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ASSISTANCE IN DYING: ACCOUNTING FOR DIFFERENCE

CATHERINE J. JONES*

We tend to live—or think we live—in a generically driven society. Sizes are unisex; directions on medicine bottles are written for adults or children (that's as specific as it gets); medical research often is conducted on patient populations that exclude many of the persons most affected by the conditions being studied, often in the name of “protecting” them. Our generic standards are no more generic, though, than Chief Justice Tindal's Nineteenth Century assertion that those charged with negligent behavior would be judged by a standard of the “man of ordinary prudence.”¹ Although Chief Justice Tindal's standard was subsequently interpreted to be gender neutral and generic, my guess is that when he said “man of ordinary prudence” he meant just that.

I believe in making legal the giving of assistance to those who would choose to end their lives by other than natural causes.² I am not sure my position on legalization of assisted dying is correct. What I am sure of, however, is that if we frame the question in terms of the so-called generic patient—if we do not consider issues

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My thanks to David Moss, who may give new meaning to the expression “Fools rush in where angels fear to tread.” Last spring, when David called to tell me about his plans for the Conference, I was overwhelmed that a new teacher, teaching four new courses in his first year at an institution, would take on such a major task. I knew, however, that David is very competent and I could hear the enthusiasm in his voice, so I encouraged him. The Conference was the result of that competence and enthusiasm. My thanks also to Joan Mahoney who, as Dean of the law school, told David to “Go for it” when he presented her with his ideas. Her support was crucial to the Conference. Finally, I am very grateful to Michele Dill LaRose and Pat Newcombe of the law school's library staff without whose assistance this paper would not have been completed, or even started. Michele's and Pat's work exemplifies what is both routine and best about the law school's superb library staff.

1. Vaughan v. Menlove, 132 Eng. Rep. 490 (C.P. 1837).

2. I prefer the term “assisted dying” rather than “physician-assisted suicide” because of the negative connotations associated with the word “suicide.”

relating specifically to gender, race, ethnicity, sexual orientation, age, and different degrees of physical or mental ability—we cannot possibly reach the appropriate answer.

Before examining the ambiguities, what certainties do we know about self-inflicted death and assisted death? We know that in 1990, 12.25 out of every 100,000 people in the United States died by intentional self-inflicted means.³ We also know that those numbers may be low because frequently deaths that occur by overdose are classified as having resulted from natural causes.⁴ We know that in 1991, intentional, self-inflicted death was the eighth leading cause of death in the United States and that most of those dying by this method were white men.⁵ We know that women attempt suicide at six times the rate of men, but that men die more often.⁶

The reason why men die more often is that they tend to use more violent means.⁷ We know that men succeed at self-inflicted death more often than women because guns are 95% lethal in suicide attempts.⁸ Women often attempt to die by overdose, a frequently ineffective method of killing oneself.⁹ What we do not necessarily know, however, is why women choose to attempt to take their lives by pill rather than by another method. Many hypotheses exist: women really do not want to die; rather, the attempt by pill is to draw attention and to ask for help. Women are less violent than men and therefore less prone to use more violent means of taking their lives. Women, always the caretakers, worry

3. See Julie Marquis, *32% Dip in State Suicides Found as U.S. Rate Rises*, L.A. TIMES, Dec. 11, 1994, at B1.

4. See Jim O'Connell, *Suicide Rate is Worrisome*, PATRIOT LEDGER, Feb. 15, 1996, at 17.

5. See Marquis, *supra* note 3.

6. See *Gun-Suicide High Among Harris County Women*, AUSTIN AMERICAN-STATESMAN, Mar. 20, 1995, at B2.

7. For example, three quarters of all elderly men who commit suicide do so by gun. See Don Colburn, *U.S. Suicide Rate Rises 9% for Elderly Since '80*, HOUSTON CHRONICLE, Jan. 26, 1996, at 1. Men also tend to commit suicide by hanging or by jumping from tall buildings. See Stephanie Gutmann, *Death and the Maiden: Dr. Kevorkian's Woman Problem*, NEW REPUBLIC, June 24, 1996, at 20, available in WESTLAW, HWD database. As most readers know, Nancy Cruzan was a young patient in a persistent vegetative state whose right to have feeding tubes withdrawn was ultimately argued before the United States Supreme Court. See *Cruzan v. Director, Missouri Dep't of Health*, 497 U.S. 261 (1990). How ironic that the father who loved her, and carried forward the fight to have her treatment withdrawn, took his own life by hanging. See Eric Pace, *Lester Cruzan is Dead at 62; Fought to Let His Daughter Die*, N.Y. TIMES, Aug. 19, 1996, at B12.

