

Fall 1997

This Is Who Will Die When Doctors Are Allowed to Kill Their Patients, 31 J. Marshall L. Rev. 95 (1997)

Michael McGonnigal

Follow this and additional works at: <https://repository.law.uic.edu/lawreview>



Part of the [Constitutional Law Commons](#), [Criminal Law Commons](#), [Elder Law Commons](#), [Health Law and Policy Commons](#), [Human Rights Law Commons](#), [Jurisprudence Commons](#), [Law and Psychology Commons](#), [Law and Society Commons](#), [Legal Ethics and Professional Responsibility Commons](#), [Legal History Commons](#), [Legislation Commons](#), [Litigation Commons](#), and the [Medical Jurisprudence Commons](#)

Recommended Citation

Michael McGonnigal, This Is Who Will Die When Doctors Are Allowed to Kill Their Patients, 31 J. Marshall L. Rev. 95 (1997)

<https://repository.law.uic.edu/lawreview/vol31/iss1/4>

This Article is brought to you for free and open access by UIC Law Open Access Repository. It has been accepted for inclusion in UIC Law Review by an authorized administrator of UIC Law Open Access Repository. For more information, please contact repository@jmls.edu.

THIS IS WHO WILL DIE WHEN DOCTORS ARE ALLOWED TO KILL THEIR PATIENTS

MICHAEL MCGONNIGAL*

One of the greatest catastrophes in British military history was the evacuation from Dunkirk at the end of May 1940. The British Army retreated from the advancing Germans, abandoning all of their heavy equipment, all of the tools needed to fight a modern war.¹ Fishing craft, desperately pressed into service to save the remnants of the shattered force, brought home many of the troops. When the operation was completed on June 2, only a strip of water stood between the German Army and the conquest of Great Britain.²

Desperate for good news, the British convinced themselves, the world and even most historians that Dunkirk was a great victory.³ School children read about the "Miracle of Dunkirk," a miracle only because the entire British force was not taken into captivity. This "Miracle" was less a product of British military acumen than that of blundering on the part of the German High Command.⁴

Recent Supreme Court decisions in the euthanasia cases⁵ represent a "Judicial Dunkirk" for the opponents of "mercy killing."

* Staff attorney, Columbus Community Legal Services, Columbus School of Law, Catholic University of America, Washington, D.C. B.A., Northeastern University, J.D., Catholic University of America. The author has supervised the Advocacy For the Elderly Clinic at the Columbus School of Law (Catholic's Elderlaw Clinic) since 1988. For their assistance in preparing and reviewing this article, the author thanks his research assistants, L. Duke Dorotheo and Darwin Bolden; his colleagues at the Catholic University, most especially Professors Sandy Ogilvy and Lucia Silecchia; the members of the Non-Tenured Faculty Discussion Group at the Columbus School of Law; Sandra Parsons, J.D., M.S.W.; and Patricia A. Corby, L.C.S.W. Not all share the author's opinions, none share the blame for his mistakes, all share the credit for making this article more accurate and more readable.

1. See generally NICHOLAS HARMON, *DUNKIRK: THE PATRIOTIC MYTH* (1980) (discussing the "Miracle at Dunkirk" and the myth behind the miracle).

2. *Id.*

3. *Id.*

4. *Id.*

5. *Quill v. Koppel*, 870 F. Supp. 78 (S.D.N.Y. 1994), *rev'd sub nom.* *Quill v. Vacco*, 80 F.3d 716 (2d Cir. 1996), *rev'd sub nom.* *Vacco v. Quill*, 117 S. Ct. 2293 (1997); *Compassion in Dying v. Washington*, 850 F. Supp. 1454 (W.D. Wash. 1994), *rev'd*, 49 F.3d 586 (9th Cir. 1995), *rev'd en banc*, 79 F.3d 790 (9th Cir. 1996), *rev'd sub nom.* *Washington v. Glucksberg*, 117 S. Ct. 2258 (1997).

The failure of the Court to read a "right to be killed" into the Fourteenth Amendment is not a victory for foes of euthanasia.⁶ Disaster has been narrowly averted, and the political juggernaut in favor of "easy death" continues to roll.

The struggle now turns to the state legislatures, state supreme courts, Congress and even the offices of county prosecutors. Advocates of euthanasia will no longer be burdened by dubious constitutional arguments that prevented them from achieving complete victory before the Court this past term.⁷ No longer will they be hindered by the force of Justice Scalia's jibe, "[T]his is [a] lovely philosophy but you want us to frame a Constitutional rule on the basis of that?"⁸

Legislators will decide the question of life and death on purely political grounds. These lawmakers have been conditioned by years of public discourse favoring euthanasia and by their own intimate knowledge and private fears concerning the horrors of a prolonged and messy death.⁹

This article attempts to show that legalizing euthanasia in any form will make death more horrible for all of us. Legalizing euthanasia solves nothing, but it creates mortal dangers for which there is no solution. This article then reveals that the practice of deliberately killing the dying, even with their apparent consent, offends our universal values. These values are as deeply cherished by the Left as by the Right, the Libertarian as by the Traditionalist, and the atheist as by the mystic. Finally, this article puts a human face on the suffering we have been spared thus far because the law continues to insist on the one bedrock principle, "Thou shalt not kill."

Ten years of practicing law leads one to conclude that most people are fools almost all of the time. At Catholic's Elderlaw Clinic, students and attorneys spend about three-fourths of the time rescuing clients from difficulties they should have averted in the first place. These clients sign contracts they do not read,

6. *Glucksberg*, 117 S. Ct. at 2269-71.

7. See generally *Id.* at 2258-93; *Quill*, 117 S. Ct. at 2293-2302.

8. Official Transcript of the Proceedings at 56-57, *Vacco v. Quill*, 117 S. Ct. 2293 (1997).

9. See, e.g., John Balzar, 'Death With Dignity' on Ballot Initiative Faces Washington Vote, NEWS & OBSERVER, Oct. 6, 1991, at A1 (discussing Washington's initiative on physician-assisted suicide); Miranda Ewell, *Voters Ponder Initiative: When does Life End?*, LAS VEGAS REV. J., Oct. 21, 1992, at 1A (discussing the California initiative on euthanasia); Dorothy Petrosky, *House Kills "Living Will" Bill, Sponsor Blames 'Religious Right' for Proposal's Failure*, INDIANAPOLIS STAR, Jan. 23, 1992, at A01 (discussing the defeat of the living will in the Indiana House); Richard Worsnop, *Oregon Residents to Vote Again on "Right-to-Die Law*, SAN DIEGO-UNION TRIB., Sept. 22, 1997, at A1 (discussing Oregon's approved Measure 16 permitting physician-assisted suicide).

marry spouses who have "wrong" written all over them, and let profligate sons and daughters leech off of them. They let workmen into their homes who do not know which end of the hammer to hold, and they agree to mortgage payments that are more than their monthly income. These people fall for scams which were old when Nimrod was a boy.

These clients are poor but not witless. When all of the facts are laid out on the table, they typically close their eyes, rest their shaking heads in their hands and whisper, "How could I have been so stupid?" It is a scene repeated in every law office in the country, serving every social class. These situations are not just limited to law offices.

Everyone in the helping professions eventually realizes that the human race is united in folly. Doctors treat patients who smoke, drink, over-eat, over-work and refuse to take their medication. Counselors labor, usually in vain, to change behaviors which are self-defeating and self-destructive. Priests, ministers and other moral teachers do not tell people what they do not know, but that which they have always known and always appear to forget.

Lawmakers know that citizens are made of common clay and that wisdom and prudence are rare among them. That is why there are divorce laws, bankruptcy laws, and a growing roster of consumer protection laws. While politicians frequently speak of "rights," "liberty" and "autonomy," the one right politicians always advance in practice is the right to change one's mind, the right to rectify inevitable errors.

People are not allowed to dig coal in dangerous mines, work for less than the minimum wage, or waive the right to social security benefits or workers compensation. They cannot buy cars without seat belts or drugs that have not been tested. But now courts are being asked to discover, and lawmakers are being asked to create, an absolute right for a person to contract to have a third person kill them, or, as it has been more delicately put, "assist in their suicide."

This article attacks the practice of consensual killing, currently hyped under the moniker of "physician-assisted suicide."¹⁰ This article is not aimed at philosophers or bioethicists, who may find some of the arguments obvious. Nor is it written for the defenders of tradition, religious or otherwise, who see the euthanasia

10. This article employs the term "physician-assisted suicide" throughout with the greatest reluctance. It is pure Madison Avenue, an archetype of the linguistic sleight-of-hand exposed by George Orwell in his famous essay, "Politics and The English Language." MODERN CRITICAL VIEWS: GEORGE ORWELL 133 (Harold Bloom ed. 1987). Using a more accurate phrase, such as "murder-by-permission," might confuse the reader, causing him to think that the article refers to a practice other than the brand of euthanasia currently being marketed to the American people.

craze as yet another blow to the foundations of Western Civilization.¹¹ Instead, this article is aimed at those who are suspicious of concentrated power and who identify with the interests of the downtrodden. It is written especially for those attracted by the prospect of an "easy death" for its undeniably compassionate appeal. This article shows that the delusion of an easy death will undermine the quality of living and degrade the quality of dying.

I. WHO ARE THE VICTIMS OF PHYSICIAN-ASSISTED SUICIDE?

The typical victim of physician-assisted suicide is not the cool-headed, non-depressed, non-pressured, life-loving patient who is both terminally ill and in intractable pain.¹² Instead, the victims are reacting to overwhelming social and emotional pressures of which they are unaware and do not understand. At the end, most people will be less like Socrates with the hemlock and more like the teenager in the tattoo parlor.

A. Footnote 120 Victims

The most obvious victims of physician-assisted suicide will be those who lack the mental or physical capacity to speak for themselves. Society must hope that any future scheme for legalized killing would exclude this group. Only in the most fanciful sense could these handicapped persons be said to be consenting to their own demise. However, our country came very close to approving the widespread killing of the mentally handicapped.¹³

11. This article makes what the teachers of rhetoric call "the argument from circumstance." The late Richard M. Weaver, in his book, *The Ethics of Rhetoric*, said this type of argument "merely reads the circumstances - the 'facts standing around' - and accepts them as coercive, or allows them to dictate the decision." RICHARD M. WEAVER, *THE ETHICS OF RHETORIC* 57 (Henry Regnery Co. 1953). Weaver called this approach "the nearest of all arguments to purest expediency." *Id.* The counterpart to the argument from circumstance is the "argument from definition" or the argument from first principles. *Id.* at 83-85. In an argument from definition, a writer might argue that killing patients is inherently wrong and ought to be prohibited, even if all the consequences were beneficial to the individual and society. It is the better argument, but it has already been made many times by many writers. This article demonstrates for the pragmatist, as well as the idealist, that legalization of physician-assisted suicide would be reckless and foolhardy.

12. Even this is not the illusive "perfect case" for physician-assisted suicide. The perfect case is the one that strikes people's hearts. It is the father dying of cancer who begs his daughter to help him die. It is the colleague dying of AIDS who awakens from a suicide attempt and whose only emotion is rage and whose only desire is to try again. Even if these people fail to meet all the established guidelines, they present the perfect case. The law, however, is a highly imperfect, human institution. If the law grants doctors the power to kill their patients, many "imperfect" victims will die and many "perfect" ones will linger.

13. *Compassion in Dying v. Washington*, 79 F.3d 790 (9th Cir. 1996), *rev'd sub nom.* *Washington v. Glucksberg*, 117 S. Ct. 2258 (1997).

The most shocking and obscure facet of the circuit court decision in *Compassion in Dying* is footnote 120,¹⁴ authorizing substitute decision-makers to decide whether incompetent patients should be killed.¹⁵ Despite the fatuous disclaimers within the footnote, it authorizes the swift involuntary killing¹⁶ of thousands of mentally disabled patients.¹⁷ This decree applies not only to those in a "permanent vegetative state,"¹⁸ but also to any persons deemed incompetent to make decisions for themselves.¹⁹

The decision of the Supreme Court in *Compassion in Dying*, vitiated footnote 120 along with the rest of the Ninth Circuit's opinion.²⁰ The philosophy behind footnote 120, however, may find its way into the statute books and into state court decisions based on state constitutional declarations of rights. Once the right to be killed is created, even by statute, courts may extend this blessing

14. *Id.* at 832 n.120.

15. *Id.* Footnote 120 reads as follows:

In the later case, "involuntary death," when the motive is benign or altruistic, we classify the act as "euthanasia." There is, however, no universally accepted meaning for that term. Some commentators distinguish between active and passive euthanasia, for example, while others do not. We define euthanasia as the act or practice of painlessly putting to death persons suffering from incurable and distressing disease, as an act of mercy, but *not* at the person's request. The issue of euthanasia is not implicated here. While we place euthanasia, as we define it, on the opposite side of the constitutional line we draw for purposes of this case, we do not intimate any view as to the constitutional or legal implications of the practice. *Finally, we should make it clear that a decision of a duly appointed surrogate decision maker is for all legal purposes the decision of the patient himself.*

Id. (emphasis added).

