The Heritage Foundation

BACKGROUNDER

No. 3004 | MARCH 24, 2015

Always Care, Never Kill: How Physician-Assisted Suicide Endangers the Weak, Corrupts Medicine, Compromises the Family, and Violates Human Dignity and Equality

Ryan T. Anderson, PhD

Abstract

Allowing physician-assisted suicide would be a grave mistake for four reasons. First, it would endanger the weak and vulnerable. Second, it would corrupt the practice of medicine and the doctor–patient relationship. Third, it would compromise the family and intergenerational commitments. And fourth, it would betray human dignity and equality before the law. Instead of helping people to kill themselves, we should offer them appropriate medical care and human presence. We should respond to suffering with true compassion and solidarity. Doctors should help their patients to die a dignified death of natural causes, not assist in killing. Physicians are always to care, never to kill.

The Hippocratic Oath proclaims: "I will keep [the sick] from harm and injustice. I will neither give a deadly drug to anybody who asked for it, nor will I make a suggestion to this effect."[1] This is an essential precept for a flourishing civil society. No one, especially a doctor, should be permitted to kill intentionally, or assist in killing intentionally, an innocent neighbor.

Human life need not be extended by every medical means possible, but a person should never be intentionally killed. Doctors may help their patients to die a dignified death from natural causes, but they should not kill their patients or help them to kill themselves. This is the reality that such euphemisms as "death with dignity" and "aid in dying" seek to conceal.

In 2015, at least 18 state legislatures and the District of Columbia are considering whether to allow physician-assisted suicide (PAS).[2] Legalizing physician-assisted suicide, however, would be a grave mistake because it would:

Key Points

- Doctors may help their patients to die a dignified death from natural causes, but they should not kill their patients or help them to kill themselves. This is the reality behind euphemisms such as "death with dignity" and "aid in dying."
- Physician-assisted suicide (PAS) endangers the weak and marginalized in society. Where it has been allowed, safeguards purporting to minimize this risk have proved inadequate.
- PAS corrupts the profession of medicine by permitting the tools of healing to be used as techniques for killing, it distorts the doctor–patient relationship, and it provides perverse incentives for insurance providers.
- PAS undermines social solidarity, increasing the temptation to view elderly or disabled family members as burdens and the temptation for those family members to view themselves as burdens.
- PAS violates equality before the law by judging some to have lives no longer "worth living."
- We should respond to suffering with appropriate medical care and human presence.

This paper, in its entirety, can be found at **http://report.heritage.org/bg3004**

The Heritage Foundation
214 Massachusetts Avenue, NE
Washington, DC 20002
(202) 546-4400 | heritage.org

- Endanger the weak and vulnerable,
- Corrupt the practice of medicine and the doctor–patient relationship,
- Compromise the family and intergenerational commitments, and
- Betray human dignity and equality before the law.

First, PAS endangers the weak and marginalized in society. Where it has been allowed, safeguards purporting to minimize this risk have proved to be inadequate and have often been watered down or eliminated over time. People who deserve society's assistance are instead offered accelerated death.

Second, PAS changes the culture in which medicine is practiced. It corrupts the profession of medicine by permitting the tools of healing to be used as techniques for killing. By the same token, PAS threatens to fundamentally distort the doctor–patient relationship because it reduces patients' trust of doctors and doctors' undivided commitment to the life and health of their patients. Moreover, the option of PAS would provide perverse incentives for insurance providers and the public and private financing of health care. Physician-assisted suicide offers a cheap, quick fix in a world of increasingly scarce health care resources.

Third, PAS would harm our entire culture, especially our family and intergenerational obligations. The temptation to view elderly or disabled family members as burdens will increase, as will the temptation for those family members to internalize this attitude and view *themselves* as burdens. Physician-assisted suicide undermines social solidarity and true compassion.

Fourth, PAS's most profound injustice is that it violates human dignity and denies equality before the law. Every human being has intrinsic dignity and immeasurable worth. For our legal system to be coherent and just, the law must respect this dignity in everyone. It does so by taking all reasonable steps to prevent the innocent, of any age or condition, from being devalued and killed. Classifying a subgroup of people as legally eligible to be killed violates our nation's commitment to equality before the law—showing profound disrespect for and callousness to those who will be judged to have lives no longer "worth living," not least the frail elderly, the demented, and the disabled. No natural right to PAS exists, and arguments for such a right are incoherent: A legal system that allows assisted suicide abandons the natural right to life of all its citizens.

Doctors should help their patients to die a dignified death of natural causes, not assist in killing. Physicians are always to care, never to kill.

Instead of embracing PAS, we should respond to suffering with true compassion and solidarity. People seeking PAS typically suffer from depression or other mental illnesses, as well as simply from loneliness. Instead of helping them to kill themselves, we should offer them appropriate medical care and human presence. For those in physical pain, pain management and other palliative medicine can manage their symptoms effectively. For those for whom death is imminent, hospice care and fellowship can accompany them in their last days. Anything less falls short of what human dignity requires. The real challenge facing society is to make quality end-of-life care available to all.

Doctors should help their patients to die a dignified death of natural causes, not assist in killing. Physicians are always to care, never to kill. They properly seek to alleviate suffering, and it is reasonable to withhold or withdraw medical interventions that are not worthwhile. However, to judge that a patient's life is not worthwhile and deliberately hasten his or her end is another thing altogether.

Citizens and policymakers need to resist the push by pressure groups, academic elites, and the media to sanction PAS. Recent experience with PAS both in

---

1. Ludwig Edelstein, *The Hippocratic Oath: Text, Translation and Interpretation* (Baltimore, MD: Johns Hopkins University Press, 1943), http://guides.library.jhu.edu/content.php?pid=23699&sid=190555 (accessed January 28, 2015).
2. State legislation as of March 20, 2015: Alaska, HB 99; California, SB 128; Colorado, HB 15-1135; Connecticut, SB 668; Iowa, HF 65; Kansas, HB 2150; Maryland, HB 1021; Massachusetts, HD 1674; Minnesota, SF 1880; Missouri, HB 307; Montana, SB 202; Nevada, SB 336; New Jersey, AB 2270; New York, AB 02129; Oklahoma, HB1673; Utah, HB 391; Wisconsin, AB 67/SB 28; Wyoming, HB 119; and the District of Columbia, B21-0031. In the courts, a New Mexico appeals court will review a lower court's decision claiming to find a right to assisted suicide in the state constitution.

the United States and in Europe suggests how problematic it is.

Endangering the Weak and Marginalized

To understand how PAS endangers the weak and marginalized, one must understand what PAS entails and where it leads. With PAS, a doctor prescribes the deadly drug, but the patient self-administers it. While most activists in the United States publicly call only for PAS, they have historically advocated not only PAS, but also euthanasia: the intentional killing of the patient by a doctor.

This is not surprising: The arguments for PAS are equally arguments for euthanasia. Neil Gorsuch, currently a federal judge, points out that some contemporary activists fault the movement for not being honest about where its arguments lead. He notes that legal theorist and New York University School of Law Professor Richard Epstein "has charged his fellow assisted suicide advocates who fail to endorse the legalization of euthanasia openly and explicitly with a 'certain lack of courage.'"[3]

The logic of assisted suicide leads to euthanasia because if "compassion" demands that some patients be helped to kill themselves, it makes little sense to claim that only those who are capable of self-administering the deadly drugs be given this option. Should not those who are too disabled to kill themselves have their suffering ended by a lethal injection?

And what of those who are too disabled to request that their suffering be ended, such as infants or the demented? Why should they be denied the "benefit" of a hastened death? Does not "compassion" provide an even more compelling reason for a doctor to provide this release from suffering and indignity?[4] As Professor John Keown points out:

> If compassion justified us in giving a lethal prescription to a terminally ill patient on request to end their suffering, it would equally justify us in giving them a lethal injection, particularly if they were physically unable to commit suicide. It would also justify us in giving a lethal injection to a terminally ill patient who was incapable of making a request.[5]

Judge Gorsuch notes that for the Dutch, "it is the *physician's* assessment of the patient's *quality of life* as 'degrading' or 'deteriorating' or 'hopeless' that stands as the ultimate justification for killing."[6]

Although the Supreme Court of the United States has ruled in two unanimous decisions that there is no constitutional right to PAS, three states permit it by statute: Oregon, Washington, and Vermont.[7]

---

[3] Neil M. Gorsuch, *The Future of Assisted Suicide and Euthanasia* (Princeton, NJ: Princeton University Press, 2006), p. 7.

[4] Leon Kass elaborates on this point: "Physician-assisted suicide, once legal, will not stay confined to the terminally ill and mentally competent who freely and knowingly elect it for themselves. Requests will be engineered and choices manipulated by those who control the information, and, manipulation aside, many elderly and incurable people will experience a right to choose death *as their duty* to do so. Moreover, the vast majority of those who are said to 'merit' 'a humane and dignified death' do not fall in this category and cannot request it for themselves. *Persons with mental illness or Alzheimer's disease, deformed infants, and retarded or dying children would thus be denied our new humane 'aid-in-dying.' But not to worry. The lawyers, encouraged by the cost-containers, will sue to rectify this inequity.* Why, they will argue, should the comatose or the demented be denied a right to assisted suicide just because they cannot claim it for themselves? With court-appointed proxy consentors, we will quickly erase the distinction between the right to choose one's own death and the right to request someone else's." Leon R. Kass, "Dehumanization Triumphant," *First Things*, August 1996, http://www.firstthings.com/article/1996/08/002-dehumanization-triumphant (accessed January 28, 2015) (emphasis added).

[5] See Emily Jackson and John Keown, *Debating Euthanasia* (Oxford: Hart Publishing, 2012), p. 102.

[6] Gorsuch, *The Future of Assisted Suicide and Euthanasia*, p. 111 (emphasis in original).

