

THE MAXIM OF SUICIDE: ONE ANGLE ON BIOMEDICAL ETHICS**Yusuke Kaneko**Faculty of Commerce,
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JAPAN.kyaunueskuok_e@yahoo.co.jp**ABSTRACT**

Addressing the question in the form of Kant's maxim, this paper moves on to a more controversial topic in biomedical ethics, physician-assisted suicide. However, my conclusion is tentative, and what is worse, negative: I partially approve suicide. It does not imply a moral hazard. The situation is opposite: in the present times, terminal patients seriously wish it. I, as an author, put an emphasis on this very respect. Now suicide is, for certain circles, nothing but justice. The arguments of thinkers who approve suicide are also cited from this angle.

Keywords: Death, Kantian ethics, Physician-assisted suicide

INTRODUCTION

The hope for the future—this is the driving force for our lives. Issues in biomedical ethics are no exception.

(1) PATIENT: Please don't tell me that... Oh God, why did He do this to me?

DR. QUILL: First thing we have to do is learn as much as we can about it, because right now you are okay.

PATIENT: I don't even have a future. Everything I know is that you gonna die anytime. What is there to do?

What if I'm a walking time bomb? People will be scared to even touch me or say anything to me.

DR. QUILL: No, that's not so.

PATIENT: Yes, they will, 'cause I feel that way...

DR. QUILL: There is a future for you...

PATIENT: Okay, alright. I'm so scared. I don't want to die. I don't want to die, Dr. Quill, not yet.

I know I got to die, but I don't want to die.

DR. QUILL: We've got to think about a couple of things. (Beauchamp & Childress, 2009, p.21).

This is a dialogue between a physician and a female HIV-infected patient. How about you? What if you get into a situation like this?

Issues of this kind are presumably called *life and death decisions of terminal patients* (Singer, 2011, pp.159). In desperate situations, which do you prefer, to live or to die?

THE MAXIM OF SUICIDE

Kant once raised a similar question in his argument, asking whether or not we should accept this maxim.

(2) *From self-love I make as my principle to shorten my life when its continued duration threatens more evil than it promises satisfaction.* (Kant, 1785, IV422)¹

Let us call this *the maxim of suicide*. Kant rejected this maxim on account of his specialty, the moral law.

In what follows, we discuss the same question from an angle of biomedical ethics. How does this maxim make the terminal patients feel?

A SHORT SUMMARY OF KANT'S ARGUMENTS

When Kant rejected the maxim of suicide, he presented two reasons². The one was the argument appealing to what Herbert James Paton called “the formula of universal law” or “the formula of nature” (Kant, 1785, IV421-422; Paton, 1947, pp. 133., pp.165). The other was that appealing to “the formula of the end in itself” (Kant, 1785, IV429-430; Paton, 1947, pp.165).

We may summarize the first argument as follows. Focus on the word “self-love” in the maxim. It is taken “a feeling³ of self-love,” the definition⁴ of whose function is *the furtherance of life*. Hence, the constant feeling of self-love drives us to prolong our lives at any time. If so, the maxim of suicide is thought contradictory, because the self-love drives us to suicide, the destruction of our lives, but this is clearly in opposition to the definition of self-love just

¹ German originals are arbitrarily translated into English by Kaneko each time. References to Kant's works are given in accordance with the volumes and pages of Academy Edition.

² According to Hector Wittwer, Kant actually put forward *seven* reasons (Wittwer, 2001, p.182). But in my sight, they are reducible to the following *four*:

- (i) Suicide is the most harmful act to our society, since the person who can commit suicide no longer fears anything, especially any punishments; so he can commit any crimes till he dies. For this reason, we must forbid suicide at all costs.
- (ii) We can derive the denial of the maxim of suicide from “the Formula of Universal Law” or “the Formula of the Law of Nature.”
- (iii) We can derive the denial of the maxim of suicide from “the Formula of the End in Itself.”
- (iv) Everybody can be regarded as a property of God. So they must not take their own lives without His permission.

(i) corresponds to the argument numbered (1) in Wittwer's text; (ii) to (3) and (4); (iii) to (2), (5) and (6); (iv) to (7), respectively. As for (iv), Wittwer simply rejects it because it contradicts (iii): a person cannot be a property of another's in any case (Wittwer, 2001, p.183).

