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*Article*

# Non-faith-based arguments against physician-assisted suicide and euthanasia

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*This article is a complement to "A Template for Non-Religious-Based Discussions Against Euthanasia" by Melissa Harintho, Nathaniel Bloodworth, and E. Wesley Ely which appeared in the February 2015* Linacre Quarterly. *Herein we build upon Daniel Sulmasy's opening and closing arguments from the 2014 Intelligence Squared debate on legalizing assisted suicide, supplemented by other non-faith-based arguments and thoughts, providing four nontheistic arguments against physician-assisted suicide and euthanasia: (1) "it offends me"; (2) slippery slope; (3) "pain can be alleviated"; (4) physician integrity and patient trust.*

***Lay Summary:*** Presented here are four non-religious, reasonable arguments against physician-assisted suicide and euthanasia: (1) "it offends me," suicide devalues human life; (2) slippery slope, the limits on euthanasia gradually erode; (3) "pain can be alleviated," palliative care and modern therapeutics more and more adequately manage pain; (4) physician integrity and patient trust, participating in suicide violates the integrity of the physician and undermines the trust patients place in physicians to heal and not to harm.

*Keywords*: Euthanasia, Physician-assisted suicide, Physician-assisted death, Debate, Apologetics

## Introduction

In its first issue of 2015, *The Linacre Quarterly* published the text of a secular debate held at Vanderbilt University School of Medicine (Bloodworth et al. 2015), hoping it would re-kindle interest in formulating arguments and contribute to increasingly common discussions in society about physician-assisted suicide (PAS) and euthanasia. As that paper was offered to engender dialog, it was hoped that other

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reflections would follow. As it happened, around the same time that the Bloodworth publication was being prepared, a debate was held by Intelligence Squared U.S. (Intelligence Squared 2014a) on legalizing physician-assisted suicide featuring Professors Peter Singer and Andrew Solomon "for" and Doctors Daniel Sulmasy and Ilora Finlay "against" the legalization of PAS.[1] Herein we build upon Doctor Sulmasy's opening and closing arguments from that debate, supplemented by other non-faith-based arguments and thoughts intended to further this conversation, focusing on objections to legalizing these practices. In this manuscript, we will thus review the Bloodworth article, present the Intelligence Squared opening and closing statements "against PAS" and then expound upon four key arguments against PAS: (1) "it offends me"; (2) slippery slope; (3) "pain can be alleviated"; (4) physician integrity and patient trust.

Before getting into Doctor Sulmasy's debate points, it is worthwhile to recount some points raised in the Bloodworth article (Bloodworth et al. 2015). While the debate points presented at Vanderbilt were well-received, common criticisms to some of the assertions made in that piece are worth consideration. For example, one of the main bases for Doctor Ely's argument against physician-assisted suicide and euthanasia involved an appeal to natural law.[2] Such appeal to natural law does not presuppose belief in God. The knowledge of natural law is discernible by reason and so it is not fundamentally theistic. While it is true that the Catholic Church in particular has made prominent use of natural law in formulating its ethical positions, natural law is not essentially rooted in any faith tradition (see, for example, Anderson 2005; Finnis 2001; Goyette, Latkovic, and Myers 2004; McInerny 1993; Veatch 1971). Nonetheless, appeal to natural law is commonly mistaken as an appeal to theism, which many in a secular society dismiss out of hand because of this misperception. These critics often forget the use of natural law reasoning by the founding fathers of the United States. The Vanderbilt debate, for instance, referenced the Declaration of Independence, which is a quintessentially natural law-based set of governing principles. Lastly, the references in that debate to C.S. Lewis from *The Abolition of Man* were placed strategically and without necessary dependence on Lewis's explicit arguments for theism as the ground of the natural law, and hence morality. Lewis's approach leaves natural law vulnerable to the charge of theism by those who do not accept an ultimate or transcendent justice or goodness as the rule and measure of human actions. Lewis's position regarding the theistic basis of natural law is not, however, widely accepted by natural law scholars, the authors of this paper, or the Catholic Church.

The Bloodworth article was, as billed, a mere starting point. Doctors Sulmasy and Finlay developed a sophisticated, philosophical "devil's advocate" approach that was ultimately successful. They discerned optimal premises for making the case against physician-assisted suicide and euthanasia to avowed non-theistic practitioners of medicine. It is thus our privilege to publish here Doctor Sulmasy's points to continue building the case towards truth in respecting human life nearing its end in the context of the practice of the vocation of medicine. In the tradition of St. Thomas, we take four strong arguments for PAS that arose during the debate (patient autonomy, no slippery slope, unalleviated pain, physician's duty) and argue against them. We base our arguments in reason, with the conviction that the truth in a principle can be discerned and its implications drawn out to a logical conclusion, and an error can be shown to have a contradiction at its heart.