16. So as to refrain from sounding shrill, the well-known, very accurate, one-word legal term for "involuntary killing" will be avoided in this article.

17. See *Compassion in Dying*, 79 F.3d at 832 n.120 (noting the last sentence in footnote 120 allows the appointed surrogate's decision to be treated as the patient's decision).

18. This is the last time in this article that human beings will be referred to as "vegetables." The fact that this barbarous phrase, in both its disguised and undisguised forms, enjoys universal acceptance in our culture condemns us all. The case against this expression was put most eloquently by Dr. Richard Lamerton in his book, *Care of the Dying*,

The use of this word 'vegetable' - or, even more repugnant, 'cabbage' - is one of the most alarming degradations of modern medicine. An attempt to make it scientifically respectable - using the word 'vegetative' to describe the bodily functions of a decerebrate patient - is laughable. What is scientific about it? Wherein does an unconscious man resemble a vegetable? Photosynthesis? Roots? Edibility? Science implies precise observation, confirmed by demonstration, leading to logical conclusions. I challenge anyone to demonstrate to me the vegetable attributes of a man.

RICHARD LAMERTON, *CARE OF THE DYING* 158 (Penguin Books 2d ed. 1981).

19. See *supra* note 17 referring to the surrogate decision-maker.

20. *Washington v. Glucksberg*, 117 S. Ct. 2258, 2275 (1997).

to the profoundly disabled on equal protection grounds.

Footnote 120 does not exist in a vacuum. There is well-developed jurisprudence dealing with termination of life support for incompetent patients which must be read *in pari materia* with footnote 120.²¹ The Ninth Circuit blindly applied this body of law to the question of physician-assisted suicide, ignoring the logical consequences of this action.

Thousands of people living today would qualify for physician-assisted suicide under footnote 120; however, an exact figure would be difficult to calculate. Included in this group are those suffering from permanent neocortical failure and those in the final stages of Alzheimer's Disease or other forms of dementia. Additionally, the victims of chronic, painful and terminal illnesses who are no longer able to make competent decisions or never had the ability to make those decisions would fall under the auspices of footnote 120.

Any of these people could be killed by judicial decree if foot-

21. The leading case is *Superintendent of Belchertown v. Saikewicz*, 370 N.E.2d 417 (Mass. 1977). In *Saikewicz*, an aging and long term resident of a state hospital for the mentally retarded was dying of cancer. *Id.* at 419. His only hope of survival, and a very slim hope at that, was a hideously painful course of chemotherapy. *Id.* The court, after pages of tortured reasoning, decided not to make the patient go through with the chemotherapy. *Id.* at 435. This was not based on humanitarian grounds, but on the court's guess at what Joseph Saikewicz might have wanted. *Id.* This was pure speculation, since Joseph Saikewicz never had the mental capacity to express an opinion on the subject or even anything remotely related to the subject. *Id.* at 419. The legal terminology for this practice is "substituted judgment," a complex and controversial area of the law with many complicated and conflicting doctrines. See generally ALLEN E. BUCHANAN & DAN W. BROCK, DECIDING FOR OTHERS: THE ETHICS OF SURROGATE DECISION MAKING (Cambridge University Press 1989) (discussing thoroughly "substituted judgment" as this topic is beyond the scope of this article).

Since *Saikewicz*, courts all over the country have been engaging in the deadly parlor game of guessing how incompetent patients would make life and death decisions had they had the competence to make them. See, e.g., *In re Fiori*, 673 A.2d 905, 910-13 (Pa. 1996) (holding a close relative can act as a substitute decision-maker for the removal of life-sustaining treatment); *In re R.H.*, 622 N.E.2d 1071, 1075-80 (Mass. 1993) (looking at substituted judgment factors in determining whether mentally incompetent patient would refuse treatment); *In re Lawrance*, 579 N.E.2d 32, 38 (Ind. 1991) (finding that the family of an incompetent patient can refuse artificial life sustaining food and hydration); *In re Estate of Longeway*, 549 N.E.2d 292, 298 (Ill. 1989) (finding guardian of incompetent patient who is terminally ill and in an irreversible coma may petition the court for removal of life sustaining treatment).

Saikewicz and its progeny are distinguished from the more numerous cases involving incompetent patients who were once competent and might have left indications of their personal preferences on the withholding of medical care. See, e.g., *Cruzan v. Director, Mo. Dep't of Health*, 497 U.S. 261 (1990) (examining the difficulty judges often have piecing together the intention of the incompetent patient based on half-remembered, off-hand comments which may have been taken out of context).

note 120 or anything like it became permanently incorporated into American law. In fact, in the perverted logic of the decision, not to promptly kill those who qualify, would be an invasion of their civil rights. A right delayed is a right denied.

In reality, the killings would occur quietly, on a case-by-case basis, with each judge struggling with the complex doctrines of substituted judgment. Ultimately, the court would conclude in these cases that this particular burden to the taxpayers really does want to die. But, this is America, not Nazi Germany.²² Even the American Civil Liberties Union would not insist on roving death squads moving from mental hospital to nursing home to enforce the right to die in great haste. It is not Prussian logic and efficiency which will guide our actions but typical American carelessness and self-deception. Many people will die; however, they will be killed in such a way as to avoid pricking society's conscience.²³

It is doubtful that the judges of the Ninth Circuit actually favored the mass-slaughter of the disabled, they just did not understand the consequences of their decision. The judges broke one of the fundamental principles of judicial procedure by writing a broad opinion, rather than a narrow one. The court went beyond a ruling responding to the specific case before them. These justices decided an issue for which they had not been briefed, for which they heard no arguments, in which there was no testimony and no fact-finding and for which there was no flesh-and-blood subject. The court was legislating instead of adjudicating, and it made the same type of mistake a legislature is likely to make when confronting this issue.

22. Germany was the first modern nation to practice euthanasia on a mass scale. In the late 1930s, thousands of mentally retarded Germans were put to death by the Nazi regime, which employed methods it would later expand upon in murdering millions of Jews and other unwanted minorities. See MICHAEL BURLEIGH, *DEATH AND DELIVERANCE: "EUTHANASIA" IN GERMANY C.1900-1945* (Cambridge University Press 1994) (describing euthanasia in Germany from 1900 to 1945); ROBERT JAY LIFTON, *THE NAZI DOCTORS: MEDICAL KILLING AND THE PSYCHOLOGY OF GENOCIDE* (1986) (chronicling the Nazi euthanasia campaign).

It is not suggested that supporters of physician-assisted suicide are any less anti-Nazi than its opponents. One can abhor the German euthanasia policy of the 1930s and still favor physician-assisted suicide. However, anyone advocating as radical a program as legalized killing should be thoroughly familiar with the German experience, especially its methods, its theoretical underpinnings and its corrupting effect on the medical profession.

23. Many disabled people are condemned without their knowledge or consent by the off-hand decision to post a Do Not Resuscitate (DNR) Code on their medical charts. See, e.g., *Care and Protection of Beth*, 587 N.E.2d 1377, 1381 (Mass. 1992) (allowing a DNR order to stand for a minor who is a ward of the state); *In re Guardianship of Mason*, 669 N.E.2d 1081, 1085-86 (Mass. App. Ct. 1996) (finding DNR order proper for terminal patient). This practice only accentuates the vulnerability of the disabled and does not justify any action to hasten their deaths by any means.

In any event, the Ninth Circuit betrayed its impatience with the euthanasia question. The court never explained, for example, how an incompetent patient is expected to cooperate in her own killing, which is one of the essential elements of physician-assisted suicide. It also put to rest the dispute regarding the role of the "slippery slope" in the euthanasia debate. Footnote 120 is not the slippery slope, it is the splat at the bottom of the canyon.

B. Victims of Bad Doctors

Others left vulnerable by any scheme legalizing physician-assisted suicide are those patients with the misfortune of having a bad doctor.²⁴ Readers are reminded of the brutal fact that physician-assisted suicide gives doctors the license to kill. It does not empower patients. It empowers doctors. It grants doctors the greatest gift the law can bestow - immunity from prosecution for killing another human being.²⁵ If legalized, physician-assisted suicide will be practiced out of the public gaze by men and women whose skills at dialogue and counseling fall woefully short of their talents at diagnosis and treatment. The most vulnerable members of our society will be subjected to the predilections of a group with the ability to manufacture consent. In many cases, if the doctor makes a mistake, the only other person who knows about the mistake will be dead. That this suspicious and cynical generation would grant any profession the right to play God²⁶ demonstrates

24. In this instance, "bad doctors" may be brilliant doctors, doctors whose skill and dedication allow them to save lives every day of their professional lives, but whose listening skills are lacking. Those skills often are better developed among nurses than among doctors, and "nurse-assisted suicide" would be a sounder policy than physician-assisted suicide, though that alternative is not suggested. Even the doctor who is an excellent counselor for some patients, might not be for others. Most doctors are highly educated, able-bodied, white men from affluent backgrounds in urban areas. Some of their dying patients will be disabled African-American women twice their age who were "educated" for six years or less in the pre-*Brown v. Board of Education* schools of the rural South and have lived their lives in poverty. If the doctor and patient fully understand each other under these circumstances without a concerted effort, it is pure serendipity. At Catholic's Elderlaw Clinic many of the same factors apply. Miscommunication and misunderstanding continually occur, despite students' and teachers' best efforts and the clients' good faith. It is impossible to emphasize enough the challenges involved in counseling across lines of race, class and gender. Yet, within the context of allowing doctors to assist their patients in committing suicide, there has been almost no discussion of this problem.

25. Giles Scofield, M.D., Remarks at the Symposium on Physician-Assisted Suicide at the Western New England College School of Law (Oct. 18, 1996) (forthcoming Giles Scofield, *Natural Causes, Unnatural Results and the Least Restrictive Alternative*, 19 W. NEW ENG. L. REV., 371 (1997)).

26. Supporters of physician-assisted suicide have quipped that doctors "play God" as much when they heal as when they kill. This jest is a deliberate distortion of the language. "Playing God" has always referred to the creation

our inherent hunger for blind faith. Notably, the one group that does not share this child-like trust is the medical profession itself.²⁷

Hard cases make bad law. The graphic and gut-wrenching vision of the helpless patient in constant, uncontrollable, unremitting pain may lead us to establish laws with vast and unpredictable consequences. This article next attempts to put a human face on those who are most likely to "benefit" from this marvelous new right - the right to be annihilated - in whatever form it finally takes.

C. *The Reasonable Man Standard*

In the movie, *Harvey*, Jimmy Stewart plays Elwood P. Dowd, a charming tippler who is convinced that he is accompanied everywhere by a six-foot rabbit named Harvey.²⁸ Harvey is a "pooka," a being invisible to all but one, but who, nevertheless, exists, at least in the mind of Elwood P. Dowd.

The advocates of physician-assisted suicide have their own pooka. This pooka is the reasonable man, in particular, the reasonable man facing death. He is weak of body, but strong of mind. He is rational before the terrors of death. Through his pain and anguish, he can make an adequate cost-benefit analysis on the biggest decision he has ever faced. He is immune to social pressure. If his children do not visit him, he takes it in stride. If his doctor has given up on him, he still cherishes his own life. Despite his condition, he is not depressed. If he decides to ask the doctor to give him poison, it will only be as a last resort to preserve his dignity and his "quality of life." He is a true hero, and, like Elwood P. Dowd's six-foot rabbit, he is a figment of the imagination.

Even under the best conditions, the notion of the reasonable man is hard to swallow. As a legal fiction, he has his uses, but as a model for humanity, he lacks credibility. Bertrand Russell said:

Man is a rational animal - so at least I have been told. Throughout a long life, I have looked diligently for evidence in favour [sic] of this statement, but so far I have not had the good fortune to come across it Aristotle, so far as I know, was the first man to proclaim explicitly that man is a rational animal. His reason for this view was one which does not now seem very impressive; it was that some people can do sums.²⁹

or destruction of human life. It has always been the province of humanity to use all means at its disposal to sustain life.

27. Though doctors are divided on the issue, most medical organizations, including the American Medical Association, are vociferous in their opposition to physician-assisted suicide. See LONNY SHAVELSON, *A CHOSEN DEATH: THE DYING CONFRONT ASSISTED SUICIDE* 209 (1995); *CODE OF MEDICAL ETHICS* § 2.211 (1994).

28. *HARVEY* (Universal Pictures 1950).

29. BERTRAND RUSSELL, *An Outline of Intellectual Rubbish*, in *THE BASIC*

The reasonable man standard was first defined in the 1837 English case of *Vaughan v. Menlove*.³⁰ The English courts sometimes refer to the reasonable man as "the man in the Clapham omnibus."³¹

The Clapham Bus has never run through my neighborhood, not when I was growing up and not now. It would not be surprising to learn that the route has been canceled altogether for lack of patronage. Clients of Catholic's Elderlaw Clinic, when faced with a major decision, do not take out a piece of paper, draw a line down the middle and write "pro" on the left side and "con" on the right. They make decisions based on impulse and instinct. It is likely that they do the same in Clapham.

