Alternatives to
Physician-Assisted Suicide

Introduction
by Roger B. Dworkin
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Key Issues in the Assisted Suicide Debate
by David H. Smith
Indiana University

Dying to Save Money:
Economic Motives for Physician-Assisted Suicide
Maxwell J. Mehlman
Case Western Reserve University Law School

Give Me Liberty and Give Me Death:
Assisted Suicide in Oregon
by Courtney Campbell
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Foreword

In October 1998, the Poynter Center convened a conference on alternatives to physician-assisted suicide. Roger B. Dworkin, Robert A. Lucas Professor of Law and Nelson Poynter Senior Scholar, Indiana University, did the lion’s share of the work in planning and organizing this special event, which was a great success.

We hope to make the proceedings of the conference available to a wider audience, and the result is the collection of papers that is enclosed here. Interest in the issues remains high, and the essays are clearly pertinent to the ongoing discussion.

I want to express the Center’s thanks to Professor Dworkin and the conference presenters whose work is featured in this monograph – Courtney Campbell, Associate Professor of Philosophy, Oregon State University, and Maxwell J. Mehlman, Arthur J. Persilge Professor and Director, Law-Medicine Center, Case Western Reserve University. In addition, the conference was graced by presentations by Kathleen Foley, Co-Chair, Pain and Palliative Care Service, Memorial Sloan-Kettering Cancer Center; Harvey Max Chochinov, Professor of Psychiatry, University of Manitoba and Manitoba Cancer Treatment and Research Foundation; David Phillips, Professor of Sociology, University of California at San Diego; Bernice Pescosolido, Chancellors’ Professor of Sociology, Indiana University. For a variety of reasons, their remarks could not be included here.

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Introduction

Roger B. Dworkin

The legal and ethical debate about assisted suicide for terminally ill persons or for persons who are in intractable pain continues to rage. Whether a person has a legal or a moral right to die or to control the manner and timing of his or her own death and whether physicians may properly assist in achieving that control are, of course, matters of enormous controversy, which is played out in a large and growing legal and ethical scholarly literature as well as in popular sources and in the courts and legislatures. But I think it is fair to say that even the staunchest proponents of a right to assisted suicide would agree that if there is such a right, it cannot be a right that anybody would be very happy about exercising.

Like abortion, assisted suicide is not a desirable option but rather a last resort. Persons who seek assisted suicide do so because they are desperate, or they are in pain, or they are depressed, or they feel hopeless, or they are guilt-ridden about being a burden to others, or for whatever reason. If their pain, their psychological suffering, their economic distress could be alleviated, then presumably many of them would not seek assistance in ending their lives. If we took better care of the dying and the suffering among us, then assisted suicide might become an issue of significance for very few persons. The question of whether there is a right to suicide would be much less important if meaningful alternatives to assisted suicide were available. This conference will explore a range of those possible alternatives — physical, psychological, spiritual, and economic — as well as the current legal state of affairs and public attitudes toward assisted suicide. To put the subject of assisted suicide into context, I shall provide a very brief (which is to say, highly superficial) overview of the current legal status of assisted suicide.
In 1971, the Supreme Court of New Jersey affirmed an order that required a Jehovah's Witness to receive life-saving blood transfusions despite her religious objections to doing so.¹ The court stated explicitly there is no constitutional right to choose to die. Only two years later, of course, the Supreme Court of the United States held in *Roe v. Wade* that a constitutional right of privacy is broad enough to include a woman's decision whether to terminate her pregnancy.² Only three years after that, in 1976, the Supreme Court of New Jersey, which had in 1971 declared there is no constitutional right to choose to die, confronted a case that everyone knows about – the tragic case of Karen Ann Quinlan.³

Karen Ann Quinlan was a 22-year-old woman in a persistent vegetative state. Her father sought authorization to remove her from the respirator that was believed to be keeping her alive. The New Jersey Supreme Court departed from its 1971 decision and, guided by *Roe v. Wade*, observed that presumably the right of privacy is broad enough to encompass a patient's decision to decline medical treatment in certain circumstances in much the same way as it is broad enough to encompass a woman's decision to terminate pregnancy under certain conditions.⁴ Thus, in 1976, for the first time, a state supreme court recognized a right to exercise some control over the manner and timing of one's death. It tied that right to the right to seek an abortion, suggesting that the same underlying principle justified both; and it applied the right to an incompetent person who could not exercise the right herself but who could only benefit from the right if somebody exercised it on her behalf. Indeed, until the Supreme Court of the United States entered the fray in 1990,⁵ courts always believed that the constitutional right accorded to persons trying to have an impact on their own deaths had to be applied in the same way for persons who were mentally incompetent as it was for persons who were competent.

In the twenty-four years since *Quinlan*, an essentially unbroken line of cases has recognized the right to have medical care withheld or withdrawn. The courts, however, have struggled to find a rationale for this right as the abortion right has come under increasing attack and has been significantly altered,⁶ and as the Supreme Court has rejected an overarching commitment to individual autonomy,⁷ and as the treatment withdrawal right has been applied increasingly often to persons who could not exercise any autonomy because given their state – comatose or mentally incompetent – they had no autonomy to exercise.

Of course, courts have recognized, particularly as they have dealt with incompetent persons, the need to devise safeguards and procedures to figure out who and in what condition will be allowed to have life-sustaining treatment withheld or withdrawn. But while they recognize the need to do it, they have failed totally to devise workable procedures. (If we had a long time or if this were a conference about the law of assisted suicide, I could regale you for hours with tales of the absurd and convoluted and impossible procedures that New Jersey has invented with a different procedure to take care of practically every different kind of patient imaginable,⁸ or the bizarre procedures that Massachusetts has developed, which created the specter of rows and rows of virtually dead bodies lying in the halls of Massachusetts hospitals.⁹) The courts know that abuse is a danger, but they have not figured out how to deal with it.
In fact, there is some evidence that those who worry about abuse in the context of any sort of a right related to death have good reason for their concerns. Two different kinds of abuses are possible. One possibility is that a person who really ought to be allowed to exercise his or her right to have treatment withheld or withdrawn will be denied that right. The other possibility is that a person who really ought to continue to live will be killed. There is some reason to believe that both kinds of abuses do occur.

In terms of denying a person his or her rights, for example, there is a case from Massachusetts called Commissioner of Correction against Myers that involved a prison inmate who needed dialysis in order to survive. He refused dialysis even though he understood full well that the consequence of doing so would be his death. The Commissioner of Correction sought an order from the courts authorizing him to force dialysis upon the prisoner. The Massachusetts courts said that while the man has a right to refuse life-sustaining medical treatment even if that means that he will die, his right has to be measured against various important interests of the State. What interest of the State is at stake here? Ah, says the Court, the important State interest in maintaining prison discipline. And so in order to maintain prison discipline, the Court authorized the Commissioner of Correction to use all force necessary to require Mr. Myers to receive his dialysis. So much for the constitutional right to reject medical care.

On the other side of the coin, we have another Massachusetts case, the tragic case of Earl Spring. Mr. Spring was a 77-year-old man who had been married to the same woman for fifty-five years. The Springs had an adult son. Mr. Spring had led an active life. He had never executed a living will, appointed a health-care representative, or done anything to indicate any desires with regard to having life-sustaining treatment withheld or withdrawn.

Mr. Spring, too, needed dialysis in order to survive. He had to be dialyzed three times a week in the dialysis center, which was some significant distance from his home, so that his wife or somebody had to drive him. In addition, Mr. Spring suffered from chronic organic brain syndrome, which made him a real pain to deal with. He swore at people, he yanked on his dialysis tubes, he even kicked nurses — he was a difficult patient. Mrs. Spring had a stroke about a year after Mr. Spring became ill, and the son believed that the stroke was caused by the strain of having to take care of Mr. Spring.

So despite the fact that Mr. Spring had never expressed the slightest desire to have treatment withheld or withdrawn, Mrs. Spring and her son went to court seeking an order to authorize them to stop the dialysis treatment, without which, of course, Mr. Spring would die. They argued that Mr. Spring would not want to live as he was. The Supreme Judicial Court of Massachusetts agreed. Who would want to live like this? And so it authorized Mr. Spring’s family to stop Mr. Spring’s dialysis treatments. They did; he died. The asserted reason was that Mr. Spring had a constitutional right to reject medical care. This, to my way of thinking, is a way to pervert what purports to be a constitutional right into an opportunity to legally kill somebody who happens to be annoying while pretending to serve his interests.

Into this morass stepped the United States Supreme Court in 1990 in the well-known Cruzan case. Cruzan involved a young woman who was in a persistent vegetative state and who was being
maintained through the use of artificial nutrition and hydration. Her parents in Missouri sought authorization to have the artificial nutrition and hydration stopped. The Missouri courts refused, saying that if they were dealing with an incompetent patient – certainly somebody in a persistent vegetative state is incompetent – that they would not authorize the withdrawal of life-supporting treatment in the absence of clear and convincing evidence that that was what the incompetent person would have wanted. They found there was no such clear and convincing evidence in this case, and they did not authorize the withdrawal.

The parents sought relief in the Supreme Court of the United States. The Court, looking back at its old cases, particularly abortion cases, said that prior cases did support an inference that competent persons have a constitutionally protected interest in refusing treatment, and the Court then assumed, for the sake of argument, that the Constitution grants competent persons the right to reject nutrition and hydration. The Court for the first time recognized the folly of treating incompetent persons as if they were competent. They said that before Cruzan everybody agreed that incompetent persons must be treated the same as competent ones because otherwise we would be demeaning the incompetent – we would be discriminating against handicapped persons. That, of course, is utter nonsense, as the Supreme Court recognized. To insist on treating incompetent persons like competent ones is in fact to demean incompetent persons by refusing to take their particular characteristics into account and by requiring them to be accommodated to the way in which we treat the majority rather than requiring the law to accommodate itself to their special needs and special interests. And, of course, you cannot very well make law based on freedom of individual choice for persons who have no ability to make individual choices.

The Supreme Court recognized all this in its ruling in Cruzan and dealt with incompetent persons on their own terms. It recognized that even if persons have some kind of a right to reject treatment that would include a right to reject nutrition and hydration, that right could be overturned by the states for good enough reasons. Focusing then on the states' interests in protecting and preserving human life and in safeguarding the personal element of choice, the Supreme Court held that it is permissible for Missouri to refuse to authorize the withdrawal of artificial nutrition and hydration in the absence of clear and convincing evidence of the incompetent person's desire to refuse continued life-support. The Court recognized, as the Missouri courts had found, that the evidence in the case was not clear and convincing, and therefore it upheld Missouri's refusal to authorize the withdrawal of artificial nutrition and hydration.

The Cruzan case had something for everyone. For those who were opposed to patient control over the manner and timing of their own deaths, there was the fact that the Court did reject the opportunity of Ms. Cruzan to have nutrition and hydration withheld; and there was the fact that the Court recognized the importance of states' interests to weigh against any interest the individual might have; and there was the fact that the Court tolerated a high and difficult burden before people could have life support terminated. For those who were in favor of maximizing patient control over the manner and timing of their own deaths, there was the fact that the Court said that one could infer a right of competent persons to reject medical care and that one could at least assume for
the sake of argument that that included the right to reject artificial nutrition and hydration.

The proponents of assisted suicide read *Cruzan* as supporting their point of view and recognizing a right to die. They saw no meaningful distinction between withholding or withdrawing life support on the one hand and assisted suicide on the other. And so, emboldened by *Cruzan*, they attacked two state statutes that prohibited assisted suicide (the statutes of New York and Washington), claiming that those statutes were unconstitutional.

The Fourteenth Amendment to the United States Constitution prohibits states from depriving persons of liberty without due process of law. In a pair of cases decided in 1997, the Supreme Court defined the question before it as whether the protected liberty includes a right to commit suicide, which itself includes a right to assistance in doing so. The Court decided that there is no such right. It upheld both statutes, finding not only that there was no due process violation but also that refusing to allow assisted suicide, while permitting the withholding and withdrawing of life-sustaining treatment, does not violate the equal protection clause of the United States Constitution either.

Interestingly, the Court specifically rejected any principled basis for deciding the question. It rejected an overriding commitment to personal autonomy, and it did not look for a logical or principled distinction between assisted suicide and withholding or withdrawing medical care. Instead, it looked to history and tradition, and it found that we have always treated assisted suicide and withholding and withdrawing medical care differently. Unlike rejecting medical care, assisted suicide has always been prohibited. Moreover, said the Court, states may choose to prohibit assisted suicide for several reasons: The state has an important interest in the preservation of life itself; it has an independent interest in preventing suicide; it has an interest, said the Court, in protecting vulnerable persons – people like Mr. Spring; it has an interest in protecting the integrity and ethics of the medical profession; and it has an interest in avoiding starting us down the path to euthanasia. Just as some people claim that there is no distinction between withholding care and assisted suicide, so, the Court said, those same people will then claim that there is no difference between assisted suicide and euthanasia, and we need to stop the march down that path right now. The Court, however, did not prohibit any state that might want to authorize assisted suicide from doing so. Indeed, the Court specifically remitted the issue to the states to experiment. One state, Oregon, does allow assisted suicide under some conditions.

Concurring, some justices in the Supreme Court insisted that situations might arise in which some individuals may have a right to assisted suicide; but they, too, eschewed principle in favor of common law, case-by-case adjudication. Thus, the legal status of assisted suicide may vary from state to state, and there may yet be further constitutional developments as well. Therefore, it behooves us to consider alternatives to assisted suicide as relevant to the context in which these developments will take place.


4 Ibid., p. 663.


11 In re Spring, 405 N.E.2d 115 (Mass. 1980).


13 Clear and convincing evidence is a very high legal standard. Ordinarily, the system allows things to be done by what is called a preponderance of the evidence, which requires only that the trier of fact conclude that the asserted proposition is more likely than not. In criminal cases convictions are only permitted if the prosecution's case is proved beyond a reasonable doubt. Clear and convincing evidence is somewhere in between. There must be very strong evidence that the patient wanted her care to be terminated before it may be ended.


Key Issues  
in the Physician-Assisted Suicide Debate

David H. Smith

The idea of shortening life for mercy, or from love, is not new. The proposal for physician-assisted suicide, approved in Oregon by two voter referenda, is but one of many specific proposals to address this issue that have been advanced in the last century. Although it may be difficult to make moral judgments about some hard cases, I shall claim that the general policy issue is less problematical and that practice and law should continue to oppose physician-assisted suicide.

I will offer a brief sketch of my rationale for this conclusion. I will argue that the issue presents at least three separate but interrelated components: presuppositions about the nature and prospects of human selfhood, the role of a religious vision in arguments about end of life care, and the proper description of acts of love near the end of life.

The clinical facts

We Americans have a profound dread of dying. We shrink from the fact that someday our loved ones and we ourselves will be dead, and we are dismayed by what we know about the process of dying. We have seen too much of pain and loneliness, physical suffering and confusion at the end of life. We have visited nursing homes filled with lonely and unhappy people who have no one to talk to and who are receiving only the most perfunctory care. We know of too many cases where the process of dying has gone on for too long, and dying persons seem to have become an endless and overwhelming burden to themselves and others.

For the past forty years or more, thoughtful social critics have pointed out the problems associated with dying in the United States. Several important reforms have been enacted, including protocols for determining when death has occurred, the federal Patient Self-Determination Act, state legislation that authorizes living wills and durable powers of attorney for health care,
and a variety of court cases in all jurisdictional contexts that have addressed decision making at the end of life. But the problems have not gone away. Few people do the necessary planning or even discuss these difficult issues within their families. For example, in a recent study of a small Indiana town we found that only a minute fraction of our respondents had signed an advance directive, 
despite their clear sympathy with the objectives of those documents. Seminal research conducted at five U.S. teaching hospitals and first reported in 1995 revealed troubling gaps in physician-patient communication and found that many physicians favored more aggressive treatment than their patients wanted. The study revealed that "only 47% of physicians knew when their patients preferred to avoid CPR; 46% of do-not-resuscitate orders were written within 2 days of death; 38% of patients who died spent at least 10 days in an intensive care unit (ICU); and for 50% of conscious patients who died in the hospital, family members reported moderate to severe pain at least half the time." In another report, the SUPPORT investigators described the problems that confront dying patients and their families. They documented pain, shortness of breath, and fatigue as common symptoms in patients who were conscious during the last three days of life; 63 percent of their respondents reported "difficulty tolerating physical or emotional symptoms." Final resuscitation attempts were reported for 11 percent of patients; use of a ventilator in 25 percent; and a feeding tube in 40 percent. Although respondents reported that most patients (59 percent) opted for treatment that focused on comfort, the research documented "treatment contrary to the preferred approach in 10% of cases." Approval of physician-assisted suicide is one natural response to particularly difficult situations. If I can't count on others to take care of me properly at the end of my life, I will assume responsibility for my own death. This option appeals to many Americans who – as I do – prize control over their own lives and deaths. However, I believe that their inference that we should support physician-assisted suicide is based on mistaken judgments.

The human prospect

The first and arguably the most basic issue raised by a recommendation for physician-assisted suicide is the question of what it means to be a person and what must be accepted in a life. I do not imagine that I can raise this complex issue without controversy. To a large extent, I agree with practical and pragmatic critics who may argue that raising general philosophical questions does not help to resolve the policy issue; in fact, it may be counterproductive. That people can agree on practical judgments without sharing rich visions of the world is an axiom of any sensible social and political philosophy, an axiom I wish to affirm. I do not think that we must agree on a sectarian creed or even a general philosophical orientation before we can understand each other and come to reasonable accommodations. Indeed, I think of myself as a casuist.

