On Helping People to Die: A Pragmatic Account

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Here is the doubt that triggers my inquiry: I have two beliefs that are apparently at odds. The first is that we should never kill; the second, that we should always attempt to alleviate pain. The apparent conflict between these beliefs arises from the fact that death may constitute the ultimate pain relief.

Certain caveats attach to both beliefs. For example, killing in self-defense or to save others' lives is acceptable (I am not a complete pacifist), and inflicting pain through medical interventions in order to cure or restore function is also acceptable (I am not a Christian Scientist). In general, however, both beliefs dispose me, as Charles Sanders Peirce would put it,[1] to distinct plans or habits of action: avoidance of killing and provision of pain relief. In healthcare, the commitment never to kill implies that euthanasia is wrong, and the commitment to alleviate pain demands actions that may hasten the dying process.

The question that arises from these two commitments is whether both can be sustained simultaneously. This question cannot be satisfactorily addressed through the doctrine of double effect because that doctrine identifies two effects, one of which is not intended.[2] Instead, my question identifies two intended effects that may be incompatible. Can I always and in every case avoid killing *and* alleviate pain? Using the term "can" to formulate the question suggests that the issue is one of possibility rather than permissibility.[3] But the two are intertwined because the possibility is both logical and moral. Is it morally possible, then, to alleviate pain while avoiding killing in all circumstances?

My inquiry will proceed according to Peirce's pragmatic method—that is, by attempting to clarify the concept of killing through consideration of the empirical consequences of alternative interpretations.[4] To clarify what it means to relieve pain, I will rely on Jane Addams's concept of maternal nurturance, relating this to an ethic of care and to opposition to killing.[5] To further examine whether my two beliefs are compatible, I will employ William James's notion of pragmatism as a method of mediation or of straddling different theoretical approaches to resolve disputes that might otherwise prove interminable.[6] Finally I will return to an essential insight of Addams, along with John Dewey, about the role of the philosopher as social critic.[7] A critical or prophetic pragmatism, I argue, provides a means of avoiding the injustices or abuses that may occur in the process of helping people to die.

A Peircean Analysis of Killing

First, then, what does it mean to kill someone? Among the possible meanings of killing, consider the following:

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1) Killing means ending the life of someone.
2) Killing means letting someone die when one could prevent it.
3) Killing means helping someone to die.

Helping someone to die can, of course, occur in contexts not associated with killing, such as hospice care, where the primary goal is to comfort the dying. If helping someone to die is equated with killing, however, it generally entails something more than comfort, viz., hastening death or facilitating suicide. The difference between this and the first definition is that in the latter case the action taken directly ends a life, whereas the action of helping someone to die only indirectly causes death. Both the first and third definitions differ from the second in that the second involves omission rather than commission.

None of these definitions says anything about whether the one killed is human or wishes to die. No information is provided about the means through which the killer "ends," "lets," or "helps" the one killed. Nor do they mention the intention of the killer, the proximity to death of the one killed, or degree of pain or suffering endured by the one killed. Such variables are relevant to determination of whether any of these "endings," "lettings," or "helpings" are morally justifiable. In fact, the variables may be more significant than the definitions in determining whether a specific act or omission is morally justified. The variables necessarily influence the consequences to be considered in forming our plans of action (or inaction).

Consider, for example, James Rachels's famous argument for the moral irrelevance of a distinction between active and passive euthanasia.[8] Rachels looked at the consequences of Jones and Smith drowning or letting their cousins drown and imputed to each the same intention, viz., the cousin's death. His description of the two cases excluded all variables except the fact that Smith directly ended his cousin's life whereas Jones ended it indirectly. But Rachels did not consider all of the consequences that could be anticipated in making his argument, and this, to the pragmatist, is a serious flaw. Different beliefs are to be formulated on the basis of different variables or circumstances.