[7] See *Glucksberg* and *Quill*: *Glucksberg v. Washington*, 521 U.S. 702 (1997) (holding that "the asserted 'right' to assistance in committing suicide is not a fundamental liberty interest protected by the Due Process Clause"), and *Vacco v. Quill*, 521 U.S. 793 (1997) (holding that because refusing treatment is logically distinct from assisting suicide, New York State's prohibition on PAS treated all patients the same and so did not violate the Equal Protection Clause). For a helpful discussion of these cases and precedents, see Gorsuch, *The Future of Assisted Suicide and Euthanasia*, pp. 8–18. Oregonians legalized PAS through Ballot Measure 16, the Death with Dignity Act in 1994; see O.R.S. § 127.800-995 (1994), which took legal effect late in 1997. Washingtonians approved Initiative 1000, the Death with Dignity Act, in 2008; see R.C.W § 70.245 (2008). In 2013, the Vermont Legislature passed the Patient Choice and Control at End of Life Act; see 18 V.S.A. § 5289 (2013). In 2009, a Montana Supreme Court decision gave physicians the ability to raise the defense of consent to a charge of violating the state's assisted suicide law; see *Baxter v. Montana*, WL 5155363 (2009). New Mexico, meanwhile, is in the middle of court proceedings over physician-assisted suicide, with a lower court having ruled in its favor, but that ruling is being appealed. Eric Eckholm, "New Mexico Judge Affirms Right to 'Aid in Dying,'" *The New York Times*, January 13, 2014, http://www.nytimes.com/2014/01/14/us/new-mexico-judge-affirms-right-to-aid-in-dying.html (accessed January 28, 2015).

Physician-assisted suicide and euthanasia are allowed in three European countries—the Netherlands, Belgium, and Luxembourg—and Switzerland allows assisted suicide.[8]

The evidence from these jurisdictions, particularly the Netherlands, which has over 30 years of experience, suggests that safeguards to ensure effective control have proved inadequate. In the Netherlands, several official, government-sponsored surveys have disclosed both that in thousands of cases, doctors have intentionally administered lethal injections to patients without a request and that in thousands of cases, they have failed to report cases to the authorities.[9]

Physician-Assisted Suicide Will Most Threaten the Weak and Marginalized. Physician-assisted suicide will most threaten the weak and marginalized because of the cultural pressures and economic incentives that will drive it.[10] The New York State Task Force on Life and the Law, established by Governor Mario Cuomo, explained in its report:

> The Task Force members unanimously concluded that legalizing assisted suicide and euthanasia would pose profound risks to many patients….
>
> … The practices will pose the greatest risks to those who are poor, elderly, members of a minority group, or without access to good medical care….
>
> … The clinical safeguards that have been proposed to prevent abuse and errors would not be realized in many cases.[11]

Dr. Paul McHugh, University Distinguished Service Professor of Psychiatry at Johns Hopkins University School of Medicine and Psychiatrist-in-Chief at Johns Hopkins Hospital from 1975 to 2001, highlights that "with physician-assisted suicide, many people—some not terminally ill, but instead demoralized, depressed and bewildered—die before their time."[12] This sad reality led Dr. Leon Kass—a medical doctor, philosopher, and former chairman of the President's Council on Bioethics—to explain that physician-assisted suicide "is, in fact, the state's

---

[8] Jose Pereira, "Legalizing Euthanasia or Assisted Suicide: The Illusion of Safeguards and Controls," *Current Oncology*, Vol. 18, No. 2 (April 2011), http://www.ncbi.nlm.nih.gov/pmc/articles/PMC3070710/ (accessed February 4, 2015).

[9] See also John Keown's discussion of the Netherlands in Jackson and Keown, *Debating Euthanasia*, pp. 118–128.

[10] Public opinion demonstrates that levels of support for PAS differ substantially along socioeconomic and ethnic lines. Those who support PAS tend to be white, affluent, and able-bodied, and those who are most worried about being killed in the name of compassion are in poorer and minority communities or are disabled. For example, a 1997 study that reviewed previous studies found that support for PAS is generally about 20 percent higher among white respondents than among black respondents. Patients who end their lives with doctor-assisted suicide are more likely to be white and college-educated. This gap may also be rooted in a disparity of palliative and hospice care available to minority groups. For instance, dementia patients in the poorest quartile for socioeconomic status are less likely to receive hospice services. Low-income black women receiving fee-for-service Medicare are also less likely than white women to receive hospice care. See Kathleen M. Fairfield et al., "Disparities in Hospice Care Among Older Women Dying with Ovarian Cancer," *Journal of Gynecologic Oncology*, Vol. 125, No. 1 (April 2012), pp. 14–18; Preethy Nayar et al., "Disparities in End of Life Care for Elderly Lung Cancer Patients," *Journal of Community Health*, Vol. 39, No. 5 (October 2014), pp 1012–1019; Melissa Lopresti, Fritz Dement, and Heather T. Gold, "End-of-Life Care for People with Cancer from Ethnic Minority Groups: A Systematic Review," *American Journal of Hospice and Palliative Care*, December 29, 2014; Ezekiel Emanuel, Diane L. Fairclough, and Linda Emanuel, "Attitudes and Desires Related to Euthanasia and Physician-Assisted Suicide Among Terminally Ill Patients and Their Caregivers," *JAMA*, Vol. 284, No. 19 (November 15, 2000), pp. 2460–2468, http://jama.jamanetwork.com/article.aspx?articleid=193281 (accessed March 4, 2015); Lilian Liou Cohen, "Racial/Ethnic Disparities in Hospice Care: A Systematic Review," *Journal of Palliative Medicine*, Vol. 11, No. 5 (June 2008), pp. 763–768; and Amanda Connolly, Elizabeth Sampson, and Nitin Purandare, "End-of-Life Care for People with Dementia from Ethnic Minority Groups: A Systematic Review," *Journal of American Geriatric Society*, Vol. 60, No. 2 (February 2012), pp. 351–360, http://www.ncbi.nlm.nih.gov/pubmed/22332675 (accessed February 23, 2015).

[11] New York Department of Health, Task Force on Life and the Law, *When Death Is Sought: Assisted Suicide and Euthanasia in the Medical Context*, May 1994, https://www.health.ny.gov/regulations/task_force/reports_publications/when_death_is_sought/preface.htm (accessed January 28, 2015). The report continued: "We believe that the practices would be profoundly dangerous for large segments of the population, especially in light of the widespread failure of American medicine … to diagnose and treat depression in many cases. The risks would extend to all individuals who are ill. *They would be most severe for those whose autonomy and well-being are already compromised by poverty, lack of access to good medical care, or membership in a stigmatized social group.* The risks of legalizing assisted suicide and euthanasia for these individuals … are likely to be extraordinary." Ibid. (emphasis added).

[12] Paul McHugh, "Dr. Death Makes a Comeback," *The Wall Street Journal*, January 22, 2015, http://www.wsj.com/articles/paul-mchugh-dr-death-makes-a-comeback-1421970736 (accessed January 28, 2015).

abdication of its duty to protect innocent life and its abandonment especially of the old, the weak, and the poor."[13]

The people most likely to be assisted by a physician in their suicide are suffering not simply from terminal illness, but also from depression, mental illness, loneliness, and despair. "Researchers have found hopelessness, which is strongly correlated with depression, to be the factor that most significantly predicts the wish for death," write Dr. Herbert Hendin, Professor of Psychiatry and Behavioral Science at New York Medical College and Chief Executive Officer and Medical Director of Suicide Prevention Initiatives, and Dr. Kathleen Foley, Professor of Neurology at Cornell University's medical school and attending neurologist, pain and palliative care services, at Sloan–Kettering Cancer Center.[14] As Dr. Hendin reports:

> Mental illness raises the suicide risk even more than physical illness. Nearly 95 percent of those who kill themselves have been shown to have a diagnosable psychiatric illness in the months preceding suicide. The majority suffer from depression that can be treated. This is particularly true of those over fifty, who are more prone than younger victims to take their lives during the type of acute depressive episode that responds most effectively to treatment.[15]

From their decades of professional medical practice, Drs. Hendin and Foley report that when patients who ask for a physician's assistance in suicide "are treated by a physician who can hear their desperation, understand the ambivalence that most feel about their request, treat their depression, and relieve their suffering, their wish to die usually disappears."[16] They conclude: "Patients requesting suicide need psychiatric evaluation to determine whether they are seriously depressed, mentally incompetent, or for whatever reason do not meet the criteria for assisted suicide."[17]

Physician-assisted suicide "is, in fact, the state's abdication of its duty to protect innocent life and its abandonment especially of the old, the weak, and the poor."

Yet only five of the 178 Oregon patients who died under the Oregon assisted suicide laws in 2013 and 2014 were referred for any psychiatric or psychological evaluation. Remarkably, patients were referred for psychiatric evaluation in less than 5.5 percent of the 859 cases of assisted suicide reported in Oregon since its law went into effect in 1997.[18] "This constitutes medical negligence," writes Dr. Aaron Kheriaty, Associate Professor of Psychiatry at U.C. Irvine School of Medicine. Dr. Kheriaty concludes, "To abandon suicidal individuals in the midst of a crisis—under the guise of respecting their autonomy—is socially irresponsible: It undermines sound medical ethics and erodes social solidarity."[19]

Regrettably, even in jurisdictions that require a doctor to mention palliative care and hospice alternatives before proceeding with assisted suicide, the doctors need not be experts. Drs. Hendin and Foley point out:

> They are not required, however, to be knowledgeable about how to relieve physical or emotional suffering in terminally ill patients. Without such

---

[13] Kass, "Dehumanization Triumphant."

[14] Herbert Hendin and Kathleen Foley, "Physician-Assisted Suicide in Oregon: A Medical Perspective," *Michigan Law Review*, Vol. 106, No. 8 (June 2008), p. 1622. In a study of 200 terminally ill cancer patients, the prevalence of depressive syndromes among patients who expressed a desire for death was 59 percent. Among those who did not desire death, only 8 percent demonstrated depressive syndromes. See H. M. Chochinov et al., "Desire for Death in the Terminally Ill," *The American Journal of Psychiatry*, Vol. 152, No. 8 (August 1995), pp. 1185–1191.

[15] Herbert Hendin, *Seduced by Death: Doctors, Patients, and Assisted Suicide* (New York: W.W. Norton, 1998), pp. 34–35.

[16] Hendin and Foley, "Physician-Assisted Suicide in Oregon," pp. 1625–1626.

[17] Ibid., p. 1622.

[18] Oregon Public Health Division, "Oregon's Death with Dignity Act—2014," http://public.health.oregon.gov/ProviderPartnerResources/EvaluationResearch/DeathwithDignityAct/Documents/year17.pdf (accessed February 24, 2015).

[19] Aaron Kheriaty, "Apostolate of Death," *First Things*, April 2015, p. 19.

> knowledge, which most physicians do not have, they cannot present or make feasible alternatives available. Nor in the absence of such knowledge are they required to refer the patient to a physician with expertise in palliative care.[20]

The Legal Protections in Physician-Assisted Suicide Are Ineffective. Even if one were to accept an argument for PAS on the basis of autonomy and compassion, one would be forced to conclude that neither value is sufficiently protected in laws that have been enacted in several states and in current bills that would authorize it in additional jurisdictions. One of the greatest concerns is that autonomy will be violated and people pressured or coerced into killing themselves.

