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“For Now Have I My Death”¹: The “Duty to Die”
versus the Duty to Help the Ill Stay Alive

FELICIA ACKERMAN

For the last three days he screamed incessantly. It was unendurable. I cannot understand how I bore it; you could hear him three rooms off. Oh, what I have suffered!²

I

Suppose you are a sixty-year-old who has worked hard and made sacrifices for your family. Now you are ill and the care necessary to keep you alive is taking up a lot of time and money, including almost all your spouse’s free time and much of the money you previously set aside for your child’s college education. You and your family still love one another, but you all have strong self-interested desires as well. You want to stay alive as long as possible. Your spouse, a dedicated amateur athlete who used to spend much time playing tennis, is tired of being your caregiver. Your child wants to go to college. Who has a duty to do what? Here are four possible answers.

1. You have a duty to die (possibly including a duty to commit suicide) in order to avoid burdening your family.
2. Your spouse has a duty to accept the loss of leisure time and take care of you (that is why “in sickness and in health” is in the marriage vows) and your child has a duty to accept the loss of your financial contribution to his education, in order to avoid burdening you with the premature loss of your life.
3. Either course of action can be justified; it is not a matter of duty.
4. It depends.

John Hardwig has recently argued in favor of (1), at least in some circumstances. This paper will criticize his views and argue for alternatives.

One way Hardwig seeks to support his view is by pointing out that

[M]any 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.”³

Hardwig thinks this reflects “moral wisdom.”⁴ He does not consider the possibility that it reflects our society’s bias against systematic devaluation of the old and ill, a devaluation some old people accept uncritically, just as many women used to accept the idea that women should be subordinate to men. After all, it would hardly be surprising to discover that fifty years ago, most married women reported that they did not want careers that would burden their families. But people (or at least liberals) nowadays would have second thoughts about calling this moral wisdom, let alone using it to support an argument that married women had a duty to avoid careers that would burden their families. We now recognize two factors. First, fifty years ago there was so much social pressure on married women, if they worked outside the home at all, not to let their work inconvenience their families that any woman who dissented from this outlook risked being instantly condemned as selfish (which is not to deny that some women genuinely felt this way). Second, there was bias involved in seeing women’s careers, but not men’s, as a burden to their families. Many people recognize these things nowadays. But how many recognize that the same

factors apply to Hardwig's uncritical report of present-day expressions of attitudes toward old age and illness? To illustrate the first factor, imagine the social reaction to a sick old person who said, "I'm sorry if it burdens my family, but my life comes first." The fact that sick old people do make "burdensome" choices often enough to give the question of a duty to die practical as well as theoretical interest suggests that many of the old and ill are less self-sacrificing than the sentiments they pay lip service to may suggest. To illustrate the second factor, consider the (deliberate) oddness of my formulation of (2), above. Sick old people are routinely called burdens to their families, but college-bound teenagers are not. It is surprising that someone who believes "life without connection is meaningless"⁵ would think it shows moral wisdom for people to talk as though they did not realize that accepting the burdens of taking care of one another is part of what a family is all about. If Hardwig really holds, as much of his writing claims, the more moderate position that there are limits to the burdens families can be expected to assume (although I will argue that his limits are unacceptably stringent), then why does he think it shows moral wisdom to speak as though any burden, no matter how small, would be unacceptable?

Similar concerns apply to Hardwig's use of such loaded words as 'individualistic' and 'selfish.' I doubt that anyone actually believes what he condemns as "the individualistic fantasy... that the patient is the only one affected by decisions about her medical treatment."⁶ And few would find fault, except on grounds of triteness, with his claim that "[t]hose of us with families and loved ones always have a duty not to make selfish... decisions about our lives."⁷ We normally use the pejorative term 'selfish' only for things we want to condemn. But in order to see what sorts of decisions Hardwig condemns as selfish or unduly individualistic, we must look at the family burdens he thinks can give rise to a duty to die. He says:

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. 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 [a] recent... study documented 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.