What are some of the variables that Rachels might have considered? When Jones let his cousin drown in the tub after he apparently fell, he surely was as responsible for not saving him as Smith was for actually drowning him. But suppose the cousin had a terminal, intractably painful disease, and Jones discovered him in the tub when he was nearly dead and then refrained from giving him cardiopulmonary resuscitation (CPR) because if he survived he would be worse off than before. Or suppose the cousin was a competent adult who not only suffered from an intractably painful, incurable disease but had written a note to Jones asking him not to interfere with his suicide attempt and to actually "finish him off" by suffocation if he did not succeed in the attempt. On the first supposition, Jones's letting his cousin die could be viewed as both legally and morally appropriate. On the second supposition, Jones's nonintervention could be both legally and morally defended. If the cousin were unsuccessful in his suicide attempt and Jones completed the task in fulfillment of his explicit request, he would be legally liable for killing. However, it is unlikely in such circumstances that a judge or jury would convict Jones of murder, and his act could be morally defended on grounds that he thus respected his cousin's autonomy and prevented a harm worse than death (i.e., survival in an even more compromised state).

The variables I introduced in the Jones-and-his-cousin scenario illustrate the second and third definitions of killing: letting someone die by not preventing it, and helping someone to die by doing something to facilitate it. In healthcare practice and in legal decisions, the former is described as forgoing lifesaving treatment, the latter as withdrawal of lifesaving treatment. If Jones had suffocated his cousin, his act would be legally described and proscribed as euthanasia; if the traditional distinction between active and passive euthanasia were invoked, the suffocation might be labeled active euthanasia. By that same distinction, his refraining from prevention of his cousin's suicide attempt could be termed passive euthanasia, even though legal rulings do not generally employ that terminology. Refraining from prevention of death could also be called assisted suicide, but legal rulings generally reserve that terminology for cases in which an individual helps another commit suicide by performing a specific act, such as prescription of a lethal dose of medication.

During the past decade, the traditional distinction between active and passive euthanasia has seldom been used in legal and clinical circles. Instead, when euthanasia is discussed, the first definition of killing, which is clearly equivalent to active euthanasia, is usually assumed. A possible reason for this assumption is the difficulty of distinguishing between doing and refraining, with regard to medical technology. Another is the proliferation of legal rulings permitting passive euthanasia without calling it that. Forgoing and withdrawing lifesaving treatment have thus been regarded as distinct from euthanasia, whether active or passive, and the second definition of killing has been ignored, rejected, or invalidated.

The distinction between doing and refraining (cf. commission and omission) is difficult to maintain because stopping treatment already started requires an action on the part of someone (e.g., turning off the switch on a ventilator). A clear case of doing occurs in the first definition of killing and may be exemplified by the infamous report of Debbie, a young woman suffering from ovarian cancer, who was apparently deliberately and actively euthanized by a house officer.[9] Clear cases of refraining occur whenever life support is withheld rather than initiated; such cases occur with and without consent of the patient. Consider, for example, a 500-gram 24-week-gestation newborn, whose parents and practitioners agree not to intubate at birth because of the high probability of severe morbidity and an even higher probability of death within a short time. Or consider a severely symptomatic AIDS patient, who has explicitly indicated that she does not wish to be resuscitated if she arrests.

Instances in which the distinction between doing and refraining is unclear commonly occur when life-sustaining treatment has already been initiated, and, with or without the patient's consent, the treatment is deliberately withdrawn. Despite legal and ethical arguments that there is no relevant difference between discontinuing and forgoing lifesaving treatment, it cannot be denied that withdrawal does not occur passively, but rather by a specific action on the part of someone, usually a clinician. The argument that discontinuation of lifesaving treatment is thus permissible because one is merely refraining from an action is at odds with an accurate description of what happens. Nonetheless, legal rulings generally assume that the patient or surrogate alone decides to stop treatment.

The active/passive distinction doesn't work, then, because it doesn't adequately divide the possibilities. Adequate division requires the three definitions

of killing I have delineated. Although Rachels assumes only two definitions, his argument for the moral irrelevance of a distinction between active and passive euthanasia may apply to all three definitions. Depending on the variables, it may be as morally wrong or right to end a life, to let die, or to help someone die.

Peirce would undoubtedly look to the consequences of different definitions of killing to resolve the dilemma posed by the dual commitment to avoid killing and to relieve pain. In doing so, I suspect he would agree with Rachels's overall argument but extend it to active discontinuation of life-sustaining treatment, and insist on consideration of the impact of all of the variables in different situations. Moreover, because Peirce would be concerned about long-term consequences, he would consider slippery slope and rule utilitarian arguments. For example, if a policy condoning assisted suicide were to prevail, he would worry about the possibility of its leading to denial of treatment of those who are severely disabled. These concerns are associated with further variables, such as cost, with which to reckon. The patient's wishes are, arguably, more morally compelling than other variables. But other morally relevant variables include the possibility of cure and whether adequate pain relief is available. The latter factor is particularly relevant to an ethic of care.