But there may be some presuppositions that are so problematical that we should reject them as the necessary basis for a social policy in any given society. The idea is not that the presuppositions are wrongheaded as the basis for an individual life (although they may be), but that a social policy that requires them for its credibility is not only unlikely to attract public support, it is a policy that is deeply incoherent with the society's basic values. If I must reform or convert the citizens of Community X before my policy proposal makes sense to them, then my proposal is not good for Community X.
Obviously I think that advocacy of physician-assisted suicide entails such a perspective, which I will call the "self-definition perspective." Its core is a belief in the importance of human self-determination, the conviction that human beings have a task of self-definition that begins with birth. On this view, people are responsible for building their own lives, structuring what and who they will be. Anything that interferes with their autonomy is an obstacle to be overcome, whether the interference is biological or social. Defenders of this sort of perspective on the self come in both religious and secular vestments, but they share a commitment to liberating individuals from what they regard as oppressive physical and social circumstances.

They argue that we should be free to exercise the right of individual empowerment right up to the end. Thus the driving principle in reform of care for the dying is institutional or social change that ensures that patients' express wishes will be respected. Professional dominance is the beast to be slain, whether it be actual malevolence or the much more common unresponsiveness of health care institutions, physicians, nurses and some religious authorities. The answer to the question "Whose life is it anyway?" is assumed to be obvious: the patient's. Control over one's own life is not only a good thing, it is the most essential thing; the more control we have, the better. We expect to take responsibility for the shape of our lives in many other important spheres (for example, in choice of career or marriage partner). Why not assume control over the way we die?

Recognition of cultural pluralism and human diversity reinforces this perspective. Although we can't identify the right way to live a life, we can respect everyone's right to make choices about the way to live, what to stand for. Diversity of opinion reigns even within many very small religious congregations; how much greater the diversity when we look at American society as a whole? The way to live in a pluralistic world (which may be all worlds that have ever been or will be) seems to be to agree to disagree. Respect for persons is a very sensible and sane moral absolute, and if respect for persons is one's only, or one's trump moral card, it will be hard to oppose exercise of individuals' right to determine the course of their deaths.

The self-definition model is a wonderful corrective to family or professional paternalism. It is empowering and liberating, and it has been the most audible voice in the social movements to enact legislation authorizing advance directives. It captures an important part of the truth. People have a right to live their own lives, and they should have the right to die their own deaths. Indeed, this way of looking at life makes the ability to choose how one will exit particularly important. Last acts and last lines should follow naturally from what has gone before, and they are often what is remembered.

The model has two apparent problems, however. First, it moves too quickly from individual choice to social policy. Even if physician-assisted suicide were the best option in some cases, it would not follow that legalisation of the practice is wise social policy. Serious dangers of abuse are obvious, and the supposedly narrow range of acceptable killings could easily be expanded to justify death for people for whom it is neither the chosen nor the best option. Wedge or slippery slope arguments can be raised against the self-definition model when it is used as a basis for policy.
For example, suffering and pain are not restricted to the competent or to the end of life. It is obvious that many persons with chronic and/or degenerative diseases suffer. Why should the right to relief be limited to terminally ill adults? Disappointments in marriage or career, loss of face, the inability to control problems of substance use or bodily imperfection— all may lead to desperate loneliness, isolation and despair. Suicide may appear as a way to take charge in the end, to exercise responsibility at least over one’s exit from the stage. Physical pain is not the only life circumstance in which it may seem important to seize control.

Second, in addition to raising problems of line drawing, the self-definition perspective oversimplifies the needs of the terminally ill, who need more than liberty. If we focus only on allowing terminally ill persons to decide for themselves, their needs for comfort and companionship are easily glossed over. Terminal patients need the empowerment that comes from company, comfort and security. Without these forms of community, the power to decide on one’s own can be worthless. Thus, the self-definition perspective leads to conclusions that are intuitively problematical. But more basically it seems to take as its ideal a life of mastery or control over nature and fate. I shall suggest that this total mastery is neither possible nor ideal. Is a different perspective available?\(^5\)

**Self-discovery**

We can get at an alternative if we consider that our more natural form of words is to refer to life as a process of self-discovery rather than self-definition. Although we make decisions about what we will do and whom we will be with, those decisions are made in a historical, biological and psychological context that we did not create. As we grow and are helped or harmed by the consequences of our prior actions, those prior actions continue to qualify only a small fraction of the circumstances in which we act. The fundamental mistake of the self-definition paradigm is that it exaggerates the possibilities—and desirability—of self-definition; it imagines a form of self-control and self-design that are impossible to attain and therefore destructive to strive for. We are better off with a perspective that acknowledges limits on human power and stresses fitting response, rather than attempting complete control.

On the terms of a self-discovery model, human identity is relational and discovered in identification with something beyond the self. True selfhood is found in living in relation to something. There are realities beyond our selves that we cannot master but can only respond to. Our identities are shaped by the way we understand those realities, by our loyalties to certain aspects of them that seem to us to be particularly important. Each of us has centers of value to which we respond with loyalty and trust.

Nothing makes these facts clearer than the experience of love and trust in another person—a parent, spouse or child. True love is not co-dependence, to be sure, but it entails an element of surrender of total control over one’s life and a recognition that the lover must adjust to changes in the beloved, as a sailor must adjust his sails to the changing course of the wind and the tide. The realities to which we respond in ourselves and each other are not our artifacts. We are not completely in charge of our own lives.

Is that unfortunate? We live in a time in which persons will go to great lengths, sparing little expense or effort, to shape their lives and their bodies as they would like them to be. If ever there has been a society that could say, “We’ll make ourselves into what we want to be,” ours is that society. And there is something wonderful about the plasticity of the human body and human selfhood in responding to our individual and
collective efforts. But our power to create ourselves is limited, as the sufferers from developmental disabilities or chronic illness, the families of accident victims or the demented know well. Nor are these limits on our power all bad news. Unearned breaks, good luck or the generosity and love of someone unknown may open possibilities better than we ever dreamed of. A completely controlled life would miss out on the good as well as the bad news.

To see everything that is outside one’s own control as an impediment or a source of frustration is to close off the possibility that true novelty will surprise us and enrich our lives. Joy and growth may enter on the back of sadness, as the success of the popular memoir and video _Tuesdays with Morrie_ makes clear. This possibility of joy and growth does not justify or explain the evil or heartache it follows, but it does mean that we should be circumspect in our claims of certainty about the unmitigated disvalue of things that are not under our control.

Let me not overstate my point. I don’t mean to argue for passive acceptance of evil, suffering and mischance. Nor do I resist all aspects of what might be called “self-creation.” Human agency is to be celebrated. But our vision of the context in which we act is all-important, and a vision that fails to recognize human limit is sadly out of touch with reality. To make a convincing argument for physician-assisted suicide, one must be able to say that the unknown future will certainly be bad, so bad that a preemptive strike is required. I do not deny that such an argument could have been made in some circumstances in the past, nor assert that it can never be made. I do contend that it is irrelevant to virtually all the highly publicized cases, and I think that many of the ablest defenders of physician-assisted suicide in the United States today equate the undesired or out of control with the bad, and they base their argument on this highly questionable equation.

A good example of this conflation can be found in Ronald Dworkin’s book _Life’s Dominion_. Dworkin argues that the fundamental issue in the debates over abortion and euthanasia is not really the question of who counts as a person. Instead, it is the “sanctity of life,” and he contends, differing conceptions of sanctity are at odds in the debates over abortion and euthanasia. He hopes that recasting the issue in terms of sanctity will allow the combatants to see their disagreements in a fresh perspective, because we are used to disagreeing over issues of sanctity – or religion. If we could be as tolerant about diverse choices at the beginning and end of life as we are about religious forms of worship or doctrine, we might not agree on the merits of the issues, but we would realize that we have to learn to live with disagreement. The result will be permissive social policies for both abortion and euthanasia.

Obviously, a great deal turns on Dworkin’s understanding of _sanctity_. He contends that there is a spectrum of views on the question of what makes life sacred. At one extreme are persons who think that life is simply sacred in itself and as such – because of an investment by God or nature. At the other pole are those who think that the sanctity of life is the product of human effort and creativity and that the greatest evil is frustration of the human contribution to life’s sanctity. Sometimes Dworkin suggests that few people’s views belong at the poles; in fact, we all acknowledge diverse forces that make a life sacred.

But his argument hinges on the idea that the individual’s own contribution is essential; as someone grows up, “he creates his life just as much as an artist creates a
painting or a poem.” Dworkin quickly goes on to say that he resists a “Romantic” conception of life as a work of art because of the inequality of basic respect it entails. Life, he contends, is sacred because of its sacred or evolutionary origins, the cultural legacies in which it may participate, and “the process of internal personal creation and judgment by which a person will make and remake himself, a mysterious, inescapable process in which we each participate, and which is therefore the most powerful and inevitable source of empathy and communion we have with every other creature who faces the same frightening challenge.”

The hard question is how to correlate the apparent diversity of positions on life’s sanctity with policy positions. Dworkin clearly thinks that anyone who holds anything but the most extreme theological or naturalistic position on the origins of the sanctity of life must agree with his permissive view on physician-assisted suicide. If “we deny that the natural contribution to life is dominant, and insist that the human contribution is important as well...” then we will have a much stronger reason for denying that euthanasia always insults the sanctity of life: we will insist that sometimes euthanasia supports that value.”

Dworkin wants to say that individuals’ contributions are highly significant, and once we recognize that fact we will have to concede that respect for individuals entails permitting them to choose their own form of ending their lives.

But I think that this entailment works only if individuals’ contribution to their own lives’ value is necessary and sufficient to establish that value. So long as other factors — religious, biological, historical or social — contribute to value, I do not see how one can assume that individuals’ own creative contribution is necessarily and always trump. Indeed, Dworkin gives very little attention to the contributions others may make to the value of a person; he writes as if the possible bases for sanctity were either physical nature or psychological strength. But we are valuable because we are loved by others, depended on by them, heirs of their habits and sources of their wit and resistance. We are loved as children of God, but even someone who doesn’t look at things this way has ample reason to resist the idea that we create ourselves. Insufficient self-respect is a serious problem; hubris is worse.

Because selves don’t constitute themselves, some have no dignity if all dignity must be achieved. The effect of Dworkin’s position is to remove the basis for respect from all who can do noting to create their lives as something of value. Self-esteem and status are certainly achieved through skill and effort, but they are distinguishable from dignity and self-respect. Those more fundamental qualities are a “function of membership” and depend “upon equal respect among the members.” They are matters “of our own qualities: hence of knowledge, not opinion, and of identity, not relative standing.”

We don’t earn or create self-respect or dignity, but discern it and then live up to it. That is what the philosopher Michael Walzer means when he says it depends on “self-possession” or the “ownership of one’s character, qualities and actions.” Because of membership in a community, we discover that we are beings worthy of respect. (Obviously, communities may send the wrong message or we may fail to get the point.)

Support of physician-assisted suicide implicitly denies the social character of selfhood and self-respect. As Michael Sandel wrote of the philosopher’s brief — a document to which Dworkin was a contributor — a particular kind of emphasis on “autonomy and choice implies that life is the possession of the person who lives it [and is] at odds with a wide range of moral outlooks that view life as a gift of which we
are custodians with certain duties.” If the value of a person’s life is not adequately described as “the value he or she attributes to it,” then the question of who should control life at the end is more difficult than Dworkin or “the philosophers” suppose. What one misses in the philosophers’ arguments in favor of physician-assisted suicide is “the sense of value in us that makes a claim on us – a value that we must live up to.”

If dignity were entirely a matter of personal creation or achievement, the case for physician-assisted suicide would be much stronger, for then it would make sense to say that the only one with any interest in the script of my life is myself. But most of us – rightly – don’t think of ourselves in that way. We realize that we are more fundamentally social, that others, I would say including God, have essential interests in us and we in them. With Aristotle, we recognize that suicide is a profoundly social act. It should not be justified solely by the agent’s prerogative.

The radical individualism of the physician-assisted suicide advocate is sometimes concealed by the fact that an argument often used on behalf of the liberal policy is compassion for the family. A loving family member may choose death to avoid burdening or interfering with the lives of her children or other care givers. But “I am truly and fully a part of a community not only when I am willing to make sacrifices for others, but also when I am willing to accept their sacrifices for me. . . . The very fact that a chronically dependent person would consider attempting to relieve her overburdened care givers through her own death suggests that her society is insufficiently supporting its care givers or failing to provide them with adequate respite from their labors.” Watching a loved one decline is inevitably and rightly painful; wanting to spare someone that pain is thoughtful and may involve genuine altruism. But these facts lead to oversimplification if they inspire us to think that we really have the power to spare others grief at our death, or that grief is the worst legacy, for bereavement entails coping with guilt as well as regret. Ironically, “when we provide social legitimation for the option of suicide . . . we effectively eliminate an option, namely, the option of staying alive without having to justify one’s existence.”

Religion
This discussion brings us to the second dimension of the issue that I hope to address: the religious dimension. Although Dworkin’s discussion of the “sacred” is untouched by the relevant scholarly literature, such as the work of Rudolf Otto, Mircea Eliade, Clifford Geertz or Jonathan Z. Smith, he is right to suggest that this argument has a religious dimension. I have just tried to show why his particular conceptions of the sacred should not be the basis for public policy.

The clash between the self-definition and the self-discovery perspectives is a clash that occurs both within and among religious perspectives. We will find exponents of both perspectives within each of the Abrahamic traditions and among those who are not involved with organized religion. I believe, although I am less sure of my ground here, that we will find them in most, if not all, of the cultures and traditions of the world.

Every people has its fatalists, its Polyannas, and those who attempt to work out a compromise position of the sort I am gesturing at. Perhaps it would be better to say that the choice between self-definition and self-discovery is a meta-religious choice, but that would not help, as religions
attempt to offer answers to just this sort of question.

In fact, the issue is more complicated than I have acknowledged—and in many ways. To take just one: Suppose a self-discovery perspective is taken to be the more correct. We still must question the extent to which the powers to which we relate are indifferent, malevolent or gracious. Rejection of the self-definition model does not automatically lead to the conclusion that the world is a comfortable home! As H. R. Niebuhr wrote nearly fifty years ago, seeing the powers with which we cope as something that can be trusted is a miracle—or perhaps a sad delusion. Trust in God is not easily come by and is almost always fleeting. Religious commitments have crucial affective and attitudinal dimensions that worship, ritual and pastoral attention seek to sustain—often unsuccessfully. These affective and attitudinal components of our perspective are of great relevance to determining, understanding and evaluating choices near the end of life. I will return to the pertinence of those differences in the next section.

Rejection of a crisp self-definition model in no way entails agreement on the value of life or of how the dying ought to care for themselves or others. It means only agreement that it is too simple to say that people live only for themselves or for those for whom they may choose to live.

But acknowledging this religious—or meta-religious—dimension of the issue leaves a major response open to the defenders of physician-assisted suicide. They may claim that because the First Amendment commits us to religious liberty in the United States, choosing among religious options is forbidden both to governmental authorities and to advocates of social policies and legislators. Thus Dworkin can say, in effect, even though you find my ideas about dignity and prerogative to be mistaken, because they are religious ideas I must be allowed the liberty to act upon them. The First Amendment prohibits establishment of any religion or religion in general, and it guarantees free exercise. Those principles count for nothing if they don’t let me follow my conscience to the death.

But this response has two serious flaws. First, as I have tried to show, it is the advocate of physician-assisted suicide, not the opponent, who is covertly establishing a specific view as a basis for public policy. Apart from a crisp self-definition perspective, that advocacy must appear highly problematical. Social morality should reflect our best understanding of reality; we would not base public policy on the assumption that the earth is flat. Similarly, our best understanding of human reality is that throughout life (and particularly at the beginning and ending of our lives), we are dependent social and relational beings, whether we want to be or not. Care for us should be particularized; that is not the same thing as moral individualism, which is destructive particularly at the end of life.

Second, it is unreasonable to suggest that advocacy of policy positions cannot be based on social views as generalized and widely held as some form of self-discovery model of the self. Free exercise presumably includes freedom of thought, and that must include thought about fundamental questions of public policy and social action. It cannot mean that anything but the self-definition model is ruled out of court as a basis for policy. Thoughtful scholars disagree about the legitimate forms of connection between religious thought and public policy proposals, but the kind of general and nonsectarian claim I am making here can scarcely be excluded on procedural grounds. For example, Sanford Levinson, writing about a much more full-blooded religious argument than I am offering, writes, “It seems enough for those of us who are secular to disagree vigorously with persons
presenting theologically-oriented views of politics. To suggest as well that they are estopped even from presenting such arguments seems gratuitously censorial rather than wise, especially in a country as remarkably pluralistic as the United States.

I do not mean to establish a covert religious perspective; I mean to suggest that dialogue is central and to resist the de facto establishment of a perspective that makes it unnecessary. The self-discovery perspective resists pre-emptive unilateral decision making. It suggests that involved parties must deliberate about the proper forms of care for someone who is dying. Discerning what is going on near the end of a life is so intellectually and emotionally challenging that these decisions call for some form of social process.