## Doctor Sulmasy's Opening Statement[3]

I am a physician. Part of my job is to help people die in comfort and with dignity. But I do not want to help you, or your daughter, or your uncle commit suicide. You should not want me to. I urge you to oppose physician-assisted suicide: it represents bad ethical reasoning, bad medicine, and bad policy. I am going to concentrate on the first of these lines of argument. Ilora will take up the latter two.

We strongly support the right of patients to refuse treatments and believe physicians have a duty to treat pain and other symptoms, even at the risk of hastening death. But empowering physicians to assist patients with suicide is quite another matter—striking at the heart not just of *medical* ethics, but at the core of ethics itself. That is because the very idea of interpersonal ethics depends upon our mutual recognition of each other's equal independent worth, the value we have simply because we are human. Some would have you believe that morality depends upon equal *interests* (usually defined by our preferences) and advance utilitarian arguments based on that assumption.[4]

*But which is morally more important, people or their interests?* As Aristotle observed, small errors at the beginning of an argument lead to large errors at the end.[5] If interests take precedence over people, then assisting the suicide of a patient who has lost interest in living certainly is morally praiseworthy. But it also follows that active euthanasia ought to be permitted. It also follows that the severely demented can be euthanized once they no longer have interests. They can also freely be experimented upon as excellent human "models" for research. It also follows that infanticide ought to be permitted for infants with congenital illness.

Many would see these conclusions as frightful, but this is not just a slippery slope. They all follow *logically* from arguing for assisted suicide on the basis of maximizing personal interests. So if you *do not* believe in euthanasia for severely disabled children or the demented, you might want to re-think your support for assisted suicide. At least if you want to be consistent.

People often argue that they need assisted suicide to preserve their dignity, but that word has at least two senses. Proponents use the word in an *attributed* sense to denote the value others confer on them or the value they confer on themselves. But there is a deeper, *intrinsic* sense of dignity.

Human dignity ultimately rests not on a person's interests, but on the value of the person whose interests they are; and the value of the person is infinite. I do not need to ask you what your preferences are to know that you have incalculable worth, simply because you are human. Martin Luther King said that he learned this from his grandmother who told him, "Martin, don't let anybody ever tell you you're not a Somebody" (Baker-Fletcher 1993, 23). This some-bodiness, this intrinsic worth or dignity, was at the heart of the civil rights movement.

It does not matter what a person looks like, how productive the person might be, how others view that person, or even how that person may have come to view herself. What matters is that everybody, black or white, healthy or sick, is a *somebody*. Assisted suicide and euthanasia require us to accept that it is morally permissible to act with the specific intention-in-acting of making a somebody into a *nobody*, i.e., to make them dead.

Intentions, not just outcomes, matter in ethics. Intending that a somebody be turned into a nobody violates the fundamental basis of all of interpersonal ethics—the intrinsic dignity of the human.

Our society worships independence, youth, and beauty. Yet we know that

illness and aging often bring dependence and disfigurement. The terminally ill, especially, need to be reminded of their value, their intrinsic dignity, at a time of fierce doubt. They need to know that their ultimate value does not depend upon their appearance, productivity, or independence.

You see, physician-assisted suicide flips the default switch. The question the terminally ill hear, even if never spoken, is, "You've become a burden to yourself and the rest of us. Why haven't you gotten rid of yourself yet?" A good utilitarian would think this a proper question—even a moral duty.

As a physician who cares for dying patients, however, I am more fearful of the burden this question imposes on the many who might otherwise choose to *live*, than the modest restriction imposed on a few, when physician-assisted suicide is illegal.

Assisted suicide should not be necessary. Pain and other symptoms can almost always be alleviated. As evidence, consider that pain or other symptoms rarely come up as reasons for assisted suicide. The top reasons are: fear of being a burden and wanting to be in control (Oregon Public Health Division 2015, 5).

You may ask, "Why shouldn't I have this option?" And yet we all realize that society puts many restrictions on individual liberty, and for a variety of reasons: to protect other parties, to promote the common good, and to safeguard the bases of law and morality. For example, we do not permit persons to drive when drunk, or to freely sell themselves into slavery.

