

A FEMINIST ANALYSIS OF PHYSICIAN-ASSISTED DYING AND VOLUNTARY ACTIVE EUTHANASIA

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For my brother, Steven Bender, always caring and attentive to others' needs.

I have titled my essay "A Feminist Analysis of Physician-Assisted Dying and Voluntary Active Euthanasia." I would like to say a little bit about the title. I say "a" feminist analysis because there are many feminist analyses and perspectives, of which my arguments are only one. Feminisms are varied and multiple. Second, I call my work "feminist" because it is grounded in a rich body of writings and thinking in feminist ethics. Because many readers are unaware of the extensive writing and theorizing within feminism and from feminist premises about every kind of subject, they think feminist is a label meaning "political struggles for women's rights." Certainly feminist means that but it also means more.

Some themes in feminist ethics are challenges to the values and conceptions of human natures and human interactions that dominate our current discourses in law, medicine, and ethics. Some feminist theorizing emphasizes the need to value and focus on care, compassion, responsiveness, responsibility, conversation, and communication, as well as learning to listen closely to others and to pay attention to others' needs, regardless of their differences from our own. I write in that tradition.

Feminist ethics also challenges power structures and systemic biases in law and ethics that undervalue or disregard the perspectives and experiences of all women in differing ways and of men of subordinated statuses, whether subordinated by structures of race, class, sexual identity, some other identity-based classification, or some combination thereof. Feminism seeks to reconstruct our understandings and practices in ways that more closely respond to the needs of those people in their daily lives and, I would argue, deaths, or, as I prefer, dying processes. I am as strongly committed to these feminist analyses, although this particular essay, limited by space and time, does not begin to address them adequately.

I have included a bibliography at the end of this essay that collects some of the many writings on euthanasia and feminist ethics that inform ongoing discussions about this topic and bioethics in general -- discussions that I hope this essay advances.

SUMMARY:

... I am limiting my discussion here to the "easy" case -- to the person who is competent and has expressed her or his wish for physician assistance. ... Questions about physician-assisted suicide, active voluntary euthanasia, mercy-killing, or, as I would prefer to call it, "medical care at the end of life" or "medical care in the dying process" have increased over the recent past. ... What should matter, and what we should be asking about, is whether a physician thoroughly discussed the medical aspects of the dying process and care options with the dying person, and whether there have been ongoing conversations about dying between the dying person and loved ones, caregivers, and medical providers. We then should ask whether the physician was "giving medical care" that responded to the dying person's needs, concerns, and values. ... If we define the physician's relationship to a dying person as "giving medical care" rather than as prolonging life or healing, we need to redefine "giving medical care" as responding to the dying person's needs during the dying process. ... There will be times under a care-based paradigm where the giving of medical care by a physician is the giving of treatment that completes the dying process rather than elongates it. ...

TEXT:

[*519] Benjamin Franklin said the only certainties in life are death and taxes. n1 As medical technology has developed, our capacity to extend [*520] human lives beyond what would be their natural deaths has been so astonishing that the keenness of Franklin's aphorism seems nearer to dying than many human bodies. Thus far, we have not mastered "suspended animation" or "immortality," n2 but medical technicians and scientists have been able to create states of "living" or "undeath" that have not been known before. Lives continue, or are restored, despite hearts stopping, lungs collapsing, livers and kidneys failing, and neocortical brains ceasing to function. For what it is worth, we now can keep bodies "alive" without minds to control them and without any recognizable connection to the personhood or personality of the former owners. Even if science defies the certainty of death, Franklin can still get his due for having it right about taxes.

Regardless of humans' valiant efforts, death remains an unavoidable issue in all our lives. Science and medicine have, at best, learned to delay its inevitability and, at worst, have painfully distorted its processes. Death is seen as a single event, rather than as part of a process of dying. The medical, scientific, and technological segments of our society seem to be in a state of frenzied denial about the inescapable reality of death in everyone's life. Recently, a significant portion of the public has begun to back away from the compulsive drive to extend life at all costs. n3 They have seen its pain, its victims, [*521] its indignity, and its costs. It is not that these people are Luddites who totally reject all medical technology; instead they want technology to be used responsibly and in accord with their needs and values. They are searching for alternative ways to die with dignity, in their homes or with their family and friends, and under circumstances over which they have more control. They are increasingly asking for their physicians to assist them in regaining control over their own dying.

This paper is an attempt to reorient discussions about legal responses to physicians who submit to their patients' pleas for help. I am limiting my discussion here to the "easy" case -- to the person who is competent and has expressed her or his wish for physician assistance. Answers to more difficult questions such as those concerning incompetent patients and patients in persistent vegetative states must be reserved for another day. I believe, however, the model I suggest will better enable us to resolve the more difficult questions, but we cannot reach them until we more fully understand the easy case. Even within this simplified inquiry, there are many complex problems that I cannot address here. In choosing which arguments to present, I have focused primarily on offering an alternative feminist legal and ethical paradigm for resolving questions about physician assistance to patients requesting it at the end of life. I realize that switching to a feminist ethic of caring, as I propose, is only part of a feminist analysis. Time constraints have forced me to exclude questions about potential gender biases and gender dynamics within

and flowing from application of my proposed model. n4 Although I am omitting these issues from my [*522] discussion, I hope it does not minimize their importance, and that you realize this paper is only a small portion of a larger work in progress.