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.⁸

These remarks cry out for critical examination. For one thing, Hardwig's conception of what can constitute an unacceptable family burden seems astonishingly weak. Several questions immediately arise. Should being "distant, uncommunicative, unresponsive, foreign, and

unreachable” really be a capital offense anywhere, let alone in a “loving” family? Does a loving family really welcome a beloved member’s suicide in order to keep a young person from having to work and/or borrow his way through college? Does the view that you have a duty to spend your hard-earned money to put your able-bodied child through college rather than to prolong your own life reflect a devaluation of the old and the ill that will someday be as offensive to liberals as 1950s attitudes toward women are today?

Hardwig’s bias is also reflected in his failure to extend his criticism of selfishness and individualism to a teenager’s decision to accept the college tuition money that could be used to extend his father’s life or to a husband’s self-interested encouragement of the suicide of his ailing wife. Such failure illustrates how terms like ‘selfish’ and ‘individualistic’ can serve in a worldview promoting not altruism, but the favoring of the interests of some *individuals* over those of others. Hardwig says, “We fear death too much.”⁹ But to the extent that his views are widespread, I think that what we fear too much is having our lives and plans disrupted by the medical needs of our loved ones. This fear may cause us to magnify such disruptions out of proportion, to the point where having to work and borrow one’s way through college or live with a distant and uncommunicative spouse seems so terrible that the sick person’s death seems preferable and perhaps even obligatory.

There are other elements of bias in the quoted passage. The burden of providing “care or even just supervision twenty-four hours a day, seven days a week,” far from being unbearable or unique to caretakers of the ill, is routine for many stay-at-home single mothers of babies and toddlers (and for stay-at-home married mothers with unhelpful husbands).¹⁰ It is likewise common for “a family member [to have] to quit work or make some other major lifestyle change” or for a family to lose “a major source of income” when a baby is born. (Of course, people are aware of such needs when they choose to have children, but people who choose to marry are likewise aware of the strong possibility that their spouse will someday be ill and need care. I will discuss this matter more in the next section.) And Hardwig’s claim that “[s]ocial 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” raises three questions. First, hasn’t Hardwig ever heard of the telephone or e-mail? Why is he so ready to see the hardships of taking care of a sick person as reasons why that sick person has a duty to die, rather than as practical problems open to practical remedies? Second, precisely why is a home with a seriously ill person “no longer a place suitable for having friends in”? Suppose that person is unpredictable and incontinent. Is a home with a rambunctious toddler who is not yet toilet trained no longer a suitable place for having friends in? Third, does a loving spouse really welcome the suicide of a beloved partner in order to preserve the spouse’s social life? What sort of values and what sort of love would this priority indicate?

The foregoing may make Hardwig look like a bigot with respect to age and health. So it is important to consider other aspects of his arguments, including the following case:

An 87-year-old woman was dying of congestive heart failure. [The prognosis was] 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.¹¹

I will return to this case after looking at some general features of Hardwig’s views.

II

Hardwig's approach has one great strength: he acknowledges the existence of genuine conflicts of interest between patients and their families. This contrasts favorably with the sentimentality of the hospice approach, on which "[p]atients, their families and loved ones are the unit of care."¹² In contrast, Hardwig points out that "[t]he conflicts of interests, beliefs, and values among family members are often too real and too deep to treat all members as 'the patient.'"¹³ He also refuses to hide behind the claim that many of the conditions he thinks can generate a duty to die can also impair patients' lives to the point where they have self-interested reasons for wanting to die. He recognizes that the most problematic cases are those where the burdensome patient wants to live.¹⁴ I follow him in focusing on such cases. In fact, unless otherwise specified, I assume as a background condition that the patient *greatly* wants to stay alive, and that the family's competing wants are equally strong.