It is comforting to look at portraits painted by John Singleton Copley, Gilbert Stuart or even Norman Rockwell and to imagine that people are actually like that. But the people who come to Catholic's Elderlaw Clinic, the people who will be most affected by physician-assisted suicide, are more accurately rendered by a Hogarth or a Breugel.

The reasonable man³² standard is easily lampooned. In the famous fictional case of *Fardell v. Potts*, English satirist A.P. Herbert notes that the "reasonable man" is always prudent, always thinking of others and always placing safety first.³³ "All the solid virtues are his, save only that peculiar quality by which the affection of other men is won."³⁴ The reasonable man does not succumb to human weaknesses, such as prejudice, procrastination, ill-nature, avarice, or absence of mind.³⁵ He is, therefore, detested by his friends.³⁶

Hateful as he must necessarily be to any ordinary citizen who privately considers him, it is a curious paradox that where two or three are gathered together in one place they will with one accord pretend an admiration for him; and, when they are gathered together in the formidable surroundings of a British jury, they are easily persuaded that they themselves are, each and generally, reasonable men.³⁷

Our law has decided that when *A* is injured by *B*, *B* must measure up to some objective standard in order to escape liability. Personal frailties are of no account. "[A]ny legal standard must, in

WRITINGS OF BERTRAND RUSSELL 73, 73 (Simon & Schuster 1961).

30. 132 Eng. Rep. 490, 492 (1837).

31. *Hall v. Brooklands Racing Club*, 1 K.B. 205, 224 (1933).

32. The term "reasonable man" is used here deliberately, rather than the more current and socially acceptable, "reasonable person" or "reasonable woman." It is, in fact, the hackneyed paterfamilias of the late Victorian novelist that the courts seem to have in mind.

33. A.E. HERBERT, *UNCOMMON LAW* 3 (Bibliophile Books 2d ed. 1986).

34. *Id.* at 4.

35. *Id.*

36. *Id.*

37. *Id.*

theory, be one which would apply to all men, not specially excepted, under the same circumstances," according to Holmes.³⁸ In some cases, the objective standard is delineated with great specificity in a statute or regulation. More often, a general rule must be applied, and thus, the "reasonable man" test was adopted in the Nineteenth Century. This standard enjoys a central place in almost every branch of the law, most notably administrative law, bailment law, constitutional law, contract law, criminal law, trust law, and tort law.³⁹ Few minds on the bench can resist the temptation of believing, at least subconsciously, that the "reasonable man" bears some resemblance to the human creature.

When the rights of *A* are to be weighed against the rights of *B*, we demand an objective standard. In such a case, the law "does not attempt to see men as God sees them."⁴⁰ When the life of *A* alone is at stake, such a standard is invalid. The suffering person must be seen as God sees him, full of weaknesses and often devoid of judgment.

Even the man or woman who can be counted on to be "reasonable" in investing trust funds or even driving a car, might be less calculating when staring death in the face. Dying, according to Edwin S. Shneidman, does not allow equanimity.⁴¹

The emotional stages seem to include a constant interplay between disbelief and hope and, against these as background, a waxing and waning of anguish, terror, acquiescence and surrender, rage and envy, disinterest and ennui, pretense, taunting and daring and even yearning for death - all these in the context of bewilderment and pain.⁴²

It is no wonder, then, that the "rational suicide" has been compared to the leprechaun.⁴³ Everyone talks as though such a creature exists, but no one ever seems to be able to find one.

D. The Rationality Factor

No stance is taken here on whether it might be rational for a person to seek death in extreme and unusual cases. The lead plaintiffs in *Compassion in Dying* and *Quill*, no doubt carefully screened for the purpose, presented intensely compelling circum-

38. OLIVER WENDELL HOLMES, *THE COMMON LAW* 88 (Mark DeWolfe Howe ed., Little, Brown & Co. 1963) (1881).

39. Ronald K.L. Collins, *Language, History and Legal Process: A Profile of the "Reasonable Man"*, 8 *RUT.-CAM. L.J.* 311, 313 (1977).

40. HOLMES, *supra* note 38, at 13.

41. EDWIN S. SHNEIDMAN, *DEATHS OF MAN* 7 (Penguin Books 1974).

42. *Id.*

43. Kenneth T. Morris & Arles Stern, Report to the Michigan Commission on Death and Dying. Morris and Stern report that they have yet to confront a rational request for suicide in their own practices, nor could they find one in any of the medical literature. *Id.*

stances for the judges.⁴⁴ The circuit courts responded as anticipated.⁴⁵ But the courts made law not only for these thoroughly counseled plaintiffs, but they made law for everyone.

An advocate of unlimited autonomy would insist on authentic autonomy, not on a sham autonomy in which the dying patient merely ratifies society's judgment that they are worthless. If someone is going to choose to be put to death, they must be rational, their decision must be rational, they must be thinking rationally at the time the decision is made and their reasons for the decision must be rational.⁴⁶ Under no circumstances should a person with impaired judgment be allowed to act as their own executioner. The same is true for the patient who is driven by pain,⁴⁷ depression or emotional distress. The decision itself must be objectively rational. Patients who are not in persistent, physical pain and who are not at death's door are not being objectively rational if they ask the doctor to kill them.⁴⁸ The decision must be

44. *Compassion in Dying v. Washington*, 79 F.3d 790, 794-95 (9th Cir. 1996); *Quill v. Vacco*, 80 F.3d 716, 720 (2d Cir. 1996).

45. *Compassion in Dying*, 79 F.3d at 838-39; *Quill* 80 F.3d at 731.

46. This begs the question, "What is rational?" What standards of rationality are to be employed? Those of society or those of the individual? If the individual is allowed to define rationality for the purposes of self-destruction, the results would be rejected by all but the libertarian fanatic. An 18-year-old may decide, quite rationally, that the world is a mess, life is a drag and neither is ever going to change. (Teenagers are often like this, which is why they drive their cars so fast and make such splendid soldiers.) Instead of taking the more traditional suicidal route (doing PCP, popping a wheelie at 60 miles per hour, etc.), this particular 18-year-old finds a doctor and requests physician-assisted suicide. The doctor may find no signs of disordered thinking, except the desire to kill oneself, and that desire alone is no longer considered an inherent sign of mental illness.

The advocates of physician-assisted suicide may protest that they would never condone the killing of a healthy, if despondent, teenager. But then the advocates are trying to have it both ways. They trumpet the principle of personal autonomy to the ultimate degree by allowing and abetting the individual in destroying himself. Then they insist that the victim be rational and define rationality by the strictest socially-imposed standard. That is, the victim must be on death's door and in intractable pain. Philosophical consistency is abandoned in favor of political expediency.

47. There is a difference between making a decision while under the influence of pain and allowing the burden of pain to be weighed in the rational decision-making process. A person in pain may be willing to do anything to make the pain stop. This person is not making an autonomous decision. A person whose pain is temporarily under control may be able to make an autonomous decision in which the prospect of future pain is a factor. In real life, the lines will always be blurred.

48. It is conceded that some people think there are other rational reasons for wanting to die. The concept of physician-assisted suicide has been sold to the American public as a special exception for people who are terminally ill and in intolerable pain. The plaintiffs in *Compassion in Dying* and *Quill* fit this profile. *Compassion in Dying*, 49 F.3d at 588; *Quill*, 80 F.3d at 718. Physician-assisted suicide for other purposes has crept on board as a free

subjectively rational as well. The patient in the final stages of AIDS or cancer may be objectively rational in wishing to hasten death, but if his real reason for hastening death is to avoid being a further burden to his family, he is being irrational.⁴⁹

Advocates of physician-assisted suicide may believe that many "rational" suicides exist. They may believe that the law can distinguish these authentic requests for death from those sullied by forces outside the genuine will of the individual. Such an attitude is founded in complete innocence of the science of psychology and especially of the complex and baffling psychology of suicide.

E. *The Autonomous Decision*

In the field of psychology, autonomy has no proponents.⁵⁰ No one is free from the unconscious forces within their own mind that drives them. Persons frequently misrepresent to themselves what they are trying to do. To become "freer," one must acknowledge and explore the unconscious motivations for one's decisions, or, at minimum, one must be aware of how these motivations affect one's thoughts or conduct.⁵¹ Few persons are able to do so. It would be especially difficult to do on one's deathbed.

Children consciously model themselves after their parents, and children are conditioned to accept their parents' views of life.⁵² Few persons, even in old age, escape these influences. "The child thus learns wholesale - through bulk purchasing, if you will - whole chunks of unexamined perceptions and behaviors that will be integrated and absorbed into the self and then become determinants of her future actions."⁵³

Parents are not the only people influencing their children's lives. Every minute of every day, our strings are being pulled by someone. The advertising industry is founded on the truth that people can be manipulated. Millions of Americans make their living in sales by using carefully honed techniques to secure the consent of their customers. As any psychologist, social worker or divorce lawyer can attest, most families consist of a network of mutual wire-pullers. Few people ever make a fully autonomous decision, and no one is going to start when they are desperately ill, weak and scared.

rider.

49. There are those who think it is sound to ask to be killed in order to free their families of the burden of their existence. See *infra* notes 244-49 and accompanying text for a discussion of freeing families of the burden of taking care of the terminally ill patient.

50. WILLARD GAYLIN & BRUCE JENNINGS, *THE PERVERSION OF AUTONOMY* 132 (Free Press 1996).

51. JAY KATZ, *THE SILENT WORLD OF DOCTOR AND PATIENT* 115 (Free Press 1984).

52. GAYLIN & JENNINGS, *supra* note 50, at 117.

53. *Id.*

The question, "Whose death is it anyway?" implies that death belongs to the dying. That is not true. This is one of the concepts that makes death such a horrifying experience under any circumstances. Death means a loss of control, then a loss of identity and, finally, a loss of existence. The notion that we can master death by orchestrating it is a conceit of the highest order.⁵⁴

A person's ability to make fully autonomous decisions is tenuous, even under the best circumstances. In the face of death, even these feeble powers will falter. In the words of Jay Katz,

Human beings are subject to the influence of reason and unreason, with the relative strength of either being affected by many innate, developmental, and situational factors. Moreover, capacities for reason are impaired whenever human beings are in pain, in love, in mourning, or in the throes of biological, environmental, or social crises.⁵⁵

Robert Burt, a prominent opponent of physician-assisted suicide, paraphrases Kipling in making this point: "If you can keep your head when everyone else around you is losing theirs, you don't realize what is going on."⁵⁶

This escape from reason and reality is not necessarily a weakness, at least for the dying. According to Shneidman,

One of the chief functions of the personality, to protect itself from its own inner workings, is not abandoned toward the end of one's life; it is maintained in force, if not actually increased. A dying person will not permit himself to hear more than he is prepared to digest at that moment. He very rarely "knows" more about his condi-

54. The notion that people have the right to do whatever they want with their own bodies is as common as it is inane. People do not, for example, have a right to put heroin or cocaine into their bodies. Even though the law looks the other way when someone chooses to kill themselves unassisted, this so-called right has its limits. Albin Eser, *The Possibilities and Limits of Help in Dying: A Lawyer's View*, in *DYING WITH DIGNITY: A PLEA FOR PERSONAL RESPONSIBILITY* 74, 87 (John Bowden trans., 1995).

In attempting suicide, men most often choose gunfire while women choose poison. DAVID LESTER, PH.D., *WHY PEOPLE KILL THEMSELVES* 40-41 (1972). It is believed that women shun firearms because they leave behind a very messy corpse. *Id.* Women, it is posited, do not want to inflict upon their loved ones the trauma of finding their brains splattered throughout the room. *Id.*

Suppose that a despondent man takes his life with a gunshot to the head. One of his young children discovers the corpse and, as a result, suffers permanent psychological injury requiring years of treatment. Although no cases on point could be found, it would appear that in many states, that child, through her next friend, could sue her father's estate for negligent infliction of emotional harm.

55. KATZ, *supra* note 51, at 110.

56. Robert Burt, Remarks at the Symposium on Physician-Assisted Suicide at the Western New England College School of Law, (Oct. 18, 1996) (forthcoming Robert Burt, *Rationality and Injustice in Physician-assisted Suicide*, 19 W. NEW ENG. L. REV., 353 (1997)).

tion than is good for him.⁵⁷

A perceptive doctor remains aware of these factors. The doctor knows that lingering, nagging and quite healthy doubts must be entertained regarding the role of unconscious and irrational factors in the process by which patients make decisions.⁵⁸ There are hidden impulses in the doctor's own thinking that do not disappear even after self-reflection and dialogue.⁵⁹

Few doctors fulfill this standard. In fact, what passes for client counseling in many hospitals is merely a tool for risk management devised by lawyers to create a liability-proof record of patient care.⁶⁰ Papers are thrust at patients for their signature, usually with only a modicum of explanation.⁶¹ The belief that the process will be any different in cases of physician-assisted suicide is wishful thinking.⁶²

This is not "death with dignity." Even when the decision does not involve life and death, this process makes a mockery of the concept of autonomy. According to Katz:

[M]ere acceptance of patients' "yes" or "no" response to a proposed intervention may not express respect for their self-determination, dignity, or integrity. Indeed, blindly accepting either response may violate their integrity and constitute an act of disloyalty to the person. Either response, if accepted without question, is disrespectful of patients' capacities for reflective thought, which might have led to a different choice more consonant with their own wishes and expectations.⁶³

II. WHAT MAKES PEOPLE POTENTIAL VICTIMS OF PHYSICIAN-ASSISTED SUICIDE?

This section discusses which patients will be put to death, along with the illusive "rational suicide" victims, if the policy of physician-assisted suicide becomes a regular part of medical practice. In real life, patients will resist type-casting. Their motives will be a changing combination of many of the motives discussed in this section and a few which are unique to the individual.

