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MAKING THE ROUNDS

IN HEALTH,
FAITH,
& ETHICS

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Court Strikes Down Ban on Physician-assisted Suicide: A Roundtable

*The announcement of the decision by the U.S. Court of Appeals for the Ninth Circuit on March 6, 1996, in *Compassion in Dying v. State of Washington* (which found the state statute prohibiting physician-assisted suicide unconstitutional) led to a lively, impromptu discussion among several staff members at the Park Ridge Center. One of the themes that emerged was dismay that the many complex issues and deeper meanings embedded in physician-assisted suicide were not being explored with sustained and open dialogue in any forum. It was suggested that our own roundtable discussion might serve as a vehicle to promote the kind of dialogue that is necessary before any determination can be made regarding the ethical, clinical, and legal parameters of physician-assisted suicide.*

Less than a month later, on April 2, 1996, the U.S. Court of Appeals for the Second Circuit ruled that New York State's ban on physician-assisted suicide was unconstitutional. Although the two courts reached the same conclusion, their reasoning differed. The Ninth Circuit reasoning, elaborated in the roundtable, found that the

Washington statute violates the due process clause of the Fourteenth Amendment. The Second Circuit decision did not find a constitutionally implicated liberty interest but found that the New York statute violates the equal protection clause of the Fourteenth Amendment. The Second Circuit based its conclusion in large part on the notion that physician-assisted suicide is no different from withholding and withdrawing treatment that results in death. Thus, the court reasoned that competent, terminally ill adults who do not have the option of forgoing or withdrawing treatment to hasten their deaths, and are denied the option of receiving medication prescribed by a physician to hasten their deaths, are similarly situated but treated differently—in violation of the equal protection clause. In a concurring opinion, Judge Guido Calabresi explained that because the issue has not been fully explored legislatively, he reached the same result. However, he left open the possibility that the same statute, if based on a legislative record of thorough deliberation, might withstand constitutional scrutiny. It is that sort of deliberation that this roundtable seeks to inform and encourage.

Larry Greenfield: The 8–3 decision of the Ninth Circuit Court of Appeals to strike down Washington State's ban on physician-assisted suicide has been rightly treated as big news across the country. Yet the opinion itself seemed to suggest a history that led to the majority decision. Becky, could you give us some context?

Becky Pruitt: One reason it was such big news is that this court did find a new liberty interest, or broader liberty interest, than had been previously found in any other court decisions. The specific question here was whether there's a constitutionally protected liberty interest in choosing the time and manner of one's death, or as this court would call it, a right to die. And this court said yes, there is a constitutionally protected liberty interest in a right to die. The

court then went on to note that this liberty interest can vary with circumstances and that it is strongest when a competent terminally ill patient is suffering and is voluntarily requesting assistance from a physician through prescription of drugs to hasten his or her death. The court then found that the Washington statute prohibiting doctors from prescribing life-ending medication for use by competent terminally ill patients who wish to die violates those individuals' substantive due process rights under the Fourteenth Amendment to the Constitution. It's important to add that even though the court found this right, they said that it certainly is not a right that can be exercised in all circumstances, and they mentioned several times in their opinion that it is not only reasonable but perhaps necessary for the state to regulate this right.

The following Center staff members participated in the roundtable: Edwin R. DuBose, consultant, Clinical Healthcare Ethics Support Services; Larry L. Greenfield, research scholar; T. Patrick Hill, research scholar and associate editor of Making the Rounds; Martha B. Holstein, research scholar; David B. McCurdy, codirector, Clinical Healthcare Ethics Support Services; Rebecca Pruitt, consultant, Clinical Healthcare Ethics Support Services, and associate editor of Making the Rounds.

The way that the court arrived at its decision was the way that courts typically answer this question when they have found a liberty interest, and that is a test of balancing the liberty interest of the individual against the state's interest. The court recognized a number of legitimate state interests in this case (itemized in the opinion), which is why they conclude that this is something that would need to be regulated.