Two more introductory caveats: First, I am deeply committed to major systemic changes in the funding and delivery of health care in our nation. We need a national health care system to ensure no citizen is forced to make medical decisions based on the scarcity of funds or insurance. We also need to re-evaluate the commodification and dehumanization of medicine. The way that most medicine is now delivered, in ten minute segments, often from a series of different physicians or specialists without any sense of continuity for patients, permits few of us to develop relationships with our physicians. It is crucial that we move to a just health care system, although it is impossible without systemic changes in funding and delivery. With that in mind, accompanied by my fears that a revamped health care system is not in our immediate future, my proposal is premised on a continuation of our current system of funding and delivery. That I ask for changes in the system we use should not be understood as an acceptance of this model but as an attempt to work within it until it is changed. Hopefully, my proposals would better serve their ends in a restructured system.

Second, I do not mean to imply that shifting to the paradigm I propose will provide simple answers to all future questions; nor will it eliminate struggles and conflicts in coping with the intersections of dying, medicine, technology, and ethics. It may, however, enable us to deal more humanely, more cooperatively, and more supportively with dying persons, those who love them, and compassionate physicians.

Questions about physician-assisted suicide, active voluntary euthanasia, mercy-killing, or, as I would prefer to call it, "medical care at the end of life" or "medical care in the dying process" have increased over the recent past. Before I make arguments advocating changes in our understandings and legal treatments of this practice, I think it is useful to share with you a brief chronology of some of the most vivid stories shaping this debate in the medical, legal, and bioethical communities.

In March 1991, Dr. Timothy Quill, a Rochester, New York physician, published an impassioned article in the New England Journal of Medicine, detailing the decision-making process involved in the death of one of his patients. n5 Diane was a middle-aged business woman, mother, and wife, who was diagnosed as having acute myelomonocytic leukemia, a fatal disease. Dr. Quill advised Diane about available [*523] treatment options and the course of her disease without treatment. After careful consideration of her options, Diane refused to undergo painful, drawn-out chemotherapy, which could have given her a twenty-five percent chance of remission. Dr. Quill reported being very troubled by his patient's decision, but he acknowledged the decision about treatment was hers to make. He had no doubt that she made it in an informed, rational manner with her husband and son.

Once she had decided to forego potential life-preserving treatment, she had to decide how to cope with the disease, her pain, and her inevitable, rapidly approaching death. Diane was advised about hospice and comfort care treatment. She asked Dr. Quill about help in dying. Because Dr. Quill was conflicted about determining his appropriate role in responding to this request, he recommended that Diane contact the local Hemlock Society to learn more. She did and later returned to Dr. Quill complaining of sleeping troubles and asking for a prescription. Knowing that this was part of a Hemlock Society "suicide," Dr. Quill questioned her about how she would use the drugs. He described the interaction as follows:

In our discussion, it was apparent that she was having trouble sleeping, but it was also evident that the security of having enough barbiturates available to commit suicide when and if the time came would leave her secure enough to live fully and concentrate on the present. It was clear that she was not despondent and that in fact she was making deep, personal connections with her family and

close friends. I made sure that she knew how to use the barbiturates for sleep, and also that she knew the amount needed to commit suicide. . . . [S]he promised to meet with me before taking her life, to ensure that all other avenues had been exhausted. I wrote the prescription with an uneasy feeling about the boundaries I was exploring -- spiritual, legal, professional, and personal. Yet I also felt strongly that I was setting her free to get the most out of the time she had left, and to maintain her dignity and control on her own terms until her death. n6

Three and one-half months later, Diane's condition had deteriorated, and she was left to choose between increasing pain and discomfort or sedation and dependence. Diane then called Dr. Quill and her friends to say goodbye. When she decided her life was over, she asked her husband and son to leave her alone for an hour, and she died peacefully on her couch at home. Dr. Quill called the medical examiner and reported her cause of death as "acute leukemia." By sharing Diane's story and his own angst in caring for her, Dr. Quill made a [*524] heart-felt plea to the medical community for more dialogue about the appropriate roles of physicians in helping their patients achieve death with dignity.

Dr. Quill's plea to the medical community was quickly transferred to the legal community when a Rochester area District Attorney, Howard Relin, said he would attempt to prosecute Dr. Quill for assisting a suicide -- a crime in New York. Initially, Relin's inability to identify "Diane" impeded prosecution, but an anonymous phone call gave him enough information to proceed. n7 The case against Dr. Quill was presented to a grand jury in July 1991, which, in its wisdom, refused to indict him. n8 Dr. Quill suffered the threat of criminal prosecution for over four months -- not a pleasant experience for a doctor who conscientiously and compassionately cared for a dying patient.