A. *Victims of Poor Pain Management*

Pain control experts believe that nearly every terminally ill

57. SHNEIDMAN, *supra* note 41, at 30-31.

58. KATZ, *supra* note 51, at 121.

59. *Id.* at 111.

60. Daniel Callahan & Margot White, *The Legalization of Physician-Assisted Suicide: Creating a Regulatory Potemkin Village*, 30 U. RICH. L. REV. 1, 27 (1996).

61. *Id.*

62. *Id.*

63. KATZ, *supra* note 51, at 125.

patient can receive adequate pain relief with existing treatments.⁶⁴ Doctors can manage over ninety percent of the pain experienced by cancer patients through modern drug therapy.⁶⁵ Today's pain control measures do not shorten a patient's life and rarely affect a patient's consciousness.⁶⁶ All of this has been accomplished despite the low priority given to pain control by the medical establishment. Only about one-fifth of one percent of the billion dollar budget of the National Cancer Institute is devoted to pain research.⁶⁷

Despite the state of medical knowledge, many patients suffer from sub-standard pain management. In a recent survey, eighty-five percent of the doctors participating admitted that a majority of cancer patients are under-medicated.⁶⁸ Most patients are treated by primary care physicians and nurses whose training lacked programs emphasizing pain management or symptom control in terminally ill cancer patients.⁶⁹ Control of pain is not considered a reason for admission to a hospital, and terminally ill patients cannot be admitted for this purpose alone.⁷⁰ Cancer patients at centers where most of the patients are members of minority groups are three times more likely to receive inadequate pain therapy treatment.⁷¹ Hospice programs that specialize in pain control do not have enough beds to meet the demand.⁷²

In the Netherlands, where euthanasia has been legalized de facto for a generation, only forty-six percent of the requests for euthanasia involve pain.⁷³ In only five percent of these cases is pain cited as the sole reason for requesting euthanasia.⁷⁴ Euthanasia requests were withdrawn, however, in eighty-five percent of the cases where pain was controlled.⁷⁵ In the words of Richard Lamerton, a leader of the English hospice movement:

64. Yale Kamisar, *Against Assisted Suicide - Even a Very Limited Form*, 72 U. DET. MERCY L. REV. 735, 744 (1995).

65. Susan D. Block & J. Andrew Billings, *Patient Requests to Hasten Death: Evaluation and Management in Terminal Care*, ARCHIVES OF INTERNAL MED., Sept. 26, 1994, at 2039.

66. LAMERTON, *supra* note 18, at 137.

67. Richard A. McCormick, S.J., *Physician-Assisted Suicide: Flight From Compassion*, in ARGUING EUTHANASIA: THE CONTROVERSY OVER MERCY KILLING, ASSISTED SUICIDE AND THE "RIGHT TO DIE" 136 (Jonathan D. Moreno ed., 1995).

68. *Id.*

69. Kathleen M. Foley, *The Relationship of Pain and Symptom Management to Patient Requests for Physician-Assisted Suicide*, J. OF PAIN & SYMPTOM MGMT., 289, 291 (July 1991).

70. *Id.* at 292.

71. Kamisar, *supra* note 64, at 738.

72. Foley, *supra* note 69, at 293.

73. Block & Billings, *supra* note 65, at 2039.

74. *Id.*

75. *Id.*

Once a patient feels welcome, and not a burden to others; once his pain is controlled and other symptoms have been at least reduced to manageable proportions, then the cry for euthanasia disappears. It is not that the question of euthanasia is right or wrong, desirable or repugnant, practical or unworkable. It is just that it is irrelevant.⁷⁶

Of course, there are rare cases in which pain relief cannot be accomplished without sinking the patient into a drug-induced coma.⁷⁷ There will be other cases in which the effect of the medication would be less drastic, but the medication is refused by patients because they wish to remain alert.⁷⁸

Far more typical is the patient whose pain could be more expertly managed.⁷⁹ It would be pleasant to believe that none of these patients will be poisoned upon request. Perhaps the patients' doctors, who did not grasp their need for more morphine, will now engage in sensitive and perceptive patient counseling. Maybe some doctors will become more perceptive, but most will not. It is highly likely that thousands of patients will take poison who would have withdrawn their request if their pain had been properly managed. Only the rash would gamble the lives of these patients on unforeseen improvements in pain control practices.

B. *The Depressed*

Cancer patients are twenty-five times more likely to suffer depression than the general population.⁸⁰ The suicide rate for dialysis patients is ten to fifteen times that for the general population.⁸¹ In a study of 283 patients with chronic pain syndrome, fifty-six percent had some form of depressive syndrome.⁸² Depression is a common symptom of multiple sclerosis.⁸³ Up to forty percent of AIDS victims have significant neurological or psychological ill-

76. LAMERTON, *supra* note 18, at 152.

77. SHAVELSON, *supra* note 27, at 211.

78. *See id.* at 15-34 (describing a patient in the final stages of brain cancer who refused sedatives for terrifying hallucinations, believing the drugs would cause her to lose control).

79. *See supra* notes 64-65 and accompanying text for success rates in pain management of terminally ill patients.

80. Foley, *supra* note 69, at 294.

81. Gary Rodin & John Craven, *Depression and Endstage Renal Disease*, in *AGING AND CLINICAL PRACTICE: DEPRESSION AND COEXISTING DISEASE* 69 (Robert G. Robinson & Peter V. Rabins, eds., 1989). Because there are so many covert ways for a dialysis patient to hasten death, this rate may be underestimated. *Id.*

82. Godfrey D. Perlson & Eric Strain, *Depression and Chronic Pain*, in *AGING AND CLINICAL PRACTICE: DEPRESSION AND COEXISTING DISEASE*, *supra* note 81, at 157.

83. Peter V. Rabins, *Depression and Multiple Sclerosis*, in *AGING AND CLINICAL PRACTICE: DEPRESSION AND COEXISTING DISEASE*, *supra* note 81, at 226.

nesses.⁸⁴ Autopsy findings suggest that the real figure may exceed seventy-five percent.⁸⁵ One study in New York City revealed that men with AIDS were sixty-six times more likely than the general population to commit suicide.⁸⁶ In one study of 103 stroke patients, thirty were found to have clinically significant depression, yet none of the thirty were receiving any sort of psychiatric treatment.⁸⁷ Two-thirds of these stroke patients remained depressed seven to eight months after the initial evaluation.⁸⁸ For the most part, physicians seldom diagnose post-stroke depression, and psychological or psychiatric treatment is rare.⁸⁹

There is a lack of data on whether people who are terminally ill, in the absence of a mental disorder, seriously consider suicide or otherwise wish to die.⁹⁰ Almost all terminally ill patients who choose suicide could be diagnosed as suffering from depression.⁹¹ According to Dr. Nicholas Pace of New York University, "When a terminally ill patient contemplates suicide, it usually means he or she is suffering from an irrational thought process, characteristic of major clinical depression."⁹²

The courts are under the unfortunate impression that the average doctor can readily detect depression in a terminally ill patient. In *Quill*, the Second Circuit relied upon a declaration filed by the plaintiffs in support of their Opposition to the Motion for Summary Judgment.⁹³ The declaration, prepared by Dr. Jack Froom, stated, in part, "Physicians can determine whether a patient's request to hasten death is rational and competent or motivated by depression or other mental illness or instability."⁹⁴ Dr. Froom does not state how readily a doctor can make this determination. He does not state how many mistakes might be made in making this determination in the course of a doctor's practice. Dr. Froom also does not state the difficulties a particularly skilled physician may have in detecting depression in the terminally ill. He gives no authority for the statements he makes in the declara-

84. Frederick W. Schaerf & Robyn R. Miller, *Depression and Human Immunodeficiency Virus (HIV-1) Infection*, in AGING AND CLINICAL PRACTICE: DEPRESSION AND COEXISTING DISEASE, *supra* note 81, at 170.

85. *Id.*

86. *Id.* at 177-78.

87. John R. Lipsey & Rajesh M. Parikh, *Depression and Stroke*, in AGING AND CLINICAL PRACTICE: DEPRESSION AND COEXISTING DISEASE, *supra* note 81, at 188.

88. *Id.*

89. *Id.* at 194.

90. James H. Brown et al., *Is It Normal for Terminally Ill Patients to Desire Death?*, AM. J. OF PSYCHIATRY, Feb. 1986, at 208.

91. SHAVELSON, *supra* note 27, at 40.

92. *Id.* at 42-43.

93. *Quill v. Vacco*, 80 F.3d 716, 721 (2d Cir. 1996) *rev'd sub nom. Vacco v. Quill*, 117 S. Ct. 2293 (1997).

94. *Id.*

tion.

Dr. Froom did not make his statement on a witness stand. He was not subject to cross-examination. Expert witnesses with opposing opinions were not brought before the Court. His statement did not even appear in a professional journal where it would be subject to peer review.

Before granting a motion for summary judgment, a court must find that there are no genuine issues as to any material fact.⁹⁵ Declarations such as Dr. Froom's are useful to show to the court that such issues still exist and that a trial is necessary to resolve the factual dispute.

An appellate court, as opposed to a legislature, would have ruled that the issue of undiagnosed depression had to be resolved at the trial level before the court could rule on the constitutional issues. Instead, the court accepted Dr. Froom's declaration as established fact.⁹⁶ Despite Dr. Froom's opinion, many doctors find that detecting depression in the terminally ill can be very difficult.⁹⁷ In order to conduct a thorough psychiatric interview, one to two hours is required.⁹⁸ The terminally ill, however, can usually only endure an interview of less than twenty minutes.⁹⁹ Further, medication can interfere with the patient's ability to participate in the interview.¹⁰⁰

Many drugs used in treating cancer, especially the corticosteroids, often cause severe psychiatric reactions, including depression.¹⁰¹ Patients with advanced pancreatic cancer and somatic symptoms are often depressed.¹⁰² Further, depression makes the pain worse, increasing the patient's suffering.¹⁰³ All of these factors make it difficult to diagnose depression without a thorough psychiatric interview and analysis of the record.

According to Dr. Robert G. Robinson:

[E]ven if a patient has an understandable explanation for their depression and some of the symptoms of the depression may be attributable to their medical illness or hospital routine, any patient who meets the diagnostic criteria for major depressive disorder or organic mood syndrome should have a trial, if possible, on antidepressant medication.¹⁰⁴

95. FED. R. CIV. P. 56(c).

96. *Quill*, 80 F.3d at 721.

97. Brown et al., *supra* note 90, at 208.

98. *Id.*

99. *Id.*

100. *Id.*

101. Donna B. Greenberg, *Depression and Cancer*, in AGING AND CLINICAL PRACTICE: DEPRESSION AND COEXISTING DISEASE, *supra* note 81, at 108.

102. *Id.* at 107.

103. *Id.*

104. Robert G. Robinson, *Introduction to Depression and Chronic Medical Illness*, in AGING AND CLINICAL PRACTICE: DEPRESSION AND COEXISTING

Some conditions require that the patient be medicated for up to eight weeks before results are achieved.¹⁰⁵

If physician-assisted suicide is legalized, many patients will be killed whose request for poison was triggered by undiagnosed depression. The poor and the downtrodden will represent more than their share of the victims.¹⁰⁶ This group is more likely to be depressed when they are terminally ill, and their depression is less likely to be diagnosed.¹⁰⁷ In Donna B. Greenberg's study of cancer patients she stated:

Vulnerability to distress following diagnosis was predicted by lower socioeconomic status, presence of alcohol abuse, living alone, marital problems if married, history of psychiatric treatment, advanced staging of cancer and more physical symptoms. These vulnerable patients had more problems of all types, expected and received little help, and saw physicians as less helpful and concerned. They were more suppressed and passive, more fatalistic and submissive, more isolated, more regretful about the past, more indecisive about therapy, and more likely to blame others or themselves for the illness. Lower ego strength predicted greater distress.¹⁰⁸

C. *The Confused Patient*

Numerous difficulties are associated with attempting to counsel ailing clients. Their attention spans may be short. They may be too ill or too preoccupied to concentrate. They may not be able to hear everything. Their thinking processes may be slowed. Their judgment may be impaired by medication. They may be nodding agreeably to everything that is said without being able to understand a word of it. They may forget vital facts that they were told yesterday or the day before. They may lack the strength to say what they know or tell about their wishes. There may be some questions about their competence, but not enough to deem

DISEASE, *supra* note 81, at 6.

