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Southern Cross Bioethics Institute

is an autonomous academic institute established in 1987 by Southern Cross Care SA Inc., an independent provider of care and accommodation to thousands of South Australia’s older people.

Southern Cross Bioethics Institute is a community resource that engages in bioethics research, teaching and professional consultation. We also provide accessible information and advice on ethical issues for those involved in health care, education, public policy and the wider community. We prepare submissions to institutions and government to encourage informed debate.

Southern Cross Bioethics Institute is founded upon: respect for universal and intrinsic human values including the inviolable and inalienable right to life of every member of the human family; a commitment to work for the due recognition of those agreed values; an openness to reasonable and fruitful debate; a commitment to outline the ethical principles by which biomedical research, health care and technology can be pursued in harmony with fundamental human values.

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The Dutch solution to end of life ‘care’ has taken a new, and perhaps not unexpected twist. Upon receiving a petition with over 100,000 signatures, the Dutch parliament has recently been forced to consider further expanding its euthanasia regime to allow healthy over 70 year-olds to receive a lethal injection at the hands of specially trained ‘suicide assistants’. Reminiscent of Western Australian retired Professor Lisette Nigot, who was ‘tired of life’ and wanted to die, eventually committing suicide and thanking euthanasia advocate Philip Nitschke in the process, the new debate is all about ‘vrijwillig levens einde’, or ‘of free will’. If individuals over the age of 70 consider their lives ‘complete’, the argument goes, why should they have to stick around any longer if there is nothing left they want to do?

Proponents of euthanasia are keen to argue that there is no slippery slope occurring in The Netherlands because the number of those accessing euthanasia has not steadily increased. However, that is to completely miss the point about a slippery slope. What has happened in The Netherlands over the past 40 years is a widening circle of eligibility for euthanasia. Euthanasia numbers may or may not be on the increase, it is hard to tell, but the eligibility criteria have been steadily expanding. So that the ‘ideal’ case of a terminally ill patient in intolerable pain who makes a persistent voluntary request for euthanasia is no longer the only recipient of euthanasia. Now euthanasia can and has been provided to the emotionally suffering, disabled, children, babies, and those who do not ask for it.

In many respects the ‘tired of life’ category is simply a natural extension of the in principle position that people have a right to expect the State to end their lives upon request. However, what is different here is that no longer is there any pretense that this is mercy killing, compassionate or aimed at ending suffering. Being ‘tired of life’ is something else again. It is more acutely about autonomy than any category that has come before. In fact, it could be argued that the very term euthanasia, understood by the general public as mercy killing, does not apply here. At face value, what this new development is all about, is pure unbridled autonomy.

However, perhaps that is only part of the story and something else is also going on.

Let’s take a really frank approach for a moment. What would someone currently healthy and over 70 but ‘tired of life’ do if they really wanted to end it all? There are many others, who for a multiplicity of reasons, take their own lives by a variety of means, either without telling anyone, or perhaps explaining it to a few key individuals, or just leaving behind a letter or note. Without wanting to sound too morbid, or wanting to encourage anyone, it is not really all that hard to find a means, even a relatively peaceful one, by which to depart this mortal coil. The Victorian Institute of Forensic Medicine recently found that...
51 Australians have died from Nembutal overdose in the last 10 years\(^3\). Even so, far more do use extreme and violent means to end their lives – presumably because their mental suffering is such that they grasp for just about any means. Perhaps the low self-worth that accompanies suicide is expressed in choosing a horrible means to go – perhaps some people sadly despise themselves so much that an unpleasant means to them may seem appropriate.

With regard to the pressure from some quarters for legal assisted suicide or euthanasia, frankly discussing the means of suicide has previously been taboo, because it has always been harsh to say to someone who is suffering that they can go ahead and ‘do it’ themselves. The comeback has always been either that there are some circumstances in which the person involved is just not able to carry through the act, or that desperate people use horrible means to suicide and need access to a peaceful means, perhaps accompanied by friends and loved ones – and presumably with their blessing. This is understandably one of the really hard parts about the euthanasia debate, yet one that must be faced squarely.

But now that the debate has shifted to those ‘tired of lifers’ who are just like any other healthy 70 plus person, but want out, it has become easier to sharpen the debate and seek answers about what end game is being played. Why are there over 100,000 signatures? Why are there so many people keen to set up facilities to kill them? Is it about ensuring an ‘insurance’ policy so that if things do get really tough there will be a peaceful way out? Or could it be that the freedom to choose is really more about seeking endorsement for that choice than simply having the choice? Is it that having the state endorse this choice is to gain legitimacy about a worldview in which the individual and his or her wishes is fundamentally central. Even to the exclusion of the needs and wishes of others. Remember, this is about the ‘tired of lifers’.