I quickly concede that it is appropriate for competent persons to decide for themselves, but that does not mean that there can be no restriction on what should be done to and for them. Nor does it require disregard for the needs of others.

**Act and context**

Asserting the greater accuracy of one generalized perspective on the world over another does not obviously lead to a conclusion about physician-assisted suicide. I must explain why physician-assisted suicide is incoherent with the views of the world – described under the heading “the self-discovery model” – that I find more plausible.

Acts take their meaning from their context, although that is not to say that they can be defined in any way that someone chooses. For example, who is around when I pay my son a compliment or criticize him is relevant to an adequate moral evaluation of what I am doing. Telling a child not to chew with his mouth open when I am alone with him is different from making the same remark in front of his friends or siblings. Whatever my motives, the latter is harder to justify as an act of love than the former, precisely because it was a different act, morally speaking. Circumstances alter cases.

When we reflect on the morality of options for end of life care, we should remember that in the face of much variability and difference there is also some commonality in circumstances. In particular, life has a common trajectory. Although boundaries are often hard to define, it is meaningful to speak of morally relevant stages of life such as birth and infancy, adolescence, aging and dying. Thinking of lifetimes in terms of these stages can lead to stereotyping and to behavior that is disrespectful, as when teenagers or the elderly are patronized. But being oblivious to the needs that are associated with a stage of life is comparably insensitive and cruel, as when teenagers are treated as if they should have their whole lives sorted out, or the elderly have their fund of experience dismissed. Proper care for ourselves and each other should acknowledge the fact of change in our lives; indeed, change should be celebrated, as it is in commencements, marriages, retirement parties – even funerals celebrate the finite life of the deceased.

In this context, it makes sense to think of dying as a distinctive stage of life, rather like adolescence or menopause. As with those stages of life, much else is going on simultaneously. Friends are being made, houses built, books read and new things learned. Again, as with those other stages in a life, the boundaries are not always clear, nor is there a crisp formula that will tell us when the stage or process begins. Indeed, dying may be episodic, with periods of recovery or plateaus punctuating a general trend of decline. But these facts don't
make it meaningless to speak of stages of a life.

On the assumption that action should be pertinent to reality, and understanding dying as a real part of life, we ask: What is a fitting response to dying? Two off-target kinds of response immediately come to mind. One is denying that the process is happening and pretending that no change is occurring. The second is acting as if one could skip the process altogether, as someone might prefer to move directly from childhood to maturity, skipping adolescence.21 Denying the process leads to refusal to provide the forms of help that this distinctive stage of life requires; physician-assisted suicide or euthanasia is an attempt to make the transition without living through it.

The first mistake, pretending that dying isn’t happening, is made easy by the enormous specialization and heavy workloads of modern health care providers. High-tech medicine and medical specialization easily lead to a situation where the care givers tend to focus on some specific part of the patient rather than the whole person. The kidneys function while the brain seems shut down; then the kidneys shut down, and the lungs close up. Organ systems seem to take turns dying and then coming back, and the specialists are territorial, reluctant to allow “their” system to be the one that kills the patient. Technology in the hands of a team of highly competent and caring specialists may deform the dying process, keeping patients from a death they are ready for.

Family dynamics reinforce the problem. No one wants to acknowledge that the party is over. Families don’t want to let go because of love, or guilt, or because they hope for a change in the distribution of an estate. Not all reasons for their reluctance are bad. Patients and families should not be hurried. Issues, as the jargon has it, must be “worked through.”

Certainly the mistake of denial and inability or unwillingness to see what is going on is the more common problem in early twenty-first century American medicine, as the SUPPORT study and other work make clear. We face a crisis in the education of health care professionals, in the spiritual lives of Americans, and in health care reimbursement policies that must be resolved in ways that help us to recognize that we or our loved ones really are dying, make that recognition more acceptable, and enable us to ease the process. In clinical settings, each patient should have some professionals (nurses or physicians) whose specific task is seeing the larger picture and who are empowered to focus on the life trajectory of the person as a whole and not just on one part or organ system.

But in this paper I am concerned with the converse error: thinking that dying can be avoided. We want to move directly from maximum power performance to nonbeing, evading the difficult terrain that we must traverse between the two states.

Any honest person can identify with this understandable hope. Dying may be protracted beyond endurance. Many of us have sat at a bedside and wished, perhaps prayed, that a loved one would die, that he or she or we might be spared the final indignity. And that has been a prayer of love. In fact, we can and should do more than pray, although prayer is no small thing. We need not simply wait for nature to take its course.

Specifically, we should feel comfortable with increasing dosages of analgesics, be prepared to wean dying patients from respirators, and refrain from “therapeutic” procedures that do not contribute to comfort and the possibility of communication. Analgesics, sedation if necessary, should be adjusted to the comfort level the patient needs. Contrary to much popular (and some professional) beliefs, controlled and substantial increase of analgesia is not
certain to lead to death.\textsuperscript{22} Withdrawal of nutrition and hydration is appropriate when the patient’s dying is being wrongly delayed.

Determining what is a wrong delay is not simply a matter of biology, although biology is a crucial element. The wishes and engagements of a dying person are central data in recognizing what is going on. Further, the family’s judgments, feelings and preparedness are highly relevant. Dying is a social event as well as a biological one. One wants to know what a person lived for, whether she needs more time to prepare, whether family members are on the way, what the family values. We should also wonder if a patient is depressed, worried about the loss of an estate to medical costs, tormented by guilt and regret. Selves are more than bodies, and death is not just a matter of the body’s failing.

Orchestrating the process for the patient’s benefit, with the patient’s fitting death at the center, is an entirely appropriate response to the reality of dying.\textsuperscript{23} But orchestration is different from composing the score. When our institutions and practices support an idea of self-definition, when we assume that people define themselves and therefore should be entitled to script their own exits, we create a destructive situation. We act on the basis of a mistaken perception and therefore run a great risk of getting things wrong. Most importantly, we close off the possibility of growth and change, reconciliation and forgiveness.

We might plausibly view the movement on behalf of active euthanasia as a religious recoil against all the medical busyness and officiousness with which we have surrounded death.\ldots While fretting in our busyness to save a life or delay the dying, we may sense that we have profaned the man or the woman doing the dying. We may have refused to open ourselves to what is happening by frantically working to make things happen. But, ironically, the movement of active euthanasia seeks to halt all those furious efforts at control by employing one more device of control.\textsuperscript{23}

A self-discovery perspective suggests that the most fundamental issue at the end of life is not “What do I want?” The prior question is “What is happening?” Pretending that this question can be avoided is a fantasy that should not be supported. Recognition of the reality of dying takes us only so far. It allows us to grasp that we have entered a period in which a new set of priorities should take over. As Paul Ramsey wrote years ago, as life draws to its end cure is no longer possible, and providing comfort and company becomes the essential thing we can do.\textsuperscript{24} Thus involved persons can be sure that there are some things it is now wrong to do: performing major surgery, limiting analgesics because of the fear of addiction, or flying to the specialists in anything other than symptom control. Those choices are wrong because they are incongruent with this time in our lives, with who we were and who we have become.

That does not settle the question of what we should do, and my conviction is that those questions are best answered on an incremental basis. What we should do is keep the patients’ overall health and prognosis in mind, focusing on which of the available options are in their best interest, as displayed in the choices they have made throughout their lives. We should increase analgesics as much as they need for effective pain control, and the patients are the best judge of what is needed. We should be willing to discontinue tube feeding as it becomes clear this strategy is prolonging the
ending to the last chapter in someone’s own story. We should agree to total sedation if that is the best way to control symptoms.

But that does not mean we should forget that there are things going on that we should be responsive to or that kill people at their or someone else’s request. When, as in physician-assisted suicide, we go beyond response to design and self-definition, a perspective that envisions life as self-discovery provides a basis for inferring that we have gone too far.

Conclusion

The self-discovery perspective leads to some restriction on the choices people may make at the end of their lives. It suggests that some ways of helping each other are off limits because, based as they are on a mistaken understanding of reality, they are destructive. It contrasts with the liberty- or autonomy-centered perspective that is so widely embraced in twenty-first century America. Recommending limits on individuals’ freedom of choice, especially at the end of life, is understandably controversial in an individualistic society.

One part of my response is to note that a significant element of community orientation complements individualism in the American psyche. As Bellah and colleagues argued in Habits of the Heart, we quickly go public with the moral language of individual rights, but in fact we speak a “second language” of interdependence. We want individual liberty in large part so as to find fulfillment in families, churches, workplaces and studios.25 Nowhere is this fact of our lives more pertinent than at our lives’ ends.

Even if that is partly right, a sympathetic critic may say, “You are getting at something important in your contrast between self-definition and self-discovery, even if it’s somewhat mystical. However, it is not clear why this distinction leads you to draw the line at physician-assisted suicide. Why is that particular policy incompatible with self-discovery when many forms of proactive symptom control or discontinuing special kinds of treatment are not?”

My response to this key criticism, in a nutshell, is that approval of physician-assisted suicide demands a greater level of certainty and self-determination than those other options. In proactive symptom control, such as increasing analgesic dosages, patients, care givers and involved others recognize the reality of ongoing events to which they are responding. Even in discontinuation of alimentation or assisted respiration – situations in which there is no doubt about the result of one’s actions – one can plausibly say that the actors are responding, albeit in ways that are appropriate only at this stage in a human life.

Obviously those chosen discontinuations or dosage increases can be described in other ways; they can be described as “killing.” But critics would not describe those acts in that way if they were not trying to score a point arguing for physician-assisted suicide. A much more accurate description is that they are attempts to make a dying person comfortable, and to treat a dying person as someone who is dying.

Let me give an analogy. A man is dying but wants to see his grown child one last time. The younger man knows the effect his arrival is likely to have on his father. When he arrives at the bedside, he touches his father, and says “I’m here, Dad.” The older man dies soon thereafter. An observer could say that the son killed his father by showing up. But that would be grotesque – almost as grotesque as is saying that someone who reasonably increases an analgesic dose kills a patient. Touch can be lethal, as when a son strangles his father even for beneficial motives. But we would never so describe a touch of love, as when care givers gradually increment analgesic dosages to levels necessary to keep patients free from pain.
The “hard-nosed” option is not more realistic; it has the description wrong.

Physician-assisted suicide, in contrast, is better described as taking over. When I assist in a suicide, or choose it for myself, I try to foreclose the possibility of unexpected responses to my action. It’s an intentionally final act, precisely designed to assure that there are no further events involving my body. The door to anything interposing from beyond the conscious self is unequivocally closed.

At the end of the day, there will be many close calls and uncertainties as to whether a given act was one of assistance in the last stages of a life or one of taking a life. And that is the way we should put the question to ourselves. We should not ask, “Is physician-assisted suicide justifiable in the exceptional case?” but rather, “Would these actions be actions of help at the end or actions of taking life?” We should assume the appropriateness of some form of self-discovery conceptualization and then ask if the morally problematical form of care, treatment or medication is coherent with it. It is impossible in advance to pronounce on the morality of many hard cases, and I have no doubt that there have been and will be again circumstances in which something that someone will describe as physician-assisted suicide is a responsive act of love. But when they do that, I will either dispute their description or their verdict. Conceding the

reality of such cases is very different from favoring a policy – whether it be legislated or enacted by local custom – in which physician-assisted suicide becomes an accepted part of standard medical practice.26

If we concede that life’s meaninglessness or individual preferences are sufficient reasons for terminating life, we create very significant problems of line drawing. The economic, political and social pressures to expand those boundaries – to increase the size of the group of people whose lives are “meaningless” – will be very difficult to resist. More fundamentally, the facts of pluralism, uncertainty and interdependence strengthen the case for rejection of the self-definition perspective as a basis for policy at the end of life. The great benefit of that perspective – empowering persons to act responsibly on their own – has the unfortunate corollary effect of cutting off conversation and justifying action in defiance of biological and social reality and possibility. That is a rich irony. The same intellectual gambit that empowers individuals to decide for themselves allows them to isolate themselves. Thus it removes the pressure for conversation, dialogue and negotiation at the end of life – things that can make the balance of a life worth living. It stands against mutual support and for arbitrary action. We can do better.

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1 I received many helpful comments on presentation of this paper in October 1998. Since then I have been particularly helped by my colleague Judith Granbois; that certainly does not mean one can infer her agreement with my argument.


3 The SUPPORT Principal Investigators, “A Controlled Trial to Improve Care for


7 Ibid., p. 83.

8 Ibid., p. 84.

9 Ibid., p. 215.


11 Ibid., p. 279.


14 *Nichomachean Ethics*, Book III Chapter 7, Book V Chapter 11


20 Marilyn J. Field and Christine K. Cassel, eds., *Approaching Death: Improving Care at*

21 A friendly critic commented on this argument that skipping adolescence is not a good analogy because adolescence is inevitably extended in time and represents a change from one phase of life to another. It is not clear what dying is a transition to, and that may seem to vitiate the analogy, as I do not mean to hinge my argument on an assumption of immortality. But endings can appropriately be described as transitions, as in the transitional period between the announcement of a retirement and the effective date. What is at stake in the argument is precisely whether dying, as a transitional phase, is something that should be lived through. I hold that it is, although, as with adolescence, I wish neither to prolong it nor to fail to do everything possible to make it easy.


23 May, Testing the Medical Covenant, p. 47.


The debate about physician-assisted suicide is replete with concern over the role of economic factors. Justice Rehnquist, writing for a majority of the Supreme Court in *Washington v. Glucksberg*, noted the state’s interest in protecting patients from “the real risk of subtle coercion and undue influence in end-of-life situations,” particularly those patients “whose autonomy and well-being are already compromised by poverty...” Rehnquist went on to object that, “[i]f physician-assisted suicide were permitted, many might resort to it to spare their families the substantial financial burden of end-of-life health-care costs.”

Justice Souter, in his concurrence, pointed out that “[p]hysicians, and their hospitals, have their own financial incentives, too, in this new age of managed care.”

These concerns are shared by many scholars. The New York State Task Force on Life and the Law warns that “patients may be pressured to consent to euthanasia when their care is expensive or burdensome to others.” Susan Wolf urges us to “consider the dangers of assisted suicide in the context of managed care.” Nancy Osgood laments ageism in America, which may lead older people to seek assisted suicide rather than become “an economic burden on younger members.” John Kilner observes that, “if choosing death becomes a socially accepted alternative, then patients needing much care may begin to consider themselves selfish merely for choosing to live.” “The very autonomy sought to be exercised [by permitting physician-assisted suicide] cannot be invoked if it is only allowed to be considered in a medical environment where the primary source of assisted suicide advice comes from physicians with economic interests that could objectively be at odds with those of the patient,” states one student law review note entitled “Undue Economic Influence on Physician-Assisted Suicide.”
Another note objecting to the practice declares simply that, "[a]mong the many factors that influence America’s health care decisions, money is the most invidious."

The economic objections to physician-assisted suicide fall into three categories: First, it is feared that physicians and other health care providers such as hospitals and managed care organizations, faced with financial incentives to reduce health care spending, will pressure patients to request assisted suicide. Managed care plans often are financed with employer self-insured funds or with premiums paid by employers (together with employees, in most cases). The managed care plan has an incentive to hold down spending in either case: to save employers money or to retain a profit by spending less than the amount of premiums collected. Managed care plans in turn employ various methods to encourage physicians to limit spending on plan enrollees. These techniques range from profit-sharing bonuses and risk-sharing arrangements (in which a portion of the physician’s fee typically is withheld and returned only upon satisfactory evidence of the physician’s fiscal frugality) to capitation (in which the physician is paid a fixed amount per enrollee per month, making the physician’s economic incentives equivalent to those of a premium-financed plan). Confronted with these financial pressures, physicians may turn to assisted suicide as a means of reducing the costs of caring for enrollees.

Physicians also may feel that they must represent the interests of society in encouraging patients to choose less costly alternatives. Physicians may see themselves as instruments of “bedside” health care rationing. They may favor assisted suicide particularly for older patients, in line with the beliefs of those like Daniel Callahan, who think that the elderly have enjoyed enough of the resources of society and should make way for the young.

Hospitals are under economic constraints similar to managed care plans. In some cases, the hospital actually may be part of a managed care plan. In other cases, such as under Medicare, the hospital may be paid a fixed amount for a patient regardless of how long the patient stays in the hospital or what services the patient receives. This arrangement may lead hospital administrators to encourage their medical staffs to recommend physician-assisted suicide to hospital in-patients.

The second type of economic objection to physician-assisted suicide focuses on the role of the patient’s family. Families, it is feared, may pressure patients to choose assisted suicide to avoid spending money that the patient otherwise could leave to the family. Or, family members may exert pressure because they are spending too much of their own money.

Finally, even without overt pressure from others, patients may opt for assisted suicide to save money. They may feel it is their duty to their loved ones. They may feel they owe it to society.