³ “Empfindung” in Kant's text (Kant, 1785, IV422).

⁴ “Bestimmung” in Kant's text (Kant, 1785, IV422).

mentioned. On this ground, the maxim of suicide is not universalized, in other words, rejected by the moral law⁵.

The second argument is summarized as follows. Taking one's own life merely to escape from presently occurring evil is nothing but utilizing internal *personhood* as a means. This contradicts the moral law⁶. So, again, the maxim of suicide is rejected.

CRITICISMS

This is a short summary of Kant's arguments. But Paton criticized them "the weakest of Kant's arguments" (Paton, 1947, pp.154-155). He asked, "Why should it not be a merciful dispensation of Providence that [a feeling of self-love] might lead to death when life offered nothing but continuous pain?"

Paton is right. Other authors also, actually, criticized Kant's arguments. As such, we may take up Iain Brassington's criticism (Brassington, 2006).

As for the first argument, Brassington criticized it as follows. There is no need for the reference to the moral law because what matters in the argument is substantially the distinction between *the self-love based on genuine interests that promotes continued life* and *a self-love based on presently occurrent desires to escape evil* (Brassington, 2006, p.572). Taking the former as the concept of self-love, it is true, the maxim is thought contradictory. But if we take the other, no contradictions will occur; furthermore, we may universalize the maxim of suicide (Brassington, 2006, pp. 571-572).

As for the second argument, Brassington criticized it as follows. It is beside the point to appeal to personhood when we talk about suicide, because suicide is a completely *private* action, whereas personhood concerns a universal aspect of human beings alone (Brassington, 2006, pp.572-573). A suicidal person does not think about such a sublime aspect of himself.

Next, let us take up Hector Wittwer's criticism (Wittwer, 2001). According to him, Kant's first argument is criticized as follows. In it, Kant lost his own distinction between practical laws and natural (descriptive) laws (Wittwer, 2001, p.193)⁷. Wittwer insists that asking if the maxim can

⁵ "The moral law" here means either of the following two:

The Formula of Universal Law: Act only on that maxim through which you can at the same time will that it should become a universal law. (Kant, 1785, IV421; Paton, 1947, p.129)

The Formula of the Law of Nature: Act as if the maxim of your action were to become through your will a universal law of nature. (Kant, 1785, IV421; Paton, 1947, p.129)

⁶ "The moral law" here mentioned is the following:

The Formula of the End in Itself: So act as to use humanity, both in your own person and in the person of every other, always at the same time as an end, never simply as a means. (Kant, 1785, IV429; Paton, 1947, p.129)

⁷ Here, Wittwer's main focus was on Kant's argument appealing to the Formula of the Natural Law.

be a natural law is meaningless, since the former is practical, while the latter is descriptive (Wittwer, 2001, p.195).

As for the second argument, Wittwer criticizes it as follows. It is principally impossible to use personhood as a means (Wittwer, 2001, p.187) because even if a man uses himself as a means, in other words, as a thing *without* free will, he himself must behave and think as a person with free will. Therefore, the problem is not that using oneself as a means, which contradicts the Formula of the End in Itself, but that it is principally impossible to do so. *We should not* use ourselves as means, but we *cannot* (Wittwer, 2001, p.189).

From these arguments, we realize, Kant's arguments are not decisive at all.

HUME'S ARGUMENT

Actually, there were a few thinkers nearly contemporary with Kant who approved suicide. Hume and Schopenhauer are their representatives. They both asked whether suicide is a crime, and answered no (Hume, 1775, p. 580, Schopenhauer, 1851, p. 157)⁸. In particular, I pick up on Hume's arguments which have similar angles to modern writers⁹.

In a bellicose article "Of Suicide," Hume argued this way. Our world is ruled by two distinct principles: general and immutable laws in the material world and mental powers ranging from lower sensual functions to higher rational faculties in the animal world¹⁰. These principles are both under the governance of God (Hume, 1775, p.581).