8. See *Gun-Suicide High Among Harris County Women*, *supra* note 6.

9. See Gutmann, *supra* note 7.

much more about the stress on those who will find them dead and would prefer to present a peaceful image rather than a body distorted by violence.¹⁰

We also know that the self inflicted death rate among the elderly is rising rapidly. Those over the age of sixty-five account for 13% of our population, and for 20% of the country's suicides.¹¹ The suicide rate for elderly white men is 38.4 per 100,000,¹² more than three times the national rate for the population as a whole.¹³ The elderly actually attempt suicide less often than the population in general, but they have a higher rate of causing their death. This may be because they are more deliberate than younger people and almost certainly because three-fourths of the elderly men and one-third of the elderly women attempting suicide do so by gun.¹⁴

In terms of assisted dying, what do we know? We know that almost three-fourths of the country's population agree that some people in some situations should be able to seek the assistance of another in dying without legal liability attaching to the one assisting.¹⁵ Those situations relate more to physical pain than to non-physical circumstances such as a fear of being a burden to one's family or feeling that life is not worth living.¹⁶ The country's physicians are fairly well divided on the question of assisted dying, with support or opposition frequently varying by specialty.¹⁷ Studies

10. See Leslie Bender, *A Feminist Analysis of Physician-Assisted Dying and Voluntary Active Euthanasia*, 59 TENN. L. REV. 519, 521 n.4 (1992); Nancy J. Osgood & Susan A. Eisenhandler, *Gender and Assisted and Acquiescent Suicide: A Suicidologist's Perspective*, 9 ISSUES L. & MED. 361 (1994).

11. See Colburn, *supra* note 7.

12. See Larry Lipman, *Elderly's Suicide Rate Stirs Concern; Doctors Urged to Be on Lookout*, ATLANTA J., July 31, 1996, at A6.

13. In 1990, the suicide rate for the total population of the United States was 12.25 per 100,000. See Marquis, *supra* note 3.

14. See Jeff Kunerth, *Suicide Rate Peaks Among the Elderly, and It's on the Rise*, HOUSTON CHRONICLE, Sept. 15, 1996, at A1; Colburn, *supra* note 7, at 1.

15. See Ezekiel J. Emanuel et al., *Euthanasia and Physician-Assisted Suicide*, LANCET, June 29, 1996, at 1805, available in WESTLAW, P-ABS database; see also *Compassion in Dying v. Washington*, 79 F.3d 790 (9th Cir. 1996), *rev'd sub nom. Washington v. Glucksberg*, 138 L. Ed. 2d 772 (1997); Linda Greenhouse, *High Court Hears 2 Cases Involving Assisted Suicide*, N.Y. TIMES, Jan. 9, 1997, at A1. The fact that three-quarters of the population believe some patients should be permitted to seek assistance in dying does not, of course, mean that three-quarters of the population would seek such assistance if they were in such a situation.

16. See Emanuel, *supra* note 15.

17. See Jonathan S. Cohen et al., *Attitudes Toward Assisted Suicide and Euthanasia Among Physicians in Washington State*, 331 NEW ENG. J. MED. 89 (1994). This study showed that 54% of physician respondents indicated that euthanasia should be legal in some situations, although only 33% were willing to participate in the act. Fifty-three

show that the medical diagnosis of those requesting, and receiving physician assistance in dying is primarily cancer, neurological disorders, or AIDS.¹⁸ However, patients' concerns in requesting assistance in dying encompass many factors that are not related to physical pain, including loss of control, burdening others, being dependent upon others for intimate, personal care, and losing personal dignity.¹⁹ In one study done in the Netherlands, pain was cited as the sole reason behind a request for assistance in dying in only 10% of all cases, and as a major factor in fewer than 50% of the request for assistance cases.²⁰

