.nationalrighttolifenews.org/news/2015/01/euthanasia-activist-nitschke-loses-legal-battle-to-practice-as-a-doctor/>>.

concern was clearly to assert the ‘fundamental and legal right to choose whether we wish to continue living’.¹² Leyonhjelm continued:

The law says we are only permitted to die by our own hand, without assistance. And if we are too weak or incapacitated to end our lives ourselves, we are condemned to suffer until nature takes its course. It is a serious offence for anyone to either help us die, at our instruction, or even to tell us how to do it ourselves.¹³

The argument was cast as relief from a supposed experience of unendurable suffering, but the force of Leyonhjelm’s reasoning means that once permission to grant assistance is afforded to someone in pain, that permission must be extended *a fortiori* to anyone wishing to exercise their freedom to commit suicide. As Leyonhjelm remarked in his speech: ‘An individual may have good reasons to take his or her own life. But even if they do not, it is still their decision to make.’¹⁴

Additionally, if the principle of individual freedom entitles a sick person in pain to assistance in committing suicide, on what basis can that principle be denied to someone who is not sick and in pain but who wishes to die? One example of a person who falls into this category is David Goodall, a 104-year-old academic from Perth who flew to a clinic in Basel in Switzerland in May 2018 where he committed suicide with the assistance of medical staff.¹⁵ The case was unusual because, while enthusiastic about accepting assistance to end his life, Goodall met none of the qualifications normally associated with assisted suicide. Indeed, much of the public support for assisted suicide comes from those who think that no one should have to endure a long and painful death. However, Goodall was not suffering from any terminal illness and enjoyed good general health; he was just old and frail, no longer enjoying life and longing to die.¹⁶

Although the terminally ill are usually listed as the first and most obvious candidates for assisted suicide, the categories of eligibility are seemingly elastic and can potentially be

¹² Commonwealth, *Parliamentary Debates*, Senate, 2 December 2015, 9,673 (David Leyonhjelm, Senator).

¹³ *Ibid.*

¹⁴ *Ibid.*

¹⁵ Charlotte Hamlyn and Briana Shepherd, ‘David Goodall Ends His Life at 104 with a Final Powerful Statement on Euthanasia’, *ABC News* (online, 11 May 2018) <<https://www.abc.net.au/news/2018-05-10/david-goodall-ends-life-in-a-powerful-statement-on-euthanasia/9742528>>.

¹⁶ *Ibid.*

extended to further categories of people. This is something admitted readily by Amanda Vanstone writing in support of Leyonhjelm's Bill:

There is no reason that we should refuse to end the suffering of two groups of people. First, those who have a terminal illness and are more worried about the quality of their remaining life than the quantity. Second, those for whom just age has taken its toll and whose consequent frailty leaves them incapable of doing much and who do not want to spend their last months being cared for as one does a baby.¹⁷

Successful passage of legislation in Victoria — the only state in Australia where assisted suicide is currently legal — has encouraged euthanasia advocacy groups such as Exit International and YourLastRight.com (a national alliance of dying with dignity and voluntary euthanasia societies in Australia) to increase the pressure brought to bear on politicians for legal reform.

Whilst all opponents of assisted suicide are, at some time or another, bound to be negatively categorised into specific groups notorious for opposing these kinds of radical ideals (such as religious groups), it should be noted that not all calls for reform come from secular advocates. For example, there are religious groups that favour assisted suicide. *Christians Supporting Choice for Euthanasia*, for example, claims that 'the overwhelming majority of people of faith support choice for voluntary euthanasia', appealing to a 2007 survey conducted by Newspoll.¹⁸ Meanwhile, opposition to the legalisation of assisted suicide in Australia comes from a broad cross-section of the community, some of whom are religious and some not. With the enactment of a law to permit assisted suicide in Victoria, their efforts will be directed to arguing clearly against the pursuit of similar changes in the law in the rest of the country.

¹⁷ Amanda Vanstone, 'Can't We Just be Decent to People at the End of Their Lives?', *The Sydney Morning Herald* (online, 1 July 2018) <<https://www.smh.com.au/politics/federal/can-t-we-just-be-decent-to-people-at-the-end-of-their-lives-20180629-p4zok5.html>>.

¹⁸ 'Public Opinion — Christian Opposition a Tiny Minority', *Christians Supporting Choice for Voluntary Assisted Dying* (Web page, 2018) <<http://christiansforve.org.au/public-opinion/>>; See, eg, Andrew Dutney, 'Christian Support for Voluntary Euthanasia' (1997) 16(2) *Monash Bioethics Review* 15.

