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Disability and the Complexity of Choice in the Ethics of Abortion and Voluntary Euthanasia

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In the polarized debates about abortion and voluntary euthanasia, disability advocates, who normally align with left-wing social forces, have tended to side with conservative and religious voices in expressing concerns about the impact of technological and sociopolitical developments on disabled futures. This paper draws on the social model of disability and the virtue ethics tradition to explain the alignment between the religious and disability perspectives, and the theory of transformative choice to highlight the limits and biases of the pro-choice logic. Yet, it also recognizes the inherent contradiction of disabled advocates taking a paternalistic position against the personal agency of women and people facing terminal illnesses. A disability perspective serves the discussion of abortion and euthanasia as an encouragement to work together for the building of a society that enables people with diverse disabilities to exist and flourish, and helps pregnant women, people facing disabling and terminal illnesses, and politicians and social influencers to make informed choices.

***Keywords**: eudaimonia, prenatal testing, pro-choice, pro-life, transformative choice*

I. INTRODUCTION

The 2017 decision by the Victorian Parliament of Australia to legalize voluntary euthanasia is likely to be the first step in the inexorable move toward its legalization nationally. Polls suggest that most Australians support the decision (Cartwright, 2017), and there is a growing intolerance toward those who dissent, who are presumed to be backward-looking, right-wing, religious conservatives. As euthanasia campaigner Andrew Denton puts it, a "subterranean Catholic force of politicians and businessmen" is thwarting the will of the compassionate majority (Edwards, 2016). There is another group of dissenters who is mostly unnoticed; disability advocates who are anything but right-wing. Religious conservatives and people with disabilities also join forces around the fraught issue of abortion. What has brought this strange partnership about? Where are their points of departure?

This article outlines the disability perspective on beginning- and end-of-life ethics, and identifies the ways in which it merges with the religious view, as well as its vital differences. The disability perspective has been set out previously, but this article adds to the earlier literature by drawing on the philosophical notion of transformative choice—the idea that certain life changes reshape our preferences (Paul, 2014)—and the logic of the virtue ethics tradition to explain why it is imperative that nondisabled people listen to the disabled voice. The aim is to show that the disability perspective helps to clarify the deeper ethical insights of both pro-life and pro-choice positions and, therein, reveals the complexity and consequences of our personal and public decisions about abortion and voluntary euthanasia.[1]

II. ABORTION

The pro-life and pro-choice arguments for and against legalized abortion are so well known, there is no need to flesh them out here. It is important to note, however, that both positions are too often simplified and caricatured. Pro-life is generally taken up by religious traditions, who argue that life, which is God's to give and take, is sacred and begins at conception. What is not often appreciated is that religious texts rarely address modern concerns; abortion is not mentioned in the Hebrew or Christian scriptures, and neither can they tell us the moment in which the fetus is deemed a fully human person, rather than a potential person since ancient people had little knowledge of embryonic development (Eberl, 2005). As a result, there is a wide range of opinions between and within religious traditions (Gorman, 1996; Simmons, 1996; Schiff, 2002; Haldane and Lee, 2003; Barilan, 2009; Bowen, 2009; Damian, 2010; Castuera, 2017). Even among those who agree that abortion is wrong, there is a variety of responses as to how this should be addressed in the public and political realm. Many religious adherents that would judge themselves pro-life do not focus their attention on divisive politics, instead of using their voice to highlight the meaning of pregnancy, the importance of family, and the value of every person—including the vulnerable fetus (Hauerwas, 2001). But, it is not surprising that many people whose faith leads them to conclude that abortion is murder respond with passionate pro-life advocacy.

While pro-choice garners support from many varied perspectives and communities, including religious voices, it is feminists who have taken the lead in pro-choice advocacy, arguing that it is women who bear the responsibility of pregnancy, and who often carry most of the burden of raising children, yet religious and political decisions about abortion are mostly made by men. Noting the perils of unsafe abortion, and the positive impact on women's lives and health that has followed its legalization worldwide (WHO, 2008; Benson, Andersen, and Samandari, 2011), they insist that making abortion illegal kills women and that legalization saves lives; that pro-choice is also pro-life. Feminists have also highlighted the hypocrisy surrounding the politics of abortion, noting that the conservative, right-wing lobbies that seek to make abortion illegal are often opposed to the social welfare systems that would provide support to women facing difficult decisions about their capacity to raise a child. From a feminist perspective, you cannot separate abortion from the complex and often difficult personal circumstances of women who find themselves with an unwanted pregnancy, nor from the broader issues of paternalism and social justice that too often rob them of the capacity to make choices about their own future (Sherwin, 1991; Cannold, 2001). The feminist position is caricatured if it is seen to make light of the fetus and of the moral challenge of abortion. On the contrary, it is precisely moral complexity, and a woman's capacity and right to negotiate that complexity, that motivates pro-choice advocacy (Peters, 2014).

