

ISSUE 9

*Legislation permitting physician-assisted
suicide would/would not be
sound social policy*



*The Question of Whether Legislatures
Should or Should Not Legalize
Physician-Assisted Suicide*



The U.S. Supreme Court has made it clear that it is leaving it to the legislatures of the individual states to decide whether or not to legalize assisted suicide. So at this point in my journey it is my turn to take a position on the question of public policy: what do I believe should be our stance toward assisted suicide at this moment in history?

In trying to think through any suggested policy, I've decided to borrow a device from the philosopher John Rawls. Rawls, who is a deontological philosopher in the tradition of the great German philosopher Immanuel Kant,¹ sought to develop a philosophical basis for preferring the types of institutions and institutional arrangements that ideally constitute a liberal democracy.² To this end, he reenacted the social contract,³ with the contractors deliberating under a "veil of ignorance."⁴ Specifically, they did not know their place in the natural and social lotteries (rich or poor, brilliant or mentally disturbed, man or woman, black or white, and so on). So, for all they knew when creating the contract, once the veil was lifted they could wind up on society's bottom rung. As such, they tended to be somewhat risk averse. Within my veil of ignorance, I imagined that I did not know my age, health, gender, race, or religion if any (although I agreed that if after the veil was lifted I found out that I possessed deep religious

beliefs regarding suicide, assisted suicide, and euthanasia opposed to what I've decided under the veil those religious beliefs would trump). I also knew that most people in modern society die in hospitals and nursing homes after long bouts with chronic illness. Even if I were denied these statistics, under the concept of "maximum ignorance" (which posits that if I have no data or a priori knowledge of plausible outcomes I should assume all outcomes equally likely),⁵ assuming there is a fifty-fifty chance that my life will end this way would be extremely compelling in my deliberations.

I knew that I could be very sick, with no money, occupying a small bed in some state-run hospital or nursing home. I could be lingering, dribbling food down my chin and soiling myself. I could also be demented, in great pain, and depressed. It was not a very uplifting snapshot of my "golden years." Being so dependent, so helpless, and then adding the fact of dribbling and soiling myself like a six-week-old baby is initially a depressing notion. It's as though I've devolved, gone back to not fully being human, and that's hard to accept. Then I thought about all of this again. If I faced reality, I had to acknowledge that what I found to be such an upsetting image of myself was just another phase of a process that had been going on for quite some time, aging. My body is gradually (and at times not so gradually) breaking down. Getting old is no fun. I feel strong and can hike ten miles, but I can't see six feet in front of me without glasses, have trouble hearing, ache in the morning, and have no cartilage and ligaments in one knee and so can't run a block. Seeing myself incontinent and such is just more of the same. A part of me that I must accept.⁶ I'd like to die with all my faculties in order, but it is nothing I can count on. To feel degraded and ashamed is a function of an illusion, a made-up "story" of myself in which the real me is somehow perpetually 28 and sexually appealing to women of all ages.

As to being demented, I cannot begin to even guess what that would be like. Would life necessarily be intolerable? Based on my mother's experience in an Alzheimer's residence, where, though deluded, she took pleasure in her day-to-day life, I see no reason why it necessarily should be. In truth, my real concern is that my wife would have to spend a great deal of money to keep me in such a facility. And part of me would rather die than take so many resources from her to maintain a demented me. I just don't know.

On the other hand, I do know that I would not want to end my life suffering beyond reason. If I was in excruciating pain or physical-emotional

misery with no end in sight except upcoming death, I'd want the option to end it. But I also do not want to have to fear that in my condition I might be coerced or that some institution would kill me against my will (particularly if I'm poor, a minority, and have no family to watch out for me in the hospital or nursing home in which I am living).

I have not been convinced by the slippery slope arguments, based on either assumptions about human nature in the context of our society or empirical studies of Oregon and the Netherlands, that assisted suicide will inevitably engender such evil that even applying it in a case such as my father's is immoral. That, however, does not mean that I do not have real concerns.⁷ Whatever one may say about studies of the Netherlands, it is hard to conclude that the Dutch experience proves there are *no* problems with PAS. The Oregon experience seems more positive, but there remain many questions and ambiguities about the official state reports and reasonable concerns about the efficiency of the standards themselves. I also know something about institutions and human psychology from having lived over six decades, and the slippery slope arguments, at least in the context of our current medical delivery system, can hardly be termed frivolous.

I see our society as being in a transition in which the momentum toward PAS has slowed. As I said when discussing the concept of resilient lines, the medical profession and our society have moved rather quickly from a professed vitalist perspective to the acceptance of DNR codes, PDE, pulling plugs, acceding to the refusal of lifesaving treatment, the contextual line between ordinary and extraordinary treatment, and terminal sedation. We have also permitted all this by means of living wills and substituted judgment. But now things have stalled a bit (although the recent U.S. Supreme Court case rejecting the attorney general's attempt to block the implementation of Oregon's assisted suicide act may change that).⁸ For all that remains in our repertoire of life-ending techniques is stark and direct: helping someone poison and/or suffocate themselves, or actually doing the poisoning and/or suffocating. That has made us slow down; but I do not believe that we have changed the eventual destination (acceptance of some form of PAS) provided the experience of the next decade (and we will learn a great deal over the next ten years about our health care system and resources) does not produce stories that confirm the worst fears of the anti-PAS position.