The District of Columbia's Death With Dignity Act of 2015 would authorize physicians to prescribe deadly drugs to patients.[21] This act is substantially similar to the laws passed in Oregon, Washington, and Vermont and others pending in various jurisdictions.[22] None of the purported protections offered in the bill are sufficient; the experience with PAS to date shows that all will prove ineffective. Professor Alexander Capron, a leading health lawyer, has concluded that the Oregon safeguards are "largely illusory."[23] So, too, are those in the D.C. proposal.

The D.C. bill states that to receive a physician's assistance in suicide, the patient must make two oral requests, separated by 15 days, to a physician of the patient's choice. Before the second request, the patient must also make a written request, no less than 48 hours before the lethal drugs are prescribed or provided. This written request must be witnessed by two individuals, neither of whom may be the physician and only one of whom may be related to the patient, stand to inherit upon the patient's death, or be an owner or employee of a health care facility where the patient is residing. The witnesses must attest that the patient is capable and acting voluntarily.

Likewise, the chosen physician must judge the patient to be capable and acting voluntarily and that the patient will likely die within six months. Then the physician refers the patient to a consulting physician who must verify these judgments.

Despite the purported safeguards, this system is ripe for abuse. One of the witnesses may be a family member with a financial or emotional incentive to see the patient die, and the other may simply be a friend willing to affirm that judgment. Patients or their more powerful guardians could shop around for a doctor who is willing to make the judgment that they are capable, acting freely, and likely to die within six months.

Moreover, the bill does not specify whether death need be likely *with* medical treatment or *without*. As a team of physicians has noted, "Deciding who should be counted as 'terminally ill' will pose such severe difficulties that it seems untenable as a criterion for permitting physician-assisted suicide."[24]

Of course, there is no reason to assume that all doctors will seek to make a serious diagnosis, because a patient can shop around for a compliant physician. Richard Doerflinger notes that Compassion and Choices (C&C), formerly known as the Hemlock Society and one of the advocacy groups pushing for assisted suicide laws nationwide, keeps a list of "friendly" doctors:

> The doctors who declare patients qualified for assisted suicide are not randomly selected. C&C has boasted of its direct involvement in the vast majority of such cases in Oregon, as it has its own list of doctors who are willing and able to get patients around any pesky "safeguards." If the patient's own physician, or the next physician, discovers a disorder such as depression, the patient can simply shop around to find one who won't care (or just call C&C in the first place).[25]

---

[20] Hendin and Foley, "Physician-Assisted Suicide in Oregon," p. 1616.

[21] Death with Dignity Act of 2015, B21-0038, Leg. Sess. 20, http://lims.dccouncil.us/Legislation/B21-0038 (accessed January 28, 2015).

[22] Oregon, O.R.S. § 127.800-995 (1994); Washington, R.C.W § 70.245 (2008); and Vermont, 18 V.S.A. § 5289 (2013).

[23] Alexander M. Capron, "Legalizing Physician-Aided Death," *Cambridge Quarterly of Healthcare Ethics*, Vol. 5, No. 1 (Winter 1996), p. 14.

[24] Joanne Lynn et al., "Defining the 'Terminally Ill': Insights from SUPPORT," *Duquesne Law Review*, Vol. 35, No. 1 (Fall, 1996), p. 334.

[25] Richard M. Doerflinger, "Flirting with Death," *Public Discourse*, January 5, 2015, http://www.thepublicdiscourse.com/2015/01/14217/ (accessed February 4, 2015).

Such shopping around for doctors claimed the life of Helen, a woman in Oregon. Judge Gorsuch recounts:

> Helen was a breast cancer patient in her mid-eighties when the Oregon law went into effect. Helen's regular physician refused to assist in her suicide; a second doctor was consulted but also refused, on the stated ground that Helen was depressed. At that point, Helen's husband called Compassion in Dying. The medical director of the group spoke with Helen and later explained that Helen was "frustrated and crying because she felt powerless." Helen was not, however, bed-ridden or in great pain.... The Compassion in Dying employee recommended a physician to Helen. That physician, in turn, referred Helen to a specialist (whose specialty is unknown), as well as to a psychiatrist who met Helen only once. A lethal prescription was then supplied.[26]

Remarkably, the D.C. bill provides explicit protections for doctors to engage in such judgments by providing immunity from liabilities: "No person shall be subject to civil or criminal liability or professional disciplinary action for: (A) Participating in good faith compliance with this act." Doerflinger explains:

> "Good faith" is the loosest of legal standards, much weaker than the negligence standard physicians are generally held to. Instead of meeting the objective standards for what doctors *should* know, a doctor need only say that he sincerely didn't know that he failed to live up to them.[27]

The political left is ordinarily quite opposed to tort reform or medical malpractice limitations, yet here they explicitly support them. Doerflinger concludes:

> So, in a matter of literal life and death, standards are much lower than anywhere else in law or medicine. You're likely to be seen as terminal (hence a candidate for assisted suicide) if the doctor feels that you are, or thinks that you could become so without treatment. If you take the lethal drugs in a few weeks based on that prediction, there is, of course, no chance to prove him wrong.[28]

Judge Gorsuch echoes this concern:

> [I]t is also rather remarkable that, while physicians in Oregon are held to a standard of professional competence in administering all other treatments they provide, the Oregon assisted suicide statute creates an entirely different regime when it comes to administering this "treatment," specifically and uniquely immunizing doctors from criminal prosecution, civil liability, or even professional discipline for any actions they take in assisting a suicide, as long as they act in "good faith." Thus, while a doctor may be found liable for mere negligence in any other operation or procedure, there is no recourse for family members when a doctor kills a patient even on the basis of gross negligence by misdiagnosing the patient as terminal or by misassessing the patient as competent.[29]

The disability-rights group Not Dead Yet agrees:

> [I]t cannot be seriously maintained that assisted suicide laws can or do limit assisted suicide to people who are imminently dying, and voluntarily request and consume a lethal dose, free of inappropriate pressures from family or society. Rather, assisted suicide laws ensure legal immunity for physicians who already devalue the lives of older and disabled people and have significant economic incentives to at least agree with their suicides, if not encourage them, or worse.[30]

---

[26] Gorsuch, *The Future of Assisted Suicide and Euthanasia*, p. 124.

[27] Doerflinger, "Flirting with Death" (emphasis in original).

[28] Ibid.

[29] Gorsuch, *The Future of Assisted Suicide and Euthanasia*, p. 119.

[30] Diane Coleman, "Assisted Suicide Laws Create Discriminatory Double Standard for Who Gets Suicide Prevention and Who Gets Suicide Assistance: Not Dead Yet Responds to Autonomy, Inc.," *Disability and Health Journal*, Vol. 3, No. 1 (January 2010), p. 48, http://www.disabilityandhealthjnl.com/article/S1936-6574(09)00089-2/fulltext (accessed March 5, 2015).

Moreover, there are no protections relating to the time when the lethal drugs are taken. Once the requirements are met, a doctor may prescribe the deadly drugs and send the patient home to self-administer them. The D.C. bill, like the state bills, provides no safeguards to ensure that the patient is mentally competent when he or she takes the drugs and is not being pressured to do so. The lack of any legal protections ensuring autonomy at the time the lethal choice is made led Judge Gorsuch to ask: "How does it serve the putative goal of autonomous patient decision making to set up a regime that allows people to commit suicide without considering whether they are, in fact, acting freely, competently, and autonomously at the time of suicide?"[31]

In sum, a family member or friend who might benefit financially from the death of a patient may act as a witness that the patient is voluntarily requesting the lethal prescription, and doctors who support the ideology of death and have never before met the patient (or the patient's family) can judge the patient to be "qualified" under the law. Finally, at the time of administering the deadly drug, there are no safeguards to ensure voluntariness or competence or to guard against coercion. Such a measure woefully fails to protect autonomy.[32]

The World's Experience with Physician-Assisted Suicide Laws Confirms the Lethal Logic. While many assisted suicide laws attempt to limit PAS eligibility to the terminally ill, and while many laws attempt to provide protections ensuring autonomous consent, the experience of countries with PAS and euthanasia suggests that safeguards fail to ensure effective control.

In 1989, while teaching law and medical ethics at the University of Cambridge, Professor John Keown began to investigate PAS and euthanasia in the Netherlands. He found that key Dutch guidelines, such as requiring an explicit request from the patient, have long been widely violated with virtual impunity.[33] He pointed out that the first of several official surveys conducted by the Dutch found that in 1990, "the total number of life-shortening acts and omissions where the doctor's *primary* intention … was to kill, and which are therefore indubitably euthanasiast, is 10,558."[34]

Shockingly, the majority of these cases were non-voluntary. Oxford legal scholar John Finnis, commenting on the Dutch data, remarks: "[W]ell over half … were without any explicit request. In the United States that would be over 235,000 unrequested medically accelerated deaths per annum."[35] In 2013, 1.7 percent (1,807 patients) of all deaths in Belgium were due to euthanasia and physician-assisted suicide.[36] A 2010 study discovered that 66 of 208 identified deaths in Belgium were administered *without* an explicit patient request.[37]

Keown confirms that "the *undisputed* empirical evidence from the Netherlands and Belgium shows widespread breach of the safeguards, not least the sizeable incidence of non-voluntary euthanasia and of non-reporting."[38] In October of 2013, three judges

---

[31] Gorsuch, *The Future of Assisted Suicide and Euthanasia*, p. 180.

[32] In some of the newly introduced bills, these problems are actually far worse, not better. For example, the California bill introduced in 2015 is modeled on Oregon's law but greatly weakens its provision on psychological counseling, dropping the requirement that, once referred for counseling, a patient must be found competent before the assisted suicide can proceed. The bill introduced in Maryland removes the language stating that an illness must be considered irreversible and incurable in order to be considered terminal and says a doctor need only find that it is "more likely than not" that the patient will die of the illness in six months.

[33] See John Keown, "Euthanasia in the Netherlands: Sliding down the Slippery Slope?" *Notre Dame Journal of Law, Ethics & Public Policy*, Vol. 9, No. 2 (1995), http://scholarship.law.nd.edu/cgi/viewcontent.cgi?article=1427&context=ndjlepp (accessed March 5, 2015).

[34] Ibid., p. 423 (emphasis in original).

[35] John Finnis, *The Collected Essays of John Finnis*, Vol. 3, *Human Rights and Common Good* (Oxford: Oxford University Press, 2011), p. 255.