Jane Addams and a Care Ethic

Caring clinicians are generally committed to reduce the pain and suffering of patients, while extending patients' lives and their ability to function. The very fact that medical *treatment* is often equated with medical *care* suggests that the concerns of clinicians for their patients include more than the mere prolongation of life. Care, even beyond the medical setting, signifies more than that and often entails efforts to reduce the pain and suffering of others as well.

The irony that arises in the relationship between alleviation of pain and prolongation of life is that death, by ending human experience, constitutes the ultimate pain relief. Rarely is this relationship tested because caregivers generally pursue both goals simultaneously and successfully. If and when severe pain and suffering are not relievable, they sometimes wish for that ultimate relief for their patients. At such times, we might see more numerous instances of active euthanasia if there were not such widespread, deeply rooted taboos and laws against it.

Since Carol Gilligan published her studies of women confronting ethical dilemmas in their own lives, an ethic of care has been developed and elaborated within the context of moral psychology.[10] A care ethic identifies the natural, nurturant experiences of women as paradigmatic for moral decision-making. Nel Noddings, for example, points to a mother's instinctive care for her newborn and argues that this represents a model for ethical caring for all of us.[11] Sara Ruddick proposes (for men as well as women) a model of "maternal thinking," listing its essential components of preservative love, fostering growth, and development of sociality.[12] Gilligan has explained how feminine moral reasoning tends to be based on attention to the particularities of cases and a desire to fulfill responsibilities to others to whom one is related. Some bioethicists have latched on to the connection between healthcare and this notion of a care ethic.[13] Although they applaud the fact that an ethic of care is based on women's experience, some feminists, including some who work in bioethics,

worry about the possibilities it entails for exploiting women's natural nurturant behavior.[14]

Long before the recent articulation of a care ethic, Jane Addams, a colleague of John Dewey, not only wrote about but lived that ethic through her work at Hull House and in behalf of world peace.[15] In her writings, Addams argued for the extension of women's natural nurturant behavior to the larger social context.[16] The connection between the two is pertinent to resolution of the problematic relationship between pain relief and euthanasia. As a committed pacifist, Addams totally opposed killing and argued just as forcefully for addressing the problem of hunger in the world. The provision of nourishment, which occupies much of women's daily labor, is essential both to sustaining life and to relief of the pain and suffering of ill health. War is an obstacle to this task of nurturance.

The rationale by which Addams maintained both her pacifism and her commitment to the alleviation of hunger is captured in her notion of "bread labor" as "the very antithesis of war."[17] The term "bread labor" was taken from historical accounts of Russian peasant leaders following the abdication of the czar. The future of each peasant depended "not upon garrisons and tax gatherers but upon his willingness to perform 'bread labor' on his recovered soil, and upon his ability to extend good will and just dealing to all men."[18] For Addams, the elimination of world hunger and the provision of conditions necessary for fostering human life and flourishing would render the competition of war unnecessary. Relieving the pain of hunger is thus not only compatible with but essential to the avoidance of killing.

Contemporarily, those who have argued most convincingly against assisted suicide illustrate the same argument as Addams. Susan Tolle, for example, maintains that public support for legalization of euthanasia and assisted suicide points to the frequent failure of clinicians to provide adequate pain relief to their patients.[19] If adequate pain relief were provided, there would be little need or desire for the practice. If it could not be provided, however, would Tolle countenance euthanasia or assistance in suicide? If she concurred with Addams's pacifism, she would not do so, but neither would she be likely to oppose forgoing or discontinuing treatment.[20] If severe pain were still not relievable, a pacifist might resort to the principle of double effect to justify hastening death as the unintended but foreseen consequence of adequate pain relief. This practice would also be supportable by a Jamesian understanding of pragmatism.