III. DISABILITY PERSPECTIVES ON ABORTION

Amid this fraught debate, people with disabilities are appropriated by both sides. Pro-choice advocates commonly cite fetal impairment as a reason for abortion. Pro-life advocates draw on the positive narratives of disability to add weight to their view that the impaired fetus is as fully human as any other, equally deserving of protection. This latter view has obvious resonance with the outlook of people with a disability, but they find themselves in a bind. For the most part, disability politics is aligned with the left, as an ally of feminism. It rejects paternalism and prioritizes the right of disabled people to choose for themselves the shape of their own future. It shares this pro-choice orientation with feminists and draws on feminist theory and strategy in making its case. And, though disability politics appreciates the pro-life affirmation of the value of the disabled person, it rankles to be used as a political tool by some right-wing activists who too often reject the social supports needed for individuals with disabilities to flourish in a world that is ill-fitted to their impairment after birth (Jesudason and Epstein, 2011; Giric, 2016, 739)—just as it rankles to be used by some left-wing activists who use the "horror" of disability as a reason for supporting early and late-term abortion.

Developments in the science of prenatal testing are responsible for bringing disability to the forefront of the abortion debate. Now a routine procedure, prenatal testing proceeds on the implicit assumption that giving birth to a disabled child is a tragedy, parenting a disabled child is a burden, and that the disabled life is not worth living. From this perspective, it seems obvious that the discovery of an impaired fetus should result in termination; "that once a prospective parent knows of the likely disability of a future child, there is nothing else to know or imagine about who the child might become: disability subverts parental dreams" (Jarman, 2015, 50). Prenatal testing is always in danger of reducing the image on-screen to a clinical diagnosis and prescribing a medical procedure as the solution. Now whatever judgments are made about the beginning of life, the impaired fetus is always more than its diagnosis.

In response, some disability rights advocates argue that prenatal testing, as currently practiced, is a form of eugenics that intends to eliminate certain categories of disabled people, that is, those with genetic impairments that can be tested for, such as Down syndrome, spina bifida, cystic fibrosis, some forms of deafness and blindness, and so on (Saxton, 2013). As Ruth Hubbard notes:

> Scientists and physicians . . . are once more engaged in developing the means to decide what lives are worth living and who should and should not inhabit the world. Except that now they provide only the tools, while pregnant women themselves have to make the decisions, euphemistically called choices. (Hubbard, 2013, 82)

The argument has been criticized as reading too much systemic intent into ad hoc scientific developments that are motivated, not by hatred of disability, but the desire to minimize human suffering (Shakespeare, 2014, 115). To the medical profession, it is a given that it should do what it can to eliminate or minimize the hardship of disability, a logic evident in the encouragement of pregnant women to avoid substances known to put the fetus at risk, such as cigarettes, alcohol, and drugs. The fixing of impairment, or minimizing of its impact, is taken to be medicine's raison d'être, a position that seems uncontroversial until we encounter people with disabilities who have flourished and are thankful for their life. Many people in the deaf community, for example, understand their inability to hear as a gift, because it embeds them in rich, deaf culture (Blume, 2009; Sparrow, 2010). Many people with Down syndrome and their families are likewise grateful for the rich experience of living with disability. Many people born with testable disabilities are thankful that tests were not available at the time of their conception, or that their parents decided to ignore the social pressure to terminate. To them, prenatal technologies seem aimed not at the minimization of suffering but at testing disability out of existence (Kafer, 2013, 23).

Such claims seem hyperbolic, especially since abortion following prenatal testing is framed, not as compulsory, but as a mother's choice. Yet, the rhetoric of choice fails to consider a person's social situation and socialized ableism (Yong, 2007, 163–6; Kafer, 2013, 161); that choice "is made under duress. Our society profoundly limits the choice to love and care for a baby with a disability" (Saxton, 2013, 96), as is readily apparent in the impact of testing for particular disabilities. For example, in Iceland, noninvasive genetic testing is said to be on the way to "eradicating" Down syndrome (Quinones and Lajka, 2017), and in many other counties the majority of fetuses diagnosed with this disability are now aborted (e.g., 93% in Australia [Maxwell, Bower, and O'Leary, 2015], 67% in the United States [Natoli et al., 2012]). While the impact of testing is partly offset by the increased incidence of Down syndrome resulting from increases in the average maternal age (de Graaf et al., 2017), given the earlier assertion that disability is co-opted by the left and the right, it is noteworthy that reporting on the data about Down syndrome abortions and births is often shaped by preexisting commitments.

