

# Exposing Some Myths About Physician-Assisted Suicide

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I wish to express my gratitude to Professor Annette Clark and the students of the Seattle University Law Review for inviting me to participate in this symposium, and to submit my remarks for publication. Although this essay reflects the essence of my remarks, I have taken the liberty of clarifying and expanding upon a few points.

## I. INTRODUCTION

When I was asked to speak at this conference, I was at first hesitant to participate. In fact, I dreaded the prospect of speaking about the legalization of physician-assisted suicide. It's not that I have nothing to say on the issue; like everyone here, I too have something to say about it. Nor have I failed to think about this issue; on the contrary, I've had more than ample opportunity to ponder it. If I've thought about the topic enough to have something to say about it, why would I hesitate accepting this invitation? Why would I dread talking about an issue that has achieved such prominence?

Basically, there are two reasons. First, we seem to have lost our ability to speak with one another about issues such as this. Instead of engaging one another in a conversation, we have substituted diatribe for dialogue and discord for discourse. The rhetoric of rights, and the simplistic thinking that such rhetoric creates and sustains, impedes our ability and even our willingness to listen to one another. The "I'm right; you're wrong" mentality that dominates these debates makes it impossible to get a word in edgewise. What is supposed to be a conversation becomes an occasion for sloganeering and moral jingoism. And I have no interest in participating in an exchange of views that proceeds in a manner that serves not to advance the discussion, but

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only to corrode the foundations of a democratic society.<sup>1</sup> Disagree though we must and should over a matter as controversial as this one, once we become intolerant of and impatient with those whose views differ from our own, we cease listening as closely as we must to what each of us has to say. Once we stop listening to one another, once we no longer take one another seriously, once we cease engaging one another in the sort of conversation on which a democratic society rests, we cease behaving democratically.

Second, even if this is a matter that we must converse about, I doubt that it merits the attention it receives. Were I asked to list those aspects of our health care system that we should devote our time and energy to discussing, or to list those features of a decent health care system that we should dedicate our scarce resources to, physician-assisted suicide would be near, if not at, the bottom of that list. From my perspective, physician-assisted suicide is a moralizing distraction. It enables those who spend their time promoting or opposing it to convince themselves and others that they are engaged in a battle royal, engaging an issue whose resolution will define the moral fiber of the nation. This debate enables the rest of us to watch and even participate, fostering the belief that we are doing something important about how we live and die in the United States. Meanwhile, we neglect such other matters as health care reform and access to care.

From my perspective, the fuss about physician-assisted suicide is about as important as re-arranging the deck chairs on the *Titanic*. Given the current state of our health care system, which remains in a state of crisis regardless—and perhaps because of—what did not happen last year, the legalization of physician-assisted suicide is morally essential only to those who are indifferent to the health care needs and concerns of most Americans.

You now know that I do have something to say about this issue. Instead of engaging in the debate, however, I intend to engage the debate. By that, I mean that I intend to expose some of the myths that surround this issue, and to challenge the notion that it is or should be the moral issue of the day. If I am hesitant or fearful of speaking, it

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1. While it was possible to elaborate somewhat on this point during my remarks at the conference, for the purposes of this essay it is best to refer the reader to the growing literature in this area. See, e.g., JEAN B. ELSHTAIN, *DEMOCRACY ON TRIAL* (1995); CHRISTOPHER LASCH, *THE REVOLT OF THE ELITES AND THE BETRAYAL OF DEMOCRACY* (1995); ROBERT D. PUTNAM, *MAKING DEMOCRACY WORK: CIVIC TRADITIONS IN MODERN ITALY* (1993); JAMES D. HUNTER, *CULTURE WARS: THE STRUGGLE TO DEFINE AMERICA* (1991); JAMES D. HUNTER, *BEFORE THE SHOOTING BEGINS* (1994); MARY A. GLENDON, *RIGHTS TALK: THE IMPOVERISHMENT OF POLITICAL DISCOURSE* (1991).

is not because I have nothing to say, but because I wonder whether what I have to say will be heard.

## II. WHAT'S THE QUESTION?

Amidst those who believe that it is certainly right to legalize physician-assisted suicide and those who contend that it is certainly right to prohibit such conduct, I find myself uncertain about what to say or do. I am willing to concede that there may be instances in which it is morally appropriate to help a patient commit suicide, and agree that, as a rule, consenting adults may establish what constitutes acceptable behavior as between themselves. I am not convinced that what some think about assisted suicide as a private matter, however, necessarily means that we all must endorse it as a matter of public policy. Deciding what course of action we wish to take as a society involves considerably more than agreeing that a private course of conduct may be morally right, or that consent justifies what two individuals decide to do within the context of a given relationship. Regardless of the moral questions this issue raises, the question of its legalization is a public policy matter.

Essentially, we need to determine whether the advantages of changing the law outweigh the disadvantages, or whether the difficulties created by leaving the law as it is merit changing the law at all. We need to assess and evaluate the arguments made in favor of this right, and determine whether the legalization of physician-assisted suicide is, on balance, the prudent course of action.

For myself, I doubt the soundness of the arguments put forth by those who advocate the legalization of physician-assisted suicide. It does not seem to me that the arguments hold together. The arguments also fail to make a compelling case for the proposition that we will be in the Dark Ages if we do not change the law. I doubt that the legalization of physician-assisted suicide is the next step we must take if we are to be a morally progressive society or that it represents the "cutting edge" issue some of its advocates make it out to be. Just as I doubt that those who advocate the legalization of assisted suicide constitute the vanguard of moral progress, I doubt that those who resist those efforts are the defenders of all that a decent society should stand for.

Ultimately, this means that I do not view this issue from the simplistic perspective afforded those who adhere to either the "pro-choice" or "pro-life" agenda; nor do I agree with many of those who, as self-styled advocates for patients or for persons with disabilities,

purport to speak for their constituents and to "know" what they want.<sup>2</sup> I wish to elaborate on these points.