Their finding of this liberty interest is rooted in very recent case law. They relied heavily on *Casey* and *Cruzan*, both cases that were decided in the 1990s. From *Casey*, they relied heavily on language stating that intimate and personal choices are central to a person's dignity and autonomy and that at the heart of any liberty interest is the right to define one's own concept of existence, of meaning, of the universe, and of the mystery of human life. From *Cruzan*, they relied heavily on the court's finding that a competent person has a liberty interest in terminating unwanted medical treatment. The Ninth Circuit Court said emphatically several times that withholding or terminating unwanted medical treatment was distinct only in degree and not in kind from the prescription of medication to hasten the death of a competent terminally ill patient who had requested assistance in dying. (In essence what the court did was to conflate the distinction between killing and letting die.) These are perhaps the most important things to be aware of in reflecting on what the court decided here.

Larry Greenfield: Should we have expected the decision, now or fairly soon?

Becky Pruitt: From a legal perspective it came sooner than I would have guessed. The legal history regarding assisted suicide and the distinctions between intention and causality would not lead one to expect a decision like this from the court. Yet, in terms of the times we're living in and the context in which these issues are arising, it is not so surprising. Ballot Measure 16 in Oregon and other statewide efforts by the public are attempts to bring physician-assisted suicide to the forefront and have it legalized. In reading the

opinion, I find the judges' very real fears of suffering, becoming debilitated, and having an undignified death. These fears are shared by the public. We have to ask ourselves, Why do we have these fears today? The general public obviously has them, or they wouldn't be passing Ballot Measure 16 in Oregon. I'm concerned about whether this decision can contribute to compassionate care of all the dying and and to the training of physicians and others to treat the emotional and spiritual needs of the dying.

Larry Greenfield: It wasn't as if the judges were dreaming this. They had in front of them, after all, three specific cases of people who suffered painful, undignified deaths.

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—Martha Holstein

Martha Holstein: I believe it was the philosopher Iris Murdoch who said that when you read philosophers—and I'll extend that to legal opinions—you have to ask, What is this person afraid of? Whatever we think of this decision, it seems clear to me that it points to the judges' fear—fear of losing one's dignity, being in diapers, being in terrible pain. It's clearly in the forefront.

Judge Reinhardt, who wrote the majority opinion, sets up a dichotomy from the beginning: *Either* we have a constitutionally protected right to die *or* we have protracted, undignified, extremely painful death. The dichotomies are rather sharp and provide an interesting clue to what his own fears are, which many of us probably share.

Patrick Hill: That is indeed a very false dichotomy, and those are certainly false choices. There is no *absolute* need to fear "death in diapers" or protracted pain. The decision talks in terms of absolute because presumably the logic of its argument is that if this fear is so extreme it will take a constitutional right to protect against it. Empirical evidence suggests we have the capacity to deal with those fears.

The decision is not so surprising if you know something about Judge Reinhardt—he has the reputation for being a judicial activist. He is highly individualistic, and this decision echoes the tradition of individualism and its emphasis on individual rights that has so characterized a great deal of American constitutional

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thinking historically. In that sense, one is not surprised at the decision. There is cause for surprise in that it came so suddenly, because it is a major departure to find a new constitutional right at this time.

Martha Holstein: Although I object to the dichotomous thinking expressed in the opinion—setting up the opposites of assisted suicide versus undignified, painful death—practically and realistically it may be the way most people perceive the options. Perhaps we can control the level of pain that most people have. But the fact that we may know how to do it, that forms of palliation exist, does not mean that they are available to the majority of people. What is possible may not be what most people get. That is the real world in which most people die or see their loved ones die. We can't pretend that people routinely die in dignified ways.