Or perhaps there is something here about power; power over life and death, or perhaps power over existing authorities, so that the majority is forced to comply with the wishes of the few. Perhaps those most strongly pushing for this are just not happy with exercising the free choice they already have, but instead want others to agree with their choice. If the focus is having the choice to exit life as a healthy ‘tired of lifer’, it is already there. No legal change is needed. But if the focus is upon changing society to one in which human life is not particularly protected because of any unique status, then the ‘tired of lifers’ campaign is more understandable.

But surely the over 70’s have much to give. Is there not something selfish about refusing to contribute in one’s latter years? Who can ever really know that a life is ‘complete’? What of the ‘wisdom of the elders’, decades of accumulated insights about how to handle life’s complexities, to offer to children, grandchildren, friends and the community? When western democracies already undervalue their elders, it is time to revalue, not further devalue.

An additional difficulty is that the already thin line between State-sanctioned suicide for certain people and supporting the many suicide prevention programmes in the community has just narrowed to vanishing point. How hard will it now be to encourage people that life is worth living when the state endorses the choice of those, who perhaps with a shrug of the shoulders say, “done all I want to do … where’s the needle?” Someone who really struggles might justifiably say, “Well if the State (and hence community) thinks suicide or euthanasia is okay for someone ‘tired of life’, then of course it must be for me, for I have far better reasons”.

Are some, or even most, of those 100,000 signatures from the strong who have lived

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Mercy is a concept difficult to define, especially in the face of life-ending decisions. Inextricably linked are ideas about relief, respect and relationships. Jones is suffering from a terminal illness. His pain is severe, he is estranged from his family and he wants to die. He calls out, “Have mercy on me!” No doubt you are moved by his story. You want to help him. Indeed, you want to have mercy on him. But what is mercy? What does it look like? What does it mean to have mercy on someone who is suffering?

A similarity between advocates both for and against euthanasia (herein meaning the intentional killing of a person with a terminal illness) is that they seek to show mercy on those who are suffering. But despite mercy being at the forefront of people’s minds, there is a fundamental disagreement about what mercy actually looks like. Here I argue that despite the good intentions of euthanasia advocates, their understanding of mercy is flawed. I propose a concept of mercy that is not about the outcome but the process and does not bring about endings but beginnings.

Mercy: Relief of Suffering?
Euthanasia advocates believe that intentionally taking the life of someone who is terminally ill or suffering severe pain constitutes an act of mercy. Their definition of mercy is clear enough: to act mercifully is to bring about a reduction in human suffering. Mercy, in this view, is ending the life of Jones where continuing to live would produce more pain than pleasure. This is based upon a version of the philosophy known as utilitarianism. Proponents of this view will accept almost any means of pain elimination, even if this means the elimination of the sufferer. This is
not dissimilar to our modern Western desire to eliminate all suffering.

If we view mercy solely as the reduction of suffering then we will have no qualms providing Jones with a lethal injection. According to a utilitarian calculus Jones has more pain than pleasure in his life; his scales are grossly uneven and so we should release him from this pain. It may also help to speak of Jones as a person who has ceased to have “a life” in any meaningful sense of the word. We can appeal to the intensity of his pain, the reality of his family situation and the inevitability of his death.

Yet, if we deny that Jones’ life has any real meaning because his pain outweighs his enjoyment of life then his worth is reduced to the sum total of the pain or the pleasure he is experiencing. Is this really an appropriate way to speak of another human? Or, have we dehumanised Jones? Our description says nothing of his biography or the context of his pain. Rather, our description of Jones seems clinical, impersonal and detached. Ethics academic Gilbert Meilaender holds that such thinking forces us to speak of ourselves in terms of “what we have” instead of “who we are”1. Is this really an example of mercy?

Euthanasia advocates may campaign us to “put Jones out of his misery”, in the same way that we might our own cat or dog. Indeed, we would never allow our cat to suffer in the same way as Jones. If we love Jones as much as our pet then surely compassion demands us to put him “out of misery”. However, philosopher Sarah Bachelard questions whether this sort of language is an appropriate way to speak of human life. She suggests that our bid to put another “out of misery” fails to capture the value of human life2:

…to act in the spirit of putting a human being out of his misery is radically demeaning. It is to treat a human being as someone incapable of responding to the claims of the meaning of his suffering, and hence as less than fully our fellow, as less than fully human.

