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THE CASE AGAINST ASSISTED SUICIDE REEXAMINED

Ani B. Satz*

THE CASE AGAINST ASSISTED SUICIDE: FOR THE RIGHT TO END-OF-LIFE CARE. Edited by *Kathleen Foley* and *Herbert Hendin*. Baltimore: Johns Hopkins University Press. 2002. Pp. xii, 371. \$49.95.

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I. INTRODUCTION: AUTONOMY, SUFFERING, AND A PARENT'S LOVE

*When the four horsemen came — schoolteacher, one nephew, one slave catcher, and a sheriff — the house on Bluestone Road was so quiet they thought they were too late . . . Inside, two boys bled in the sawdust and dirt at the feet of a nigger woman holding a blood-soaked child to her chest with one hand . . . What she go and do that for? On account of a beating? . . . “What she go and do that for?” — Toni Morrison, *Beloved*¹*

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1. TONI MORRISON, *BELoved* 148-50 (Signet 1991) (1987).

In Toni Morrison's acclaimed novel *Beloved*, Sethe, a runaway slave woman on the brink of capture, gruesomely murders one of her infant children and is halted seconds before killing the second. Cognizant of the approaching men, Sethe's actions are deliberate, swift, confident, and unflinching. Afterwards, she sits erect in the Sheriff's wagon. The reader is left to struggle, situating the horror of the event within the context of the reality of slavery. Was this an act of mercy to prevent the suffering Sethe's child would know as a slave? Is loss of autonomy, even rising to the condition of slavery, sufficient justification for ending a life? Was this a desperate attempt to control an unjust situation?

These questions of suffering, self-determination, and control are similar to the ones raised within the context of the euthanasia debate today. The two primary justifications for euthanasia are often identified as the prevention of suffering and respect for autonomous choice to end one's life (or, for the incompetent person, respect for the guardian's autonomous choice, presumably supporting the interests of the incompetent individual). Certainly slavery is the extreme example of diminished autonomy, and arguably of suffering. Nevertheless, an intuitive response that Sethe's actions are morally wrong, or an emotive reaction of shock, is understandable.

Reflections about such an intuition or emotive response likely would reveal concern — not that Sethe ended the life of an infant or even that she ended the life of her own child — but that she ended the life of a healthy child who might have known a situation other than slavery. Further, even if *Beloved* lived her entire life as a slave, it is unclear that her life would have been one only of suffering. At the very least, the child could have known love and friendships, even within a situation of gross social injustice.

The killing of *Beloved*, though an instance of euthanasia, is different from assisted suicide, where individuals who are suffering intolerably from illness choose to end their lives and require assistance to do so. Consider the case of Carla, who received a physician's assistance to terminate her life.

Carla was 47 years old . . . In 1988, Carla noticed a painful swelling in her lower abdomen and went to her family doctor. He referred her to a gynecologist . . . A subsequent operation revealed that the pain had been caused by a large malignant tumour on one of Carla's ovaries. By the time the operation was performed, the tumour had already grown so large that it could not be totally removed

Carla underwent chemotherapy and by June her condition had greatly improved . . . [in] March 1990 . . . it was found that the tumour had re-grown. Chemotherapy was tried once more, but this time it was in vain.

By the middle of the year, Carla's pain had increased to such an extent that her family doctor had to prescribe opioids (morphine-like

drugs). Her condition deteriorated quickly and it was not long before Carla had to be readmitted to [the] hospital

She was vomiting constantly To prevent thirst, Carla received an infusion of a saline solution

Carla lost a lot of weight and became extremely weak, unable even to move around in her bed. This made it very difficult for the nurses to prevent bedsores. While Carla lost weight, the tumour continued to grow and was soon obstructing the blood flow in her legs, causing them to swell painfully.²

Many opponents of assisted suicide argue as if there is no moral difference between the death of Beloved and the death of Carla. They fear any action intended to terminate the life of a suffering individual. This includes actions by doctors within regulated schemes of assisted suicide for irreversible and terminal illness requiring informed consent, secondary medical opinions, and waiting periods. One's capacity to choose to die is not viewed as morally relevant. Opponents object to the assisted suicide of competent individuals as well as those who are in a persistent vegetative state. Support for these views purportedly stems from the potential for abuse within regulated schemes, the availability of other means to alleviate suffering, and the moral distinction between intending and foreseeing death. The authors whose work is the subject of this Review are no exception.

II. OVERVIEW

The Case Against Assisted Suicide: For the Right to End-of-Life Care is edited by Kathleen Foley³ and Herbert Hendin.⁴ Foley and Hendin are medical doctors who present the self-proclaimed first comprehensive examination of the arguments against assisted suicide in favor of greater palliative care. The book, a collection of fourteen articles by distinguished contributors such as Daniel Callahan, Yale Kamisar, and Leon Kass, establishes the case against assisted suicide in four steps, comprising each of the book's sections, respectively. The first section argues that the philosophical and legal foundations for the right or interest in assisted suicide cannot be sustained. Broadly, the authors conclude that assisted suicide is inconsistent with autonomy,

2. Pieter Admiraal, *Listening and Helping to Die: The Dutch Way*, in *BIOETHICS: AN ANTHOLOGY* 332-39 (Peter Singer & Helga Kuhse eds., 1999).

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compassion, and rational choice.⁵ Even if one believes the philosophical foundations for assisted suicide are sound, the second section emphasizes that, in practice, there are abuses within assisted suicide schemes, as the Dutch, American (United States), and Australian experiences demonstrate. The third part of the book addresses the implications of assisted suicide for vulnerable persons, with special attention to the concerns of the disabled. The final section argues for the importance of quality and more robust hospice and other palliative care, leading to the editors' favored solution in the conclusion of a states-based initiative to improve end-of-life care, avoiding the need for assisted suicide.

The book combines the work of several authors to establish foundations for better palliative care and the prohibition of assisted suicide. It purports to show that assisted suicide should not be allowed because it increases vulnerability at the end of life, undermines palliative and other care, and is unnecessary to relieve suffering. The book thereby rejects the claims that assisted suicide supports autonomy of the affected person and is needed to relieve suffering at the end of life. While I do not believe the collection is persuasive on these points, its value lies in its approach to the issue: a philosophical-legal-empirical perspective on assisted suicide, advocating a practical solution.

In order to dismiss the authors' case against assisted suicide, one must rebut the conceptual claims as well as account for the empirical data and anecdotal evidence presented. This Review focuses primarily on philosophical claims. This is accomplished, I believe, while taking seriously the editors' charge that philosophers and lawyers, removed from patient care, must account for the realities of clinical practice (pp. 4-5). Any philosopher writing in the field of medical ethics who is worth her salt must accept this task. I do not attempt to dispute the empirical data provided by the physicians in this book, but only to reveal problems with the conclusions and inferences drawn from that data. I have both macro and micro concerns, but first there are some preliminary issues to resolve.

III. PRELIMINARIES

It is necessary to clarify what I mean by "euthanasia" and "assisted suicide." Different forms of euthanasia are often conflated in the collection. *Euthanasia* literally means "good death"; the prefix "eu" in Greek means "good" and "thanatos" means "death." The *Oxford English Dictionary* defines "euthanasia" as "[a] gentle and easy death," and this is the definition commonly used.⁶ Either definition

5. Yale Kamisar provides a particularly valuable overview of the current state of the law on the matter. See chapter 4.

6. THE NEW SHORTER OXFORD ENGLISH DICTIONARY 862 (1993) [hereinafter OED].

may include death not caused by illness. The *Oxford* definition, however, refers only to the mode of death or the way in which someone dies. Adopting the *Oxford* definition, opponents of euthanasia, including several of the authors of the collection, invoke the specter of Nazi concentration camps, where the gas chambers killed those unsuspecting of wrongdoing "gently and easily."