[36] Government of Belgium, Commission Fédérale de Contrôle, *Et D'évaluation de L'euthanasie*, 2014, p. 7, http://www.health.belgium.be/filestore/19097638/Rapport_Euthanasie12-13_FR.pdf (accessed March 5, 2015). Commenting on the report, the European Institute for Bioethics noted, "The deaths caused today represent 1.7% of all deaths in Belgium." European Institute of Bioethics, "Belgian Euthanasia Increases by 89% in Four Years," September 15, 2014, http://www.ieb-eib.org/en/document/belgian-euthanasia-increases-by-89-in-four-years-382.html (accessed March 11, 2015).

[37] Kenneth Chambaere et al., "Physician-Assisted Deaths Under the Euthanasia Law in Belgium: A Population-Based Survey," *CMAJ*, Vol. 182, No. 9 (June 15, 2010), p. 896, http://www.cmaj.ca/content/182/9/895.full (accessed March 5, 2015).

[38] John Keown, "A Right to Voluntary Euthanasia? Confusion in Canada in Carter," *Notre Dame Journal of Law, Ethics & Public Policy*, Vol. 28, No. 1 (2014), p. 30, http://scholarship.law.nd.edu/ndjlepp/vol28/iss1/1/ (accessed March 5, 2015) (emphasis in original).

of the High Court of Ireland voiced the same concern: "[T]he incidence of legally assisted death without explicit request in the Netherlands, Belgium and Switzerland is strikingly high."[39] And the numbers of those assisted in committed suicide keep growing.[40]

Part of the reason for these troubling statistics is that any purported legal safeguards can be and have been abused, and over time the logic of a "right to die" is extended to ever-wider groups of patients, including the incompetent. Keown describes the logic of PAS as based on judging some lives as unworthy of life:

> Once a doctor is prepared to make such a judgment in the case of [a] patient capable of requesting death, the judgment can, logically, equally be made in the case of a patient incapable of requesting death.... If a doctor thinks death would benefit the patient, why should the doctor deny the patient that benefit merely because the patient is incapable of asking for it?... The logical "slippery slope" argument is unanswerable.[41]

Dr. Ezekiel Emanuel, writing in the *Atlantic Monthly*, affirms that this is the lesson to take from the Netherlands and that proposed American PAS laws cannot avoid the same outcome:

> The Netherlands studies fail to demonstrate that permitting physician-assisted suicide and euthanasia will not lead to the nonvoluntary euthanasia of children, the demented, the mentally ill, the old, and others. Indeed, the persistence of abuse and the violation of safeguards, despite publicity and condemnation, suggest that *the feared consequences of legalization are exactly its inherent consequences*.[42]

In 1996, two doctors prosecuted in the Netherlands for the nonvoluntary euthanasia of disabled infants were acquitted when they argued medical necessity.[43] The Dutch courts simply followed the inexorable logic that drives the case for PAS and voluntary euthanasia to a new extent. If necessity justifies ending the life of a suffering patient who requests it, it equally justifies ending the life of a suffering patient who cannot request it. Dutch pediatricians have now devised a protocol for infanticide.[44]

Any purported legal safeguards can be and have been abused, and over time the logic of a "right to die" is extended to ever-wider groups of patients, including the incompetent.

A 2005 study in the *New England Journal of Medicine* recorded that in the previous seven years, 22 cases of infant euthanasia were reported in the Netherlands.[45] A 2013 Netherlands commission on euthanasia argued that as many as 650 infants per year should be eligible for euthanasia on the basis of the children's diagnosis as "babies who in spite of very intensive treatment are certain to die in the short term, babies with a poor prognosis and very poor expected quality of life, or babies who are not dependent on intensive

---

[39] *Fleming v. Ireland & Ors*, IEHC 2 (2013), para. 102, http://www.bailii.org/ie/cases/IEHC/2013/H2.htm (accessed March 5, 2015).

[40] The number of official euthanasia cases grows year by year in both the Netherlands and Belgium, the first European countries to legalize PAS. In 2013, according to the Netherlands official report, the total number of doctor-administered deaths was 4,829—a 15 percent increase from the previous year. See Netherlands Regionale Toetsingscommissies, *Euthanasie: Jaarverslag 2013* (Euthanasia: Annual report 2013), http://www.euthanasiecommissie.nl/Images/Jaarverslag2013_NL_tcm52-40686.pdf (accessed January 28, 2015). There were 1,807 reported cases of euthanasia in Belgium in 2013—a 27 percent increase over 2012, which was a 25 percent increase above 2011. See Leo Cendrowicz, "Euthanasia and Assisted Suicide Laws Around the World," *The Guardian*, July 17, 2014, http://www.theguardian.com/society/2014/jul/17/euthanasia-assisted-suicide-laws-world (accessed January 28, 2015).

[41] Keown, "A Right to Voluntary Euthanasia?" p. 23.

[42] Ezekiel J. Emanuel, "Whose Right to Die?" *The Atlantic*, March 1, 1997, http://www.theatlantic.com/magazine/archive/1997/03/whose-right-to-die/304641/ (accessed January 28, 2015) (emphasis added).

[43] *Arrest Gerechtshof te Leeuwarden* d.d.4 April 1996, in the Case Against K, 20.5 *Tijdschrift Voor Gezondheidsrecht* 284, 19 (1996).

[44] Eduard Verhagen and Pieter J. J. Sauer, "The Groningen Protocol—Euthanasia in Severely Ill Newborns," *The New England Journal of Medicine*, Vol. 352, No. 10 (March 10, 2005), pp. 960–961, http://www.nejm.org/doi/full/10.1056/NEJMp058026#t=article (accessed February 9, 2015).

[45] Ibid.

treatment but who face a life of severe suffering with no prospect of improvement."[46] The U.N. Human Rights Committee formally condemned this Dutch infanticide: "The Committee is gravely concerned at reports that new-born handicapped infants have had their lives ended by medical personnel."[47]

In March 2014, Belgium became the first country to legislatively allow doctors to euthanize "consenting" minors, despite the objections of 160 physicians.[48] In an open letter, these doctors argued that legalization without age restriction was unnecessary, as palliative care is sufficient, and the bill would create excessive pressure on both children and parents to choose premature death.[49] Nevertheless, Belgium went forward and removed the age restrictions.

Diagnoses of disability are now considered sufficient grounds for death. In December 2012, Marc and Eddy Verbessem, 45-year-old deaf twins, were euthanized in a Belgian hospital after they discovered they were going blind.[50] Nancy Verhelst, a 44-year-old transsexual Belgian whose doctors made mistakes in three sex change operations, was left feeling as though she was a "monster." She then requested—and was granted—euthanasia by lethal injection.[51]

In the Netherlands, the euthanized include Ann G., a 44-year-old woman whose only ailment was chronic anorexia.[52] In the beginning of 2013, Dutch doctors administered a lethal injection to a 70-year-old blind woman because she said the loss of sight constituted "unbearable suffering."[53] In early 2015, a 47-year-old divorced mother of two suffering from tinnitus, a loud ringing in the ears, was granted physician-assisted suicide in the Netherlands.[54] She left behind a 13-year-old son and a 15-year-old daughter.[55] Gerty Casteelen was a 54-year-old psychiatric patient with molysomophobia, a fear of dirt or contamination. Her doctors decided that she would not be able to control her fear and agreed to administer a lethal injection.[56]

---

46. Press release, "Clear Criteria for Medical End-of-Life Decisions in Neonates with Very Serious Defects," Royal Dutch Medical Association, June 12, 2013, http://knmg.artsennet.nl/web/file?uuid=4406e682-5e7b-4a5b-9fca-a0454ef124e0&owner=a8a9ce0e-f42b-47a5-960e-be08025b7b04&contentid=134424 (accessed January 28, 2015). The pro-euthanasia mindset has been long established in the country, and the legal barrier is often ignored. As early as 1997, a study examined the causes of all infant mortalities in the country and discovered that "57% of all deaths had been preceded by a decision to forgo life-sustaining treatment; this decision was accompanied by the administration of potentially life-shortening drugs to alleviate pain or other symptoms in 23%, and *by the administration of drugs with the explicit aim of hastening death in 8%.*" Agnes van der Heide et al., "Medical End-of-Life Decisions Made for Neonates and Infants in the Netherlands," *The Lancet*, Vol. 350 (July 26, 1997), p. 251, http://dare.uva.nl/document/2/2127 (accessed January 29, 2015) (emphasis added).
47. U.N. Human Rights Committee, "Concluding Observations of the Human Rights Committee, The Netherlands," U.N. doc CCPR/CO/72/NET, July 19 and 23, 2001, http://www1.umn.edu/humanrts/hrcommittee/netherlands2001.html (accessed February 16, 2015).
48. Derek Blyth, "Federal Parliament Passes Euthanasia Law for Minors," *Flanders Today*, February 14, 2014, http://www.flanderstoday.eu/politics/federal-parliament-passes-euthanasia-law-minors (accessed January 29, 2015).
49. Open Letter, "Fin de vie des enfants : une loi inutile et précipitée" (End of life of children: unnecessary and hasty legislation), *La Libre* (Brussels), January 29, 2014, http://www.lalibre.be/debats/opinions/fin-de-vie-des-enfants-une-loi-inutile-et-precipitee-52e93c5b3570e5b8eeea1a00 (accessed January 29, 2015).
50. Naftali Bendavid, "For Belgium's Tormented Souls, Euthanasia-Made-Easy Beckons," *The Wall Street Journal*, June 14, 2013, http://www.wsj.com/articles/SB10001424127887323463704578495102975991248 (accessed January 28, 2015).
51. Editorial, "Belgian Helped to Die After Three Sex Change Operations," BBC News, October 2, 2013, http://www.bbc.com/news/world-europe-24373107 (accessed January 28, 2015).
52. Graeme Hamilton, "Death by Doctor: Controversial Physician Has Made His Name Delivering Euthanasia When No One Else Will," *National Post*, November 22, 2013, http://news.nationalpost.com/2013/11/22/death-by-doctor-controversial-physician-has-made-his-name-delivering-euthanasia-when-no-one-else-will/ (accessed January 29, 2015).
53. DutchNews.nl, "Woman, 70, Is Given Euthanasia After Going Blind," October 7, 2013, http://www.dutchnews.nl/news/archives/2013/10/women_70_gets_euthanasia_after/ (accessed January 28, 2015).
54. DutchNews.nl, "Euthanasia Clinic Criticized for Helping Woman with Severe Tinnitus to Die," January 19, 2015, http://www.dutchnews.nl/news/archives/2015/01/euthanasia-clinic-criticised-for-helping-woman-with-severe-tinnitus-to-die.php/ (accessed January 28, 2015).
55. Sue Reid, "The Country Where Death Is Now Just a Lifestyle Choice: A Mum with Ringing Ears. Babies Whose Parents Don't Want Them to Suffer. They've All Been Allowed to Die by Assisted Suicide in Holland," *Daily Mail*, January 1, 2015, http://www.dailymail.co.uk/news/article-2893778/As-debate-assisted-suicide-dispatch-Holland-thousands-choose-die-year.html (accessed March 11, 2015).
56. Joke Mat, "In the Netherlands, Nine Psychiatric Patients Received Euthanasia," *NRC Handelsblad* (Amsterdam), January 2, 2014, http://www.nrc.nl/nieuws/2014/01/02/in-the-netherlands-nine-psychiatric-patients-received-euthanasia/ (accessed January 28, 2015).