In any event, the reason testing inevitably leads to increased termination is that nondisabled individuals are poorly equipped to imagine disabled lives. Reflection on the nature of choice can help us to see the difficulty. The choice about whether to go ahead with a pregnancy is transformative. Paul (2014) describes a transformative experience as one that changes a person epistemically. It changes their understanding of the world, their subjective perspective, and their preferences. Some transformative experiences, such as the incurrence of a spinal cord injury, are a matter of chance, beyond an individual's control. For most of human history, the decision about whether to raise a disabled child was of this type (assuming infanticide is immoral, a view that Peter Singer [2011, 151–4] infamously rejected in the case of a disabled newborn). The development of accurate prenatal testing now presents a pregnant woman with a transformative choice, and her difficulty is that she cannot know the effect of such a choice on her worldview and preferences prior to living through the transformation. As one mother observed, "If I had had amnio[centesis], I would have terminated, and I would have missed out on what has been not only the most difficult but also the most enriching experience of my life" (Solomon, 2013, 171).

The choice to have a child is inherently transformative, especially so if the fetus presents with an abnormality. The choice to continue with the pregnancy of a child with Down syndrome will lead to a life very different from the choice to terminate and try for an unimpaired child, so much so that the choice can create a radically different future, populated by transformed people, whose outlook, preferences, and experiences will be worlds apart from their former self. Few people have any reference point for living with disability, and fear and uncertainty about its challenges thus loom large. When fear meets the medical presumption that living without a disability is better than living with one, then, barring the intervention of some external factor such as religious faith, the choice to abort is almost inevitable. There is no meaningful choice.

Nondisabled people are generally unaware that people with disabilities report to be living good lives; that disabled people are as happy (and as sad) as everyone else (Clifton, 2018, 95–118). Indeed, there is a tendency to underestimate the functional capacity of disabled people, overestimate their suffering, and ignore the love and joy experienced by the families and friends with whom they share their lives (Saxton, 2013). More broadly, mainstream culture fails to appreciate the rich contribution made by the diversity of people with disabilities to the flourishing of local communities and the broader society. The shared negotiation of our limits and vulnerabilities is "a natural binding force in society," empowering creativity and life, rather than detracting from it (Hockenberry, 1995, 257). While we need to be careful not to romanticize disability, nor forget that some impairments are more difficult to live with than others, ungrounded fear of disability is more likely than its romanticization.

Reflection on the meaning of happiness can help to clarify precisely why disability is not antithetical to the good life. Recent studies of happiness in the psychological sciences (such as Seligman, 2012) have drawn on the Aristotelian virtue ethics tradition (Aristotle, 2011), asserting that happiness (*eudaimonia*) is not short-term pleasure but, rather, whole-of-life flourishing. A person flourishes when she lives well, when she fulfills her potential and lives meaningfully and for others, when the story of her life, through all its joys, hardships, successes, and failures, is good. To achieve that end, she will need to exercise virtues, which are habits of character that facilitate success; dispositions such as courage, self-control, prudence, generosity, patience, truthfulness, justice, and the like. In the context of decisions around abortion, the virtue ethics tradition moves us away from absolutist ethical demands and black-and-white debates about legislation, and invites us to think about what it means for both individuals and our broader society to flourish (Hursthouse, 1987). Far from being antithetical to happiness, disability provides a context within which the deep things of life can be fully realized (Clifton, 2018). In all its wondrous diversity, the beauty and meaning of life are discovered in the exercise of virtue to negotiate the challenges of our physical and sociocultural environment. While it would be silly to argue that a disabled life is the best life per se, people with disabilities insist that it is equally mistaken to make the same assumption of a nondisabled life. Disability need not be a barrier to happiness, but the impetus for its attainment. This is not to suggest that a person or a parent deliberately seeks out disability but, rather, that when faced with a prenatal test that indicates impairment, they recognize they face a transformative choice and open their minds to the potential joys of a disabled future (Manninen, 2015).