Although such language may be suitable for describing the experience of animals, it is an insufficient portrayal of what it means to have mercy on another human.

Mercy: Respect for Autonomy?

It might help our justification for euthanasia to emphasise that Jones begged for death. “Oh well,” we might say, “it’s what he wanted.” Voluntary euthanasia advocates emphasise the role of patient autonomy in exercising mercy. Euthanasia may constitute an act of mercy only if it is what Jones chooses. It is insufficient for Jones to say, “Have mercy on me!” Rather, his plea must also be a request: “Have mercy on me! I want to die!” This justification for euthanasia is based on notions of personal autonomy or self-rule. Philosopher and euthanasia advocate James Rachels explains the position succinctly3:

If a person prefers – and even begs for – death as the only alternative to lingering on in this kind of torment, only to die anyway after a while, then surely it is not immoral to help this person die sooner.

Modern medicine has moved away from paternalistic ideologies where doctors were the sole medical decision-makers. Medicine today embraces notions of patient autonomy, where the patient participates in the decision about what treatment he or she wants. Although much is to be praised about this model, autonomy alone does not give us an accurate picture of what mercy is. If we are to say that a doctor acts mercifully because he or she succumbs to the pleas of the dying patient, then mercy is nothing but a doctor acting under instructions. It robs doctors of responsibility and professional judgement and makes the patient his/her own doctor. What place does mercy have in a society where doctors merely follow orders

1 http://www.firstthings.com/article.php3?id_article=6047
instead of responding in ways they deem appropriate as medical professionals, such as providing love, care, shelter and warmth? To see mercy as the granting of Jones’ wish is to say that mercy is all about the patient and not about the carer. It is to admit that doctors are in some way divorced from their patients and unaffected by the treatment they provide to them.

Autonomy also fails to display mercy on other accounts. For instance, it is hard to verify that a plea for death was made without any coercion. How can we be sure that Jones’ wife, supposing he has a wife, wasn’t pressuring his decision because she felt “burdened” by his illness? Or perhaps Jones’ plea for death was made in a period of deep depression where his full expression of autonomy was temporarily suspended. An example of this abuse was in Chabot’s case where a Netherlands doctor granted a woman access to euthanasia because she was suffering “unbearable” mental distress over a marriage break-up and the death of her two sons. Surely, voluntary euthanasia advocates would not call this mercy anymore. So what, then, does mercy look like?

Mercy Implies Relationship

Saying that a person is merciful in itself has little meaning unless that person’s acts of mercy are directed towards something or someone. Mercy does not describe a human person in isolation. The phrase “That person is merciful” only makes sense if the act of mercy is directed towards someone or something. Mercy is reliant on relationship. I am not mercy. But I can show mercy. And I can only show mercy if I am in relation to someone else. It doesn’t even work to say that I am merciful to myself. All the main usages of the word mercy are requests: “Have mercy on me!” This request certainly doesn’t make sense if it is self-imposed. For mercy to exist there must exist a giver and receiver of mercy.

However, defining mercy solely as relationship might indicate that euthanasia is not incompatible with mercy. We can envisage a conversation taking place where Jones cries out, “Have mercy on me!” and the doctor who responds, seemingly lovingly, with a lethal injection. Indeed, there must have been some sort of relationship between the two people in order for the one to ask the other to end his life. However, to accept this definition of relationship is to admit that a doctor who provides Jones with a lethal injection acts in a way that is morally equivalent to a doctor who nurses Jones to his death. But surely the two ends are distinguishable.

The point we need to emphasise is that euthanasia brings about a person’s death. And death brings about the end of any existing relationships with the person who has died. Induced death is incompatible with mercy as mercy does not separate but it binds. Mercy draws the most unlikely people closer together. Death interrupts the vehicle for mercy: relationship.

Mercy as Love

The act of showing mercy requires a relationship between subject and object, or giver and receiver, but not any relationship will do. Mercy requires love. Philosopher Peter Kreeft distinguishes kindness from love, where kindness is interested in the reduction of suffering as opposed to love, which wills the higher good of another in the toughest situations⁴. According to Kreeft’s distinction we can show kindness to someone by putting an end to their suffering, yet to love someone means we need to get our hands dirty and enter their humanity.

Philosopher Raimond Gaita speaks of love as a powerful tool that can reveal deeper realities about the human person. Love is revelatory. By showing love and mercy to someone, especially when they least expect it, we see them in a different light. Gaita writes, “Often, we learn that something is precious only when we see it in the light of someone’s love.”⁵ Therefore, by loving Jones

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⁴ http://www.peterkreeft.com/topics/love.htm
or by seeing that Jones is loved, we realise Jones to be a person with inherent dignity. More than this, however, by loving Jones he too may realise his true human worth.