I think this slowdown phase reflects wisdom as much as skittishness. I therefore would not recommend, for example, the immediate adoption of nationwide legislation legalizing assisted suicide and euthanasia. Individ-

ual states, such as Oregon, that want to legalize physician-assisted suicide should do that. We can all study and learn. But the world of managed care is just too new, and the real medical resource crunch as the baby boomers continue to age has not yet hit full force.⁹ Go slowly. This is particularly so given that there are available, though admittedly imperfect, stopgap measures that can suffice until we learn more. Thus, I am taking into account the range of available methods through which a very ill person can end his or her life, including PDE, refusing treatment, pulling the plug, and terminal sedation, and the recognition that there are doctors who will make pills available or will even conduct PAS or euthanasia, even though it is against the law.¹⁰

At this point, I should note that I considered a middle ground between either permitting or forbidding PAS—a form of legal defense. This would hardly have been novel,¹¹ such accommodation being found in the laws of other nations.¹² And, in truth, there are sympathetic cases (such as my father's) in which the suffering person could not find release from any of the currently available measures. For those cases, I considered providing a complete defense to criminal prosecution under certain circumstances. The defense would have been based on the reality of human needs and weaknesses. As such, it would take the form of a legal "excuse" (such as duress) rather than a legal "justification" (such as self-defense). The result, however, would be the same regardless of whether the action was labeled excused or justified. The defendant would be acquitted.

In the end, however, I abandoned the enterprise as ill-advised. First, most people will be able to die through such accepted methods as pulling the plug and PDE. As to someone like my father, it is hard to imagine anything but the most remote chance that, if my sister and I had helped him die, anyone would have questioned the cause of his death (unless I put a bullet in his head). After all, he was in the final stages of dying from cancer. So one must wonder whether it is worth all the cost, resources, and time that would necessarily go into first creating the system and then running it. Perhaps not. Second, it is conceivable that any such "stopgap" measure will in fact tend to impede real discussion on the issue of PAS by providing a rationale to avoid facing this complex set of issues altogether (e.g., "We don't really have to deal with this most complex issue because we have given a defense in the criminal law"). Third, the very existence of such a defense may lead to tortured interactions in which the dying, suffering person will be forced to beg another for assistance, trying to convince the needed assistant that he or she will be protected by that defense.

Finally, I had to ask myself, if such a defense had existed, would it have made any difference in my decision whether or not to help my father? I don't think so at all. I would have been just as scared of criminal prosecution. Of course, it would seem that with such a defense I at least would have been better off if I had helped Dad and somehow been caught. But even that is not necessarily true. A prosecutor (or prosecutor's office) may be antagonistic to the very fact that such a defense exists, thereby giving some legitimacy to assisting suicide. Thus, while had the legislature not provided such a defense, the prosecution might have looked at my individual case with compassion and mercy; now the prosecutor might not see me, but only the existence of the defense, and might then decide to attack the policy decision to permit such a defense by prosecuting me to the limit.

In the end, I decided not to oppose the idea of PAS. The coming years may well show that PAS is an appropriate option in end of life care and that this option is worth the risks (and/or we have found we are able to significantly mitigate those risks). If so, PAS should be available when reasonable in every state, just not today.

There is a final approach that superficially might appear to resemble the one I have just taken but is really quite different: intentionally leave things the way they are and do nothing. The reasoning underlying this approach is surprisingly intricate. First, we must understand that we are allocating a resource—the means to terminate one's life. Initially, there would seem to be a sufficiently available supply of razors, guns, bridges, poisons, drugs, DNR orders, trains, high cliffs, and such that this resource is available to everyone in the country who wishes to terminate his or her life. But, of course, to make that resource available there are other costs in terms of lost lives, lost workers, lost productivity, lost taxes, lost family support, and so forth.

Moreover, even if this resource is seen as plentiful, its allocation, as we have seen, involves tensions between certain basic values (sanctity of life, autonomy, freedom from suffering), none of which we are prepared to compromise and all of which we desire to promote. So leave things as they are, replete with rough accommodations using pulling plugs and giving fatal doses of pain medications in which we hide from questions about who is making the actual choice that results in terminating life.¹³ Let all this happen, including a euthanasia “underground,” letting it all coexist with a legal prohibition without meaningful enforcement, and we have an American form of pragmatic tolerance or even tacit approval. We de facto

allow autonomy its place, know that suffering will be dealt with, and yet have not formally passed a law devaluing the absolute sanctity of life.

While completely rational, this is not a feasible alternative in this instance. The pressure from the now aging baby boomers, who as a generation have sought to choose how to live their lives without being constrained by prior tradition and conventions, combined with a sizable euthanasia underground¹⁴ and a health care system (managed care and HMOs) that operates according to a business rather than a medical model, will not permit us to rely on the status quo. It is far too dangerous. Significant regulation and oversight will be required. Again, if experiments like that in Oregon function well, alleviating our fears of a slippery slope, then regulated PAS would be appropriate. If, however, the experiment fails, and other data confirm our worst fears, then law must aggressively address the euthanasia underground and any de facto practices resembling euthanasia in managed care facilities. Either way, we will not be able to leave things as they are.