### III. SHOULD WE MODERNIZE DEATH?

The argument in favor of the legalization of physician-assisted suicide is fairly straightforward. Simply put, if you are in favor of self-determination and against pain and suffering, then you must favor the legalization of physician-assisted suicide.<sup>3</sup> Because it advances the goals of promoting patient self-determination and preventing unnecessary suffering, the legalization of physician-assisted suicide upholds two values that we highly prize: autonomy and beneficence. Thus, the legalization of physician-assisted suicide offers something to both patients and physicians, advancing their interests simultaneously. It seems there are good reasons to support this change in the law, and no good reason to resist it.

Politically and rhetorically speaking, this is a very nice argument. It is simple, uncomplicated, and easy to grasp; it can probably be made to fit onto a bumper sticker. Yet what makes it so attractive is what makes it so seductive and dangerous. First, this argument suggests that the issue is syllogistically simple, as if questions about how we are to die can be reduced to the moral equivalent of an algorithm. Such an approach obscures the complex, nuanced, ambiguous, and ambivalent nature of dying.<sup>4</sup> Second, this argument promotes the sort of

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2. Having spent three years working with patients and families, I am convinced that they are capable of speaking for themselves. I doubt that we listen to them as attentively as we should.

3. See Robert A. Sedler, *The Constitution and Hastening Inevitable Death*, HASTINGS CENTER REP., Sept.-Oct. 1993, at 20; Robert F. Weir, *The Morality of Physician-Assisted Suicide*, 20 LAW, MED. & HEALTH CARE 116 (1992). Because the literature on physician-assisted suicide is so vast and redundant, I offer the reader an eclectic sampling of those articles that are representative of the perspective typically brought to bear on this issue. Nothing is intended by including some authors and not including others.

4. Although I am not a physician, my three years of work in the clinical setting gave me the impression that death is much more uncertain and contingent than we would like to believe. Based on the numerous television shows, articles, and books that attempt to tell us what dying "is like," it follows that many of us must want to know what it is going to be like to die, perhaps because we dread the anxiety created by not knowing. I concur with the view of those who, like E.M. Forster in commenting on how we are born and how we die, observed that these experiences are strange, indeed, alien to us,

because they are at the same time experiences and not experiences. We only know of them by report. We were all born, but we cannot remember what it was like. And death is coming even as birth has come, but, similarly, we do not know what it is like. Our final experience, like our first, is conjectural. We move between two darknesses. Certain people pretend to tell us what birth and death are like[.] . . . But it is all from the outside, and the two entities who might enlighten us, the baby and the corpse, cannot do so, because their apparatus for communicating their experiences is not attuned

bumper-sticker mentality and moral jingoism that has come to dominate discussions of such matters, and the dangerous polarization and dichotomization I alluded to earlier. Once one pierces the rhetoric, it is fairly easy to see where the difficulties lie.

A. *Physician-Assisted Suicide as the Next Possible Step?*

First of all, in arguing that the legalization of physician-assisted suicide is the logical next step for the "right-to-die" movement to take, advocates of this perspective gloss over some important aspects of what that movement has concerned itself with until now. While the "right-to-die" movement has dedicated itself to advancing the cause of patient self-determination, it has not done so in ways that lend unquestioned support to the argument that physician-assisted suicide is the logical next step that the movement must take.

For the past twenty-five years, the primary focus of the "right-to-die" movement has been to resist the medicalization of death. From the *Quinlan*<sup>5</sup> case through the *Cruzan*<sup>6</sup> case and beyond, the movement has directed its efforts toward protecting a patient's right to die a natural death. This explains why Living Will Acts are often referred to as Natural Death Acts. A central concern of the legislation and litigation that has dominated this area has been to resist the medicalization of death—to enable patients to die without the encumbrances of tubes, ventilators, cardiopulmonary cerebral resuscitation, dialysis, surgery, transfusions, and drugs. In short, the concern has been about preserving the right to die the way we used to die before advances in medicine and medical technology enabled physicians to attenuate the dying process; it has been about insuring that patients, not doctors, determine when and how such a death is to occur.

To the extent the "right-to-die" movement has concerned itself with resisting the medicalization of death, it is difficult to see how the right to die a drug-induced death, made possible only by a physician's intervention, can be regarded as the logical next step. The legalization of physician-assisted suicide does not naturalize death, it medicalizes death. Setting aside the question of whether we should or should not take this step, one cannot say that it flows inexorably from those which

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to our apparatus for reception.

E.M. FORSTER, *ASPECTS OF THE NOVEL* 76 (1927). Of all the many attempts to convey what dying is like, for my money the best current offering is SHERWIN B. NULAND, *HOW WE DIE: REFLECTIONS ON LIFE'S FINAL CHAPTER* (1994), because it is as blunt as it is uncertain about what it is like to die.

5. *In re Quinlan*, 355 A.2d 647 (N.J. 1976).

6. *Cruzan v. Director, Mo. Dep't of Health*, 497 U.S. 261 (1990).

have come before it. If anything, physician-assisted suicide endorses the view that "technology" can "fix" our problems, a sentiment not found in the "right-to-die" movement's tendency to oppose technologically-enhanced death.<sup>7</sup>

### B. Differentiating the Two "Rights-to-Die"

Another assumption, or myth, is that the right to forgo life-sustaining treatment and the right to physician-assisted suicide are the same "right-to-die." They are not. Just how different the one "right-to-die" is from the other becomes clearer when we consider the philosophical principles on which each rests.

Where the "right-to-die" consists of a decision to forgo life-sustaining treatment, it rests on a familiar principle: the right to protect one's physical integrity against unwarranted intrusion. At common law, this right was protected by the action for battery—a trespass of the person which was permitted only if the individual had consented. Out of these simple considerations grew the notion that patients have the right to refuse treatment, even life-sustaining treatment. The right not to be touched against one's wishes is the value that underlies the principle of self-determination protected under the law in the name of the "right to die."<sup>8</sup> In the world of philosophy and ethics, this has meant respecting a patient's *negative* right of noninterference—the right to be let alone. Respecting that right requires forbearance; we must either not initiate treatment or withdraw a treatment we have initiated. Whichever it is, we are to back off.