Elsewhere, however, Hardwig is not so clearheaded. He uses the phrase 'duty to die' indiscriminately to apply to a duty to eschew aggressive life-prolonging medical care and a duty to commit suicide.¹⁵ He holds that "[t]here can be a duty to die before one's illness would cause death, even if treated only with palliative measures,"¹⁶ and that "there may be a fairly common responsibility to end one's life in the absence of any terminal illness at all,"¹⁷ and he offers a detailed discussion of whether a person with a duty to die should carry out his own suicide or solicit suicide assistance from his loving family or from doctors.¹⁸

Hardwig's use of the phrase 'duty to die' to cover both a duty to commit suicide and a duty to eschew aggressive life-prolonging medical treatment leads him to exaggerate the originality and daringness of his position. The view that sick people can have a duty to commit suicide may indeed strike people as "just too preposterous to entertain. Or too threatening."¹⁹ But this is hardly true of the view that the old and/or terminally ill have a duty not to burden their families and society by insisting on the most aggressive life-prolonging treatment possible, regardless of financial and other costs. This latter view is popular nowadays to the point of cliché. It occurs with varying degrees of explicitness in numerous newspaper and magazine pieces, as well as in highly praised, widely read, and widely influential books by Daniel Callahan²⁰ and Sherwin B. Nuland,²¹ the latter a National Book Award winner. The *denial* of this latter view is what strikes people as "just too preposterous to entertain. Or too threatening." (When did you last hear anyone, bioethicist or otherwise, say that terminally ill old people are entitled to extend their lives as long as possible and by the most aggressive care possible, regardless of the cost to their families and society?)²² Hardwig is conventional, not original, when he says that "we must now face the fact: deaths that come too late are only the other side of our miraculous, life-prolonging modern medicine." What is amazing is his claim (in 1996!) that "[w]e have so far avoided looking at this dark side of our medical triumphs."

Unsurprisingly, Daniel Callahan, who is hostile to aggressive life-extending care for the old and ill but to whom suicide is anathema, has criticized Hardwig's moral equation of suicide and the refusal of aggressive life-prolonging medical care. Since I accept neither Callahan's views about suicide nor his views about aggressive life-prolonging medical care, I will not defend this sort of criticism. Instead, I find Callahan and Hardwig similar in the low value they place on the lives of the old and the ill. Callahan's objection to Hardwig that

it trivializes the relationship of family members to each other to act as if their mutual obligations to each other are to be judged by some benefit-burden calculus. Hardwig seems to be saying in effect: "for better or worse, in sickness and in health—well, sort of, it all depends"²⁵

should be read in light of things he says elsewhere. For example:

It is not improper for people to worry about being a burden on their families. A family member should reject [a technologically extended death] for the sake of the family's welfare after he or she is gone.²⁶

Callahan even says that “the *primary* aspiration of the old [should be] to serve the young.” He also says, “We do not need a . . . set of moral values that will impose upon families the drain of extended illness and death.”²⁸ (Note the bias in Callahan's use of “we” here. Who are the “we” who do not need such a set of moral values? Families eager to free themselves of burdensome sick “loved ones” do not need such a set of moral values, but the sick people themselves may, if they want to stay alive. What “we” (i.e., such actual and potential sick people) do not need is a set of moral values that impose on us the drain of being pressured to forgo high-tech life-extending care and die sooner than necessary, in order to avoid burdening our families—a description of the situation that is no more biased than Callahan's own. “We” old people also do not need a set of moral values that tell us our primary aspiration should be to serve the young.) Callahan's real objection thus seems to be to suicide, rather than to a benefit-burden calculation.²⁹ In contrast, I have only a practical reason for finding Hardwig's views about the duty to commit suicide more objectionable than Callahan's views about the duty to refuse aggressive life-prolonging medical care: the former duty casts a much wider net. This paper will not distinguish further between these two possible duties, but will follow Hardwig's practice of using ‘duty to die’ to apply indiscriminately to both.

Hardwig's second conflation is also interesting. He makes no distinction between the duty to die in order to avoid burdening your children and the duty to die in order to avoid burdening your spouse. (Interestingly, none of his examples mentions young adults with a duty to die in order to avoid burdening their caregiving parents.) But there are obvious differences between parental and “adult child” cases, on the one hand, and spousal cases on the other. Parents have often made great sacrifices for their children, including an approximation of the hyperbolically described “twenty-four hours a day, seven days a week” care that Hardwig considers so onerous in the case of the old and the ill. There is a large literature on what, if any thing, grown children owe their parents, but, to my mind, nothing that refutes Joel Feinberg's “My benefactor once freely offered me his services when I needed them. . . . But now circumstances have arisen in which he needs help, and I am in a position to help him. Surely I *owe* him my services now, and he would be entitled to resent my failure to come through.”³⁰ He would also be entitled to resent my hypocrisy if I claimed to love him. (What if I have significant obligations elsewhere? This issue will be touched upon later.)

