NATURAL CAUSES, UNNATURAL RESULTS, AND THE LEAST RESTRICTIVE ALTERNATIVE

Giles R. Scofield
ARTICLES

NATURAL CAUSES, UNNATURAL RESULTS,
AND THE LEAST RESTRICTIVE
ALTERNATIVE

Giles R. Scofield*

INTRODUCTION

The United States Supreme Court has decided that the question of whether physician-assisted suicide should be against the law is one of the most important legal, ethical, and moral1 questions confronting patients who are struggling to live and die, and physicians who are struggling to practice medicine in our health care system.2 As the Quinlan3 and the Cruzan4 cases once captured our attention, so have the physician-assisted suicide cases grabbed the headlines this year. Presumably, if anyone has anything to say about this issue, now is the time to speak, or to forever hold one’s peace.

Although I am grateful to again have the opportunity to say something about the legalization of physician-assisted suicide,5 I honestly do not know what is left to be said. So much has been written, and so many people have spoken to the issue that, like

---

* Associate Professor of Community Medicine, University of Connecticut School of Medicine. A.B., Princeton University; J.D., New York University School of Law. Thanks to Heather Gunas, a student pursuing a law degree at the University of Connecticut School of Law and an M.P.H. degree at the University of Connecticut School of Medicine, for her research support, and to Kramer Scofield for his unique support.

Debbie, I very much feel like saying, "Let's get it over with."6

More than that, I am more convinced than ever before that saying anything will not matter, for the simple reason that we have lost the ability to listen to and converse with one another.7 We seem to suffer from a peculiar kind of locked-in syndrome, so convinced that we are right that we see little point in taking seriously the possibility that we might be wrong. Not only do we seem no longer capable of hearing one another, we seem incapable of hearing patients as well. But since we know what is right, and know what patients must or should want, we plod ahead on our respective missions. Yet, if the choice we face is to converse or perish,8 our inability and unwillingness to converse9 suggests that more is at stake than the undue killing of patients, significant though that issue is in its own right. Although I suspect that what I have to say will fall on deaf ears, I intend to speak as plainly and directly as I can.

To some, this occasion probably seems to offer me a golden opportunity: the chance to say and write something that might make a difference. Perhaps a Supreme Court clerk, or even a Supreme Court Justice will read this10 and decide that I deserve honorable mention in any of the several opinions likely to accompany the Court's decision in these historic cases. Unfortunately, such a perspective reflects a belief about mortality and immortality that is as common as it is mistaken (i.e., that the successful pursuit of money, power, material goods, or, in this instance, fame, can and will enable one to overcome the dread of having lived an insignificant life).11 This is the perspective held by those who fear mortal-

10. Of course, if they truly wish to understand my meaning, they have to do some listening too. See infra note 76.
ity. Hence, it is the very perspective that gives rise to the anxious need to dominate death, to get death to obey our will, and to avoid the grip death has on us.

This being the case, it would be hypocritical for me to adopt a death-denying perspective in the course of condemning the death-defying response that I believe physician-assisted suicide to be. Because I think about mortality\(^{12}\) and immortality—my own and others—from an altogether different perspective,\(^{13}\) I speak and write for an altogether different purpose: which is not to praise physician-assisted suicide, but to bury it.

From my perspective, that we are even discussing this issue this year suggests how easily distracted we are, and how deluded we have become.\(^{14}\) Given all that we possibly can and arguably should be talking and doing something about, we remain obsessed with discussing, and fixated on doing something about, the one fact of life that we cannot change: our mortality.\(^{15}\) For some absurd reason, we pursue the impossible instead of the possible, intent on doing something about death instead of making something of life.\(^{16}\) As a result, we have embroiled ourselves in a Lilliputian, but nonetheless lethal, debate about whether we should legalize individualized murder.\(^{17}\) We have managed to avoid discussing the far more pressing

\(^{12}\) Simply stated, knowing full well that one day I shall be dead, I only hope that my death comes not a moment too soon, nor a moment too late. I know and accept, however, that the likelihood of my dying where, how, and when I wish, is completely a matter of chance. This being the case, then, however understandable it might be for me to obsess about whether death will turn out to be my enemy or my friend, I know that death just is, regardless of what I interpret it to be.

The interpretation of and the significance we assign to death affects how we respond, individually and societally, to death, and to the nagging knowledge that each of us one day will die. These perceptions about the reality of death perfuse any and all discussions of death, in ways that can and often do escape our individual and collective consciousness. See Zygmunt Bauman, Mortality, Immortality and Other Life Strategies 129-60 (1992); see also Giles R. Scofield, Lost and (Not Yet) Found, 8 HEC Forum 372 (1996). For this reason, much of this article will focus on how we interpret death, with an eye to enhancing our understanding of the current situation.


\(^{14}\) See Bauman, supra note 12, at 129-60; Scofield, supra note 12, passim.

\(^{15}\) See Hans Jonas, The Burden and Blessing of Mortality, in Mortality and Morality, supra note 13, at 87-98.

\(^{16}\) See Albert Camus, The Myth of Sisyphus (1955) (proposing a solution to the problem of suicide); Albert Camus, The Rebel (1969) (proposing a solution to the problem of murder).

\(^{17}\) For a patient's story of struggle with life and death, see Timothy E. Quill,
issue of whether we should condemn as immoral and illegal a health care system that commits mass murder in the name of economic apartheid.\(^{18}\)

For this reason, I have no intention of employing the framework commonly used to analyze the legalization of physician-assisted suicide,\(^{19}\) but intend instead to suggest three possibilities for your consideration. They are: (1) that the legalization of physician-assisted suicide is not and cannot be what it purports to be; (2) that the legalization of physician-assisted suicide is and can only be something that it should not be; and (3) that the movement to legalize physician-assisted suicide is not what it should be. In so doing, I intend to cast doubt on the following beliefs: (1) that the legalization of physician-assisted suicide is the ineluctable result of a logical, consistent application of existing law; (2) that the legalization of physician-assisted suicide empowers patients; and (3) that the movement to legalize assisted suicide, as well as the movement to resist its legalization, is a legally and morally progressive response to our mortal condition.

I. THE LEGALIZATION OF PHYSICIAN-ASSISTED SUICIDE IS NOT AND CANNOT BE WHAT IT PURPORTS TO BE

Rhetorically, the argument in favor of legalizing physician-assisted suicide is a form of murder. The point being, since we are already engaged in murder, why not do so openly and honestly? If that is taken to be the truth, then it must be as true for decisions to withhold as it is for decisions to withdraw treatment, since they are legally and ethically equivalent. And if that is true, then to the extent that Americans die more quickly than they otherwise would have because they lack access to care, we are engaged in mass murder, a kind of involuntary, passive euthanasia. If that is so, I think it makes more sense to halt the mass murder that we are engaged in than to permit individualized killing that is currently prohibited.


---


sisted suicide proceeds with all the intellectual rigor of a Madison Avenue advertising campaign. "If you hate pain and suffering, and you like liberty, you'll love physician-assisted suicide. It takes the muss, the fuss, and the wait out of dying. No more nasty machines. No more waiting for death. Now you can make death happen—instantly! Call your doctor today. You'll be glad you did." The fact that so many Americans seem to be demanding this technological quick fix must mean something. What that something is, of course, is a matter of interpretation.

Legally, physician-assisted suicide is said to be the ineluctable product of reasoning that underlies two distinct, but related,

---


22. See Yale Kamisar, The Reasons So Many People Support Physician-Assisted Suicide and Why These Reasons are Not Convincing, 12 Issues L. & Med. 113 (1996). In order to know what to make of these data we need to know a few things. First, we need to know what the pollsters were looking for, and how they decided to write the questions. Then, we need to know how the respondents to these polls interpreted the questions. For all we know, they were asked one thing, and answered another. Third, we need to know whose interpretation of these polls matters, and why. Having briefly represented a polling organization, I recall the cautionary phrase bandied about among pollsters: "Figures don't lie, but liars can figure." Before dismissing this aphorism as so much cynicism, consider this editorial response to the recently published data concerning the practice of euthanasia in the Netherlands. "As with the 1990 study from the Netherlands, . . . both sides in the American debate will most likely claim that the findings support their position as the controversy intensifies and the matter comes before our highest court." Marcia Angell, Euthanasia in the Netherlands—Good News or Bad?, 335 New Eng. J. Med. 1676, 1678 (1996); see also, Paul J. van der Maas et al., Euthanasia, Physician-Assisted Suicide, and Other Medical Practices Involving the End of Life in the Netherlands, 1990-1995, 335 New Eng. J. Med. 1699 (1996); Gerrit van der Wal et al., Evaluation of the Notification Procedure for Physician-Assisted Death in the Netherlands, 335 New Eng. J. Med. 1706 (1996).