At first glance, Hume says, suicide seems encroachment on the immutable law. Our physiological functions, for example, are interrupted by the act of suicide. But, in contrast, our mentality, a part of the animal world, is not affected by the act. So we are entrusted with the ability of suicide as far as taken as a member of the animal world.

According to Hume, God never set aside the ability of suicide as something special; humans can exert it anytime they want. Suicide does not differ from ordinary course of events.

(3) *The life of man is of no greater importance to the universe than that of an oyster.* (Hume, 1775, p.582)

To this extent, our ability of suicide is realized as a benefit from God.

(4) *Do you imagine that I repine at providence or curse my creation, because I go out of life, and put a period to a being, which, were it to continue, would render me miserable? Far be such sentiments from me. I am only convinced of a matter of fact, which you yourself acknowledge possible, that human life may be unhappy, and that my existence, if farther prolonged, would become ineligible. But I thank providence, both for good, which I*

⁸ To this question, Kant answered yes (Kant, 1797, VI422).

⁹ Hume was also a motivist: the same standpoint as Kant (Kaneko, 2009, Hepfer, 1997). It is of interest to see that two motivists had opposite views on suicide.

¹⁰ Note that Hume did not distinguish humans from animals even on the highest faculties such as reason (Hume, 1739-40, pp.176f.).

have already enjoyed, and for the power, with which I am endowed, of escaping the ill that threatens me. (Hume, 1775, p.583)

There is, unfortunately, a case where, “my existence, if farther prolonged, would become ineligible.” However, we should rather “thank providence” for giving us the power of committing suicide.

PROPOSERS OF SUICIDE

In this way, Hume says, there is nothing special in committing suicide. This conclusion has some affinity with current discussions on *voluntary euthanasia* or *physician-assisted suicide*¹¹.

Peter Singer, for example, argues like Hume.

(5) *Once it is clear that a patient in a persistent vegetative state has no awareness, and never again can have any awareness, her life has no intrinsic value. These patients are alive biologically but not biographically. If this verdict seems harsh, ask yourself whether there is anything to choose between the following options: (a) instant death; or (b) instant coma, followed by death without recovery in ten years. I can see no advantage in survival in a comatose state if death without recovery is certain* (Singer, 2011, p.168).

Here, Singer picks up on a *vegetative state*, an everlasting comatose state, and daringly says living in such a state is *meaningless*.

Thomas Nagel gets in step with Singer. According to him, the meaning of our lives is the goods they contain (Nagel, 1970, p.74). “Goods” here means “being alive,” “doing a certain thing,” “having certain experiences,” and so on; in a word, *leading a full life*. But in the case of a vegetative state, we do not hope for such lives. So Nagel says as follows.

(6) *The value of life and its contents does not attach to mere organic survival: almost everyone would be indifferent between immediate death and immediate coma followed by death twenty years later without reawakening.* (Nagel, 1970, p.74)

UNPREDICTABILITY OF THE FUTURE

This is how modern writers, Singer and Nagel, approved suicide. But here it should not be overlooked that their approval is only *provisional*: suicide is admitted within the agents’ recognition of their unbearable situations—otherwise, it is not carried out.

To tell the truth, this is the logic of the maxim of suicide as well, which is understandable in the following reformulation¹².

¹¹ Let me clarify these concepts in advance here. In biomedical ethics, *euthanasia* is customarily divided into three sorts: voluntary euthanasia, involuntary euthanasia, and non-voluntary euthanasia (cf. Singer, 2011, pp.157-159). *Voluntary euthanasia* is euthanasia carried out by a physician at the voluntary request of the patient, which we may identify with *physician-assisted suicide*, although Singer did not articulate it (Singer, 2011, p.155, p.157). On the contrary, *involuntary euthanasia* is euthanasia carried out without the patient’s agreement for the reason that either he has never been asked, or articulately chose to live (Singer, 2011, p.158). *Non-voluntary euthanasia* is euthanasia carried out without the patient’s agreement for the reason he has no capacity to choose to live or die (Singer, 2011, p.159). It is explicit that our present focus is only on voluntary euthanasia or physician-assisted suicide.