**Mercy as Sacrifice or Joint Suffering**

There is a fundamental difference in the way we respond to Jones by providing palliative care as opposed to intentionally ending his life. The difference is qualitatively and quantitatively different. The individual who provides palliative care makes a sacrifice of himself. It means staying by Jones’ bedside, tolerating his groans and requests, seeking pain relief when it is required and providing ice for his lips when pain relief is not sufficient enough. This is accepting pain and suffering as a part of life and learning to love in spite of it. It means carrying a part of Jones’ burden. When we avoid the experience of Jones’ suffering, or are unwilling to encounter Jones in the face of his illness, our care becomes merely a series of tasks and technical activities. This sort of care is not uplifting for the patient, but neither is it for the carer. Carers who view their patients in relation, rather than in isolation, reveal not only their patient’s humanity, but also their own.

**Mercy as Promise**

Mercy is the promise to care. By establishing a covenant of trust, the carer assures the patient that he will not be abandoned in his suffering. By establishing a covenant of trust we can avoid euthanasia under duress where a patient asks to be killed due to coercion or depression. To take another person’s life intentionally is to seek to make that person solely an object, says Meilaender. It is to fail in our task to show mercy and extend our hand to the vulnerable and downtrodden. Dr. Karel Gunning, a general practitioner in the Netherlands, warns against state-sanctioned suicide by stating, “Once you accept killing as a solution for a single problem, you will find tomorrow hundreds of problems for which killing can be seen as a solution.”

**Conclusion**

The best examples of mercy reveal stories of human connection, self-sacrifice and love. What we have seen in recent years is the hi-jacking of the term “mercy” to mean things that, although motivated by good intention, lack the personal and relational aspects that true mercy requires. What is often lost when euthanasia or physician-assisted suicide is employed as a means of mercy is the human connection that reveals our innate dignity. True mercy is about responding to people who call out from the depths of illness, depression and isolation and showing them the love which our common humanity demands.

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Opinion

Understanding the Nature of Drug Addiction
By Matthew Tieu

Introduction

The attempt to understand the nature of drug addiction, why people become addicted and how to treat them raises many perplexing issues concerning the nature of free will, autonomy, self control, rationality, responsibility, justice and blame. The way we regard and treat drug addicts depends on the crucial question of whether drugs addicts are to a lesser or greater extent, in control of their drug taking behaviour. As researchers shed further light on these matters, we will gain a better understanding of the nature of drug addiction, which will mean that ethically appropriate and effective treatment practices can be implemented. Whilst we have a reasonably good understanding of the neurobiology of drug addiction, there is still much debate on whether drug addicts are properly regarded as sufficiently autonomous and thus in control of their addiction such that they can be held accountable for their continued addiction, or whether they have lost a sufficient degree of autonomy, such that they are unable to voluntarily refrain from further drug taking. In light of our current understanding of neuroscience as well as what we know about the behaviour of addicts, it is incorrect to conclude that drug addicts are not responsible for their continued drug taking on the grounds that they have significantly diminished autonomous agency.

The Neurobiology of the Addicted Mind

We now have a general understanding of the common neurobiological mechanism that underlies addiction whether they are addictions associated with particular substances or behaviours. The neurobiological basis of addiction is based on the activation of common neural systems associated with “reward”. The reward system is in place to subserve normal biological functions such as obtaining food and other resources for survival such as finding potential mates (for species survival). Activities such as eating and sex are pleasurable actions and are not intrinsically addictive, however, it is by virtue of the experience of reward that such activities can become addictive. The distinguishing feature of addictive drugs is their ability to directly, and with greater intensity, activate the brain’s reward system. Drugs known to be highly addictive such as cocaine, amphetamines and heroin directly activate the reward system, giving rise to feelings of pleasure as well as reinforcement of the behaviour that leads to that pleasure. Interestingly, behavioural addictions such as pathological gambling and sex addiction also involve activation of the reward system and related neurophysiological and biochemical pathways. This gives us a unified neurobiological theory of the addictive process.