23. The most basic values that support and guide all health care decision making,
strands of case law: abortion and the treatment refusal cases. Assuming arguendo that following premises to their logical conclusion is never wrong, is the argument as logically correct as advocates of physician-assisted suicide say it is?

If we stick to simple logic, we encounter the immediate difficulty of deriving a right to physician-assisted suicide from the treatment refusal cases. There is an inherent logical fallacy in deriving a positive right to physician-assisted suicide from the negative right on which the treatment refusal cases rest. Regardless of whether one approaches the question legally, philosophically, or mathematically, one cannot simply derive a positive from a negative. That we have a right to be let alone does not mean that we have the right to be aided. A right not to have something done to you does not create a right to have things done for you. Thus, the mere fact that

including decisions about life-sustaining treatment, are the same values that provide the fundamental basis for physician-assisted suicide: promoting patients' well-being and respecting their self-determination or autonomy.

\[\ldots\]\[M]aking physician-assisted suicide available to patients who choose it is not a radical departure in medical practice or public policy, but a natural and appropriate extension of presently accepted practices.


25. I do not share this assumption. "Logic relentlessly and inappropriately pursued to its end can as readily lead to destructive results as can muddled emotions." Guido Calabresi & Philip Bobbitt, Tragic Choices 70 (1978).

26. The distinction between the two rights is nicely drawn by Professors Chervenak and McCullough:

Refusal of medical intervention is a negative right simpliciter . . . .

A negative right is usually understood in ethics as a right of noninterference in decision-making and behavior. A negative right therefore generates duties on the part of others to leave the individual in question alone. . . . By contrast, positive rights involve a claim on the resources of others to have some need, desire, or want met.


we have decided that physicians must or should exercise forbearance when it comes to decisions about life-sustaining treatment does not, without more, warrant the conclusion that they must or should prescribe life-ending medication upon request.28

After all, if patients did have positive rights to health care, access to health care would not be such a problem.29 If citizens did
have a right to health care, we would be sorting out who gets what
treatment from the array of health care options society has decided
its members deserve, instead of watching the numbers of those
without access to care grow steadily, and hearing stories about
those who thought they were covered find that all they possess is
"virtual" access to care.\textsuperscript{30} It is, therefore, as incongruous for physi-
cian-assisted suicide's advocates to be asserting that Americans al-
ready have rights to health care as it is odd for them to be saying
that the first such right Americans want and need is the right to life-
ending medication.\textsuperscript{31} Not only is this an odd way of thinking about
health policy, it is an odd way of interpreting what patients are
saying.\textsuperscript{32}

That there is no such thing as a right to health care is equally

\footnotesize{for the proposition that there is no constitutional right to health care); see also INSTITU-
TUE OF MED., COMMITTEE ON MONITORING ACCESS TO PERSONAL HEALTH CARE SERVS., ACCESS TO HEALTH CARE IN AMERICA (Michael Millman ed., 1993). As one
advocate for the rights of patients succinctly puts it, "Is there a legal right to health care
1989).

30. Wendy K. Mariner, Liability for Managed Care Decisions: The Employment
Retirement Income Security Act (ERISA) and the Uneven Playing Field, 86 AM. J. PUB.
HEALTH 863 (1996) (discussing how ERISA enables health care plans to deny benefits
with relative impunity). It is difficult to know which is more worrisome, the medicaliza-
tion of death, or the corporatization of medicine. I find the prospect of their combined
impact to be quite disturbing. See Scofield, supra note 12. In each instance, however,
one observes a fairly radical shift in attitudes and beliefs. For example, we currently
accept the concept of managed care even though we know that

[\text{from a short-term financial standpoint—which we do not suggest is the only
standpoint that an HMO is likely to have—the HMO's incentive is to keep
you healthy if it can but if you get very sick, and are unlikely to recover to a
healthy state involving few medical expenses, to let you die as quickly and
cheaply as possible.}

Blue Cross & Blue Shield United v. Marshfield Clinic, 65 F.3d 1406, 1410 (7th Cir.
1995). The present acceptance of the corporatization of medicine is a far cry from the
law's earlier response. See Parker v. Board of Dental Exam'rs, 14 P.2d 67 (Cal. 1932).

31. There is at least some evidence suggesting that many Americans want and
need access to the sort of care that enables them to live better lives, and not simply to
have better deaths. See INSTITUTE OF MED., ALLIED HEALTH SERVICES: AVOIDING
CRISIS (1989); INSTITUTE OF MED., IMPROVING THE QUALITY OF CARE IN NURSING
HOMES (1986); INSTITUTE OF MED., THE SECOND FIFTY YEARS: PROMOTING HEALTH

32. In criticizing the move to legalize physician-assisted suicide, at least one phy-
sician has interpreted what patients are saying a bit differently:

Too many people have seen their friends and relatives endure needless suffer-
ing at the hands of their doctors. The best response we physicians can make to
the euthanasia movement is to provide better terminal care. We must reject
the technological imperative that compels us to use whatever treatments are
available, regardless of whether they are likely to offer our patients genuine
benefit. We should seek better forms of pain control and should not wait until
well demonstrated by the Lilliputian dispute about whether patients have a right to medically futile treatment, a debate that is connected to the physician-assisted suicide debate. If patients had a right to treatment, we would be arguing over whether that right to treatment does or should extend to the right to medically futile treatment. Instead, one of the arguments in favor of denying patients medically futile treatment is that they have no right to treatment in the first place.

No matter how one looks at it, patients lack positive rights when it comes to health care, which is why physician-assisted suicide's advocates have to pull a rabbit out of their metaphysical hat to concoct the notion that patients have a limited right to the sort of "treatment" that will end their lives, but not the sort of treatment that will better their lives. One has to wonder what patients would say if they were given the choice between a health care system that would give them a better life and one that would give them a faster death.

patients are moribund before referring them to a hospice. Above all, we must recognize that dying is a part of life . . . .


33. The literature on medical futility is almost as vast as the literature on physician-assisted suicide. See generally Lawrence J. Schneiderman & Nancy S. Jecker, Wrong Medicine: Doctors, Patients, and Futile Treatment (1995); Tom Tomlinson & Howard Brody, Futility and the Ethics of Resuscitation, 264 JAMA 1276 (1990).

34. See Scofield, Exposing Some Myths About Physician-Assisted Suicide, supra note 5, at 486 n.22.

35. See Keith Shiner, Note, Medical Futility: A Futile Concept?, 53 Wash. & Lee L. Rev. 803, 837-39 (1996) (noting the distinction between negative and positive rights); id. at 838 (observing that "[e]ven if autonomy implies a right of access to care, it may not provide a legal right to futile care.").

36. As the Ninth Circuit stated in Compassion in Dying:

No magician—not David Copperfield, not even Harry Houdini—can produce a rabbit from a hat unless the rabbit is in the hat to begin with. Moreover, if a hat does not contain such an animal, a magician cannot claim that anything he is able to produce from it is in fact a rabbit, no matter how sincere he may be or how great his forensic skills. All of this has something to do with basic physics.

. . . Maybe some of us . . . would like to see this rabbit in the hat because we believe it's a nice rabbit . . . but we do not get to change the Constitution any more than we get to change physics.


37. "[A]t a time when many millions of Americans lack adequate health care and Congress has refused to do much about it, 'it would be ironic if the judiciary selected physician-assisted suicide as the one health care right that deserves constitutional status.'" Yale Kamisar, Against Assisted Suicide—Even a Very Limited Form, 72 U. Det.
To overcome this difficulty, physician-assisted suicide's advocates perform a metaphysical sleight of hand, and add the abortion cases to the treatment refusal cases. In some respects, this is a more appealing formula, since it ties the notion that physicians may make end-of-life decisions to the perception that they can render positive assistance in order to terminate human life. Although appealing this formulation cannot withstand scrutiny either.

First, if the belief that a fetus is not a person is fundamental to Roe v. Wade's holding—that abortion is not murder—then unless we are willing to believe that the dying are not persons, Roe does not help us here. If it is not the nature of the human life, but the nature of the medical intervention that supports the argument, the matter remains just as problematic. Although physician-assisted suicide and abortion resemble each other, in that each results in the termination of a human life, they are not identical interventions.

Whereas physician-assisted suicide expedites what would happen if nature ran its course, abortion prevents nature from running its course. Crude though it may be to speak explicitly, dying patients die anyway, but pregnant women do not abort anyway. Unless they abort spontaneously, women give birth. However much physician-assisted suicide and abortion may seem to be the same, they could not be more different in terms of their impact on what would happen were nature's course not altered technologically.