Where the "right-to-die" consists of physician-assisted suicide, respecting this right requires doctors to assist, not desist. Medical forbearance simply will not produce the desired result. Whether the patient's request is for a prescription or an injection, the type of death the patient wants will not occur if the physician fails to provide a specific good or service. The doctor must do something for the patient, not simply stop doing something to the patient. Physician-assisted suicide, therefore, has nothing to do with respecting a patient's negative rights; it has to do with respecting a patient's *positive* rights.<sup>9</sup>

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7. As Professor Jonsen has indicated: "Active euthanasia for the voluntary and competent patient seems so plausible and liberal. Yet it suggests a technologic solution to a perennial human problem." Albert R. Jonsen, *Death, Politics and Philosophy*, 157 W. J. MED. 192, 193 (1992).

8. RUTH R. FADEN & TOM L. BEAUCHAMP, A HISTORY AND THEORY OF INFORMED CONSENT 3-49 (1986); ALAN MEISEL, THE RIGHT TO DIE 49-54 (1989).

9. Because Professor Paul Menzel disputed this point, arguing that decisions to forgo life-sustaining treatment rest on a negative right and that physician-assisted suicide rests on what he termed a "virtual" negative right, it may be helpful to refer the reader to a basic text on medical

On this point, a few observations are in order. It is generally agreed that one cannot derive a positive right from a negative right. As every first year law student knows, the duty not to commit a battery does not generate a duty to rescue; a duty not to touch does not generate a duty to render aid. For this reason one cannot argue that the right to physician-assisted suicide naturally or logically grows out of a patient's right to refuse treatment. The one has nothing to do with the other—at least not insofar as respecting a negative right creates a duty to respect a positive right.

In order to legitimate the right to physician-assisted suicide, we would have to acknowledge that the right of self-determination ought to embrace positive as well as negative rights. For years we have said that patients do not have positive rights to health care; that's how we justify saying that patients have no "right" to health care or to specific services from physicians. To acknowledge that patients *do* have positive rights constitutes a remarkable reversal in thought, albeit one that is long overdue. What is odd about this reversal is that we are attempting to begin by recognizing a patient's right to enlist a physician's assistance in dying—not in living.

If we are to recognize positive rights, then why not dedicate ourselves to protecting the patient's right to receive the sort of care that makes life worth living? If we were to tell patients that we are going to recognize their positive rights, and offer them the options of living a better life or dying a quicker death, are we so certain that they would prefer life-ending medication to life-enhancing medical services? Does anyone really believe that if we were to tell patients that they now have a right to health care, the first item on their wish list would be physician-assisted suicide?<sup>10</sup>

Not only are the right to forgo treatment and the right to physician-assisted suicide conceptually distinguishable, they are empirically different. Running through the arguments made by proponents of the legalization of physician-assisted suicide is the notion that this activity is "just like" what doctors do when they forgo life-

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ethics:

Whereas a positive right is a right to be provided with a particular good or service by others, a negative right is a right to be free from some action taken by others. A person's positive right entails another's obligation to do something for that person; a negative right entails another's obligation to refrain from doing something.

TOM L. BEAUCHAMP & JAMES F. CHILDRESS, *PRINCIPLES OF BIOMEDICAL ETHICS* 72-73 (4th ed. 1994).

10. Of course, if we told them that they have the right to demand only as much health care as they can afford, we still might find patients willing to pay for the quick exit from our health care system that physician-assisted suicide offers them.

sustaining treatment. To explain fully the distinction between a decision to forgo life-sustaining treatment and physician-assisted suicide would require an elaborate and tedious exegesis on such topics as *mens rea*, *actus reus*, cause in fact, and proximate cause. Short of such discussion, there is an easier way to discern the fine line that separates killing from non-killing where medical professionals are concerned.

The law has held that decisions to forgo life-sustaining treatment do not give rise to civil or criminal liability, if they are made in the right way and for the right reasons.<sup>11</sup> Before examining what the law says about assisted suicide and the sensibility of the law's concern in that area, however, we need to be clear about what the law does and does not say about taking someone off life-sustaining treatment.

The law does not hold that taking someone off life-sustaining treatment can never run afoul of the criminal law. For example, if someone wandered through a hospital's intensive care unit, intentionally disconnecting patients from ventilators, would we allow that person to claim immunity on the grounds that decisions to forgo life-sustaining treatment do not give rise to criminal or civil liability? I doubt it. Similarly, if a physician, on his or her own initiative, disconnected patients from life-sustaining treatment, we would not say that no questions of civil or criminal liability arise. Dying patients can be murdered, and one way of murdering them is to indiscriminately and unjustifiably disconnect them from life-sustaining treatment.

Courts have ruled that when such a decision is properly reached and properly carried out, even though it does hasten death, the decision does not violate the prohibition against the wrongful taking of a human life.<sup>12</sup> What the law has done here is to reconcile eighteenth century concepts of homicide to the twentieth century's ability to prolong life.

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11. Leonard H. Glantz, *Withholding and Withdrawing Treatment: The Role of the Criminal Law*, 15 LAW, MED. & HEALTH CARE 231 (1987).

12. See, e.g., *Cruzan v. Director, Mo. Dep't of Health*, 497 U.S. 261, 279-80 (1990) (finding that a competent person's constitutionally derived liberty interest to refuse life-saving treatment may, given proper procedural safeguards, transfer to a representative of that person when that person becomes incompetent); *Thor v. Supreme Court of Solano County*, 855 P.2d 375, 383 (Cal. 1993) (concluding that a health care provider has no duty to treat a person declining treatment after "reasonable disclosure" of the alternatives and their respective risks); *In re Dubreuil*, 629 So. 2d 819, 823-24 (Fla. 1993) (finding that "[w]hen a health care provider, acting in good faith, follows the wishes of a competent and informed patient to refuse medical treatment, the health care provider is acting appropriately and cannot be subjected to civil or criminal liability."); *Guardianship of Doe*, 583 N.E.2d 1263, 1270 (Mass. 1992) (discussing assisted suicide and adopting the trial court's finding that the disease rather than the removal of feeding and hydration tubes causes death, and finding that "[m]edical ethics do not require health care professionals to preserve life in every circumstance").