Ed DuBose: One fear associated with an undignified death is the fear of dying a meaningless death. You find yourself in circumstances that are demeaning and ask, Is this the meaning of the end of my life? Perhaps one way people seek meaning in their dying is through controlling it. I don't know the particular judges in the Ninth Circuit, but perhaps they, as well as many other people, fear a death that's out of control. We can control by medical technology. In an interesting way, we can now die controlled by the court's interpretation of the liberty interests of the Constitution in this case. People want to seize control of their dying by choosing the time and the manner of death and bringing physicians in on it.

Dave McCurdy: I wonder, How new is this? Many people assume that at one time death was relatively quick, that people died fairly quickly, even if they suffered intensely for a while. But I'm not convinced of that. Technologically prolonged life is a newer phenomenon, but when we didn't have technologically prolonged life, we also had in some cases lingering deaths from conditions that no longer kill people.

Ed DuBose: For hundreds of years, there wasn't much that medicine could do. People did die horrible deaths. But also the meaning systems that surrounded death were probably very different from what many people share today. When modern medicine began to acquire the ability to intervene, I think a lot of folks in this country began to assume that they really didn't need the other resources to deal with dying. They could turn that over to the professionals. Now we're learning that intervention itself may lead to a pretty horrible death—further down the line, but still there.

Patrick Hill: The whole question of meaning in dying cannot be avoided. Religious communities should join the discussion, because within those religious traditions there is a wealth of reflection

on the meaning of death—certainly within the Christian tradition, founded as it is on the mystery of the Resurrection, which is central to any understanding of human existence and human death and salvation. Religious bodies could make a significant contribution without in any sense proselytizing. The Catholic religious tradition was actually able to influence in a very positive way the New Jersey Supreme Court's formulation of the decision in the Karen Ann Quinlan case, which became a landmark both nationally and internationally and which has served as a major guiding light for decisions as they relate to withdrawal of life-sustaining treatment. It obviously took enormous courage on the part of the religious leaders involved. They engaged in the debate within the arena of a trial, right at the heart of the public arena. It sets a model that could be adopted by religious bodies in this country. As this debate unfolds, they have a moral obligation that to participate in such a fashion, to share those resources, to share that long tradition of reflection and consideration.

Larry Greenfield: It's clear that new legal ground has been broken. Has new ethical ground been broken by this case?

Patrick Hill: The reasoning in the decision is based in part upon the

premise of the principle of double effect, yet that principle has been misrepresented and misrepresented grossly. Therefore, one has to question the ethical legitimacy of the thinking itself. It's obviously based on a very false premise.

The principle of double effect as it has traditionally been understood is based on the recognition that any intervention by a physician may have several outcomes, not all of which are going to be desirable and specifically desired. Let's take the example that was, in fact, decisive in this case: that of administering drugs to deal with pain. Such drugs can also suppress the respiratory system of a very sick patient. That being the case, the action to relieve pain also incurs the risk of hastening the patient's death. The ethical question has always been, Are you at liberty to run that risk? The way we have tended to resolve that ethically is by saying that to the extent that the intention of the action is to relieve pain we may incur the risk of hastening the death of the patient. As used in this decision, the principle of double effect amounts to saying that in this case, pain relief is accompanied by "self-inducing death," implying that both outcomes are intended and both are legitimate. That, to my mind, stands the principle on its head. It doesn't make sense.

Martha Holstein: The principle of double effect is not a universal principle; therefore Judge Reinhardt's misinterpreting it does not put the whole decision on shaky ground. What we need to look at is the underlying issue, not whether the principle is being misinterpreted. The court also conflates omission and commission, conflates stopping or withholding treatment and providing treatment to cause death.*

***Editors' note:** There is a discrepancy in how the words *commission* and *omission* are understood by the Ninth Circuit Court and how they are understood in the world of religion and ethics. That is, in this opinion the term *commission* applies to treatments to hasten death and to acts to withdraw treatment (for example, pulling the plug). The term *omission* applies to withholding treatment from the outset. Ethically

Is it error to conflate them, or is it appropriate to conflate them? I think that's a much more troubling issue. I have always had an extremely difficult time seeing the distinction. I have really tried. But I think if you withdraw food and water you are deliberately killing somebody. They are going to die. As Reinhardt points out in the decision, Nancy Cruzan did not die of the underlying disease; she died of starvation. Your intent is to let the person die, or you would continue feeding her.