Dr. Quill's story is just one of a number of stories about physician-assisted death and the legal system's response. Several physicians have been prosecuted over the years, and others have avoided prosecution by keeping their actions secret from the public and sometimes even from the families of the patients they helped die. Other physicians, like Dr. Quill, have sought publicity to raise the public's consciousness on the issue. In some ways, Dr. Quill's story was an antidote to powerful, contemporaneous media stories about Dr. Jack Kevorkian, a retired Michigan pathologist, who invented a "suicide machine" to enable dying patients to voluntarily end their lives once the suffering or loss of dignity accompanying their diseases became unbearable. In 1990, Dr. Kevorkian's actions captured the public and medical ethicists' attention when he permitted Janet Adkins, a fifty-four year old woman suffering from Alzheimer's disease, to use his machine to end her life. n9 The apparent publicity-seeking nature of Dr. Kevorkian and the strange conditions of Adkin's death -- that is, the use of this jury-rigged machine in the back of a 1968 Volkswagen van -- had skewed the debate about physician-assisted death. Dr. Kevorkian ultimately avoided criminal prosecution in December 1990 because Michigan did not have a law criminalizing the assistance of suicide, and his actions did not amount to murder since he did not cause her death. n10 He was subjected to a civil court order in early 1991 enjoining his further use [*525] of his machine or one like it to aid someone else in committing suicide. n11 Last October, while he was still in the process of appealing that order, Dr. Kevorkian assisted two other women in ending their lives. n12 He is now being threatened with contempt proceedings for violating the injunction. His medical license was revoked on November 20, 1991, and on February 5, 1992, he was arrested after a grand jury returned two murder indictments and criminal charges for illegal delivery of a controlled substance against him. n13

Nonetheless, in March 1991, when Dr. Quill's article was published, his presentation of the issues recaptured the public debate and returned it to a seemingly more medicalized model. Because I am a teacher of bioethics and law, these stories instantly seized my attention. They have also affected political and legislative processes. Washington citizens, through the initiative process, introduced a Death with Dignity proposal on their November 1991 ballot, which, had it passed, would have been the first in the country to explicitly permit

physician aid-in-dying. n14 The measure failed by a small margin at the polls (fifty-four percent to forty-six percent), despite earlier polls that indicated a sure victory. n15 California citizens are currently attempting to get a slightly different referendum regarding physician-assisted death on the 1992 ballot -- one providing for a waiting period and family notification. n16 Citizens in Oregon and Florida are pressing initiatives for 1994 and 1996, respectively. n17 Other states are also engaged in these debates. n18 Additionally, Derek Humphry, founder of the Hemlock Society, [*526] a group organized around the right to die, recently published *Final Exit*, a book of explicit instructions on suicide methods directed toward the terminally ill. n19 The book has been a best seller since its release. Sales have been impeded only by a shortage of printed copies.

This brief summary of some recent stories about death and dying in our culture raises many questions for lawyers. How ought our legal system respond to these human experiences of dying, medicine, and technology? What role should law play in resolving these foundational ethical dilemmas? More particularly, as a lawyer and academician interested in bioethics, I want to examine how law ought to deal with physicians who assist their patients in ending their lives. Soon after Dr. Quill's story reached the press, I began my research on laws about suicide, assisting suicide, and homicide. I learned that no longer do any states have laws criminalizing suicide, and about half the states have laws making assisting or causing suicide a crime, but my questions about what the law ought to do and why remained unanswered. I then read ethicists, philosophers, physicians, and legal scholars' writings on euthanasia, suicide, and terminal illnesses. I can assure you there is more material out there about this area of inquiry than any one person could ever read in a lifetime. n20

[*527] The more I read and thought, the more it seemed that my questions about the role of law in these situations could not be answered without a final determination about the meaning of life, the meaning of personhood, and the meaning of death. As I drifted in a sea of philosophical and spiritual inquiry, Dr. Quill and Diane's story kept calling me back. This was not a hypothetical problem or an abstract investigation. The legal system's treatment of this problem was affecting the resolution of these dilemmas in people's lives every day, whether I ever figured out the propriety of using a sanctity-of-life or quality-of-life analysis, whether I could discern under what circumstances suicide was ever morally justified, or whether a meaningful difference between "letting die" and "killing" existed. Questions about the legality of physician-assisted death concerned real people, immediate dilemmas, and intense suffering.