105. *Id.* at 8.

106. This prediction may turn out to be wrong. African-Americans, who bear the brunt of poverty in this country, have a suicide rate of only one-fourth that of white Americans. See Statistical Abstract of the United States, 1996-97, Table 132 (stating that as of 1993, the suicide rate for Caucasian Americans is 13.1 per 100,000 and the suicide rate for African Americans is 7.0 per 100,000). It is suspected that people who are wrapped-up in the struggle for day-to-day existence seldom become suicidal. Suicide is not the impulse of reason, but of pernicious brooding. Tolstoy, when wrapped in the nihilism of the intelligentsia, flirted with suicide. SARA N. CARROLL, A BIOGRAPHY OF LEO TOLSTOY 106 (Harper & Row 1973) He was rescued by his later identification with the Russian peasantry. *Id.* at 108-09.

The discrepancy in suicide rates is further evidence that the decision to kill oneself is seldom the result of careful, rational decision-making, but the fruit of social conditioning and social environment.

107. Greenberg, *supra* note 101, at 108.

108. *Id.*

them incompetent.

Doctors face the same problems with their patients, but not all doctors have the talent, patience and sensitivity to work through them. Given the stage of life at which physician-assisted suicide is likely to be an option, thousands of confused patients will be considered candidates for poisoning. The persevering doctor will explore, in depth, the reasons for a request for death even with a tough patient. Many doctors will be less exacting.

D. Diagnosis as an Excuse

There are countless people in this country who hate life and want to die, and a terminal diagnosis will only give them the opportunity to carry out this desire. Their gloomy outlook may not have prevented them from holding a job or getting on with life. They may have hidden their melancholy behind a sociable facade. A sense of duty, a lack of will, or a lack of imagination may have ruled out the possibility of committing suicide in the past. However, a terminal diagnosis now makes suicide an acceptable option. Perhaps these patients ought to be diagnosed as depressed, but they will not be. Their gloom will be viewed as an intricate element of their character.

E. The Physician-Influenced Suicide

Almost every patient who requests poison will be influenced to some degree by the reaction of the treating doctor and the medical staff. If the request is met with horror, the patient probably will dismiss the idea as unacceptable.¹⁰⁹ If the request is met with support or tolerance, this reaction will morally bind the patient. A cool reaction or no reaction at all will have the same effect as a doctor who tells the patient that suicide is the correct alternative. If the doctor broaches the subject, it often will shatter the patient's morale. Whether a patient lives or dies will often depend on the ideology of the treating doctor.

Sixteen years ago, Dr. Gary Reiter, now of the Tufts University School of Medicine, began practicing in San Francisco. He specializes in treating AIDS patients. Dr. Reiter reports that no patient has ever asked him to assist them in committing suicide.¹¹⁰ He readily admits that the same result is often achieved by terminating unwanted medical treatment.¹¹¹ Dr. Reiter's experience is remarkable, given the fixation on euthanasia which has gripped

109. In most situations, the question asked will not be "What do I really want?" but, rather, "Am I doing this right?"

110. Gary Reiter, Remarks at the Symposium on Physician-Assisted Suicide at the Western New England College School of Law (Oct. 18, 1996). See *supra* note 25 referring to the Symposium and the forthcoming Symposium issue of the Western New England Law Review.

111. *Id.*

the gay community since the advent of the AIDS epidemic.¹¹² It may be that Dr. Reiter projects the attitude that killing is unacceptable and that even gay men with AIDS are worthy of life.

As pointed out by the three-judge panel which heard the initial appeal in *Compassion in Dying*, physician neutrality and patient autonomy, independent of the advice of the doctor, are largely myths.¹¹³ Most patients follow their doctor's recommendations.¹¹⁴ "Once the physician suggests suicide or euthanasia, some patients will feel that they have few, if any, alternatives but to accept the recommendation."¹¹⁵

This reality may be hidden from the very people who will decide if doctors will be given the license to kill. Most judges and legislators are the social equals of doctors. They include doctors in their circle of friends. Judges are not in awe of doctors. They know that doctors make mistakes and that second opinions are often in order. They may even refer to a doctor by his first name. The same is not true of people on the other side of the tracks. For many people living on that side of the tracks, the word of the doctor is virtually the word of God.

F. The Abandoned

Many terminally ill people die alone. This occurs in all social classes and even to people who had a wide circle of friends before they became ill. In the words of Dr. Leon Kass:

Dying people are all too easily reduced ahead of time to "thinghood" by those who cannot bear to deal with the suffering or disability of those they love. Objectivication and detachment are understandable defenses. Yet this withdrawal of contact, affection and care is probably the greatest single cause of dehumanization of the dying.¹¹⁶

In Anna Quindlen's novel, *One True Thing*, Kate Gulden is a popular "faculty wife," well-known and widely respected both on and off campus.¹¹⁷ Yet during the last two months of her illness,

112. SHAVELSON, *supra* note 27, at 46.

113. *Compassion in Dying v. Washington*, 49 F.3d 586, 592 (9th Cir. 1995), *rev'd en banc*, 79 F.3d 790 (9th Cir. 1996), *rev'd sub nom. Washington v. Glucksberg*, 117 S. Ct. 2258 (1997).

114. *Id.*

115. *Id.* See also NEW YORK STATE TASK FORCE ON LIFE AND THE LAW, WHEN DEATH IS SOUGHT: ASSISTED SUICIDE AND EUTHANASIA IN THE MEDICAL CONTEXT 122 (1994) (evidencing the best one-volume study of "physician-assisted suicide" in print, superior to those offered by commercial and academic publishers). It is available for nine dollars from Health Education Services, P.O. Box 7126, Albany, New York 12224.

116. Leon R. Kass, *Death with Dignity and the Sanctity of Life*, in ARGUING EUTHANASIA: THE CONTROVERSY OVER MERCY KILLING, ASSISTED SUICIDE AND THE "RIGHT TO DIE," *supra* note 67, at 229.

117. See generally ANNA QUINDLEN, ONE TRUE THING (Random House 1994) (chronicling the last days of a dying cancer patient and the decisions regard-

almost no one, except her nurse, came to visit her.¹¹⁸ Even though Kate Gulden is a fictional character, her experience rings true. The ability to deny death is reinforced by refusing to face the dying.

Dying alone is even worse for the poor. The poor are more likely to come from disorganized families. They are more likely to have lost their spouses to early death or divorce. They are more likely to have suffered alcoholism, drug abuse and other forms of mental illness which tend to ravage the ties of friendship and family. In many cases, the very illness which isolates the individual is also that which renders him poor. People enjoy the stereotype of the large, closely knit family of straightened means, rich in spirit, if poor in wealth. Thousands of such families do exist. More common are the families which try to practice this ideal, but fail. Too common are families which are families in name only. The late Christopher Lasch wrote that the Hobbesian war of all against all had become a reality in many of our poorer neighborhoods.¹¹⁹

Those who die abandoned by all but the medical staff are less able to resist suggestions, veiled or otherwise, that poison is the best solution. These patients lack the strength, both literally and figuratively, to stand up for themselves. They lack that special person who will sit by their bedside and say the words they are longing to hear in a loud, firm voice, "I do not want you to die."

G. Victims of Fashion

The current crusade for consensual killing is not the result of more people suffering agonizing deaths. Despite inadequate research and development in palliative care,¹²⁰ despite deficient training in pain management,¹²¹ we enjoy better pain control than any other generation in history. The vast majority of terminally ill patients need not suffer chronic, debilitating pain.

German legal scholar Albin Eser notes an "almost Copernican shift" in attitudes toward life in our time.¹²² Sherwin Nuland, in his book, *How We Die*, describes the decline of his beloved grandmother a generation ago.¹²³ Late in her nineties, nearly blind, unable to leave her home, losing all of her physical and mental facul-

ing suicide that she and her daughter had to make).

118. *Id.*

119. See generally CHRISTOPHER LASCH, *THE REVOLT OF THE ELITES AND THE BETRAYAL OF DEMOCRACY* (1995) (discussing the decline of democracy and discourse in America).

120. McCormick, *supra* note 67, at 136.

121. Foley, *supra* note 69, at 289.

122. Eser, *supra* note 54, at 87.

123. See generally SHERWIN B. NULAND, *HOW WE DIE: REFLECTIONS ON LIFE'S FINAL CHAPTER* 43-63 (1993) (discussing the death of the author's grandmother).

ties, she suffered a serious stroke.¹²⁴ Her doctor told her family that hers was a hopeless case.¹²⁵ All they could do is sit and wait for death.¹²⁶

But the Nuland family could not accept that prognosis.¹²⁷ They rallied around their beloved matriarch.¹²⁸ They did everything they could to help her recover because that is what people did in those days.¹²⁹ Despite the long odds, Grandmother recovered within a few weeks and lived another eight months before another illness took her.¹³⁰

The more modern attitude is exemplified by German theologian Hans Küng:¹³¹

Would it not be consistent to assume that the same God now, more than before,¹³² has made the end of human life a human responsibility? This God does not want us to foist responsibility on him that we ourselves can and should bear. With freedom God has also given human beings the right to utter self-determination.¹³³

Freedom? Yes. Responsibility? Yes. Self-determination? Yes. Life? Maybe. People living in this age would rather weigh the value of life than embrace it. For those like Shurland Nuland's grandmother who need the unconditional, unquestioning support of those around her to survive, these are dangerous times to be alive.

H. The Faulty Diagnosis

Doctors may know to a medical certainty that a particular illness is fatal. What they cannot predict to any degree of scientific accuracy is how long the patient may be expected to live. Doctors'

124. *Id.* at 59.

125. *Id.*

126. *Id.*

127. *Id.* at 60-61.

128. *Id.*

129. NULAND, *supra* note 123, at 60-61.

130. *Id.* at 61.

131. Hans Küng, *A Dignified Dying*, in *DYING WITH DIGNITY: A PLEA FOR PERSONAL RESPONSIBILITY*, *supra* note 54, at 30.

132. It is puzzling as to why Küng thinks that God would be more disposed to give the power over life and death to the men and women of our day than He was to our forebears. *Id.* What, exactly, have people done to earn this Divine trust? Which world war? Which set of concentration camps? Which mass bombing of civilian targets? We live in a century in which no tyrant can hope to win world attention for more than a year or two unless he has killed at least a million people. Despite this, Küng assumes people are more enlightened than those who have gone before them. He confuses change with progress, and progress with wisdom.

133. *Id.* It is difficult to understand how Küng's doctrine of the "right of utter self-determination" can be squared with any residual notion of sin or ethics, as ethics has been traditionally understood.

predictions often turn out to be inaccurate.¹³⁴ As currently contemplated, a patient could ask for physician-assisted suicide at any time after a terminal diagnosis is rendered. Many patients who are told they have a few weeks to live may opt for poison immediately rather than experience the trying physical decline into death. Given the guesswork involved in predicting when death will come, many of these patients may have enjoyed many months of pain-free, productive, and perhaps rewarding life. Disregarded in this guesswork is the effect of hope, love and support which often delays the progression of disease in ways which current medical knowledge does not fully comprehend.¹³⁵

I. Unintended Consequences

Many of those who will choose poison may not anticipate the consequences of their actions, especially upon their family and friends. Those who choose physician-assisted suicide rather than burdening their families, may well lay a burden of guilt on their loved ones which they never will be able to shake.

The consequence of this inability to read the minds of others is illustrated in Wallace Stegner's novel, *Crossing to Safety*. The central character, Charity Lang, is a charming and magnetic New England grande dame who is dying of cancer.¹³⁶ Her outstanding vices are her obstinate faith to her own judgment and her condescension toward her husband, Sid, whom she loves nevertheless.¹³⁷ As her disease reaches its final stages, she steals away unannounced with her best friend to live out her final days.¹³⁸ In this way, she hoped to spare Sid the agony of her last moments and to shield herself from his grief.¹³⁹ Sid is devastated by this maneuver.¹⁴⁰ He disappears and his best friend spends several anxious hours searching for him, fearing that he may have committed suicide.¹⁴¹ He had not, but it would not have been out-of-character if he had.¹⁴²

The novel is set in 1972, which, in terms of euthanasia, was centuries ago. In 1997, a real-life Charity Lang might choose poison, without appreciating the effect it would have on those she loved.

134. Callahan & White, *supra* note 60, at 46.

135. *Id.*

136. See generally WALLACE STEGNER, *CROSSING TO SAFETY* (Thorndike Press 1987) (recounting the death of Charity Lang).

137. *Id.*

138. *Id.*

139. *Id.*

140. *Id.*

141. *Id.*

142. STEGNER, *supra* note 136.

J. Unwarranted Fear of the Dying Process

The popular press is filled with so many stories about the horrors of medicalized dying that many people assume the worst scenario is also the most common. Doctors now encounter many ill-informed patients who refuse resuscitation or ventilator use, even though the use of these machines might restore life and meaningful function.¹⁴³ Patients with an unrealistically pessimistic outlook on their final days are apt to choose physician-assisted suicide. A disturbing minority of deaths are as bad as they are painted. "Natural" death, although bearable, is often horrible. What is disturbing is that many people who would have chosen to bear the burden of a natural death will be stampeded into taking poison because of exaggerated foreboding.