The reward system is a highly complex system and is composed of sub components and several distinguishable neurobiological mechanisms. Reward often manifests as hedonic pleasure and motivation to seek out that pleasure as well as to avoid displeasure. Motivation is best understood in terms of affinitive versus aversive moti-

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4 For example Berridge and Kringelbach (2008) refer to three sub components of reward. Firstly, there is the “liking” component which constitutes the pleasurable impact. Secondly, there is the “wanting” component which is the motivation for reward seeking behaviour and thirdly there is the “learning” component which involves associations, representations and predictions about future rewards based on past experiences. The operation of these components involves both conscious and non-conscious processing. Berridge, K.C. and Kringelbach, M. L. (2008) Affective neuroscience of pleasure: reward in humans and animals. Psychopharmacology. 199: 457-480.
vation, where the former involves behaviour directed towards achieving pleasure and the latter involves behaviour directed away from unpleasantness. Addiction also involves the memory and reinforcement of pleasurable experiences as well as appraisal of them, combined with the aversion to the characteristic physiological withdrawal symptoms associated with particular drugs. The manner in which this process may facilitate addiction is that over time it may render an addict depressed after their high, and unable to be motivated by normal rewards, driving the intense cravings for future drug use. Conversely and somewhat paradoxically, the reward system also becomes even more sensitive to the drugs themselves. These mechanisms of tolerance and sensitivity mean that after a period of cessation, memories of past highs, cues, and small doses could elicit strong reward responses and thus facilitate relapse.

The Prefrontal Cortex (PFC) is responsible for carrying out executive functions, such as working memory, reinforcement learning, planning, adapting, inhibitory control and integration of information for goal directed guidance of behaviour. The PFC is integrated with the reward system and is involved in the encoding of reward based goals. Drug related cues and reward experiences after taking drugs can become integrated into the goal directed behaviour that the PFC is responsible for thus allowing a drug to become a valued goal above other learned goals. Furthermore, a number of studies have also demonstrated that inhibitory control is also impaired by such drug induced maladaptive changes to the PFC.

Gradually there is shift from conscious motivated seeking of drugs to a stimulus-response driven drug habit. The drug taking habit essentially becomes more ingrained making it harder to break. Combined with the characteristic withdrawal symptoms associated with particular drugs, the user develops both a psychological and a physiological dependence on the drug and finds themselves in the grips of addiction. Hence arises the popular notion that an addict’s mind has been “hijacked”. They are perhaps no longer autonomous agents who are able to have authority over their actions. Perhaps they have a disease that they cannot of their own volition overcome?

Addiction as a “Disease”

When it comes to deciding whether addicts are sufficiently autonomous to control their addiction it is important to determine whether it is indeed the case that addicts do not have authority over their drug taking habit or to put it another way, whether they lack a basic capacity for self control. Is their free will significantly diminished due to their drug addiction? The answer to this question has significant implications for how an addict may respond to their situation and how we may wish to treat them, given that a person’s beliefs will influence their subsequent behaviour. For example, believing that one is capable of flying over the edge of a cliff is detrimental given that it is indeed the case that one cannot. Though consider a corollary of this - the belief that one is incapable of passing a school exam, even though one is clearly as competent as any other person. An incorrect belief that one is helpless or that one lacks free will is detrimental. The molecular basis for this involved delta FosB, a transcription factor that may cause hypersensitivity to drugs. This is reviewed in Esch, T and Stefano, G. B. (2004) The neurobiology of pleasure, reward processes, addiction and their health implications. Neuroendocrinology Letters No.4 August Vol.25: pg. 240-41.

will can indeed be detrimental also. Hence the latter example is a detriment to oneself in a different sense than the former in that such beliefs and attitudes may give rise to what we might call “learned helplessness”\textsuperscript{10}. It is a false belief that one is incapable of performing a particular task. Essentially it means that one mistakenly believes that one’s situation cannot be resolved by use of one’s free will.

This kind of deterministic view of addiction seems to be the logical conclusion to draw from a “disease model” of addiction. Empirical research by psychologist Roy Baumeister has also demonstrated that a belief that one’s behaviour is determined, rather than being the product of free will, can give rise to a number of anti-social behaviours such as increased cheating behaviour\textsuperscript{11}, increased aggression toward others and reduced helpfulness\textsuperscript{12}. Those in this situation are less likely to think for themselves or feel guilty or responsible for their actions\textsuperscript{13}.