Paradoxically, in physician-assisted suicide and euthanasia, patients turn the control over to physicians, who assess their eligibility and provide the means. Further, death obliterates all liberty. Therefore, saying that respect for liberty justifies the obliteration of liberty actually *undermines* the value we place on human freedom.

## Doctor Sulmasy's Closing Statement

I have been on talk shows and received call-in questions from patients who ask how I can be opposed to physician-assisted suicide when they are getting sick from chemotherapy, suffering complications from the big IV they have in their neck, have intense pain, and are spending more time in the hospital than outside it. But I ask them, why are you still getting chemotherapy? Why not have the IV removed? Why not ask for hospice or palliative care to control your pain? Why not just stay home? You should have no need for assisted suicide.[6] Most supporters of physician-assisted suicide want what opponents want—respect for their dignity and attention to their individual needs.

But we are all human beings—fragile, interdependent, and connected in bonds of mutual respect and support. Suicide is always an act of communication and has profound interpersonal implications. Many persons who raise the question of suicide are really testing the waters, asking us if we care enough to try to stop them. When we do not stop them, or even say, "I'll help you," we confirm their deepest fears and make it difficult for them to see an alternative. And when the suicide happens, physicians and families must live for the rest of their lives with fact that they did not try to intervene.

We should not construct a society that makes assisted suicide easy or common. We should re-direct our energies towards making sure that all patients get the kind of care we all want—helping us live to the fullest even as we are dying. Vote for that kind of high quality, compassionate care at the end of life, and the sort of moral world that makes it possible, by voting No on physician-assisted suicide.

## Debate Result and Some of the Arguments

Doctors Sulmasy and Finlay won the debate according to its rules, by persuading the most members of the live audience to change their minds. While the live audience in New York City began the debate with 65 percent in favor of legalizing assisted suicide, only 10 percent opposed, and 25 percent undecided, after the debate, 67 percent were in favor but 22 percent were opposed to legalization. The unofficial online polling changed from 5 percent opposed to legalization before the debate to 51 percent opposed as of March 21, 2016. (See the Results tab at Intelligence Squared 2014a)

In the rest of this article we highlight and expound upon some of the arguments against physician-assisted suicide gleaned from the debate and from the audience comments and questions following it: (1) "It offends me"; (2) the slippery slope; (3) "pain can be alleviated"; and (4) physician integrity and patient trust. We take care not to frame them within a faith-based context. While we believe that faith-based arguments are strong, our intention in arguing from reason is that all too many people are quickly dismissive of faith-based arguments. Our aim is to advance the conversation from this perspective. As noted earlier, the hope is to have new and other iterations of the pro-life arguments readily available to reach as broad a swath of people as possible, believers and non-believers alike.

## "It Offends Me" Argument

Certainly everyone should strive not to be offensive to others, but whether one is offended or not, partly depends upon the person potentially offended. To offend someone is to attack, violate, or cause resentful displeasure to a person. This presupposes that the one offended recognizes the attack, violation, or resentment, and so the argument vis-à-vis assisted suicide is that when one willfully kills oneself, or requests to be killed, every other human being should rightfully be offended. Why? Because subsumed in the action of one killing oneself (or requesting to be killed) is the implied announcement that one's life (human life) is somehow not as valuable as it otherwise would be if one were not in a position to seek one's death (For to value life contradicts the act of killing, and if one values life, one does not commit suicide or ask to be killed.). To assert that one values human life, and at the same time to commit suicide is contradictory and illogical. So, to kill oneself (willfully, i.e., to distinguish this form of suicide from suicide in association with mental illness or other clinical pathology) necessarily devalues human life. And, because we are all human beings, therefore, every human being is (or should be) resentful of his or her life being devalued.

Now some may grant that killing oneself is an expression of devaluing life, but only that individual person's life, and no one else's, arguing therefore, that there is no basis for one's willful suicide (or its request) to be offensive to anyone else. The fundamental problem, however, with this reasoning is that human beings are relational (natural law). It is part of the essence of being human to exist in a relationship to another. According to Thomas Aquinas, the third precept of the natural law is "an inclination to good, according to the nature of his reason … thus man has a natural inclination … to live in society" (Aquinas 1948, I–II, q. 94, a. 2). And Aristotle viewed a particular relationship, that of friendship, to be a virtue and "most indispensable for life" (Aristotle 1962/1980, bk. 8, ch. 1).