K. The Loss of an Enriching Experience

Some people do their best living when they are dying. Edwin Shneidman writes, "We can love a dying person, and permit a dying person to love us, in a meaningful way that is not possible in any other psychotherapeutic encounter."¹⁴⁴ Things can be said that cannot be said at any other time of life. In Shavelson's book, one of the dying patients enjoys an unexpected reconciliation with her long estranged son on the day before her death.¹⁴⁵ Another of Shavelson's subjects, an AIDS victim contemplating suicide, has shut himself off from the world, convinced it has nothing more to offer him but suffering.¹⁴⁶ He frustrates all efforts of his hospice nurses to work with him.¹⁴⁷ However, when his energetic young daughter comes to visit him, his attitude enjoys a complete reversal.¹⁴⁸ His final months, though full of pain, are also full of joy.¹⁴⁹ He dies of natural causes.¹⁵⁰ The third subject is a woman in the final stages of brain cancer.¹⁵¹ Shavelson shoots a picture shortly before her suicide showing her surrounded by four of her friends.¹⁵² This is not a horrible death. For the four sitting by her, it is one of the richest and most authentic experiences of their lives. It is possible that other such experiences awaited her had she chosen

143. Erich H. Loewy, *Advanced Directives: Panacea for Safeguarding Patient Autonomy or a Convenient Way of Avoiding Responsibility?*, in *HEALTH CARE ETHICS: CRITICAL ISSUES* 120 (John F. Monagle & David C. Thomasma eds., 1994).

144. SHNEIDMAN, *supra* note 41, at 9.

145. SHAVELSON, *supra* note 27, at 158-202.

146. *Id.* at 35-67.

147. *Id.* at 39.

148. *Id.* at 52-53.

149. *Id.* at 53-55.

150. *Id.* at 63.

151. SHAVELSON, *supra* note 27, at 15-67.

152. *Id.* at 26.

against suicide.

If euthanasia becomes legal, if it becomes a common and accepted part of our culture, it will completely distort the nature of our dying. For those who are broodish by nature, the practice will destroy any hope for a final, unhurried reconciliation. Once people understand that they are terminally ill, not an hour will pass for the remainder of their lives that they will not ask themselves, "Why not do the right thing and take poison?"

Anna Quindlen's fictional creation, Ellen Gulden, is highly ambitious, yet she quit the staff of a leading New York City magazine to care for her mother, Kate, during the last six months of Kate's life.¹⁵³ Though the final weeks of Kate Gulden's life were hideous, the previous months were the most important in both women's lives.¹⁵⁴

Had euthanasia been an accepted part of their culture, it would not have been out of character for Kate. Gulden to seek physician-assisted suicide, rather than ruin her daughter's career prospects. In fact, given Kate Gulden's combination of altruism and grit, she probably would have given her daughter an ultimatum - "go back to New York or I will do it now." Ms. Quindlen may not appreciate the alternative ending, especially since it turns a fine novel into a drab short story. But in real life, for every "Kate Gulden" who fights it out until the final stages, there will be another who will "do their duty" when they realize that they are being a burden.

L. *The Incomprehension of Finality*

Even atheists tend to talk about death as a "journey," as though it would take people somewhere. The bitter truth is that death exterminates one's existence. All that remains is a corpse which, unless disposed of promptly, will become offensive to the eyes and nose. The decision to help a patient commit suicide requires that both the doctor and the patient conclude that the patient's life is not worth living. But if the doctor wants to be accurate, he should say, "You are not worth living."

However, it may be inherently impossible for human beings to truly imagine their own non-existence. The religious imagery of "looking down from Heaven" is so ingrained that it remains universal even in this secular age. Many atheists, such as Freud, believe that the visceral need to deny the finality of death gave rise to religion.

According to Avery D. Weisman, "Man accepts the reality of organic and objective death, but cannot imagine his own extinction. Consequently, despite obvious depletion and deterioration,

153. See generally QUINDLEN, *supra* note 117.

154. *Id.*

most patients still cling to an image of survival which promises to preserve their unique, distinctive *consciousness*.¹⁵⁵ In the words of Miguel Unamuno, "It is impossible for us, in effect, to conceive of ourselves as not existing, and no effort is capable of enabling consciousness to realize absolute unconsciousness, its own annihilation."¹⁵⁶ This echoes an earlier statement of Freud's:

Our own death is indeed unimaginable, and whenever we make the attempt to imagine it, we can perceive that we survive as spectators. Hence, the psychoanalytical school could venture on the assertion that at bottom no one believes in his own death, or to put the thing in another way, in the unconscious every one of us is convinced of our own immortality.¹⁵⁷

Many who would choose physician-assisted suicide will bear within themselves a powerful, unexamined, sub-conscious belief in their own survival following death. These people do not make a fully informed decision, and this decision can never be considered autonomous.

M. *Hesitation at the Threshold*

The same subconscious thought that may delude persons with respect to their own immortality may also restrain them from suicidal impulses. Only a tiny fraction of suicide attempts succeed, even those attempts which are more than cries for help.¹⁵⁸ The will to live is written deep within our psyches.

A classic case of a "rational suicide" is told by Richard Selzer, a professor of medicine at Yale.¹⁵⁹ The patient is in the final stages of AIDS.¹⁶⁰ He finds his current suffering meaningless and wants to preserve his dignity and control.¹⁶¹ Everyone in his circle, including his mate, support his decision.¹⁶² A month passes and the patient remains committed to his decision to commit suicide.¹⁶³ Selzer, in an act of mercy, provides him with an ample overdose of a prescription drug.¹⁶⁴ Selzer, at the urging of the patient's friends,

155. AVERY D. WEISMAN, ON DEATH AND DENYING: A PSYCHIATRIC STUDY OF TERMINALITY 100 (1972).

156. SHNEIDMAN, *supra* note 41, at 46.

157. *Id.* The irony of citing perhaps the most famous physician-assisted suicide in history in opposition to the practice is appreciated.

158. See generally *Cognitive Characteristics Predict Adolescent Suicide Attempts*, BROWN U. CHILD & ADOLESCENT BEHAV. LETTER, June 1997.

159. Richard Selzer, *A Question of Mercy*, N.Y. TIMES MAG., Sept. 1991, reprinted in ARGUING EUTHANASIA: THE CONTROVERSY OVER MERCY KILLING, ASSISTED SUICIDE AND THE "RIGHT TO DIE," *supra* note 67, at 63-76.

160. *Id.* at 63.

161. *Id.* at 67.

162. *Id.* at 66.

163. *Id.* at 73-74.

164. *Id.* at 74.

decides not to attend the suicide.¹⁶⁵ The evidence would be such that prosecutors could easily finger him.

When the suicide is botched, the patient is rushed to the hospital and survives.¹⁶⁶ Horrified and guilt-ridden, Selzer confronts his patient on the ward.¹⁶⁷ Surprisingly, after staring death in the face, the patient now wants to live.¹⁶⁸ He dies of natural causes twelve days later.¹⁶⁹

A more horrifying ending occurs in Lonny Shavelson's book.¹⁷⁰ "Gene Robbins" is a depressed and lonely man in his sixties who is obsessed with suicide.¹⁷¹ Robbins is prone to strokes and fears that he will be too physically disabled to take his own life if he waits much longer.¹⁷² Shavelson, a medical doctor, realizes that Robbins is depressed but does nothing to prevent his suicide attempt.¹⁷³ In fact, Robbins admits that he had been prescribed Prozac but refused to take it.¹⁷⁴

Shavelson observes Robbins' suicide, assisted by "Sarah," a fanatical official of the local chapter of the Hemlock Society.¹⁷⁵ At the last moment, Robbins tries to tear the bag that is suffocating him from off his head.¹⁷⁶ Sarah physically restrains him and a dumb-struck Shavelson watches Robbins die.¹⁷⁷

One of the problems with physician-assisted suicide is that it helps the patient to smother that incomprehensible will to live. Physician assisted suicide makes it very socially awkward for the patient to scream out at the last minute, "No! No! No! No! No!" It turns the physician from healer into Charon, ferrying his passengers across the River Styx to the abode of the dead.

N. *The Dignity Myth*

Justice Brennan wrote in *Cruzan v. Director, Missouri Department of Health*,¹⁷⁸ "Dying is personal. And it is profound. For

165. Selzer, *supra* note 67, at 74.

166. *Id.* at 75.

167. *Id.* at 75-76.

168. *Id.* at 76.

169. *Id.*

170. SHAVELSON, *supra* note 27, at 93-94.

171. *Id.* at 68-69. The name "Gene Robbins" is a pseudonym.

172. *Id.* at 71.

173. *Id.* at 75-92.

174. *Id.* at 92.

175. *Id.* at 78. "Sarah" is also a pseudonym.

176. SHAVELSON, *supra* note 27, at 94.

177. *Id.* Leaders of the Hemlock Society movement, including the celebrated Derek Humphrey, learned of this murder (murder being the proper term) and did not report it. *Id.* at 97-99. Shavelson, perhaps out of a misplaced and highly inaccurate sense of journalistic ethics, did not report it either. It is believed he is still practicing medicine unhindered in California. "Sarah" remains as president of a chapter of the Hemlock Society. *Id.* at 95.

178. 497 U.S. 261 (1990).

many, the thought of an ignoble end, steeped in decay, is abhorrent. A quiet, proud death, bodily integrity intact, is a matter of extreme consequence."¹⁷⁹

That such discourse is commonplace is one of the reasons euthanasia in any form must not be legalized. Many people are ready to kill themselves for such specious reasons if given the chance. This is not a question of a clash of values. This is a case of hysterical nonsense versus reality.

If death were not hidden behind institutional walls, public officials would not be talking about dying with our "bodily integrity intact." The whole process of dying is the dismemberment of the self. In the words of Dr. Sherwin B. Nuland, death "is all too frequently a series of destructive events that involve by their very nature the disintegration of the dying person's humanity."¹⁸⁰ According to German physician Dietrich Niethammer, "[O]nly in a small proportion of cases does dying take an acceptable course for the person concerned. There is never anything idyllic about dying. It is bound up with pain, being alone, anxiety, anger, helplessness, resignation, denial and despair."¹⁸¹

Physician-assisted suicide is usually a painful death, often devoid of any dignity. Recall that the most famous assisted suicide in literature is that of Crassus in Shakespeare's *Julius Caesar*, the antithesis of the noble death.¹⁸² There is nothing inherently noble in suicide.

One of the primary justifications for physician-assisted suicide is pain - chronic, serious, intractable, debilitating pain. At the last conscious moment, death might be made less painful by a massive dose of analgesics, but that is not required for euthanasia. It has long been the consensus of bioethicists that patients should receive whatever dosages of pain killers they need to obtain relief, even if, as a secondary consequence, the patient dies. The Catholic Church has long been a part of this consensus.¹⁸³

For most patients, the decision to seek poison will not come as the fruit of quiet contemplation. It will come in a period of physical agony, when the patient literally has reached a physical, emotional and spiritual dead end. Few will die like Socrates, surrounded by friends. Most will die depressed and abandoned, in the depths of despair or uncomprehending, after some hospital committee or group of nephews and nieces has decided they are no

179. *Id.* at 310-11 (Brennan, J., dissenting).

180. NULAND, *supra* note 123, at xvii.

181. Dr. Dietrich Niethammer, *Dignified Dying from a Doctor's Perspective*, in DYING WITH DIGNITY: A PLEA FOR PERSONAL RESPONSIBILITY, *supra* note 54, at 69.

182. WILLIAM SHAKESPEARE, *JULIUS CAESAR* act 5, sc. 3.

183. DECLARATION ON EUTHANASIA (1980), reprinted in VATICAN COUNCIL II 514 (Austin Flannery, ed., 1987).

longer worthy of life.

When Brennan talks about a "quiet, proud death," he only promotes the nonsense that people have to put on some sort of show on their deathbeds. These people need to be told, in a loud, firm voice, that the show is over. When we are dying, composure should go out the window. As for dying with "dignity," dignity is not something people can lose through non-volitional acts. Dignity is something that all people are born with and cannot lose except by committing some reprehensible, discretionary act. They do not lose it because they moan in pain, have tubes coming out of their bodies, fail to recognize their wives or even forget their own names.

The concept that all people have dignity, even the disabled, is the essential dogma of a democratic society. Dignity is not something that can be proved, it is an axiom. It is one of those principles upon which this country was founded. Because of the internal logic of this principle, the right to vote was extended first to poor men, then to men of all races and finally to women. No liberty-loving people will ever allow this precept to be disregarded.