Corrupting the Practice of Medicine

Physician-assisted suicide threatens to:

- Corrupt the culture in which medicine is practiced;
- Corrupt the profession of medicine by permitting the tools of healing to be used as a technique for killing;
- Fundamentally distort the doctor–patient relationship, greatly reducing patients' trust of doctors and doctors' undivided commitment to the healing of their patients; and
- Create perverse incentives for insurance providers and the financing of health care.

Physician-Assisted Suicide Corrupts the Profession of Medicine. The heart of medicine is healing. Doctors cannot heal by assisting patients to kill themselves or by killing them. They rightly seek to eliminate disease and alleviate pain and suffering. They may not, however, seek to eliminate the patient. Allowing doctors to assist in killing threatens to fundamentally corrupt the defining goal of the profession of medicine.

In testimony before the U.S. House of Representatives, Dr. Kass elaborated on this point:

> The legalization of physician-assisted suicide will pervert the medical profession by transforming the healer of human beings into a technical dispenser of death. For over two millennia the medical ethic, mindful that power to cure is also power to kill, has held as an inviolable rule, "Doctors must not kill."[57]

Dr. Paul McHugh agrees that this inviolable rule is essential to the practice of medicine:

> Since ancient Greece physicians have been tempted to help desperate patients kill themselves, and many of those Greek doctors must have done so. But even then the best rejected such actions as unworthy and, as the Hippocratic Oath insists, contrary to the physician's purpose of "benefiting the sick."[58]

For this reason, the American Medical Association (AMA) code of ethics rejects physician-assisted suicide. The AMA states: "Physician-assisted suicide is fundamentally incompatible with the physician's role as healer."[59] As law professor O. Carter Snead notes,[60] dozens of professional associations and groups representing vulnerable persons oppose physician-assisted suicide, including the:

- American Medical Association,
- World Health Organization,
- American Nurses Association,
- American Association of Critical-Care Nurses,
- Hospice Nurses Association,
- Oncology Nurses Society,
- American Osteopathic Association,
- American Psychiatric Association,
- American Academy of Hospice and Palliative Medicine,
- American Academy of Pain Management,
- American Academy of Pain Medicine,
- American Academy of Orthopaedic Surgeons,
- American Academy of Physical Medicine,
- Society of Critical Care Medicine,
- American Academy of Neurology,
- American Neurological Association,
- American Society of Anesthesiologists,
- American Society of Clinical Pathologists,
- College of American Pathologists,
- American Society of Abdominal Surgeons,
- American Association of Clinical Endocrinologists,
- Society of Medical Consultants to the Armed Forces,
- American Institute of Life Threatening Illness and Loss,
- Massachusetts Medical Society,

---

[57] Kass, "Dehumanization Triumphant."

[58] McHugh, "Dr. Death Makes a Comeback."

[59] American Medical Association, "Opinion 2.211—Physician-Assisted Suicide," June 1996, http://www.ama-assn.org/ama/pub/physician-resources/medical-ethics/code-medical-ethics/opinion2211.page (accessed January 28, 2015).

[60] O. Carter Snead, "Physician Assisted Suicide: Objection in Principle and Prudence," *Notre Dame Law School Faculty Lectures and Presentation*, Paper 26, 2014, http://scholarship.law.nd.edu/cgi/viewcontent.cgi?article=1023&context=law_faculty_lectures (accessed January 28, 2015).

- Disability Rights Education and Defense Fund,
- American Disabled for Attendant Programs Today,
- American Association of People with Disabilities,
- Association of Programs for Rural Independent Living,
- Justice for All,
- National Council on Disability,
- National Council on Independent Living,
- National Spinal Cord Injury Association,
- Not Dead Yet,
- TASH,
- World Association of Persons with Disabilities, and
- World Institute on Disability.

Diagnoses of disability are now considered sufficient grounds for death.

Practicing medicine is a not a morally neutral act of mere technical skill. Physicians do not practice medicine simply to fulfil the desires of consumer-patients, whatever those desires may be. Rather, medicine is a profession governed by its core commitment to healing patients. Dr. Kass explains that professionals profess their devotion to the purposes they serve and the ideals to which they look. Teachers are devoted to learning, lawyers to justice, clergy to things divine, and "the physician devotes himself to healing the sick, looking up to health and wholeness." Dr. Kass adds: "Healing is thus the central core of medicine: to heal, to make whole, is the doctor's primary business."[61]

Killing is incompatible with caring. Dr. Kass explains: "Can wholeness and healing ever be compatible with intentionally killing the patient? Can one benefit the patient as a whole by making him dead?... 'Better off dead' is logical nonsense." Indeed, "to bring nothingness is incompatible with serving wholeness: one cannot heal—or comfort—by making nil. The healer cannot annihilate if he is truly to heal. The boundary condition, 'No deadly drugs,' flows directly from the center, 'Make whole.'"[62]

Dr. McHugh illustrates what happens when this boundary is crossed: "Once doctors agree to assist a person's suicide, ultimately they find it difficult to reject anyone who seeks their services. The killing of patients by doctors spreads to encompass many treatable but mentally troubled individuals, as seen today in the Netherlands, Belgium and Switzerland."[63] Disability groups note that "numerous studies have demonstrated that physicians underestimate the quality of life of people with disabilities compared to our own assessments."[64]

Physician-Assisted Suicide Distorts the Doctor–Patient Relationship. Physician-assisted suicide will not only corrupt the professionals who practice medicine, but also affect the patients because it threatens to fundamentally distort the doctor–patient relationship, greatly reducing patients' trust of doctors and doctors' undivided commitment to the healing of their patients.

Our laws shape our culture, and our culture shapes our beliefs, which in turn shape our behaviors. The laws governing medical treatments will shape the way that doctors behave and thus shape the doctor–patient relationship. Legal philosopher John Finnis explains how a change in the law will lead to a change of heart on the part of doctors:

> Now change the law and the professional ethic. Killing with intent becomes a routine management option. Oh yes, there are restrictions, guidelines, paperwork. Well meant. Not utterly irrelevant. But as nothing compared with our

---

[61] Leon R. Kass, "Neither for Love nor Money: Why Doctors Must Not Kill," *Public Interest*, Vol. 94 (Winter 1989), pp. 29 and 39.

[62] Ibid., pp. 40 and 41.

[63] McHugh, "Dr. Death Makes a Comeback." McHugh continues: "The fundamental premise of medicine is the vocational commitment of doctors to care for all people without doubting whether any individual is worth the effort. That means doctors will not hold back their ingenuity and energies in treating anyone, rich or poor, young or old, prominent or socially insignificant—or curable or incurable. This is the heart and soul of medical practice. The confidence with which patients turn to their physicians depends on it, and it is what spurs doctors to find innovative ways of helping the sick." Ibid.

[64] Coleman, "Assisted Suicide Laws Create Discriminatory Double Standard," p. 46.

> doctors' change in heart, professional formation, and conscience.[65]

On this point, Dr. Kass agrees:

> Won't it be tempting to think that death is the best treatment for the little old lady "dumped" again on the emergency room by the nearby nursing home? Even the most humane and conscientious physician psychologically needs protection against himself and his weaknesses, if he is to care fully for those who entrust themselves to him. A physician friend who worked many years in a hospice caring for dying patients explained it to me most convincingly: "Only because I knew that I could not and would not kill my patients was I able to enter most fully and intimately into caring for them as they lay dying."[66]

Dr. Kass asks us to consider the new normal that PAS would bring to patients:

> Imagine the scene: you are old, poor, in failing health, and alone in the world; you are brought to the city hospital with fractured ribs and pneumonia. The nurse or intern enters late at night with a syringe full of yellow stuff for your intravenous drip. How soundly will you sleep? It will not matter that your doctor has never yet put anyone to death; that he is legally entitled to do so—even if only in some well-circumscribed areas—will make a world of difference.[67]

Finnis dramatizes this new normal, highlighting how the change in law leads to a change in patients' behavior:

> A new zone of silence. Can I safely speak to my physician about the full extent of my sufferings, about my fears, about my occasional or regular wish to be free from my burdens? Will my words be heard as a plea to be killed? As a tacit permission? And why does my physician need my permission, my request?[68]

The trust that patients place in their doctors will be seriously breached if patients fear that their doctors may encourage—and actively facilitate—their death.

Physician-Assisted Suicide Creates Perverse Incentives for Insurance Providers. Physician-assisted suicide will create perverse incentives for insurance providers and the financing of health care. Assisting in suicide will often be a more "cost-effective" measure from the perspective of the bottom line than is actually caring for patients. In fact, some advocates of PAS and euthanasia make the case on the basis of saving money.

Assisting in suicide will often be a more "cost-effective" measure from the perspective of the bottom line than is actually caring for patients.

Baroness Mary Warnock, a leading ethicist in the United Kingdom, has argued, "If you're demented, you're wasting people's lives—your family's lives—and you're wasting the resources of the National Health Service." Warnock went on to suggest that such people have a "duty to die."[69]

---

65. Finnis, *The Collected Essays of John Finnis*, Vol. 3, *Human Rights and Common Good*, p. 260. Finnis explains how a change in the law regarding physician-assisted suicide will change the mindset and dispositions of professionals who are operating within the new culture: "So do not think of the euthanasia law being administered by today's medical practitioners and nurses and hospital administrators, whose codes of ethics exclude killing as a treatment and management option…. [T]he ethics of all those professions and classes would—and would be bound to—change." Ibid., p. 260.
66. Kass, "Neither for Love nor Money," p. 35. Elsewhere, Kass adds: "Even conscientious physicians will have trouble caring wholeheartedly for patients once death becomes a 'therapeutic option.' The prohibition against killing patients, medicine's first principle of ethical self-restraint, recognizes that no physician devoted to the benefit of the sick can serve the patient by making him dead. The physician-suicide-assistant or physician-euthanizer is a deadly self-contradiction." Kass, "Dehumanization Triumphant."
67. Kass, "Neither for Love nor Money," p. 35.
68. Finnis, *The Collected Essays of John Finnis*, Vol. 3, *Human Rights and Common Good*, p. 260.
69. Martin Beckford, "Baroness Warnock: Dementia Sufferers May Have a 'Duty to Die,'" *The Telegraph*, September 18, 2008, http://www.telegraph.co.uk/news/uknews/2983652/Baroness-Warnock-Dementia-sufferers-may-have-a-duty-to-die.html (accessed January 28, 2015).