Indeed the very origin of an individual necessitates the relationship of two other human beings—a mother and a father—and a human being exists in relationships with others by his or her very nature. Human beings then are always, and essentially a part of a community of persons, and as such because of this connection with others (as part of humanity), when another person kills him- or herself or allows him- or herself to be killed, life for every other human being is cheapened (devalued). Such an action says to some degree, that life is not worth it; and although the effect on others may be seemingly miniscule, the more it happens the greater the effect on others (like compounding interest on money). Moral actions very much and very often have consequences for others, even when there appears to be no connection.[7]

## The Slippery Slope Argument

One of the issues brought up in the debate over physician-assisted suicide is the slippery slope argument: If physician-assisted suicide is made legal, then other things will follow, with the final end being the legalizing of euthanasia for anyone for any reason or no reason. The experience of other countries shows that this is not theoretical. The Netherlands is an example of the slippery slope on which legalizing physician-assisted suicide puts us. In the 1980s the Dutch government stopped prosecuting physicians who committed voluntary euthanasia on their patients (Jackson 2013, 931–932; Patel and Rushefsky 2015, 32–33). By the 1990s over 50 percent of acts of euthanasia were no longer voluntary. This is according to the 1991 Remmelink Report, a study on euthanasia requested by the Dutch government and conducted by the Dutch Committee to Study the Medical Practice Concerning Euthanasia (Euthanasia.com 2014; Patients Rights Council 2013a; Van Der Maas et al. 1991). In 2001 euthanasia was made legal. And in 2004 it was decided that children also could be euthanized. According to Wesley Smith, in a *Weekly Standard* article in 2004, "In the Netherlands, Groningen University Hospital has decided its doctors will euthanize children under the age of 12, if doctors believe their suffering is intolerable or if they have an incurable illness." The hospital then developed the Groningen Protocol to decide who should die. Smith comments,

> It took the Dutch almost 30 years for their medical practices to fall to the point that Dutch doctors are able to engage in the kind of euthanasia activities that got some German doctors hanged after Nuremberg. For those who object to this assertion by claiming that German doctors killed disabled babies during World War II without consent of parents, so too do many Dutch doctors: Approximately 21% of the infant euthanasia deaths occurred without request or consent of parents. (Smith 2004)

*Euthanasia in the Netherlands went from illegal but not prosecuted, to legal, to including children*. And it is not stopping there (Schadenberg 2013). Now, in 2011, Radio Netherlands reported that "the Dutch Physicians Association (KNMG) says unbearable and lasting suffering should not be the only criteria physicians consider when a patient requests euthanasia." The association published a new set of guidelines, "which says a combination of social factors and diseases and ailments that are not terminal may also qualify as unbearable and lasting suffering under the Euthanasia Act." These social factors include "decline in other areas of life such as financial resources, social network, and social skills" (RNW 2011). So a person with non-life threatening health problems

but who is poor or lonely can request to be euthanized.

In another example of the slippery slope to which physician-assisted suicide leads, in 2002 Belgium "legaliz[ed] euthanasia for competent adults and emancipated minors." In February of 2014, Belgium took the next step:

> Belgium legalized euthanasia by lethal injection for children…. Young children will be allowed to end their lives with the help of a doctor in the world's most radical extension of a euthanasia law. Under the law there is no age limit to minors who can seek a lethal injection. Parents must agree with the decision, however, there are serious questions about how much pressure will be placed on parents and/or their children. (Patients Rights Council 2013b)

Some say that the US state laws concerning physician-assisted suicide are very restrictive and so there is no chance of erosion such as has happened in the Netherlands or Belgium (Intelligence Squared 2014b, 34). Yet, if there is no moral or philosophical basis for PAS laws in the common good, then there is no telling how far changes to PAS laws will go in the future, and no stopping the changes.

## "Pain Can Be Alleviated" Argument

In medicine, we talk much these days about a "good death," not necessarily one that is completely free of suffering, but a dying process in which we are attendant to pain and symptom management, optimize clear decision making, and affirm the whole person in as dignified a manner as possible. Importantly, this can often be effectively accomplished through incorporation of palliative care services. Palliative care is a healing act adjusted to the good possible even in the face of the realities of an incurable illness. Cure may be futile but care is never futile (Pellegrino 2001). With appropriate utilization of palliative care, far fewer patients would be driven by fear to request that physicians actively end their lives via PAS/E.