My critical feminist consciousness was aroused. Why were the debates framed in terms of abstract principles like autonomy, paternalism, and beneficence or revealed through abstract, hypothetical situations perched tenuously on slippery slopes -- for instance, some theorists argue that if we let a doctor respond to a request by a terminally ill patient to die, this would lead to doctors killing disabled people or the elderly poor against their will. Why did the ethical or legal analyses seem to emphasize labeling actions as suicide, assisted suicide, euthanasia, murder, or refusing treatment rather than to emphasize examining the specific facts and context, discussing people's feelings and relationships, and responding to patients' needs? Why do we discuss informed consent and who should decide, without discussing caregiving, compassion, responding to needs, interpersonal relationships, dignity, empowerment, and love? And last, but not least, why are we always very careful to leave out the needs and interests of family, friends, and caregivers when we discuss a dying person, as if those subjects are taboo?

Feminist theories help me in my inquiries because they press me to question assumptions and labels and to eschew universal rules, abstractions, and generalizations that impede attention to contexts and lived experiences. Feminist theories promote the values of caring, responsibility, and responsiveness to needs absent in our current legal paradigm.

I. POWER OF NAMING

An elementary premise of feminist theories recognizes that defining or naming a problem is a political act. n21 When we call doctors' actions [*528] "aiding suicide," "euthanasia," or "killing," we prefigure the ensuing debate. These labels carry pejorative baggage. Suicide is often connected with notions of irrationality and wrongdoing, whether a spiritual or religious wrong or a mistake in judgment that ought to be corrected. When we think someone behaves nobly in consciously sacrificing her life, we do not label her act suicide. If someone throws himself before an oncoming car to prevent his child from being hit, we do not say he committed suicide. If a fire fighter dies putting out a fire, we do not label her act "suicide."

Freud committed suicide by asking his physician to end his suffering from cancer of the jaw. n22 Bruno Bettelheim committed suicide. n23 [*529] So did the eminent jurist, Judge Henry Friendly. n24 So, arguably, did Socrates. n25 Yet we rarely talk about rational suicide because the words seem incongruous. Many of our legal opinions are carefully crafted to distinguish between suicide and decisions to forego medical treatment. When a patient asks that a ventilator be withdrawn or refuses consent for chemotherapy, the law does not say that the patient is committing suicide. Jurists have recognized the need to distance these acts from that label. An act or decision is not inherently suicide. A social context is needed to understand the act, making suicide a social construct. At least for the time being, the social construction of that word imbues the event or act with a taint of illegitimacy. State laws making it criminal to aid a suicide are based on underlying assumptions that suicide is irrational or the aid represents a form of coercion. Therefore, if we label the doctor's conduct as "aiding suicide," we raise up those senses of wrongfulness, irrationality, or coercion, when they may, in fact, be totally absent from the event.

Likewise, the word "euthanasia," while originally meaning "good death," n26 has also taken on images of coercion. Despite careful distinctions in law and ethics between voluntary and involuntary euthanasia, or between murder and euthanasia, mention of the word raises the specter of Nazi Germany in too many minds. The word is infused with imagery of forced exterminations and immoral medical practices. It almost seems that many contemporary physicians and bioethicists think euthanasia is a German word meaning gas chambers, lethal injections, and selective exterminations. Hence, discussing this problem as one of active voluntary euthanasia brings forth debates about slippery slopes and bad actors doing immoral acts.

The words "killing" or "kill" color the discussion even more negatively. Killing sounds criminal. To say it is "mercy killing" for a physician to give a patient a requested lethal dose to end her suffering is to invest the act with an air of criminality that the word "mercy" does not adequately temper. Words affect how we think and feel about acts, how we classify them, and how we treat them legally.

Understanding the politics of naming, as any feminist lawyer does, I prefer to discuss this "issue" as one about death, not suicide, [*530] euthanasia, or mercy-killing. Yet even death is inadequate because it seems to indicate one moment or event rather than an ongoing process. A better naming would be to say this is about "dignified dying," or about "timing of dying decisions," "end of life decisions," "care for dying people," "controlling our own dying process," or "life-completing decisions." Certainly we do not object to giving people control over the completion of their lives. Few, if any, would be morally offended by the provision of care for dying people.

There are other phrasings of these problems that subvert constructive conversations. I am troubled by use of the phrase "physician-assisted" or "doctor-assisted." By starting with the physicians or doctors, we center our attention on them, even though they ought not be the focus. By labeling the event "physician-assisted dying," we concentrate on the actions of the physician, almost making it sound as though the physician is a decision-maker, rather than orienting ourselves toward a discussion of the entire decision-making process and the dying person. And while I am seeking new labels, I would like to reject the word "patient." As the hospice movement has so aptly

discerned, the word "patient" has come to connote passivity -- someone acted upon. n27 It is objectifying and distancing. Certainly we can find a better word with more decision-making agency and more subjectivity.