Given the likely economic impact of assisted suicide, these fears arguably are worth taking seriously. Emanuel and Battin estimate that legalizing physician-assisted suicide could save as much as $627 million each year in the United States. While, as they point out, this is less than .1 percent of total annual U.S. health care spending, the savings for an individual health plan or provider institution could be substantial enough to cause them to exert pressure on patients, either directly or through patients’ physicians or families. Emanuel and Battin calculate, for example, that a managed care plan with 1.7 million enrollees would save $3.3 million a year if the expected number of patients (351) chose physician-assisted
suicide. The economic impact on the patient's family is likely to be even more dramatic, particularly if the patient lacks health insurance. According to Emanuel and Battin, the average family of such a patient could save $20,000 if the patient chose physician-assisted suicide. Finally, studies not surprisingly show that terminally ill patients already take the costs and burdens of their care into account in making end-of-life treatment decisions; they are likely to be even more sensitive to these considerations if they perceive physician-assisted suicide as a more attractive alternative to currently available ways of dying.

The fears that physicians and other health care providers, families, and patients themselves may favor assisted suicide for economic reasons therefore seem real. The question, however, is whether they should be fears.

Let me begin by considering the third category of concerns: that patients, on their own initiative and without pressure from others, may take financial considerations into account in choosing physician-assisted suicide. Is there something necessarily improper about that? Or, more to the point, is there something so improper about it that we ought to deny patients the right to do so lawfully, by making physician-assisted suicide illegal?

Are economic motives for physician-assisted suicide inherently unacceptable?

Suppose the patient choosing physician-assisted suicide is wealthy, and fits whatever medical criteria are required to be a candidate. One motivation for her choice is that she wishes to leave her wealth to her family rather than to spend any more of it on her own health care. But apart from this consideration, she does not want to live.

It is difficult to imagine that we would deny physician-assisted suicide to this person solely because she is taking economic considerations into account in making her decision. There is nothing inherently wrong in having an economic motive, among others, for one's behavior.

Suppose instead that the wealthy patient would want to go on living, but for her desire to leave her wealth to her family rather than spending any more of it on health care for herself. In other words, economic considerations are what tip the scales for this patient in favor of physician-assisted suicide. It is still difficult to accept that the patient's economic motivation alone should disqualify her from carrying out her wish. We may disagree with her decision. We even may question her competence in choosing to die in order to leave more money to her family when her heirs already would receive a great deal of money even if she went on living. But a competent patient's right to autonomous decision making undoubtedly extends this far.

Now suppose instead that the patient is poor, or at least significantly less well-off than the patient in the previous example. Unlike the wealthy patient for whom physician-assisted suicide may make no more difference than being able to leave another luxury automobile or two to her heirs, the poorer patient who goes on living faces the prospect of not being able to leave her family enough to live on decently.

This scenario clearly is more disturbing, at least if we assume that the patient is poorer through no fault of her own. (Of course, that may not be the case: The patient may have less money because she gambled it away, or took expensive vacations, or chose to have a large family.) Even then, we may feel sorry for the patient, just as we might feel sorry for a smoker who was dying of lung cancer. There is something morally
wrong with someone being in such a situation. We ought to object to it, and to a society that places people in such a predicament. We ought to work tirelessly to achieve a better social system. But in the meantime, should we deny the poorer patient the ability to make her choice? Indeed, some might say that the poorer patient’s ability to choose physician-assisted suicide is all the more valuable to her because of her predicament, that precisely because so much more is at stake for their families, it is more important for this option to be available to poorer patients than to richer ones.

The problem with this reasoning might seem to be that the poorer the patient, the fewer options she has. If she is sufficiently poor, the patient may feel that she has no option but physician-assisted suicide, that her family’s financial predicament is so dire that she has no real choice at all. In this case, we might object that, in contrast to the wealthy patient, the poorer patient’s decision simply is not voluntary.

But consider the patient who chooses physician-assisted suicide to escape intractable pain, or indignity and loss of control, or simply the prospect of a lingering demise, and who faces these conditions through no fault of her own. Like the poorer patient, this patient too faces a truly “tragic choice,” to borrow a term from Calabresi and Bobbitt. Her dilemma moves us deeply. Her predicament, by depriving her of a viable alternative, may seem to deny her a voluntary choice. But does denying her the option of physician-assisted suicide improve her condition in any way? The same seems true of denying physician-assisted suicide to the poorer patient.

The two types of patients – the one facing the Hobson’s choice of unbearable suffering or death, the other the Scylla of death or the Charybdis of familial impoverishment – are in morally equivalent circumstances. One seeks to be free of oppressive pain, the other of economic oppression. The plight of the poorer patient profoundly affects us. We redouble our efforts to create a more just society. We might even take up a collection. But allowing these patients to obtain physician-assisted suicide may, in the end, allow them to make the best of a bad situation.

If, nevertheless, we deny them this option, we can have only two reasons. First, we could take the position that economic constraints are fundamentally improper grounds for making this kind of decision. In the context of the poorer patient, as in the case of the wealthy patient, this position is unpersuasive. Second, we could object that by giving these patients a way out of their predicament – albeit a distasteful one – physician-assisted suicide would impair our efforts to achieve a more just society. For example, it could deflect us from research on better types of end-of-life care. But it seems unfair to force the poorer patient to endure in order to benefit future patients. In any event, it can be argued that permitting poorer patients to avail themselves of physician-assisted suicide for economic reasons and dramatizing their plight is the most effective way to promote social change.

If that is so, then there is no convincing reason why patients who are acting completely on their own initiative, whether they be rich or poor, should be denied physician-assisted suicide because their decisions turn, in whole or in part, on economic factors. If there remains a valid objection to economic motivations for physician-assisted suicide, it must stem from the concern that the patients are not acting completely on their own initiative, but under pressure from others, from health care providers and managed care organizations, or from their families.
What if patients are being pressured by others?

Even though it is morally acceptable for patients voluntarily to take economic factors into account in choosing physician-assisted suicide, there are two ways in which their choice might not be voluntary. First, patients might be forced for economic reasons into physician-assisted suicide when they didn’t really want to die. This pressure might take the form of physical coercion — in the case of physician-assisted suicide, a little too much “assistance,” so to speak — or it could comprise psychological coercion, such as badgering or threatening patients until they assented. Second, patients’ choice of physician-assisted suicide might be said not to be voluntary if for economic reasons they based their decision on faulty information. Patients might lack access to the correct information because the information was too expensive for them to obtain, or because no one went to the expense of making the information available to them in a manner that they could understand. Alternatively, the information might be deliberately withheld from patients for economic reasons, or the information that was given them might intentionally be false. All of these cases arguably would constitute economic pressure that tended to negate the voluntary nature of the patients’ decision, leading us to want to protect these patients by refusing to sanction physician-assisted suicide in their cases.

The problem is that, if we nevertheless want to preserve patient access to physician-assisted suicide when the choice was voluntary — even though based in whole or in part on economic factors — we need some way of distinguishing voluntary from involuntary choices. But at the same time, we must recognize that these patients do not exist in a vacuum, but in an environment that necessarily involves contact with the very entities — providers, plans, and family — that are the potential sources of the pressures we are concerned about.37

Most commentators on the topic of physician-assisted suicide recognize this dilemma implicitly, but they rarely describe how it can be resolved. For example, the Supreme Court refuses to recognize a constitutional right to physician-assisted suicide in part because of the danger of, in Justice Rehnquist’s words, “subtle coercion and undue influence,”38 and Nancy Osgood declares that “[t]he stress on the family, regardless of its palpability and magnitude, can never be a morally or legally acceptable justification for unduly influencing a vulnerable older person to agree to premature active death hastening.”39 But neither Rehnquist nor Osgood explain what they mean by “unduly.”40 Donald Spencer similarly warns that “a health care professional expressing personal values or trying to meet a perceived provider goal may improperly influence a patient’s decision-making,”41 but never tells us when influence becomes “improper.” The American Geriatrics Society states: “[P]ressure or encouragement from family, friends, and caregivers may cloud or overwhelm the patient’s independent judgment and thus amount to inappropriate coercion.”42 (One assumes the Society does not envision an “appropriate” form of coercion.)

Could the patient’s family and physicians be forbidden from exerting pressure on the patient for economic reasons? Not without prohibiting any discussion with the patient whatsoever about physician-assisted suicide, which in itself would be unenforceable since it is not feasible to have someone monitor all interactions with the patient.43 Even if constant surveillance were possible, it would be impossible to determine whether
economic considerations were being brought up for the patient’s benefit or for someone else’s self-interest. If we simply forbade any overt discussion of economic matters in the patient’s presence, there would be no way of determining whether economic considerations were the tacit reason behind the ostensibly noneconomic discussion of physician-assisted suicide. In any event, if we agree that patients ought to be allowed voluntarily to choose physician-assisted suicide for economic reasons, we would not want to prohibit all discussion of economic considerations between patient, physician, and family, since the physician and the family are likely to be important legitimate sources of the economic information that patients need in order to make informed, voluntary choices. Indeed, we might want to mandate that family members and professional caregivers engage in economic discussions with the patient, for example, to provide patients with accurate information about the economic consequences of their options, or to disclose to the patient that the person in question had an economic conflict of interest.

Yet at some point, interaction undoubtedly becomes pressure, and pressure becomes coercion. Moreover, this point may be reached sooner in the case of more vulnerable patients. So how can we distinguish between permissible and impermissible conduct on the part of persons in contact with the patient who may have an economic conflict of interest?

One option, of course, is to admit that we can’t and stop worrying about it. We simply could accept that fact that, in an era of managed care and scarce family resources, some patients are bound to choose physician-assisted suicide because of pressure from family or health professionals and that this is the price we have to pay so that other patients voluntarily may obtain access to a desired way of dying. But we should hesitate to reach this conclusion if there is any practical way to avoid it, not only so that we can protect patients as much as possible, but because, as noted at the outset, concern over the role of economic factors in physician-assisted suicide is a major reason why only one state has legalized the practice and why the Supreme Court has refused to recognize a constitutional right to it. Faced with the prospect of patient deaths caused by economic pressures, especially active pressures exerted by those with an economic conflict-of-interest with the patient, the public is less likely to accept a certain number of economically motivated deaths as inevitable, than to ban the practice altogether.

Are there practical ways to protect patients from being pressured by others?

Economic conflicts of interest are not foreign to the law. In fact, an entire doctrine has been formulated to deal with them in contexts similar to this one – the doctrine of fiduciary relationships.  

Fiduciary law seems particularly appropriate as a potential source of solutions to our policy dilemma because it is designed to apply specifically to relationships of “trust” – that is, relationships in which paradoxically the benefit to one party is maximized by leaving that party vulnerable to being taken advantage of by the other.  

One of the relationships in question here – the relationship between patient and health care provider – is explicitly recognized by the courts as fiduciary. The relationship between patient and managed care plan arguably also is a type of fiduciary relationship, insofar as the plan is regarded as an insurer and insurers are said to owe a fiduciary duty to their insureds, and insofar as the plan is a qualified employee benefit


plan under ERISA.\textsuperscript{48} Finally, family relationships – at least those between parents and children – are increasingly being characterized as fiduciary.\textsuperscript{49}

Fiduciary law is complex, particularly since the rules that it imposes on fiduciaries vary depending on the precise fiduciary relationship in question.\textsuperscript{50} However, the law employs only a certain number of methods to protect against fiduciary conflicts of interest. Would any of them be useful in the context of physician-assisted suicide?

One of the protections embodied in fiduciary law seems particularly ill-suited to our patients’ predicament: the approach in which a court undoes the consequences of the improper behavior of the fiduciary and restores the patient to the condition she would have been in had the fiduciary not betrayed the patient’s trust.\textsuperscript{51} If the patient has died, it is too late to benefit her, and even if the pressure were detected before the assisted suicide had taken place and an attempt were made to offset the impact of the pressure in the patient’s mind, it would seem hard at that point to restore her to a state of true mental equilibrium. Elements of this remedy might be imposed as a deterrent in future cases, but even these efforts would be of questionable value. For example, the director of a corporation must inform the other directors of a financial interest that might make his advice detrimental to the corporation.\textsuperscript{52} In the case of familial pressure, it ought to be obvious to the patient that the family stands to gain economically from the patient’s early demise, although perhaps it might be necessary for someone to point this out to a patient who was particularly naïve. On the other hand, many patients may be unaware of the financial incentives that may impel their physicians to push for assisted suicide. Certainly a law legalizing physician-assisted suicide might require disclosure of this conflict of interest, either by the physicians themselves or by some third party – if necessary, the government.\textsuperscript{53}

A third approach is to reduce the risk created by the conflict of interest by limiting it to certain situations. For instance, the Oregon Death With Dignity Act extends physician-assisted suicide only to adult patients suffering from a terminal disease, defined as “an incurable and irreversible disease that has been medically confirmed and will, within reasonable medical judgment, produce death within six months.”\textsuperscript{55} Many proponents of physician-assisted suicide would limit its availability to patients who were competent at the time they requested it as well as when it was carried out.\textsuperscript{56} Still others would prohibit the use of methods that did not require the patient’s physical collaboration, such as lethal injection, and permit the physician only to prescribe a fatal dose of drugs that the patient consumed herself.\textsuperscript{57} While these restrictions can be objected to on the ground that they deny physician-assisted suicide to patients suffering from unbearable but nonterminal conditions and to patients with disabilities that have left them unable to place pills in their mouths or to swallow.\textsuperscript{58}
they find support in the desire to reduce the risk of involuntary death.\textsuperscript{59}

Another approach taken by fiduciary doctrine is to rely on external monitoring and sanctioning. The idea is that the weaker party can reposes trust in the fiduciary in part because someone else is making sure that the trust is well deserved.\textsuperscript{60} Some version of this protection is built into virtually all proposals for physician-assisted suicide.\textsuperscript{61} For example, the Oregon law requires that the patient’s request be in writing and be witnessed by two persons, one of whom is not a family member, associated with the health care facility, or entitled to any portion of the patient’s estate.\textsuperscript{62} Richard Posner specifically argues that the danger of economically inspired abuse “can be minimized by relatively simple regulations, such as a requirement that the patient’s consent to euthanasia be witnessed or in writing, that the physician performing euthanasia report any case in which he performs it to a hospital committee, and that before performing it he consult with a duly certified specialist in the ethics of dealing with dying patients.”\textsuperscript{63}

The problem, of course, is that these procedural steps can be circumvented by anyone determined to pressure the patient. Posner’s witnesses can be interested family members. Even under the Oregon scheme, one of the two required witnesses can have an economic stake in the patient’s decision. Posner’s hospital committee can bow to the same financial incentives as the physician. The same is true of the “ethics specialist,” particularly if he or she is employed by the hospital.\textsuperscript{64}

It is also clear that far more elaborate procedural protections are possible. Completely disinterested witnesses could be required. Their number could be increased. The patient could be required to make multiple requests over an extended period, as the Oregon Death with Dignity Act specifies.\textsuperscript{65} The hospital ethics committee could be made to conduct an evaluation before the physician is allowed to assist the patient. Ultimately, a court order could be required.

The question is whether the benefits from these additional protections would exceed their costs. These costs include intrusion into the patient’s privacy and into her relationship with her family and her physician; delay, which could cause the patient additional suffering; the possibility that a patient’s genuine wish for assisted suicide would be denied because economic pressure was detected; and the financial and administrative costs of oversight and review.

Yet some commentators would not be content with even the most elaborate patient protections. They would point to the most extreme approach that the law sometimes takes in response to economic conflicts of interest: banning the transaction in question altogether. An example in the realm of health care would be the rules under Medicare and Medicaid that forbid physicians from referring patients to facilities in which the physicians have an economic interest.\textsuperscript{66} In the context of physician-assisted suicide, the practice could be made, or kept, illegal on the basis that the risk of economic coercion simply is too great.

This approach too has its cost, however. It would prevent patients who were not pressured from obtaining a service that, in their opinion, would ease their suffering. So the question ultimately becomes: Does the risk that some patients will die because of economic coercion exceed the benefit of providing physician-assisted suicide to those patients who were not being coerced?

But posing the question in this dichotomous fashion ignores the potential role of different patient protections. A more
appropriate way of asking the question would be: Do the costs of requiring additional patient protections— including both the costs of implementing the protections (such as their intrusiveness and the probability that they will end up thwarting some patients who are not in fact being coerced by family and physician) and the likelihood that even the most elaborate protections will fail to protect some patients—outweigh the benefit from making physician-assisted suicide, accompanied by these protections, legally available?

Again, some might say that even one involuntary patient death is too great a price to pay. But this conclusion certainly is not self-evident. Before we reached it, we might want to consider experimenting with some additional patient protections. Three of them seem to me to be key:

First, patients in a position to request physician-assisted suicide should be given comprehensible information about their alternatives, including the economic consequences of these alternatives, and should be warned about the potential conflicts of interest between them, their health care providers, and in some cases, their families. This information should be provided both orally and in writing. The concern is that this strategy will encourage patients to distrust their families and caregivers precisely when the patients most need their support. But that may be the price that must be paid in order to legalize physician-assisted suicide in an era of managed care in a nation that lacks comprehensive, national health insurance.

Second, patients should be given access to a medical advocate whose services are not paid for by the family, the provider, or the patient’s health plan.67 (One approach would be to have the medical advocate program be a service of the probate court, paid for by a taxpayer-funded supplement to the court’s budget.) This individual, who could be a health care professional, a social worker, a member of the clergy, a bioethicist, an attorney, and so on, would be available to discuss the patient’s request with the patient, and would attempt to ensure that the patient was not making the request as the result of economic coercion. Additionally, the medical advocate could be responsible for furnishing the necessary information in a caring manner.