The whole issue of whether these things are to be conflated is something philosophers argue about. Most people who are on their deathbed do not see a significant difference. If we're going to do ethics at a practical level, we have to think about how people make meaning, make sense, not how we can develop an elegant argument.

Ed DuBose: I agree. I'll go out on a limb and say that the decision is prophetic in the sense of certain biblical traditions—not foretelling the future but correctly assessing the present, discovering what is really going on now and what that implies for our lives, our communities. I think the judges put their finger on the pulse of the people who are really wrestling with these issues.

Dave McCurdy: One thing that troubled me was Judge Reinhardt's underlying assumption that physicians really intend for death to occur when they administer high doses of medication even though they don't say so, not even to their patients. There is the idea that we all know, of course, that that's what they are doing even though they don't say it. I was troubled by that. I'm sure that is the case for some people in medicine, but I think for others it's not. They don't intend for death to occur in the usual sense of the word *intend*. It happens, but that's not what they're up to.

Larry Greenfield: In that sense it's a little like Dr. Kevorkian saying he really doesn't intend death but just wants to relieve suffering?

Dave McCurdy: Well, now that you mention it, yes.

When Ed mentioned seeing the case as prophetic—about the courts finally catching up with the culture—it struck me that it's not only the courts that must catch up with the culture. There's a reference in the opinion to what doctors will do once the law changes—the idea is they'll get with the program. They may not like it, but it doesn't matter what the AMA thinks: physicians will do what culture dictates. I remember hearing a tape by physician and historian of medicine Michael Thaler a few years ago talking about the Nazi “euthanasia” program: the doctors got in line with what the law and society wanted. He's saying that if you want society to hold fast to

moral principles, don't look to the physicians to do it, because society and culture are too strong. We see an example of that here. It will also eventually happen to the law just as it does to medicine and everything else. That may or may not be a bad thing, but I think it's going to happen.

Patrick Hill: Eliminating the distinction between omission and commission makes it easier to argue that Nancy Cruzan, for example, died of starvation, with the implication that death by starvation was intended. You could say she died of starvation because she

was unable to swallow, but that does not entail that it was the intention when feeding was withdrawn that she would starve to death. If we don't make these kinds of distinctions we will paralyze everyone. One of the major concerns, for example, about Kevorkian's activities, is that by condoning them, the difference between assisting a suicide and withholding medical treatment would be blurred. In that case, clinicians willing to withdraw

treatment but unwilling to assist a suicide would hesitate to do the former for fear that it would be equivalent to doing the latter. That is an enormous concern in the clinical setting. In a very ironic way, championing this right while arguing for it on the basis of a complete destruction of these distinctions may result in a crippled exercise of this right, not indeed, presumably, what the court intends here: what would amount to a free exercise of this right.

Larry Greenfield: Yet it is the case that in the view of many of the public, this is a distinction without a difference. Whose responsibility now is it, if there really is a difference here? Who is responsible now for articulating that so that a persuasive argument can be made for the distinction?

Patrick Hill: Certainly in criminal law, intention is a very significant factor determining the seriousness of the crime. It seems to me that one of the beauties of such a distinction is, of course, that it allows for the close observation and scrutiny of intention. If we're talking about ethics, intention is central to the ethical enterprise.

Becky Pruitt: While many would accept that the court's application of these concepts is confusing, that's straining at gnats in a way, because this opinion sets out many other grounds on which the court reached its decision. The judges make it very clear that whether the request is voluntary, whether it's coming from a competent terminally ill patient who's suffering, is critically important. Throughout the opinion they focus much more on the person who's requesting this assistance—not so much on the intent of the

“It's troubled me for a long time that we haven't quite figured out what it means to belong to our faithful Savior in this day and age when it comes to questions like, How do you die?”