To the extent that physician-assisted suicide expedites the naturally occurring process of dying, the most analogous intervention in the area of reproduction is the caesarean section. Having medi-

---

38. See Compassion in Dying, 85 F.3d at 1447 (Trott, J., dissenting) (“[P]ulling a nonexistent liberty interest out of thin constitutional air" amounts to “simply constitutional sleight of hand.”).
40. Interestingly, Tom Beauchamp and James Childress argue that the abortion cases protect a woman's right of privacy from state interference, while acknowledging that “[m]any people thought that the Court had concomitantly recognized a positive right in its early [abortion] decisions, namely a right to receive aid and assistance.” Beauchamp & Childress, supra note 27, at 73. If a negative is an individual's right to be let alone, it strains credibility to suggest that a woman's right to an abortion is a right to be let alone, since physician forbearance will not result in the termination of a pregnancy. It is more reasonable to argue that the Court stated that the states could not, through criminal prosecution, prevent women from exercising this right (i.e., from seeking medical assistance to terminate a pregnancy). Thereafter, the Court set limits on this positive right by holding that the government was not required to fund it. That the Court felt the need to contain this right lends further credence to the idea that the right is positive, not negative in nature.
calized how we come into the world, physicians now wish to medicalize how we leave it. Given the troubled history of caesarean sections, we ought to wonder whether physician-assisted suicide will be any better for all patients than caesarean sections have been for women, or whether it will simply free patients of the difficulties nature creates in order for them to face the difficulties that technology creates. If so, medicalizing death may turn out to be as poor an idea as medicalizing birth has become.

Finally, there is at least one fundamental and undeniable difference between abortion and physician-assisted suicide. It is possible to avoid pregnancy, but impossible to avoid mortality. Some of us are fertile and can become pregnant; each of us is born mortal and will die. Pregnancy is a temporarily and voluntarily (one hopes) acquired condition; mortality is a lifelong condition that is thrust upon us. Through contraception, sterilization, and abstinence, one can reasonably hope to avoid pregnancy; there is no prophylaxis for death. One can no more prevent death from occurring than one can abstain from being mortal. In fact, the only way to avoid the unwanted condition of being mortal is to never have been born alive. Thus, whatever physician-assisted suicide may be, it is neither prophylactic nor curative relief to the physical condition of being mortal. This means that it can only be some kind of therapeutic response to the psychological state of mind created by the knowledge that we are mortal. If we could and would examine

41. Thus, a recent suggestion to improve the care of dying patients takes the "systems" approach, arguing that medicine needs to restructure its approach to the dying process as it already has to the process of childbirth. See Franklin G. Miller & Joseph J. Fins, A Proposal to Restructure Hospital Care for Dying Patients, 334 NEW ENG. J. MED. 1740 (1996).


44. See Daniel Callahan, The Troubled Dream of Life: Living with Mortality (1993). As Dr. Callahan eloquently observes:

The care of the dying has remained a kind of open moral wound in our health care system, bedeviling us for decades now, full of hopeful initiatives that do not quite work out, court cases that only give way to further cases, and moral
why we are so troubled by mortality\textsuperscript{45} we would be better situated
to assess whether legalizing killing is a reasonable and prudent re-
response to being mortal. For now, such an examination seems be-
yond us.\textsuperscript{46}

How incongruous it is to combine the treatment refusal and the abortion cases becomes clearer if we examine the limitations that physician-assisted suicide's advocates are willing to place on their “new” (and not-so-new) right-to-die. For one thing, they expect to limit this right to competent, terminally ill, adults. Whether the right to physician-assisted suicide owes its origins to the right to refuse treatment or to the right to an abortion, there is little reason to believe that this position can or will withstand legal scrutiny. As the right to refuse treatment extends to the incompetent, the chronically ill, and to mature and emancipated minors,\textsuperscript{47} this new right to die may not be limited although its advocates wish it so. And because the right to refuse treatment and the right to undergo an abortion also extend to the mentally retarded and the mentally dis-
able,\textsuperscript{48} it is difficult to see how the state can be successful at categ-
lorically denying incompetent patients the legalized right to physician-assisted suicide that competent patients would enjoy.

Similarly, to the extent that waiting periods and second opin-
ions can and have been successfully challenged in the abortion con-
text as substantial obstacles that impose an undue burden on an individual’s right to choose, one must assume that they can and will

\begin{quote}
solutions that seem to require still further moral solutions to clear up the problems created by the earlier ones.
\end{quote}

Cultures that live by the values of self-realization and self-mastery are not especially good at dying, at submitting to those experiences where freedom ends and biological fate begins. . . . Their strong side is Promethean ambition: the defiance and transcendence of fate . . . . Their weak side is submitting to the inevitable.


\textsuperscript{45} See Bauman, \textit{supra} note 12, at 129-60.

\textsuperscript{46} See Scofield, \textit{supra} note 12, passim.


be in the physician-assisted suicide context as well. Yet, physician-assisted suicide’s advocates seem willing to write into their legislation the very sort of restrictions that right-to-die and abortion advocates traditionally have opposed, adding one more contradiction to the already noted contradictions that surround this movement.

That physician-assisted suicide’s advocates must commit so many contradictions, and resort to such odd twists and turns in the course of arguing that physician-assisted suicide naturally and logically “fits” into the values that underlie how we live and die, suggests that the fit is both contrived and forced. I now wish to develop more fully the notion that the fit may not be nearly as good as physician-assisted suicide’s advocates would have us believe.

There are several ways to demonstrate that physician-assisted suicide does violence to traditional notions about the prohibition against the wrongful taking of a human life. We could, for instance, compare and contrast decisions to forgo life-sustaining treatment and decisions about physician-assisted suicide, in terms of classic notions of actus reus, mens rea, cause in fact, and proximate cause. Through such analysis, we would see that the courts are trying to integrate life-sustaining technology into society in order to reconcile decisions about using and not using such technology with traditional concepts of wrongful taking of human life, while at the


same time preserving those concepts for use in instances where treatment is wrongfully terminated or the conduct in question is a form of homicide as traditionally defined.\footnote{51} Admittedly, this opens the door to difficult questions of causation for both criminal\footnote{52} and civil\footnote{53} cases. While a fine distinction separates letting someone die from killing them,\footnote{54} the distinction does exist.\footnote{55}

forced the courts to determine whether the conviction for an attempted murder precludes a subsequent prosecution for murder if and when the victim's life is saved, but the victim later dies for reasons having to do with the permanent nature of the wounds suffered in the original assault. See People v. Harding, 506 N.W.2d 482 (Mich. 1993).

It is precisely because medical technology alters the natural timing of events, and places the timing of death somewhat within the discretion of human judgment that the question of whether someone has died at the right time, as well as for the right reasons and in the right manner, is central to decisions at the end of life. See Sandra Segal Ikuta, Dying at the Right Time: A Critical Legal Theory Approach to Timing-of-Death Issues, 5 Issues L. & Med. 3 (1989). That we are allowed to “hasten” some deaths does not mean that we may hasten death in any manner or for any reasons we can imagine.


54. Professor Glanville Williams notes that a physician who furnishes poison (such as sleeping pills) for the purpose of enabling a patient to commit suicide is technically guilty of abetting a murder. See Glanville Williams, The Sanctity of Life and the Criminal Law 319-20 (1957). Professor Williams does not deny that such conduct runs contrary to the criminal law, but argues that it should not do so. Even his proposal would not decriminalize assisted suicide, but would create a defense to this crime where none currently exists. See id. at 339-46. The mere fact that a change in the law must occur in order to accommodate physician-assisted suicide stands in stark contrast to the ability of the courts to integrate decisions to forgo life-sustaining treatment into existing criminal and tort law concerns without having to re-write the law at all.

55. See Will Cartwright, Killing and Letting Die: A Defensible Distinction, 52 Brit. Med. Bull. 354 (1996). Although decisions to forgo treatment seem to resemble physician-assisted suicide when one gets into decisions to forgo ventilator support, when drugs are used to prevent agonal breathing, a resemblance is not an identity. Most anesthesiologists can attest to the fact that an acknowledged, acceptable side effect is not the same as intended direct effect. See Lawrence J. Schneiderman & Roger G. Spragg, Ethical Decisions in Discontinuing Mechanical Ventilation, 318 New Eng. J. Med. 984 (1988); Robyn S. Shapiro, Liability Issues in the Management of Pain, 9 J.
Instead of simply arguing, as critics of the Ninth and Second Circuit decisions have done, that there is a genuine legal or factual distinction between the resultant death when one forgoes life-sustaining treatment and the death caused by physician-assisted suicide, I intend to ask whether the conclusion they have drawn withstands scrutiny once one moves beyond the limited framework within which the courts elected to analyze the question. Even if it may be true that knowing how and of what someone has died is inconsequential from the constitutional perspective, there is a body of case-law that regards it as legally and factually important.