The majority of those requesting assistance in dying appear to be women. Certainly that is true with those who have died with the assistance of Dr. Kevorkian. To date, Dr. Kevorkian has assisted at least forty-five individuals, thirty women and fifteen men.²¹ Some cast Dr. Kevorkian as a misogynist who aims most of his activity at women and only works with men when people begin to wonder why so many women die in his presence. Stephanie Gutmann, writing in *The New Republic*, has noted that the men who sought Dr. Kevor-

percent thought physician assisted suicide should be legal in some situations, but only 40% indicated a willingness to assist. Hematologists and oncologists were more likely to oppose euthanasia and assisted suicide and psychiatrists were more likely to support the practices. *See id.* at 89. *See also Geriatricians' Attitudes Toward Assisted Suicide; Tips from Other Journals*, 47 J. FAM. PRAC. 949, 949 (1993) (stating that a majority of physicians support a patient's right to die); *Report of the Board of Trustees of the American Medical Association; Transcript*, 10 ISSUES L. & MED. 81, 83 (1994) (indicating that the Board of Trustees of the American Medical Association opposes euthanasia and physician-assisted suicide). In a study of Colorado physicians, 60% indicated they cared for patients for whom they believed active euthanasia to be justifiable, and 59% indicated a willingness to supply lethal drugs in such cases were the act legal. In a study of San Francisco physicians, 70% stated that patients with incurable terminal illnesses should have an active euthanasia option, but only 45% expressed a willingness to assist with such a request were it legal. *See id.*

18. *See* Anthony L. Back et al., *Physician-Assisted Suicide and Euthanasia in Washington State Patient Requests and Physician Responses*, 275 JAMA 919 (1996). In San Francisco, there is an active "underground," consisting of AIDS patients, doctors, lovers, and friends assisting people with AIDS in dying. *See* Sheryl Stolberg, *Ending Life on Their Own Terms; An Underground Network Helps San Francisco AIDS Patients Who Choose to Die with a Doctor's Help, Surrounded by Loved Ones*, L.A. TIMES, Oct. 1, 1996, at A1. A survey of 118 San Francisco physicians specializing in the treatment of AIDS found that 53% admitted to having helped patients commit suicide by writing prescriptions for narcotics. The suicide rate in such cases is artificially suppressed because of the tendency to ascribe a death by overdose to "natural causes." *Id.*

19. *See* Back et al., *supra* note 18, at 921 (describing a study which reflects patient concerns as perceived by physicians).

20. *See* Emanuel, *supra* note 15, at 1809.

21. *See* Todd Nissen, *Kevorkian May Face More Criminal Charges*, REUTERS NORTH AMERICAN WIRE, Nov. 4, 1996; *Kevorkian Suicide List Stands at 44*, BOSTON HERALD, Oct. 25, 1996, at 6.

kian's assistance had been diagnosed as terminally ill by their own physicians, were in constant and severe pain from their medical diagnoses, and often were physically incapacitated.²² The women, Gutmann stated, had symptoms that were much more ambiguous, had not been diagnosed as terminally ill, and had not been complaining of severe and constant pain.²³ She suggested that women, who seemingly worry more about their illness' impact on others, are more vulnerable to those like Dr. Kevorkian.²⁴ She also noted that Dr. Kevorkian took so long in deciding to assist individual men that a number of his prospective male clients killed themselves before he set a date for assisting them.²⁵

I am not an apologist for Dr. Kevorkian and, in fact, he may be a misogynist. Misogyny, however, is not why women seek him out. They may, however, seek him out because they need assistance in ending their lives and the regular medical establishment will not generally provide it, nor will state legislatures make such assistance legal.

When we talk of the so-called right to die—for the last two decades, withholding or withdrawing medical care and more recently providing prescription drugs or even a lethal injection—the discussion is based in a framework which is culturally very western, white, heterosexual, and male focused. While the views of western, white, heterosexual men need to be considered, there is something wrong with reaching a conclusion that applies to all by using that framework exclusively.