—Dave McCurdy

and religiously, *commission* has applied to treatments intended to hasten death; *omission* has applied to withdrawing or withholding treatment.

Many religious traditions have found acts of *omission* morally acceptable—essentially taking a position that it is okay to allow the patient to die; it is a passive “letting” something happen that is naturally in progress. However, few traditions have found acts of *commission* morally acceptable except when such acts hasten death unintentionally—as a by-product, for example, of attempts to control pain. The principle that permits acts that hasten death if they are not intended to hasten death is known as the principle of double effect.

physician. It's on that, and also on the reasoning from *Casey* that I cited in my opening comments, that they most heavily base their decision. Regardless of where you come down on their use of notions of double effect and their collapsing the distinction between withholding and withdrawing treatment and prescribing the drugs to hasten death, there is this decision now to deal with.

What is the medical profession going to do with this now? How are patients and physicians going to respond to this decision? At the end of the opinion, the decision makes good note of the fact that most will argue that these sorts of matters do not belong in the court. The judges tend to agree, and they believe that what they've done in this decision is to put the issue squarely back into the lap of patients and physicians although this is certainly not something that all patients must consider and choose, nor is it something that all physicians must participate in.

Patrick Hill: Unfortunately—and this has certainly been true for *Roe v. Wade*, the decision is a preemptive strike in one particular direction. It configures the tenor and the direction of the conversation. It's no longer a neutral discussion. Although some kind of appeal is likely and presumably at some point the Supreme Court may hand down a decision, nevertheless, this particular holding is going to skew the conversation.

Martha Holstein: It's an issue around which we've had some public discussion, but we haven't dealt with it in any other way, so it winds up in the courts. Not ideal. Ideally it should be dealt with personally. The next thing would be through the legislature. The legislatures probably would not touch this issue. By default it winds up in the courts. There seems to be no other way of dealing with it in our society. It can't be an informal patient-physician transaction. Many physicians would be too frightened to commit an illegal act. It's terribly discriminatory if some physicians are willing and some are not. Even though I too wish it were not in the courts and could be kept on a much more private basis, it seems to me this was an inevitability given the kinds of public discussions that occurred where ballot initiatives were being considered. A great deal of discussion occurred, and enormous amounts of money were poured into it, largely on the side opposing legalization of assisted suicide. It's not been a coast to this particular decision.

Dave McCurdy: It is ironic that in Washington where there was a referendum, it still ended up going to the courts.

Larry Greenfield: Has anything impressed you about the response to the decision at this point?

Ed DuBose: I've been impressed by how relatively little response there's been. I thought there would be more outcry, either those who would throw their hands up in disgust or those who'd cheer.

Becky Pruitt: I've had the same impression, and I've noticed that even on the Bioethics Discussion Forum it took several days before

it started to appear. It wasn't immediately following. The question is, Where and how can we get good quality discussion about the compassionate care of the dying from the health care community and the general public?

Larry Greenfield: Where should the discussion be taking place in light of this?

Becky Pruitt: Maybe health systems such as Advocate [Chicago-area Advocate Health Care] should and could create forums, either within their own institutions, inviting the public in, or out in the community, in churches or other community forums. There inter-

ested and knowledgeable physicians could engage in some public discussion. I've not seen that occur in Illinois. Perhaps in the other states where there have been ballot initiatives that has happened. That is one possibility.

Dave McCurdy: The churches and synagogues are a strategic and logical place to do this. There groups of people gather on a regular basis

to talk about the moral life and things that affect them at the core of their being. That's also where you'd get the voice of the people. That's where you can hear what the public has to say about "Did they really experience the difference between intended death or not-intended death?"

Martha Holstein: Talking about the voice of the people takes me to the basic question, Where does ethics come from? Should this decision be in the hands of philosophers? Is it an inductive exercise or a deductive exercise? Is it discovered? Is it created? Is it invented? to quote political philosopher Michael Walzer. Where does ethics come from, especially about a matter so intimate as how I am going to die?