James's Notion of Pragmatism as a Mediating Method

That James extended and possibly distorted Peirce's understanding of pragmatism is well known.[21] Whereas James's account of pragmatism as a theory of truth is problematic for ethics, his account of pragmatism as a mediating method goes beyond Peirce in suggesting a means of resolving the apparent dilemma between pain relief and medical pacifism. Traditional philosophy might resolve it, however unsatisfactorily, through a theory of prima facie duties based on W. D. Ross or through a utilitarian rationale that subordinates both commitments to a broader social goal.[22] But case-based reasoning, often identified with Jonsen's and Toulmin's reinstatement of casuistry, needs to be considered as well.[23]

Traditional ethicists might invoke the Georgetown mantra of respect for autonomy, beneficence, nonmaleficence, and justice, as principles to be observed in

determining the solution to the pain-relief/avoidance-of-killing dilemma.[24] Casuistry would start with the nuances of cases, compare these with paradigmatic cases, and determine a resolution based on the maxims that govern the closest paradigm.[25] A Jamesian pragmatism would utilize both approaches, straddling back and forth as along Papini's corridor, using both or whichever is most conducive to resolution.[26] This approach, in fact, reflects the way most people think most of the time in resolving their doubts or dilemmas. It also makes explicit what any careful examination of principlism or casuistry reveals—namely, that the content of the principles articulated is drawn from our experience of particular cases, and that our understanding of cases is only possible through the generalizations that are identifiable as principles or maxims.

Jamesian pragmatism demands that we maximize our chances of resolving practical dilemmas by invoking both empirical and rational considerations. Shorthand ways of doing this, such as matching new cases with old paradigms and applying the governing maxims, are favored if we are faced with a genuine option—that is, a choice between living, momentous, and unavoidable alternatives.[27] But principle-based decisionmaking may be used as a shorthand method, too. Both are fallible, and neither is thinkable or applicable without the other.

One way in which the straddling method of James may be applied to the dilemmatic relationship between pain relief and medical pacifism is by examining the variables of cases in the context of the pertinent moral verities or principles.[28] The verities are the principles of respect for autonomy, beneficence, and justice. The variables go beyond those mentioned in our revised version of Rachels's case of Jones and his cousin. Here are some, listed in no particular order:

1) whether the patient is dying, and if so, how imminently
2) the extent of the patient's unrelievable pain or suffering (if it can be ascertained)
3) the patient's desires with regard to pain relief and its side-effects, including reduced ability to interact as well as risk of hastening death
4) cost and availability of means of pain relief
5) the means by which death may be hastened—for example, removal or forgoing life support, administration of a drug intended for pain relief, or provision of the means by which the patient may effectively commit suicide

In a Jamesian application of pragmatism as a mediating method, the verities would have to be interpreted in the context of the variables, all of which need to be examined. None of the principles would be construed as absolute, not even respect for patient autonomy; rather, the principles are tools or instruments to be used in a way that maximizes their observance in light of the variables of each case. Mere definitional distinctions are thus not adequate in resolving concrete dilemmas. James would hardly, therefore, be opposed to assisted suicide or even active euthanasia solely on grounds that they are not classifiable as passive euthanasia or letting someone die. Like Peirce, he would insist on looking to the consequences as crucial to determination of whether a particular plan of action should be undertaken. The consequences to be concerned about would necessarily stretch beyond those that affect particular patients, families, and caregivers to those affecting the larger society as well. So under-

stood, pragmatism demands a critique of unjust practices toward particular groups and individuals whose interests might be threatened by social policies that endorse assisted suicide or euthanasia. Among the unjust practices to be avoided are those driven by eugenics—the "science of improvement of the human race."[29]

"Critical Pragmatism" and Avoidance of Eugenics

Jane Addams developed a radical extension of the tenets of pragmatism to a critique of those elements of society that compromise the autonomy and well-being of some of its citizens. This extension, called "critical pragmatism," is coincident with a socialist version of democracy and what Cornel West characterized as "prophetic pragmatism." West described this view as "the culmination of the American pragmatist tradition."[30] Social equality is its fundamental goal, and education and democracy are the principal means to its accomplishment. Addams applied these means more broadly and informally than Dewey, for whom they were also central themes. For example, she organized numerous talks and seminars to which academic as well as nonacademic types, and people of other cultures, were invited as presenters and participants. One of the main motives for the creation of Hull House, she said, was "the desire to make the entire social organism democratic, to extend democracy beyond its political expression."[31]

Addams's concept of democratic equality was not one of sameness; instead, she emphasized the different contributions of individuals and groups to social health and education. Like Dewey, she opposed individualism in order to promote the rights of diverse individuals in a social context.[32] Addams insisted, as do contemporary feminists, on social equality not only between genders but also for African-Americans, other minorities, the aged and youth, workers, the poor, and immigrants.[33] Social equality, as she construed it, would also demand avoidance of the potential for eugenics entailed by liberal policies with regard to assisted suicide or euthanasia.