IV. THE SOCIAL MODEL OF DISABILITY AND ITS ANALYSIS OF PRO-CHOICE AND PRO-LIFE POSITIONS

Does this mean that crip advocates (a label reclaimed as a term of political power—Kafer, 2013) should join forces with pro-life lobbyists and take a stand against prenatal testing and legalized abortion? The answer will depend on the ethical horizons of the individual; the disability community is diverse and constituted by religious and nonreligious voices, so that there is no single disability outlook. Generally, disability advocates do not seek to make abortion illegal, aware of the importance of a woman's right to self-determination, and the complexity of disability—that some disabilities are harder to live with than others.

The pro-life position also shares a fundamental problem with the pro-choice view. Both are predicated on an individualist, medical model of disability. The medical model identifies the problem of disability as being with the individual, a problem that in the context of the prenatal discovery of an impairment is currently thought to have only two solutions: (1) by termination (pro-choice), or (2) by declaring the fetus sacred, and protecting that individual through legislation that sets the life of the fetus against a mother's right to choose (pro-life). The social model of disability, in contrast, recognizes that a person's life is socially constructed, and that disability is not just a product of impairment, but of a social and cultural environment that is shaped to exclude people whose physical and intellectual function is different from the (arbitrarily defined) norm. The social model of disability enables fresh analysis of both pro-life and pro-choice advocacy.

Pro-life advocacy too often fails, even under its own terms, because it concentrates on the life of the fetus without paying adequate (or any) attention to its social context before and after birth. The very idea that it makes sense to legislate against a mother's choice makes this plain. If a pregnant woman does not want a child, or, more likely, cannot imagine a positive future with that child, whether it is impairment, poverty, personal capacity, or mere preference informing her perspective, legislation cannot protect the fetus. This is apparent in the WHO data that shows that rates of abortion remain much the same in countries in which it is illegal as they do in places where the procedure is readily available. The only difference is that in the former case, women who undergo an unsafe abortion risk their health and even death. And since pro-life advocates should be as concerned about a pregnant woman's life as they are about that of the fetus, this reality cannot be ignored.

The social model of disability challenges pro-life practice, not by denying the value of the fetus, but by insisting that its identity is socially located. If pro-life advocacy is more than mere political rhetoric, then its goal cannot be primarily legislative, but, rather, to make it possible for women who become pregnant to imagine a bright future. If, for example, a woman is told her baby has an impairment, she will need to be able to see that bringing it into the world is a wise, life-enhancing choice for the child, for its siblings, and for her. Given she faces a transformative choice about a life that she cannot yet envisage, she will need to hear the voices and stories of people living with disability to see that they and their families can flourish.

More substantially, meaningful pro-life advocacy involves creating a socio-cultural environment that includes and values disability, and that addresses the problems of poverty and racial injustice that leave many women with the invidious choice of bringing a child into an unfriendly world or going through the trauma of abortion. Pro-life advocacy needs to look beyond the birth of a child toward the creation of a just and equitable society. In the context of disability, this will include the implementation of social welfare systems and equity and inclusion structures that are too often opposed by conservative politicians. If the choice to have an abortion is understood as a complex interaction between a woman's personal and social context, then understanding, grace, and support are the only appropriate response to women who choose termination. Women make their decisions based on how they envision the future, and we have yet to create societies where disabled flourishing is easy to imagine.

Crip advocates and pro-choice feminists share a critique of paternalism and look to reshape the world to empower all people to be able to choose their own future. Crip justice cannot reject reproductive justice without the charge of hypocrisy, especially since the history (and present experience) of disability is rife with presumptive practices that rob people with disabilities of the opportunity to choose to become parents (Llewellyn et al., 2010). But, disabled people have good reason to be concerned about the pro-choice agenda, given its present trajectory is to create a future without them. Pro-choice advocacy too often fails, because it also individualizes a pregnant woman's choice. It is true that a person has the ultimate right to make decisions concerning her own body, but no choice is made in isolation. As things currently stand, women are given the mirage of choice, yet they are forced to carry its weight on their own, when in fact the medical system and socio-cultural environment directs (and controls) that choice, while offloading its burden onto women.