When used in the medical decisionmaking context, however, a more sophisticated definition of euthanasia is necessary. Euthanasia is viewed as a gentle and easy death that is *for the sake or the good of the person who dies*.⁷ This places the focus upon the *purpose* of death — the good of the patient — rather than upon the *mode* of death.⁸ It is a more suitable understanding of what euthanasia is for ethical and legal purposes, as the relevant question is whether euthanasia is for the benefit of the one who dies, not whether the method used to terminate the patient's life is of a certain sort.⁹

There are several types of euthanasia.¹⁰ *Voluntary euthanasia* occurs at the request of the person killed. It may be a request for immediate action or one for future action, for example, through a "living will," a request not to continue living under specified conditions. *Involuntary euthanasia* is when a person's life is taken without her consent, even though the individual possesses the capacity to consent. This might occur if the person's desires are not known, or, in the alternative, if her desire to continue living is known but ignored. *Nonvoluntary euthanasia* occurs when the person whose life is terminated is not capable of understanding the choice between life and death; in this sense, she is incompetent. Persons without the capacity to consent include newborns and very young children as well as adolescents and adults who have lost the capacity due to accident, illness, or old age. Only voluntary and nonvoluntary euthanasia are relevant for present purposes.

Assisted suicide is understood as euthanasia involving the assistance of another, usually to provide the drugs or implement that a patient will use to end her life. If the patient is physically incapable of ending her own life, the third party may assist more directly by administering the drugs or employing another mechanism to end the patient's life.¹¹ *Physician-assisted suicide* is assisted suicide when the third

7. Philippa Foot, *Euthanasia*, 6 PHIL. & PUB. AFF. 85 (1977).

8. *Id.*

9. Here the concern is only with intentional acts. The conceptual claim that there is a moral difference between death arising from foreseen but unintentional acts and death that occurs as the result of foreseen and intentional acts is discussed below. See *infra* Section V.B.

10. These basic distinctions are taken from PETER SINGER, PRACTICAL ETHICS 176-81 (2nd ed. 1993).

11. The introduction to the collection limits assisted suicide to cases where the patient administers lethal drugs prescribed by a physician who understands the patient's intention to use them to end her life. P. 5. Euthanasia is distinguished from assisted suicide on the ground

party is a medical doctor. The common understanding of physician-assisted suicide (hereinafter “assisted suicide”) is that it requires explicit (current or former) consent of the patient or, in the case of an incompetent person, consent of the guardian. Nonvoluntary euthanasia and some forms of voluntary euthanasia may involve assisted suicide.

“Palliative care” may be understood as care that temporarily alleviates suffering or the symptoms of disease without curing it.¹² This care is often associated with the terminally ill, who are the focus of this Review.¹³ Those who are terminally ill and request assisted suicide are understood to be in the process of dying and to be suffering unbearably, as defined by the person herself (if competent) or her guardian (if incompetent), but within medical understanding of pain and incapacity.¹⁴ This might include those who have lost all control of their muscles, are in intolerable pain (or extreme, visible pain, in the case of the incompetent person), or are suffering from severe dementia.

Some of the authors argue that there is no strong correlation between suffering and the decision to commit suicide, and that most who make such a request do so out of a feeling of loss of control, often with a history of mental illness.¹⁵ If loss of control is a result of physical or mental incapacitation resulting from illness, there may be a substantial correlation to suffering. In other cases, such as those of mental illness where a person is incompetent to make an autonomous decision, assisted suicide may be inappropriate.¹⁶

that it may involve direct physician action to terminate a patient’s life. This distinction does not appear to be used consistently throughout the book. For example, in chapter 8, Gregory Hamilton discusses assisted suicide of individuals who are unable to self-administer lethal drugs who may need or ask for lethal injection. Pp. 183-84.

12. See OED, *supra* note 6, at 2077.

13. Palliative care and assisted suicide may be relevant in other contexts, however, including those of the chronically ill, depressed, and brain dead, and these topics merit discussion elsewhere.

14. This is not intended as a comprehensive definition of “terminally ill,” but rather as a starting place to explore the issues raised in the collection.

It is difficult to know where to place assisted suicide for persons who are in a persistent vegetative state, since one may “live” for many years in such a state. It is only after life-sustaining equipment (“extraordinary means”) is removed that the end of an individual’s life is near, and she may be understood to receive palliative care for a terminal condition in the sense that the term is being used here.

15. See, e.g., p. 67; see also *infra* p. 1388 and accompanying notes.

16. At various points throughout the book, the authors make an argument against assisted suicide along the lines that few individuals would benefit from assisted suicide, given suffering and autonomy requirements. For example, they argue that those who are depressed should not be allowed to request assisted suicide; few individuals cannot be relieved of suffering by pain medication; and knowledge of palliative care options shifts a physician’s or patient’s desire to perform and request assisted suicide in some cases. Whether or not these claims are true, they only speak to the type of individuals who may appropriately request assisted suicide, not to the morality of the practice.

IV. ASSISTED SUICIDE AND PALLIATIVE CARE

A. *The Argument from Mutual Exclusivity*

The authors present a case against assisted suicide in order to “advance an open and tolerant discussion to address how we as a society can provide better health care and social support to those who are uniquely vulnerable and suffering” (p. vii). Assisted suicide and palliative care are thereby viewed as mutually exclusive. What is curious about this is that there is no necessary connection between the availability (legally and effectively) of assisted suicide and excellent palliative care and social support. Legally prohibiting assisted suicide will neither necessarily improve palliative care or social support nor make it more accessible to patients. Palliative care is one form of health care, and it simply might not be a political or social priority. It is the unfortunate situation in the United States, for instance, that health care of many sorts is denied to people who cannot afford it.

Similarly, legalized and accessible assisted suicide services need not preclude excellent palliative care and social support (for ease, the argument will now focus upon palliative care). The two end-of-life options are not mutually exclusive, in principle or practice. In principle, there may be strong moral reasons to provide both assisted suicide and palliative care. Respect for autonomy in deciding how best to end an individual’s pain and suffering, for example, might morally justify both practices.

The argument from mutual exclusivity also relies upon the false assumption that individuals, in practice, would not choose assisted suicide if excellent palliative care were available. Consider cases where the terminally ill person faces a choice between heavy sedation (a palliative care option) and death (assisted suicide). There is no reason to assume that all individuals would prefer heavy sedation, seriously impairing cognitive abilities and other functioning.¹⁷ Others may utilize both options, for example, choosing palliation during the initial stages of their illness, when heavy sedation is not required to relieve pain, and assisted suicide during the later stages, when such sedation is necessary.

17. See *infra* note 27 and accompanying text (discussing “C3,” a case presented by Herbert Hendin in chapter 6).

The intention/foresight distinction is of relevance here. See *infra* Section V.B. for argument toward its refutation.

Leon Kass speaks about the “distort[ion] [of] awareness” sometimes associated with analgesia that is adequate to relieve pain. P. 23. He claims that in most cases, sedation can remove the patient from a state of suffering. *Id.* Some argue, however, that the resulting quality of life may have no value for the patient. *Id.* If the only possible relief of suffering is a state of life that an individual does not value, it is unclear how this presents the patient with a dignified and decent alternative.

Relatedly, the authors incorrectly claim that assisted suicide is not necessary to relieve suffering. Suffering may have both a subjective and an objective element. Standard medical practice may dictate that X units of pain or discomfort may be treated with Y drug, for example, but even accounting for necessary variations in doses between individuals with the same condition, one individual may suffer while another does not. Perhaps the time spent, or side effects of, receiving Y drug is part of the suffering for one person but not for another. Of course, the opposite may also be true. An individual may require less of Y drug for X units of pain due to coping mechanisms, social supports, or spiritual or other beliefs that reduce suffering. This is not universalizable, though, and fails to support a prohibition of assisted suicide. It is also doubtful that even in very technologically advanced societies it will be possible to relieve all pain and discomfort without hastening death through drug use.

B. *Undermining Palliative Care?*

The falsely perceived mutual exclusivity of assisted suicide and palliative care leads the authors to conclude that allowing assisted suicide would necessarily undermine the development and availability of palliative care, forcing individuals who are suffering to choose assisted suicide. The authors' argument relies upon an interpretation of caregivers' incentives. They argue that caregivers will offer assisted suicide instead of palliative care because it is less costly and more expedient. As a result, there will be no incentive to develop palliative care.