II. FALSE DUALISMS

Feminist and post-structuralist theories have also criticized our tradition of viewing the world in dichotomies -- seeing events as polar opposites; drawing lines that divide the world of concepts into twos. n28 It is not just our naming of things that is problematic but also our narrow bipolar classification schemes. I would like to highlight a few examples of how this has impeded our ability to work through problems of physician assistance to dying people. Dualistic thinking leads us to an either/or, self/other analysis instead of plural, multiple, variant, and contextualized analyses. While dividing all things into two groups, where some thing or event must fall in or out of the group, simplifies our tasks of classification, it papers over the ever-changing relationships and interconnections between categories and experiences and deludes us into believing the categories are fixed, natural, or inherent.

As technology has advanced, we have learned that our understanding of life and death as opposites and fixed categories is inadequate. [*531] Life and death seem more like interrelated processes on a continuum than clearly delineated and oppositional states. Although our culture holds fast to a view of science as distinct from faith, we continuously encounter difficulties differentiating science from spirituality, especially when we analyze birth and death issues. Nonetheless, our dominant cultural norms seem to privilege doctors' medical knowledge over others' knowledges in caring for dying people, as if death and dying were purely "scientific" or "medical" processes. Despite the ill-fitting nature of our bipolar categories, we continue to separate and favor science over spirit, body over soul, reason over emotion, and self over others. An ontology that examines relationships and interactions among concepts, actions, people, and institutions seems preferable to one fixated on delineating boundaries.

Another false dualism that dominates discussions about euthanasia in law and ethics is active/passive or act/omission. Whether we call something "active" or "passive," or "killing" or "letting die," it is a conclusion, not an inherent fact. Criminal laws and tort laws often distinguish between acts and omissions. If a doctor gives a patient a lethal injection, it is considered an affirmative act, resulting in a charge of active euthanasia or homicide. Yet, if a doctor withdraws a life-support system, whether a respirator or a feeding tube, that is "letting nature take its course," an "omission," or being "passive." Even though there is an "act" of detaching, it is not considered active. Even though the need to detach is related to the earlier "act" of attaching the person to life-prolonging machinery, it is considered merely passive or omissive to withdraw it. An original decision not to attach a patient to life-support, whether due to triage resource allocations or apparent futility, is also passive. There is no legal liability and, for most ethicists, no ethical liability. In each case, the patient dies in conjunction with a decision about her care that is effected by a physician. Yet when a person dies in conjunction with a decision to end her suffering from a terminal illness that is effected by a physician giving her a lethal injection or a prescription for a potentially deadly dose of medicine, the law seems to say it falls on the killing side of the dichotomy.

Once an appropriate decision to complete the life process and allow death to occur has been made, physicians, ethicists, and the legal system should seek out the most compassionate way to care for the dying person. It is unseemly for the legal system's analysis to turn on whether the physician's role was active or passive, or whether the conduct is more appropriately labeled killing or letting die. Many prominent theorists have argued against this distinction's relevance much better than I can. n29 They challenge legal and ethical paradigms [*532] that evaluate physicians' conduct through an active/passive, act/omission lens.

Physicians are not immune from this dualistic approach to assessing active voluntary euthanasia. Many physicians measure appropriate conduct through a healing/killing dichotomy. Doctors say they are trained to heal, not kill, as

if those terms covered the whole universe of actions, as if they are fittingly contrasted, and as if actions could clearly fall in one category or the other. I have heard doctors claim that the bright line between healing and killing is necessary to keep physicians principled and honorable. If the law permits a blurring of the line, they argue, doctors may prematurely end the lives of dying or obstreperous patients out of impatience or exhaustion from the heavy demands of caring for a desperately ill, dying patient, out of frustration or a sense of defeat at their lack of success in curing the patient, or even for economic reasons.

The law seems to use similar justifications for its active/passive or killing/letting die distinctions. These rationales are legitimate only if we agree with three underlying assumptions: 1) laws and ethical principles must be designed for the "bad actors"; 2) each line must be firmly set to prevent a precipitous decline down the proverbial slippery slope; and 3) truly bad actors are in fact deterred by laws. I am unpersuaded by each. Although there are, and always will be, a number of bad actors, most of us do not fall in that category. If we write our laws or set our standards to curtail the actions and improper motivations of a small contingent of people on the margin, we may disempower the majority of us in the center from acting on noble and virtuous impulses. Physician aid-in-dying exemplifies this critique.

To deter negligent, indifferent, malevolent, or lazy physicians from involuntarily terminating some patients' lives (or wrongfully persuading patients that death is their only option), we have to endure a rule that deters compassionate physicians from providing competent, suffering patients requested dignity, security, and control over their dying processes. Similarly, we prohibit family members from mercifully ending the suffering of loved ones or create high legal barriers to families making termination of life-support decisions for incompetent loved ones based on our fear of bad families. The social and ethical price of designing our laws and rules for the bad actors is significant suffering and indignity to innocent, humane people because of unnecessary restraints on their freedom to act out of care in a manner responsive to particularized circumstances of need.