Some crip activists have argued that the way to protect a woman's right to access a safe abortion while ensuring disabled futures is for public policymakers to set a limit on what tests are undertaken, or to make abortion illegal for particular impairments (as has been implemented or debated by some US states ("Abortion Bans in Cases of Sex or Race Selection or Genetic Anomaly", Guttmacher Institute, 2018). Just as concerns have been raised about testing that would allow for "designer babies" (consider the bioethical dilemmas explored in the movie *Gattaca* [Berube, 2013]), disability rights campaigners have argued that disability is a neutral trait that should not be designed away. In the late 1990s, when the technologies of testing were first coming to public prominence, the Hastings Center bioethics research center in New York convened a 2-year project bringing together scholars from disability studies and professionals in medicine, genetics, and the humanities to discuss the issue, and while participants came to appreciate the concerns of the disability community, most found the argument to limit testing unconvincing when set against a woman's right to make informed choices (Parens and Asch, 2000). Even those few participants who envisaged a public policy position that drew the line at testing for certain disabilities could not agree on where that line might be drawn. Two decades on, prenatal testing technology and usage have advanced past the point of no return. The knowledge gained from testing is now recognized as being inseparable from a woman's right to choose, and so routine is testing that most pro-life women participate, recognizing that knowing as much as they can about the fetus helps them prepare for its arrival. In respect to potential legislation preventing abortion for certain identified disabilities, the fundamental problem remains; even if the community could agree about which impairments warrant protection (which is doubtful), there is very little evidence that legislative measures are effective in forcing women to keep fetuses against their will.

That prenatal testing will continue does not mean that the disability critique is invalid. On the contrary, the social model of disability unmasks the biases of the medical profession in the delivery of its prenatal diagnostic practices. If the disabled perspective is taken seriously, medical professionals will need to have the humility to admit that they do not know much about disabled lives (the virtue of humility is sorely lacking in the medical and scientific disciplines) (Clifton, 2018, 195–202). Disability, including the difference between the medical and social models, should be a central part of the training of all professionals involved in prenatal testing. Thereafter, prospective parents need to be helped to understand that life with disability can be good, that along with its complications and challenges (which are common to every life) comes the opportunity for love and joy (which is also common to most lives). This is best accomplished by actively encouraging prospective mothers who learn about a fetus' impairment to access information about support services and, where possible, meet with disabled people and hear their stories (Jarman, 2015, 51). Such an approach will not make their choice easier (transformative choices are inherently difficult), but it will enable them to imagine the possibility of flourishing with disability, and thus present them with a real choice—without which, pro-choice rhetoric is empty.

The social model of disability also challenges pro-choice advocates to be more thoughtful about their usage of disability in the furthering of their agenda. It invites them to recognize the social nature of choice; to acknowledge that families and communities raise children, or choose not to do so, together. Thus, while women will need political support to protect their right to have a safe abortion, they also need political support to be able to choose to bring a disabled child into a world that values its existence and is structured to enable it—and its mother and family—to flourish. This is a goal that pro-choice shares with pro-life, at least by those for whom life and choice are more than political expediency.

It is beyond the scope of this paper to examine the extent to which the disability perspective is included in the delivery of prenatal testing throughout Australia or globally. But by way of illustration, it is noteworthy that in my home state, the NSW Government Health Centre for Genetics Education includes fact sheets on various genetic conditions for which there is prenatal testing, and none of them provides information that reflects the insight of the disability community (Centre for Genetics Education, n.d.). The brochure on Down syndrome, for example, describes the condition and its complications in detail, with the only hint to the possibility of a rich life lived with the disability being the statement that "while intellectual disability is a feature of Down syndrome, most children are able to learn and develop at their own pace" ("Fact-Sheet-36-Trisomy-21-Down-Syndrome.pdf", 2016). There is no suggestion that a person contact Down Syndrome Australia for information about the stories and perspectives of people with the disability. The brochure leaves the reader with the overwhelming impression that the wisest course of action is termination. In another 30-page booklet entitled "Diagnosis of abnormality in an unborn baby," there is a detailed discussion of the nature of testing and the potential discoveries, but apart from a reference to Down Syndrome Australia as a potential resource, this lengthy document provides no details of life with a disability ("Diagnosis of Abnormality in an Unborn Baby: The Impact, Options and Afterwards", 2006).

V. VOLUNTARY EUTHANASIA

Abortion and voluntary euthanasia pose unique ethical issues, but they overlap at key points, including in the alignment between religious voices and disability activists in opposing libertarian free choice advocacy. Given the ground already covered, my intent is not to provide a comprehensive analysis of voluntary euthanasia, but to continue the focus of the previous section on the disability perspective, virtue ethics notions of flourishing, and the dilemma of transformative choice to see whether these add clarity and facilitate points of contact between polarized views.