A disease model can also in some sense be rather seductive given that it provides a causal explanation of addiction at the level of biology or genetics, which may provide a convenient escape from personal level responsibility. Herbert Fingarette, had infamously argued against the disease model of alcoholism based on precisely such reasons. In his book “Heavy Drinking: The Myth of Alcoholism as a Disease” Herbert Fingarette describes the typical perception of alcoholism as a disease concept\textsuperscript{14}. In the 1940s and 50s this concept became widely accepted due to the influence that Alcoholics Anonymous (A.A.) had in the US. The development of alcoholism begins with apparently innocent social drinking which inevitably leads to increased involvement with alcohol. The alcoholic loses control over his drinking and cannot stop once he has started. The alcoholic eventually hits a low point that requires an enormous effort to regain his/her senses and achieve total abstinence. Thus on this concept of alcoholism, one drink leads to more and more drinks contrary to one’s volition. Inherent in this conception of alcoholism is the idea that one has total control prior to drinking, yet there is a total lack of control thereafter. However, our understanding of the nature of self control is clearly contrary to this.

\textbf{If our righteous condemnation is not in order, neither is our cooperation in excusing heavy drinkers or helping them evade responsibility for change. Compassion, constructive aid, and the respect manifest in expecting a person to act responsibly—these are usually the reasonable basic attitudes to take when confronting a particular heavy drinker who is in trouble. (Fingarette, 1989; pp 111-112)}

Furthermore, this kind of view of alcoholism prevents us from seeing the drinking within the context of the person’s way of life. It prevents us from looking at the role that alcohol plays for that person in their life, whether it is leisure, sociability or coping with adversity. As Fingarette states\textsuperscript{15}:

\textbf{The logic of the disease concept does the contrary. It leads all concerned, including the drinker, to deny, to ignore, to discount what meaning that way of life may have. Seen as an involuntary symptom of a disease, the drinking is isolated from the rest...}
of life, and viewed as the meaningless but destructive effect of a noxious condition, a ‘disease’. (Fingarette, 1985; pg. 60-61).

So the crucial question is whether addicts have a sufficient degree of autonomy and self control that will enable them to be able to overcome their addiction(s)? The answer is yes, because they still retain a very basic competence for self control. No matter how strong the cravings, how stimulus driven an addict becomes, it is not necessarily the case that this persistence of the desire for drugs and the cues that elicit those desires means that an addict would inevitably give in to those persistent desires. Why not? Addicts are able to take the appropriate measures to avoid certain people, environments and drug cues which trigger the strong desires. After all it takes self control to be able to remove oneself from an environment that is conducive to drug taking behaviour. It takes some basic competence for self control to be able to recognise that one has a problem and seek help. What this demonstrates is that the capacity for self control (diachronic – longer term self control) was always present in drug addicts. What this reveals is that the diminished self control of drug addicts is essentially no different from those who we may regard to be poor at performing tasks that require self control, but yet those are people who we would regard as fully autonomous.

Perhaps our best conception of autonomy in this debate is one which allows us to say that a drug addict is able to autonomously choose to take their drug even though they may be aware of the negative implications associated with the drug. Much like a person who, in the midst of their struggle to stay on their diet, chooses to have the extra serving of cookies, even though they know that they should not. It seems that every person’s capacity for self control can wax and wane, and the only clear cut cases where one can say that a person lacks this capacity is at the extreme end of the spectrum where a person no longer has the capacity or competence required for self control. Such persons are one’s who genuinely lack autonomous agency in a significant sense. Consider the example of Tourette’s syndrome as a condition that manifests as involuntary physical and vocal tics. There is a genuine sense in which people with this syndrome lack the basic capacity or competence to exercise self control over such behaviours.

Furthermore, it is possible for people to hold conflicting beliefs and desires whether they are conscious of such conflicts or not. So it is always possible for a drug addict to deliberate and choose of their own volition to take a particular drug even when they know there are good reasons not to. Of course over a period of time during which the addict undergoes a process of reward related learning, they can form a habit that becomes primarily a non-deliberative (stimulus-response) driven habit, much like other skills that one can acquire through experience and practice. However, this aspect of human agency and autonomy applies to all normal human beings. Therefore, despite the neurological changes that occur in drug addicts, there does not appear to be any significant difference between the autonomous agency of drug addicts and that of normal persons who belong within the spectrum of autonomous agency, some of whom are able to exercise greater self control than others.

**Upholding and Promoting Autonomous Agency**

The extant basic competence of a drug addict to exercise inhibitory control means that it is always possible for an addict to choose to avoid drug taking albeit under duress and against the tide of motivational salience of drug cues and the desire for drugs. Hence a crude disease model based on impaired autonomy or the “hijacking” of executive function does not do justice to what we understand about human agency and autonomy. However, this is not to say that we do not recognise the circumstances and developmental trajectory associated with drug addiction. Many drug addicts are people who find themselves in or have had
a history of adverse social circumstances of abuse, crime and violence.