Marriages differ from parent-child relationships in two ways that are relevant here. First, they do not normally begin with a long period of one-sided caregiving, let alone one-sided caregiving by the party most likely to need care later on. Second, marriages are freely entered into by both parties. This gives couples the opportunity for prenuptial discussions and agreements that will generate their own agreed-upon caregiving duties. Of course, such an approach has its own problems. The first, which also applies to living wills, is that it may be virtually impossible for many healthy young people to enter imaginatively into hypothetical situations in which they would be seriously ill and debilitated. As Ellen Goodman puts it, “No one. . . . wants to live to be senile. But once senile, he may well want to live.”³¹ The second problem, which also applies to prenuptial financial agreements, is that such an arrangement may seem cold-blooded and destructive to the loving spirit of the marriage. Hardwig also advocates discussions in families. He even advocates having them once a person is ill, which avoids the first problem and enables people to consider the “particular and contextual”³² details of their actual situation. But it enormously intensifies the second problem. Hardwig's sentimental claim that “[h]onest talk about difficult matters almost always strengthens relationships”³³ raises the question of just how it would strengthen a relationship to say to your father, even in response to his query, “Well, Dad,

you're not pleasant to have around anymore, and if you don't die soon, your care will use up all the money you saved for my college education, so I'd really appreciate it if you killed yourself now or at least stopped getting treatment." This may be a crude formulation, but what could be a better one of such a crude thought? The plain fact is that letting your father know you value his life less than your college tuition is unlikely to strengthen your relationship. It is surprising that someone hard headed enough to see that the slogan "the patient is the family" glosses over genuine conflicts of interest (see the material leading up to note 13) would slip into the senti mentality of supposing that honest discussion of such conflicts will almost always strengthen relationships. Prenuptial agreements may seem cold-blooded, but at least they do not involve the cruelty of telling a sick and vulnerable person that you would welcome his death. Prenuptial discussions also give a couple the option of calling off the wedding if they find that their values are too far apart.

III

Hardwig realizes that a duty to die may seem harsh. "And yet," he says, "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 not want to make choices that compromise their futures."³⁴ But if he loves his ill wife, will he want to protect her and her life? Will he want to avoid compromising her future by encouraging her to commit suicide so he will be free of the burden of caregiving? Hardwig says that "there is something deeply insulting in . . . an ethic that . . . [treats] me as if I had no moral responsibilities when I am ill or debilitated."³⁵ Will he also be insulted if his ill wife commits suicide because she thinks he is the sort of person who would rather have her dead than take care of her? I would be enormously insulted if a loved one had such a view of me. Hardwig tells us that his "own grandfather committed suicide after his heart attack as a final gift to his wife—he had plenty of life insurance but not nearly enough health insurance, and he feared that she would be left homeless and destitute if he lingered on in an incapacitated state."³⁶ Hardwig does not tell us whether his grandmother appreciated this "gift." What sort of person would she be if she did? If she welcomed this sacrifice, how could she be worth it? What sort of love could she have felt for her husband? What sort of love could he have thought she felt for him? And was there no one else in this loving family who could help his grandmother so she would not have to be left "homeless and destitute" if her husband lingered on?

This brings me to a discussion of what I have elsewhere called "the paradox of the selfless invalid."³⁷ In its most extreme form, the paradox goes as follows. Either the patient's loved ones want him to die quickly in order to save money or otherwise make their lives easier, or they do not. If they do not, the patient does not respect them by dying for their sake. If they do, then why is the patient sacrificing what would otherwise be left of his life for people who love him so little that they value his life less than money and/or freedom from encumbrance? Wouldn't a truly loving family find such a sacrifice appalling? Of course, families can have mixed feelings, which include both the desire to have the patient stay alive and the self-interested desire to get it all over with and to keep expenses down.³⁸ But the basic point remains. Decent and loving families, as part of their decency and lovingness, will recognize the latter desire as ignoble and, on balance, will not want patients to pander to it.