II THE “DIGNITY” DEBATE

Language is used in very elliptical ways in the debate about euthanasia and assisted dying.¹⁹ One of the phrases that feature prominently is “dying with dignity”. It is a coded phrase, of course, referring to the idea that each of us should be entitled to decide exactly how and when we die — as if an unexpected death, or one that comes as a result of illness rather than our own volition, is by that very fact lacking in dignity. Additionally, as in the case of David Goodall, one does not even need to be terminally ill to decide that it is time to die.

“Dying with dignity” is almost being promoted as little more than a lifestyle choice. Mourning what it saw as an opportunity to reform the law on assisted suicide missed by the UK Parliament back in September 2015, *The Economist* argued that ‘the state should no more intrude on personal decisions at the close of life than at any point during it’, continuing that ‘governments everywhere should recognise that, just as life belongs to the individual, so should its end’.²⁰ Yet, the demand that the dignity of the person be respected is at the heart of many arguments propounded by both advocates and opponents of euthanasia and assisted suicide.

The *Oxford English Dictionary* (‘OED’) gives eight definitions for *dignity*, the first two of which are the most relevant here: ‘the quality of being worthy or honourable; worthiness, worth, nobleness, excellence’ and ‘honourable or high estate, position or estimation; honour, degree of estimation, rank’.²¹ Worthiness, excellence, and estimation, therefore, are the central notions of dignity which is a term of distinction and therefore not necessarily something to be found or expected in every human being. “Dignity” is clearly not synonymous with “life” because a person can live without dignity; but human life is obviously a necessary condition of there being human dignity, for without life there can be no possibility of dignity.

¹⁹ Although frequently closely associated with each other, the terms assisted suicide and euthanasia must not be used interchangeably. In assisted suicide, the individual kills himself or herself with assistance; in euthanasia, the individual is killed by another person. The distinction is important: it does not turn on whether or not the individual who dies or wishes to die has given their full, informed consent; it turns on who does the killing.

²⁰ ‘One Door Closes, Another Opens’, *The Economist* (online, 19 September 2015) <<https://www.economist.com/leaders/2015/09/17/one-door-closes-another-opens>>.

²¹ *Oxford English Dictionary* (online at 20 January 2019) ‘dignity’ (def 1–2).

But what can it possibly mean to “die with dignity”? In their appeals to dignity, those on either side of the debate about assisted suicide claim that their position is the ethically correct one. This seems paradoxical; but, as bioethicist Margaret Somerville has noted, the paradox is resolved once we understand that each side uses the term human “dignity” differently.

According to Somerville, opponents of assisted suicide regard dignity as an *intrinsic* characteristic that human beings have simply by virtue of being human. It is a dignity that cannot be lost or diminished. A full conception of intrinsic human dignity is grounded in the inherent moral worth of human beings — a worth that is not diminished by disease or infirmity. It should be noted, incidentally, that Somerville’s interpretation does not completely accord with the OED definitions of dignity, which indicate that dignity refers to worthiness and an honourable standing rather than to an intrinsic characteristic. It is quite possible to live without dignity. Somerville’s interpretation is helpful, however, for capturing a conception of the inherent value of human life.

Turning to pro-euthanasia advocates, Somerville says that they ‘see dignity as an extrinsic characteristic that can be lost with an individual’s loss of autonomy, independence, and control’.²² Providing assistance in suicide, pro-euthanasia advocates argue, is a means of restoring control and, thereby, safeguarding the dignity of the individual.²³ Clearly, this conception of what may be considered *social* dignity aligns more closely with the OED definition of dignity because it is a status that can be both gained and lost. Yet this extrinsic or social conception of human dignity is surely impoverished because it means that dignity, understood in this way, is always compromised by any form of disability or dependence. However, this cannot be correct: an individual can surely enjoy the quality of being ‘worthy’ or ‘honourable’ whilst living with disability or infirmity. It is clear that the word “dignity” is used in very different ways in the debate about assisted suicide and that some uses somewhat stretch the principal accepted meanings.

Some have argued, in response to this, that a subjective approach to dignity always needs to be adopted when discussing ways of dying; if a person *thinks* dying in a certain way lacks dignity then it would be undignified for that person to die in this way. ‘It is easy to

²² Margaret Somerville, *Death Talk: The Case against Euthanasia and Physician-Assisted Suicide* (McGill-Queen’s University Press, 2nd ed, 2014) xxviii.

²³ *Ibid.*

see why this is popular,' notes Christopher Coope, a moral philosopher, 'for it seems to by-pass our problems with definitions, and it has an attractive air of autonomy about it'.²⁴

III THE COMPASSION ARGUMENT

There can be little doubt that fears about a loss of extrinsic, or social dignity, have been fuelled, in part, by advances in medical technology that can allow people to live for far longer than in earlier times. In their arguments for people to be afforded relief from the ravages of technology, advocates of assisted suicide frequently appeal to compassion which often forms a very strong component of their case. There are two elements to the argument from the perspective of compassion.