The overwhelming majority of those cases come from death benefits litigation. A vast body of case law, dealing with testamentary claims, life insurance, mortgage and homeowners insur-

---

PAIN & SYMPTOM MGMT. 146 (1994); William C. Wilson et al., Ordering and Administration of Sedatives and Analgesics During the Withholding and Withdrawal of Life Support from Critically Ill Patients, 267 JAMA 949 (1992); see also Robert D. Truog & Charles B. Berde, Pain, Euthanasia, and Anesthesiologists, 78 ANESTHESIOLOGY 353 (1993) (suggesting that anesthesiologists may be asked to consult on cases if physician-assisted suicide is legalized). But see Albert R. Jonsen, To Help the Dying Die—A New Duty for Anesthesiologists?, 78 ANESTHESIOLOGY 225 (1993) (arguing that such a role lies beyond the proper practice of anesthesiology). There is a difference between using analgesics in a manner that is careful, careless, or reckless in light of the risk involved, and using analgesics with the intention of bringing about the consequence of death. See Karen L. Posner et al., Professional Liability, Risk Management, and Quality Improvement, in CLINICAL ANESTHESIA 93-100 (Paul G. Barash et al. eds., 3d ed. 1997); Norman L. Cantor & George C. Thomas, III, Pain Relief, Acceleration of Death, and Criminal Law, 6 KENNEDY INST. ETHICS J. 102 (1996). Risking death is one thing; intending death is something else.

Are we to believe that in order to prevent undue killing, we must stop attending to undue suffering? That is to say, in order to eliminate the possibility that analgesics hasten death when used to prevent agonal breathing, are we to cease using them altogether and require patients who wish to forgo ventilation to do so knowing full well that they will have to experience suffocation?


insurance,\(^6\) insurance taken out on the lives of animals,\(^6\) and other areas of the law,\(^6\) turns on knowing precisely what caused death and the decedent’s state of mind at the time of death. The fact that the courts apply the law to the facts of these cases suggests that the legal distinctions do matter, and that they can, may, should, and must be made. The fact that a good many of these cases are tried, or remanded for trial when summary judgment has been improvidently granted, suggests that the factual determinations do matter, and that they can, may, should, and must be made.

By saying that these types of subtle distinctions make no difference, the Second and the Ninth Circuits have either ignored or *sub silentio* overturned a large body of well accepted law.\(^6\) The belief that death by drug overdose is the same as death by natural means is not universally shared.\(^6\) Nor do courts agree that it is unimpov-


\(^{64}\) See, e.g., State v. Ruane, 912 S.W.2d 766 (Tenn. Crim. App. 1995). For example, in *People v. Velez*, 602 N.Y.S.2d 758 (N.Y. Sup. Ct. 1993), the court ruled that a patient’s voluntary decision to forgo nourishment did not warrant dismissal of murder charges against the defendant, because what made the patient dependent on artificial nourishment was the gunshot wound inflicted by the defendant. See also *People v. Vaughan*, 579 N.Y.S.2d 839 (N.Y. Sup. Ct. 1991).

tant to decide, when, how, and what caused the decedent's death. Simply put, motives and means do matter when the end result is death.

Because the Second and Ninth Circuits do not seem to have

---


67. See Donaldson v. Lundgren, 4 Cal. Rptr. 2d 59 (Cal. Ct. App. 1992) (holding that patient with fatal brain tumor has no right to be cryogenically suspended until such time as a cure can be found). The court in Donaldson stated that:

It is one thing to take one's own life [or to forego life-sustaining treatment], but quite another to allow a third person assisting in that suicide to be immune from investigation by the coroner or law enforcement agencies.

... In the case of assisted suicides ... the state has an important interest to ensure that people are not influenced to kill themselves. The state's interest must prevail over the individual because of the difficulty, if not the impossibility, of evaluating the motives of the assister or determining the presence of undue influence.

Id. at 63-64.

The issue of undue influence assumes that there is an amount of influence that is or would be acceptable. There is little reason to believe that any amount of influence would be acceptable, considerable reason to believe that it would not be, and every reason to believe that it is impossible to prevent patients from being influenced in reaching these decisions. In the context of decisions about genetic counseling, regard for the patient's moral autonomy and respect for the dark history of eugenics has led genetic counselors to prefer non-directive to directive counseling, so as to avoid any possibility of influencing the patient's decision. See INSTITUTE OF MEDICINE, ASSESSING GENETIC RISKS: IMPLICATIONS FOR HEALTH AND SOCIAL POLICY 151-57 (1994). Notwithstanding this approach, there is considerable reason to believe that it is not possible to be non-directive. See Angus Clarke, Is Non-Directive Genetic Counselling Possible?, 338 LANCET 998 (1991) (stating that non-directive counselling is a sham because of the structure of the counsellor-client encounter). But see Richard Wachbroit & David Wasserman, Patient Autonomy and Value—Neutrality in Non-Directive Genetic Counseling, 6 STAN. L. & POL'y REV. 103 (1995) (stating that value neutrality is neither desirable nor possible, but non-directiveness is possible). Presumably we can all agree that physician-assisted suicide also has a dark history and that it should not be provided under circumstances that risk compromising a patient's moral autonomy. Given that physician values can and still do dominate end-of-life decision-making, see infra notes 72-96 and accompanying text, and the belief of two advocates of physician-assisted suicide that physicians generally should influence the informed consent process, see Timothy E. Quill & Howard Brody, Physician Recommendations and Patient Autonomy: Finding a Balance Between Physician Power and Patient Choice, 125 ANN. INTERNAL MED. 763 (1996), there is every reason to believe that physicians may unduly influence decisions about physician-assisted suicide. See Ann Alpers & Bernard Lo, Physician-Assisted Suicide in Oregon: A Bold Experiment, 274 JAMA 483 (1995).
intended to overturn this case law, they have created a unique test for determining the cause of death in physician-assisted suicide cases, and another test for all other instances. These courts are simply refashioning the rules for determining what it means to cause death, as a matter of law, if not as a matter of fact.


69. "The opinions of the Second and Ninth Circuit Courts and the language of the Oregon statute indicate that the drafters were reformulating the categories of permitted and prohibited aid in dying to create a better proxy for the distinction between morally justified and morally unjustified cases of hastening death." David Orentlicher, The Legal­ization of Physician-Assisted Suicide 335 N. ENG. J. MED. 663, 666 (1996); see also Beauchamp, supra note 27, at 1182-85. In a discussion that conflates cause-in-fact with proximate cause, Professor Beauchamp states the matter succinctly: "[V]alue judgments about justified and unjustified actions, rather than factual judgments, control judgments about what constitutes 'killing' and how it differs from letting die; causal judgments do not determine what constitutes killing and letting die. 'Killing' thus functions more as an evaluative category than a causal category." Id. at 1183 (footnotes omitted). To support this position, Professor Beauchamp simply refers to two works: H.L.A. Hart & A.M. Honore, CAUSATION IN THE LAW (1959), and Samuel Gorovitz, Causal Judg­ments and Causal Explanations, 62 J. PHIL. 695 (1965). See Beauchamp, supra note 27, at 1183 n.37. In so doing, Professor Beauchamp truncates the analysis.

While it is true that causal judgments and causal explanations can and do reflect evaluative considerations, that is not all that these explanations include. See H.L.A. Hart & Tony Honore, CAUSATION IN THE LAW 62-68 (2d ed. 1985). Before reaching the question of whether one ought to be held responsible for the death of another, one ordinarily must determine whether one can be held responsible for the death of another. If the facts are such that one cannot be said to have caused another's death, it ordinarily makes little sense to be saying that one should not be blamed for a death one did not cause.

This being the case, Professor Beauchamp's argument makes sense only if one assumes or concludes that the conduct comprehended under the phrase "physician-assisted suicide" can be said to have been a cause-in-fact of another's death because it satisfies the "but for" or the "substantial factor" tests used for deciding whether the defendant's conduct resulted in the decedent's death. See Wayne R. LaFave & Austin W. Scott, Jr., CRIMINAL LAW 277-301 (2d ed. 1986). Only when the trier of fact has determined that the defendant's conduct had the effect of shortening the decedent's life, see id. at 279-81, may the evaluative considerations of proximate cause (i.e., of whether what was the cause of death ought or ought not be regarded as such) come into play. See id. at 281-83. Even Professors Hart and Honore agree with this. See Hart & Honore, supra, at 239-40.