Because we can extend life, a decision not to extend life arguably becomes a decision to hasten death; the civil and criminal law are quite clear on the point that one person normally may not cause, i.e. hasten, another's death. If the law had remained rigid on this point, medicine would have been stopped dead in its tracks, because any decision to forgo treatment would raise questions of criminal and civil liability. But because the only way we can offer patients and doctors the chance to prolong life—use life-sustaining treatment—is by also allowing them to decide when to cease such efforts, we have had to explain why this manner of “hastening death” does not give rise to civil or criminal liability.

The law has reconciled itself to this result by closely scrutinizing the legal cause of the patient's death and the intentions of those who participate in a decision to forgo treatment. Insofar as the legal cause of death is concerned, even if the immediate cause of death is the cessation of treatment, the legal cause of death is the underlying condition that caused the patient to be dependent on life-sustaining technology. For example, if a patient refuses chemotherapy, he or she is said to have died of cancer, a natural cause of death. If a patient is taken off life-sustaining treatment necessitated by injuries sustained in a motor vehicle accident, the cause of death will be the motor vehicle accident. If a patient dies as the result of a suicide attempt that medical intervention was unable to reverse, the cause of death is suicide. Finally, if treatment for a lethal wound inflicted by an assailant is stopped and the patient dies as a result, what was an assault or an attempted murder charge can become a murder charge.

While all of this may sound like fancy footwork on the law's part, it reflects the law's desire to allow life-sustaining treatment to be used or not used in ways that accommodate the legitimate concerns of patients, physicians, and society. The same is true where the intent of the parties involved in the decision to forgo treatment is concerned. Because the intention is not to cause the death of the patient (someone or something else already has done that), but to respect the patient's right not to be treated against his or her wishes, the state of mind brought to bear on a decision to forgo life-sustaining treatment is not the state of mind associated with the taking of a human life.<sup>13</sup>

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13. Another way to think about this is to consider those cases where a decision to forgo treatment is made, but the patient does not die. While such a decision is made with the expectation that death will follow, it is not made with the intention that death should follow. Thus, if a patient unexpectedly survives a decision to forgo life-sustaining treatment, one would not expect those who participated in such a decision to be charged with attempted murder.

Are decisions to forgo life-sustaining treatment "just like" physician-assisted suicide? The easiest way to see how different they are is to consider the case of Diane, Dr. Timothy Quill's celebrated patient.<sup>14</sup> Diane was dying of leukemia, and ended her life by taking the medication Dr. Quill had prescribed for her—a medication he knew was intended for that purpose. Was her death "just like" that of someone who decides to forgo treatment? No. Was her death accidental? Hardly. Did she die of natural causes? No. If she had died simply as the result of forgoing treatment, we could say that she died of natural causes; but dying of a drug overdose is not dying of natural causes in any known jurisdiction. Was the cause of her death unknown? Again, the answer is no.

Only two possible boxes remain in which to put her death: Homicide or suicide. This explains Dr. Quill's dilemma when he reported Diane's death to the coroner. Had she simply committed suicide, by being one of those patients who stores medicine unbeknownst to her physician, or by using such non-medical means as a gun, knife, rope, water, or carbon monoxide, we could safely, but regrettably, say that Diane had simply killed herself. But Diane did not simply kill herself. She killed herself with the knowing assistance of someone else. Because assisted suicide is a form of homicide, that left Dr. Quill with only one box to check off.

When Dr. Quill reports Diane's cause of death to the coroner, we can see just how different her death is from that of someone who refuses treatment. Although he reports that she died of acute leukemia, he does this to avoid the investigation and autopsy that would result had he reported her death as a suicide.<sup>15</sup> If the death that patients die as the result of physician-assisted suicide were "just like" the death they die when they decide to forgo life-sustaining treatment, we would have no problem attributing Diane's death to natural causes. But we cannot do so without being dishonest about the legal cause of her death.

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14. See Timothy E. Quill, *Death and Dignity: A Case of Individualized Decision Making*, 324 NEW ENG. J. MED. 691 (1991).

15. I should also mention the death certificate where I recorded acute leukemia as proximate cause of death. Had I acknowledged the contribution of the barbiturate overdose to the medical examiner, everyone who was present, including the family, would be interrogated and an uninvited autopsy would follow even if the patient's underlying disease was known for certain. I definitely could not subject Diane or her family to such a process, so I avoided the issue by writing "acute leukemia" as the cause of death.

Timothy E. Quill, *Risk Taking by Physicians in Legally Gray Areas*, 57 ALB. L. REV. 693, 703 (1994).

This means two things insofar as the debate is concerned. First, deaths like Diane's are not "just like" the deaths of patients who forgo life-sustaining treatment because they do not fit into the boxes normally reserved for deaths that follow such decisions. Second, the legalization of assisted suicide would require us to create a new category for death on the death certificate; the fact that we have to create a new box is proof that this death is not "just like" the deaths that now occur when patients forgo life-sustaining treatment.<sup>16</sup>

### C. Practical Problems with Legalization

Once one moves beyond the conceptual and empirical inconsistencies that plague this area, one comes to thornier, more practical problems. Even if those who advocate the legalization of physician-assisted suicide were honest enough to admit that it is not the same right that the courts have been struggling with for years, this would not end the difficulties. Assuming that it is a legitimate new right, we must consider the legal consequences of recognizing it as such.

One myth that pervades this area is that we can and will enact legislation that limits the exercise of this right to competent adults who are terminally ill, and who satisfy other qualifications about the nature and duration of their pain and suffering and the numerosity and sincerity of their requests for assistance.<sup>17</sup> Faith in such safeguards rests on two assumptions: (1) Physicians can and will make these assessments accurately, reliably, fairly, and objectively, and (2) such a statute will survive legal challenge.