The first element is that people who are terminally ill should not be forced to be kept alive against their wishes and should be permitted to die when they choose. This, however, fails to acknowledge the extremely important point that if faced with medical intervention — such as the use of a respirator or a therapy such as kidney dialysis which is intended only to sustain life and alleviate pain rather than cure an illness — any person has the right to refuse treatment, even though to do so may lead to an increased risk of death.

At first glance, the assertion of a right to refuse treatment looks very much like the assertion of a "right to die". This is especially so since proponents of assisted suicide frequently demand not only the discontinuance of treatment, but also positive assistance in dying by, say, a lethal dose of a drug administered either by a physician or the individual patient. As Somerville has argued, however, '[a] right to refuse treatment is based in a right to inviolability — a right not to be touched, including by treatment, without one's informed consent. It is not a right to die or a right to be killed.'²⁵ Although the call for the discontinuance of treatment looks very much like the assertion of a "right to die", it might also be described as the assertion of a "right to commit suicide" or a "right to become dead". According to Somerville, '[a]t most, people have a negative content right

²⁴ Christopher M Coope, 'Death with Dignity' (1997) 27(5) *Hastings Center Report* 37, 37.

²⁵ Donald Boudreau and Margaret Somerville, 'Euthanasia is Not Medical Treatment' (2013) 106 *British Medical Bulletin* 45, 60.

to be allowed to die, not any right to positive assistance to achieve that outcome'.²⁶ Perhaps it is more accurate to say a person is *free* to become dead.

Proponents of assisted suicide often insist there is no significant difference between deliberately withdrawing essential medical life support and deliberate intervention to bring about death because the outcome is the same.²⁷ However, there is a most significant difference. Letting a patient die at some point is a practical condition of the successful operation of modern medicine, as Yale Kamisar has observed. The same cannot be said of physician-assisted suicide:

To allow a patient to reject unwanted bodily intrusions by a physician is hardly the same thing as granting her a right to determine the time and manner of her death. The distinction between a right to resist invasive medical procedures and the right to [physician-assisted suicide] is a comprehensible one and a line maintained by almost all major Anglo-American medical associations.²⁸

The second element is that advocates for assisted suicide also profess to want to spare vulnerable patients who are experiencing what is usually described 'unbearable pain'. Yet available data suggests the experience of unbearable pain does not appear to be a principal reason why people seek assisted suicide.

The Oregon *Death with Dignity Act* ('DWDA') Data Summaries record in great detail those who have taken advantage of Oregon law's permission to end their lives by means of a voluntary self-administered lethal dose of medications.²⁹ As such, they are a reasonably reliable guide to what motivates people to seek a lethal dose. According to the 2017 DWDA Data Summary, 218 people in Oregon received prescriptions for lethal medications. As of January 2018, 143 people were reported to have died from ingesting the medication.³⁰ Of these, 21% gave inadequate pain control as their reason for seeking assisted suicide; for 37%, it was loss of control of bodily functions; for 55%, it was concern about becoming a burden on others; for 67%, the reason was loss of dignity; and

²⁶ *Ibid.*

²⁷ See, eg, James Rachels, 'Active and Passive Euthanasia' (1975) 292 *New England Journal of Medicine* 78.

²⁸ Yale Kamisar, 'The Reasons So Many People Support Physician-Assisted Suicide — And Why These Reasons Are Not Convincing' (1996) 12(2) *Issues in Law and Medicine* 113.

²⁹ *Death with Dignity Act*, Or Rev Stat § 127.800–127.897 (2017).

³⁰ Oregon Health Authority, 'Death with Dignity Act Annual Reports', *Oregon.gov* (Web Page, 9 February 2018) <<https://www.oregon.gov/oha/PH/PROVIDERPARTNERRESOURCES/EVALUATIONRESEARCH/DEATHWITHDIGNITYACT/Pages/ar-index.aspx>>.

for 87%, it was a loss of the ability to engage in activities that make life enjoyable.³¹ If the DWDA report figures are representative of other places where assisted suicide is available, it would appear that relief from intolerable pain is the reason for seeking assistance in only a minority of cases. Anxiety about the loss of ability to participate in society and loss of autonomy are by far the more prevalent reasons.