Traditionally, the law has taken the view that it is possible for someone to kill a dying person. "A person is liable for a homicide in accelerating the death of another whose death would necessarily have soon occurred from an existing incurable disease, and the degree of the homicide is not changed by the presence and effect of such disease." 1 Oscar Leroy Warren & Basil Michael Bilas, Warren on Homicide § 59, at 176 (perm. ed. 1938) (footnotes omitted). Under the Model Penal Code, it remains possible for one to be said to have caused the death of another through the
To create a situation in which murder means one thing for the purposes of physician-assisted suicide and something else for all other purposes is as credible, and is likely to be about as enduring, as the personhood solution was in the context of abortion. Eventually, this solution will be exposed as a subterfuge, when it returns to haunt the courts in the context of death benefits litigation; where the courts will have to explain why the rules about causing death work one way when the question is whether a physician should go to jail, but another way when the question is whether a survivor may recover death benefits. Therein lies the problem. While decisions to forgo life-sustaining treatment routinely do not create difficulties when it comes to collecting death benefits, decisions to use physician-assisted suicide routinely will. However the courts ultimately decide to treat this matter, the fact that they must address it means that the credibility of the solution arrived at by the Ninth and the Second Circuits will be tarnished.

conduct associated with assisting a suicide. See I American Law Inst., Model Penal Code and Commentaries § 2.03 (1985); II American Law Inst., Model Penal Code and Commentaries § 210.5 (1985). Even Glanville Williams, in arguing that euthanasia and assisted suicide ought to be condoned under the doctrine of legal necessity, neither denies that the chain of physical causation is absent nor asserts that what counts as killing is simply a matter of evaluation. See Williams, supra note 54, at 318-26. Indeed, by arguing that necessity may be a proper defense to the charge of murder, Professor Williams admits that the elements of the charge of murder have been made out, since, as any law student knows, one does not and need not raise and prove a defense until the prosecution has met its initial burden of proof. See id. at 318-20.

Similarly, the courts have, to some extent, struggled with these causation issues in those cases where a defendant who has mortally wounded an individual contends that the subsequent decision to forgo treatment is an intervening, superseding cause that eliminates his liability for the decedent's demise. See United States v. Hamilton, 182 F. Supp. 548, 550 (D.D.C. 1960); People v. Velez, 602 N.Y.S.2d 758, 760 (N.Y. Sup. Ct. 1993); State v. Ruane, 912 S.W.2d 766, 774-75 (Tenn. Crim. App. 1995). Thus, what Professor Beauchamp seems to be arguing for is the contention that, as a matter of law, the physician's conduct is not and may not be regarded as the cause of death, even though the trier of fact might and could determine that the physician's conduct, as a matter of fact, was the cause of death. In short, Professor Beauchamp wishes to insulate physicians from being scrutinized by juries and immunize them from being scrutinized by prosecutors (i.e., place physicians above the law in a manner that others who engaged in the same conduct would not be). See Beauchamp, supra note 27, at 1182-85.


71. Although this is a prediction, it's not a "hunch." It is based on the cases referred to supra, notes 56-69, and on the fact that the model statute states that a patient's decision to "use medical means of suicide to end such a patient's life in compliance with the applicable provisions of this Act shall not be considered suicide for the purpose of voiding a policy on insurance on the life of such a patient." This section, in the authors' minds, "protects patients from discrimination (including the voiding of life insurance policies) because they have chosen to pursue assisted suicide." Baron et al., supra note 23, at 23, 32.
Thus, the Second and the Ninth Circuits have done nothing other than create a sort of legal time bomb: a subterfuge that one day will go off in some court's face, when it has to explain why an act that seemed inconsequential from the constitutional or criminal law perspective nonetheless has significant consequences from the insurance law perspective. At that point the court will either have to overturn the insurance case law that the Second and Ninth Circuits have ignored—a result not likely to be accepted by the insurance industry—or determine that causing death means one thing for some purposes, and something else for other purposes, a distinction likely to be lost on just about everyone. This is what comes of trying to fit a round peg into a square hole; of invoking a subterfuge in order to make the world seem as some think it ought to be. For our purposes, this result is enough to suggest that the move to legalize physician-assisted suicide is not and cannot be what it purports to be, a natural fit into all that has come before.

II. PHYSICIAN-ASSISTED SUICIDE IS SOMETHING THAT IT CLAIMS NOT TO BE

The popular perception is that physician-assisted suicide is the final stage of the patients' rights movement, the ultimate empowerment of patients, fulfilling their dream of controlling death by giving them the fullest possible power to determine where, how, and when they die. The illusion that patients have been empowered by the patients' rights movement masks a quite different reality: that physicians continue to dominate end-of-life decision-making. For one thing, the authors of the model act have cited no authority whatsoever to support the proposition that this section of their statute has support in any case law. For another, the question of survivors' benefits extends beyond the obvious, important, but limited realm of life insurance. The authors, for example, do not address the question of how a state statute may govern determinations made under federal statutes. See Johnson v. Peabody Coal Co., 26 F.3d 618 (6th Cir. 1994). Unless the authors of this model statute persuade Congress to enact it, then it is unlikely that a statute passed by the states will be read to govern the determination of federal benefits.

72. See David Orentlicher, The Illusion of Patient Choice in End-of-Life Decisions, 267 JAMA 2101 (1992); see also Henry J. Silverman, How Decisive are Physician Values in End-of-Life Decision-Making?, 24 CRITICAL CARE MED. 909 (1996) (stating that studies indicate that physician values may dominate end-of-life decisions); Mildred Z. Solomon et al., Decisions Near the End of Life: Professional Views on Life-Sustaining Technology, 83 AM. J. PUB. HEALTH 14 (1993) (providing a survey of over 1,400 doctors and nurses showing that they are not aware of, but may be in agreement with, national recommendations regarding end-of-life patients' rights).
their wishes honored, there is no doubt that the medical profession’s inability and unwillingness to cede or share decision-making authority in matters of life and death remains an obstacle to respecting the autonomy of patients.73

To the extent that physicians refuse to cede or share authority in end-of-life decision-making, one cannot rule out the possibility that physician values can and will dominate decisions about physician-assisted suicide.74 That the illusion of patient choice masks the reality of physician domination is consistent with the observation that physicians exploit the belief that they have some power over death.75

Medicine’s perception of death, and its interpretation of what mortality means, contributes significantly to the confused state in which we now find ourselves. While death is medicine’s friend, to the extent that physicians can exploit others’ fear of death to their own advantage, death is also medicine’s enemy.76 If, when death

73. “Physician reluctance to cede decision-making authority in end-of-life decisions is not unexpected. If patient autonomy [were] taken seriously, the impact [would] extend[] far beyond the right to refuse life-sustaining treatment. . . . [R]ecognition of patient autonomy can be perceived as threatening to traditional concepts of medical decision-making.” Orentlicher, supra note 72, at 2103 (endnotes omitted).

74. “[M]oves toward acceptance of assisted suicide or euthanasia should be tempered by the possibility that physician values may prevail in these decisions. One of the greatest concerns about permitting assisted suicide or euthanasia is that lives may be ended without the truly voluntary participation of patients.” Orentlicher, supra note 72, at 2104. Given the difficulties that medical professionals—especially physicians—have encountered in achieving the goal of non-directiveness in genetic counseling, there is little reason to believe that they will be any more successful here.

Indeed, even if it were possible for physicians to discuss physician-assisted suicide with patients without unduly influencing the decision-making process, the context within which patients make such decisions may be sufficiently coercive to prohibit the exercise of free choice. “[M]any persons who suffer greatly with conditions likely to end in death are abandoned by our health care system, left to suffer without recourse. Demands for legitimation of being killed may well reflect the coercion of the abandonment rather than any semblance of free choice.” Greg A. Sachs et al., Good Care of Dying Patients: The Alternative to Physician-Assisted Suicide and Euthanasia, 43 J. AM. GERIATRICS SOC’Y 553, 554 (1995).


76. According to George Annas, “Lewis Thomas has noted that doctors ‘are as frightened and bewildered by the act of death as everyone else.’ ‘Death is shocking, dismaying, even terrifying,’ Thomas has written. ‘A dying patient is a kind of freak[,] . . . an offense against nature itself.’” George J. Annas, Physician-Assisted Suicide—Michigan’s Temporary Solution, 328 NEW ENG. J. MED. 1573, 1573 (1993) (footnotes omitted) (quoting Lewis Thomas, Dying as Failure, 447 ANNALS AM. ACAD. POL &
wins, medicine fails, then for so long as death never appears to have


A telling example of the ingrained nature of this view of death is found in physician discussions of music. For example, two physicians have used Mahler's Ninth Symphony, as a vehicle for talking about death. To one, the piece at first seems to evoke "an open acknowledgment of death and at the same time a quiet celebration of the tranquility connected to the process [of dying]." Lewis Thomas, Late Night Thoughts on Listening to Mahler's Ninth Symphony 164 (1984). This view then yields to the sense that the symphony evokes the image of "death everywhere, the dying of everything, the end of humanity." Id. at 165. Another physician hears "a swirling maelstrom of discord and destruction, of violence and despair," as the music brings one "face to face with a menacing figure whose shadowy features [are] distorted by a hatred and loathing that [are] directed solely at me." Dan Gehlbach, Message from Mahler, 261 JAMA 104, 104 (1989).

If one believes, as these physicians evidently do, that music is a form of knowledge, see Lawrence Kramer, Classical Music and Postmodern Knowledge 1-32 (1995), at least in the sense that composers say something about the world from which others can derive meaning, see generally Jean-Jacques Nattiez, Music and Discourse: Toward a Semiology of Music (Carolyn Abbate trans. 1990), it may be worth pursuing this theme a bit further to examine what it reveals about physicians, dying, and killing.