Proponents of assisted suicide and euthanasia posit the scenario of uncontrollable pain as a straw man for advancing their cause. Such proponents apparently view death as the ultimate analgesic. In fact, in medical practice today, pain relief is almost always possible given modern therapeutics in analgesia and the medical specialty of pain management. Since pain can be alleviated, there is no basis to assert a need for PAS because of intractable pain. This may explain in part why many requests for PAS are no longer related to or initiated because of intolerable pain, but because of fear of such intolerable pain. Further, closely related to a patient's fear of intolerable pain, and sometimes associated with a patient's fear of being abandoned (Coyle 2004), is a patient's request for PAS because of not wanting to burden others. This too poses a curious contradiction, for on the one hand there is not wanting to be a burden on a loved one, and on the other hand a fear of being alone and abandoned. Such a contradiction, once considered and coupled with the fact that pain can be addressed successfully through optimal palliative care implementation, enhances the power of this argument against PAS/E.

The Oregon law was enacted on the basis of intolerable pain — no one should be forced to endure pain that is uncontrollable and unendurable. Most of us can sympathize with that, but the law is not restricted to pain, and it is not pain that is the top reason people choose physician-assisted suicide in Oregon. The state's "Death with Dignity Act Annual Report" for 2014 shows that the top reason is "losing autonomy" (Oregon

Public Health Division 2015, 5). Concern about pain was not even the second or third reason: "Less able to engage in activities making life enjoyable" and "Loss of dignity." It was ranked sixth out of seven, above only financial concerns, and included not only "inadequate pain control," but also "concern about it." These patients were not necessarily in uncontrollable pain themselves, however they were concerned about it (as are we all). But even that concern did not rank high on their list of reasons that they wanted to commit suicide. Even if the line drawn is unbearable pain, how can that be restricted to only physical pain? Who can judge that mental anguish is not unbearable pain? Or that economic distress (or anything else that causes anguish) is not unbearable pain?

## Physician Integrity and Patient Trust Argument

When a patient asks a physician to assist in killing him- or herself, not only is there disrespect shown to the physician's integrity, but a contradiction is created. Asking a physician to participate in PAS undermines the principled ethic and integrity of the physician whose noble profession is defined as one of compassionate service of the patient who is vulnerable, wounded, sick, alone, alienated, afraid; and undermines the integrity or wholesomeness of the patient, who him- or herself is in desperate need of trying to achieve. To ask and expect a physician to participate in the destructive act of suicide violates both personal and professional integrity of the physician, and leaves both the patient and the physician at risk for moral confusion about what is good, true, and beautiful about the human person.

The threat of euthanasia posed by legalizing PAS also undermines trust between physician and patient.

> Both euthanasia and physician-assisted suicide would undermine the medical profession by eroding the trust of patients in their physicians as caregivers. If doctors were permitted to engage in practices that harm their patients, then patients would never know if their doctors were truly acting in their best interests. (Austriaco 2011, 148)

Will your doctor kill you if he or she thinks you are too ill or in too much pain or unconscious? The Oath of Hippocrates has guided physicians for twenty-four hundred years. The Oath states,

> I will apply dietetic measures for the benefit of the sick according to my ability and judgment; I will keep them from harm and injustice…
>
> I will neither give a deadly drug to anybody who asked for it, nor will I make a suggestion to this effect. Similarly I will not give to a woman an abortive remedy. (Tyson 2001)

Even with all the advances in medicine over the last one to two hundred years, the public perception is still that the Hippocratic Oath is an important indicator that the patient in his or her vulnerability can put trust in the physician (Lederer 1999, 102). Euthanasia by health-care professionals undermines that trust.

Lack of trust is not just something that may or may not happen if euthanasia is legalized. It is happening in countries that have legalized euthanasia. Austriaco points out that "many Dutch patients, before they will check themselves into hospitals, insist on writing contracts assuring that they will not be killed without their explicit consent" (Austriaco 2011, 148). As stated earlier, in the 1980s the Dutch government stopped prosecuting physicians who committed voluntary euthanasia on their patients. By the 1990s over 50 percent of acts of euthanasia were no longer voluntary. This has had a

deleterious effect on the relationship of patients to health-care professionals. An article in 2011 in the *Telegraph*, a newspaper in the UK, stated that "Elderly people in the Netherlands are so fearful of being killed by doctors that they carry cards saying they do not want euthanasia" (Beckford 2011). The Dutch elderly mistrust their own doctors.