To support this proposition, the collection cites the situation in the Netherlands, where assisted suicide is legal and there is limited physician knowledge about palliative care and there are few palliative care centers. Despite the fact that this seems less of a concern in the United States, where limited access to palliative care results in substantial part from lack of funding of health care and quality of care standards (pp. 307-08), there need not be a correlation between a physician recommending assisted suicide and that physician lacking knowledge about advanced palliative care options.¹⁸ One contributor to the collection, Zbigniew Zylicz, a palliative care specialist, observes a reluctance among general practitioners to support requests for hastening death, presumably by any means (p. 127). Yet, these same practitioners are understood to have "only a superficial knowledge of palliative medicine" (p. 123).

18. Kathleen Foley identifies lack of physician knowledge about palliative care in the United States mostly in terms of physicians' fear that use of morphine and other pain-relieving drugs may hasten death and thereby be a form of active euthanasia. Pp. 304-05. This does not show substantial lack of knowledge about palliative care options.

The authors present a weaker argument that assisted suicide will undermine palliative care because it will lead to abuses resulting in the denial of such care. They cite underreporting of assisted suicides and lack of consultation with an independent physician as two indicators of abuse. In the Netherlands, underreporting of assisted suicides was at 82% and 59% in 1990 and 1995, respectively (p. 104), and lack of consultation with another, independent physician occurred in approximately 50% of cases (p. 103).

Killing when individuals are not terminally ill and lack of informed consent present perhaps the greatest concern over use of assisted suicide in the Netherlands. Those suffering from depression might fit either or both categories. In their essay about the Oregon experiment with assisted suicide, Foley and Hendin assert that "most of those who respond to terminal illness with a desire to hasten death are suffering from depression" (p. 150). Contributor and psychiatrist Gregory Hamilton stated of the Oregon experience that "depression played a part in any of that year's fifteen cases" (p. 179). Similarly, David Kissane argues that the "prominent features of depression" (p. 203) or patient "demoralization," characterized by a "loss of any worthwhile hope and meaning" (p. 203) in one's life, was a factor in seven documented assisted suicides performed in the Northern Territory of Australia, including at least three of the four that occurred under the Rights of the Terminally Ill Act (1995).¹⁹

Foley and Hendin cite statistics pertaining to the Dutch experience, where according to studies performed in 1990 and 1995, 0.8% and 0.7%, respectively, of patients were killed without their consent (p. 104). Of these patients, 37% (1990) and 21% (1995) were competent (pp. 105-06). Foley and Hendin claim that the death rate of such persons actually is much higher, as the researchers did not include deaths caused by pain medication administered with the intention of causing death; this increases the figures to 3.7% and 4.7% of all deaths for 1990 and 1995, respectively (p. 105). The competence rate for these later persons is believed to be about 20% (pp. 105-06).

Assuming these figures are accurate and the studies are valid (the 1990 study has been challenged),²⁰ it is unclear how prohibiting assisted suicide as the authors understand it would correct these abuses. Using the authors' own figures, in the Netherlands, euthanasia listed independently of assisted suicide is much more frequent than assisted suicide, 2.2% and 0.4% percent of all deaths, respectively (p. 123). Prior to the legalization of assisted suicide, the suicide rate of those over fifty was one-third higher (p. 112). Anecdotal evidence presented

19. Pp. 199-202, 204-05. The Act was in effect from 1996-97.

20. See PETER SINGER, *RETHINKING LIFE AND DEATH: THE COLLAPSE OF OUR TRADITIONAL ETHICS* 151-54 (1994) [hereinafter SINGER, *RETHINKING LIFE AND DEATH*].

by the authors suggests that when assisted suicide was unavailable to individuals, patients found other means to take their lives, with and without the assistance of others.²¹

Nevertheless, serious concern remains that competent individuals may have their lives taken without their consent if assisted suicide is allowed. The above statistics and the conclusion of the 1995 study, that patients should make an affirmative statement of their desire to continue living (p. 117), is of special alarm, as is noncompliance with the independent, second physician opinion requirement. More factors need to be known about these cases. Did the individual express a desire not to live in a certain condition, even though explicit consent to take her life was not provided? Was she experiencing such great suffering that pain medication was administered (without an intention to kill) that took her life before consent could be given (or that blurred the capacity for consent)? Was another physician unavailable to provide a second opinion?

Regardless, noncompliance is an enforcement rather than an ethical issue. It is unlikely that the degree of alleged noncompliance with guidelines in the Netherlands would occur in the United States where litigation is more frequent.²² There also is suggestion that assisted suicide would be more heavily regulated in the United States. For example, the Oregon Death with Dignity Act (1997),²³ in addition to requiring a written request signed by two witnesses and two oral requests fifteen days apart (p. 155), states that “[a] person who coerces or exerts undue influence on a patient to request medication for the purpose of ending the patient’s life . . . shall be guilty of a Class A felony” (p. 155; internal quotation marks omitted). Oregon, however, applies a subjective “good faith” standard, rather than the stricter negligence standard typical of malpractice claims, to physicians who engage in assisted suicide (p. 159). Additionally, censure of physicians by medical organizations is forbidden (pp. 190-91). The truth is that, as Foley and Hendin and Gregory Hamilton demonstrate in their respective chapters, much is unknown about the practice of assisted suicide in Oregon. Abuses may occur, but greater safeguards are in place in the United States than those existing in the Netherlands. Speculation about such abuse does not justify legal prohibition of assisted suicide.

21. *See, e.g.*, pp. 182-83, 188, 196-97.

22. Hendin states that, in the Netherlands, malpractice suits are rare. P. 118. He also perceives a unique Dutch character and culture, one ambivalent towards (medical) authority, as responsible for the prevalence and abuse of assisted suicide in the Netherlands. Pp. 117-20.

23. OR. REV. STAT. §§ 127.800-.995 (2001).

C. Forcing Death?

The authors attempt to demonstrate that the availability of assisted suicide will result in individuals being pressured or otherwise forced to die, foregoing palliative or other care. This claim about restricted choice is one version of the argument about voluntariness or autonomy. The authors hold that even if consent is given, it will not be truly voluntary, due to the familial pressures that individuals experience, lack of broader social supports for those who are alone, or physician suggestion.²⁴ In short, the best scenario under this argument is that terminally ill individuals will perceive a duty to die. Here the implicit assumption is that rational people would not choose to die. In the worst scenario, their lives will be taken without consent of any sort. The latter is not the type of assisted suicide in question because it would be involuntary; the assisted suicide considered is based upon consent or prior consent of competent persons or caregivers of the incompetent. Note that the claim that the availability of assisted suicide will result in individuals *perceiving* a duty to die is different from the conceptual claim that there *is* a duty of some terminally ill patients to die. The first is the empirical claim we are addressing, and the second is a separate conceptual claim, which the authors do not address.²⁵

The authors do not provide sufficient empirical evidence that individuals who choose to die perceive a duty to die because of lack of palliative care options. The three case studies presented — the Netherlands, Oregon, and the Australian Northern Territory — demonstrate at best, and largely anecdotally, that individuals choose to die because they perceive death as their best option.

The article by Dutch palliative care doctor Zylicz is most informative. Zylicz, who asserts that he refuses to practice assisted suicide, states that many of his patients want to die quickly (p. 129) and that the median stay at the hospice he directs is twelve days (p. 125). Care is provided to one group of patients with the explicit intention of hastening death (pp. 137-38).

Setting aside the issue of whether Zylicz really practices a sophisticated form of euthanasia in these particular cases (given the intention to accelerate death), Zylicz's article illuminates what really is at issue.

24. The authors argue that a physician merely suggesting assisted suicide as an option might not only violate the doctor-physician relationship, as discussed *infra* Section V.A., but subtly coerce patients to choose assisted suicide. *See, e.g.*, pp. 24, 155-56. In the United States, however, legal conceptions of informed consent require knowledge of one's alternatives; in fact, one might sue if not provided this information. P. 156.