Laws making doctor assistance illegal may deter caring physicians from acting. Few doctors want to be vulnerable to the whims of prosecutorial discretion, particularly if it is an election year, and even fewer want to risk the possibility of criminal prosecution or license revocation, although they are likely to prevail ultimately. Compassionate and caring doctors who want to comply with their patients' pleas will be deterred, unless we have laws clearly authorizing them to act [*533] and outlining conditions under which they will be free from prosecution.

Why are we so quick to constrain the power of most people's moral agency? Why do we presume that if we give physicians freedom to implement their patients' decisions about care at the end of dying, they will behave irresponsibly? As a society, we readily give physicians a great deal of responsibility to exercise their best judgments and skills in caring for patients. If we are willing to presume they are responsible enough under most situations to deal with matters of life and death, why would they suddenly be less responsible in helping to implement patients' decisions at life's end?

Moreover, I am not completely convinced that such laws or rules are very effective deterrents to the truly bad actors -- the lazy or callous physicians or parsimonious families who are cruel to those in their care. Despite the existence of these rules, we still have bad actors who violate them. Clearly some in the small group of bad actors in the margin are never deterred by laws. For this reason, the class of people for whom we are calibrating our laws is reduced in size even further. Maybe we should reconsider whether the cost of pitching our laws to this relatively small number of people, at least in cases of aid-in-dying, is too great for the benefit we receive. If we respect the autonomy and dignity of dying people, we should make laws that create an environment where people can get the care they need from their physicians, rather than laws that merely deter a few dishonorable, bad physicians.

Our legal system loses its legitimacy when faced with questions of doctor-assisted death. Laws seem to make doctor-assisted death criminal, based on active/passive distinctions or notions of irrational suicide, and yet doctors are rarely prosecuted and even more rarely convicted. n30 The law says it is impermissible, but then winks at the conduct. Prosecutors often use their discretion not to prosecute, and juries use their discretion to dismiss acts of mercy. n31

In one way, one could say that our legal system is responding appropriately. It is contextualizing our system of justice to fit the circumstances. To that extent, these verdicts or results excusing physician conduct are good. But there are other dynamics about which we need to be concerned. If the active/passive distinction is a correct ethical and legal analysis, then juries and prosecutors ought not subvert the law. If there is something fallacious or ill-fitting about the active/passive [*534] distinction, then we should find a better analysis for judging the legality and rightness of compassionate acts complying with patient requests to end their lives. More often than not, juries reject our present model because it does not reflect their experiences and understandings of justice. If, for the most part, our legal system is clandestinely applying an ethic of care in these cases, why not bring it out in the open? It would not be a radical shift because it represents the current practice, if not the language, of the legal system. To permit the laws to be overtly disrespected by judges, prosecutors, and juries impairs the legitimacy of our legal system.

If what we are talking about is physician participation in the care of dying people, it should not matter whether a physician helps by disconnecting machines, by giving an injection, or by giving a prescription. The appropriateness of the conduct should not turn on an artificial distinction between healing and killing. What should matter, and what we should be asking about, is whether a physician thoroughly discussed the medical aspects of the dying process and care options with the dying person, and whether there have been ongoing conversations about dying between the dying person and loved ones, caregivers, and medical providers. We then should ask whether the physician was "giving medical care" that responded to the dying person's needs, concerns, and values.

III. A CARING PARADIGM FOR MEDICAL ETHICS AND LAW

It is this notion of "giving needed medical care," informed by an ethic of care paradigm, that I want to explore for the rest of this paper. My feminist critique of medical ethics and legal practice regarding this issue is ultimately a critique of the paradigm we use. In part because of the language usage and dualism problems I discussed, but more because of our dominant, liberal paradigm premised on a society composed of autonomous individuals who interact with others by choice out of self-interest, we look for resolutions of problems about end-of-life medical care in an ethic of justice and rights. We construct abstract, generalized rules that are supposed to cover all situations for all time. Our current analysis prevents people from aiding others to die with dignity because we understand rights as barriers to interference by others, rather than as enabling conditions. Our ethical constructs grow out of elaborate conversations, which are deeply philosophical and richly argued, and yet we leave out the heart and soul of real people's concerns about dying. We leave out discussions about caring, empathy, love, compassion, relationships, and the dying person's needs and perspective. When applying our existing rules to the legality of physician assistance in the dying process, we may talk of "mercy seasoning justice," but I would prefer an understanding that speaks of "justice tempering care." We can change the substance of our normative discourse in medical ethics and law by moving to a care-based paradigm like the one I propose.

[*535] In addition to the absence of values like compassion and care, and the focus on rights as barriers between independent equal individuals, our current ethical paradigm is defective because it fails to account for the effects of changes in technology on analyzing issues of dying. Medical ethics, for instance, is ahistorical because it relies on ancient ethical codes, such as

the Hippocratic Oath, n32 devised 2500 years ago in a a wholly different historical and social context in which our present medical technologies were unfathomable. Many medical ethicists and doctors follow these codes and declare that active killing of dying patients is wrong, regardless of the circumstances.