Finally, legislation should require that any health care plan that funded physician-assisted suicide also provide adequate financing of patient alternatives, such as palliative and hospice care. Numerous criticisms have been directed at third-party payers for failing to provide adequate coverage of the costs of pain medication.68 Recently, for example, the Oregon Medicaid Plan was accused of moving physician-assisted suicide up in its ranking of health services so that the practice would be fully covered while at the same time restricting payment for high doses of pain medication for noncancer patients.69

Some advocates of physician-assisted suicide will object that the first two recommendations would introduce an overly intrusive bureaucracy into the patient’s private affairs, and that health plans would respond to the third suggestion by funding neither physician-assisted suicide nor adequate palliative care. Yet others will object that these protections are not enough. Being caught between these extremes may mean that I have failed to satisfy anybody. On the other hand, I may have found the appropriate middle ground.
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Judge Richard Posner argues that physician-assisted suicide is really just "a subset of medical events (or nonevents)," including physician withholding or withdrawing treatment, double-effect euthanasia resulting from the effects of painkillers, and allowing the patient to refuse food and water, "that have the effect of bringing on death earlier than is medically inevitable," Richard A. Posner, *Aging and Old Age* (Chicago: University of Chicago Press, 1995), p. 236. Others, including a majority of the Supreme Court, believe that physician-assisted suicide differs in morally and legally significant respects from other forms of voluntary patient death. See generally Harry R. Moody, "Can Suicide on Grounds of Old Age Be Ethically Justified?" in Margaret Tallmer et al., eds., *The Life Threatened Elderly* (New York: Columbia University Press, 1984), p. 89. The discussion in this paper, which is limited to physician-assisted suicide, does not attempt to resolve this debate. Nor, in being limited to a discussion of voluntary physician-assisted suicide — that is, suicide at the patient’s request carried out by the physician or by the patient with the physician’s help — does this paper address the issues that would be raised by involuntary physician-assisted suicide.


Stephanie Graboyes-Russo, "Too Costly to Live: The Moral Hazards of a Decision in Washington v. Glucksberg and Vacco v. Quill," Note, University of Miami Law Review 51 (1997), pp. 907, 919. The author continues: "Financial decisions may not make a patient's decision to make suicide irrational. However, for certain groups, those financial considerations are so predominant as to be coercive, and therefore inconsistent with true voluntariness." Ibid.

See Washington v. Glucksberg, 117 S. Ct. at 2291 (concurring opinion of Justice Souter); Wolf, "Physician-Assisted Suicide in the Context of Managed Care"; Garzino, "Undue Influence." Wolf states, for example, that "[u]nder managed care, physicians and organizations lose money by doing all of these things [i.e., caring aggressively for patients at the end of life] and profit instead by encouraging patients considering assisted suicide to go ahead with the practice." Wolf, "Physician-Assisted Suicide in the Context of Managed Care," p. 473.

The managed care plan might be able to endure a losing ratio of spending to premiums for a time, making up the difference from reserves, but eventually it would have to raise premiums – putting it at a competitive disadvantage compared to other plans – or become insolvent.


By killing the enrollee, of course, assisted suicide dries up the stream of revenue from that particular enrollee’s premiums. But it is cheaper to lose the premiums than to pay for aggressive care for the seriously and terminally ill, since the high costs of care for those individuals exceed the value of their premiums. That is true even of less costly palliative and hospice care. Emanuel and Battin calculate the costs of hospice care at $9,548 per patient during the last two months of life, in contrast to $14,507 for conventional care. See Ezekiel J. Emanuel and Margaret P. Battin, "What Are the Potential Cost Savings from Legalizing Physician-Assisted Suicide?" New England Journal of Medicine 339 (1998), pp. 167, 168; 169. But hospice costs still far exceed two months of individual health insurance premiums.

This role for physicians has been advocated by Daniel Callahan, Setting Limits: Medical Goals in an Aging Society (New York: Simon and Shuster, 1987).

Ibid. Marshall Kapp, for example, worries about ageist physicians pressuring older patients:

[O]ld age per se is used consciously or unconsciously by many physicians as the basis for... applying gentle or firm pressure on the patient to accept less aggressive care than might otherwise be advised. ... This specter of age discrimination in medical practice bodes poorly for any reasonable expectation of just, fair administration of a legalized physician-assisted suicide option for older patients.
Kapp, “Old Folks on the Slippery Slope,” pp. 450-451. Noting that “[t]he position that suicide and assisted suicide should be available for older people is not new,” Nancy Osgood cites data showing that approximately 50 percent of all nonindustrial societies direct some form of “death-hastening behavior” toward older people. Osgood, “Assisted Suicide and Older People,” p. 419.

18 This is basically the effect of Medicare’s system for paying hospitals, known as the “diagnosis-related group” or “DRG” system. For a fuller description of the DRG system, see Maxwell J. Mehlman, “The Patient-Physician Relationship in an Era of Scarce Resources: Is There a Duty to Treat?” Connecticut Law Review 25 (1993): 349.

19 See New York State Task Force, When Death is Sought; Osgood, “Assisted Suicide and Older People”; Kilner, Life on the Line.

20 See, e.g., Donald E. Spencer, “Practical Implications for Health Care Providers in a Physician-Assisted Suicide Environment,” Seattle University Law Review 18 (1995), pp. 545, 549: “[p]ressure from heirs for the patient to avoid costly care ... is not unknown to those who work with terminally-ill and other vulnerable patients.”

21 Ibid., referring to pressure to void “care that burdens a family caregiver.”

22 See Washington v. Glucksberg, 117 S. Ct. at 2273 (opinion by Justice Rehnquist); Osgood, “Assisted Suicide and Older People”; Kilner, Life on the Line; Graboyes-Russo, “Too Costly to Live.”

23 John Hardwig states that “[t]hose of us with families and loved ones always have a duty not to make selfish or self-centered decisions about our lives. We have a responsibility to try to protect the lives of loved ones from serious threats or greatly impoverished quality, certainly an obligation not to make choices that will jeopardize or seriously compromise their futures.” John Hardwig, “Is There a Duty to Die?”, Hastings Center Report (March-April 1997), pp. 34, 36. Graboyes-Russo observes that “[e]ven patients who desperately want to live for whatever time they have left may choose death rather than financial ruin for those who survive them.” Graboyes-Russo, “Too Costly to Live,” p. 920.

24 See Osgood, “Assisted Suicide and Older People,” p. 418 (“older people may come to feel it is their social duty to kill themselves”).

25 Emanuel and Battin, “What Are the Potential Cost Savings,” pp. 167, 168. The authors note that this amount is expressed in 1995 dollars.

26 Ibid., p. 170. The authors state that this total would amount to only .08 percent of the plan’s annual budget, implying that this savings is too small to influence plan behavior. However, faced with rising health care costs on the one hand and employer insistence on holding down premiums on the other, managed care plans are likely to take advantage of all the sources

27 Emanuel and Battin, “What Are the Potential Cost Savings?”, p. 170. The Study to Understand Prognoses and Preferences for Outcomes and Risks of Treatment (SUPPORT) found that 31 percent of families having a family member with an expected six-month mortality rate of between 30 and 70 percent reported losing most of their savings as a result of the illness. Kenneth E. Covinsky, et al., “The Impact of Serious Illness on Patients’ Families,” *Journal of the American Medical Association* 272 (1994), pp. 1839, 1841.


29 Schneiderman and his colleagues use their findings instead to argue that, since patients already take economic burdens into consideration, they will not suddenly begin to worry about these burdens if they are given the option of physician-assisted suicide. *Ibid*.

30 These criteria typically include requirements that the patient is terminally ill – that is, that she suffers from an illness or condition that is expected to cause her death within six months – and that the patient is mentally competent and free from serious depression. Some proponents of physician-assisted suicide would extend its availability to patients who were not terminally ill, but who had incurable diseases or untreatable pain. See, *e.g.*, Timothy Quill, *Death and Dignity: Making Choices and Taking Charge* (New York: W. W. Norton, 1993).

31 Note that there might be other objections to allowing physician-assisted suicide even in this case, such as religious beliefs or concern over its adverse effect on the proper role of the physician. All that I am addressing here, however, is the role of economic factors.

32 The patient also may have less money because she chose to purchase a more expensive health care plan. On the other hand, what if she chose a cheaper health plan, but one that was cheaper because it offered physician-assisted suicide in place of end-of-life care? At least one commentator sees nothing wrong – and indeed, much right – in giving people this sort of option. See Leonard M. Fleck, “Just Caring: Assisted Suicide and Health Care Rationing,” *University of Detroit Mercy Law Review* 72 (1995), pp. 873, 881-883.


34 Cf. Alan Schwartz, “A Reexamination of Nonsubstantive Unconscienability,” *Virginia Law Review* 63 (1977), pp. 1053, 1057 (arguing that the less a party is able to afford an
alternative, the more reason to enforce a contract against them, since the greater the benefit they
derive from the bargain).


36 Cf. Graboyes-Russo, “Too Costly to Live,” p. 917 (“[a] continued prohibition on
physician-assisted suicide may have a direct impact on the number and availability of hospices in
the United States” and may promote research on better forms of palliative care). This is one of
the main reasons that the American Medical Association maintains its opposition to legalizing
physician-assisted suicide. See *Brief of the American Medical Association et al. as Amici Curiae

37 Of course, if one believes that patients have a duty to consider the economic
repercussions of their condition on their families, and to spare their families economic
dislocation by voluntarily agreeing to physician-assisted suicide, then one also might feel that it
was appropriate for the family (or someone purporting to be acting on their behalf, like the
physician) to remind the patient of this obligation. The problem is the slippery slope issue of how
far the family is entitled to go in enforcing the patient’s obligations to it. Taken to the extreme,
for example, could the family insist that the patient die, regardless of the patient’s own wishes?

38 117 S. Ct. at 2273 (emphasis added).


40 See also Garzino, “Undue Economic Influence,” p. 570 (“... at such critical times, the
state has a substantial interest in protecting the individual form being undue influenced”
[emphasis added]); Graboyes-Russo, “Too Costly to Live,” p. 919 (“[t]hose most likely to be
victimized by the practice are patients whose choices are not truly voluntary, because no other
realistic options are available to them” [emphasis added]). Recognizing the vagueness of terms
such as “undue” influence, Garzino cites *Ohralik v. Ohio State Bar Ass’n*, 436 U.S. 447 (1978), a
case in which the Supreme Court upheld a state prohibition against lawyers soliciting business
from accident victims in person:

Like the lawyer’s undue influence on the accident victim in Ohralik, in physician-assisted suicide
the undue economic influence exerted by the physician on behalf of the managed-care group
comes at a time when the terminally-ill patient is in a stressful, vulnerable state, both physically
and mentally. Similar to the lawyer’s irresistible financial offer, the managed-care promise of a
quick, pain-free death, one that spares loved ones additional financial burdens, could appear
“irresistible” to a person in need of pain management and emotional support. Also, like the
accident victim in Ohralik, terminally-ill patients are prone to “uninformed acquiescence” with
the wishes of the person attempting to unduly influence them for that person’s own economic
gain.

41 Spencer, “Practical Implications,” p. 549 (emphasis added).


43 This approach not only would be extraordinarily expensive, but who would this person be – a government official? Even if we wanted to expend the resources to conduct such full-time surveillance, how could we be sure that impermissible interactions had not taken place at the patient’s home or at the doctor’s office? And if the answer is that these places would be monitored as well, the invasion of privacy that this would entail clearly would be intolerable.


45 To understand this paradox, consider the classic patient-physician relationship. The patient relies on the physician to act in the patient’s best interests, including providing the patient with information necessary to enable the patient to make informed decisions. The more the patient trusts the physician to be trustworthy, the fewer resources the patient must expend to verify that the physician is in fact behaving in this way. If the patient distrusts the physician, on the other hand, the patient will feel bound to expend resources on obtaining second opinions, researching the medical literature herself, and so on. The paradox arises because the fewer the resources the patient expends to verify the physician’s good faith, the more vulnerable the patient is to the risk that the physician will betray the trust. A fuller explanation may be found on pages 388-389, notes 72 and 74 of Mehlman, “Fiduciary Contracting.”


48 The Employee Retirement Income Security Act (ERISA) is a federal law that, among other things, makes an employer who offers a qualified benefit plan to its employees a fiduciary in regard to the plan and its enrollees. See, e.g., Shea v. Eesensten, 107 F.3d 625 (8th Cir.), cert.

49 See Elizabeth S. Scott and Robert E. Scott, “Parents as Fiduciaries,” Virginia Law Review 81 (1995) 2401. While the authors focus on the obligations of parents to their children, the reversed roles of children whose parents suffer from a serious or terminal illness suggests that the fiduciary obligation should extend to the children in that situation as well.

50 See Restatement (Second) of Trusts section 2 comment b (1959) (“the duties of a trustee are more intensive than the duties of some other fiduciaries”); Deborah DeMott, “Beyond Metaphor: An Analysis of Fiduciary Obligation,” Duke Law Journal 879 (1988): 908-909 (“the scope of the fiduciary’s obligation, as well as the obligation’s precise formulation, necessarily varies with the context of the relationship”). Scott and Frankel attribute the variation to differences in the fiduciaries’ ability to harm the entrustor. See Austin Scott, “The Fiduciary Principle,” California Law Review 37 (1949): 539, 541 (“the greater the independent authority to be exercised by the fiduciary, the greater the scope of his fiduciary duty”). Frankel states: “The extent of the fiduciary duty varies with the degree of potential abuse of power stemming from the relationship. Thus, the standard is stricter for trustees than for corporate directors because the beneficiary does not control the trustee and is locked into the relationship, whereas the shareholders can terminate the directors or sell their shares if they are dissatisfied with the director’s performance.” Tamar Frankel, “Fiduciary Law,” California Law Review 71 (1983): 795, 810.

51 This is the effect when the court creates a so-called “constructive trust.” In the celebrated case of Moore v. Regents of the University of California, 793 P.2d 479 (Cal. 1990), for example, the plaintiff alleged that his physicians betrayed his trust by commercializing a cell line derived from his tumor cells without giving him a piece of the action. Although the court did not realize it (because the plaintiff’s attorneys did not understand fiduciary doctrine and therefore did not make the correct argument), the appropriate remedy would have been to place the assets – consisting of the cell line – into a constructive trust for the benefit of the plaintiff.

52 One could tinker on, however. For example, it may make sense to establish the family penalty but levy it only on wealthy families, on the basis that there is less justification for a wealthy family to pressure the patient than for a family dependent on an early patient death for basic necessities. Furthermore, if the profit that the provider or plan was forced to disgorge were multiplied by some large factor (akin to the trebling of antitrust damages), the sting might become an effective deterrent.

53 Restatement (Second) of Trusts section 170.25 (1998).

54 A model, although one that may leave much to be desired in terms of effective communication and patient comprehension, is Medicare’s “Notice to Patients” that they receive upon admission to the hospital. 42 U.S.C. section 1395 cc(f) (1994).

53 Ibid.


56 Note that the widely held view among proponents of physician-assisted suicide that it should be permitted only when the patient is in a terminal condition is harder to justify on this basis, since terminally ill patients as a class, being in extremis, may be less able to resist economic pressure than other types of patients. See, e.g., Garzino, “Undue Economic Influence,” p. 570, where he states that “[i]n physician-assisted suicide the undue economic influence exerted by the physician on behalf of the managed care group comes at a time when the terminally-ill patient is in a stressful, vulnerable state, both physically and mentally.”

57 This theory goes on to maintain that, so long as the monitor is external to the trust relationship itself, such as by being a governmental entity, relying on it to help keep the fiduciary in line does not represent a diminution in the trust within the relationship, but an enhancement of that trust. See, e.g., Susan P. Shapiro, The Social Control of Interpersonal Trust, American Journal of Sociology 93 (1987), p. 634 (calling these external monitors “guardians”).


60 Posner, Aging and Old Age, p. 243.

61 See Mehlman, “Medical Advocates” (explaining why hospital-employed “patient advocates” have a conflict-of-interest with patients), p. 299.

62 The Oregon law, for example, requires the patient to make at least two oral requests for physician-assisted suicide, with a 15 day delay between them. (Ore. Rev. Code §3.06.) California’s ballot initiative required patients to make “an enduring request” for aid in dying (§2525.7), defined as a request made on more than one occasion (§2525.2).

63 See 42 USC §1395nn (Supp. 1995); 42 CFR §411.350. Since these prohibitions are imposed by federal law, technically they might not be regarded as part of fiduciary doctrine, which is a set of common law principles. But at least part of the impetus for the federal law
undoubtedly is the appreciation of the patient's vulnerability and need to trust the physician to act only in the patient's best interest.

67 The role of medical advocate does not currently exist in the U. S. health care system. For an elaboration of their potential role and a description of their background and training, see Mehlman, "Medical Advocates."

68 See, e.g., Joseph P. Shapiro, "Death Be Not Swift Enough: Fraud Fighters Begin to Probe the Expense of Hospice Care," U. S. News and World Report 122 (March 24, 1997): 34; "The Pain Coverage Conundrum," Business and Health 14 (Fall 1996) 22. Two forthcoming studies reveal the gaps in public and private funding of pain management and palliative care: Diane E. Hoffman, "Pain Management and Palliative Care in the Era of Managed Care: Issues for Health Insurers" and Timothy S. Jost, "Leaky Umbrellas and Holey Safety Nets: Public Financing of Pain Management." Both manuscripts are in the author's possession. In order to apply to self-insured employer plans, which are exempt from state mandated benefits laws under ERISA, the legislation would have to be enacted by Congress and pre-empt ERISA.