25. This issue is addressed in John Hardwig, *Is There a Duty to Die?*, in *BIOETHICS*, *supra* note 2 (finding a duty to die in some circumstances). Diane Coleman mentions this article in passing but fails to address the underlying conceptual claim in any detail. P. 228.

The ideal situation is improved medical care.²⁶ It is a world in which terminally ill patients understand their palliative care options and spend their last days under the care of a physician like Zylicz in one of his nine hospice beds in a pristine, wooded environment. If possible, all pain is removed in dying, and one's life might be extended in a meaningful way (as determined by the patient herself) for a brief interval in the process. This is not, however, the world in which most people live, since they cannot afford such care.

Patients choosing assisted suicide, then, make up the following categories:

- C1*: Those who do not understand their palliative care options and choose to die by assisted suicide.
- C2*: Those who understand their palliative care options and are unable to afford palliative care or for whom it is otherwise unavailable (e.g., due to long waiting lists) (p. 124) and choose to die by assisted suicide.
- C3*: Those who understand their palliative care options, are able to afford palliative care, have access to it, and choose to die by assisted suicide. These include the "extreme" cases Zylicz speaks of (although Zylicz would disagree with this characterization),²⁷ where individuals are unable to be relieved of the pain from which they suffer (pp. 137-38). They may be assisted in suicide, although "sedation" may be used over other means of assisted suicide such as lethal injection.

C1 and *C2* are the situations faced by most people discussed in the collection. Certainly informing patients of palliative care options (relevant to *C1*), which seems an overriding concern for many of the authors, is easily accomplished through national information campaigns or physician education and more properly enforced informed consent regulations. It is indeed wrong to solve medical problems with euthanasia when there are other, less drastic measures available to an individual that one would choose, if only one had knowledge of them. That says nothing, however, about whether individuals should be entitled to assisted suicide, if they autonomously desire it.

In both *C1* and *C2*, death may be chosen because the patient lacks family or friends able to care for her and is financially unable to afford any other option, or, in the alternative, does not wish to receive insti-

26. P. 142-43. Zylicz comes close to acknowledging this when he states, "we need to depolarize the discussion of euthanasia and move forward. We should concentrate on providing good care and preventing the disappointments and the neglect that terminally ill patients often experience." P. 143.

27. The basis for Zylicz's disagreement is unclear. How does one distinguish between sedation to bring about immediate death and assisted suicide by other means? *C3* represents a case where palliation is no longer appropriate.

tutional care. Inability to pay for palliative care, though a tragic reason to choose to die, may in some countries, especially those without universal health care coverage, be one's best option. It would be immoral, and a serious violation of autonomy, to suggest that individuals who cannot afford palliative care should be made to suffer intolerably.

It seems that the authors confuse the weight of the moral arguments for health care with those against assisted suicide. Kissane asserts, for example, that "[w]hile we remain unable to guarantee the quality of medical care within our societies, there can be no place for euthanasia."²⁸ This statement is seriously misguided, as a right or interest in palliative care does not rise or fall with a right or interest in assisted suicide. There are strong moral reasons that better palliative care should be developed and available. The availability of assisted suicide does not undermine such development, however, lack of resources for health care does.²⁹ Assisted suicide is justifiable independently on the ground that it provides relief for terminally ill patients experiencing unbearable pain or other suffering.

Cutting across these arguments about palliative health care are concerns about access to mental health care, especially for the depressed dying. The complicating factor is that even an attending physician who is knowledgeable about the range of available mental health care services may fail to recognize a dying patient's need for them. Physician education about depression is vital to avoid *C1*. If access to mental health care is limited by inability to pay for such services, as it is under *C2*, the arguments above apply with equal force.

In sum, while the lack of any form of health care (palliative or otherwise) or other basic social goods, for that matter, might lead one to desire to end one's life, that has nothing to do with whether there is a moral justification for the availability of assisted suicide. The moral (and concomitant legal) justification either exists or not, regardless of material resources and supports. A valid point could be made to support the authors' claim along the lines that it is unjust that the society in which we live today, due to political constraints, limits funding for health care services (including palliative care services), but that is a different issue.

28. P. 208. Foley cites the World Health Organization as holding a similar view: "member states [should] not consider legislation allowing for physician assisted suicide or euthanasia until they ha[ve] assured for their citizens the availability of services for pain relief and palliative care" P. 294 (internal quotation marks omitted); *see also* Coleman, p. 224, "[t]he inadequacy of the in-home long-term care system is central to the assisted suicide and euthanasia debate."

29. The exception would be if assisted suicide is funded but palliative care options are not funded. Gregory Hamilton states that "Oregon's rationed health plan denies payment for 171 needed services, while it fully funds assisted suicide for the poor." P. 180. These services are not described by Hamilton, however.

In a utopian society, where palliative care is the best that it can be and alleviates greater amounts of suffering, there may indeed be fewer cases of assisted suicide. In fact, this is likely to be the case. This does not preclude one from arguing consistently, however, that there are moral reasons that assisted suicide should be available. It would be grossly paternalistic to argue that since palliative care is an option, it must be the only option.³⁰

V. AUTONOMY AND SUFFERING REVISITED: THE CONCEPTUAL CLAIMS

The conceptual arguments cutting across the essays, though expressed in different terms at times, may be understood to embody four premises:

- P1*: Assisted suicide violates the professional ethic of medical practitioners.
- P2*: There is a moral difference between actions and omissions.
- P3*: Assisted suicide violates the autonomy of those individuals who are killed.
- P4*: Assisted suicide discriminates against vulnerable populations.

Premise two may be understood as having several sub-premises:

- P2/SP1*: There is a moral difference between killing and letting die.
- P2/SP2*: There is a moral difference between ordinary and extraordinary life-sustaining treatments.
- P2/SP3*: There is a moral difference between providing care where one foresees death and intending death through the same medical act. (This also is known as the intention/foresight distinction or the doctrine of double-effect.)

The first sub-premise, *P2/SP1*, is most closely related to the general understanding of the umbrella distinction between actions and omissions. The second sub-premise, *P2/SP2*, seeks to make a distinction between ordinary or routine medical care and extraordinary life-sustaining treatments, where the former but not the latter need be provided.³¹ The problem is that what is ordinary in one case may be extraordinary in another. Consider the difference between providing

30. A similar point is made in SINGER, *supra* note 10, at 199.

31. This view is set forth by the Sacred Congregation for the Doctrine of the Faith, DECLARATION ON EUTHANASIA (Vatican City 1980), *reprinted in* BIOETHICS, *supra* note 2, at 203-06.

antibiotics to treat the throat infection of an end-stage AIDS patient predicted to live only a few days and providing them to a seven-year-old schoolgirl who is otherwise healthy. Given limited resources, aiding the dying patient may be viewed as extraordinary, whereas treating the schoolgirl, who presumably has a long, healthy life ahead, would be ordinary medical practice.

The third sub-premise, *P2/S3*, holds that if one action has two effects — one morally justified and one not morally justified, it is the intention behind the action that matters.³² So, providing a high dose of morphine might reduce pain and end someone's life, but this is acceptable if the medical practitioner administering the morphine did not intend for the patient to die. Stated another way, there is a moral difference between a physician foreseeing the death of the patient from the morphine, when it is merely an unwanted side effect of relieving suffering, and providing morphine with an intention to kill the patient. This premise is alternatively termed the active/passive euthanasia distinction, where "active" includes an intention to kill and "passive" does not. All three of these sub-premises will be discussed in terms of the umbrella distinction of acts versus omissions.

Premise four, *P4*, the conceptual claim that assisted suicide discriminates against vulnerable populations, cannot be sufficiently addressed within the confines of this Review and warrants discussion elsewhere. A few points are of necessary note here, however, especially since the editors emphasize a related *empirical* claim, namely that legalizing assisted suicide increases the vulnerability of those who are dying (p. vii). All individuals who are terminally ill and seek assisted suicide are vulnerable. The elderly, the depressed, and the disabled — the focus of *P4* — are especially vulnerable, in the sense that there may be negative external perceptions about the value of their lives that limit their material resources or social supports in ways that other people with terminal illnesses do not experience. For these reasons, *P1* and *P3* — concerns about the role of physicians in assisted suicide and autonomous patient decisionmaking — may apply with greater force to these particularly vulnerable populations, but no new issues are raised. If there is discrimination to be found, it results from limits upon financial or social supports for particularly vulnerable populations that are not experienced by other terminally ill patients. If such discrimination exists, it should be prevented, but it fails to provide justification for prohibiting assisted suicide.