Modern society is characterized by a boundless quest for technological innovation to dominate nature and control life processes. Our drive for technological mastery of natural pheonomena has often eclipsed our humanitarian and ecological concerns. In medicine, technology has been as wonderful as it has been alienating and destructive. Sometimes our strivings for medical and technological glory and for conquering death are so strong that we lose sight of the suffering we prolong and create.

Even where technology has succeeded in fending off death's assaults, it often distances us from the feelings and experiences of those who are dying. People seem less touchable, less human, and less real when connected to complicated medical equipment and tubing. They are often in intensive care or special hospital units, blocked off from visitors and all things familiar. Our technological revolution in medicine has usurped many people's opportunities to die with dignity at times or in manners of their own choosing, with their family or friends around, and in their homes.

Concepts of justice and rights should not be jettisoned when shifting to an alternative feminist analysis, but they should be used as correctives to an ethic of care when needed to make sure that power is not abused. A care- and responsibility-based ethic rests on assumptions that seem closer to the experiences of dying and death in people's lives than assumptions underlying a rights- or rule-based ethic, which arguably might be more appropriate in other settings. A care-based ethic arises out of perceptions of human beings as relational, interdependent, and supportive as opposed to our current rights-based ethic in which people are separate, autonomous, and equally empowered actors. A care-based ethic acknowledges that emotions are as important as reason in our lives, decision-making, and dying, and that preserving relationships with and enabling others is as important as having rights to protect us from others. n33

[*536] Feminist ethics derive from an alternative or richer conception of human nature -- one that understands people as being motivated by love, friendship, responsibility, and caring rather than solely by self-interest and fear. A responsibility-based ethic, or an ethic of care, does not reject all the assumptions about human nature that undergrid a rights-based ethic. Instead it contextualizes them, and at a minimum, it credits people in relationships with finer motivations and qualities. Although each ethic comes from different original premises about human nature, they are ultimately reconcilable if we can maintain an ongoing dialogue regarding both of them. n34

Finding bridges from our current ethic's foundation in personal autonomy to a care-based ethic is critical to our making a successful shift. Autonomy, the power of an individual to control her own life and death, is as much a cornerstone of a care-based ethic as it is of modern medical ethics and legal practice. n35 The differences are in the sources and meanings of autonomy. In a care-based ethic, individual autonomy is a process nurtured in webs of relationships and responsibilities instead of a static condition pre-existing them. n36 Whereas the ideological basis of a rights-based ethic rests on an assumption of equally empowered, independent people, an ethic of care recognizes that many relationships contain dependencies between differently empowered

[*537] people -- parents and children, caregivers and mentally or physically impaired people, teachers and students, doctors and patients, and at times lovers and friends. n37 The autonomy of an ethic of care can be melded with the autonomy concerns in a rights-based medical ethic, if it is understood to mean self-governing moral agency, rather than independent or self-contained decision-making. Self-governing in an ethic of care does not mean governing alone by abstract reasoning and distant observations, but means choosing options with respect to responsibilities, relationships, conversations, and dialogues with others.

Autonomy, the premiere value in contemporary medical ethics, is transformed from a notion of independent decision-making to an interactive process of developing agency and empowerment through relationships, connections, and interdependencies. Caregiving becomes a means of empowering a cared-for person -- of enhancing her autonomy. An ethic of care framework implores a caregiver to use his or her power, expertise, knowledge, and attention to respond and enable the cared-for person to communicate and meet her needs. If the empowerment to act as a moral agent or decision maker in one's own life is dependent upon the care or assistance of others, non-interference or failure to assist may be contrary to, rather than consistent with, autonomy. n38 In a care-based ethic, refusing care or assistance in particular contexts might be neglectful and unethical rather than obedient to abstract norms.

We need to reconceptualize the physician's role as medical caregiver in light of an ethic of care in the context of our contemporary society, which has pursued technology and science to its outer limits. If we define the physician's relationship to a dying person as "giving medical care" rather than as prolonging life or healing, we need to redefine "giving medical care" as responding to the dying person's needs during the dying process. Legal and ethical questions about appropriate medical practice should be about "how best to care for" the person in need. Sometimes dying people have needs for radical technological interventions, sometimes for maintenance care, sometimes for pain relief and comfort, sometimes for security and dignity, and sometimes for aid in their dying process. All of those may be appropriate ways for doctors to give medical care, but the ethical propriety of a particularized method of caring is context-specific.