When it comes to the question of whether addicts are blameworthy in any legal or moral sense we can take into consideration the possibility that there may be mitigating circumstances. We already do take diminished autonomy seriously when it comes to justice. After all, we grant that diminished capacity to control one’s conduct can be used in arguments for mitigation in criminal law. However, even if we were to conceive of drug addiction as a disease, this does not imply that the disease exculpates them. Perhaps as Voh’s and Baumeister have proposed, we need to formulate a slightly more nuanced notion of a “disease” model of addiction:

If a disease model for addiction is to be retained, we suggest abandoning the virus or germ models in favor of something more like Type II diabetes. One does not become infected with diabetes. Rather, a natural bodily vulnerability becomes exacerbated by experiences, many of which are based on personal choices. (Voh’s & Baumeister, 2009; pg. 234)

On this view however, personal responsibility is retained and thus the appropriate treatment measures can be encouraged which therefore ought to focus on abstinence and the promotion of self control as Eric Matthews states:

Conscious choice can, however, lead to the correction of a moral disorder that was originally not consciously chosen. Therapy for such disorders would take the form of helping the sufferer to make such choices by informing him or her of what the good life for a human being is like. (Matthews, 1999; pg. 208)

Without entering into the traditional discussions of what constitutes “the good life”, it is clear that the importance of the constituent elements of, and one’s development within, one’s social environment, is crucial for successful recovery from addiction and a return to the “good life”. Having something to do, having alternative healthier goals – both long and short term, as well as having the opportunity to train oneself to stay on track with one’s goals in spite of temptations to stray, is the kind of treatment that is the most ideal for it is what upholds a person’s autonomous agency. However, as Dalrymple has poignantly stated, “it is easier, after all, to give people a dose of medicine than to give them a reason for living. That is something the patient must minister to himself”.

As bioethics increasingly turns its philosophical attention to the expanding territory of medical killing – euthanasia, assisted suicide, eugenics, abortion – it is helpful to consider the psychology of traditional killing in combat and society. Lieutenant Colonel Dave Grossman is a former army Ranger, paratrooper, psychology teacher and Military Science Professor in the United States, a combination that renders him eminently suitable to be an expert on what he has termed ‘killology’. His book *On Killing* was published in 1995, and for bioethicists and many others it still warrants attention even fifteen years later.

What this book is not about is the ethics of war and killing. Interestingly, he uses the word ‘murder’ throughout the book, implying that killing in combat is not a lesser kind of killing, even in self-defence. But he never condemns soldiers; “If … the reader senses moral judgment or disapproval of the individuals involved, let me flatly and categorically deny it.” (Pg. xxxii)

*On Killing* explores in vivid detail the psychological cost on Western society of training soldiers to kill. This cost includes the trauma experienced by soldiers and their families, and the broader effect on society at large.

Soldiers, it turns out, don’t find it easy to kill. There is a great natural resistance against the killing of fellow human beings. This resistance is so strong, in fact, that recent military field studies have shown a stunning fact: less than ten percent of untrained soldiers fire their guns. (Pg. xxxiii)

Of these men, Grossman accepts his own mixed emotions. “As a soldier who may have stood beside them I cannot help but be dismayed at their failure to support their cause, their nation, and their fellows; but as a human being who has understood some of the burden that they have borne, and the sacrifice that they have made, I cannot help but be proud of them and the noble characteristic that they represent in our species.” (Pg. xxxiii)

Modern militaries have invested much time and money to remedy this situation, bringing a trained soldier’s shooting rate close to one hundred percent at the time of writing. The important point here is that soldiers need to be trained to kill. Their natural inhibition needs to be destroyed so that they can be recreated as a killing machine.

There are many mechanisms that enable the modern soldier to kill more effectively. Grossman spends a lot of time showing these mechanisms which are only briefly mentioned in this review. Training methods to deconstruct the soldier and dehumanise the enemy are key; bayonette charges into bags filled with offal (even though bayonettes are rarely any longer used in combat), marching to aggressive chants, violent video simulators. The demands of authority in a military command structure effectively lower inhibition to kill, particularly in training when one has a sergeant screaming at you to “kill, kill, kill”! Grossman also discusses the predisposition of the killer (is he trained or a natural killer?), the attractiveness of the victim and what one stands to gain by killing the enemy. He explains the importance of operant conditioning based on B. F. Skinner’s research.