I have long believed that a physician, a patient, and the family ought to be able to make this decision in private. My great fear is what happens when you bring the legal system into it. Then you have the doctor, the lawyer, the mother, the father, the child, and you also have the lawyer, the judge, the witnesses, and everybody else. It would transform death.

I am also concerned that once assisted suicide is an option, we will give up trying to make palliative care better and more widely available. Although we know from evidence in Oregon that as long as the ballot initiative was there palliative care got a big push, we have to think about the ways the interest in palliation can be sustained if this decision is upheld.

Patrick Hill: One unfortunate thing about this decision is the false alternative that it sets up at the very outset. A great deal is already available to us; there is a fully developed medical specialty called palliative medicine. That it's not widely practiced is obviously lamentable. But this decision seriously misrepresents the reality by ignoring the existence of this specialty. In my years of working with people in pain management, I've met people like physician Kathy Foley at Memorial Sloan-Kettering. She can recount case after case

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where, by working very closely with patients and their families, natural deaths were made possible. She has fought any effort to legalize physician-assisted suicide on the grounds that there is so much more we can do, but aren't, before having to resort to physician-assisted suicide.

Dave McCurdy: The clinical challenge is not only to develop better palliation. Most people still don't even believe—leaving palliation out of it—that they can get the health care system to stop treating them when they want it to. So that's the option people need to believe is actually there—to have treatment withdrawn.

Martha Holstein: I do not want my support for this decision to imply that we should give up the remarkable efforts of physicians like Kathy Foley; it's just that most of us don't have access to the kind of physicians who are willing to take the time to try to figure it out. She's at a top-notch medical institution. Most people do not go to top-notch medical institutions. We ought not to base that which we ought to do or what we think is right on the best there is to offer. I wish the best that we have to offer was available to everyone. Even then, for some people the suffering—not the physical suffering necessarily—would be such that they would still want this as an option. We have to define palliative care very differently from just relief of pain. Suffering can be more than pain.

In part this decision was based on the plight of the most disabled people, those unable to find ways to take their own life. But few people can take their own life in a dignified way—whether it's carbon-monoxide poisoning or putting a shotgun to your head. With assisted suicide people could be with family and friends and end their lives in a nonviolent, nonsecretive way. Still, I think few would choose it. Many of the older people I've talked to in nursing homes believe their lives and deaths are in God's hands, not in theirs. They would never choose assisted suicide—even though every day they pray to die. I want to balance what might be desirable and good options with what actually happens in the corporatized, for-profit health care universe.

I want to know that I can make this choice. I don't necessarily fear the dichotomies the judges raise, but in the practical world of medicine, of managed care, I think abandonment in death is a very real possibility. I feel very strongly that I want to preserve people's memories of me. I have been around many dying people and many nursing homes. That is a life about as undignified as one could imagine. I don't like to think about making a choice of assisted suicide as an attempt to control. I like to think about it as making a choice of meaning, of having the end of my life consistent with how I have lived.

Larry Greenfield: We've heard the liberty interest side. Does someone want to speak to the state's interest side on this particular decision?

"In reading the opinion, I find the justices' very real fears of suffering, becoming debilitated, and having an undignified death. These fears are shared by the public."

—Becky Pruitt

Martha Holstein: If the state has an interest in protecting life, then why doesn't the state guarantee health care to everybody? There are lots of people who would like to live but who have to die because they can't get in the front door of the ER or the hospital. If the state really cares, it will care about people who desperately want to live, not people who don't want to live.

Becky Pruitt: This is a thoughtful opinion and a courageous decision. It acknowledges a lot of the real concerns and difficulties with the matter before the court, pointing out that there ought to be universal health care in this country, that there is a moral obligation to have it, and that it is a very sad thing that we don't.