There is no basis for believing that physicians make reliable, accurate, and objective judgments about who is terminally ill and who is competent. Even if doctors could make those judgments in a manner that would inspire confidence in their ability to do so, determining when a patient's pain is "sufficient" or when a patient has

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16. For similar reasons, the practice of sedating patients (so that they do not experience agonal breathing, for example) does not legitimate lethal prescriptions. While the difference between a coincidental and a superseding cause is small, such a difference does exist. Anesthesiologists, for example, know the difference between medicating a patient to sleep and medicating a patient to death; those who ignore the difference do not remain anesthesiologists for very long. Here again the law has decided that if the choice is between forcing patients to die in pain and allowing patients to die without pain, even if it coincidentally hastens death, the law will allow appropriate amounts of pain medication to be used. See, Lawrence J. Schneiderman & Roger G. Spragg, *Ethical Decisions in Discontinuing Mechanical Ventilation*, 318 NEW ENG. J. MED. 984 (1988).

17. See generally Guy I. Benrubi, *Euthanasia—The Need for Procedural Safeguards*, 326 NEW ENG. J. MED. 197 (1992); Timothy E. Quill et al., *Care of the Hopelessly Ill: Proposed Clinical Criteria for Physician-Assisted Suicide*, 327 NEW ENG. J. MED. 1380 (1992).

asked for aid in dying "enough" times introduces an intolerable amount of subjectivity into what is supposed to be the product of unbiased, scientific assessment.

Moreover, even if doctors could medically limit the exercise of this right to competent, terminally-ill, adult patients, they would be legally prohibited from doing so. The courts have stated that a patient's right to refuse treatment may not be conditioned on qualifying language about being terminally ill or imminently dying.<sup>18</sup> If this "right-to-die" is the same as the "right-to-die" we've been litigating for years, the considerations that invalidated such qualifications in natural death acts will invalidate the same provisions if they appear in assisted suicide statutes.

Nor would we be able to limit the exercise of this right to competent adults. The "right to die" already extends to mature minors, which means that assisted suicide would as well. And because we cannot deny incompetent patients the rights that competent patients enjoy, once we extend this right to competent patients we must also extend it to incompetent patients. Even if that means offering assisted suicide only when we have clear and convincing evidence that an incompetent patient would want it, we must agree to some amount of surrogate decisionmaking in this area, for we are constitutionally prohibited from denying incompetent patients substantive rights that competent patients enjoy. While this may sound like a slippery slope argument, it is not. I am only restating what the law is in the "right-to-die" area. Once this new right is inserted into the existing law, this right cannot be limited, as its advocates say it will be, unless we are to disregard the jurisprudence that already has been firmly established in this area.

#### IV. THE MORAL OPPOSITION

Having exposed some of the more obvious myths that plague this area, let me address two others. The first myth is that the physician-assisted suicide movement advances the cause of patients. The second

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18. See, e.g., *Bouvia v. Superior Court of Los Angeles County*, 225 Cal. Rptr. 297, 302 (Cal. Ct. App. 1986) (concluding that the right to have life support equipment disconnected is not limited to comatose, terminally-ill patients or representatives acting on their behalf); *In re Conroy*, 486 A.2d 1209, 1226 (N.J. 1985) (determining that "a young, generally healthy person, has the same right to decline life-saving medical treatment as a . . . person who is terminally ill"); *In re Deleo v. Westchester County Medical Ctr.*, 516 N.Y.S.2d 677, 690-91 (N.Y. App. Div. 1987) (finding that "[t]he decisional law confirms that the desires of a young, generally healthy person to refuse treatment are entitled to the same protection as those of an elderly, terminally-ill individual").

is that those who oppose and resist the legalization of physician-assisted suicide from the pro-life or disability rights perspective are saving us from a fate worse than a medicalized death and have our real interests at heart.

The legalization of physician-assisted suicide does not empower patients; it empowers physicians. No one is talking about legalizing assisted suicide; all that's on the table is legalizing *physician*-assisted suicide. It would allow physicians to act with impunity in an area where they now may act only by running a substantial risk of civil or criminal liability. If an indicator of power and authority is the ability to act with impunity, then a statute that grants doctors immunity from civil and criminal liability for doing what is now regarded as a form of homicide certainly gives physicians considerable power.

The fact that the immunities afforded to physicians would not be extended to others, whether they be other health care professionals or family members, suggests that the legalization of *physician*-assisted suicide strongly benefits physicians. After all, if we wanted to maximize a patient's autonomy we could extend these immunities to family members who render such services, or eliminate the statutes that allow physicians to monopolize the distribution of controlled substances. If we legalize *physician*-assisted suicide, then anyone other than a physician who helps a dying patient secure the drugs needed to hasten death can be prosecuted for murder (which the state has an interest in prohibiting) and for practicing medicine without a license (which the medical profession has an interest in prohibiting).

While physicians clearly stand to benefit from such legislation, it is not so clear that patients do. Patients will be left where they have always been since the medical profession assumed authority over decisions about death—having to ask for a physician's permission to die how and when they wish. Physicians will be in a position to deny such requests as they always have, by saying that the patient is not competent or terminal, or by suggesting that the patient's pain is not sufficient or the patient's requests not sufficiently sincere. Of all the myths that plague this area, the most pernicious is that the legalization of physician-assisted suicide would be a victory for patients. This legalization would merely be a victory for the medical profession dressed up as a victory for patients. It would not enhance the autonomy of patients; it would maximize the power and authority of physicians.

It comes as no surprise that some physicians are seeking to enhance their power in this manner. For years, the medical profession has gotten what it wants from civilians and legislators by playing its

ace in the hole: power over death. Because physicians can "do something" about death, we fund initiatives to postpone death and turn to doctors when we are afraid of dying. As Jay Katz has shown, physicians exploit the belief that they have some power over death.<sup>19</sup> Although medicine cannot eliminate death, it can demonstrate its power over death in one of two ways: by postponing it or expediting it.<sup>20</sup> The recent emergence of the concept of medical futility suggests that medicine's ability to postpone death clearly is waning, which means that medicine can sustain the privileged position it traditionally has enjoyed only if it can convince us that it still has power over death.<sup>21</sup> Simply put, the profession is struggling to convince us that the emperor still wears his regal robes. Thus, it is no coincidence that some in the medical profession are seeking immunity for denying patients medically-futile treatment at the same time that they are seeking immunity for physician-assisted suicide. Although each movement purports to protect the interests of patients, each is simply about protecting the authority and power of the medical profession, by seeing to it that death is completely medicalized.<sup>22</sup>

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19. JAY KATZ, *THE SILENT WORLD OF DOCTOR AND PATIENT* 213-14 (1984).