No one disputes that Mahler's Ninth Symphony reflects his concern about mortality, with which he was obsessed, especially as he approached his own death. See Derick Cooke, Gustav Mahler: An Introduction to His Music 3-18, 114-18 (2d ed. 1988); Paul Griffiths, Modern Music 15-17 (rev. ed. 1994). Mahler's Tenth Symphony, however, indicates that he moved on from the despair found in the Ninth to an acceptance of death, indicating that the sentiments expressed in the Ninth were but a phase in the development of his outlook on death. Cooke, supra, at 118-21. Thus, what is interesting is that Mahler moved on, but evidently medicine has not.

In a debate where words seem to have lost all meaning, perhaps music can enable us to appreciate the difference between dying and killing; between what it means to accept death and what it means to try to conquer death. That can be done by comparing two works, Mahler's Tenth Symphony, in which he moves to an acceptance of death, and Arnold Schoenberg's, A Survivor from Warsaw, in which he says something about the most infamous instance of legalized killing in this century. See Arnold Schoenberg, A Survivor from Warsaw (rev. ed. 1979). The Adagio in Mahler's Tenth Symphony develops to a chord that has been described as an "atonal chasm," Griffiths, supra, at 25, a "terrifying dissonance," Cooke, supra, at 121, and as "the most dissonant chord in all Mahler," Jeremy Noble, Adagio from the Symphony No. 10, found in inside cover, Gustav Mahler, Symphonie No. 8, Symphonie No. 10-Adagio, at 13 (PolyGram Records 1991). "Adagio from the Symphony No. 10," in Gustav Mahler, Symphonie No. 8/Symphonie No. 10—Adagio 13 (1991), reflecting the discord that death creates in life, a discord that is harmoniously and quite peacefully resolved as the Adagio concludes. Compare Mahler's treatment of dying, see Paul Griffiths, Modern Music and After: Directions Since 1945, at 52-53 (1995), with Schoenberg's treatment of killing, see Schoenberg, supra. In A Survivor from Warsaw, Schoenberg "express[es] an entire culture's outrage at Nazi brutality." Umberto Eco, The Open Work 143 (1989). "[T]he effect of A Survivor is unprecedented. In the whole history of music, there can be nothing to match the overwhelming, almost
won, medicine will not have appeared to have failed. It's that simple. These beliefs lead to the death-defying ethos that has come to dominate American medicine.

For example, Professors Renée Fox and Judith Swazey have described the value system that is prevalent among organ transplantation and artificial organ "pioneers" as follows:

This ethos includes a classically American frontier outlook: heroic, pioneering, adventurous, optimistic, and determined. But it also involves a bellicose, 'death is the enemy' perspective; a rescue-oriented and often zealous determination to maintain life at any cost; and a relentless, hubris-ridden refusal to accept limits. It is disturbing to witness, over and over, the travail and distress to which this outlook can subject patients . . . 77

If only physicians held this view, we might believe that they somehow had simply taken over and oriented our health care system towards one goal: conquering death. As Professors Fox and Swazey observed in an earlier work, the attitudes physicians hold about death are reinforced by broader societal attitudes about death.

This orientation is further strengthened by the general cultural disposition to actively delay or prevent death whenever possible, and by the correlative extent to which the physician's obligation to maintain life usually comes to prevail over his responsibility to

____


Assuming that Mahler and Schoenberg are trying to say something, what might that be? One plausible interpretation of the Mahler piece would be that death, terrifying disruption though it is, can be accepted and harmonized into the world. One plausible interpretation of the Schoenberg piece would be that killing disrupts the world in a manner that cannot lead to a peaceful or harmonious resolution. Odd though it may seem to suggest, I recommend to anyone who doubts that there is much difference between dying and killing to give these works a listen.

I realize, of course, that some will take umbrage at the suggestion that a piece of music written to express outrage at Nazi brutality has something to say about physician-assisted suicide. There is some sense that health care professionals ought to heed the lessons of Nazi Germany. See Victor W. Sidel, The Social Responsibilities of Health Professionals: Lessons from their Role in Nazi Germany, 276 JAMA 1679 (1996), a view with which I concur. See Scofield, supra, note 12, at 381-88.

77. RENEE C. FOX & JUDITH P. SWAZEY, LEAVING THE FIELD, HASTINGS CTR. REP., Sept.-Oct. 1992, at 9, 10 (emphasis added); see also RENEE C. FOX & JUDITH SWAZEY, SPARE PARTS: ORGAN REPLACEMENT IN AMERICAN SOCIETY 155 (1992) ("[T]he personalities . . . of the chief physicians and patients involved in . . . experiments were imbued with evocative 'American story' qualities.").
ease death.\textsuperscript{78}

taken together, ours is a society that struggles against mortality, unable and unwilling to accept the fact that human limitations do exist.\textsuperscript{79} Because integrating death into life presents a struggle to all societies,\textsuperscript{80} what matters is the particular nature of our response to the knowledge that we are mortal.

Given our need to believe that we are the masters of our fate, the arbiters of our destiny, we seem to be responding as one would expect, in ways that are consistent with the belief that we control death, and that death does not control us.\textsuperscript{81} Simply put, when it comes to death, we will call the shots. Because this perspective dominates our view of death, physicians and patients become natural allies in a war against death,\textsuperscript{82} an alliance whose basic rationale

\begin{itemize}
  \item \textsuperscript{78} Renée C. Fox & Judith P. Swazey, The Courage to Fail: A Social View of Organ Transplants and Dialysis 379 (1978).
  \item \textsuperscript{79} See Philippe Aries, The Hour of Our Death (Helene Weaver trans., 1981); John McManners, Death and the Enlightenment (1981). Americans' resistance against death is a cultural curiosity.
  \item \textsuperscript{80} Foreign medical visitors to our country have long spoken with amusement of the apparent belief of many Americans that death is just one more disease to be conquered, a tenacious but not invincible foe.
  \item \textsuperscript{81} To the extent that patient autonomy is conceived of primarily or exclusively as the exercise of freedom in the form of control, and given moral pluralism as to the normative content of this control, patient autonomy can be claimed to include the choice of killing oneself as just another treatment to which subjects who are suffering in their dying can give their informed consent.

  \item \textsuperscript{82} As Dr. Callahan writes: The idea of a managed death[ ] catch[es] perfectly the American spirit

\begin{itemize}
  \item \textsuperscript{78} James F. Breshnan, Contemporary Art of Dying, Encyclopedia of Bioethics 551, 553 (1995).
  \item \textsuperscript{82} As Dr. Callahan writes: The idea of a managed death[ ] catch[es] perfectly the American spirit
seems to be "the enemy of my enemy is my friend." That physicians
and patients are allies does not necessarily mean, however, that
their agendas are identical. Therein lies the ultimate truth about
what motivates the trend to legalize physician-assisted suicide.

Fighting death requires practice, research, and resources to im-
plement and refine the technological weaponry used to stave off
death. In medicine's war on death, no weapons combine more
technical and symbolic power than do cardio-pulmonary cerebral
resuscitation (CPR) and solid organ transplantation, without which
many of medicine's miracles would be impossible. Transplanta-
tion, among other things, requires an adequate supply of organs;
CPR requires practice and research. The problem is that procuring
organs, practicing CPR, and engaging in resuscitation research re-
quire consent, because, technically speaking, one may not remove
an organ from, practice resuscitation on, or conduct research on
human beings without their consent.

The medical profession has been remarkably and successfully
creative in manipulating consent in a manner that enables it to
wage war on death by using humans as a means to that end. In
order to make it easier to teach physicians how to intubate patients,
for example, the medical profession presumes that recently de-
ceased individuals consent to be used in this manner unless they
have explicitly stated their refusal. In order to engage in resusci-
tant's control, beautifully orchestrated to allow a final flourishing of familial
love and reconciliation leave-taking. . . . Nature does not . . . provide us with
an acceptable 'natural' death. [Natural death] does not measure up to the
highest standards of accommodation to our proclaimed right of self-determi-
nation or our penchant for dominating control. Thus, it must be tidied up, and
how better to manage that than through physician-assisted suicide?

Callahan, supra note 44, at 227 (endnotes omitted).