Patrick Hill: I don't in principle have anything against physician-assisted suicide, but I wouldn't want to argue for it as a constitutional right. That's overreaching on the part of the court. It's taking a sledgehammer to kill an ant.

Larry Greenfield: How would you guarantee it then, if not through a constitutional guarantee?

Patrick Hill: One problem we have when these issues end up in court by default is that we are forced to discuss them in terms of rights. That means we discuss the issues almost exclusively in terms of the individual. The interesting thing about this argument is that the type of patient the judges had in mind were those who are particularly helpless because of a physical disability or a mental disability—people who do not have the means to end their own lives. They are dependent on the assistance of others. So the thinking is, "How then can they achieve that assistance?" They can achieve it by first positing a right and then by exercising that right as the need presents itself. What that doesn't take account of, particularly with regard to physician-assisted suicide, is that as soon as somebody else is involved, in this case a physician, this ending of life becomes a public matter. In that sense it is quite distinct from suicide. We've recognized that suicide is a private act, not a public act. But physician-assisted suicide, or any other kind of assisted suicide, is, by its very nature, a public act, and therefore the entire community is involved.

You can argue, and I certainly would argue, that society has an obligation to provide health care to everybody. But if you make that argument, then everybody also has a role to play in something like physician-assisted suicide. In other words, you can't have it both ways. You have then to begin to consider physician-assisted suicide for what it really is: it's a public act. That's a critical distinction, and it's one that is not properly addressed. A decision that rests on constitutional principles and interpretation is intended to be a very narrow decision; it has to be. But by that very fact it is also, almost by definition, an incomplete decision.

Becky Pruitt: The judges clearly recognize that this is a decision that many people will have extreme difficulty with, based on religious beliefs or other moral values. The court says just because

there may be difficulties in implementing this, that should not stop this option from being available in certain individual cases. Others should not be forced to suffer because there can be no consensus reached here.

Larry Greenfield: Insofar as it will provoke a wider discussion and insofar as the Park Ridge Center has devoted some attention to the topic in the past and at present, what do you think, from our perspective of health, faith, and ethics, needs to be added to the discussion at this point?

Dave McCurdy: The ironic flip side of the court's decision is that the availability of this option, in a managed-care era, when resources devoted to health care are shrinking, may unintentionally provide another basis for people to feel shunted away from available treatments, especially those that sustain life. After all, we're now saying as a matter of social policy that physician-assisted suicide to terminate suffering is available. We can then rationalize that treatment denial is also a means to achieve the same end—when it's really done not out of compassion but for other reasons. Whether the court decision will actually push that, I'm not sure.

Martha Holstein: As much as I like the decision personally and for many people who are suffering, I think we also have to ask, Is it a good public policy? If health care resources are scarce, how will this be used? What does it mean to carve out an area of the law in which we say that this is okay? What does it mean when managed care institutions simply don't have treatments available and people die as a result?

Larry Greenfield: Is there anything that can be done in the clinic at this point to promote compassionate care?

Becky Pruitt: I hope this decision—like Ballot Measure 16—will get the clinical community in gear to minimize the number of people who might feel, for whatever reason, a need for physician-assisted suicide. A concrete example is the development of palliative care teams. Many physicians admit they don't know how to control pain optimally. Medical schools should teach students how better to provide compassionate care of the dying. And how ironic that the word *hospice* is never mentioned in this opinion. The court addresses the need to help people end—not just minimize, but end—their suffering; but other things—attending to their spiritual and emotional and psychological needs as they face and proceed toward death—are not considered. There's a lot that can be done clinically. Some authors have suggested that in limited circumstances hospice programs may need to offer the option of assisted suicide to competent, terminally ill individuals who request it.

Martha Holstein: One problem with hospice that needs to be resolved is how to offer hospice home care services to people who live alone, people who have no regular caregiver with them. Those are the people who are abandoned. Fear of abandonment is terrible.