Miles and August studied final state appellate court rulings in cases of twenty-two patients once competent but later incompetent and existing on various forms of life support that their families or guardians sought to terminate.²⁶ None of the individuals had executed advanced directives addressing end-of-life decisions. Fourteen of those cases involved women and eight involved men. In six out of the eight cases involving men (75%), the court determined what the patient's decision concerning life-sustaining treatment would have been, and permitted that decision to be effectuated.²⁷ In all six, the court determined that the patient's decision would

22. See Gutmann, *supra* note 7.

23. See *id.*

24. See *id.*

25. See *id.*

26. See Steven H. Miles & Allison August, *Courts, Gender and "The Right to Die,"* 18 L. MED. & HEALTH CARE 85 (1990).

27. See *id.* at 85.

have been to have treatment withdrawn.²⁸ In one of the two remaining cases involving men, the court delegated decision making power to a family member and in the other to a physician.²⁹ Of the fourteen cases involving women, in only two (14%) was the court able to discern the patient's preference.³⁰ In another six (43%), the court delegated decision making power to a family member,³¹ in three (21%) to a physician,³² and in three (21%) to an institution, such as the court itself, or a hospital ethics committee.³³ Miles and August found that the courts' reasoning in the cases brought on behalf of male patients accepted evidence of the men's treatment preferences, and found their right to have those preferences exercised a matter of autonomy.³⁴ The courts' reasoning in the cases involving women found the women's expressions of preferences to be unreflective, emotional, or immature. Women, but not men, were described in childlike terms—fetal position, infantile state. The *parens patriae* doctrine was asserted only in relation to women, not men. The male patients were regarded by the courts as victims of medical assault and therefore entitled to assert their autonomy against that assault. Women, however, were perceived as being vulnerable to medical neglect. In fact, in 86% of the cases someone else was empowered not only to speak for them but also to decide what they would say.³⁵

So, women have been treated differently by the courts when compared to similarly situated men in withdrawal of treatment cases. Women tend to use less violent means when they attempt to take their own lives. They are traditional caretakers, so they do not want to burden others either with their care or with a long, slow death watch. Is it so hard to imagine, then, that women would seek the assistance of Dr. Kevorkian? Is it not understandable that if assisted dying is prohibited, the primary effect of that prohibition will fall on women because they are more reluctant or unable to take their own lives, and because they are not provided with legally sanctioned assistance?

Some might argue that women are lucky to be so "protected,"

28. *See id.* at 86.

29. *See id.* at 87.

30. *See id.*

31. *See id.* at 89.

32. *See id.*

33. *See id.*

34. *See id.* at 90.

35. *See id.*

and that in fact society should find a better way to protect men. That, of course, raises the question of whether women need to be, or want to be, protected. It is reminiscent of the issues surrounding surrogate motherhood's debate in which even the feminist community is split over whether surrogacy should be prohibited in order to protect the vulnerable from exploitation, or whether all women, including the poor and minority, should be accorded full decision-making power as competent adults.

Just as women may have concerns different from men in end-of-life decision making, those of different races or ethnicities, those who are not heterosexual, those who are elderly, those who are not able bodied, may have concerns different from able-bodied, heterosexual, white men. Those concerns must be taken into account in formulating any rules concerning assisted dying.

One of the major arguments offered in opposition to assisted dying is that the economically disadvantaged or racial and ethnic minorities might become vulnerable to the assisted dying process. Such a scenario is unlikely. First, white men are much more likely to die of self-inflicted death than any other group in this country.³⁶ Second, non-Hispanic whites are much more likely to execute advanced directives—making formal plans for end-of-life decision making—than are members of minority groups.³⁷ In fact, only 2% of Asian Americans have formalized their end-of-life plans, although they frequently tell their physicians their wishes, trusting the spoken word over a writing.³⁸ Some Asian American elders do name surrogate decision makers, generally a son, for end-of-life decision making,³⁹ reflecting the position of sons in Asian society. African Americans and Hispanics are also less likely than non-Hispanic whites to designate a surrogate, but if they do, the surrogate is likely to be a daughter, reflecting the importance that women play in African American and Hispanic families and social structures.⁴⁰ African Americans and Hispanics are also much more likely to favor aggressive treatment at the end of life,⁴¹ possibly based on distrust resulting from lifetimes of discrimination and less than optimum medical care.

36. See *supra* notes 5-7 and accompanying text.

37. See *Culture Explains People's Attitudes Toward Living Wills* (National Public Radio, Morning Edition, Aug. 28, 1996), available in LEXIS, News Library, Scripts File.