69 See Diane M. Gianelli, "Suicide Opponents Rip Oregon Medicaid's Pain Control Policy," American Medical News 7 (September 28, 1995), p. 7. The Oregon Medicaid program ranks medical services in order of "importance," and the state legislature then decides how many of the services, in descending order of priority, it wishes to finance. For a description of this program, see Maxwell J. Mehlman, "The Oregon Medicaid Program: Is It Just?" Health Matrix 1 (1991) 175.
Give Me Liberty and Give Me Death: Assisted Suicide in Oregon

Courtney S. Campbell

A rallying cry of the political revolution for American independence, attributed to Patrick Henry, was “Give me liberty or give me death.” Some 225 years later, the rallying cry of the “death with dignity” revolution for independence at the end of life has changed the conjunction: “Give me liberty and give me death.” This revolution in support of a dignified death has been fought most successfully in the state of Oregon. In 1994, Oregon became the first jurisdiction to legalize physician-assisted suicide when voters approved the “Oregon Death with Dignity Act” (DDA), which authorizes physicians to prescribe lethal medications to terminally ill patients in order to achieve a humane and dignified death.¹ After a series of legal disputes and legislative considerations, an effort to repeal the DDA in November 1997 failed by 60 percent to 40 percent of votes cast. Oregon has thus embarked on what is quite literally a lethal experiment, as terminally ill patients have begun to avail themselves of their legal right to receive medication to end their lives.

The two votes that culminated in the initiation of the Death with Dignity Act have been widely interpreted as a resounding endorsement of physician-assisted suicide. That is a misleading interpretation in many respects. The legalization of physician-assisted suicide per se actually assumed tertiary importance in these campaigns at least relative to much more significant themes about the sovereignty of individual choice, the problem of medical fallibility, the limits of legal implementation, and the place of religious convictions. One consequence of these foci was that the public debates have been almost empty of ethical discourse, and deliberately so. This fact raises some disturbing questions about the possibility of ethically substantive civic discourse on biomedical issues. This essay will use the prominent themes in Oregon’s
second debate about physician-assisted suicide during 1997 to illustrate this interpretation.

The Legal Journey

Before beginning the analysis, it will be helpful to describe the many tortuous twists and turns en route from the first voter approval of "death with dignity" in 1994 to the failed repeal effort in 1997.

November 1994 Oregon voters passed "Measure 16," the Death with Dignity Act (51 percent to 49 percent).²

December 1994 A federal district court judge, Michael Hogan, issued a preliminary injunction, preventing the Death with Dignity Act from taking effect until constitutional questions were considered.

August 1995 Judge Hogan declared the DDA unconstitutional on the grounds that it violated constitutional guarantees of equal protection under the law.³ The State of Oregon appealed the ruling (Lee v. Oregon).

March 1996 In its ruling in a physician-assisted suicide case from Washington (Compassion in Dying v. Washington), the Ninth Circuit found that Judge Hogan "clearly erred" in his ruling on the Death with Dignity Act.⁴

February 1997 The Ninth Circuit overturned Hogan's decision on the basis that the plaintiffs (physicians and terminally ill patients) do not have legal standing to challenge the DDA.⁵ The plaintiffs appealed this decision to the U.S. Supreme Court.

June 1997 The Oregon legislature referred the Death with Dignity Act to the voters for a second vote, under the designation "Measure 51."

October 1997 The U.S. Supreme Court declined to hear the plaintiff's appeal on legal standing.⁶ The Ninth Circuit Court ordered the implementation of the Death with Dignity Act, effective 27 October, although the Attorney General of Oregon did not receive the order until 4 November.

November 1997 Measure 51, under which the Death with Dignity Act could be repealed, was defeated by a 60-40 percent margin. As ordered by the Ninth Circuit Court, Judge Hogan dismissed the original lawsuit (Lee v. Oregon) against the Death with Dignity Act. However, Hogan permitted attorneys for the plaintiffs to present another argument on the issue of standing and scheduled a hearing for 17 February 1998.

March 1998 The first two known deaths under the Act were reported.

September 1998 Judge Hogan, citing the decision of the Ninth Circuit Court, refused to revive the lawsuit.

The myth of medical failure

While this overview illuminates why both the Death with Dignity Act and efforts to challenge it through the courts have received (premature) declarations of "death" by advocates and commentators, it is the efforts to rescind or amend the 1994 vote through the legislative process that will command most of my attention in the first part of this paper. The seeds for the repeal effort were sown shortly after the DDA was originally passed into law. In an interview in December 1994, Dr. Pieter Admiraal, a prominent proponent and practitioner of euthanasia in the Netherlands, commented that, in a study of clinical experience, one in four patients who used prescribed drugs as a means to death instead experienced an induced coma and a dying that lingered for hours or even days. Admiraal was critical of the DDA because it failed to permit the
medical “back-up” available in the Netherlands should the lethal medication not bring about a hastened death – a lethal injection by the physician. These observations provided a lightning rod for efforts both to expand and contract the Act. On one hand, the prospects of a lingering death revealed fragmentation in what had been a relatively unified right-to-die movement. Derek Humphry, the founder of the Hemlock Society and best-selling author of Final Exit, for example, argued that the Dutch experience illustrated the need to broaden the DDA to include lethal injections. Meanwhile, opponents of physician assistance in death began to consider the possibility that there were medical and pharmacological reasons for seeking to reverse the decision of the voters. On the basis of this “new evidence” about the inefficacy of prescribed barbiturates to hasten death, opponents took their case to the state legislature in early 1997 and claimed that voters had not had the full facts in the 1994 vote.

It is important to understand the significance of the study discussed by Admiraal for the legislative process. While proponents of repeal certainly had other substantive and procedural objections to DDA, their entire case for legislative scrutiny of the law rested on the credibility of the 25 percent failure rate. The problem, however, was that the only evidence for this ratio of “bad deaths” from prescribed medication lay in Admiraal’s comments. The study itself was not translated into English until early September 1997, and had not actually been seen by repeal proponents and legislative leaders prior to the legislative vote to refer the DDA back to voters for repeal. Thus, it is not too great a stretch to say that for an extended period, the case for repeal and the legislative decision for referral rested on hearsay rather than verifiable data.

When an English translation of the Admiraal study finally began to be circulated in the fall of 1997, it did in fact contain percentage ratios similar to what the anecdotal reports had indicated, but the study sample was so small that it is difficult to see how, on its own, it would warrant a change in public policy. In the midst of a broader discussion about the most reliable way of administering euthanasia, the report indicated that a lethal dose of barbiturates had been provided to 75 patients. Among these 75 patients:

- 58 (77 percent) died without further medical intervention.
- Of the 17 other patients, 15 (20 percent) received a muscle relaxant subsequent to the ingestion of the barbiturates.
- 45 (60 percent) of patients died within the first hour following ingestion, while 9 patients (12 percent) lived longer than five hours subsequent to consuming the medication.
- “In a rare case, the patient is still alive after 24 hours,” at which point the report recommended injection of a muscle relaxant to bring about death.
- On the basis of this study, the Dutch study group recommended parenteral administration as the “most reliable and fastest way to carry out euthanasia.” When a patient requested oral administration, the study group recommended an anti-emetic medication in advance of taking the barbiturates to minimize vomiting. A dose of 9 g of pentobarbital sodium or secobarbital sodium in a 100 ml elixir was recommended to physicians, with the proviso that “as this may not always result in a rapid death, the physician must be willing, if necessary, to inject a muscle relaxant, when death does not materialize for a long
time (e.g., longer than 5 hours)."

Even though these specific details of the study were not accessible at the time the state legislature began its review of the Death with Dignity Act, the 25 percent medication “failure” figure was seized upon as a medical reason for opposing the DDA on the grounds that it would impose a high risk of a lingering death for terminally ill patients. Following the legislative decision to refer the DDA to voters, leaders of Oregon Right to Die (the primary political advocates of a legal right to assisted suicide) asked Admiraal to clarify his interpretation of the study. He maintained that his analysis had been grossly misinterpreted in a politicized context: “Let’s face the facts. . . . After an oral dose of 9 grams of barbiturates (three times the lethal dose), every patient will die. During that time the patient is in a deep coma without awareness and so without any suffering. A period of 24 hours or longer will be very exceptional.”

The problem with Admiraal’s second and more benign reading of the significance of the clinical study is that the study clearly does contain evidence that the deaths of some patients were hastened by lethal injection of muscle relaxants. So, while it may be true that “every” patient will die following ingestion of barbiturates, it is not the case that the barbiturates are the sole cause of the death. The lingering deaths were ended in the Netherlands rather quickly through lethal injection, but, since lethal injection is forbidden both by Oregon law and is specifically prohibited by provisions of the Death with Dignity Act itself, then it appears that patients would be exposed to risks that had not been anticipated during passage of the law in 1994, and that in some cases, or “rare cases,” physicians would have to act outside the law to ensure a hastened death. However, when the state legislature began considering whether the Act should be revised in some way, it had only one newspaper interview and anecdotal reports to rely on. If proponents of repeal could claim that the voters in 1994 did not have the full facts when they approved the Act, it is equally clear that lobbyists and members of the state legislature were not fully informed as the Act began to be subjected to legislative scrutiny.

Legislative concerns

As the Oregon legislature met at the beginning of its 1997 session, revisiting the issues of physician assistance in death did not have a high priority. Court injunctions had blocked the Death with Dignity Act from taking effect for over two years, and no action was expected until the U.S. Supreme Court ruled on the constitutionality of a right to physician-assisted suicide in late spring 1997. However, a sense of urgency appeared in late February, when a panel of the Ninth Circuit Court ruled 3-0 for immediate implementation of the Death with Dignity Act. While Supreme Court Justice Sandra Day O’Connor quickly granted a stay, the prospect of legalized physician assistance in death seemed to spur legislative action. No fewer than seven bills were introduced in the Judiciary Subcommittee on Family Law, taking three main tacks:

Legislative repeal: Some bills, particularly those introduced at the behest of the Oregon Catholic Conference and Oregon Right to Life, requested that the legislature overturn the 1994 vote. This approach received little support in the legislature.

Legislative review and amendment:
Other bills asked that the legislature amend the Act to tighten safeguards (e.g., mandatory psychiatric assessment and counseling, and family notification) and to provide conceptual clarification (e.g., of the meaning of “residency” in Oregon). This approach would have permitted implementation of a statute with additional restrictions and requirements. Some lobbyists proposed a variation, which called for the legislature to delay implementation pending review by a legislative task force, with the law to be amended subsequent to the review.

Legislative referral: A third alternative, which almost no interest group supported at the outset, was a referral of the DDA to the voters for a second vote. Advocates of Oregon Right to Die worried, with some validity, that such a vote might mean defeat and the loss of the achievements of the 1994 vote, while proponents of repeal 1) placed more trust in the legislative process than in the voting booth, and 2) did not as yet have a compelling rationale for a referral. That rationale soon presented itself, however, in the form of uncertainty among leading Oregon physicians and pharmacists as to the effectiveness of prescribed drugs in ensuring death. It was in this context that the study of Dutch patients and the “25 percent failure rate” assumed guiding significance.

Pharmacists contended that a lethal dose of a barbiturate like Seconal, for example, could be 20-100 100 mg. tablets, depending on the patient’s general health status and underlying condition. Such variability seemed to undermine public expectations that taking the pills was accompanied with the certain expectation of a hastened, painless death. In place of reliance on pills, a leading pharmacist proposed to the legislature that patients use an “infusion” device. The efficacy of such a device already had been demonstrated in clinical practice, as it is commonly used to administer antibiotics to patients by providing medication directly into the bloodstream through an IV line. However, drafters of the Death with Dignity Act argued that use of such a device did not fall within the statute’s boundaries of “medication,” and legislators worried that, since a physician or nurse would be required to begin the IV line, health care professionals would be more directly responsible for a patient’s death. It is unlikely, however, that any legislative action would have succeeded had not the stance of organized medicine toward the Death with Dignity Act changed during the course of the legislative session.

Resolutions and fragmentation

The Oregon Medical Association (OMA) had assumed a posture of “no official position” with regard to the Death with Dignity Act in 1994, inviting patients and voters to determine the standards of medical practice in the care of the terminally ill. In so doing, the OMA was the only medical association in the United States to be on record as not opposed to physician-assisted suicide. This view changed in April 1997, when a coalition of physicians formed Physicians for Compassionate Care and persuaded the OMA House of Delegates to adopt a resolution (by a 121-1 vote); although the resolution did not condemn physician-assisted suicide in principle, it described the Death with Dignity Act as “seriously flawed.”

RESOLVED: The association [OMA] affirms its policy in support of and advocacy for compassionate and competent palliative care at the end of life.

FURTHER RESOLVED: The association acknowledges that medical
efforts to eliminate irreversible and extreme pain and suffering at the end of life are an appropriate medical response that may result in hastening the patient’s death.

FURTHER RESOLVED: The association acknowledges patients’ legitimate right to autonomy at the end of life but does not accept the proposition that death with dignity may be achieved only through physician-assisted suicide.

FINALLY RESOLVED: The association specifically opposes Measure 16 as seriously flawed.15

What led to this change in the association’s position? The coalition of physicians that developed and passed the resolution again cited the Dutch study on lingering deaths from oral administration of barbiturates. This evidence was coupled with arguments that assisted suicide would inevitably lead to euthanasia by lethal injection, perhaps as a recourse for patients in drug-induced comas. While American physicians in general seem to favor the concept of assisted suicide for terminal patients, and a majority appear willing to participate in prescribing the needed medication, physicians are clearly less comfortable personally and professionally with administering lethal injections. Thus, the 1997 OMA resolution was as much a statement about drawing a line against lethal injection as a claim about prohibiting prescribing lethal medication. Moreover, concerns were voiced that under the managed care system, which has a higher penetration rate in Oregon than in other states, patients would experience pressure to end their lives prematurely in order to save money or to avoid being a burden on their families. Oregon physicians generally share some of these concerns.16

The resolution held significant implications for the medical profession’s role in the ensuing legislative and political debate. An immediate consequence of the resolution was the beginning of fragmentation within the OMA. Proposed and passed largely through the efforts of Physicians for Compassionate Care, the resolution was the catalyst for the formation of a second group, Physicians for Death with Dignity, who claimed with some justification that a vote of 122 persons should in no way be taken as the conclusive last word for a professional body with over 5,700 members. These two coalitions became the primary special interest groups through which professional concerns about physician-assisted death were communicated to other providers and to the public in general; in short, the organizations by which medical interests were politicized. Needless to say, their competing views sowed only confusion as to whether medical professionals as an organized constituency had anything constructive to contribute to the public discussion. Indeed, while the OMA resolution galvanized the lobbying efforts of members of Physicians for Compassionate Care to request a legislative referral of the Death with Dignity Act, as described below, the impact of organized medicine on the actual campaign to repeal was almost undetectable.

The referral option

Infused by the controversy over whether physicians had the knowledge and capacity to do what the law actually asked, the state legislature moved inevitably down the path toward referral to the voters of the same Act that they had approved in 1994. Defeated in
floor votes were bills proposing to strengthen some of the DDA’s procedural safeguards, such as a clear definition of Oregon “residency” for purposes of assistance in suicide (rather than the common law definition of “declaration of intent to reside”); mandatory counseling for terminally ill patients who requested lethal medication (rather than counseling only upon diagnosis of impaired judgment); and an addition to the informed consent process indicating that patients were informed and understood they might linger in a comatose condition for a short period of time.

The defeat of these amendments to the Death with Dignity Act was the culmination of an “all-or-nothing” strategy by lobbyists and legislators opposed to the DDA’s implementation. Rather than support amendments that would have increased regulatory control, and, in all likelihood, restricted recourse to assisted suicide, these constituencies expressed a willingness to support referral, rather than political compromise, in the hope that the voters would rescind their prior approval and opt for prohibition rather than regulation.

In these legislative debates over possible amendments, the basic themes of the impending campaign were first articulated. Significantly, none of these themes actually concerned physician-assisted suicide as an ethical issue. Indeed, repeal proponents dismissed ethical debates over assisted suicide as “wandering into tangled territory.” In part, the general legislative and campaign strategy of those in favor of repeal involved a refusal to engage the moral or philosophical arguments on assisted suicide. This refusal stemmed from a perception that the case for patient autonomy, the ideology of “give me liberty and give me death,” was too socially accepted and compelling to overcome on ethical grounds. Instead, the view was that the case for repeal would have to be made on medical grounds such as patients’ risks of lingering death, aspiration of the medication, or coma.