¹² I have fully dealt with this reformulation in other papers (Kaneko, 2008, Kaneko, 2009). So let me omit the detailed

(7) *If I am in so grim a situation that there is no hope for the future, I will commit suicide.*

Through this reformulation, it is clarified, the agent commits suicide to escape from *despair*. Certainly, such a mentality is reasonable, but on what ground does he think his situation that way? In other words, what is the criterion for him to think his current situation desperate?

You may take, here, a utilitarian viewpoint as a kind of relief measure¹³. Imagine, for example, you would soon be in a vegetative state. In spite of this desperate situation, you might say, “Even if my life become meaningless for myself, my relatives would find some meaning in my ‘iconic’ existence.”

We can formulate this mentality as follows.

(8) *My choice of living → Pleasure of others*

Here “→” stands for causal relationship; as long as it holds, you might find, in your future comatose state, some meaning—utility¹⁴.

But the problem here is whether the connection expected is truly reliable. My answer is definitely no¹⁵. But in the present context the following story would be more persuasive.

(9) *In 1988 Samuel Linares, an infant, swallowed a small object that stuck in his windpipe, causing a loss of oxygen to the brain. [G]iven the availability of modern medical technology, he was admitted to a Chicago hospital in a coma and placed on a respirator. Eight months later, the hospital was planning to move Samuel to a long-term care unit. Shortly before the move, Samuel’s parents visited him in the hospital. His mother left the room, while his father produced a pistol and told the nurse to keep away. He then disconnected Samuel from the respirator and cradled the baby in his arms until he died. When he was sure Samuel was dead, he gave up his pistol and surrendered to police. (Singer, 2011, pp.158-159)*

Singer cited this story as an instance of non-voluntary euthanasia (cf. note11). But it makes no difference. The point is that there is a case where even relatives think the iconic existence of the patient bothersome.

PHYSICIAN-ASSISTED SUICIDE IS JUSTICE

Recently BBC¹⁶ and CNN¹⁷ broadcasted the news about Tony Nicklinson, a 58-year-old married father of two children, from Wiltshire, who had lead a full life before he got in the locked-in

argumentation here.

¹³ As for utilitarianism, see Kaneko, 2012b. Singer is also known as a utilitarian, and indeed, makes such an argument in his book (Singer, 2011, pp.167f.). But intentionally, I omit this aspect; my emphasis is on the imminence and sincerity of Singer’s argument, not his philosophical techniques.

¹⁴ Let us review Bentham’s definition of utility here.

“By utility is meant that property in any object, whereby it tends to produce benefit, advantage, pleasure, good or happiness [...] to the party whose interest is considered.”(Bentham, 1789, ch.i, par.iii).

¹⁵ I have long discussed this point under the title of “subjectivity.”See Kaneko, 2012a, Kaneko, 2012c, Kaneko, 2012d.

¹⁶ June 19, 2012 (<http://www.bbc.co.uk/news/health-18495973>).

syndrome¹⁸ following a stroke in 2005. He hopes death, assisted-suicide, which is expressed with his eyes' movement, but not allowed under British law. Every day, he must make others do everything for him. Such a life is, he says, a "living nightmare."

More or less, the reality is, probably, like this. However confidently one¹⁹ thinks, "My relatives would be consoled if I prolonged my life even after the loss of awareness", the actual situation might make him feel in a quite different way.

If so, the only option left to us is simply to take the maxim of suicide, giving up a faint hope described in (8).

Singer's report of the Netherland's case reflects this mentality directly.

(10) *In the Netherlands, a nationwide government-commissioned study found that many patients want an assurance that 'their doctor will assist them to die should suffering become unbearable'. Often, having received this assurance, no request for euthanasia eventuated. The availability of euthanasia brought comfort without euthanasia having to be provided.* (Singer, 2011, p.170)

Now we realize how serious they are when people talk about the approval of physician-assisted suicide. It is their long cherished wish, and *justice* at least for them.

DETERRENCE

Is this the conclusion we should reach? Beachamp&Childress warn us against the rush. According to them, we must address the problem more carefully; our question was, so far, simply whether the *patient* is allowed to choose suicide; but the true question is, they insist, whether the *physician* is allowed to assist suicide (Beachamp & Childress, 2009, p.181).