As with abortion, the religious case against voluntary euthanasia is based on the sanctity of life; that life is a gift from God, so that decisions about life and death are God's alone. There is greater consistency among the differing religions on the ethics of euthanasia than there is with abortion. This is because exactly when life begins is debated, but at the time when decisions about death are voluntary, there is no debate that a person is alive. Thus, at least formally, most religions judge voluntary euthanasia as suicide or state-sanctioned murder, and people committed to religious beliefs generally oppose legalization (Sikora, 2009; Jason, 2016; Chakraborty et al., 2017; Cherry, 2018; Ahaddour, Van den Branden, and Broeckaert, 2018).

By contrast, advocates for legalizing euthanasia emphasize a person's right to self-determination, so that a competent person, informed of her diagnosis and treatment options, has the moral right to avoid suffering and indignity by choosing the time and manner of her death.

Although the libertarian position is normally free from any metaphysical claim, it is noteworthy that theological arguments can be made to support it. That life is a sacred gift does not do away with human responsibility and self-determination, since divine action is normally thought to establish human responsibility rather than override it. Just as human action prolongs life—and in so doing sometimes creates the situation where voluntary euthanasia becomes desirable—so can it be argued that "the all merciful God, who has given men and women freedom and responsibility for their lives, has also left to dying people the responsibility for making a conscious decision about the matter and time of their deaths" (Küng and Walter, 1995, 37–8).

As with abortion, if it was just a matter of freedom of individual choice, most of the nonreligious voices within the disabled community would be onside. The right of every individual to decide his own future is the foundation of disabled advocacy. But, the religious position, that all human life is valuable and sacred, also resonates strongly with disabled people. Throughout history, people with disability have been judged as subhuman. Crip advocacy insists they are as valuable as any other person. The legalization of voluntary euthanasia once again sends a signal that some lives are not worth living. It is the same assumption that lies behind prenatal testing, and its echo is heard in the celebration of the suicides that continue to accompany Hollywood's presentation of disability; in Andy Serkis' *Breathe* (2017), Jojo Moyes *Me Before You* (2016), Darren Aronofsky's *The Wrestler* (2008), Clint Eastwood's *Million Dollar Baby* (2006) to name but a few ("Bury Your Disabled", n.d.; Clifton, 2016, 2017; "Media Roundup of Me Before You Criticism", 2016; Tischer, 2017).

Proponents of legislative change are often surprised by the crip position, and insist that legalization of voluntary euthanasia has no implications for people with disabilities. They promise that safeguards are in place to ensure that legislation is not coercive and that it excludes disability, but most in the disability rights movement do not believe the promise. Gregor Wolbring (1998) summarizes their perspective:

> We believe that as long as disabled people are viewed as a suffering entity, as an object of charity, as a life not worth living, we cannot accept the broadening of our access to death.
>
> We believe that the legalization of euthanasia will force people to be euthanized in a misbegotten effort to do the right thing: save their loved ones from financial ruin,

> remove family members from the care taker role, cease to be a burden on the state. In a time where the percentage of elderly people is increasing and governments are reducing health care budgets and more and more people are without a circle of friends to support them, people find themselves facing the societal reality: that there is a decreased willingness to provide social and economic support. The British Medical Journal reported on 29 October 1994 that, "People in Britain are more likely to request euthanasia to avoid being a burden on their relatives than because they are in pain."
>
> We believe that euthanasia is another technique to free society of unwanted members of society, among them disabled people, and another expression of the ableism in western societies.

Part of the difficulty is that there is no consistency in the legislation submitted to parliaments. In Australia, for example, there were 51 separate (failed) bills submitted to national and state parliaments prior to the bill that passed in Victoria in 2017 (Stackpoole, White, and Willmott, 2016). While these bills shared an underlying logic, each was unique, and the protection they offered to disability varied from one bill to another. On a purely practical level, disability groups do not have the power, influence, and resources to respond to every bill, and even if they accomplished the task, it is inevitable that legislative change will follow. "Euthanasia creep" describes the attitudinal and legislative changes that occur as voluntary euthanasia is normalized, and the social pressure to "volunteer" for death increases (Although evidence for whether this occurs varies, see Boer, 2003; Lewis, 2007; Jason, 2016, 238.)