**Medical and culture wars**

Thus, repeal proponents sought to focus on the inadequacies of the law from a medical perspective, which included concerns about the risks of lethal medication, physicians’ lack of ability to diagnose depression, and medical uncertainties about the prognosis of patients deemed terminally ill. If there was moral content to this position, it had little to do with assisted suicide per se and much more to do with using the question of assisted suicide as the means to draw a line against voluntary euthanasia and lethal injections. As implied in the OMA’s resolution, some proponents of repeal were willing to concede that the concept of assisted suicide and its legal implementation by a law such as the Death with Dignity Act were two different matters. Moreover, given the disputed interpretations of the Dutch accounts of the failure rates of lethal medication, repeal proponents argued that were the Death with Dignity Act implemented, Oregon practitioners would inevitably be drawn down the path of using injection or asphyxiation to ensure the death of a lingering patient. Indeed, some legislators maintained that rather than seeking to minimize potential abuses through an amended Death with Dignity Act, “the only real way to fix [the law] is to allow the doctor to give a lethal injection.”

In short, lethal medication was the slippery slope to lethal injection and the eventual legalization of euthanasia. Rather than take a step down this slope through an amended law, the law was characterized as so “flawed” in its foundations that repeal by
the voters was the only safe policy option. And, as will be detailed below, these “flaws” had much more to do with pragmatic medical issues than with statements of ethical principle. In adopting that approach, the supporters of repeal essentially conceded the moral ground on assisted suicide to Oregon Right to Die and its advocacy of “give me liberty and give me death,” as supported by personal autonomy and the sovereignty of choice.

Oregon Right to Die, which strongly opposed legislative referral of the law without amendments, also refrained from arguing the merits of assisted suicide. Rather, their concerns were directed at procedural issues. First, they argued that returning precisely the same measure to citizens for a second vote implied governmental rejection of the will of the voters, and indeed, an insult to the democratic process. The way to defuse the controversy over the legality of the right to assistance in suicide was to appeal to a more foundational civil right about which there should be no controversy, namely, the right to vote. This argument, although it failed to convince legislators, became extremely persuasive in the subsequent political campaign, especially among an electorate that was already distrustful of, if not cynical about, elected legislative bodies. In a post-vote survey, some 24 percent of persons who voted against repeal did so on the grounds that Oregon voters had already decided this question in 1994.19

If one line of the procedural argument appealed to a circumvention of the democratic process, another line appealed to the need to avoid entanglement of public policy with religious views; a strict church-state separation was affirmed. In legislative debates, legislators contemplating repeal were warned that they were “imposing personal religious beliefs on citizens” of the state. And Barbara Coombs Lee, the chief petitioner for the Oregon Death with Dignity Act and executive director of Compassion in Dying, contended that the state legislature's deliberations reflected a political body that had been “held hostage” by the “raw political power” of religious institutions, particularly the lobbying efforts of the Roman Catholic Church.20

Voters received the separationist argument more warmly than legislators, in part because the citizenry of Oregon is claimed to be the least religiously affiliated of any in the United States outside Alaska. But religious affiliation on issues of the right to die is not a guarantor of voting patterns by any means; among the general populace, Roman Catholics, Protestants, and Jews support the concept of assisted suicide at a level close to general popular support, even if they may have reservations about a specific way of implementing assisted suicide as policy.

So, the mere fact of religious affiliation is not a sufficient (or even a necessary) explanation of the reason that the separationist argument resonated so significantly with Oregon’s populace. Rather, the separationist argument succeeded because it played off a background of recent attempts by an alliance of fundamentalist Christians (specifically, the Oregon Citizens Alliance) to make biblical appeals the explicit basis of public policy on such issues as abortion, education in the public schools, and gay rights. Those efforts, also largely conducted through the ballot initiative, had all been defeated, some by quite substantial margins, but they had
clearly poisoned the public’s receptivity to arguments made from religious perspectives. In short, the separationist argument took hold in the death with dignity debate because of the background of the “culture wars.”

Moreover, in the context of the debate over physician-assisted suicide, the separationist theme had been given a vigorous judicial endorsement by the Ninth Circuit Court in its March 1996 ruling overturning a Washington statute prohibiting assistance in suicide. The final paragraph of the majority opinion concludes: “Those who believe strongly that death must come without physician assistance are free to follow that creed. . . . They are not free, however, to force their views, their religious convictions, or their philosophies on all the other members of a democratic society, and to compel those whose values differ with theirs to die painful, protracted, and agonizing deaths.”

Any fair assessment of the question must view this judicial interpretation as mistaken and anti-democratic. The claim first comes very close to suggesting that all opposition to assistance in suicide must have a religious character, that is, that opponents are following a “creed.” As an empirical matter, that is simply false. Second, the expression of a religious opinion cannot logically be held to constitute “force” or “compulsion”; if so, then the law seems to have abandoned any hope of maintaining a distinction between persuasion and coercion, and seems finally to rely on the settling of civic disputes according to emotion, manipulation, and power. Third, the concluding clause raises the specter of religious inquisition bordering on torture— that is, religious belief will be used to compel nonbelievers to “die painful, protracted, and agonizing deaths.” This simply misses (deliberately, one suspects) the historical focus of religious concern in end-of-life care. Finally, the Court presents a false dichotomy. Terminally ill patients may opt for assisted suicide or for the painful death apparently sanctioned by religious beliefs. This dichotomy is implausible, neglecting as it does the substantial attention given to palliative care and hospice by religious communities, and increasingly by the medical community.

Despite these flaws, the religious “card” played very well as a matter of political rhetoric. The issue of the unfairness of “imposing” religious positions on others was vigorously (and vitriolically) advanced, primarily under the banner of the “Don’t Let Them Shove Their Religion Down Your Throats” committee, and commonly cited in public discussion. In this context of hostility toward politicized religion, it comes as no surprise that some 20 percent of voters who opposed repeal agreed that “the vote was not so much about the merits of the law, but about the role of outside religious groups trying to tell Oregonians what to do.”

The sentiments of DDA proponents, who sought to affirm the integrity of the democratic process and its immunity from legislative circumvention and religious tyranny, were initially voiced in legislative debate in the spring of 1997, and they set the tone and presaged the content of the public debate in the fall. I wish to emphasize two central issues. First, neither the legislative nor the public debate directly examined the moral merits of physician-assisted suicide per se, which may limit some of the more triumphal claims of commentators that Oregon voters had resoundingly endorsed physician-assisted suicide itself. Second, if the vote cannot correctly be interpreted as a referendum on physician assistance in suicide, it does seem possible to see the
results as a cultural comment on the primacy of individual autonomy, and correspondingly, a rejection of authoritarianism, whether that is displayed in the form of governmental/legislative, religious, or medical authority.

**A green light from the Supreme Court**

The Oregon debate, of course, did not occur in a social vacuum. Legislative debates about the repeal, amendment, or referral options were being joined just as the U.S. Supreme Court was preparing to issue its opinions in *Washington v. Glucksberg* and *Vacco v. Quill*, cases in which the constitutionality of prohibitions on assisted suicide in Washington and New York were contested. Ironically, even though the Supreme Court denied that the federal Constitution protected a right to assisted suicide, the wording of the majority opinion, as well as the comments in several concurring opinions, provided encouragement to supporters of the Death with Dignity Act. The concluding paragraph of the majority decision in *Glucksberg*, written by Chief Justice Rehnquist, observed: “Throughout the Nation, Americans are engaged in an earnest and profound debate about the morality, legality, and practicality of physician-assisted suicide. Our holding permits this debate to continue, as it should in a democratic society.”

Justice O’Connor’s concurrence, which appealed to the “democratic process” to strike the appropriate balance between the interests of terminally ill patients and those of the state, was interpreted as offering a similar message: The Court was giving a green light to resolve the question of legalized assisted suicide through democratic forums in the states, such as legislatures, or more significantly in the context of Oregon, by appeal to the voters’ will. Since voters had initially approved the Death with Dignity Act in 1994, the Supreme Court’s decision seemed to give a judicial endorsement to the process used in Oregon. This interpretation was reiterated in the Supreme Court’s October 14 decision to refuse to hear the challenge on whether the plaintiffs in *Lee v. Oregon* had standing to sue.

Neither the Circuit Court nor the Supreme Court’s decisions addressed the substantive merits of the Death with Dignity Act, but focused only on the procedural question of whether the plaintiffs had legal standing to bring suit. However, the Supreme Court decision to deny *certiorari* could not have been, depending on one’s position, any better or more ill-timed. The decision was issued at the beginning of the week that ballots were distributed to citizens for their “yes” or “no” vote on repeal of the DDA, Measure 51. Thus, a procedural question became an important symbolic victory and a victory in the court of public opinion for Oregon Right to Die. The cumulative effect of these rulings was held to be that if the voters of Oregon wanted to legalize physician-assisted suicide, the U.S. Supreme Court would not stand in their way, at least absent a showing of immediate and tangible harm. The proponents of repeal, meanwhile, sought to alert the public to findings of harm that they claimed were more than speculative, and indeed constituted “fatal flaws” in the Act.

**The fatal flaws and professional reticence**

Proponents of repeal, coordinated by the “Yes on 51” committee, identified several “fatal flaws” in the Death with Dignity Act:
• The failure of prescribed medication to hasten a peaceful death in 25 percent of cases (again, until the last month of the campaign, based almost entirely on anecdotal information);
• Physicians’ immunity from liability in such cases, which was viewed as lowering the required standard of medical care, or constituting abandonment of patients;
• The risks of error in physicians’ diagnoses of terminal illness, raising the prospect of premature and unnecessary deaths (A study of 2,761 Oregon physicians in the New England Journal of Medicine indicated that 50 percent could not confidently predict that a terminally ill person would die within six months, as required by the law. 28);
• The risks that physicians would not diagnose depression accurately, thus depriving some patients of counseling and raising questions the voluntariness of requests for medication (The same study reported that 28 percent of the physicians could not reliably diagnose depression; at conferences, physicians have told me that they suspect the 72 percent of the respondents who did express confidence in a diagnosis of depression are over-estimating their diagnostic capabilities.).

It is clear that most of these “flaws” are procedural rather than substantive in nature. They are flaws that could have been remedied by legislative action, and indeed, most were discussed in the course of legislative debates. They are also largely speculative flaws, inasmuch as they focus on what might happen should the law be implemented, matters of possibility rather than probability or actuality. Leaders of Oregon Right to Die maintained that the procedural remedies to these “flaws” were already incorporated in the Death with Dignity Act, through requirements of a medical assessment of patients’ capacity and prognoses by a second, consulting physician, and waiting periods to ensure voluntariness and informed consent. The evidence to support the case for repeal rested largely on the first claim, that death by prescribed medication was not safe, because the possibility of induced coma or lingering death could not be ruled out in all cases; as we have seen, this evidence turned out to be absent for much of the campaign and then less than compelling when finally publicly distributed.

To a large extent, then, proponents of repeal implicitly conceded the medical legitimacy of assisted suicide in many cases. Having opted for moral disarmament by dismissing substantive ethical arguments as “tangled territory,” or by granting the moral superiority of arguments from autonomy, repeal proponents could argue that in individual acts of assisted suicide, things could go badly for the patient from a medical standpoint. However, they had very little in the way of a compelling case to present to voters about the dangers of a practice of assisted suicide.

Although proponents of repeal stated their case in terms of these various medical risks, the organizations best positioned to make this case credible – national and state medical, nursing, hospital, and hospice organizations – offered symbolic rather than substantive support. Physicians for Compassionate Care was the only provider organization that assumed an active advocacy role in the public debate. Only two provider associations (the OMA and the Oregon Association of Hospitals and Health Systems) presented statements in favor of repeal in the state voters’ pamphlet distributed to Oregon citizens. Yet, even these statements were perplexing. The OMA statement described the Death with Dignity Act as “seriously flawed,” but it did not say
why, nor did it specify the “serious medical deficiencies” it had found in the law. And, despite the central role some professional practitioners might play in implementation of “physician”-assisted suicide, state associations representing pharmacists and psychiatrists adopted neutral positions on the question of repeal.

To what might this reticence and negligible public role of major health care professions and associations be attributed? Certainly one factor was the range and depth of internal dissent among individual members of the professional communities. Professional associations’ statements in favor of repeal papered over vigorous disputes among individual members or institutions affiliated with the larger organization. These internal disputes at times surfaced publicly in editorial rebuttals. It was clear, for example, that the membership of the OMA was not at all united behind the April House of Delegates resolution; indeed, it is not evident that the resolution could claim to be a majority position within the OMA. These patterns of internal dissent certainly blunted the prospects of organized providers’ efforts in support of repeal.

A second factor in the marginal role of medicine and other professional providers in the pre-vote discussion reflected a pragmatic concession to post-vote realities. Should voters retain the Death with Dignity Act, political adversaries would need to forge (and in some cases already had forged) collaborative care-giving relationships. Professional bodies could not afford to antagonize other professionals who might become partners in providing modes of health care to terminally ill patients, including assistance in suicide. This approach was perhaps best symbolized in the decision of an influential interdisciplinary and interprofessional body, the Task Force to Improve the Care of Terminally Ill Oregonians. The Task Force, comprising members from almost all the state’s significant provider organizations and institutions, remained neutral on the repeal issue in order to maintain a cohesive organization that would be positioned to provide constructive guidance on how to implement physician assistance in suicide should the repeal effort fail. In many cases, then, pragmatism triumphed over fidelity to the ethical principles constitutive of professional identity.

The demise of ethics and religion

The role of religious traditions in the debate over repeal is no less a story of ethical compromise to political realities. Many religious communities and ecumenical bodies expressed support for repeal, but the most prominent advocate (as had been the case in 1994) was the Roman Catholic tradition, as politically institutionalized in the Oregon Catholic Conference (OCC). The OCC had initially lobbied the legislature for review of the Death with Dignity Act, but settled for referral to the voters when it became clear that the other options could not generate sufficient legislative support.

Despite its intense lobbying effort in the legislature, when the debate moved to the public forum and the campaign to repeal was formally initiated, the OCC deliberately opted for a diminished public presence. This strategy was explained in part by ecclesiastical prudence: a desire to protect the Catholic Church from some of the scathing attacks directed at it during the
1994 campaign. Diminished public presence also was compatible with the repeal coordinators' strategy of framing the issue as a question of safe medical practice, rather than a value clash between religious and secular ethics. Medicine, not morality, was held to be the winning card for repeal proponents. 31

This strategy created the worst of all possible worlds for repeal proponents and for the churches. They had opted to wage a campaign that was ethically vacuous, conceding the political and moral primacy of the ideology that linked liberty and autonomy with death. To avoid making the issue a referendum on religion, repeal proponents asserted that assisted suicide was not only not an ethical issue, it was not a religious issue either. Yet, this argument seemed hardly credible when campaign finance information revealed that close to $4 million had been raised by religious communities (primarily state and national Catholic constituencies) to support the repeal effort. Not only did the strategy fail, then, to disentangle the medical questions from religious concerns, but the public perceived that repeal proponents were engaged in dissembling, if not outright deception, about religious influences.

It thus became much easier for Oregon Right to Die and other opponents of repeal to argue that a hidden religious agenda lay behind the drive to repeal. This conclusion was reinforced by an onslaught of vitriolic attacks against various religious communities, who were characterized in campaign literature and media advertisements as "radical, right-wing, and extremist." Despite its lower public profile, the Roman Catholic Church was not immune from such attacks; the OCC was portrayed by leaders of Oregon Right to Die as a "powerful and wealthy political machine." Catholic views on assisted suicide were denounced as "arrogant" and "smug moralism," and the church's perceived dominance of the repeal effort portrayed as an attempt to ensure "dogmatic conformity," and to "force its beliefs," or "impose its values," on a democratic process and on citizens. The repeal strategy to focus on issues of medical safety and fallibility was thus countered by Oregon Right to Die's focus on religious tyranny and the "culture wars."

There should be little question that assisted suicide is an issue in medical practice with profound religious implications; to claim otherwise, as repeal proponents did, is simply disingenuous. There should also be no dispute that many religious communities -- and not only Roman Catholicism -- invested moral capital and credibility in the repeal effort. While all that may be conceded, it does not justify the incivility directed at religion in general and Catholicism in particular.

Indeed, if the claims of Oregon Right to Die and other repeal opponents about religion are taken seriously, they have chilling and discriminatory implications. A foundational principle of democratic discourse is its reliance on persuasion as a mode of resolving civic disputes. The politicized interpretation of religious discourse by Oregon Right to Die, however, places such discourse squarely in the realms of coercion, manipulation, and indoctrination. These would be legitimate grounds for excluding religious views from the public forum, but they are hardly fair in their representation of religious discourse. Ultimately, the moral logic of this separationist strand treats freedom of religious expression as less fundamental to the make-up of a democratic society than assistance in suicide. While the sharpness of some of these critiques of religion
undoubtedly may be attributed to the heat of a political campaign, they cannot be entirely dismissed as irrelevant to the role of religious discourse in society for, as already illustrated, it is precisely such claims that have been advanced in the context of assisted suicide by jurists on the Ninth Circuit Court.

In a society as pluralistic as Oregon’s, it simply is not possible for any religious community to “impose” or “force” its values upon persons outside the community. Arguments that appeal to religious values are efficacious only to the extent that they stimulate public imagination and enable persons to see a problem in a different perspective; they may as well illuminate and resonate with values already embedded in social practices and accepted by citizens. Credible religious discourse must rely on modes of perception and persuasion similar to other forms of democratic discourse. Coordinators of the repeal effort, as well as leaders of religious communities, simply reinforced the perception of religion as coercive and intimidating in their effort to downplay the religious dimensions of the debate over assisted suicide.