The role of changing combat and military technology is an important theme – but importantly, not the central one. Modern technique has allowed great distances to separate the killer from the victim and now most combat occurs from rifle distance or farther. The natural inhibition of killing a fellow human is shown to have a direct association with the distance from which one
has to kill. Our humanity, particularly in the image of our eyes and face, implores other humans to respond in love and the soldier must resist. This is why, for example, American soldiers are taught to remove their helmets if captured. It also explains why an attacker who turns and flees from his enemy is much more likely to be killed by being shot in the back.

Accordingly, ranged weapons were an evolution of warfare much favoured by soldiers, since they removed the soldier from the enemy. The quick uptake of both the bow and arrow and later, the rifle, are the immediate historical examples. With the greater use of bombs and rockets to destroy the enemy, even bombing civilian populations becomes possible. The distance factor enables a soldier, while he logically knows the end result of what he is doing, to deny the humanity of the enemy. The bombadiers in World War II did not have to hear the screams of civilian men, women, and children as they obliterated London, Dresden, Hamburg, Tokyo and Hiroshima. Artillerymen, bomber crews, and naval personnel have little difficulty with killing. They are able to internally deny what is actually happening.

The demands of authority and group absolution are concepts that make sense. When someone commands a group of men to commit the murder of another group of men they are able to mutually commit such deeds without personally feeling completely responsible. This group absolution does not suggest that the men feel no guilt. It is simply a coping mechanism to help absolve themselves of the large of amounts of guilt they are in fact shown to feel. Rather than something “I” did, it is easier to cope with the guilt of murder committed by a group when conceptualised as something “we” did.

Readers of the Boomer generation may be especially challenged by Section VII which recounts and analyses the experience of soldiers involved in the Vietnam War. This particular chapter is gentle and objective, yet gripping, arousing confusion and grief regarding a situation that many readers will never before have considered. The unique circumstances and politics of the Vietnam War resulted in up to 1.5 million Vietnam vets suffering from Post Traumatic Stress Disorder (PTSD) in the USA.

Why? Among many factors, Grossman explains that the rationalisation of killing failed in that war. As just one example, he quotes a former Vietcong agent who said, “Children were trained to throw grenades, not only for the terror factor, but so the government or American soldiers would have to shoot them. Then the Americans feel very ashamed. And they blame themselves and call their soldiers war criminals.” (Pg. 267). Grossman observes: “it worked.” (Pg. 267)

Comparing the Vietnam War with World Wars I and II, Grossman offers a defense for the Vietnam Veterans of whom he writes that “never in American history, perhaps never in all the history of Western civilisation, has an army suffered such an agony of many blows from its own people.” (Pg. 280) And silently a gauntlet is thrown down to all of us. Do we hate killing because we love humanity? If we love humanity, can we hate killers? Do humanists hate the military, or only the politicians who send the military? Perhaps they only hate war criminals? While most agree that killing is wrong, war is a vexed topic. How can we make sense of it? Grossman’s own unconcealed discordant emotions give his book a unique authenticity.

The final section is entitled Killing in America: What are we doing to our children? This concerns every one of us by questioning the movies, role models and video games that have become ubiquitous in modern Western culture. Once used as techniques for desensitisation of soldiers, these are now routine forms of entertainment.

Grossman tries to answer the question of whether rising assault and murder rates are linked to rising levels of violence in television, films and computer/console games. In short, are we making a society of killers? Is society looking critically at media violence
and its effect on society, or being blindly complicit?

It has become clichéd to blame the media for violence but Grossman’s case is persuasive. He suggests that younger generations have learned to associate scenes of violence with soft drink, junk food, pleasure, and intimate contact with one’s date. He points out that the implicit social pressure not to avert one’s eyes or look away during scenes of horror and cruelty is a mechanism similar to a head clamp a la A Clockwork Orange.

He advocates for the censuring of violence by various means, stopping short of censorship. Grossman strikes out at the creators and marketers of violent images: “They participate in a diffusion of responsibility by referring to themselves as ‘the tobacco industry’ or ‘the entertainment industry,’ and we permit it, but they are ultimately individuals making individual moral decisions to participate in the destruction of their fellow citizens.” (Pg. 330) Pointing once again to man’s natural inclination not to kill, he offers hope and strategy for social recovery.

Grossman wants society to learn how to put the psychological safety catch back on, to restore our natural resistance to killing. Most healthy people find the subject of killing to be repulsive and offensive, yet Grossman insists that we must face it if we are to understand and control it. This book, a highly informed, balanced and human account of the psychology of killing, is price-less for those who honestly seek to understand killing and war without the politics and rhetoric.