38. See *id.*

39. See *id.*

40. See *id.*

41. See *id.*

People from different cultures may also disagree over the notion of a "good death." Hospice care for the dying emphasizes a peaceful, accepted death, at home with family present: in essence, a white, middle class death. African Americans, however, are not as favorably disposed to hospice care.⁴² After all, admission to the hospice program requires accepting the inevitability of death within months and agreeing to forego aggressive end-of-life treatment, which, to some, is tantamount to giving up or surrendering.⁴³ Those of Chinese descent may not want to die at home because of cultural beliefs that their ghost will haunt the place where they died, and they do not want to impose that on their family.⁴⁴

Of course, there is also the obvious danger when we begin to consider the beliefs and traditions of those from different cultures, that we will make assumptions based on stereotype. That is, we might now assume that an African American patient wants aggressive care and that an Asian American prefers death in an institution rather than at home. And, those assumptions might be wrong.⁴⁵ The message is that we must not operate on, or construct our rules and our procedures based on, assumption, but rather on what we know and learn from those at the center of our discussion.

Again at the risk of falling into opposite stereotypes, serious scholars have shown us that not all people think alike, not all people make decisions in the same way.⁴⁶ When those courts deciding withdrawal of treatment cases involving women patients referred to the expressions of preference by women as unreflective, emotional, or immature, and when the women assisted by Dr. Kevorkian were described as having more ambiguous symptoms than the men whom he assisted, what the courts and the author may well have been describing was not the indecisiveness of which we traditionally accuse women, but rather a reflection of women's means of making decisions.⁴⁷ Women and perhaps members of many ethnic and cultural groups are much less individually oriented and much more communally oriented than non-Hispanic white men. That sense of

42. See Barbara A. Koenig & Jan Gates-Williams, *Understanding Cultural Difference in Caring for Dying Patients: Caring for Patients at the End of Life*, 163 W.J. MED. 244 (1995).

43. See *id.*

44. See *id.*

45. See *id.*

46. See CAROL GILLIGAN, *IN A DIFFERENT VOICE: PSYCHOLOGICAL THEORY AND WOMEN'S DEVELOPMENT* (1982) (examining the different modes of thinking between men and women).

47. See *id.* at 71-74.

relationship is reflected in their conversations, in their decision making patterns, and in the effectuation of their decisions.⁴⁸ Rather than attempting to force women and minorities into the mold we have developed for end-of-life decision making, including how we deal with assisted death, we need to consider how our practices should reflect differences among all members of our society.

The simplest solution would be to say that assisted death will be prohibited. That way there will be no negative repercussions from incorrect diagnoses, no coercion of the vulnerable, and no suggestion that physicians violate their ethical codes. Sometimes, I find that argument appealing and one I can defend, because I too fear that mistakes sometimes will be made, that the diagnosis may not be correct, that the patient may be suffering from a treatable mental illness from which she may recover and live a long, satisfying life.

On the other hand, I find myself torn both professionally and personally. There are persons in pain so severe it cannot be alleviated, there are persons so overcome by life's circumstances that their non-physical pain also cannot be soothed, there are those whose personal dignity is so invaded that I have serious doubts about a blanket prohibition on assisted death. Many know the story of Dax Cowart, a man severely burned in a gas line explosion who begged to have treatment withdrawn so he could die and escape the pain.⁴⁹ His treatment was not withdrawn and he survived. His life subsequent to his recovery has seen a marriage that did not work, but a second one that did; a law degree; attempts at suicide; severe vision and hearing impairments.⁵⁰ Today Mr. Cowart says his life is worth living, but he also says that despite that, he thinks his wishes regarding withdrawal of treatment should have been honored, and he should have been allowed to die.⁵¹ I would not presume to second guess Dax Cowart, and I do not think the law should do so either.

My own personal concern goes even further than the competent patient in intractable pain or near death from cancer or AIDS. My personal concern would take us down that slippery slope to the

48. See *id.* at 8-9, 16-17, 169-74.

49. See Leslie Sowers, *Burn Victim is Working to Ensure Patients' Rights*, *TIMES-PICAYUNE*, Sept. 21, 1996, at A15; Christine Wicker, 'Can't You See I'm a Dead Man?' *Miracle Workers Made Dax Cowart Survive; He Still Wishes They Hadn't*, *CHI. TRIB.*, May 18, 1989, at C1.