20. For this insight, I am indebted to Zygmunt Bauman's brilliant essay, *Modernity, or Deconstructing Mortality*, in Zygmunt Bauman, *MORTALITY, IMMORTALITY & OTHER LIFE STRATEGIES* 129-60 (1992).

21. See Giles R. Scofield, *Is Consent Useful When Resuscitation Isn't?*, *HASTINGS CENTER REP.*, Nov.-Dec. 1991, at 28.

22. The easiest way to see this is to examine the strikingly different arguments about the role consent should play in decisions about assisted suicide and decisions about medically-futile treatment. Where assisted suicide is at issue, dying patients are portrayed as competent, rational persons whose wishes we should not deny. Where medically-futile treatment is at issue, these dying patients become irrational, emotional persons, incapable of knowing what they want. Because the same class of persons cannot be simultaneously capable and incapable of thinking for themselves, the need to legitimate consent in the one instance and invalidate consent in the other must rest on some other common denominator. Because the only result that each argument justifies is granting immunity from civil and criminal liability to physicians for decisions to deny futile treatment or to prescribe lethal medication, one is forced to conclude that this is what motivates physicians to assume such contradictory, otherwise irreconcilable positions on such matters. See, e.g., Howard Brody, *Assisted Death—A Compassionate Response to a Medical Failure*, 327 *NEW ENG. J. MED.* 1384 (1992); Howard Brody, *The Physician's Role in Determining Medical Futility*, 42 *J. AM. GERIATRICS SOC'Y* 875 (1994). As medicine does what it can to perpetuate the belief that doctors have some power over death (which they use to exploit patients, among others), one is reminded of Anna Yeatman's apt observation of how doctors view discussions about sharing power with patients and others. "The doctors interpreted this debate as a zero-sum game: either they continued to be God, or civilization (science) as we have known it would disappear." ANNA YEATMAN, *POSTMODERN REVISIONINGS OF THE POLITICAL* 51 (1994).

## V. THE ARGUMENT AGAINST LEGALIZATION: HOW SOUND IS IT?

Having cast doubt on the argument made by those who favor the legalization of physician-assisted suicide, it would be unwise for me not to say something about those who have dedicated themselves to resisting this trend. There are just as many good reasons to wonder about the soundness of the "right-to-life's" opposition to the legalization of physician-assisted suicide as there are to wonder about the soundness of the arguments made by those who favor such legalization.

Interestingly, the "right-to-life" movement seems to have fallen into the same error as the "right-to-die" movement has, i.e. of equating decisions to forgo life-sustaining treatment with decisions about physician-assisted suicide. Having committed this basic error, it is no wonder that its strategies have been so misguided. In addition to resisting physician-assisted suicide, this movement has tended to oppose a patient's right to forgo life-sustaining treatment, and has made it particularly onerous for patients in New York and Missouri to die naturally. The reasoning behind these tactics is as absurd as it is simple, and runs something like this: If we make it too easy for patients to forgo life-sustaining treatment, the next thing they will want is the right to physician-assisted suicide. To avoid the legalization of physician-assisted suicide, therefore, we must circumscribe decisions to forgo life-sustaining treatment.

Think of what this really means. It amounts to saying that the way to resist the call for one form of a medicalized death is to make it as difficult as possible for patients to resist another form of a medicalized death. Further, this reasoning says that in order for patients not to think that it is too easy to die, we must make it as hard as we possibly can for them to die. Does anyone really think that if patients were assured that they would be allowed to die naturally that they would want physician-assisted suicide? Does anyone really believe that a policy of requiring patients to endure a medically prolonged dying discourages them from wanting a medically hastened exit?

On the basis of thinking such as this, Nancy Cruzan and her family were dragged through the courts for several years, pounded relentlessly by something called the clear and convincing evidence test. Although one purpose in doing this was to quell the call for physician-assisted suicide, I suspect these events only served to fan the flames. The entire nation witnessed a decent family being prevented from burying its daughter, with the blessings of the Missouri Supreme Court and the United States Supreme Court. The impression created by the

Cruzan debacle was that if one became incapacitated, one's family could not, and the courts would not, come to one's aid. And if a person is fearful of losing autonomy when incompetent, that person understandably may try to maximize autonomy while competent. Simply put, some people watched what happened to Nancy Cruzan and decided that they'd better be able to get while the getting's good, the very sentiments likely to make them demand the legalization of physician-assisted suicide.

Just as there is reason to wonder about the coherence of the "right-to-life" movement's strategies and tactics, there is reason to doubt that this movement has the real interests of patients at heart. Although the pro-life movement claims to have the interests of persons with disabilities at heart, it is fairly clear that persons with disabilities are interested in a good deal more than the assurance that the last six months of their existence will be completely medicalized. From my own experience working with catastrophically injured patients, my impression is that they are less concerned with how *long* they are going to live than they are with how *well* they are going to live. To presume that a longer life necessarily is a better life ignores how important the quality of life is to the individual living it. If anything is clear, it is that the disabilities rights and the "right-to-life" movements do not share common ground, because persons with disabilities are interested in more than living an extended life.<sup>23</sup>

## VI. A NEW APPROACH

On the basis of the observations, what conclusions may we draw? First, I think that many Americans are as afraid of living as they are of dying in our health care system. All they see awaiting them is the prospect of a medicalized death, over which neither they nor even their families will have much control. And if forced to choose between a medicalized death that prolongs the dying process and one that shortens it, many are going to prefer the latter to the former—because nothing else seems to be available. For that reason, I join with those who believe that the call for physician-assisted suicide should be taken

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23. See Dave Matheis, *Still Looking for Common Ground: The National Right-to-Life Committee and the Disability Rights Movement*, DISABILITY RAG RESOURCE, Sept.-Oct. 1993, at 34; Marilyn Golden, *Do the Disability Rights and Right-to-Life Movements have Any Common Ground?*, DISABILITY RAG, Sept.-Oct. 1991, at 1. On this point, however, the "right-to-die" movement does no better. Members of each group are so obsessed with insuring that no one dies a bad death that they have lost sight of the fact that enjoying a good death does not mean much to people who have not enjoyed a good life.



as an indication that there is something terribly wrong with our health care system.<sup>24</sup>

Second, I suspect patients want something that neither the "right-to-die" nor the "right-to-life" movements are offering. Patients want the assurance that life-sustaining treatment will be used sensibly and sensitively, that their dying will not be prolonged or premature, and that they will not have to suffer while awaiting their death. They want to know that they and their families will be listened to and not abandoned. They want to be able to die without inflicting emotional and financial devastation on their families. And they want a system of care in which they are not treated as corporate accounts whose medical problems are managed by physicians who are technically competent but personally distant. In short, what patients want is not a system of care, but a system that cares.