Derek Humphry, founder of the Hemlock Society, also points to the role of money, noting that "the pressures of cost containment provide impetus, whether openly acknowledged or not, for the practicalities of an assisted death." He goes on to add that "the connections between the right-to-die and the cost, value, and allocation of health care resources are part of the political debate, albeit frequently unspoken." Humphry, however, was one advocate willing to speak about that cost: "It is impossible to predict exactly how much money could be saved.... Conservative estimates, however, place the dollar amount in the tens of billions."[70]

Physician-assisted suicide has affected the financing of health care in the United States as well. Dr. McHugh notes:

> When a "right to die" becomes settled law, soon the right translates into a duty. That was the message sent by Oregon, which legalized assisted suicide in 1994, when the state-sponsored health plan in 2008 denied recommended but costly cancer treatments and offered instead to pay for less-expensive suicide drugs.[71]

Richard Doerflinger adds:

> Last year, over half the patients who committed assisted suicide in Oregon relied on the government for their health coverage or had no coverage at all. Over three-quarters of those dying under Washington's assisted suicide law were partly or completely dependent on Medicare or Medicaid.[72]

This sets the stage for a perverse alignment of public financing and patient death, just as the New York Task Force predicted in its 1994 report:

> Limits on hospital reimbursement based on length of stay and diagnostic group, falling hospital revenues, and the social need to allocate health dollars may all influence physicians' decisions at the bedside.... Under any new system of health care delivery, as at present, it will be far less costly to give a lethal injection than to care for a patient throughout the dying process....
>
> Physicians who determine that a patient is a suitable candidate for assisted suicide or euthanasia may be far less inclined to present treatment alternatives, especially if the treatment requires intensive efforts by health care professionals.[73]

These perverse financial incentives will exercise a subtle but profound pressure on patients as the advice from their physicians and the procedures covered by their insurance increasingly point toward PAS. Given the increasing number of elderly patients in modern societies, their increasing longevity, and the increasing cost of treating their chronic illnesses, PAS will increasingly be seen as a cost-effective option and one that the elderly should be encouraged to consider.

Compromising the Family and Intergenerational Obligations

Physician-assisted suicide will also negatively affect our culture, especially the family and our intergenerational obligations. The temptation to view elderly or disabled family members as burdens will surely rise. The temptation for elderly and disabled family members to view themselves as burdens will also surely rise. Instead of the solidarity of civil society and true compassion, PAS threatens to create cheap solutions by eliminating those who are perceived as socially and economically burdensome.

The Family Has Responsibility for Disabled and Elderly Relatives. There is a natural cycle to human life. Human beings enter the world as entirely needy, totally dependent newborns. Many people exit life dependent on others as well. Along the way, there will undoubtedly be periods of trial and tribulation when people need the assistance of others. Traditionally, the family has been a central social institution for weathering life's storms. Mothers

---

[70] Derek Humphry and Mary Clement, *Freedom to Die: People, Politics, and the Right-to-Die Movement* (New York: St. Martins, 2000), pp. 339, 340, and 353.

[71] McHugh, "Dr. Death Makes a Comeback."

[72] Doerflinger, "Flirting with Death."

[73] New York Department of Health, Task Force on Life and the Law, *When Death Is Sought: Assisted Suicide and Euthanasia in the Medical Context*, chap. 6, quoted in Finnis, *The Collected Essays of John Finnis*, Vol. 3, *Human Rights and Common Good*, p. 265.

and fathers take care of children at the dawn of life, and then children take care of their aging parents at the twilight.

Family life is meant to include shouldering one another's burdens and assisting those in need. In his provocatively titled essay "I Want to Burden My Loved Ones," ethicist Gilbert Meilaender explains why he refuses to accept the logic of atomistic individualism:

> Is this not in large measure what it means to belong to a family: to burden each other—and to find, almost miraculously, that others are willing, even happy, to carry such burdens? Families would not have the significance they do for us if they did not, in fact, give us a claim upon each other. At least in this sphere of life we do not come together as autonomous individuals freely contracting with each other. We simply find ourselves thrown together and asked to share the burdens of life while learning to care for each other.[74]

While the family is the primary institution tasked with intergenerational care, no family is an island. As Dr. Kass and Eric Cohen point out, families are situated within a larger culture—and the law shapes this culture:

> Even if the burdens of aging and death are always borne most fully by individuals and families, how we age and die are not only private matters. Our communal practices and social policies shape the environments in which aging and caregiving take place—not only in moments of crisis, when life-or-death decisions need to be made, but in the long days of struggle and everyday attendance. Faith-based institutions and community groups support families in meeting those needs they cannot meet alone. Programs like Medicaid assist those who are old and impoverished, in need of nursing that they cannot themselves afford.[75]

Physician-Assisted Suicide Creates Heightened Pressures on Disabled and Elderly Family Members. The introduction of PAS would undermine familial relationships and promote the view that disabled and elderly relatives are not people to be loved but burdens to be managed. Physician-assisted suicide would alter how people in general view the disabled and elderly and how the disabled and elderly view themselves. On the interaction between the two groups, Professor Finnis describes a dramatic scene:

> Another zone of fearful silence. Outside the door are the relatives. What will they be telling the doctor about my condition and my wishes? What is prudent to tell them about my suffering, my depression, my wishes? Are they interpreting my state of mind just as I would wish? Are their interests in line with mine?[76]

Physician-assisted suicide creates a temptation for relatives and thus undermines trust. Because of its potential to corrupt these intergenerational ties, Finnis concludes that in a world with PAS, "[m]any people will find that their nearest and dearest are less and less near, and less and less dear."[77]

---

[74] Gilbert Meilaender, "I Want to Burden My Loved Ones," *First Things*, October 1991, http://www.firstthings.com/article/1991/10/003-i-want-to-burden-my-loved-ones (accessed January 28, 2015).

[75] Leon R. Kass and Eric Cohen, "Cast Me Not Off in Old Age," *Commentary*, January 1, 2006, http://www.aei.org/publication/cast-me-not-off-in-old-age/ (accessed January 28, 2015). Dr. Kass and Cohen conclude: "In the end, there is no 'solution' to the problems of old age, at least no solution that any civilized society could tolerate. But there are better and worse ways to see our aging condition. The better way begins in thinking of ourselves less as wholly autonomous individuals than as members of families; in relinquishing our mistaken belief that medicine can miraculously liberate our loved ones or ourselves from debility and decline, and instead taking up our role as caregivers; and in abjuring the fantasy that we can control the manner and the hour of our dying, learning instead to accept death in its proper season as mortal beings replaced and renewed by the generations that follow." Ibid.

[76] Finnis, *The Collected Essays of John Finnis*, Vol. 3, *Human Rights and Common Good*, p. 261.

[77] Ibid. Finnis continues: "[What] could remove or even appreciably diminish the patient's subjection to the pressure of the thought that my being killed is what my relatives expect of me and is in any case the decent thing to do, even though I utterly fear it and perhaps perceive it as the uttermost and ultimate indignity, an odious, devastating subjection to the needs and will of others? And likewise with the other sources of tyranny, the new power, opportunity, and ethic of doctors, and the real and novel power of the relatives." Ibid., p. 262.

Victoria Reggie Kennedy, widow of the late Senator Edward Kennedy (D–MA), campaigned against a bill that would have legalized PAS in Massachusetts on precisely these grounds. Kennedy noted that "the proposed law is not about bringing family together to make end of life decisions; it's intended to exclude family members from the actual decision-making process to guard against patients' being pressured to end their lives prematurely."[78] She went on to explain how her husband was able to die a true death with dignity by avoiding the pressures of assisted suicide:

> When my husband was first diagnosed with cancer, he was told that he had only two to four months to live, that he'd never go back to the U.S. Senate, that he should get his affairs in order, kiss his wife, love his family and get ready to die.
>
> But that prognosis was wrong. Teddy lived 15 more productive months…. Because that first dire prediction of life expectancy was wrong, I have 15 months of cherished memories—memories of family dinners and songfests with our children and grandchildren; memories of laughter and, yes, tears; memories of life that neither I nor my husband would have traded for anything in the world.
>
> When the end finally did come—natural death with dignity—my husband was home, attended by his doctor, surrounded by family and our priest.[79]

Mrs. Kennedy concluded that most people wish for a good death "surrounded by loved ones, perhaps with a doctor and/or clergyman at our bedside." But with PAS, "what you get instead is a prescription for up to 100 capsules, dispensed by a pharmacist, taken without medical supervision, followed by death, perhaps alone. That seems harsh and extreme to me."[80] Indeed it is.

Even if legal protections against pressure and coercion could somehow be made effective, how could they prevent the corruption of culture? In a society with PAS, legal safeguards will not mute the clear moral message transmitted by laws allowing PAS: that some lives are "not worth living" and that some people have a duty to end their lives.

Physician-assisted suicide creates a temptation for relatives and thus undermines trust.

These cultural pressures are not merely the suppositions of cultural philosophy. They play out in real life. Dr. Hendin has documented many such stories, such as this one:

> A wife who no longer wished to care for her sick, elderly husband gave him a choice between euthanasia and admission to a home for the chronically ill. The man, afraid of being left to the mercy of strangers in an unfamiliar place, chose to have his life ended; the doctor, although aware of the coercion, ended the man's life.[81]

These stories are not isolated incidents. Dr. Hendin reports that a study of Dutch hospitals found that "doctors and nurses reported that more requests for euthanasia came from families than from patients themselves. The investigator concluded that the families, the doctors, and the nurses were involved in pressuring patients to request euthanasia."[82] The same pressure is evident in the limited places where physician-assisted suicide is legal in the United States. Oregon Health Authority research found that

---

[78] Victoria Reggie Kennedy, "Question 2 Insults Kennedy's Memory," *Cape Cod Times*, November 3, 2012, http://www.capecodtimes.com/article/20121027/OPINION/210270347 (accessed March 5, 2015).