50. See Sowers, *supra* note 49; Wicker, *supra* note 49.

51. See Sowers, *supra* note 49; Wicker, *supra* note 49.

incompetent patient who made end-of-life decisions concerning assisted dying when she was competent. I have watched Alzheimer's Disease destroy people of three generations in my family—my great-grandfather, his daughter (who was my grandmother), and her daughter (who was my mother). I did not know Grandpa Moore very well, but I have heard a lot about him. I knew my grandmother and my mother very well. They were proud, bright, capable, fiercely independent women. They rarely asked anyone for anything, and my mother was the classic caretaker. They valued their dignity above all other personal characteristics, and they never wanted anyone to take care of them. When my grandmother became ill and deteriorated through confusion to the point where she was a danger to herself, to the stage where she could no longer live alone, to the days in which she was in a nursing home, finally bedridden, and unable to speak during the last several years of her life, I heard my mother wish for her mother's death on many occasions, and wish for her own if she ever seemed headed for the same end. Eventually, she did head to that end. She was somewhat luckier than Grandma; her disease progressed faster, an eight to ten year duration. Unlike Grandma, who was over ninety years old when she died, my mother died at the age of seventy-six. Furthermore, unlike Grandma, my mother never went to a nursing home because my sister sacrificed two years of her own life to care for her. However, despite the fact that she was cared for by a loving daughter, she had lost that quick, bright mind that she valued so, and she suffered personal indignities that most of us care not to think about. Naturally, I wonder if I am next in line.

When Janet Adkins sought and received Dr. Kevorkian's assistance in dying, many people were appalled not only at him, but at her. She was in her fifties and had recently been diagnosed with Alzheimer's.⁵² The week before her death, she was able to play tennis with her son and even to win the match, but she could not remember the score.⁵³ Janet Adkins feared what her life would be like over the course of her disease. I assume she knew that should she become incompetent she could no longer seek assistance in dying, so she acted while she was competent and still had time. Had Janet Adkins known that when her disease reached a certain point she would in fact be assisted in dying, she might not have sought

52. See Bonnie Johnson et al., *A Vital Woman Chooses Death*, PEOPLE, June 25, 1990, at 40.

53. See *id.*

Dr. Kevorkian's assistance when she did. In fact, many people who die from intentional self-inflicted injuries might choose to live longer if they could be assured that someone would help them to end their lives at a future time.

I think we talk much too theoretically and perhaps disingenuously about end-of-life decision making. Admittedly, I worry that when we move away from abstractions the debate focuses on "worst case" scenarios. The opponents raise the specter of the poverty stricken, eighty-five year old woman, alone, in the nursing home with no one to care for her and protect her, and the proponents compare the inhumane treatment of patients in intractable pain with the humane euthanasia of dying pets. I agree with those who equate withdrawal of treatment with assisted death. The person from whom the ventilator or feeding tubes are withdrawn dies because she can no longer breathe or because she no longer draws sustenance. The physician or some other person acted to create that end. It is disingenuous to pretend that assisted dying is not going on every day, not only through withdrawal of treatment but through injections of lethal doses of pain killers, and through the writing of prescriptions. *Compassion in Dying v. Washington*⁵⁴ and *Quill v. Vacco*⁵⁵ did not come from suddenly discovered scenarios. Those cases just happen to be the first legal challenges to statutes prohibiting physician-assisted suicide, brought by, and because of, physicians who fear legal liability for assisting others in dying just as they earlier feared legal liability if they were to withdraw life-sustaining treatment from patients.⁵⁶

It is naive or hypocritical to pretend that, whatever the Court's decision, assisted dying will not continue. Rules relating to end-of-life decision making are made by the living and may well be based on what we hope, or fear, will happen to us when the rules are applied. While those opposed to assisted dying may caution those in favor "to be careful what they wish for because they might get it," the proponents of assisted dying might urge the same caution against the opponents. Furthermore, since assisted dying occurs on a regular basis, with the agreement and participation of health care providers, some of those who publicly oppose assisted death may well believe that if their pain—however it is defined—is ever so

54. 79 F.3d 790 (9th Cir. 1996), *rev'd sub nom.* *Washington v. Glucksberg*, 138 L. Ed. 2d 772 (1997).

55. 80 F.3d 716 (2d Cir. 1996), *rev'd*, 138 L. Ed. 2d 834 (1997).