One of the failed bills submitted to the South Australian Parliament in 2011 permitted voluntary euthanasia for "an illness, injury or other medical condition that irreversibly impaired the person's quality of life so that life had become intolerable to that person" (Stackpoole, White, and Willmott, 2016, 36). This would have allowed a person who incurs a serious spinal cord injury to volunteer for termination. Given the prevailing cultural assumptions about the horror of living with quadriplegia (reflected in Hollywood), many would judge this a reasonable provision—notwithstanding the overwhelming evidence that, although thoughts of suicide are common in the early years of adjusting to a spinal cord injury, most people rebuild their lives and live well over the longer term (Clifton, Llewellyn, and Shakespeare, 2018). Faced with the possibility of ending a life that seems intolerable, people would be confronted with a transformative choice. Enculturated under ablest norms, they could not know that living with quadriplegia will transform their outlook, and that a future self is likely to come to the realization that life is good; that suicide would have been a misguided choice.

The recently passed Victorian legislation has stricter qualifying conditions, under which:

> A person is not eligible for access to voluntary assisted dying if they have a mental illness only, or if they have a disability only. Those with a mental illness and/or a

> disability, however, are not precluded from taking part if they also fulfil the eligibility criteria. (Otter, 2017)

Now there is nothing preventing euthanasia creep, which might occur even without legislative change, as doctors and the wider community come to interpret legislation according to cultural norms. Even the definition of a terminal illness is potentially fuzzy, with many disabled people living with conditions that can be defined as terminal and incurable, such as cystic fibrosis, muscular dystrophy, multiple sclerosis, and high-level quadriplegia. It may be that legislative frameworks give a clearly defined definition of terminal, such as the expectation for death to occur in a relatively short timeframe. Notably, disability tends to blur boundaries, and real-world judgments about defined terms come to be interpreted according to prevailing cultural prejudices.

Most crip advocates do not trust politicians to keep people with disabilities safe. As with disability and abortion, nondisabled people, including politicians, libertarian advocates, and medical professionals responsible for the carriage and implementation of euthanasia practice, do not have the experiences or relationships to imagine living well with a disability. I understand the difficulty because until I had the (involuntary) transformative experience that left me with quadriplegia, I too thought a person living with the injury would be better off dead. In a world in which we have learned to control and minimize much of the esthetic, physical, and psychological vulnerabilities that go with finite embodied existence, one in which we sequester the indignities of sickness, aging, and disability out of view, much of the impetus behind euthanasia comes from our failed imagination and the fear it engenders.

The phrase "dying with dignity" is telling here, because it suggests that what lies behind the push for euthanasia is not so much the desire to avoid pain, which is an inevitable part of every life, but the fear of meaningless pain. It is a fear that may be grounded in the inadequacy of our imagination. Again, I can draw on the virtue tradition to make my point. Eudaimonia is earned in negotiating the ups and downs of life, especially in dealing well with its challenges. Encounters with disability and illness are among the greatest of challenges we can face, yet they also present opportunities for developing personal meaning, strengthening familial and friendly relationships, and exercising virtue. Thus, disability and illness are not necessarily in opposition to happiness, but present the contexts in which it can be found. This is not to suggest that euthanasia cannot be experienced as meaningful, relational, and virtuous, enacted courageously and compassionately, but to counter the prevailing cultural attitude that suffering must be avoided at all costs. Significantly, people with disabilities argue that the risk of sociocultural pressure to terminate their lives is too high a price to pay.

The case for voluntary euthanasia is framed as being about the freedom of an individual to choose, but the social model of disability reminds us that individual choices are limited by social horizons. In an ideal world, when disabled people are no longer viewed as objects of charity living harsh and pitiable lives, they might “accept the broadening of our access to death” (Wolbring, 1998). However, that is not the world we live in, so disability rights campaigners tend to side with those who say that advances in palliative care now render arguments for voluntary euthanasia obsolete. Whether palliative care is so effective is disputed, and beyond the scope of this paper. It is important to note, though, that one of the reasons religious communities speak with some authority in this field is that they have long been involved in care for people that are sick and dying, and they have learned that the messiness that accompanies the body’s deterioration is not undignified or to be feared. It is an insight that many people with disabilities, for whom the messiness of care is a part of everyday life, can appreciate (Epstein, 2006; Newell, 2006).