83. See Kathleen Nolan, In Death's Shadow: The Meanings of Withholding Resus-
84. See AMERICAN HEART ASS'N, TEXTBOOK OF ADVANCED CARDIAC LIFE SUP-
port (Richard O. Cummins ed., 3d ed. 1994); FOX & SWAZEY, SPARE PARTS, supra
note 77; PETER SAFAR & NICHOLAS G. BIRCHER, CARDIOPULMONARY CEREBRAL
RESUSCITATION (3d ed. 1988); James T. Niemann, Cardiopulmonary Resuscitation, 327
85. See generally Jay Katz, The Nuremberg Code and the Nuremberg Trial: A
86. See Scofield, supra note 12, 376-81.
87. See D. Gary Benfield et al., Teaching Intubation Skills Using Newly Deceased
Infants, 265 JAMA 2360 (1991); Kenneth V. Iserson, Law Versus Life: The Ethical Im-
perative to Practice and Teach Using the Newly Dead Emergency Department Patient, 25
ANNALS EMERGENCY MED. 91 (1995); James P. Orlowski et al., The Ethics of Using
Newly Dead Patients for Teaching and Practicing Intubation Techniques, 319 NEW ENG.
J. MED. 439 (1988); see also A.D. Goldblatt, Don't Ask, Don't Tell: Practicing Mini-
tation research, the medical research community has persuaded the Food and Drug Administration and the National Institutes of Health to issue regulations under which consent may be waived. Finally, increased pressure to supply more solid organs for transplantation has led to practices that allow solid organs to be obtained from non-heart-beating cadavers, and to proposals to modify the rules of informed consent so that consent facilitates,

---


rather than inhibits, the procurement of solid organs for transplantation.91

In addition to doing what it needs to do in order to combat death, the medical profession also needs to preserve the illusion that it has mastered death. To do that, the medical profession resists the open acknowledgement that its power over death is mythic.92 But it also promotes patient participation and upholds the otherwise intrusive principle of patient autonomy when doing so is consistent with sustaining the illusion that medicine can in fact do something about death. This explains how and why physicians resist allowing patients to participate in decisions about treatment that is medically futile, but welcome patient participation in the move to legalize physician-assisted suicide. Although each trend purports to be about respecting patients, each is about one thing and one thing only: preserving medicine's power by conferring legal immunity on physicians for conduct that hastens the death of human beings.93 Thus, the medical profession is simply medicalizing death under the pretext of democratizing it, dressing up as a victory for patients what is simply a victory for doctors.94

While the legalization of physician-assisted suicide clearly empowers physicians, it hardly empowers patients. To the extent that


It is clear that those involved in procuring organs do not always follow the niceties of consent. See Brotherton v. Cleveland, 923 F.2d 477 (6th Cir. 1991); Perry v. Saint Francis Hosp. & Med. Ctr., Inc., 886 F. Supp. 1551 (D. Kan. 1995). In one instance, a patient was sufficiently dead for physicians to ask for permission to salvage his organs, but insufficiently dead for them to honor the parents' request that he be released for burial. See Strachan v. J.F.K. Mem'l Hosp., 538 A.2d 346 (N.J. 1988).


93. See Sandra H. Johnson, Setting Limits on Death: A View from the United States, 5 CAMBRIDGE Q. HEALTHCARE ETHICS 24, 26 (1996) (“The movement to legalize assistance in suicide in the United States is properly seen as a movement to provide legal immunity to physicians engaging in the practice.”).

94. See Scofield, Exposing Some Myths About Physician-Assisted Suicide, supra note 5, at 484-86; Scofield, supra note 12.
it enables and allows physicians to continue to exploit their power over death, the legalization of physician-assisted suicide simply introduces us to a new game, albeit, a deadlier one, played according to the same rules. Patients will need a physician's permission to procure legally endorsed assisted suicide; and physicians can use their discretionary power to decide for whom they will and for whom they will not write a prescription. Patients have the power to ask, physicians the power to grant or deny that request; new game, same rules.

That doctors are the clear winners is further demonstrated by the fact that what is at issue is physician-assisted suicide. If immunity from legal liability for what would otherwise be murder is not the greatest power that the law can confer, I don't know what is. Certainly, if someone other than a physician were to engage in the same conduct, he or she would be subjected to prosecution and unable to raise the defense of legal immunity.95

For these reasons, it is difficult to see how the legalization of physician-assisted suicide empowers patients.96 Not only may patients avail themselves of this option only if they can get a note from their doctor, they can take advantage of it only if they are willing to risk jeopardizing whatever insurance benefits might go to their survivors. Therefore, legalization of physician-assisted suicide will leave doctors as well off as they are now, and make patients worse off than they have ever been.

III. WHAT PHYSICIAN-ASSISTED SUICIDE CAN AND SHOULD BE

If the movement to legalize physician-assisted suicide is not and cannot be what it purports to be, and if it is something that it does not purport to be, then what is it? For one thing, it is not progressive, but regressive. Instead of accepting the reality that we


96. Indeed, it is difficult to see how legalization of physician-assisted suicide empowers individuals. If the right to determine how and when one dies is a personal right, then why does one even have to be a patient (i.e., sick) to avail oneself of physician-assisted suicide? If it is my right, I should be able to ask for such assistance whether I am sick or not. Because only patients can avail themselves of this option, and then only with their physician's permission, the legalization of physician-assisted suicide has more to do with professional than with personal autonomy.
cannot master death, physician-assisted suicide stubbornly insists that we can. This insistence is born of some belief that we must master it. Whether one wishes to characterize this response as infantile, childish, or adolescent, it is anything but mature.

To say that the movement to legalize physician-assisted suicide is not progressive is not to say, however, that simply opposing this movement is any more enlightened, or that a decision reversing the assisted suicide cases should be regarded as something of a landmark. If the United States Supreme Court overturns the assisted suicide cases, it will have prevented a bad situation from getting worse. That is not the same as improving the realities that confront dying patients. Indeed, the Court will have committed the same error that the advocates of physician-assisted suicide commit: not hearing or heeding what patients are saying. Unless we have heard what patients are saying, we cannot claim to have solved the problem, no matter what result the Court reaches.97

Were we to listen seriously to patients, we would discover that their basic complaints are as simple and reasonable as their anxiety and anger. By and large, people want physicians who can and will talk with and listen to them, not talk at and ignore them. They want physicians who can and will use pain medication appropriately, not dreadfully and fearfully. They want life-sustaining treatment to be used sensibly and sensitively, and not in a manner that locks them in for life, or that batters them against their wishes, or that terminates them against their wishes. They want technology that does things for them, not simply to them, and that is useful to them instead of simply used on them. And they want care to be provided in a manner that does not jeopardize their physical, financial, and emotional well-being.98

Basically, patients know one thing that the rest of us seem not to: that there is a big difference between a system of care, and a system that cares. All that most patients increasingly encounter are physicians who do not know them, and do not have the time, inclination, or opportunity to get to know them. They hear of others who live with unremitting pain and discomfort, and about families being dragged through the courts; pawns in someone else's struggle

97. See George J. Annas, The Promised End—Constitutional Aspects of Physician-Assisted Suicide, 335 New Eng. J. Med. 683, 687 (1996) (“Obviously we must understand the patients' problems before we can be sure that our solution will do more good than harm.”).
to determine what makes for a good death. In short, they see that what awaits them is a death that is not of their own, but of someone else’s choosing. If all that awaits patients is a medicalized death that has nothing to do with them or their values, in a society that delivers care so that individuals are as afraid of living as they are of dying, we should not be surprised to find patients seeking a hasty exit.

To the extent that this is what patients complain about and fear, the legalization of physician-assisted suicide is overkill in more ways than one. As a matter of constitutional law (as well as a matter of simple judgment), physician-assisted suicide arguably violates the least restrictive alternative doctrine, which limits the manner in which the state may pursue legitimate objectives; in this instance, the objective of giving patients a “good death.” As the United States Supreme Court has stated:

In a series of decisions this Court has held that, even though the governmental purpose be legitimate and substantial, that purpose cannot be pursued by means that broadly stifle fundamental personal liberties when the end can be more narrowly achieved. The breadth of legislative abridgment must be viewed in the light of less drastic means for achieving the same basic purpose.99

If it is true that one should not swat a fly with a baseball bat, then the mere fact that we are doing poorly when it comes to dying does not mean that we should try to excel at killing.