56. *See, e.g., In re Quinlan*, 355 A.2d 647, 666-67 (N.J. 1976).

great they cannot continue living, they will have access to assistance in dying, even if such assistance is prohibited.⁵⁷

Perhaps I believe as I do, or at least think the discussion to be both too theoretical and disingenuous because I am a woman. I may think and communicate differently than others engaging in this debate. I am much more persuaded by individual scenarios than I am by theory. I believe that not only is it permissible for the debate to be emotional, but also that we will lose important perspectives if we do not allow it to be emotional. I do not claim to be objective in the assisted dying debate. Nor do I claim that my views are necessarily correct or that my way of thinking is the only appropriate approach to the topic. I claim only that to define the terms of the debate in the traditional western, white, heterosexual male analytical method will lead to the wrong conclusion for many.⁵⁸ I have long told my students that the times I worry most about my ideas, and the times I most need to continue to think about them, is when I truly believe I am right. I think that is a fitting caution for all who engage in the assisted dying discussion.

There is no objection that has been raised to assisted dying that was not also raised to withholding or withdrawing treatment, yet, the fears that were forecast when the withdrawal of treatment cases were being decided have not materialized. The elderly, the disabled, the poor, and members of minority groups have not been coerced into having treatment withheld. We have not seen any

57. Such a scenario would not be unlike that which existed before abortion became a legally protected procedure. Despite prohibitions on abortion, many women from educated, financially secure situations were able to procure abortions, frequently under the guise of therapeutic gynecologic treatment. There is no reason to believe that those who oppose assistance in dying for the general population would not avail themselves of access to assisted dying for themselves or their loved ones, further illustrating the disingenuousness of the opponents' arguments. Some readers may accuse me of raising unsubstantiated fears about those who oppose assisted dying. However, one of the participants in this symposium, an articulate critic of assisted dying, made exactly this suggestion to me, indicating that I need not fear an outcome like my ancestors', even if assisted dying is banned, because I will be educated enough and savvy enough to find someone to help me die even if the practice is prohibited.

Of course the reverse analogy is even worse. That is, like women who sought illegal, "back alley" abortions before the procedure became legal (and still do in those instances where abortion is geographically or financially beyond their means), some of those who want assistance in dying will turn to "back alley" specialists. Indeed, at least forty-five individuals have already sought the assistance of Dr. Kevorkian. The result of those decisions—if the procedure is "botched"—may be continued life in an even worse physical, mental, or emotional condition.

58. In fact, one of the mistakes we make in this debate is to assume that there is one conclusion to be reached. There may well be many appropriate conclusions based upon many factors relevant to different people.

greater diminishing respect for the value of life. We have, some would say, started down the slope, not in the direction of withdrawing care from the vulnerable, but in the direction of hastening death in a different manner.⁵⁹ Part of that hastening, however, is more apparent than real given the fact that assisted dying has been occurring and will continue to occur. Perhaps the vulnerable would be much better protected were the practice performed openly rather than in secret.

Will there be mistakes made if we make assisted dying legal? It is hard to imagine that there will not be, just as it is hard to imagine that there have not been mistakes concerning withdrawal of treatment. But why do we assume bad faith, rather than good faith, on the part of physicians, families, and society?⁶⁰ And, why do we focus on worst case scenarios rather than engaging in the discussion in which we need to participate, both to determine how to set our standards and how to effectuate individuals' wishes?

In his superb essay, *Dying as Failure*,⁶¹ Dr. Lewis Thomas wrote,

It is true, as everyone says these days, that doctors do not know what to do about death. Patients who are known to be dying are segregated as much as possible from all the others, and as the clinically unmistakable process of dying gets under way the doctors spend as little time in attendance as they can manage.

What is not so generally recognized is that doctors, especially young doctors, are as frightened and bewildered by the act of death as everyone else. . . . Death is shocking, dismaying, even terrifying.

A dying patient is a kind of freak. It is the most unacceptable of all abnormalities, an offense against nature itself.

. . . .

The difference [between a hospital in the 1930s and] a modern hospital, apart from the change from open wards to mostly

59. Some of the current opponents to assisted dying were instrumental in pursuing the rights of individuals to have life sustaining treatment withheld or withdrawn. They were then opposed by others who warned that one of the next steps would be calls for assisted suicide or active euthanasia. Perhaps some of those who now oppose assisted dying do so as a defensive reaction to those who earlier warned against the slippery slope leading from withdrawal of treatment. That is, as the withdrawal of treatment opponents are saying "I told you so," the withdrawal of treatment proponents/assisted dying opponents respond, "this far, but no further."