To this question, their answer²⁰ was: the physician is allowed to assist suicide only if the patient requests it, and it constitutes his *interest*.

(11) *[I]f a person freely authorizes death and makes an autonomous judgment that cession of pain and suffering through death constitutes a personal benefit rather than a setback to his or her interests, then active aid-in-dying at the person's request involves neither harming nor wrongdoing. [...] Assisting an autonomous person at his or her request to bring about death is [...] a way of showing respect for the person's autonomous choices.* (Beachamp & Childress, 2009, p.181)

¹⁷ July 5, 2012 (<http://edition.cnn.com/TRANSCRIPTS/1207/05/nwsm.01.html>).

¹⁸ "Locked-in syndrome is a condition in which a patient is aware and awake but cannot move or communicate verbally due to complete paralysis of nearly all voluntary muscles in the body except for the eyes." (Wikipedia "Locked-in syndrome": http://en.wikipedia.org/wiki/Locked-in_syndrome)

¹⁹ Of course, I do *not* mean Mr. Nicklinson thought this way.

²⁰ Beachamp&Childress warn, on the other hand, that any answer to this question could be a "slippery slope" (Beachamp&Childress, 2009, p.177). What they fear is physicians' abuse of the qualification to assist suicide, especially. As an example, they take Jack Kevorkian's machine (Beachamp&Childress, 2009, pp.181f.). They insist: before we admit physician-assisted suicide, plenty of evidence must be provided.

Now, at the time of 2011, physician-assisted suicide is legal in five countries: Switzerland, the Netherlands, Belgium, Luxemburg, and a few states in the United States, i.e. Oregon, Washington, and Montana (cf. Singer, 2011, p.155). Concerning this, picking up Oregon's case, Beachamp&Childress called it "experiment" (Beachamp&Childress, 2009, p.176f.). Against that, Singer said as follows: "Oregon legalized physician-assisted suicide in 1997, so there is now considerable experience of that practice in one part of the United States. There has been no evidence of any abuse of the law." (Singer, 2011, p.172)

Physician-assisted suicide is a way of *showing respect for the patient's own decision*. The patient decided his end by himself; to this extent, the doctor has no reason to interrupt it. Physician-assisted suicide is justified within *respect for autonomy*, Beachamp & Childress' principle of biomedical ethics (Beachamp & Childress, 2009, p. 8)²¹.

TENTATIVE CONCLUSION

The female HIV-patient said she had no future (§1). Samuel Linares' parents thought their child's life meaningless (§7). Tony Nicklinson called his life a "living nightmare" (§8).

When one faces a situation like these, a temptation to die will loom large in his mind. For there seems to be no hope for the future.

But who decides it? Nobody but himself. Even physicians do not know what exactly happens in the future (as we saw in §7). Just for this reason, physicians must respect patients' decision.

No one knows which is correct, to live or to die. As long as he lives, the day might come when he knows the answer. But if he dies, the answer will not be given.

(12) *We can also regard suicide as an experiment, in which we ask nature a question, forcing it to answer: "What change would our existence and cognition experience after death?" But this question is irrational. For soon after asked, it goes out of the hand; the questioner would be no more, the answer being given.* (Schopenhauer, 1851, §160).

This fact may seduce indifferent questioners into death.

²¹ This principle is not attributed to Kant alone; there are various backdrops (Beachamp&Childress, 2009, p.99f.). However, they have a couple of things in common.

The word "autonomy" is characterized by two conditions: *liberty*, i.e. the independence from controlling influence, and *agency*, i.e. the capacity for intentional action (Beachamp&Childress, 2009, p.100).

Again, the whole word "respect for autonomy" can be defined, both negatively and positively (Beachamp&Childress, 2009, p.104). As negative obligation, it is defined from J.S. Mill's viewpoint; i.e. "Autonomous actions should not be subjected to controlling constraints by others." For example, nurses and physicians may be sometimes tempted to perpetuate patients' dependency on them. But this attitude will surely spoil their autonomy. So it must be abstained. As positive obligation, respect for autonomy is defined from Kant's viewpoint; i.e. "Foster patients' autonomous decision making." As a typical example, we may take the disclosure of information.

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