This extreme view is itself open to objections. Just as it is inhumane to suppose a sick person has a duty to forgo an extra year of life in order to conserve money for a child's college tuition, it is unreasonable to suppose there are no limits to what a loving family can be expected to do for a sick member, even to the point of selling literally everything they own in order to give him a minute of extra life. The devil is in the details, or, as Hardwig puts it, "the really serious moral questions are. . . how far family and friends can be asked to support and sustain the patient."³⁹ I have argued that some of Hardwig's answers are ludicrous. Where should we draw the line? I hardly have an exact answer, nor does Hardwig. But here are his general guidelines.

- 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.
- 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 a 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. . . . 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.⁴⁰

I suggest we reconceptualize the problem by asking how these and related conditions might affect the duty to make sacrifices in order to extend the life of a burdensomely ill loved one. I will call this “a duty to aid.” Here are nine conditions parallel to Hardwig's.

1. A duty to aid is more likely when failing to do so will impose significant burdens when the ill loved one wants very much to go on living and needs your help. This is the fundamental insight underlying a duty to aid.
2. Perhaps a duty to aid becomes greater as you grow older, because you will be sacrificing a smaller portion of your life plans. Alternatively, a duty to aid may be greater when you are

young, because you have more stamina as well as more life ahead of you, with more opportunity to recoup your losses. At any rate, to have reached adulthood without being ready to undertake major financial burdens and changes in “lifestyle” in order to aid a seriously ill loved one is itself a moral failing, a sign of a life out of touch with life’s basic realities.

3. A duty to aid 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 a greater duty to aid if your ill loved one’s life has already been difficult or impoverished, if he has had only a small share of the good things that life has to offer (especially if through no fault of his own).

5. A duty to aid is more likely when your loved one has already made great contributions—perhaps even sacrifices—to make your life a good one. Especially if you have not made similar sacrifices for his well-being. This imbalance frequently exists between grown children and the parents who raised them.

6. To the extent that there are others able to share the burden of aiding, there is less you have a duty to do. To the extent that you cannot make a good adjustment to the duty of aiding, there is less of a duty to aid. Still, we must also recognize that unwillingness to make a good adjustment does not constitute inability to do so, nor does making a good adjustment mean you must enjoy aiding.

7. There is less of a duty to aid if you have significant obligations elsewhere. However, you must also bear in mind that your obligations to your children do not automatically outweigh your obligations to your parents. The popular slogan “The best thing you can do for your parents is to take good care of their grandchildren” is obviously false if your father needs and wants a heart trans plant, which he cannot afford without your help, and your son “needs” and wants four years at Yale.

8. A duty to aid is more likely when your loved one is painfully aware that the part of him that was loved will soon be gone or seriously compromised and is terrified that his loved ones will abandon him. And if you genuinely love your “loved one,” then to the extent that the part that is loved is not compromised, you will have a strong self-interested reason for wanting to help him stay alive; you would hate never seeing him again.

9. There is a greater duty to provide physical care to the extent that you have lived a relatively lavish “lifestyle” that has prevented you from saving enough to provide financial help.

These guidelines are not formally incompatible with Hardwig’s. He grants that families “must be prepared to make significant sacrifices to respond to an illness in the family,”⁴¹ although his examples I quoted earlier of what can constitute an intolerable family burden raise the question of just what sort of “significant sacrifices” he has in mind. His statement “I cannot imagine that it would be morally permissible for me to . . . compromise the quality of [my grandchildren’s] lives simply because I wish to live a little longer”⁴² illustrates the importance of this question. What deprivation could *not* be said to compromise the quality of one’s grandchildren’s lives? Going without private schooling? Going without summer camp? Going without tennis lessons? At any rate, my guidelines and Hardwig’s reflect (although they do not entail) different orientations. Hardwig believes we can find meaning in death by recognizing our duty to die, thus engaging in an “affirmation of connections.”⁴³ I am less inclined to find meaning in death at all. I find Malory’s “Let me lie down and wail with you”⁴⁴ a much more humane response to adversity than today’s relentless tendency to insist we turn adversity into an opportunity for “growth,” a tendency Hardwig at any rate follows very selectively. His selectivity reflects his characteristic bias. After all, if we are going to urge people to regard death and dying as opportunities for growth and “affirmation of connections,” why not urge families to seize the