Some critics fear that policies that permit or encourage negative eugenics (e.g., forgoing life-sustaining treatment of those who are profoundly impaired) naturally or inevitably move from willingness to implement the desires of competent, dying, suffering persons to willingness to do this for those who are not dying, whose pain is relievable, and those who are incompetent. Mere willingness in such circumstances could lead to something yet more onerous, positive eugenics—that is, a readiness or desire to end the lives of those whose health status is severely compromised or costly to support. Persons with disabilities are strongly opposed to legalization of assisted suicide on this basis.[34] They are often opposed as well to the apparent ease with which the law allows termination or noninitiation of life support.

If Addams had addressed the concerns of persons with disabilities about the eugenic potential of policies about euthanasia and assisted suicide, she would probably have had two main worries: the possibility of pressuring the disabled to die, and the possibility of exacerbating prejudices or negative attitudes and practices toward the disabled. At the same time, Addams would not want to deprive the disabled of the same right to die and to be relieved of pain and suffering that the nondisabled experience. Her ideal of social equality would thus demand measures designed to place wedges along the slippery slope of

social permissiveness to ensure that eugenics is not practiced through measures that help people to die. Addams would support rules formulated to restrict such measures to the extent that they insured maximally just consequences for all of those affected.

The worry about positive eugenics in attitudes or practices involves a more complicated understanding of autonomy than the individualistic, rights-based rationale that prevails in health practice, the law, and American society. Some people who appear to make competent, informed, and totally voluntary decisions regarding treatment or nontreatment, for example, may in fact be strongly influenced, even pressured, by family members or social attitudes about the appropriateness of prolonging their lives. The fact that the great majority of patients whom Dr. Jack Kevorkian has helped to die have been women suggests that women may be more likely than men to look for such assistance because their sense of self-worth has been based primarily on their capacity to care rather than be cared for.[35] Whether their decisions are then truly autonomous is questionable.

A similar argument applies to persons with disabilities, some of whom believe that supporters of assisted suicide "just want to get rid of us."[36] If a person becomes convinced through the attitudes of others that he or she no longer deserves to live, or ought not to continue living in dependence on others, these thoughts may eventually become articulated as his or her own "autonomous" request. Fulfilling such a request may be totally different from respect for what the person would desire if social pressures had not intervened to compromise his or her genuine autonomy.

One concrete means that Addams would surely have advocated to maximize justice in policies about helping people to die is the involvement of those most affected by the enactment of those policies. Like Peirce, she viewed genuine collaboration as a way of overcoming the nearsightedness that compromises the reliability of beliefs emerging from our inquiries. From the standpoint of critical pragmatism, this strategy can only be enhanced through collaboration with those most affected. The probability of erroneous beliefs decreases to the extent that those involved in formulating them are affected by their implementation. She would therefore regard bioethicists and clinicians who attempt to resolve the dilemma of pain relief versus medical pacifism as not only undemocratic but illogical if they fail to involve those most affected in the process. Bioethicists and clinicians who wish to resolve the dilemma of pain relief versus medical pacifism are therefore not only undemocratic but illogical if we attempt to do so without acknowledging our nearsightedness, and if we don't seek and rely on those whose experience is more pertinent than our own. Addams fully recognized that those who were not formally students or teachers had much to teach those who were. On this matter of pain relief and avoidance of killing, we who work in bioethics need to do the same.

To return to the question that provoked my inquiry, my doubt about the compatibility between amelioration of pain and avoidance of killing has been assuaged through an examination of the consequences that arise in different circumstances for different definitions of killing. My attempt to follow a pragmatic method has utilized not only principlist and casuistic but care-based approaches, which led to realization that pain relief is in fact a means of avoiding killing.[37] It also involved examination of short-term as well as long-

term consequences of helping people to die, especially the consequences to those most affected by such "helping" measures.