Trust is not the only issue concerning the integrity of medicine: PAS also calls into question the very ends of medicine to cure and to care. Christopher Saliga, a nurse, explains that

> One can rightly say that in Oregon, the balance has shifted such that respect for autonomy currently has greater weight among the principles hanging in the balance than it had prior to the legalization of assisted suicide. As a result, the contradictory patient outcomes of life and death via continued care or willful suicide respectively are considered equally valid. (Saliga 2005, 22–23)

Medicine and the medical profession traditionally aimed at curing and healing. Assisting in a suicide is neither cure nor healing. It pits the medical profession against itself: curing and caring versus killing.

## Summary

We offer the following table of the salient points comprising the non-faith-based arguments against PAS (Table 1).

## Concluding Remarks

As the secular world pushes more and more the agenda of personal autonomy and relativism, breeches of long-held ethical standards and our oath as physicians are increasingly apparent. On this topic of PAS and euthanasia, it is worth pointing out that in the practice of critical care medicine at the highest level of academia, there are now movements to endorse "shortening of the dying process" (SDP), which is a euphemism for physician-assisted suicide at best, and in effect, a synonym for murder when unilaterally committed by a health-care professional in the absence of legal approval. In fact, in one Belgian statement, the authors endorsed using medications to end patients' lives *even in the absence of suffering* (Vincent et al. 2014, n. 6), a practice that was found offensive and actively rebutted by a group of Dutch physicians (Kompanje et al. 2014). Such SDP is a practice that was reported by 2 percent of physicians in seven European countries (Sprung et al. 2003), but which is

***Table 1*** *Non-faith-based arguments against physician-assisted suicide and euthanasia*

| Argument | Main points |
|---|---|
| "It offends me" | Life has infinite value, and PAS devalues life<br>Devaluation of life is offensive<br>Human beings are relational and share in value of life<br>PAS is an offense to all human beings |
| Slippery slope | PAS in limited circumstances has led to PAS performed with markedly reduced limits (e.g., children, disabled people) |
| "Pain can be alleviated" | Embracing excellent palliative care is the correct answer |
| Physician integrity and patient trust | PAS undermines the integrity of both physician and patient as it is a contradiction to the patient's seeking to be well; and a violation of the principled duty of the physician to help the patient to become well<br>Undermined physician integrity is leading to loss of patient trust in physicians |

felt by 79 percent of physicians to be wrong and intolerable even if allowed by law (Sprung et al. 2014). With such active conversations occurring, especially now that the Canadian Supreme Court has recently ruled in favor of physician-assisted suicide, it is more important than ever to be adept with defense of life arguments, which are also arguments in defense of the healing profession of medicine at large.

All is not lost in medicine just because we have no cure and see a patient's life nearing its end. This represents a time in which we as physicians must focus, as Edmund Pellegrino taught, on elevating human dignity and the preservation of self-worth for each and every patient:

> To care, comfort, be present, help with coping, and to alleviate pain and suffering are healing acts as well as cure. In this sense, healing can occur when the patient is dying even when cure is impossible. Palliative care is a healing act adjusted to the good possible even in the face of the realities of an incurable illness. Cure may be futile but care is never futile. (Pellegrino 2001)

We invite others to contribute to this ongoing debate, and to continue the dialog, hoping that some of it will be captured on the pages of this journal.

## Notes

1 Intelligence Squared U.S. is a program which presents prominent figures before a live audience debating important timely issues of our time. More information can be found at http://intelligencesquaredus.org.

2 In essence, the natural law expresses the original moral sense which enables man to discern by reason the good and the evil, the truth and the lie. *Catechism of the Catholic Church* (2000), n. 1954.

3 Doctor Sulmasy's opening and closing statements are printed verbatim. A few notes and references have been added. For the transcript, see Intelligence Squared (2014b).

4 See Singer (1993, 13–14, 21–26, 57, 94–95).

5 Aristotle. *On the heavens* (I.5, 271b9–10), in *The Basic Works of Aristotle*, ed. Richard McKeon (New York: Random House, 1941), 404.

6 The authors' understanding of palliative care is that it is present first and foremost to help the patient (and family) live maximally in the face of life-threatening illness and, in that sense, can provide great benefit to the patient and loved ones well before he or she is imminently dying. Whenever it is deemed appropriate in the course of a patient's life and dying process, the palliative care team's focus on "iving maximally" may be best achieved by coordinating activities to optimize the patient's comfort, function, relationships, healing, dignity, and preparation for natural death.

7 Further, if we were to develop this line of reasoning in a faith-based model, it would involve the notion that there is no such thing as a private sin.

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