opportunity to grow and “affirm connections” by making loving sacrifices to prolong the life of a seriously ill loved one? Hardwig says, “Caring for the sick or aged can foster growth. . . . 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.”⁴⁵ He does not criticize such unsuccessful families for having a “sense of community [that] is so weak.”⁴⁶ He reserves this harsh judgment for old and/or ill people who are unwilling to unburden their families by dying (although he does grant that “man who can leave his wife the day after she learns she has cancer, on the grounds that he has his own life to live, is to be deplored”).⁴⁷

Hardwig’s guidelines, as well as his whole approach, raise another question. Why does he fail to consider cases where the sacrificial suicide of someone who is healthy and far from old could benefit his (not overly) loving family? Suppose you are a forty-year-old mid-level executive who has been downsized. The only job you can get pays the minimum wage, not enough to support your family, even with the added income of your wife, who now has to work fifty hours a week as a home health aide, doing the caregiving Hardwig finds so onerous when done for a family member. Your family is about to lose their home; you will all have to move to a rat-infested apartment in an unsafe inner-city neighborhood. “For [your children], the chance to go to college [will] be lost”⁴⁸ (if we assume, as Hardwig inexplicably does in cases involving illness, that young people’s working and/or borrowing their way through college is not an option). There is, however, a solution. Like Hardwig’s grandfather, you have excellent life insurance. (If your life insurance has the common two-year “suicide clause” denying payment if the insured person commits suicide within two years of purchasing the policy, that clause has long since expired.) In accord with Hardwig’s guidelines, we can build in that your life so far has been rich and full, your wife has had a difficult, impoverished childhood, and your family has made sacrifices for your career (your wife sacrificed her own career and also spent much time in the tedious pseudosocializing necessary to further your ambitions, and your children endured the dislocation of frequent moves). We can even say that you lost your job not through downsizing but through your own fault and that you have little in the way of savings because you lived a “relatively lavish lifestyle instead of saving.” Would Hardwig then say you could have a duty to commit suicide instead of burdening your family by depriving them of your life insurance money? If not, why not?

Like Hardwig, I cannot lay down a series of precise rules saying who owes whom what when a sick family member needs care. In Hardwig’s case of the eighty-seven-year-old woman, for example, I think much hinges on her prior relationship with her daughter. How much did that mother sacrifice for her daughter? Did the mother pay, and make sacrifices to pay, for the education that enabled the daughter to have the career Hardwig is so distressed about her losing? What was their relationship like once the daughter grew up? Did the mother, like many parents now a days, give her daughter some of the money that enabled the daughter to buy the home Hardwig is so distressed about her losing? What happened after the mother died? Did the daughter ever find another job? Hardwig does not tell us any of these things.⁴⁹ But I think it is clear that in my own example with which I opened this paper, alternative (2) is the right answer. A teenager should work and borrow his way through college in order to free up money to prolong the life of a beloved parent who raised him and sacrificed for him. A spouse should forgo tennis (even if it is not a trivial recreation but an important part of his life) in order to take care of the beloved partner “that he promised his faith unto.”⁵⁰ “Sometimes, it’s simply the only loving thing to do.”⁵¹