60. See Bender, *supra* note 10, at 533.

61. Lewis Thomas, *Dying as Failure*, 447 ANNALS AM. ACAD. POL. & SOC. SCI. 1 (1980).

private rooms, was in the age of the patients who died. Dying could occur, and did, at any age. It was not an event reserved for the very old, or for the middle-aged patients who had reached the end of their long battles with cancer or heart disease or strokes. Many of the patients who died on the open wards of the City Hospital were young people, overwhelmed by an infectious disease—lobar pneumonia, meningitis, septicemia, tuberculosis—for which there was no effective treatment of any kind.

The inevitability of death was plainer to see in those days. For a great many of the ordinary illnesses that brought patients into the hospital, dying was the expected outcome, beyond the control of any doctor. Death was more normal.

....
... Everyone knew about death at first hand; there was nothing unfamiliar or even queer about the phenomenon. People seem to have known a lot more about the process itself than is the case today. The "deathbed" was a real place, and the dying person usually knew where he was and when it was time to assemble the family and call for the priest.

....
Today, the average span of human life in our society stands at around 73 years, the longest run at living yet achieved. Obviously, most of the dying is done by old people. It makes a different sort of problem for the human mind. Dying is not so often the tragic striking-down that it was; it is more like the end of a slow process of running-down, more like a slow collapse. We know about its inevitability, but we do not have the same apprehension that it is there, waiting just around the corner, ready to leap.

And so we have come, just in the past 40 years, to view death as a sort of failure, just as we now look at the process of aging itself as failure. We have lost, in this changed view, the old feeling of respect for dying, and all the awe.

I do not know what we are doing to the first-hand experience of dying itself with our technology, but I suspect we may often be interfering with an important process.

....
Dying *is* a process, I believe. I'm not sure of it, but I think so. The organism seems to come apart in orderly stages.

....
Most of the time, it is not a bad feeling. Sir William Osler wrote about it, pointing out that the popular notion of death agony was a fiction; people died, at the moment of the dying, in tranquility.

.....
The time may come when medicine will have found out enough about disease mechanisms to think its way around all of today's other lethal human diseases, as effectively as by the techniques for treating infection. We may be left then with no way of dying except by wearing out in old age, barring trauma. It will be the kind of event we now call natural death, ending the lives of very old people in their sleep.

Meanwhile, we are part way along. We have not lost our fear of dying, nor our sense of its ultimate inevitability. But I am afraid that we have lost something else—our respect for it. In a sense quite new to our culture we have become ashamed of death, and we try to hide it, or hide ourselves away from it. It is, to our way of thinking, failure.⁶²

As we continue the debate on assisted dying, perhaps we need to remember that dying is not an event, but the end of the process of living. And in providing individuals with options in the dying process we need to consider whether, rather than decreasing our respect for life, we are in fact increasing that respect. Perhaps we need to think of death not as failure, but as a successful, dignified, humane end to a life well lived.

EPILOGUE

As this volume was going to press, the United States Supreme Court reversed the decisions of the Circuit Courts in *Compassion in Dying v. Washington* and *Quill v. Vacco*.⁶³ Those decisions will not end assisted dying. Rather, the practice will continue as it has until now—patients will die as their morphine is increased and their breathing suppressed; some physicians will prescribe drugs that they know will be lethal to their patients if the patients take an excessive amount; in the worst case scenario, family members and friends will kill, sometimes using violent means, their loved ones who beg to die. Occasionally, mistakes will still be made—both in those instances where patients are assisted in dying and in those where they are not. Had the Supreme Court affirmed the decisions in *Compassion in Dying v. Washington* and *Quill v. Vacco*, states would have begun to search for new ways to regulate assisted dying. With the reversal, assisted dying proponents will search for new ways to change the law and continue the practice. The effort of

62. *Id.* at 2-4.

63. See *Vacco v. Quill*, 138 L. Ed. 2d 834 (1997); *Washington v. Glucksberg*, 138 L. Ed. 2d 772 (1997).

both sides must recognize that the issues raised by assisted dying have many appropriate responses and solutions. In crafting those responses, both proponents and opponents of assisted dying must take into account the life circumstances of all those affected by assisted dying. To paraphrase the eloquence of Dr. Thomas, to do otherwise is failure.