The fact that few people appear to seek a lethal dose because of intolerable pain surely undermines the arguments based on compassion that are advanced by proponents. Critics such as Kevin Yuill are quite sceptical about the compassion argument, arguing that '[m]uch of what passes for compassion is simply reflected fear on the part of those with little prospect of death in the immediate future. [It] is really self-centred fear for one's own prospects.'³² It seems then, that flaws in the argument from the perspective of compassion arise, in part, because of its close association with the problematic concept of "dignity" to which proponents of assisted suicide appeal. Notwithstanding the problems identified earlier with the analysis of dignity, Somerville's account is nonetheless helpful because it lays bare the subjective element of the responses of individuals to the prospect of death.

Thus, when people advocating for the legalisation of assisted suicide appeal to "dignity", the dignity to which they most frequently seem to refer, and which it is held to be important to retain, does appear to be the *social* dignity of independence and capacity rather than the intrinsic *human* dignity that comes simply from the fact of human *being*. This conclusion is supported by successive DWDA Data Summaries.

IV A DIGNIFIED DEATH?

If the meaning of "death with dignity" is to be entirely subjective, dying without dignity will simply be a felt experience. It will commit us to hold that merely for a dying person to *think* they were dying without dignity would mean they actually *were* dying in such a manner. Concern for addressing the "felt" experience of lost social dignity by the patient lies behind the emergence of a form of psychotherapeutic intervention known as 'dignity

³¹ *Ibid.*

³² Kevin Yuill, *Assisted Suicide: The Liberal, Humanist Case against Legalization* (Palgrave Macmillan, Kindle edition, 2013) 43.

therapy' pioneered by psychiatrist Harvey Max Chochinov.³³ Dignity therapy seeks to mitigate against a loss of social dignity and helps patients to see that ingesting a lethal dose of medication is not the best way to restore that dignity. For opponents of legalised euthanasia and physician-assisted suicide, such as Somerville, dignity therapy offers their case significant weight:

[Dignity therapy] identifies the reasons people want euthanasia, explains why many of them change their minds, and describes in personal detail what they and others would have lost if [physician-assisted suicide and euthanasia] were available. Dignity therapy can assist health-care professionals to help patients at the end of their lives who see their circumstances as unbearable and have lost a "why" to re-find one.³⁴

The notion of "dying with dignity", which is advocated by proponents of euthanasia and physician-assisted suicide, really appears to reflect a state of *pre-mortem* anxiety and loneliness that can beset the terminally ill; a lethal injection which cuts life short is hardly an appropriate way to address this experience of distress or despair. Dignity therapy, increasingly available as a component of palliative care in Australia, enables the terminally ill to reclaim their identity and sense of social dignity.

Death happens to everyone. While it is certainly true that one can die in undignified circumstances — by execution or torture, for example — such a death can, at the same time, surely be a dignified one if the person confronting death does so with a certain spirit of worthiness, nobleness, and honour. External circumstances do not determine the dignity with which death is met. Indeed, it is difficult to understand how the sort of death that occurs naturally can be either dignified or undignified, as Leon Kass has observed:

A death with dignity — which may turn out to be something rare or uncommon even under the best circumstances — entails more than the absence of external indignities. Dignity in the face of death cannot be given or conferred from the outside but requires a dignity of soul in the human being who faces it.³⁵

³³ See, eg, Harvey Max Chochinov, *Dignity Therapy* (Oxford, 2012).

³⁴ I am grateful to an anonymous referee for drawing Dignity Therapy to my attention, and for referring me to Margaret Somerville's remarks about Dignity Therapy: Margaret Somerville, 'Dr Harvey's Must-Read Book Unpacks What Dignity Means', *Catholic Weekly*, (online, 8 June 2017) <<https://www.catholicweekly.com.au/margaret-somerville-dr-harveys-must-read-book-unpacks-what-dignity-means>>.

³⁵ Leon R Kass, 'Averting One's Eyes, or Facing the Music?: On Dignity in Death' (1974) 2(2) *Hastings Center Studies* 67, 70.

Dignity in the face of death is a possibility for everyone as they die; it is something that depends on the character and bearing of the individual who is dying. The phrase “dying with dignity”, as it is deployed by proponents of legalising assisted suicide, is thereby exposed as meaning preciously little. It is used to describe the state that precedes death rather than the death itself.

Once the categories of eligibility for assisted suicide and voluntary euthanasia extend beyond terminal illness and the experience of ‘unbearable suffering’ — as they already have done in the case of David Goodall — the dignity ascribed to the *pre-mortem* state will, soon enough, turn upon the human conditions of vulnerability, weakness, and infirmity.

In the twentieth century, we have witnessed the consequences of the profound contempt shown, at times, for the weak and the infirm. Now it is important to affirm that those very human conditions do not become the pretext for arguing that a point can be reached when a life is no longer worth living.

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