NOTES

1. Sir Thomas Malory, *Le Morte D'Arthur* (London: Penguin, 1969), v.2, 515. As for the subtitle, for simplicity of exposition I will focus my discussion on the ill and their families. But note that the same issues can arise when people are severely enough disabled to need care, even when the disability arises not from illness, but from some other source, such as an injury. (Some disability rights activists set great store by the fact that they are disabled, not ill, and feel insulted when considered on a par with the ill. For examples of this attitude, see Joseph Shapiro, *No Pity* [New York: Times Books, 1993, 21, 22, and 49]. I consider this attitude to be morally on a par with that of a dark-skinned Caucasian who sets great store by the fact that he is white and feels insulted when considered on a par with blacks.)
2. Leo Tolstoy, *The Death of Ivan Ilych* (New York: New American Library of World Literature, 1960), 10. Tolstoy, of course, intended this remark (by a cancer patient's widow) to show monumental selfishness and callousness.
3. John Hardwig, "Is There a Duty to Die?" *Hastings Center Report* 27, no.2(1997), 36.
4. John Hardwig, "Dying at the Right Time: Reflections on (Un)assisted Suicide," in Hugh La Follette (ed.), *Ethics in Practice* (Cambridge, MA: Blackwell, 1996), 54.
5. Hardwig, "Is There a Duty to Die?" 41. Hardwig's book, *Is There a Duty to Die? and Other Essays in Bioethics* (New York: Routledge, 2000), was published too late for general discussion in this paper, but I will be reviewing it in a forthcoming issue of the *American Philosophical Association Newsletter on Philosophy and Medicine*. One point can be mentioned here, though. Hardwig praises a list of "Responsibilities of Those Facing the End of Life" (ibid., 197—99) compiled by a group of old people in a discussion he led. One item on the list is "Don't live so long that your loved ones will wish you were dead" (198). This treats life as a dinner party where the "loved ones" are hosts and the elderly are guests who should not be so rude as to overstay their welcome. Note that the complete lack of qualification entails that the elderly should honor every reason their loved ones may have for wishing them dead. Such a low valuation of the lives of the elderly is hard to take seriously. What if your loved ones wish you were dead so they can inherit your money and buy a Jaguar?
6. Ibid., 35.
7. Ibid., 36.
8. Ibid.
9. Ibid., 40.
10. Or, more accurately, this burden is as closely approximated in both sorts of cases. Hardwig's description is, of course, hyperbole. No one actually provides care or supervision "twenty-four hours a day." (When would he sleep? Even someone whose caregiving tasks often interrupt his sleep does not actually provide care or supervision "twenty-four hours a day.") This is not a trivial stylistic point, but an illustration of Hardwig's tendency to exaggerate the horrors of taking care of the ill.
11. Ibid., 37.
12. See B. Manard and C. Perrone, *Hospice Care: An Introduction and Review of the Evidence* (Arlington, VA: National Hospice Organization, 1994), 4.
13. John Hardwig, "What about the Family?" *Hastings Center Report* (March/April 1990), 5.
14. See Hardwig, "Is There A Duty to Die?" 35.
15. See the letters to the editor from Larry Churchill, Elizabeth A. Linehan, and Daniel G. Flourney, *Hastings Center Report* (November/December 1997), 4—6.
16. Hardwig, "Is There a Duty to Die?" 35.
17. Ibid.
18. See Hardwig, "Dying at the Right Time."
19. Hardwig, "Is There a Duty to Die?" 34.