Just as the least restrictive alternative doctrine obligates physicians to exhaust any and all possibilities before even contemplating assisting in a suicide, it requires us as a society to exhaust any and all other means to improve the care of the dying before we take the most drastic step of all: altering the rules about what it means to kill.100 Certainly the results of the recent Study to Understand

100. See American Med. Ass’n Council on Scientific Affairs, Good Care of the Dying Patient, 275 JAMA 474 (1996) (recommending that the American Medical Association encourage research into the needs of dying patients and how the healthcare system could better serve them); Zail Berry & Joanne Lynn, Hospice Medicine, 270 JAMA 221 (1994) (arguing that the needs of the dying patient must receive a reasonable priority in political, economic, and medical discussions which will prompt the financing needed to deliver hospice services); Greg A. Sachs et al., supra note 74; Martin L. Smith et al., A Good Death: Is Euthanasia the Answer?, 59 CLEVELAND CLINIC J. MED. 99 (1992) (arguing that it is the best interest of patients, society, and health care providers to continue the prohibition against euthanasia and to direct the attentions of health care professionals to better pain control and psychological support of terminally ill patients); Lucy G. Sullivan, Euthanasia: Wrong Problem, Wrong Answer, 165 MED. J.
Prognoses and Preferences for Outcomes and Risks of Treatment (SUPPORT) lend credence to the notion that much remains to be done in terms of the proper care of the dying.101

Of course, such an undertaking would force us to find out why so many Americans die "bad" instead of "good" deaths.102 Were we to examine this question as seriously as we should, and as assiduously as the Constitution and good judgment require us to, we would likely come to terms with the unpleasant realities created, not by death, but by us.103

This would force us to admit a basic truth: Death does not discriminate, but we, and our health care system, surely do. Death remains the greatest equalizer; it takes you regardless of your condition, age, race, sex, creed, religion, nationality, or wealth. Our health care system, however, doles out treatment consistent with the principle of economic apartheid on which it is so solidly based. Sad though it is to admit, I can do no more than repeat here what I have written and said before:

Australia 558 (1996) (arguing that only when problem areas in euthanasia have been clarified will we be able to see if the public really wishes to usher in the dangers for the right to live, and that the predictable pressures on the choice to live will accompany the legislation of euthanasia); see also New York State Task Force on Life and the Law, When Death is Sought: Assisted Suicide and Euthanasia in the Medical Context 153-81 (1994); Washington State Med. Ass'n, Report of the Executive Committee: End of Life Issues (1996).

Put another way, before we even consider experimenting as the Dutch are with physician-assisted suicide, we ought to consider creating a system of health care that is as accessible and affordable as the Dutch health care system. See Sjef Gevers, Euthanasia: Law and Practice in the Netherlands, 52 Brit. Med. Bull. 326 (1996)

101. See generally The SUPPORT Principal Investigators, A Controlled Trial to Improve Care for Seriously Ill Hospitalized Patients: The Study to Understand Prognoses and Preferences for Outcomes and Risks of Treatments (SUPPORT), 274 JAMA 1591 (1995).


103. Of these, few are more striking than the studies which indicate that black men living in Harlem are less likely to reach the age of 65 than are men in Bangladesh. See Colin McCord & Harold P. Freeman, Excess Mortality in Harlem, 322 New Eng. J. Med. 173 (1990). As the most recent studies indicate, "[l]ife expectancy is shorter, and mortality rates greater, for black than for white Americans." Jing Fang et al., The Association Between Birthplace and Mortality from Cardiovascular Causes Among Black and White Residents of New York City, 335 New Eng. J. Med. 1545, 1545 (1996); see also Arline T. Geronimus et al., Excess Mortality Among Blacks and Whites in the United States, 335 New Eng. J. Med. 1552 (1996).
We do not die equal deaths. Too many Americans die wretched deaths because they live wretched lives—they live and die in squalor. They are the politically, economically, and medically disenfranchised. The moral issue of our day is not whether we ought to enable or prevent a few individuals’ dying in the comfort of their homes in the presence of their private physicians. The moral issue of the day is whether we ought to do something about our immoral system of care, in which treatment is dispensed according to a principle best characterized as that of economic apartheid.

Emily Friedman said it best in her remarkable essay, *The Torturer’s Horse*,104 where she wrote:

> The medically indigent . . . represent the risk of moral rot at the heart of our society, born of a callousness about those whose suffering we can not see and therefore do not acknowledge.

> . . . Should we continue to treat the most fragile members of our society as strangers, we will not be acting like the torturer’s horse; we will be the torturers.105

Simply put, access to death is not the problem; access to health and to health care is. If we are genuinely looking for a “bold experiment,”106 why don’t we experiment with reforming our health care

---

104. Emily Friedman, *The Torturer’s Horse*, 261 JAMA 1481 (1989). The title for the essay comes from W.H. Auden’s poem, *Musée des Beaux Arts*, in which Auden describes the world of the haves and the have-nots, which Ms. Friedman then weaves into her essay, as follows:

> About suffering they were never wrong,
The Old Masters; how well they understood
Its human position; how it takes place
While someone else is eating or opening a window or just walking dully along . . .
They never forgot
That even the dreadful martyrdom must run its course
Anyhow in a corner, some untidy spot
Where the dogs go on with their doggy life, and the torturer’s horse
Scratches its innocent behind on a tree.

> Most insured Americans are like the torturer’s horse, minding their own business while somewhere, in another part of the forest, the uninsured poor suffer. Some of this is the product of ignorance, but some of it is the product of bigotry. The poor, the nonwhite, the homeless, the oddball, the mad, and (increasingly) the very elderly are simply not considered as valuable as the white, employed, middle-class stereotype of American privilege.

*Id.* at 1481.

105. *Id.* at 1482. Of course, if we legalize physician-assisted suicide, we will be murderers as well as torturers.

system so that it is affordable, accessible, and equitable? That would be something new and different.

The last time I was invited to discuss physician-assisted suicide, I said that "the fuss about physician-assisted suicide is about as important as re-arranging the deck chairs on the Titanic." I now believe that I picked the right image, but the wrong ship. Again, Emily Friedman said it best in a more recent discussion of the quest for universal access to affordable care. Arguing that "the moral imperative is to help Americans . . . understand that [the] problem [of limited access] affects all of us, every day—and that it is getting worse," Ms. Friedman notes:

Historically, it takes a long time for the people of this country to understand and embrace the moral cause; but in time, they do. It is thus our responsibility to keep sending the message: We all pay for the uninsured, in the form of epidemics, avoidable lifetime disabilities, crippled and closed hospitals and clinics, expensive last-minute care, misallocation of resources, and wasted lives and money.

Asking herself how long we should keep "sending the message," she responds plainly:

The answer comes from the words of the captain of a boat that was attempting to rescue passengers from the sinking ship Andrea Doria in 1956, in heavy seas. He was hailed by another rescue boat captain who was returning to shore, abandoning the drowning passengers, who warned him that he would be in danger if he continued to try to save them. The first captain shouted back, "We ain't leaving 'til we don't hear no more screaming."

So must it be with those of us who understand that until all of us know we will be cared for when we are sick, none of us is truly safe.

Having said all this, what else is left to say?


108. See Emily Friedman, Welcome to Year 83, 273 JAMA 256 (1995). The title comes from her observation that Theodore Roosevelt, in 1912, became the first presidential candidate to run for office on a platform that included universal access to health care. Id. at 256.

109. Id. at 257.

110. Id.

111. Id. Of course, physician-assisted suicide certainly can silence patients, but whether silencing patients is the same as "stopping the screaming" is another question.
CONCLUSION

Societies define themselves not by what they choose, but by how they choose, especially when the choice has to do with suffering. Choosing responsibly requires choosing prudently and honestly. Therefore we must acknowledge and balance the consequences of legalizing physician-assisted suicide against the consequences of not doing so.

If physician-assisted suicide is not legalized, one likely consequence will be the existence of some undue suffering, for those whose pain and suffering cannot be medically addressed and for whom physician-assisted suicide seems the only real option. If, on the other hand, physician-assisted suicide is legalized, one likely consequence will be some degree of undue killing, in those instances where the choosing was not as careful as it ought to have been.

If the real choice we face is between living in a world in which there is undue suffering, and one in which there is undue killing, can it be so difficult for us to choose? We can and should do something about undue suffering; sometimes, we can even undo it. When it comes to undue killing, the situation is different. There is no way to undo killing. The only way to avoid undue killing is to not get into the business of doing killing in the first place. However

112. Guido Calabresi and Philip Bobbitt discuss suffering as follows:
We cannot know why the world suffers. But we can know how the world decides that suffering shall come to some persons and not to others. While the world permits sufferers to be chosen, something beyond their agony is earned, something even beyond the satisfaction of the world’s needs and desires. For it is in the choosing that enduring societies preserve or destroy those values that suffering and necessity expose. In this way societies are defined, for it is by the values that are foregone no less than by those that are preserved at tremendous cost that we know a society’s character.

Calabresi & Bobbitt, supra note 25, at 17.

unfortunate undue suffering is, it is an acceptable consequence in a way that undue killing can never be. The remorse we will feel about undue suffering pales before the regret we will feel about undue killing.

To choose honestly, however, we must come to terms not only with what it means to suffer, but also with what it means to be mortal: truths about ourselves that we seem unable and unwilling to admit. If we could see that accepting our mortality is not, need not, and should not be akin to succumbing or acquiescing to fate, we might also see that even though we cannot alter the facts of death, we can alter the conditions of life. If, as the saying goes, “Living well is the best revenge,” then instead of trying to improve on death, why don’t we try to improve on life? How? By dedicating ourselves to the task of assuring that each of us and all of us receive sensible care from sensitive providers, care that enables us to enjoy rich, meaningful lives from the moment we are born until the moment that we die. Were we to do that, we might find that the secret of having a good death lies in having lived a good life, and that if we succeed at taking good care of the living, we will have succeeded at taking good care of the dying as well. Although I know we can and believe we should do this, I continue to wonder when and whether we will.