Frequently discussed under the conceptual claim that assisted suicide discriminates against vulnerable populations, particularly the dis-

32. This view is widely held among Roman Catholic theologians and moral philosophers and dates back at least to the philosophy of Thomas Aquinas. In chapter 4 of the collection, especially pp. 78-82, Kamisar provides a discussion of the role of this doctrine in *Washington v. Glucksberg*, 521 U.S. 702 (1997).

abled, is the view that external quality of life judgments, assumed to be moral judgments, discriminate against the disabled. Under this view, external quality of life judgments cast a value judgment about the moral worth of someone living with a particular disability. This is a different argument, however, from the claim about disparate treatment provided above, for it relies upon proof that quality of life judgments are moral judgments and that they actually do cast judgment on the worth of the *person* with the disability. I have argued elsewhere that these judgments do not discriminate against the disabled, although they are moral judgments and may be deeply hurtful and offensive.³³ The other premises, *P1-P3*, will now be discussed in turn.

A. *The Role of the Professional Ethic*

Leon Kass presents perhaps the most direct argument that assisted suicide violates the principles and values of the medical profession. He argues that contemporary ethical approaches to assisted suicide, those based upon autonomy or objective measures about quality of life, misunderstand the ethical foundations of medical practice.³⁴ Rather, the medical profession, based upon an ethic where the “technique and conduct are both ordered in relation to an overreaching good, the naturally given end of health,” cannot support assisted suicide.³⁵ This conclusion is based upon a negative duty that doctors must not kill, which is part of the Hippocratic Oath taken by physicians since the fifth century: “I will neither give a deadly drug to anybody if asked for it, nor will I make a suggestion to this effect” (p. 32; internal quotation marks omitted).

33. Ani B. Satz, *Prenatal Genetic Testing and Discrimination Against the Disabled: A Conceptual Analysis*, MONASH BIOETHICS REV., Oct. 1999, at 11.

34. See generally chapter 1.

35. P. 20. Edmund Pellegrino presents a similar position based not upon the role of the physician *per se* but upon the morally justifiable way to exercise compassion. Pellegrino believes that “true compassion” entails “acts of co-suffering.” See generally chapter 2. These acts are ones in which family, friends, and medical practitioners must share the burden of dying with the patient by generally showing solidarity and identifying with her needs. Pp. 48-51. Pellegrino argues that true compassion requires relieving pain to the greatest extent possible without hastening or taking life. P. 51. Assisted suicide does not support true compassion, according to Pellegrino, because it relies upon a notion of compassion that is not linked to a particular moral standard, presumably like co-suffering. P. 48. As a result, many possible abuses may ensue under the name of compassion, largely because the patient who is under family and social pressures cannot autonomously decide to end her own life. Pp. 46-48. It is unclear, however, why co-suffering could not support assisted suicide. If Callahan is correct to state that “[s]uicide is . . . not a private act at all. Families have to live with its aftermath,” then could not co-suffering occur by supporting that person’s decision to end her life? P. 67. Also, accompanying a person to physician appointments that precede her decision to end her life or being a supportive presence during the decisionmaking process itself seems like a form of co-suffering. Further, Pellegrino is incorrect that a patient is incapable of making an autonomous decision about ending her life due to family and other pressures. See *infra* Section V.C.

Kass defends his position on grounds appealing to both what he perceives as the negative consequences of assisted suicide and the proper role of medicine. The negative consequences result from the lack of autonomous decisionmaking on the part of patients (the discussion will return to this below) and from taking lives when pain and suffering may be relieved in other ways.³⁶ Kass believes changes in the doctor-patient relationship will affect the role of medicine. He asks:

For how can you trust stranger-doctors to be wholeheartedly devoted to your best interests once they have a license to kill? . . . The nurse or intern enters late at night with a syringe full of yellow stuff . . . Never mind that, for now, death can be *legally* prescribed only on request. How soundly will you sleep? (p. 28; emphasis in original)

Although he is not writing from a utilitarian perspective, Kass presents a classical utilitarian argument. Widespread fear of being killed when one desires to continue living will undermine the good of providing assisted suicide. The fear itself would be detrimental to an individual and would disrupt the trust inherent to the doctor-patient relationship. Patients undoubtedly would be reluctant to seek care. This fear is only rational, however, if consent is not involved in assisted suicide. Kass states that he makes this argument “[a]ctual abuses aside,” so it does not hold if we are concerned only with autonomous decisionmakers (p. 27). The possible exception might be fears about being temporarily insane or having impaired judgment. This would not be a problem with trusting a doctor to act in accordance with your will, however, and is mitigated by the requirement of a second physician opinion, as under the Dutch and Oregon systems.

In addition, Kass asserts there will be a more subtle disruption of trust between doctors and patients. The availability of assisted suicide will cause the patient to question whether the doctor wishes that the patient were dead (p. 28). As a result, the patient will become mistrustful, “produc[ing] stress, anger, and resistance to treatment” (p. 28). Whether or not one’s particular physician engages in the practice will not matter; entitlement of the profession to conduct assisted suicide causes the trust violation (p. 29). On the other side, Kass believes that doctors may act with less interest in maintaining their patients’ lives, particularly if they are difficult to cure (p. 29). He cites disparate treatment of individuals with “do not resuscitate” (“DNR”) orders as an example of the mistreatment of patients who may die (p. 29). He goes one step further to say that preventing assisted suicide guards against physicians’ weaknesses and arrogance that may lead to prejudicial judgment about the value of others’ lives.³⁷ Kass believes

36. See *supra* Section IV.B.

37. P. 29. It is ironic that, as evidence of the need to guard against physician arrogance and biased opinions, Kass cites a friend and doctor’s opinion that “ [o]nly because I knew that I could not and would not kill my patients was I able to enter most fully and intimately

that these quality of life judgments necessarily must be “decidedly nonmedical and nonprofessional.”³⁸

This second set of arguments lacks intuitive force. If some patients with DNR orders are treated inappropriately, this does not mean that DNR orders should be prohibited. It means only that there must be enforcement of proper medical practice. Similarly, assisted suicide need not be prevented in order to guard against physician weakness and arrogance in end-of-life decisionmaking for others. Professional organizations and regulations should enforce the physician’s role as a professional who discloses information to the patient, rather than one who makes end-of-life decisions for the patient.

Further, physician-assisted suicide does not pose a unique threat to individuals’ lives. There are many people that one must trust who might legally, under certain circumstances, take our lives — such as police or soldiers acting in the line of duty or individuals who act in self-defense — and in these situations, one’s life is even taken *with* one’s (tacit) consent. It is true that these people are not in the same fiduciary relationship as doctor and patient, and that one does not make oneself vulnerable to them in the same ways, but in either group of situations, there is a possibility that one’s life could be taken. In addition, patients accept a multitude of other ways in which doctors might violate their trust legally without the consequences Kass suggests. These include failing to address one’s concerns or treating them as insignificant, subjecting one to slightly unnecessary testing for research purposes that the doctor could justify if pressed, or engaging in very directive or biased counseling.

It is also unclear why incorporating a subjective element in the decisionmaking process to elucidate what constitutes intolerable suffering is both nonmedical and nonprofessional and why it must be based upon the *physician’s* personal standards. If the patient believes that she is suffering intolerably and the level of suffering is clinically viewed as severe, why is it wrong for the physician to help that person die? Does the fact that another patient with the same condition might not ask to die support this claim? Certainly not; the subjective assessment must initially come from the patient. The doctor merely acts within the realm of standard medical practice, where some discretion is allowed.³⁹

into caring for them as they lay dying.’ ” P. 30.