I conclude that so long as permissive practices are restrained sufficiently to avoid eugenics or other injustices, it is morally both possible and desirable to resist killing while relieving pain. To protect for all of us the right to die and to adequate pain relief, while ensuring that our right to life and dignity be respected no matter what our circumstances, critical pragmatism demands the placement of wedges at appropriate points along life's inevitably slippery slope.

Peirce acknowledged that the belief in which inquiry culminates is not unmixed with doubt that may prod subsequent inquiry. His doctrine of fallibilism asserted that "our knowledge is never absolute but always swims, as it were in a continuum of uncertainty and indeterminacy."[38] Being conscious of my own fallibility, while disposed to act on the beliefs I have developed here, future experiences and input from those directly affected may compel revision. Like the classical pragmatists, I remain dogmatic about not being dogmatic.

Notes

1. Peirce CS. In: Moore EC, ed. *The Essential Writings*. New York: Harper and Row, 1971:125–6.
2. For an excellent critique and defenses of the doctrine of double effect as applied to pain medication, see Fohr SA, The double effect of pain medication: separating myth from reality. *Journal of Palliative Medicine* 1998;1(4):315–26; Brody H, Double effect: does it have a proper use in palliative care? *Ibid*:329–30; and Quill TE, Principle of double effect and end-of-life pain management: additional myths and a limited role. *Ibid*:333–5. Fohr believes and argues persuasively that the principle of double effect that "is used to justify adequate opioid analgesics contributes to the undertreatment of pain" (p. 326).
3. It may be that pain is always relievable, if, after other means or doses fail to provide relief, sedation renders the patient unconscious. But terminal sedation does not resolve the apparent conflict because it probably hastens the moment of death. Cf. note 2, Fohr 1998:318 and Brody 1998:330.
4. See note 1, Moore 1971:137–46.
5. Cf. Deegan MJ. *Jane Addams and the Chicago School, 1892–1918*. New Brunswick, N.J.: Transaction, 1988:225–308.
6. James W. *Pragmatism and Other Essays.* New York: Washington Square Press, 1968:22–38.
7. For example, Dewey J. *Reconstruction in Philosophy*. Boston: Beacon Press, 1966:1–26.
8. Rachels J. Active and passive euthanasia. *New England Journal of Medicine* 1975;292:78–80.
9. Name withheld. It's over Debbie. *JAMA* 1988;259:272.
10. Gilligan C. *In a Different Voice: Psychological Theory and Women's Development.* Cambridge, Mass.: Harvard University Press, 1982.
11. Noddings N. *Caring: A Feminine Approach to Ethics and Moral Education*. Berkeley and Los Angeles: University of California Press, 1984.
12. Ruddick S. *Maternal Thinking: Toward a Politics of Peace*. New York: Ballantine Books, 1989.
13. Reich WT. Care. In: Reich WT, ed. *Encyclopedia of Bioethics, Vol. 1*. New York: Simon & Schuster Macmillan, 1995:319–36.
14. Sherwin S. Feminist and medical ethics: two different approaches to contextual ethics. In: Holmes HB and Purdy LM, eds. *Feminist Perspectives in Medical Ethics*. Bloomington: Indiana University Press, 1992:17–29, and Mahowald MB. Care and its pitfalls. In: Haddad AM and Buerki RA, eds. *Ethical Dimensions of Pharmaceutical Care.* New York: The Haworth Press, 1996:85–102.
15. Hull House was a residence and education center for the poor in Chicago. Some of Addams's activities in behalf of the poor are documented in her *Forty Years at Hull House* (New York: Macmillan, 1935). Her efforts in behalf of world peace led to her founding and serving as first president of the Women's International League for Peace and Freedom. Although these efforts were unpopular in the United States, Addams was a corecipient (with Nicholas Murray Butler) of the Nobel Peace Prize in 1931. I have elaborated on Addams's contributions to philosophy

through her activities as well as her writings in What classical American philosophers missed: Jane Addams, critical pragmatism, and cultural feminism. *Journal of Value Inquiry* 1997;31:39–54.