Becky Pruitt: Hospice is good as far as it goes, but it doesn't go far enough. Many patients who could appropriately be referred never are. Many people cannot get into the health care system in the first place. This is not simply a clinical dilemma; it gets back to religious groups and communities too. Even if we cannot go back to the way community living was 50 or 100 years ago, we might be able to create a new type of a community to decrease this fear of abandonment.

Martha Holstein: Until about the late 1920s and 1930s, hospitals had very little to offer people. People died at home. In the nineteenth century there were communities of women who cared for the dying. You were not alone. Now caregivers are generally alone. There's one caregiver, who is often desperate. In the nineteenth century, communities of women tended births, tended illness, tended deaths. They did it communally, helping one another through difficulties and providing practical assistance and loving presence to the dying person. And they found comfort in knowing that they too would find support when they needed it. In this way, dying was a part of living. The ill may have been suffering from pain and the kinds of awful things that we fear, but at least they were in their own community with their own people surrounding them. Now the social situation is such that we'll have a very hard time recreating the kinds of dying that allowed people at least to feel connected. I think one of the great fears now is to be unconnected. You're in a hospital bed, somebody comes in and says, "Hi, there. Doing okay? You look great. You just look terrific. You're dying" and walks right out again. We're not surrounded by loving communities, and I don't know that we can ever go back to that.

Dave McCurdy: An article on hospice that I read a while back discussed expanding the notion of what palliative care is to include addressing the emotional and spiritual needs of the person—whatever it is that creates the suffering and unpleasantness of the patient's experience. You may not be able to take it away, but how do you address that? I think that is a challenge to the religious communities. How, in our day and age, do they put their beliefs and creeds into practice as a community as well as as individual members of the community? The old Heidelberg Catechism was part of the tradition I grew up in. The first question in the Heidelberg Catechism is "What is your only comfort in life and in death?" And the answer is "I belong in body and soul, in life and in death, not to myself but to my faithful Savior." They follow with a recital of the benefits of salvation for the person who has faith in Jesus and all that flows from that. It's the sense that my death and my life are not my own and by extension that community members also have a stake in one another's life and death and in creating a space for that. It's troubled me for a long time that we—let's just take the Christian community and maybe the brand of Protestants that would use the Heidelberg Catechism—haven't quite figured out what it means to belong to our faithful Savior in this day and age when it comes to questions like, How do you die? What way of dying expresses that or incorporates that? What is the relationship between choosing physician-assisted death and belonging to our Savior? □

In this issue:

Roundtable discussion: Court strikes down ban on assisted suicide

"A COMPETENT, TERMINALLY-ILL ADULT, having lived nearly the full measure of his life, has a strong liberty interest in choosing a dignified and humane death rather than being reduced at the end of his existence to a childlike state of helplessness, diapered, sedated, incompetent," wrote Judge Stephen Reinhardt in the majority opinion of the U.S. Court of Appeals for the Ninth Circuit.
(reported in *Chicago Tribune*, 14 March 1996)

"LIKE RIGHT-TO-LIFE ISSUES, right-to-die decisions are bitterly controversial. Opinions are fiercely held, often based on unyielding moral principles, strongly felt ethical tenets of medicine and primordial fears of death and losing control over one's self. And like abortion, the right to die is becoming a national flashpoint, a political impasse, a heart-breaking battle between compassion and protection of all human life."
(Joan Beck, *Chicago Tribune*, 14 March 1996)

"[DR. JACK KEVORKIAN'S] SIGNIFICANCE in the national debate over assisted suicide has suddenly waned. The fight now is among appellate judges, and the next battleground is likely to be the U.S. Supreme Court late this year or early next."
(*Newsweek*, 15 April 1996)

"WHY WOULD YOU LEAVE THAT TO NINE LAWYERS, for heaven's sake?" responded Supreme Court Justice Antonin Scalia when asked whether the Supreme Court should tackle the matter of physician-assisted suicide.
(reported in *Newsweek*, 15 April 1996)