38. P. 29. Daniel Callahan presents a parallel argument:

A decision for physician-assisted suicide is not a medical but a moral decision. Faced with a patient reporting great suffering, a doctor cannot, therefore, justify physician-assisted suicide on purely medical grounds . . . It must be *the doctor’s* moral reason to act, not the patient’s reason (even though their reasons may coincide).

P. 64 (emphasis in original).

39. This also responds to Kass’ concern that respecting the “wishes of the patient as client or consumer” means that any service may be bought for a price. P. 19.

The last and perhaps greatest threat to the medical profession posed by assisted suicide, as identified by Kass, is the separation of the person from the body (pp. 32-40). The medical profession must seek, in part, to heal people.⁴⁰ The “person” has a mind and body, and in order to be able to heal that person, she must continue to exist. Quite simply, a physician cannot engage in assisted suicide because there is no benefit to the person — the entity whose mind and body is at stake — after death (pp. 33-34). Kass appeals mostly to tradition as a justification for this role of medicine. Throughout history, physicians have helped people “experience peaceful *dying*” but not “*achieve a peaceful death*” (p. 35; emphasis in original; internal quotation marks omitted).

Kass presents no argument, other than tradition (including “standard medical ethics”), for why the benefit to the person derived from the medical act must follow the act (p. 35). “It’s tradition” is a weak argument. Many medical traditions have been abandoned, including exclusion of women from medical practice and much of the culture of the gentleman physician.

Further, why must the benefit follow the act? In the case of assisted suicide, the person who benefits is the one who dies. The benefit *is* the death. Kass is correct that this is not “healing,” but rather relief from suffering.⁴¹ It is unclear, though, why serving the body and mind must entail healing and not relief from suffering, especially since Kass recognizes relief from suffering as a goal of medicine (p. 35).

Kass argues that we owe a heightened duty to humans (humanity) that we do not owe to other animals, which we need only treat humanely (p. 38-40). While relief from suffering may require the death of non-human animals, for humans it requires encouragement to live.⁴² Kass justifies this distinction on the basis of what he perceives as some unique human characteristics:

We put dumb animals to sleep because they do not know that they are dying, because they can make nothing of their misery or mortality, and therefore, because they cannot live deliberately (i.e., humanly) in the face of their own suffering or dying Compassion for their weakness and dumbness is our only appropriate emotion But when a conscious human being asks us for death, by that very action he displays the presence of something that precludes our regarding him as a dumb animal. (p. 38)

There are conceptual flaws with this argument. Pig number forty-five for slaughter at the local abattoir smells and sees death. Studies show that such an animal will manifest physical symptoms of stress

40. I say “in part” because Kass also believes that medicine serves the goal of relieving suffering, which may be accomplished through analgesics. Pp. 34-35.

41. P. 35. Suffering is understood as “pain, discomfort, and distress.” *Id.*

42. Kass suggests that acting only humanely will cause doctors to be “technical dispensers of death.” P. 39.

and fear and may try to escape. In this sense, the pig understands misery and mortality and acts deliberately. Pigs and other lower animals suffer if ill or mistreated, as they are sentient beings, capable of experiencing pleasure and pain. Animals, like humans, are conscious in this regard. They have well-being; this demands that we act to preserve their interests. Kass does not demonstrate that it is morally right to terminate the life of a suffering lower animal yet morally wrong to terminate the life of a suffering human animal, especially when the latter makes an explicit request for such action.

Kass might argue that he is concerned with relieving only *some* forms of suffering. An argument presented by Daniel Callahan in a subsequent chapter is of note here. Callahan suggests a limited duty of physicians to relieve suffering. Physicians, he argues, should do all they are able to relieve suffering associated with “fear, uncertainty, dread, or anguish of the sick person in coping with the illness” (the “psychological penumbra of illness”), but not with the “meaning of life itself” (p. 58). Callahan views assisted suicide as relieving the second level of suffering. The justification for drawing the line at this point is physician competence; Callahan states that “medicine [cannot] manage the meaning of life and death, only the physical and psychological manifestations of those problems . . . [its] role must be limited to what it can appropriately do . . .” (p. 59). Thus, the first level of suffering relates to the problems of illness, and the second level to the problems of life, presumably outside of illness.

This distinction between forms of suffering is forced. Terminally ill patients request assisted suicide *because* of their illness; they are not questioning the meaning of life and death from an actual or hypothetical state of health. Further, the competence of physicians to determine the meaning of life and death for a given person is irrelevant. It is up to the patients to make their own determinations about living lives with illness. Physicians must only confirm that pain and suffering similar to Callahan’s first level of suffering are present and that their patients are making autonomous decisions. In other words, physicians need only determine from clinical observation and medical measures that pain, discomfort, or other suffering related to the disease supports patients’ requests for assisted suicide.

In addition, Kass seems to be placing unjustifiable moral weight on the temporal difference between killing and letting die. He cites the famous withdrawal-of-life-support case of Karen Ann Quinlan as an example of how doctors do not cause death, since Karen, who was in a persistent vegetative state, “lived” for another ten years after being removed from her respirator. This is an odd assertion, since Karen might have died the next day. Regardless, without the removal of life

support, Karen would have “lived” longer; the doctor’s actions clearly brought about her circulatory death, though not immediately.⁴³

B. *The Actions and Omissions Distinction*

In addition, the articles in the collection operate against the background assumption that there is a distinction to be made between physician action intended to cause death and death arising out of physician omission or provision of pain relief. This assumption relies upon what is known as the actions/omissions distinction. The distinction is rooted in religious ideals, like the Commandment that “thou shall not kill.” The main idea behind the distinction is that there is a moral difference between performing an act and omitting one, even though the same consequences result. So, under a literal reading of the doctrine, it would be wrong to shoot someone dead but not wrong to watch someone drown. In the euthanasia context, the doctrine is most often known as the distinction between killing and letting die. It would be wrong to provide someone with a lethal injection at their request but not immoral to fail to provide a surgical procedure at patient request, which causes death. Alternatively, the distinction might be expressed as providing ordinary medical care, but withholding extraordinary care. It also could be understood to support the provision of pain relief with foreseeable but unintended death.

Rejecting the moral significance of the acts/omissions distinction has important consequences for the assisted suicide debate.⁴⁴ If there is no *moral* difference between acts and omissions in this context, it is morally arbitrary to prohibit assisted suicide to relieve suffering and to provide only palliative care for this purpose. In this case, other arguments would have to be made, for example, an argument about infringement of rights or interests or the violation of autonomy, to support the prohibition of assisted suicide.⁴⁵ The autonomy argument is discussed below. A rights-based claim would entail that someone has a right to life and desires her continued existence, correlating with a duty in others not to take her life.⁴⁶ The autonomy discussion below

43. In their contribution to the collection, Felicia Cohn and Joanne Lynn misunderstand this point. They state, “[a]lthough a physician may be active in removing life support, the physician’s action is not a proximate cause of the death. If the particular life-sustaining technique had not been available, death would already have resulted.” P. 247.

44. This distinction cannot be fully discussed within the confines of this Review. See SHELLY KAGAN, *THE LIMITS OF MORALITY* (1989) and literature references therein, rejecting the moral validity of the acts/omissions distinction.

45. An argument from a person’s interest in assisted suicide would be a consequentialist one, mirroring the above analysis.

46. One could make other rights-based arguments stemming from an inalienable right to life, a right that one cannot dispense of through one’s own deliberative choice. Under this understanding, taking one’s own life may violate others’ rights in the sense that one’s death causes serious harm to others. In the alternative, one could argue that taking one’s own life

suffices to address the rights-based claim with respect to a competent person's choice to die, but further discussion is warranted elsewhere with respect to noncompetent persons.⁴⁷

Returning to the main question, if it is morally acceptable to allow death (of the terminally ill) when life-saving actions are possible, is it wrong to assist them in suicide? From the view of overall consequences, there is no moral difference between killing and letting die. In either case, the doctor knows the result, she decides to act based upon knowledge of the alternatives, and she must bear moral and legal responsibility for her decision.⁴⁸ On this account, there is no moral difference between acts and omissions.⁴⁹ A doctor's intention to kill or relieve pain is not morally relevant in this context because, in either case, she foresees the death, and the same result ensues.