Death with dignity is an ideal in the myth of a good death.¹⁸⁴ "Think of being a heap of charred offal, like a haltered horse burned in his stall; and all in one flash!"¹⁸⁵ That is how Herman Melville described death.¹⁸⁶ In the words of Edwin Shneidman:

[O]ne should know that cessation is the curse to end all curses, and *then* one can, as he chooses, rage, fight, temporize, bargain, compromise, comply, acquiesce, surrender, welcome or even embrace death. But one should be aware of the dictum: Know thine enemy. Death is not a tender retirement, a bright autumnal end of man's cycle, 'as a chock of corn is to his season.' That notion, it seems to me, is of the same order of rationalization as romanticizing kidnapping, murder, impressment, the draft, or rape.¹⁸⁷

For most of the poor people in this country, death with dignity is worse than a myth. It is a farce. It will strike them as odd that a society which has not treated them with a shred of dignity for twenty or thirty years will suddenly become overwhelmed by these sentiments when they are tying up a bed in an intensive care unit. For most of the poor, the fastest and safest method of euthanasia would be to treat them with dignity and compassion. They would die of shock.

184. NULAND, *supra* note 123, at xvi.

185. SHNEIDMAN, *supra* note 41, at 67 (quoting HERMAN MELVILLE, *THE LIGHTNING-ROD MAN* (1952)).

186. *Id.*

187. *Id.*

P. *The Illusion of Control*

Often matched with a desire for a "dignified" death is the wish to avoid a life sullied by dependence or a loss of control. One of the key cases in the development of the law on euthanasia in the Netherlands involved a ninety-five year-old woman in Alkmaar who was killed at her request in 1982.¹⁸⁸ One of the reasons she wanted to die was that she considered dependence on another to be intolerable.¹⁸⁹ The same theme runs through American case studies.¹⁹⁰

The truth is, except for a few survivalists in the mountains, people are dependent on others. Even survivalists rely on the Postal Service to deliver their mail. The reality of dependence might not strike most people until they have to be spoon-fed or can no longer walk to the bathroom. But the reality is always present. People who want to be killed because they can no longer maintain the illusion of control do not need physician-assisted suicide. They need physician-assisted psychiatry.¹⁹¹

Q. *The Pathology of Purpose*

There is nothing wrong with lying in bed, accomplishing nothing. There is nothing immoral about it. Americans are some of the few people in history to whom this must be explained. Most people just do not know how to live in repose. This is especially true of judges, legislators and the opinion-leaders who will influence the decision on physician-assisted suicide. Many of them would go crazy unless they always had something to do. There is little evidence that any more than a handful of them have any interior life at all. If it gets out that a judge might have spent a month fishing, he is compared favorably to Justice Douglas. If a senator publishes a book of poetry, Washington speculates as to the identity of the ghostwriter. The "thoughtful" statesman in America is so rare that he always runs the risk of being captured and placed on display in a circus sideshow.

The three-judge panel in *Compassion in Dying* recognized that American society is an achievement-oriented society and that those who do not conform may feel pressured to remove themselves.¹⁹² Unlike other cultures, there is no role for the dying in American society. They are a costly encumbrance whom we shunt away into institutions. When people say, "I would not want to live

188. CARLOS GOMEZ, REGULATING DEATH: EUTHANASIA AND THE CASE OF THE NETHERLANDS 34 (1991).

189. *Id.*

190. See, e.g., SHAVELSON, *supra* note 27, at 23, 166 (discussing case studies where patients could not tolerate having to depend on others).

191. This is not meant as a jest. Loss of bladder and bowel control is excruciating. This is exactly the type of crisis which demands professional help.

192. *Compassion in Dying v. Washington*, 49 F.3d 586, 593 (9th Cir. 1995).

like a vegetable,"¹⁹³ they usually mean something beyond, "I would not want to live if I had permanent neocortical failure." In fact, being permanently bed-ridden with a fully functioning mind would be more painful for them than a state of permanent semi-consciousness. For them, the right to be is forever entangled with the duty to do. Many people who suffer from this form of pathological thinking will choose physician-assisted suicide if it is available, without ever confronting the hollowness of their view of life. Many others will feel pressured to conform, even if they could tolerate being a permanent lay-about. They will not be able to ignore the social stigma.

Another variant of the pathology of purpose is expressed by the German theologian, Hans Küng, an advocate of physician-assisted suicide. Küng states, "[T]he fight for health is meaningful as long as healing is possible, but a fight against death at any price is nonsensical: it is a help which becomes a torment."¹⁹⁴

Küng, however, is wrong. Life has meaning, even if healing is not possible. Every moment of life has meaning right to the very end. The fight against death is never nonsensical. It may make sense to accept an inevitable death. This outlook is central to the hospice movement. But if one should choose to fight for life by any means at hand right to the final breath, it makes all the sense in the world.

Note well that Küng does not say it is nonsensical not to give patients the choice. That is an entirely different question. He is saying that to choose life under such extreme circumstances is nonsensical.¹⁹⁵ Küng's philosophy reflects that of a vast majority of the social elite. The dying will have to deal with this philosophy if given the choice to have themselves poisoned.

R. *The Vengeful Playwright*

Throughout this debate, it is interesting to discover that many people look upon their lives as some sort of stage play in which they serve as both playwright and leading character. Instead of enjoying life as it comes, they are always trying to put on a show. That is what all the "shame" and "dignity" nonsense is all about.

In the Netherlands, one of the reasons for allowing euthanasia is to prevent "potential disfigurement of the personality" or to prevent a life which would "tarnish the patient's personality."¹⁹⁶ Küng illustrates the point when he states that he would rather be

193. See LAMERTON, *supra* note 18, at 158 (discussing why the use of the term "vegetable" in reference to a human being is a sign of bad breeding).

194. Küng, *supra* note 131, at 16.

195. *Id.*

196. GOMEZ, *supra* note 188, at 39, 42.

dead than be an Alzheimer's patient, even a merry Alzheimer's patient.¹⁹⁷ "I don't want to see myself wandering through Tübingen one day to the amusement of the survivors!"¹⁹⁸ Another example comes from Lonny Shavelson's case study of Renee Sohm.¹⁹⁹ "I'm not convinced she wants to do it," said one of her friends.²⁰⁰ "She's feeling the pressure of what she's told us for the last four years."²⁰¹ Another friend talks of Renee's "intellectual commitment to suicide."²⁰²

In other words, these people would rather die than make fools of themselves. No wonder these people are so full of anxiety. When the "actor" can no longer perform the part assigned by the "playwright," the "playwright" has vowed to kill him. It is a classic murder-suicide pact; a pervasive and pernicious form of mental illness whose symptoms do not become apparent until our faculties begin to fail.

S. *The Pawns of Custom*

One of the most horrifying aspects of the majority opinion in *Compassion in Dying* is its paraphrase of the 1901 New Jersey case, *Campbell v. Supreme Conclave Improved Order Heptasophs*.²⁰³ Here is what the Ninth Circuit took out of the *Campbell* case: "[A]ll will admit that in some cases it (suicide) is ethically defensible," the court said, as when a woman kills herself to escape being raped or "when a man curtails weeks or months of agony of an incurable disease."²⁰⁴

Once in a while people have to be shocked into facing just how bad things were in the not-too-distant past. In 1901, it was universally considered proper for a woman to kill herself to avoid sexual assault. The exact words the New Jersey court used were, "Suicide may be self-sacrifice, as when a woman slays herself to save her honor."²⁰⁵ I doubt that many women, even in that benighted time and place, were so brainwashed as to follow this savage practice. Leaping from the cliff probably was more a part of Victorian novels than of Victorian reality. But it speaks volumes about the status of women that a court, without reflection, would pass off such pathological behavior as commendable.

197. Küng, *supra* note 131, at 108.

198. *Id.*

199. SHAVELSON, *supra* note 27, at 26-27.

200. *Id.* at 26.

201. *Id.*

202. *Id.* at 27.

203. 49 A. 550 (1901).

204. *Compassion in Dying v. Washington*, 79 F.3d 790, 809-10 (9th Cir. 1996) (quoting *Campbell v. Supreme Conclave Improved Order Heptasophs*, 49 A. 550 (1901)).

205. *Campbell*, 49 A. at 553.

What is more shocking is that a Federal Circuit Court in 1996 would cite this case and its illustration with approval. At the very least, it should have made the court wonder if the dignity-obsessed patients of 1996 might be just as much the pawns of social custom as the chastity-obsessed women of 1901.

People are all victims of social brainwashing and none more than the person who thinks they are above such things. Everyone is living out life scripts, many of them destructive, but few people even have the insight needed to change the stage directions. According to Gaylin and Jennings:

By the time the average child reaches adulthood, he carries within him certain values and sensibilities that force much of his behavior into automatic patterns. He has been, in other words, so indoctrinated by conditions of his early childhood and by the values of his caretakers that his in-built set of values and propriety, his conscience, and his self-image impose limitations on his freedom of action.²⁰⁶

All of people are deluded to some degree by corrupt social mores. Clemenceau said that "America is the only nation in history which miraculously has gone directly from barbarism to degeneration without the usual interval of civilization."²⁰⁷ Nothing illustrates his point better than the Ninth Circuit's approval of suicide to avoid heavy medical expenses.²⁰⁸

In 1901, a woman's chastity was more important than her life. In 1996, money is more important than life. One-hundred years from now, people may realize that suicide to reduce medical bills is the suttee of a money-mad culture. They may even come to realize that nothing is more important than life.

T. Continence

Janet Good is the founder of the Hemlock Society of Michigan and an associate of Jack Kevorkian's.²⁰⁹ She has cancer.

"Pain is not the main reason we want to die," says Janet Good. "It's the indignity."

It's the inability to get out of bed, or get onto the toilet, let alone drive a car and go shopping, without another's help.

"I can speak for literally hundreds of people whose bedside I've sat

206. GAYLIN & JENNINGS, *supra* note 50, at 118.

207. ROBERT ANDREWS, *THE COLUMBIA DICTIONARY OF QUOTATIONS* 938 (Columbia University Press 1993), *quoted in* SATURDAY REVIEW OF LITERATURE, Dec. 1, 1945.

208. *Compassion in Dying*, 79 F.3d at 826. See *infra* notes 250-52 and accompanying text for an elaboration on the issue of expenses.

209. Richard Leiby, *Whose Death Is It Anyway?*, WASH. POST, Aug. 11, 1996, at F1.

over the years. Every client I've talked to - I call them 'clients,' because I'm not a medical professional - they've had enough when they can't go to the bathroom by themselves. Most of them say, 'I can't stand my mother, my husband,' " - she gropes for a delicate expression - 'wiping my butt,' "210

It is not about pain. It is about incontinence. Of all the absurd reasons for killing one's self, none matches this. Millions of people in this country suffer from incontinence. It is a very big business. Incontinence is very embarrassing and humiliating at first, but people get over it.

The Ninth Circuit shares in this childish revulsion to a basic human need.²¹¹ The court clings to the taboo against incontinence while abandoning the taboo against killing.

U. *The Hidden Message Is - Drop Dead*

What moral are we sending our infirm and disabled when we tell them there is more dignity in a cadaver than in a suffering human being? Kelly Niles was a man who spent his entire adult life in a wheelchair and needed an electronic box to communicate with others.²¹² A lawsuit had secured for him \$4,000,000, with which he was able to hire a relay of attendants and assistants.²¹³ His every physical need was met.²¹⁴ He had a magnetic personality and hordes of well-wishers were drawn to him.²¹⁵ When Niles decided to starve himself to death, he was interviewed by therapists, a court-appointed reviewer, a police inspector, a psychologist, family members and friends.²¹⁶ None of them interceded to stop him because they could not see beyond the chair.²¹⁷ All of them concluded that Kelly Niles' death wish was the reasonable desire of a mature and rational man.²¹⁸ Paul Longmore, who has studied the emotional complications of physical disability, has called this attitude "the ultimate act of oppression."²¹⁹

Elizabeth Bouvia, a California woman with quadriplegia, created a sensation when she successfully petitioned the courts to allow her to cut off her life support system.²²⁰ The court said:

210. *Id.*

211. *Compassion in Dying*, 79 F.3d at 814. Perhaps this is a reflection on the severity of the judges' early childhood training.

212. SHAVELSON, *supra* note 27, at 110.

213. *Id.* at 114.

214. *Id.*

215. *Id.* at 109.

216. *Id.*

217. *Id.* at 113.

218. SHAVELSON, *supra* note 27, at 109.

219. *Id.* at 109.

220. *Bouvia v. Superior Ct.*, 179 Cal. App. 3d 1127, 1134 (Cal. Ct. App. 1986).