20. See Daniel Callahan, *Setting Limits* (Washington, DC: Georgetown University Press, 1987), *What Kind of Life* (Washington, DC: Georgetown University Press, 1990), and *The Troubled Dream of Life* (New York: Simon and Schuster, 1993).
21. Sherwin B. Nuland, *How We Die* (New York: Knopf, 1994).
22. Hardwig claims that “ 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 them selves as patient advocates” (“Is There a Duty to Die?” note 3, p. 42). These claims overlook the enormous influence of Daniel Callahan. They also fail to take account of the huge (and hugely influential) hospice movement, one of whose basic principles is the above-quoted “Patients, their families and loved ones are the unit of care” (Manard and Perrone, *Hospice Care*, 4). Elsewhere, however, as I have indicated (see note 13), Hardwig distinguishes the hospice sort of approach from his own.
23. Hardwig, “Dying at the Right Time,” 63.
24. Ibid.
25. Callahan, letter to the editor, *Hastings Center Report* (November/December 1997), 4.
26. Callahan, *The Troubled Dream of Life*, 218—9.
27. Callahan, *Setting Limits*, 43 (italics in original).
28. Callahan, *The Troubled Dream of Life*, 218—9.
29. See my “Death, Dying, and Dignity,” in K. Brinkmann (ed.), *Proceedings of the Twentieth World Congress of Philosophy. Vol. 1: Ethics* (Bowling Green, OH: Philosophy Documentation Center, 1999), 196, for another example of how Callahan professes disdain for quality-of-life considerations, but freely uses them when the issue is “letting die.”
30. Joel Feinberg, “Duties, Rights, and Claims,” *American Philosophical Quarterly* 3, no. 2 (1966), 139 (italics in original). Obviously, this general claim leaves much unanswered. Feinberg is not specifically discussing parents and children, but Callahan cites this passage in that context in *Setting Limits*, 91. The general issue of what grown children owe their parents has many complexities that I lack space to go into here. For more discussion of the issue, see Jane English, “What Do Grown Children Owe Their Parents?” in La Follette, *Ethics in Practice*, 174—8; Christina Hoff Sommers, “Filial Morality,” *Journal of Philosophy* (1986), 439—56; and Norman Daniels, *Am I My Parents’ Keeper? An Essay on Justice between the Young and the Old* (New York: Oxford University Press, 1988).
31. Ellen Goodman, “Who Lives? Who Dies? Who Decides?” in E. Goodman, *At Large* (New York: Simon and Schuster, 1981), 161. (The first part of Goodman’s statement is false. I want to live to be senile. I would rather be mentally intact than senile, of course, but I would rather be senile than dead.)
32. Hardwig, “Is There a Duty to Die?” 38.
33. Ibid., 38. He gives a less sanguine picture in his earlier paper, “What about the Family?”
10. See also his reply to the letter from Daniel Callahan, *Hastings Center Report* (November/ December 1997), 6.
34. Hardwig, “Is There a Duty to Die?” 40.
35. Ibid., 40—1.
36. Hardwig, “What about the Family?” 6.
37. For further discussion of this paradox, see my “Assisted Suicide, Severe Disability, Terminal Illness, and the Double Standard,” in M. P. Battin et al. (eds.), *Physician-Assisted Suicide: Expanding the Debate* (New York: Routledge, 1998), 156, and my “Goldilocks and Mrs. Ilych: A Critical Look at the ‘Philosophy of Hospice,’” *Cambridge Quarterly of Healthcare Ethics*, 6(1997), 319.
38. I owe this point to Sara Ann Ketchum.

39. Hardwig, "What about the Family?" 6.
40. Hardwig, "Is There a Duty to Die?" 3 8—9. With respect to the third sentence of his second guideline, note that attempts to postpone death normally reflect people's (frequently attainable) goal of living *longer*, rather than the obviously unattainable goal of immortality. A similar point applies to Elizabeth A. Linehan's speculation about the "denial of mortality" (letter to the editor, *Hastings Center Report*, November/December 1997, 5) in Hardwig's case of the eighty-seven-year-old mother (discussed above) who insisted on the most aggressive possible treatment for her congestive heart failure. Like young diabetics who take insulin, this old woman was trying to prolong her life. The term 'denial of mortality' is no more appropriate to her case than to theirs, however much one may begrudge this sick old lady the extra time she craved.
41. Hardwig, "Is There a Duty to Die?" 37.
42. *Ibid.*, 38.
43. *Ibid.*, 41.
44. Malory, *Le Morte D'Arthur*, v.2, 172. Malory himself, as a devout Catholic, found a completely different sort of meaning in death as a passage to a better world, but when believers and disbelievers in an afterlife talk about death, what they take themselves to be talking about is very different.
45. Hardwig, "Is There a Duty to Die?" 36.
46. *Ibid.*, 42.
47. Hardwig, "What about the Family?" 7.
48. Hardwig, "Is There a Duty to Die?" 36.
49. In "SUPPORT and the Invisible Family" (Special Supplement, *Hastings Center Report*, 25, no. 6, 1995, S23—5), Hardwig discusses a real-life case of this sort but considers none of these questions. He also expresses great sympathy and concern for the daughter, whom he identifies as a personal friend, but none for the mother.
50. Malory, *Le Morte D'Arthur*, v. 2,426.
51. This is a claim Hardwig makes about killing yourself in order to avoid burdening your loved ones: "Dying at the Right Time," 57.