Kissane argues in the collection that it is not the outcome that matters morally, but culpability for the outcome, determined by the norms of clinical practice. Omissions that fail to prolong dying of irreversible conditions are part of proper clinical practice and do not carry the same culpability as killing, even if they have the same result. He states:

For an action involving the omission of a treatment to carry culpability for causing death, the treatment must be proven to be clinically effective in the circumstances and the underlying condition potentially reversible. As the dying process unfolds in a terminal patient, the condition becomes irreversible, and interventions could cause harm through prolonging the dying if they were inappropriately applied. "Moral equivalence" arguments based on outcome cannot ignore the assessment of clinical proportionality and appropriateness. (pp. 207-08)

Kissane's statements reflect a misunderstanding of what is at stake. The treatments in question, that is, those that are withheld, are for

violates one's own right to life. These arguments are discussed by Joel Feinberg in his classic essay *Voluntary Euthanasia and the Inalienable Right to Life*, 7 PHIL. & PUB. AFF. 93-123 (1978). Feinberg concludes that the right to life is discretionary in the sense that it may be waived but not renounced or relinquished. The authors of the collection do not offer these arguments, however; rather, they focus upon the idea that consent will not be truly voluntary.

47. Philippa Foot, addressing the rights-based claim of noncompetent individuals, argues that one cannot assume that a noncompetent person who is suffering would want to be killed. She maintains that a duty of noninterference applies to active nonvoluntary euthanasia, but she supports passive nonvoluntary euthanasia as well as all forms of voluntary euthanasia. Foot, *supra* note 7, at 104-05.

48. See SINGER, *supra* note 10, at 208.

49. In other contexts, there may be *extrinsic* moral differences between acts and omissions. The differences are extrinsic because they are normally present, but they need not come into play. For example, there are extrinsic differences between terminating the life of someone who is starving versus failing to donate money to help starving people. One possible extrinsic difference is that it is uncertain when one donates money, for example to UNICEF, that the money will be put to good use and one will save someone from starving. Whereas, if one shoots a starving person at close range, it is almost certain that she will die. This example is borrowed from Peter Singer. See *id.* at 223-24.

conditions that *are* easily reversible. Often they are antibiotics or other drugs for common ailments like infections, or they are minor surgical procedures.⁵⁰ These treatments are withheld because it is the patient's *overall health prognosis*, not the particular condition, which is irreversible. It is for this reason that withholding such treatments to hasten or cause death is of the same moral significance as directly causing the death of the patient who wishes to die.

If anything, withholding drug treatments and minor surgeries ignores clinical proportionality and appropriateness. It makes morally irrelevant the factors that determine death. For example, it might be a throat infection, an intestinal blockage, or untreated nausea preventing sufficient food intake that eventually results in the death of a cancer patient. Also, death through omissions may be slow and increase suffering. A particularly dramatic example from another context is the documented case of untreated infants with spina bifida, a condition causing a lesion in the back that exposes the spine, who survived in a hospital for more than two years after birth with no treatment.⁵¹

Contributor Yale Kamisar accounts for the use of the distinction in *Washington v. Glucksberg*⁵² on the ground that the right to refuse unwanted treatment supports "bodily integrity and freedom from unwanted touching" (p. 77; internal quotation marks omitted). The implication is that assisted suicide does not. The failure to extend the legal notion of bodily integrity to a right to assisted suicide is, however, arbitrary. As Kamisar himself astutely states — the more the constitutional right to an abortion is viewed as grounded in sexual equality rather than a right to due process or privacy (bodily integrity) — the less the abortion right, perhaps the closest constitutional right to assisted suicide, offers support for assisted suicide (p. 72).

The authors make heavy use of the moral validity of the acts/omissions distinction without showing much awareness that it is a very controversial assumption. Without it, they are unable to distinguish morally between a lethal injection that causes death and a morphine-induced death resulting from pain relief efforts. In addition, no distinction may be made on moral grounds between a lethal injection and withholding necessary treatment. The authors do not weaken the claim that palliation involving omissions accelerating death is morally equivalent to death by intended, direct physician action like lethal injection.

50. In one American study, 81% of nursing home patients with a fever were left untreated; 48% of those patients died. See SINGER, *RETHINKING LIFE AND DEATH*, *supra* note 20, at 156.

51. See SINGER, *supra* note 10, at 212.

52. 521 U.S. 702 (1997) (holding that there is no constitutional right to assisted suicide).

C. *The Autonomy of Those Who Wish to Die*

Another conceptual claim advanced by the authors is that assisted suicide violates the autonomy of those individuals who are killed.⁵³ It is necessary to distinguish two forms of autonomy. Autonomy in an *external sense* is an absence of external impediments to exercising one's will. Autonomy as an *internal conception* is being a lawgiver to oneself in a Kantian sense, or determining one's moral maxims are derived from one's own reason. These conceptions will be used interchangeably, but the context should make them clear.

Since most arguments for a right or interest in assisted suicide are based upon arguments for autonomy, the conceptual claim that assisted suicide violates autonomy deserves close attention. The classic argument for assisted suicide is, in fact, that individuals who are suffering should be able to decide when to end their own lives. It is for this reason that some proponents of assisted suicide argue further that physicians have a duty to perform assisted suicide. As Dutch physician Pieter Admiraal quite powerfully states:

As doctors we have two primary duties: to ensure the well-being of our patients, and to respect their autonomy. . . . The second duty entails that we listen closely to, and respect the wishes of our patients. Suffering, loss of control, and physical decline are subjective experiences, and nobody but the patient herself is in a position to decide when enough is enough.⁵⁴

There are several justifications for the conceptual claim collectively presented by the authors. The overriding justification is that assisted suicide necessarily involves coercion.⁵⁵ It cannot be truly voluntary because of family, economic, and social pressures. Kass and others argue that illness means dependence upon both one's family and physician (p. 24). As a result, familial needs, and the views of both family and physician about the value of living life with a terminal illness, influence the patient's desire to die.

Physicians' influence is, in addition, bolstered by their monopoly as professionals on vital information (p. 25). Physicians diagnose and de-

53. Ironically, one of the arguments presented by the authors against assisted suicide is that one may live a noble and heroic life without self-determination. Kass argues that "deaths we most admire are those of people who, knowing that they are dying, face the fact frontally and act accordingly. . . ." Pp. 38-39. This appears to derive a duty from the observation of supererogatory behavior. While it is true that one may live a noble and heroic life without self-determination, as in the case of a prisoner of war, for example, a duty to suffer clearly undermines autonomy when someone would choose instead to end her life to avoid suffering. Similarly to Kass, Callahan claims suicide is an inappropriate response to suffering. Pp. 66-67.

54. Admiraal, *supra* note 2, at 332-33.

55. Another concern of note is that an individual with a terminal illness who is depressed cannot autonomously choose to die. While I believe there are compelling reasons to reject this claim if one assumes that the individual is aware of her depression and treatment options (or lack thereof), the argument requires further examination elsewhere.

termine prognoses as well as treatment options, given costs and other limitations. The manner in which this information is presented and the number of palliative care alternatives suggested may directly determine a patient's choice to die. Edmund Pellegrino contends that in determining what information to convey to the patient, the physician judges the patient's quality of life and makes a paternalistic assessment about what is best for the patient (p. 48). Suggesting the option of assisted suicide may be perceived as indicating a duty to die (p. 24).

While it is true that subtle or overt family pressures and directive physician counseling may affect patient decisionmaking with respect to assisted suicide, this is true for any other medical decision as well. Clearly the authors do not mean to suggest that a patient may never make an autonomous decision. Rather, their position seems to be that, when the stakes are high, that is, when the decision occurs at the end of life, autonomous decisionmaking is more important and extrinsic influences of more concern than at other times in a patient's care. The reasoning for this is unclear, as autonomous decisionmaking may actually be more significant at the beginning of a patient's treatment, when the treatment course for the terminal illness is plotted.