In the light of these various arguments, most disability advocates oppose the legalization of voluntary euthanasia. It is noteworthy that this is a stronger stance than with abortion, where concerns about aborting a fetus due to disability do not lead advocates to oppose legalization per se. This stronger stance may be an implicit recognition of the difference in the status of a post-birth person and a fetus, although it may highlight a contradiction in disability advocacy: its failure to recognize that the choice of a disabled person is as important as that of a woman. Unsurprisingly, then, there are dissenting disabled voices. Tom Shakespeare, who has long advocated against the tendency to set the medical and social models of disability against one another, notes that disabled people can and do experience the types of terminal pain, suffering, and indignity that voluntary euthanasia legislation intends to relieve. He also asserts that disability activists “who have achieved so much in terms of independent living for disabled people are inconsistent in campaigning to deny disabled people a choice at the end of life” (Shakespeare, 2009; 2014, 164). There is some irony in a disability rights movement, with a history of fighting against paternalism and fear, working to reduce choice for fear that people with disabilities will be coerced into suicide (Riddle, 2017, 487).

That the legalization of voluntary euthanasia carries risk is not necessarily enough reason to oppose it. Every human activity involves balancing risk and reward, and the benefit of relieving extreme suffering is not something that should be let go of easily (Riddle, 2017, 489). I started by noting that the impetus toward the legalization of voluntary euthanasia is unstoppable, at least in Australia and many other Western nations. As with abortion, the debate has been acrimonious, and those involved have largely talked past one another. It may be time to take a more collegial approach. Also, it may be that disability provides a bridge between opposing parties, as people with disabilities have reason to see the world from both perspectives.

That crip activists have largely campaigned against legalization is a vital reminder to those pushing for change that opposition is not primarily religious dogmatism, but arises out of genuine concern for the value and dignity of the most vulnerable people in our community. Such concern warrants respect rather than contempt, so that disabled voices, as well as those of religious and nonreligious people at the coalface of the caring professions, be kept front and center as legislation is enacted and put into practice.

That crip activists have also campaigned for personal autonomy is a reminder to religious people that the sanctity or value of every human life is the basis of responsible choices, which are not made in isolation but in the context of the attitudes and values of family, friends, and the wider community.

VI. CONCLUSION

We are used to beginning- and end-of-life ethics being rife with polarized and irreconcilable perspectives, and too often advocates on both sides of the political and religious divide use disability as a weapon in their political arsenal. On the one hand, impairment can be cited as a reason for elevating individual choice for abortion and voluntary euthanasia, but people with a disability point out that pro-choice logic and practice are too often based on the assumption that disabled (and ill) lives are not worth living. This logic also fails to recognize the constraints of transformative choices, which are limited by biased assumptions against disabled futures, and by the inability to imagine life with a disability as good. Thus, crip advocates, normally aligning with the political left, find themselves in an unlikely partnership with religious people on beginning- and end-of-life ethics. On the other hand, neither faith nor disability is well served by paternalism, or by simplistic black-and-white positions. Religious faith and disability politics have a complex and nuanced history that belies the angry slogans of contemporary politics. Newborns with disabilities need mothers that want them, not that are forced into motherhood against their will. No person of religious faith should support policies that risk women's lives, nor should people with disabilities take positions that undermine the personal agency that is at the heart of the disability rights movement. In this light, I am conscious that I write about abortion as a man belonging to a religious tradition in which predominantly (often exclusively) male leaders have enforced ethical dictates about women's bodies, choices, and responsibilities.

When we look below the surface—which disability helps us to do—pro-life and pro-choice advocates share some common goals. Disability reminds us that all life is valuable, and its meaning is revealed by the context of its limits and vulnerabilities. Thus, its early termination, whether at the beginning or end of life, or because of a poorly performed abortion, is a moral issue and no small matter. Disability also reminds us that within its limits, the right to make choices about our future is important, so that legislating against choice is no small matter. Choices are too often constrained by cultural bias and social injustice. The solution to bias is to develop the virtue of listening, the habit of being open and generous to the perspective of those with whom we disagree. Since the lives of people with disabilities are at stake in the ethics of abortion and euthanasia, their voices and stories warrant special attention. The fight against social injustice is the hardest task of all, but it is the only effective way to safeguard human life in all its stages, varieties, and abilities. We are likely to continue to disagree about the politics and morality of abortion and euthanasia, but we can still work together in the building of a society that enables people with disabilities, as well as those facing the embodied challenges of aging and illness, to exist, exercise personal agency, and live well. In this way, disability serves the discussion of beginning- and end-of-life ethics, not as a partisan weapon, but as a reminder of the value of listening to alternate perspectives, and a symbol of rich diversity.

NOTE

1. This complexity has personal significance as I seek to navigate my identity and responsibilities as a theologian and ethicist, a feminist (ally), and a disabled person. Except for reasons of style, I deliberately choose not to use first-person language in this paper (i.e., person with a disability), because I am not embarrassed about my disability and embrace the history of disabled advocacy.

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