If this is what concerns patients, then it will do little good to spend much time thinking about whether we should offer or deny them physician-assisted suicide. We are talking about more complex, systemic problems than either the "right-to-die" or "right-to-life" movements address. For this reason, I find the debate to be largely irrelevant and quite distracting, which brings me to the last myth that dominates this area: the myth that physician-assisted suicide is *the* moral issue of our age.

Underlying the movement to legalize physician-assisted suicide is the belief that we cannot regard our society as truly progressive and morally sound until we eliminate the laws prohibiting assisted suicide, which makes those who lead this cause the moral vanguard of patients' rights. By the same token, those who spend their time resisting these efforts pride themselves on defending the nation against the forces of evil. What each shares is the belief that they are doing something vitally important for us all, and that something dreadful will happen if their view does not prevail. I wonder how valid such beliefs are.

They seem to stem from the wake of *Roe v. Wade*,<sup>25</sup> which is as much the darling of the "pro-choice" movement as it is the villain of

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24. Too many people have seen their friends and relatives endure needless suffering at the hands of their doctors. The best response we physicians can make to the euthanasia movement is to provide better terminal care. We must reject the technological imperative that compels us to use whatever treatments are available, regardless of whether they are likely to offer our patients genuine benefit.

Robert I. Misbin, *Physicians' Aid in Dying*, 325 NEW ENG. J. MED. 1307, 1311 (1991). See also Elizabeth J. Latimer, *Euthanasia: A Physician's Reflections*, 6 J. PAIN & SYMPTOM MGMT. 487 (1991).

25. 410 U.S. 113 (1973).

the "pro-life" movement. The dichotomized perspective adopted by the United States Supreme Court in *Roe* dominates the debate about decisions affecting life's beginnings and endings. The polarization and politicization of questions concerning how and when life begins has made it difficult, if not impossible, to converse sensibly about how and when life ends.<sup>26</sup>

Without getting too much into the question of whether *Roe* was rightly or wrongly decided,<sup>27</sup> let me suggest that the court got off to a poor start by attempting to decide what our position on abortion should be by limiting its perspective to the values of life and liberty, and by digressing into a discussion about personhood. Instead of asking how our beliefs about life and liberty inform our opinion on abortion, the court should have asked a more fundamental question: Do we take seriously the notion that men and women are and should be equal before the eyes of the law? If so, how does our position on equality inform our perspective on abortion? While I cannot say what sort of conversation we would have had if the court had addressed and answered those questions, I daresay it would have been a different and more productive conversation than the one we have been having for the past twenty-two years.

Suppose we considered legalizing physician-assisted suicide from the perspective of justice, and not from the perspective of what life or liberty are supposed to mean? If we asked what our belief in equality suggests that our position on assisted suicide should be, we would not be having the conversation we have been having here today. Think how our discussion would alter.

I am certain that everyone has heard the expression about death being the "great equalizer." The notion behind this sentiment is a simple one: No matter who you are, rich or poor, privileged or not, death treats us all alike; it does not discriminate on the basis of anything. In reality, that sentiment has probably never been true,<sup>28</sup>

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26. See generally Sandra H. Johnson, *From Medicalization to Legalization to Politicization: O'Connor, Cruzan, and Refusal of Treatment in the 1990s*, 21 CONN. L. REV. 685 (1989).

27. For such a discussion, see Giles R. Scofield, *Rethinking Roe*, in TRENDS IN HEALTH CARE, L. & ETHICS, Summer 1993, at 17.

28. There is a tendency to sentimentalize death, to believe that dying is worse for us than it was for our predecessors, as if harkening back to the "good old days" would improve on how we die. I doubt that anyone seriously wants to die the way people did during the years of plague, famine, or warfare. I suspect that there really is no such thing as a "good death," if by a good death one means a death that involves no sense of tragedy on the part of the deceased or the survivors. What we really seem to want is that death not be as bad as it could be. In any event, I suspect that it is not pleasant to die a violent death, which many Americans do. Those of us who like to believe that modern medicine has spared or can spare us a "horrible" death should

but it has never been less true than it is today. We do not die equal deaths. Too many Americans die wretched deaths because they live wretched lives—they live and die in squalor. They are the politically, economically, and medically disenfranchised. The moral issue of our day is not whether to enable or prevent a few individuals' dying in the comfort of their home in the presence of their private physicians. The moral issue of our day is whether to do something about our immoral system of care, in which treatment is dispensed according to a principle best characterized as that of economic apartheid.<sup>29</sup>

In a health care system such as ours, I fail to see how anyone can claim to have the "right" to die a drug-induced death of one's choosing in suburban comfort, while others die drug-related deaths, not of their choosing, in urban squalor.<sup>30</sup> I fail to see how anyone can claim that the "special nature" of their relationship with their physician<sup>31</sup> gives them the "right" to have their death hastened, while the deaths of others are hastened because they lack the very access to care needed to have any, much less a *special* relationship, with a physician. By the same token, I fail to see how anyone can claim to have helped the elderly and the disabled when they do what they can to resist the legalization of physician-assisted suicide, but do nothing to improve the conditions under which the elderly and the disabled live and the treatment that they receive.