Nevertheless, extrinsic factors like family resources and support and physician assessment of the patient's situation may play a role in a terminal patient's desire to die, and one may question whether a physician's advice, even within the legal requirements for informed consent, may ever be value-neutral.⁵⁶ While family and physician input may influence an individual patient's decision, these extrinsic factors do not affect what is of most concern with autonomous decisionmaking: that is, that one decides what is best for oneself. Provided that the physician operates within legal requirements for informed consent that enable patient choice, the patient's autonomy is sufficiently protected from physician influence. Family hardship and pressure certainly are not desirable, but it would be strongly paternalistic, and thereby a significant violation of autonomy, to suggest that the competent, terminally ill patient be forced to continue living in a state in which she does not wish to be. Some philosophers, such as Robert Young, argue that strong paternalism may actually *support* autonomy when it promotes an affected individual's life plan.⁵⁷ This exception does not hold in the case of a terminally ill patient, however, whose life plan is sufficiently truncated.

56. The issue of medical practitioner value neutrality receives great attention within the context of genetic counseling where abortion of a fetus may be at issue. See generally GENETIC COUNSELLING: PRACTICE AND PRINCIPLES (Angus Clarke ed., 1994); PRESCRIBING OUR FUTURE (Diane M. Bartels et al. eds., 1993).

57. See generally ROBERT YOUNG, PERSONAL AUTONOMY: BEYOND NEGATIVE AND POSITIVE LIBERTY (1986).

A corollary to the authors' argument about coercion is that if assisted suicide is perceived as voluntary despite the above-mentioned potential for physician influence, it poses a slippery slope to physician-instigated, nonvoluntary euthanasia (pp. 25-26). The physician will come to believe that she is justified in ending the life of incompetent patients, since she does so in order to benefit competent patients experiencing the same or lower levels of suffering (p. 25). Thus, according to Kass, "in *actual practice* physician-assisted suicide and euthanasia will be performed by physicians not out of simple deference to patient choice, but for reasons of mercy" (p. 25; emphasis in original). This line of argument is deeply flawed. In the case of nonvoluntary euthanasia, the guardian of the noncompetent person, not the physician, would make the decision to end or sustain life in accordance with what are perceived as the patient's best interests. When the patient is not suffering but will fail to recover, such as when the patient enters a persistent vegetative state, it is the interests of the family, not the physician, that matter.

Another justification for assisted suicide undermining autonomy, presented by Callahan, is that it is inherently a social act. In other words, it takes two people — the physician and the patient — to execute the patient's will to die (p. 60). This argument relies upon a fundamental misunderstanding about autonomy. It is the patient's autonomous decision to die that matters, not whether the patient achieves that state with or without assist. Certainly we do not believe that the blind, deaf, or wheelchair mobile are not autonomous, even though they must rely upon social accommodation to be functional. Further, many executions of one's will, such as one's choice to be married, to bear children, or to have an abortion safely, rely upon others to be carried into effect.

Callahan suggests, within the context of addressing the classic requirements for assisted suicide — self-determination and suffering — that assisted suicide could be understood to limit autonomy, not because it depends upon another person, but because it requires suffering.⁵⁸ The idea is that the requirement of suffering inherently limits self-determination (p. 62). This is true, but it must be so, at least within the context of physician-assisted suicide. The physician must act only to relieve suffering of the patient that she is able to confirm, at least roughly, within the realm of objective medical measures of disease prognosis and clinical observations of pain and discomfort.⁵⁹ An argu-

58. P. 62. Callahan believes the requirements of suffering and self-determination are arbitrarily combined and therefore "offe[r] little resistance to denying any competent person the right to be killed, sick or not, and little resistance to killing those who are not competent, so long as there is good reason to believe they are suffering" P. 63.

59. Callahan argues that suffering is demonstrated to be a poor indicator of the decision to commit suicide in general, where loss of control and mental illness are large factors, but

ment could be made for autonomously choosing suicide outside of suffering as it is understood here, but that is an entirely different matter.⁶⁰

VI. CONCLUSION: PRACTICE VERSUS POLICY — ANOTHER SOLUTION

The authors argue that the practice of assisted suicide is not sufficiently restrained by legal and other protections. The solution they propose is to prohibit assisted suicide and develop and promote palliative care. I present arguments demonstrating that there is no necessary connection between the legality of assisted suicide and the availability of palliative care. They are not mutually exclusive. Assisted suicide need not undermine access to palliative care or force people to end their lives.

Further, the main conceptual claims offered by the authors against assisted suicide do not withstand philosophical scrutiny. Assisted suicide fails to violate the professional ethic of medical practitioners or the autonomy of the individuals who are killed. In addition, the fundamental distinction that allows both support for palliative care that hastens death as well as opposition to assisted suicide — the acts and omissions distinction — is not philosophically sound.⁶¹

It is for these reasons that the collection fails to establish a case against assisted suicide. It does succeed in causing the reader to question whether assisted suicide is sound policy, even if it is morally justifiable. In her classic article, *Euthanasia*, Philippa Foot discusses the difference between morally justifying some acts of euthanasia and legalizing these practices.⁶² She maintains that there are profound psychological barriers against killing as well as concerns about voluntariness of death, due to both subtle and overt coercion that lawmakers should consider.⁶³ Callahan argues more forcefully that the risks of legalized assisted suicide outweigh society's duty to relieve suffering, even when no other options are available.⁶⁴ It would entail "a dispro-

he presents no data relating to physician-assisted suicide. Pp. 66-67. This is consistent with the view that such reasons would not be sufficient for *physician-assisted* suicide.

60. See Julian Savulescu, *Should All Patients Who Attempt Suicide be Treated?*, MONASH BIOETHICS REV., Oct. 1995, at 33 (claiming that some patients who attempt suicide and refuse treatment are both competent and rational and should be allowed to die); Susan Bailey, *Should All Patients Who Attempt Suicide be Treated? A Response to Savulescu*, MONASH BIOETHICS REV., Jan. 1996, at 42; Julian Savulescu, *Response to Bailey*, MONASH BIOETHICS REV., Jan. 1996, at 44.

61. I am aware that this case is not made conclusively in this Review. For a more complete discussion, see KAGAN, *supra*, note 44.

62. Foot, *supra*, note 7, at 111-12.

63. *Id.*

64. P. 65; see also Cohn and Lynn, p. 260 ("In developing policy, we must remember that physician-assisted suicide is about more than individual rights and distressing situations

portionate social change to . . . socially sanctioned killing . . . not easy to stop once unleashed in society” and discourage other remedies and supports (p. 65).

While the underlying concerns may have some validity, they are insufficient to override the moral justification for assisted suicide. It seems likely, as James Rachels suggests, that opponents to assisted suicide who invoke psychological barriers are merely expressing an aversion to killing in most cases, like those resulting from domestic violence and street crime.⁶⁵ They are displacing a general and understandable aversion to killing onto euthanasia, which operates for a different purpose, namely relief from intolerable suffering based upon irreversible, terminal illness.

Voluntariness concerns, on a praxis level, also do not outweigh the benefits of having assisted suicide available. Consent requirements work against gross autonomy violations by the physician, while family and social pressures remain. People may choose to die because they believe themselves to be a burden upon others or because they lack the money to afford proper palliative care or it is otherwise unavailable. These situations are unfortunate, even tragic, but to demand that these terminally ill individuals continue living, suffering in perhaps squalid circumstances, is unjustifiably paternalistic. It is illogical to argue that the availability of assisted suicide precludes the development of palliative care; rather, political and social priorities are responsible for limiting such health care access.

With respect to abuse, it is important to keep in mind that physician-assisted suicide necessarily involves a physician, who is under a fiduciary obligation to act to relieve suffering based upon an irreversible medical condition. The physician cannot kill a patient to relieve her from an unwanted pregnancy, an abusive husband, a military draft, or a prison term. The arguments for physician-assisted suicide do not justify Sethe’s actions.

Hard individual situations make bad public policy.”).

65. James Rachels, *Active and Passive Euthanasia*, in *BIOETHICS*, *supra* note 2, at 229.