Federal checks, professional balances

With the simultaneous defeat of the repeal measure and the federal court’s mandate in early November that the injunction barring implementation be lifted, the question was no longer whether assisted suicide would be legally available to terminal patients, but how. Success brought in its wake, however, another intervention by the federal government and professional controversies and confusions, including the threat of a lawsuit between two groups – physicians and pharmacists – whose collaboration is vital to implementation of the law.

Shortly after challenges to the Death with Dignity Act had been exhausted in the judicial branch of the federal government, the executive and legislative branches took their turn in the process. The occasion was the interpretation of the fine points of federal law on controlled substances. Acting at the behest of influential conservative Republican legislators, the Drug Enforcement Administration (DEA) initiated a review of the Death with Dignity Act and its compatibility with the federal Controlled Substances Act.33

The question at issue – whether a prescribed barbiturate for assisted suicide would violate the CSA’s requirements that prescriptions of controlled substances have a “legitimate medical purpose” – had actually been anticipated in the wake of the 1994 vote, but had subsequently been buried by other litigation concerns. The DEA has authority to revoke physicians’ registration to prescribe controlled substances in cases of professional noncompliance. Congressional efforts to specify the scope of the CSA eventually succumbed to the press of other legislative issues in October 1998, and it is not clear whether this issue will be revisited in the future. Whether a hastened death is a legitimate purpose of medicine is a profound philosophical question, but this dispute will more likely be resolved in terms of whether the regulation of medicine ultimately falls under federal or state jurisdiction.

Congressional representatives have also introduced bills under the guise of promoting better pain control at the end of life that would limit what kinds of medication can be made available to dying patients. The fate of the Pain Relief
Promotion Act, currently pending in Congress, is not clear.

In Oregon, questions of implementation were initially raised by those professionals that would dispense the medications, the pharmacy community, which has been continually marginalized in the public discussion of assisted suicide. The language of “physician”-assisted suicide neglects the role of pharmacists in dispensing lethal medications; indeed, as the Death with Dignity Act includes no requirement that a health care professional attend a patient’s ingestion of medication, a pharmacist may well be the last professional provider with whom the patient has contact. Thus, for various reasons, it is no surprise that the Oregon Board of Pharmacy issued the first professional guideline subsequent to the vote. The OBP adopted an emergency rule requiring physicians to specify in writing whether the medication was requested for use in assisted suicide. The Board argued that this knowledge was necessary 1) to inform pharmacists who wished to exercise their legal right to refuse to participate in an assisted suicide, and 2) to allow participating pharmacists to provide appropriate instructions and counseling to patients.

The medical profession, which had publicly expressed willingness to let patients set the standards of good medical practice, was not so welcoming of the pharmacists’ initiative. The OMA objected to the rule on the grounds that it would violate the confidentiality of patients who request the medication and publicly expose participating physicians. While pharmacists argued that this kind of information exchange is standard modus operandi between physicians and pharmacists without challenging patient confidentiality or physician secrecy, in the harsh light of the DEA review of whether to rescind physicians’ registration over controlled substances, the OMA understandably viewed disclosure of this information in this particular context as more sensitive and professionally compromising. The OMA therefore threatened court action against the OBP, all the while seeking a mutually satisfactory compromise. It was finally left to the state Board of Medical Examiners to propose a rule to resolve this interprofessional controversy: 1) Physicians can personally dispense lethal medications and any related drugs to the patient so long as they conform to state dispensing guidelines. 2) Physicians could, with the patient’s written consent, contact a pharmacist and inform him or her of the purpose of the prescription, thus avoiding any publicly reviewable documentation.

The OMA, meanwhile, was still struggling to articulate practice guidelines for its members within the new medical world of assisted suicide. Given the OMA’s “public” support of repeal, and the internal dissent and fragmentation prompted by the April resolution, the OMA was obliged to formulate some common ground for its fractious membership. To this end, the OMA issued a “statement of philosophy” and a “compliance checklist.” The statement of philosophy reiterated the association’s support for comprehensive, palliative care at the end of life, but also indicated it would provide physicians with resources to practice medicine in accordance with the law, including provision of assisted suicide, and undertake protection of the “sanctity of the doctor-patient relationship.” It also affirmed close scrutiny by the OMA of efforts to change the law in a manner detrimental to physicians’ responsibilities.

The OMA’s “compliance checklist” largely reiterated professionally relevant
features of the Death with Dignity Act with respect to what physicians are required, permitted, and prohibited from doing (accompanied by continual reminders about documentation). A set of guidelines more revealing of the practice issues raised by professional participation in assisted suicide was developed by the Mid-Valley Physician-assisted Suicide Interest Group, a group of OMA members pledged to support patient requests for assisted suicide. These guidelines recognize the pharmacist’s right to know the reason for a prescription, and they are refreshingly candid about the lack of professional knowledge about lethal medications; thus, “during the early years of assisted suicide, physicians must be present to observe the effects of our treatments if we hope to improve them.” The guidelines then consider the lengths to which physicians may go in “assisting” a suicide without “abandoning” a patient:

- A doctor or nurse can assist in preparing the drugs, and in bringing the drugs to the patient’s mouth, but the act of ingestion by the patient must be voluntary.
- The physician can provide medication by injection should the patient develop “distressing symptoms” from ingestion of the drugs so long as the dosage and method are “consistent with an attempt to control symptoms rather than to hasten death.”

- Once a patient is unconscious from drug ingestion, a physician may leave the patient, but only if another physician or RN remains present.

Some of the ambiguities about professional practice and responsibility were addressed thoughtfully and comprehensively in a report issued in March 1998 by The Task Force to Improve the Care of Terminally-Ill Oregonians, *The Oregon Death with Dignity Act: A Guidebook for Health Care Providers*. The Guidebook addresses fifteen topics of professional concern, organized throughout by a three-fold schema of philosophy of care, practice guidelines, and resources for information, but issues of practice are the central concern, and indeed, on many issues, there is no clear connection between the philosophy of care and the practice guidelines. Nonetheless, the document goes well beyond the minimalist provisions of the Death with Dignity Act by devoting sustained attention to the meaning of patient requests for assistance in suicide, patient rights and responsibilities, physician roles in conscientious practice, the concerns of families, professional noncompliance, and reporting requirements.

The practice guidelines, of course, are not binding, and now that 43 deaths and hundreds of requests have occurred under the DDA’s provisions, it remains a question whether these or other guidelines can provide much-needed professional unity. After all, it is not clear whether a professional association can affirm positions of “neutrality” (1994 to spring 1997), then “opposition” (spring to fall 1997), and then “compliance” (November 1997 onward) on something as critical to professional identity as assistance in suicide and retain its ethical integrity and credibility.

**The experiment begins: 1998**

As litigation to block the Death with Dignity Act ran a course of futility, and provisions for federal oversight stalled in Congress, the first steps toward integrating assistance in the suicide of terminally ill patients within the practice of medicine were undertaken in 1998. The implementation of
the DDA by patients and practitioners has raised some additional questions.

First, it is unclear just how many patients have used lethal medication under the DDA to end their lives. As required by law, the Oregon Health Division has published an annual statistical report on the numbers of terminally ill patients who make use of the DDA. The OHD has documented that 16 patients died following ingesting prescribed lethal medication in 1998, while 27 died during 1999.\textsuperscript{42} Physicians have reported writing lethal prescriptions for 57 patients during these two years.

When the DDA was first proposed to Oregon voters in 1994, its advocates argued it provided a model of “reasonable regulation” for public policy, in contrast to the actions of Jack Kevorkian in Michigan (unreasonable)\textsuperscript{43} or the practice of euthanasia in the Netherlands (unregulated). Yet, as even the OHD acknowledges, the reporting mechanisms by which policy oversight and the public can be assured of a medically safe and justifiable practice currently are not reliable. However, all of the information contained in the OHD report is based on interviews with reporting physicians and family members. There is no incentive for a physician or family member who experiences a difficult or failed death to report it, and indeed every reason not to report. As the OHD acknowledges, “underreporting cannot be assessed, and noncompliance is difficult to assess because of the possible repercussions for noncompliant physicians reporting data to the division.” Thus, it may well be the case that, even two years into this social experiment, we know little more about the practice of physician-assisted suicide than we did prior to the implementation of the DDA.

The claim has been that it is necessary to release only minimal information to the public, other than the “body count,” in order to protect patients’ confidentiality and physicians’ privacy. Yet there are several other areas in medicine in which epidemiological data that are vital to determine the efficacy of a practice or policy are successfully tracked and disclosed without violating claims of confidentiality and privacy.

Not surprisingly, the implementation of physician-assisted suicide has also been caught up in the economic waves currently influencing health care provision. In December 1998, the Oregon Health Plan, the state's program of insurance for the indigent, began to provide coverage for assistance in suicide as a form of “comfort care,” a category that also includes hospice and pain medication. This category ranks 263 of the 743 health care services on the plan’s list of priorities.\textsuperscript{43} The financial costs of including assisted suicide are anticipated to be minimal relative to the overall plan; nonetheless, a very disturbing symbol is embedded in this decision. While Oregon still does not provide access to a basic minimum of health care services for all its citizens, it does provide equal access to the means to end one’s life. A principle of economic rationality here seems to contradict a philosophical principle of equal protection.

**Forging common ground**

The death with dignity debate in Oregon presents some disturbing lessons about the limits of substantive civic discourse on issues of medical ethics. A democratic society is committed to fulfilling the will of the people, which presupposes that citizens are reasonably informed about the central issues at stake in a matter concerning the public good. The Oregon discussion,
however, revealed no agreement on the core issues around which meaningful public discourse could occur. The focus on medical issues by proponents of repeal did not intersect with the anti-authoritarian arguments advanced by Oregon Right to Die.

It could be argued that both positions implicitly assume the legitimacy of principles of patient autonomy and of benefit-risk assessments, or the principle of utility. In this perspective, the Death with Dignity Act begins with a presumption acknowledging the autonomous decision-making capacity of terminally ill patients, and its safeguards seek to provide benefits—control, a dignified death—while minimizing risk. Proponents of repeal, meanwhile, also implicitly affirmed the principle of autonomy in their tendency to deny that a choice to request suicide could be autonomous. In addition, their emphasis on the disproportionate risks of lethal medication presupposes a utility assessment. This construction provides some common ground for debate, even if the interpretation and application of normative ethical principles are disputed. It does assume, however, that the central issue is the moral legitimacy of assisted suicide, rather than what was discussed by advocates and opponents, namely, medical fallibility, state authority, or religious tyranny. In this respect, the arguments of both proponents of repeal and Oregon Right to Die were more effective in obfuscating the issues than in providing clarity for public discourse.

Beyond the rather thin framework of autonomy and utility, however, it is difficult to identify other sources for public moral discourse, or certainly any that had bearing on the Oregon debate. It is no longer possible to speak of a coherent tradition of professional ethics in medicine. Rather, there are rival interpretations claiming professional credibility. The Hippocratic ethos, with its guiding principle of “do no harm,” is now in conflict with and to some extent has been supplanted by a provider ethos in which professionals cater to consumer autonomy. The consequence of these rival moral traditions is the increasing fragmentation of the medical community as a coherent and cohesive social organization.

The possibility of substantive moral discourse also seems precluded by the primacy of choice on one hand and the conflation of “morality” with the ethics of religious traditions on the other. The moral sovereignty of autonomy is held to grant immunity from ethical scrutiny of particular choices. The ethics of choice can also be readily aligned with the emphasis in legal discourse on the unlimited exercise of freedom when immediate and tangible harms cannot be established.

The ethic of choice is a procedural ethic in the sense that it is most concerned with the issue of who decides rather than what is decided. It is thus compatible with, if not reducible to, legal rights, liberties, and permissions. It is in this respect that the ideology that makes an intrinsic connection between liberty and a “dignified” death through assisted suicide is legally compelling. A substantive ethic, that is, one that addresses the question of what is decided from a normative perspective, tends to be relegated to traditions of religious ethics, at least in the Oregon context. This helps explain, I believe, why any substantive “moral” position on assisted suicide is viewed with suspicion and seen as a manifestation of “force” and “coercion.” The
The traditions of religious ethics, however, do not assume the importance of public reasoning in the moral life, i.e., that it is valid to distinguish between a choice that is legally permissible, or an exercise of a legal right, and a morally right (justified) choice. When public reasoning is neglected, ethics is compartmentalized, and public discourse focuses increasingly on procedural questions. Religious traditions that embody moral resources to evaluate particular choices are increasingly marginalized in the public discussion to the point that they are characterized as “extremist.”

I have portrayed a bleak and impoverished landscape for discourse on biomedical ethics. I maintain that it is an accurate portrayal of the moral landscape of Oregon’s debate over assisted suicide; this moral desert was created through a polarizing concentration by political advocates on both sides on what separates and divides. I want to suggest, in contrast to some philosophical perspectives, that scarcity of moral resources and empty moral discourse is not a necessary condition of a post-modernist society. Instead, all parties — patients, providers, advocates — share several common commitments that can provide the basis for a constructive civic discourse.

First, there is a shared commitment to improve care for terminally ill persons. This, I maintain, is the core ethical question that the political campaign neglected or obfuscated. Yet, no one has argued that current kinds or levels of terminal care are optimal. By contrast, there has been a renewal of medical attention to palliative care and a corresponding increase in the incidence of patient referrals by physicians to hospice programs.

Second, there is a shared affirmation of the importance of patient control over the dying process. This emphasis is already embedded in current policy with respect to advance directives. Moreover, the discourse of terminal patients and their advocates suggests the language and mechanisms of “control” have an important placebo effect, offering psychological reassurance that patients will not be abandoned in their dying. Thus, structural efforts that permit the dying more say about where they will die, in whose presence, and with what levels of care are essential to improvements in care.

Third, there is a common conviction about the centrality of “dignity” in a meaningful death. It is unfortunate that the politicization of dignity in the recent political campaign did not lead to any clarity about the meaning of dignity in the context of dying. The moral language of terms like “dignity” and “compassion” were appropriated for rhetorical purposes whose assumptions were never articulated. Thus, I here offer a few themes about dignity in dying that I believe would command consensus.

- Dignity is constituted in part by a set of negative liberties and freedoms, including freedom from severe pain or suffering; freedom from technological control of life and dying; and freedom from demeaning dependency.
- Dignity in dying also refers to certain positive liberties and responsibilities, including control over the dying process, as well as “authenticity,” that is, a person’s claim to die in a manner consonant with the values by which the person lived. Dignity is not a characteristic that can be legally conferred on one’s deathbed, but rather is acquired over a lifetime. As Sherwin Nuland has insightfully commented, the art of dying well (ars moriendi) is integrally intertwined with the art of living well (ars vivendi).
continuity of meaningful life relationships that endure until death. Although the Oregon Death with Dignity Act does not require patients to inform their families of a request for assistance in suicide, even advocates of the act do not see dying by one's own hand with no other human presence as philosophically preferable. Instead, they instead strongly affirm the need to avoid lonely deaths for patients who have made a choice because of a sense of "burdensomeness" to others, or who otherwise have been abandoned by professional and familial caregivers. Dignity requires in part, then, a faithful and compassionate human presence to the dying person by his or her intimates, rather than impersonal care by strangers.

- Fourth, even if assisted suicide is upheld as a legal option for terminally ill patients, that option should be exercised only as a last recourse. It is clear that the commitments of hospice can, in most circumstances, provide acceptable care for the terminally ill that is directed toward providing symptom control and preserving patient dignity. In addition, the debate over assisted suicide has been a catalyst for caregivers to give comprehensive attention to palliative care at the end of life, especially more liberal use of medication to provide relief from pain. There is strong empirical evidence that as pain is brought under medical control, the incidence of requests for assistance in suicide decline dramatically. In short, the prospect of assisted suicide may serve as an incentive for patients and physicians to make better use of available end-of-life care, such as hospice, or to improve modes of pain relief and palliative care.

- Implicit in the criterion of "last resort" is a fifth common imperative: a need for the society to make a strong stand against a "duty to die," which may be personally perceived or socially imposed through health care rationing or other forms of economic stratification in health care delivery. Whatever arguments from liberty or self-determination may support a "right to die" through assisted suicide, they are incompatible with economic rationality and a utilitarian philosophy that affirms persons have a duty to end their lives prematurely for the sake of social benefits and resources.

As assisted suicide begins to be practiced in Oregon, and the debate over its legality continues in other jurisdictions, a focus on these common commitments, rather than on what is divisive, will provide the best direction for enhanced care for terminally ill persons. The adversarial language of "rights" (e.g., right to die, right to life) obscures these commonalities. If, however, patient advocates, professionals, and policy makers are serious in their efforts to improve care for the terminally ill (rather than seeking to advance a political agenda), then these commitments must underlie and be integrated within public and professional discourse and displayed in clinical practice.


5 *Compassion in Dying v. Washington*, 79 F.3d 790, at 838 (9th Cir. 1996).


21 Compassion in Dying v. Washington, 79 F.3d 790, at 839.


23 NCCB Secretariat for Pro-Life Activities, “Why Did Oregon Voters Reject Measure 51?”, p. 3.


25 Ibid., at 2303.


28 Lee et al., “Legalizing Assisted Suicide.”

29 State of Oregon, Oregon Voters’ Pamphlet, November 1997, p. 3.


37 Erin Hoover, “Medical board seeks to end dispute with pharmacists on assisted suicide,” The Oregonian, 18 March 1998, B1.