[79] Ibid.

[80] Ibid.

[81] Herbert Hendin, "The Dutch Experience," in Kathleen Foley and Herbert Hendin, eds., *The Case Against Assisted Suicide* (Baltimore, MD: Johns Hopkins University Press, 2002), p. 109.

[82] Ibid. Hendin and Foley write: "One can readily see how in the best of circumstances frail, elderly patients can feel coerced to die. Caregiver burden has been identified as a serious issue, particularly for women … who are asked to shoulder the work and responsibility of providing twenty-four-hour care to a parent." Kathleen Foley and Herbert Hendin, "The Oregon Experiment," in Foley and Hendin, *The Case Against Assisted Suicide*, p. 157.

40 percent of those who were assisted with suicide cited being a burden on family or friends and caregivers as their motivation to end their lives.[83]

These considerations are particularly disturbing because suicide is a phenomenon that can spread throughout a society, based on imitation. Social scientists, Dr. Kheriaty notes, "know that there is a 'social contagion' aspect to suicide."[84] In its guide to preventing suicide, the World Health Organization notes the scholarly research on the imitative nature of suicide:

> Over 50 investigations into imitative suicides have been conducted. Systematic reviews of these studies have consistently drawn the same conclusion: media reporting of suicide can lead to imitative suicidal behaviours.... Particular subgroups in the population (e.g., young people, people suffering from depression) may be especially vulnerable to engaging in imitative suicidal behaviours. Finally, and probably most importantly, overt description of suicide by a particular method may lead to increases in suicidal behaviour employing that method.[85]

Commenting on Brittany Maynard's suicide, Dr. Kheriaty argues that "given what we know about suicide's social effects, and given the media portrayal around her death, we can anticipate that her decision will influence other vulnerable individuals."[86] Dr. Kheriaty concludes that PAS will send a signal to legitimize such suicidal desires:

> Refusing to legitimate suicide helps those in need. The practice of physician-assisted suicide ... sends a message that some lives are not worth living. The law is a teacher: If assisted suicide is legalized, this message will be heard by everyone who is afflicted by suicidal thoughts or tendencies.[87]

In doing so, PAS undermines our entire culture.

Betraying Human Dignity and Equality Before the Law

Perhaps the most profound injustice of PAS is that it violates human dignity and denies equality before the law. Every human being has intrinsic dignity and worth. For our legal system to be coherent and just, the law must respect this dignity by taking all reasonable steps to prevent the taking of innocent lives. Classifying a subgroup of people as legally eligible to be killed violates our nation's commitment to equality before the law and shows profound disrespect for the elderly and disabled.

No natural right to physician-assisted suicide exists, and arguments for such a right are indeed incoherent. A legal system that permits assisted suicide undermines the natural right to life for all of its citizens.

A legal system that permits assisted suicide undermines the natural right to life for all of its citizens.

Every Human Being Has Intrinsic Human Dignity and Worth. The American Creed, best articulated in the Declaration of Independence, holds it to be a self-evident truth "that all men are created equal, that they are endowed by their Creator with certain unalienable Rights, that among these are Life, Liberty and the pursuit of Happiness." Philosophers Patrick Lee and Robert P. George explain that "every human being, of whatever age, size, or degree of development, has inherent and equal fundamental dignity and basic rights."[88]

This dignity does not depend on subjective evaluations of worth, even of self-worth, or on the ability to "contribute" to society. Rather, the dignity is *intrinsic*. Human dignity is not based on an instrumental account of what a person *can do*, but on recognition of what a human being *is*: a person made for reason, freedom, and love. Lee and George explain

---

[83] Oregon Public Health Division, "Oregon's Death with Dignity Act—2014."

[84] Kheriaty, "Apostolate of Death," p. 19.

[85] World Health Organization, Department of Mental Health and Substance Abuse, "Preventing Suicide: A Resource for Media Professionals," 2008, http://www.who.int/mental_health/prevention/suicide/resource_media.pdf (accessed March 5, 2015).

[86] Kheriaty, "Apostolate of Death," p. 20.

[87] Ibid., p. 20.

[88] Patrick Lee and Robert P. George, *Body-Self Dualism in Contemporary Ethics and Politics* (Cambridge, U.K.: Cambridge University Press, 2008), p. 93.

that "a human being is valuable as a subject of rights in virtue of what he or she is.... And so a human being remains a subject of rights, someone who has a right not to be intentionally killed, for as long as he or she exists."[89]

Of course, a belief in human dignity is not unique to the United States. The Universal Declaration of Human Rights begins by noting that the "recognition of the inherent dignity and of the equal and inalienable rights of all members of the human family is the foundation of freedom, justice and peace in the world."[90] The European Convention on Human Rights also emphasizes the inalienable right to life: "Everyone's right to life shall be protected by law. This right is one of the most important of the Convention since without the right to life it is impossible to enjoy the other rights."[91]

The Law Must Respect Human Dignity and Equality Before the Law. The deepest injustice of PAS, then, is that it treats some human lives as lacking dignity or worth—and therefore unworthy of the law's protection. Lee and George conclude that "the choice to kill an innocent human life, whether one's own or another's, even for the sake of avoiding terrible suffering, is intrinsically immoral. Euthanasia and suicide are contrary to the intrinsic dignity of human persons."[92]

Obviously, this does not require that every medical procedure to extend life must be accepted. As the Supreme Court held in a unanimous decision upholding New York's prohibition on PAS, there is a significant difference between allowing someone to die of natural causes and killing him.[93]

The D.C. assisted suicide bill, like most, attempts to define which lives are unworthy of legal protection and thus eligible for physician assistance in killing. That definition is unavoidably a statement of who is unworthy of legal protection. There is no way around it. While the evidence discussed in the first section of this paper indicates that its proposed safeguards would fail to ensure effective control, even the attempt to define which lives are eligible for suicide is a grave injustice: It violates human dignity and equality before the law. It declares that some lives matter less than others.

Disability-rights groups are particularly concerned about the ways in which assisted suicide deprives disabled people of the law's equal protection. In 2009, for example, Not Dead Yet, ADAPT, the Disability Rights Education and Defense Fund, the National Council on Independent Living, and the National Spinal Cord Injury Association filed a joint amicus brief in the Montana court system in a case reviewing Montana's law on assisted suicide.

Diane Coleman, president of Not Dead Yet, summarized these arguments in an article for the *Disability and Health Journal*.[94] Coleman explains that the push for assisted suicide undermines the value of the lives of people with disabilities:

> The primary underlying practical basis for the physician's determination that the individual is eligible for assisted suicide is the individual's disabilities and physical dependence on others for everyday needs, which is viewed as depriving them of what nondisabled people often associate with "autonomy" and "dignity," and may also lead them to feel like a "burden." This establishes grounds for physicians to treat these individuals completely differently than they would treat a physically able-bodied suicidal person.[95]

In addition to denying the intrinsic human dignity of the disabled, PAS laws violate the equal protection of the law. The law and government officials would treat suicidal disabled citizens differently from able-bodied citizens:

> Not Dead Yet's central argument is that legalized assisted suicide sets up a double standard for how

---

[89] Ibid., p. 155.

[90] The Universal Declaration of Human Rights, http://www.un.org/en/documents/udhr/ (accessed February 24, 2015).

[91] Council of Europe, Convention for the Protection of Human Rights and Fundamental Freedoms and Protocol, http://www.echr.coe.int/Documents/Collection_Convention_1950_ENG.pdf (accessed February 27, 2015).

[92] Lee and George, *Body-Self Dualism in Contemporary Ethics and Politics*, p. 156.

[93] *Vacco v. Quill*. The Supreme Court overturned a ruling of the 2nd Circuit Court that, among other things, argued that because patients could deny care resulting in their death, they should be able to have assistance in killing.

[94] Coleman, "Assisted Suicide Laws Create Discriminatory Double Standard," pp. 40 and 48.

[95] Ibid., p. 41.

> health care providers, government authorities, and others respond to an individual's stated wish to die. Some people get suicide prevention while others get suicide assistance, and the difference between the two groups is the health status of the individual.[96]

As the joint amicus brief notes, "Assisted suicide singles out some people with disabilities, those labeled 'terminal' or very severely impaired, for different treatment than other suicidal people receive."[97] Government policy should seek to respect the innate dignity of the disabled by eliminating every form of unjust discrimination against them, not by expressly approving the worst form of discrimination of all.

A "Right" to Physician-Assisted Suicide Is Incoherent, Grounded in Neither Nature Nor Reason. Not only does PAS violate human dignity and equality, but any supposed right to assisted suicide is incoherent, grounded neither in nature nor in reason.

Dr. Kass highlights the absurdity of a "right to die": "As the ultimate new right, grounded neither in nature nor in reason, it demonstrates the nihilistic implication of the new ('postliberal') doctrine of rights, rooted in the self-creating will." He later adds: "If we start at the beginning, with the great philosophical teachers of natural rights, the very notion of a right to die is nonsensical." This is partly because "the right to life is a matter of nature, not will."[98] Dr. Kass notes that:

> We Americans hold as a self-evident truth that governments exist to secure inalienable rights, first of all, the right to self-preservation; now we are being encouraged to use government to secure a putative right of self-destruction. A "right to die" is surely strange and unprecedented, and hardly innocent.[99]

If there is a right to the pursuit of happiness, how could one argue that the pursuit of happiness could entail the elimination of the person with that right?[100]

The American Founders would agree with Professors Kass, Lee, and George. They distinguished liberty from license. Liberty, they rightly understood, is self-directed action in accord with the moral law; license is self-destructive action that debases one's community. The Founders would have little patience for an argument based on "autonomy" (what they would view as license) to commit PAS, especially as the legal allowance of such a practice would threaten other people's right to life. Dr. Kass highlights the absurdity in terms of the philosophy of Kant:

> For Kant, autonomy, which literally means "self-legislation," requires acting in accordance with one's true self—that is, with one's rational will determined by a universalizable, that is, rational maxim. Being autonomous means not being a slave to instinct, impulse or whim, but rather doing as one ought, as a rational being. But "autonomy" has now come to mean "doing as you please," compatible no less with self-indulgence than with self-control.[101]

Any purported right to assisted suicide is both incoherent and impossible to specify. To highlight this incoherence and lack of specificity, John Finnis reflected on the phrase "right to die":

> Where is the proposition specifying *who* has the right, to *what* acts, by *which* persons? Is it the right of terminally ill patients? (And what is terminal illness?) Or only of those who are suffering? (And what sort and degree of sufferings?) Or of all who are suffering whether or not their illness is terminal? Is it a right only to be assisted in killing oneself...? Or also that others be permitted (or

---

[96] Ibid., p. 43.