The cause of working for or against the legalization of physician-assisted suicide involves rights. However, that does not make the cause itself right, unless there is a "right" to remain indifferent to the cause of justice, or a "right" to treat equality as a second-class value. Those of us who allow ourselves to be swept up in this debate, to believe that we are on the cutting edge of the battle between right and wrong, are simply using the cause of active euthanasia to create and sustain our disposition towards what Judith Shklar calls passive injustice—indifference to matters that we can do something about, but

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wonder whether that is so. See LAURIE GARRETT, *THE COMING PLAGUE: NEWLY EMERGING DISEASES IN A WORLD OUT OF BALANCE* (1994) (examining the history of diseases caused by microbes and discussing the newly emerging viruses around the globe and the conditions which support them).

29. Cf. Norton J. Greenberger et al., *Universal Access to Health Care in America: A Moral and Medical Imperative*, 112 *ANNALS INTERNAL MED.* 637 (1990) (major reforms are necessary in order to address problem of providing universal access to health care).

30. See PANEL ON UNDERSTANDING AND CONTROL OF VIOLENT BEHAVIOR, NATIONAL RESEARCH COUNCIL, *UNDERSTANDING AND PREVENTING VIOLENCE* (Albert J. Reiss, Jr. & Jeffrey A. Roth eds., 1993).

31. See Nancy S. Jecker, *Giving Death a Hand: When the Dying and the Doctor Stand in a Special Relationship*, 39 *J. AM. GERIATRICS SOC'Y* 831 (1991).

choose not to.<sup>32</sup> Once we bring questions of equality and justice into this debate, things change radically. For while death does not discriminate and treats each of us equally, we ourselves clearly do discriminate and treat one another quite unequally, and nowhere more so than in questions about how we live and how we die.

Several years ago Isaiah Berlin penned an important essay on the nature of liberty, and wrote:

What troubles the consciences of Western liberals is not . . . the belief that the freedom that men seek differs according to their social or economic conditions, but that the minority who possess it have gained it by exploiting, or, at least, averting their gaze from, the vast majority who do not. . . . If the liberty of myself or my class . . . depends on the misery of a number of other human beings, the system which promotes this is unjust and immoral.<sup>33</sup>

More recently, the medical ethicist Emily Friedman has observed that the medically indigent and disenfranchised represent the risk of moral rot at the heart of our society, born of the callousness made possible when we avert our gaze from human suffering created not by disease, disability or even death—but by us.<sup>34</sup>

Death does not discriminate. We do. In choosing to focus our attention on the rights of the few, we demonstrate our indifference to the needs of the many. It is time for us to realize that our obsession with the cause of individual rights, whether of liberty or of life, enables us to ignore issues of justice. Regardless of whether it is right to be for life or liberty (and I had always thought we were supposed to be in favor of life *and* liberty), is it right to permit injustice, to ignore inequality, to perpetuate the inequities that make some deaths so horrible for so many? If we truly cared for and about one another, we would turn our system of care into a system that cares, one that is affordable, decent, available, and equitable. But in keeping with the disposition of a country dedicated to possessive individualism, we have decided to look out for ourselves, and not to look out for others. The myth here is that none of us can or will become the "other"—someone who is economically, politically, and medically disenfranchised.<sup>35</sup> Such a fate can befall more of us than we would like to believe.

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32. See JUDITH N. SHKLAR, *THE FACES OF INJUSTICE* (1990).

33. ISAIAH BERLIN, *FOUR ESSAYS ON LIBERTY* 125 (1969).

34. Emily Friedman, *The Torturer's Horse*, 261 JAMA 1481, 1482 (1989).

35. See KATHERINE S. NEWMAN, *FALLING FROM GRACE: THE EXPERIENCE OF DOWNWARD MOBILITY IN THE AMERICAN MIDDLE CLASS* (1988); KATHERINE S. NEWMAN, *DECLINING FORTUNES: THE WITHERING OF THE AMERICAN DREAM* (1993).

To change the perspective of the issue alters one's view about what our solution ought to be, a shift not welcomed by those who advocate the legalization of physician-assisted suicide.<sup>36</sup> For to alter the perspective from one of rights to one of justice forces us to admit that our health care system is unjust—and for that reason, the system cannot be right. To make it “right” would require much more than changing an obscure section of the criminal law. It would require us to take seriously what it means for us to care for and about one another. It is easy to come out in favor of life or liberty. To come out in favor of *justice*, on the other hand, means that you have to put your money where your mouth is, something that we are reluctant to do in this day and age.<sup>37</sup>

## VII. CONCLUSION: DOING THE DUTCH, OR DOING WHAT THE DUTCH DO?

From my perspective, our solution to the legalization of physician-assisted suicide is both simple and complex. If, as we are led to believe, we should be doing what they are doing in The Netherlands, then our path is clear. First, we should not legalize physician-assisted suicide, because it remains a crime in the Netherlands. Second, we should commit ourselves to creating a health care system that is as accessible, affordable, decent, and equitable as the Dutch health care system is. While I suspect that there are limits to what we can and should do to improve how we die, we have not reached the limits of what we can do to improve how we live. If what really makes for a good death is a good life—one that is as rich, meaningful, and fulfilling as it can be—then once we have improved on life, we may find ourselves agreeing with the ancient wisdom that we should leave death alone. Death can take care of itself. What we need to do is take care of one another.

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36. When Dr. Quill went public about the case of Diane in the *New England Journal of Medicine*, a few readers wrote in wondering if it would be more progressive to do something about the sort of care everyone gets than about the sort of death a few are able to procure. Joanne Lynn & Joan Teno, Letter to the Editor, 325 *NEW ENG. J. MED.* 659 (1991); Giles R. Scofield, Letter to the Editor, 325 *NEW ENG. J. MED.* 659 (1991). While agreeing that our health care system is “woefully inadequate in meeting the basic needs of housing, food, and access to medical care,” Dr. Quill states that “to deny self-determination to hopelessly ill persons until these systematic inadequacies can be solved only compounds the injustice.” Timothy E. Quill, Reply, 325 *NEW ENG. J. MED.* 660 (1991). Under this line of reasoning, granting new rights to a few while many still lack basic rights eliminates an injustice. The mistake in this logic is the belief that the wants of the few are worth more than the needs of the many.

37. See generally *For Richer, for Poorer*, *ECONOMIST*, Nov. 5, 1994, at 19.