Petitioner would have to be fed, cleaned, turned, bedded, toileted by others for 15 to 20 years! Although alert, bright, sensitive, perhaps even brave and feisty, she must lie immobile, unable to exist except through physical acts of others. Her mind and spirit may be free to take great flights but she herself is imprisoned and must lie physically helpless subject to the ignominy, embarrassment, humiliation and dehumanizing aspects created by her helplessness It is incongruous, if not monstrous, for medical practitioners to assert their right to preserve a life that someone else must live, or, more accurately, endure for 15 to 20 years.²²¹

When Elizabeth Bouvia petitioned the court, she had a number of other problems, including a recent miscarriage, a broken marriage, no one to care for her and no place to live.²²² There was much more to her wish to die than her medical condition.²²³

A less celebrated case was that of David Rivlin, a thirty-eight year old man who had been paralyzed in a swimming accident eighteen years before and was dependent on a respirator.²²⁴ Like most of the 15,000 Americans in his position, Rivlin was forced to live in a nursing home on \$300 a month from the government.²²⁵ The court granted Rivlin's petition without pondering whether his request might be colored by his grinding poverty or bleak prospects.²²⁶

Of the many evils addressed in the decision in *Brown v. Board of Education*,²²⁷ the greatest, perhaps, was the damage that segregation inflicted on the psyches of African American children.²²⁸ The Court was moved by the results of the research compiled by sociologist Kenneth Clark, that showed how segregation led many African American children to believe in their own inferiority.²²⁹

In the same way, the practice of physician-assisted suicide encourages the frail, the elderly and the disabled to look upon their lives as meaningless.²³⁰ The language in the *Bouvia* decision is blatant about it.²³¹ In termination of life support cases, the

221. *Id.* at 1143-44. The *Bouvia* court appears to be ignorant of the fact that thousands of our fellow citizens are completely dependent on others to meet their daily needs and that they feel no ignominy, embarrassment or humiliation. Incidentally, Elizabeth Bouvia changed her mind.

222. Donald J. Beschle, *The Role of the Courts in the Debate on Assisted Suicide: A Communitarian Approach*, NOTRE DAME J.L. ETHICS & PUB. POL'Y 367, 376 (1995).

223. *Id.*

224. SHAVELSON, *supra* note 27, at 133.

225. *Id.* at 133-34.

226. *Id.*

227. *Brown v. Board. of Educ.*, 347 U.S. 483 (1954).

228. *Id.* at 494.

229. *Id.* at 494 n.11.

230. *Bouvia*, 179 Cal. App. 3d at 1143-44 (1986).

231. *Id.*

courts, by implication, have developed a macabre two-part test, although have been candid enough to state it. The first prong is the determination that the patient wants to die. The second prong is the determination that the patient's life is no longer worth living.

There is, however, a vast middle group of people with conditions which are similar to those suffered by patients who have met the two-part test, but who do not want to die; at least not yet. They are living lives which the courts have declared are no longer worthy of living.

V. *The Guilt-Plagued*

When one-half or three-fourths of the terminally ill choose to kill themselves, where does that leave the remainder? Their feelings of guilt and shame will be almost unendurable, especially if they are causing their families financial and emotional hardship. Many who want to continue living, many who are more afraid of death than of pain, may yet feel compelled to ask for poison to escape the demon of guilt. "All upbringing is a cultivation of the sense of guilt on an intensive scale," said the Swiss psychiatrist, Paul Tournier, in a study published more than thirty years ago.²³² "A guilty conscience is indeed the inevitable seasoning of our daily life."²³³

The strata of society which promotes physician-assisted suicide is the same group that denigrates the validity of feelings of guilt. But as much as the "New Man" tries to deny guilt, he cannot escape it. Though he would never admit it, he even feels guilty about feeling guilty. Tournier noted that in the optimism of the Nineteenth Century, even the guilty were innocent, but since 1945, even the innocent are guilty.²³⁴ "Today, the atheists have an acute sense of guilt, and they are more pessimistic about man than the Calvinists."²³⁵

But while wholly secular men and women of the 1990s try to hide from guilt, millions of the tradition-bound live under a cloud of irrational, pervasive remorse which does not become apparent until mortal illness sets in. For them, "religion . . . can crush instead of liberate,"²³⁶ said Tournier, a profoundly religious man. "There is a kind of unavoidable reverse side to every declaration of faith, which follows it as faithfully as shadow follows sunshine."²³⁷

232. PAUL TOURNIER, GUILT AND GRACE: A PSYCHOLOGICAL STUDY 10 (Arthur W. Heathcote trans., 1962). See generally Block & Billings, *supra* note 65 (discussing specifically the interplay of guilt with suicidal ideation in the terminally ill).

233. TOURNIER, *supra* note 234, at 28.

234. *Id.* at 78.

235. *Id.* at 79.

236. *Id.* at 23.

237. *Id.*

Most people feel guilty, not so much for what they have done, but for what they have failed to do.²³⁸ Most people are disappointed in themselves and console themselves with bitter aphorisms about life.²³⁹ The ill are even more prone to these feelings of remorse. Tournier states:

One always feels rather guilty at arousing revulsion in others, at causing, by illness, a disturbance in the family, an extra burden of work for one's colleagues at the office, extra work and worry for one's wife All this false guilt about illness is a very common cause of culpable self-neglect.²⁴⁰

Many people live their lives in fear of other people's judgment, preventing them from being who they really are.²⁴¹ They conceal their tastes, desires and convictions.²⁴² Their fears hinder them from expanding freely according to their own nature.²⁴³ Tell these people they are terminally ill. Tell them death will be ugly, as it almost always is. Make suicide both legal and acceptable, even if not yet widespread. Many of these people will be driven by irrational self-loathing to embrace self-destruction.

W. *The Family Sacrifice*

Many people will choose to put themselves to death rather than expose their loved ones to the pains of a long and harrowing death. The late Sidney Hook emerged from a critical illness late in life both glad to be alive and determined not to re-experience his recent horrors.²⁴⁴ "I have paid my dues to death," said Hook, in an article advocating euthanasia.²⁴⁵ Among the reasons offered by Hook was that he would not want to see his family and friends suffer as they had before.²⁴⁶

Such sentiments are common. Shavelson reports the case of Mary Bowen Hall, a writer dying of cancer.²⁴⁷ Hall went to great lengths to protect her family from the reality of her dying, which was the one thing that bothered her most.²⁴⁸ She said she did not

238. *Id.* at 51.

239. TOURNIER, *supra* note 234, at 53.

240. *Id.* at 20.

241. *Id.* at 17.

242. *Id.*

243. *Id.*

244. See generally Sidney Hook, *In Defense of Euthanasia*, in ARGUING EUTHANASIA: THE CONTROVERSY OVER MERCY KILLING, ASSISTED SUICIDE AND THE "RIGHT TO DIE," *supra* note 67, at 237-40 (arguing that love of life and involuntary euthanasia are not incompatible).

245. *Id.* at 237-38.

246. *Id.* at 238.

247. See generally SHAVELSON, *supra* note 27, at 158-202 (telling the story of cancer victim Mary Bowen Hall).

248. *Id.* at 161.

want to be a burden to them.²⁴⁹

These two are very modern people who have placed the perceived needs of their family and friends above their own right to exist. They appear to be the antithesis of Tournier's guilt-driven neurotics, but they still stand ready to sacrifice themselves rather than inconvenience others.

This very common attitude illustrates the manner in which physician-assisted suicide subtly destroys the social underpinnings which have made death bearable. When someone is dying, they are not supposed to worry about others. Everything is supposed to be done for them. They are supposed to be given the best medical care, even if they cannot pay for it and even if they have never done anything to deserve it. They are supposed to have an emotional blank check. They are supposed to say whatever is on their minds. Their true friends are supposed to stand by them. In the most trying circumstances, they want to prove themselves. It makes them feel good about themselves.

A long illness can exhaust those closest to the sick person both physically and emotionally. Hook appears to have suffered such an illness, but Hall had not. She sealed off her family from her sufferings not because of what they endured, but in anticipation of what they might endure. If physician-assisted suicide is legalized, there probably will be as many who fit Hall's circumstances as those who fit Hook's. The answer to Hook's legitimate concerns is not poison, but more and better respite care and social customs that spread the burden of devotion to a wider circle.

There are very few Sidney Hooks and Mary Bowen Halls among the poor. However, there are a large number of people, many of them women, who think their role in life is to slave for their families. They can never say no to their sons, daughters or husbands. They are the co-dependent moms who enable their children to live their lives in a drunken haze or wallowing in crack. They know what is happening, they are bitter about it, but they can find no escape. Given their social conditioning and their pathological vulnerability to self-sacrifice, physician-assisted suicide is not an option for these people; it is a death sentence.

X. Pernicious Altruism

As stated above, the Ninth Circuit considers it acceptable for patients to have themselves put to death in order to save money for their estates.²⁵⁰ This attitude illustrates the court's incapacity to cope with, or even recognize, a question of fundamental, axiomatic values. Or perhaps the court did understand the question and chose to embrace a set of principles inimicable to all of the

249. *Id.* at 165.

250. *Compassion in Dying v. Washington*, 79 F.3d 790, 826 (9th Cir. 1996).

highest traditions of our civilization.²⁵¹

Many frail, elderly people would take the fatal dose rather than use the money they have set aside for their grandchildren, which is frightening. It is a radical example of pernicious altruism. To give up one's life to save the life of another is noble. To give up one's life for the sake of money is sick.

Some people may not want to forfeit a year's tuition for their daughter in favor of a fortnight of "futile" nursing care for themselves.²⁵² The appeal of noble self-sacrifice, the chance to give death additional meaning, is almost irresistible. But that is not an option people should have. The dying have a lot of issues to sort out and very little energy left to do it. They do not need to have this awful choice facing them.

The choice will seldom be as simple as a year in college versus a week in an intensive care unit. More likely, it will be the choice between a better college and an indefinite stay in a nursing home with a chronic and ultimately terminable disease. In any event, very few young people would want to go to college on what they would know was grandmother's blood money.

Y. *The Exploited*

The specter of the greedy heir haunts the discussion of physi-

251. The paramount question of human values is beyond the scope of this article. Life is priceless. One month, one week or one day of life is priceless. Society cannot put a price tag on human life. It cannot allow others to put a price tag on human life, even one's own life. Society can no more allow a man to commit suicide to save his family \$50,000 than it could allow him to sell himself into slavery to raise the same sum for his offspring. In fact, the latter option would be preferable because the slave would still be alive and could yet be redeemed.

These "value-of-life" arguments often become muddled in the public mind with the issue of abortion. This has nothing to do with abortion. It has nothing to do with imposing on society Christian ethics, Judeo-Christian ethics or religious ethics of any type. All that makes civilization worthy of existence is based on the supremacy of the value of the individual human life. This is the one shared principle upon which the law is based.

This basic question also illustrates why it is impossible to answer the query, "Is it ever possible to have a rational suicide?" Rationality depends on a few accepted axioms. If one accepts the axiom that the preservation of human life is the ultimate good, then the answer is always no. If one accepts the axiom of the nihilists that life is meaningless, then the answer is always yes. If one accepts the fashionable axiom that "quality" of human life is the ultimate good, the answer is sometimes yes, at least theoretically. There are other possible axioms, but of these three, "quality of life" is the least philosophically defensible. Among other things, it turns human life into the ultimate consumer good, to be discarded like a broken watch or a defective television set. In any event, it will always be society which chooses the axiom in these cases and never the individual.

252. This quandary illustrates the need for some form of universal health coverage. It also reveals that for the uninsured, physician-assisted suicide is nothing more than the poor man's hospice.

cian-assisted suicide. The Ninth Circuit dismisses these concerns, musing that a grasping relative would not promote physician-assisted suicide because death would come soon enough.²⁵³

The court does not understand the dynamics or methodology of family abuse or the exploitation of the elderly. For those who practice family law and elder law, family breakdown is not the stuff of sociological treatises. There is an unfathomable malice that exists in many families every day.

There is plenty of motivation on the part of the rapacious to promote physician-assisted suicide, even when the victim is at death's door. Just how long the victim will lay at death's door is always an open question. Terminal care is proverbially expensive. Each day makes a difference. Often, relatively small sums are at stake. For families of modest means, an estate of \$20,000 or \$30,000 is a fortune. Then there is always a chance that the victim will recover enough to change her will.

The greedy relative need not pester and cajole the victim; nothing needs to be said. An awkward glance when the victim mentions physician-assisted suicide may be more than enough to tell her that she is no longer wanted. Even the failure to visit may be sufficient. The doctor who prepares the fatal dose almost never will know what really went into the patient's decision.

This issue, like so many others, should not have been considered by the circuit court without extensive expert testimony at the trial level on the likely effects of family exploitation on the practice of physician-assisted suicide. This court's ignorance on this issue is understandable. Its ignorance of its own ignorance is unforgivable.

IV. CONCLUSION

As this article illustrates, legalizing euthanasia creates problems that are not easily solved. The victims will be many and varied: from those suffering from depression, to those with bad doctors; from those whose pain is not being properly managed, to those who do not want to burden their families; from those who have succumbed to the dignity myth, to those who feel that physician-assisted suicide will allow them to again control their lives. In reality, the economics and characteristics of the poor and the downtrodden dictate that they are far more likely to be damaged than the nation's elite by the practice of physician-assisted suicide.

253. *Compassion in Dying*, 79 F.3d at 826.