16. See note 5, Deegan 1988:225–308.
17. Addams J. *Peace and Bread in Time of War*. New York: King's Crown Press, 1945:96.
18. See note 17, Addams 1945:92.
19. Tolle SW. Measure 16: a wake-up call to medicine. *The Oregonian* 1994 Nov 13:C1 and Lee MA and Tolle SW. Oregon's assisted suicide vote: the silver lining. *Annals of Internal Medicine* 1996;2:267–9.
20. In fact, Tolle has not taken any public stand on the issue. Cf. Ethicist remains neutral. Editorial in *The Oregonian* 1997 Oct 23: "Since 1994 Tolle has been neutral on assisted suicide initiatives." Personal communication reaffirms her neutrality (Feb. 24, 1999).
21. Commenting on James's and Ferdinand Schiller's broadened use of the term "pragmatism," Peirce proposed that the doctrine he had introduced through that term be renamed "pragmaticism." The latter term, he thought, was "ugly enough to be safe from kidnappers." See note 1, Moore 1971:266.
22. Ross WD. *The Right and the Good*. Oxford: Clarendon Press, 1930.
23. Jonsen AR and Toulmin S. *The Abuse of Casuistry.* Berkeley and Los Angeles: University of California Press, 1988.
24. Beauchamp TL and Childress JF. *Principles of Biomedical Ethics*. New York: Oxford University Press, 1994.
25. Jonsen AR. On being a casuist. In: Ackerman TF, Graber G, Reynolds CH, Thomasma DC, eds. *Clinical Medical Ethics: Exploration and Assessment.* Lanham, Md.: University Press of America, 1987:117–29.
26. Cf. Thayer HS. *Meaning and Action: A Critical History of Pragmatism.* Indianapolis: Bobbs-Merrill, 1968:328.
27. James W. The will to believe. In: *Essays on Faith and Morals.* Cleveland, Oh.: Meridian Books, The World Publishing Company, 1962.
28. I have developed the distinction and relationship between verities and variables in Medically assisted reproductive technology: variables, verities, and rules of thumb. *Assisted Reproduction Reviews* 1996;6:175–80.
29. Francis Galton coined the term "eugenics" in 1883, defining it as "the science of improvement of the human race germ plasm through better breeding." Cited in ASHG (American Society of Human Genetics) Statement, Eugenics and the Misuse of Genetic Information to Restrict Reproductive Freedom. *American Journal of Human Genetics* 1999;64:335–8.
30. See note 5, Deegan 1988:247–67 and Cornel W, *The American Evasion of Philosophy: A Genealogy of Pragmatism*. Madison: University of Wisconsin Press, 1989:211–39.
31. Lasch C, ed. *The Social Thought of Jane Addams.* New York: Bobbs-Merrill, 1996:29.
32. Cf. Dewey J. *Individualism Old and New*. New York: Capricorn Books, 1930.
33. For example, Mahowald MB. Gender justice and genetics. In: Hudson Y, Peden C, eds. *The Social Power of Ideas*. Lewiston, N.Y.: Edwin Mellen Press, 1995:225–52.
34. Gill CJ. Suicide intervention for people with disabilities: a lesson in inequality. *Issues in Law & Medicine* 1992;8:37–51.
35. Another factor that may in part explain the greater number of women whom Kevorkian has "helped to die" is that women outnumber men in the elderly population.
36. Silvers A, Wasserman A, Mahowald MB. *Disability, Difference, Discrimination: Perspectives on Justice in Bioethics and Public Policy.* Lanham, Md.: Rowman and Littlefield, 1998:238, n. 65.
37. Admittedly and importantly, avoidance of pain is not the only motive of those who consider or seek assisted suicide. A study of those who sought such assistance during the first year of its legalization in Oregon concluded that "the decision to request and use a prescription for lethal medication was associated with concern about loss of autonomy or control of bodily functions, not with fear of intractable pain or concern about financial loss." Chin AE, Hedberg K, Higginson GK, Fleming DW. Legalized physician-assisted suicide in Oregon: the first year's experience. *New England Journal of Medicine* 1999;340(7):577–83.
38. Peirce CS. In: Hartshorne C, Weiss P, eds. *Collected Papers of Charles Sanders Peirce, Vol. 1*. Cambridge, Mass.: Harvard University Press, 1931: para. 71.