[97] Ibid. The brief continues: "Central to the civil rights of people with disabilities is the idea that a disabling condition does not inherently diminish one's life; rather, surrounding barriers and prejudices do so. In contrast, assisted suicide gives official sanction to the idea that life with a disabling condition is not worth living." Ibid., p. 44.

[98] Leon R. Kass, *Life, Liberty and the Defense of Dignity: The Challenge for Bioethics* (San Francisco: Encounter Books, 2002), pp. 203, 212, and 214.

[99] Ibid., p. 203.

[100] Lee and George argue that "it makes no sense to hold that the fulfillment of entity is intrinsically valuable, and yet the entity itself is not." Lee and George, *Body-Self Dualism in Contemporary Ethics and Politics*, pp. 160–161.

[101] Kass, *Life, Liberty and the Defense of Dignity*, p. 216.

> perhaps under a duty) to kill me? (When I cannot do so myself? Or also when I choose?)[102]

In truth, the entire concept of a right to assisted suicide will be applied only to certain people whom government officials have classified as "eligible." Finnis explains:

> Even when you fall seriously ill, or become clinically depressed, you will find (if the reformers [i.e., those proposing bills to allow assisted suicide] are to be believed) that your right to autonomy does not give you the right to be assisted in suicide unless you are ill *enough* or suffering *enough*, or depressed severally and incurably *enough*—in each case "enough" in the view of somebody else, *other people*.[103]

Rather than allow the government to decide whose life is unworthy of life, it is much better to have the government respect the intrinsic dignity of every human life and thus provide for the equal protection in law of all human beings. The alternative, as Finnis presents it, requires that we "allow some people to sit in judgment on the life of another human person, to judge that person's life worthless, and so to authorize themselves or others to carry out that person's request for death."[104]

If we empower such people to judge other people's lives as worthless, how long will it be until the choice for death under certain circumstances becomes an obligation—perhaps enforced by other people. Thus, an incoherent "right" to assisted suicide might very well result in a duty to have oneself euthanized.

The Legal System as a Whole Must Protect Rights. Physician-assisted suicide would transform our nation's legal system. A society that creates a right to assisted suicide will seriously compromise the natural right not to be killed. As Finnis has argued, "A whole new breed of lawyers and law teachers and judges will rapidly come into existence to give effect to the new régime."[105] With this new set of legal officials interpreting and enforcing new laws, society can expect to see more people have their right not to be killed violated.

A society that creates a right to assisted suicide will seriously compromise the natural right not to be killed.

Given the various ways in which PAS will change the practice of medicine, law, and the culture, Finnis asks "which legal framework will *take … rights most seriously*." He answers:

> [T]he secular, highly experienced, and sophisticated members of the Walton Committee [House of Lords Select Committee on Medical Ethics, chaired by Lord Walton] and the New York Task Force judge that if euthanasia were legalized at all, the right *not* to be killed would be catastrophically nullified for very many more people than the few whose supposed right to die is compromised by present law.[106]

The right not to be killed cannot be protected effectively in a nation that allows physician-assisted suicide.

The Alternative: Respecting Human Dignity and Equality and Offering True Compassion

Physicians are always to care, never to kill. They are to eliminate illness and disease but never eliminate their patients. Not every medical means must be used. Patients can refuse or doctors can withhold particular treatments that are useless or causing

---

[102] Finnis, *The Collected Essays of John Finnis*, Vol. 3, *Human Rights and Common Good*, p. 257 (emphasis in original).

[103] Ibid., p. 258 (emphasis in original).

[104] Ibid., p. 259. Finnis later explains how assisted suicide laws threaten the very justice of a political community: "A just society cannot be maintained, and people cannot be treated with the equal concern and respect to which they are all entitled, unless we hold fast to the truth … that none of us is entitled to act on the opinion that the life of another is not worth living. To trash this truth … is to discard the very foundations of just and *equal respect* for persons in their liberty, their pursuit of happiness, and their life." Ibid., p. 270 (emphasis in original).

[105] Ibid., p. 259.

[106] Ibid., pp. 262 and 264 (emphasis in original).

more harm than good.[107] But in deciding that a treatment is useless, we must not decide that a patient is worthless. Doctors should not kill.

Mental Health and Palliative Care: True Compassionate Treatment. Instead of embracing PAS, we should respond to suffering with true compassion. Most people seeking PAS suffer from depression or other mental illnesses, physical illness, or simply loneliness. Dr. Kheriaty notes:

> Suicidal individuals typically do not want to die; they want to escape what they perceive as intolerable suffering. When comfort or relief is offered, in the form of more-adequate treatment for depression, better pain management, or more-comprehensive palliative care, the desire for suicide wanes.[108]

Rather than helping suicidal people to kill themselves, we should offer them treatment and support. For those in physical pain, palliative care and other pain management can manage their symptoms effectively. For those for whom death is imminent, hospice care and fellowship to accompanying them in their last days is what a true death with dignity looks like. Victoria Reggie Kennedy has said it best:

> My late husband Sen. Edward Kennedy called quality, affordable health care for all the cause of his life. [PAS] turns his vision of health care for all on its head by asking us to endorse patient suicide—not patient care—as our public policy for dealing with pain and the financial burdens of care at the end of life. We're better than that. We should expand palliative care, pain management, nursing care and hospice, not trade the dignity and life of a human being for the bottom line.[109]

Palliative care focuses on improving a patient's quality of life by alleviating pain and other distressing symptoms of a serious illness. Palliative care is an option for people of any age at any stage in illness, whether that illness is curable, chronic, or life threatening.

When a patient receives a terminal or life-altering diagnosis, the subsequent life changes are not limited to the medical challenges. Patients encounter the physical trauma of the medical diagnosis while also experiencing psychological difficulties, social changes, and even existential concerns. In Oregon Health Authority research, 91 percent of those who were assisted with suicide cited loss of autonomy as their motivation to end their lives, and 71 percent cited loss of dignity as their motivation. Only 31 percent cited inadequate pain control.[110] These needs require different forms of care. Palliative care seeks to take into consideration every facet of the patient's situation—with professionals who can attend to all aspects of the patient's needs.

The most common structure in which patients receive palliative care is in hospice. Hospice care can be provided in patients' homes, hospice centers, hospitals, long-term care facilities, or wherever a patient resides. By rejecting PAS and committing to palliative care and hospice care, we can better people's lives at the end of life. As Dr. Kass notes:

> We must care for the dying, not make them dead. By accepting mortality yet knowing that we will not kill, doctors can focus on enhancing the lives of those who are dying, with relief of pain and discomfort, moral and social support, and, when appropriate, the removal of technical interventions that are merely useless or degrading additions to the burdens of dying.[111]

Regrettably, palliative care is not as widely available as it should be. The United States has only one palliative care physician for every 1,200 persons

---

[107] Dr. Kass explains: "Ceasing medical intervention, allowing nature to take its course, differs fundamentally from mercy killing. For one thing, death does not necessarily follow the discontinuance of treatment.... Not the physician, but the underlying fatal illness becomes the true cause of death. More important morally, in ceasing treatment the physician need not intend the death of the patient, even when the death follows as a result of his omission. His intention should be to avoid useless and degrading medical additions to the already sad end of a life. In contrast, in active, direct mercy killing the physician must, necessarily and indubitably, intend primarily that the patient be made dead. And he must knowingly and indubitably cast himself in the role of the agent of death." Kass, "Neither for Love nor Money," pp. 43–44.

[108] Kheriaty, "Apostolate of Death," p. 19.

[109] Kennedy, "Question 2 Insults Kennedy's Memory."

[110] Oregon Public Health Division, "Oregon's Death with Dignity Act—2014."

[111] Kass, "Dehumanization Triumphant." Elsewhere, Kass adds that "death with dignity, understood as living dignifiedly in the face of death, is not a matter of pulling plugs or taking poison." Kass, *Life, Liberty and the Defense of Dignity*, p. 249.

living with a serious or life-threatening illness. Even with the aging population, only 63 percent of hospitals report a palliative care program.[112]

In order to increase the availability and understanding of palliative care, medical schools should ensure that students are trained in managing pain and other common distressing symptoms and that they learn how to talk to patients about palliative options at the end of life. As Drs. Hendin and Foley note, when there is a lack of comprehensive support for patients with terminal or life-altering diagnosis, "the focus shifts away from relieving the distress of dying patients considering a hastened death to meeting the statutory requirements for assisted suicide."[113] This we must resist.

Always to Care, Never to Kill

Doctors should help their patients die a dignified natural death, but doctors should not assist in killing or self-killing. Physicians are always to care, never to kill.

Physician-assisted suicide endangers the weak and marginalized in society. Where PAS has been allowed, safeguards that were put in place to minimize this risk have proved inadequate and over time have been weakened or eliminated altogether.

Introducing PAS changes the culture in which medicine is practiced. It corrupts the profession of medicine by permitting the tools of healing to be used as techniques for killing. It also distorts the doctor–patient relationship by reducing patients' trust of doctors and doctors' undivided commitment to the healing of their patients. Physician-assisted suicide also creates perverse incentives for insurance providers and the financing of health care.

Worse yet, PAS negatively affects our entire culture. The temptation to view elderly or disabled family members as burdens will increase, as will the temptation for elderly and disabled family members to view themselves as burdens. Instead of solidarity through civil society and true compassion, PAS creates quick-fix, discriminatory, and lethal solutions.

The most profound injustice of PAS is that it violates human dignity and denies equality before the law. Every human being has intrinsic dignity and is the subject of immeasurable worth. No natural right to PAS exists, and arguments for such a right are incoherent. A legal system that sought to vindicate a right to assisted suicide would jeopardize the real natural right to life for all of its citizens.

For all of these reasons, citizens and policymakers need to resist the push for physician-assisted suicide.

*—**Ryan T. Anderson, PhD,** is William E. Simon Fellow in the Richard and Helen DeVos Center, of the Institute for Family, Community, and Opportunity, at The Heritage Foundation.*

---

[112] R. Sean Morrison and Diane E. Meier, "America's Care of Serious Illness: A State-by-State Report Card on Access to Palliative Care in Our Nation's Hospitals," Center to Advance Palliative Care and the National Palliative Care Research Center, May 2011, p. 9, http://reportcard.capc.org/pdf/state-by-state-report-card.pdf (accessed January 30, 2015).

[113] Hendin and Foley, "Physician Assisted Suicide in Oregon," p. 1616.