Caring for dying people requires careful attention to their particularized needs. The caregivers must discover what those needs are by listening to the patient; conversing with her and those who know her [*538] best and are responsible for her care; and learning about her options, beliefs, and her concerns for her well-being and the well-being of others about whom she cares. Depending upon the person and the context, these needs may be met by empowering the dying person to act for herself -- whether by refusing potentially life-extending treatments, by utilizing self-administered, pain relief pumps, or by giving a prescription for a potentially lethal dose of drugs as Dr. Quill did. There will be times under a care-based paradigm where the giving of medical care by a physician is the giving of treatment that completes the dying process rather than elongates it. If this medical care responds to a patient's request for assistance in dying with dignity -- a request which has been made after ongoing conversations with family, friends, and caregivers that carefully considered all options -- it is the ethical response of a physician to use her special knowledge and skills to help her patient implement this meaningful decision.

In shifting from a rule-based ethic to a care-based ethic we can also reclaim the dying process from a totally medicalized definition. By reclaiming it, rehumanizing it, and returning it to the person dying and the people with whom that person is interconnected, we can establish more agency, more responsibility, and more control over our own deaths. We can reclaim it as a process that centers on our bodies, but is about our lives, our roles, our relationships, and our connections.

Dying, particularly dying from illness or old age rather than from a sudden accident, is not a process involving only one person. Although the process focuses on the dying person's wants and needs, it is interactive, relational, and connected. It is social and communal. We show our love and care as a community when we act responsively and compassionately in accord with the dying person's needs. These are not abstract questions about isolated individuals. These are concrete processes in lives of interconnected people. Dying must be reconceived as the social, communal process it is. Decision-making about dying ought to grow out of ongoing conversations among interrelated people.

Participating in and responding to the dying person's experiences and needs is the caring response, the role of the physicians and health care workers, and the compassionate act. The doctor becomes one of a community of people involved

in the process. She can share information, explain options, and implement treatment decisions made by patients with loved ones. The decision to end life ideally would be worked out collaboratively with multiple inputs, including the physician's, but it is not the physician's decision to make. The physician's role is to provide the requested medical care or to enable the patient to receive it.

Usually at this point, a doctor responds: "Why doctors? If you want people to aid others in ending their lives, why not let families do it or hire special people as executioners?" "We do not want the responsibility," say the doctors. "It is not our job." While I understand these arguments, I would respond to physicians that it is your [*539] job. Part of a doctor's medical expertise is caring for dying people. This model does not empower doctors to make the decisions for patients; they are asked only to help implement patients' decisions. We are not increasing their responsibility beyond what they undertook when they agreed to provide medical care for a patient. We are legally empowering them to use their medical training and expertise to care for someone dying in a manner that is most compatible with their expressed needs. If this is what they were licensed to do, why should they remove themselves?

Families and friends, while in closer relationships with the dying person to help decide about appropriate avenues of care consistent with that person's needs, lack the necessary medical expertise and access to means of easy pain relief, or quick "death with dignity," to perform direct acts of assistance in dying. Lay people often have to resort to violence and crude methodologies, like guns and strangulation, to end someone's life. Even if given access to the drugs, they are unfamiliar with their administration and dosages, with what to do if difficulties arise, and with mechanisms for determining their success.

In addition, I would be remiss if I did not acknowledge the added emotional torment to a dying person of having to ask a friend or family member to assist in her dying and the emotional strain that such assistance must place on the loved one asked. It seems to me that the doctor's slight removal from the inner web of relationships puts him or her in a better position to give the medical care that ends life, if that is what the patient needs. I emphasize again that even though the process of dying is not a medical process, the physical action of giving life-ending medical care is.

IV. CONCLUSION

The important change that results from applying a care-based paradigm is the understanding of requested life-ending treatment as one form of medical caregiving for dying patients. We can establish guidelines that assure that patients are clear and consistent in their request and that they have discussed their decisions with friends, family, and caregivers. The guidelines should not be an impediment to implementing a person's end-of-life option for medical assistance but a mechanism for preventing abuse. Under a care-based analysis, the option of physician assistance may give dying people the security, dignity, and control that Dr. Quill spoke of giving Diane. That would be empowering and consistent with autonomy.

In summary, my arguments are addressed toward cases like the one presented by Dr. Quill -- terminally ill patients who request physician assistance to end their suffering during their dying process. At a minimum, the law and medical ethics must be able to respond appropriately to this easy case before it can tackle the more difficult ones. I have reserved for another day questions about terminally ill [*540] versus non-terminally ill patients and questions about physical versus psychic pain. I explicitly avoided cases of patients unable to communicate their desires. I would ultimately hope that my arguments will serve to enrich conversations about those patients as well. I also focused on the role of the physician rather than other health care providers, in particular nurses, who play a critical role in caring for dying patients. Time limitations prevent me from addressing issues of nurses' roles here.

The crux of my argument is that we ought to alter the paradigm and language of our discussion about physicians' roles in care for the dying. By utilizing a

care-based ethic, we can better realize goals of patient autonomy and dignity while emphasizing values of care, compassion, and responsibility.

Our battles over physician-assisted death seem to be smokescreens for our unwillingness to accept the inevitability of death. Our denial of death and the strength of the medical model to resist it at all costs have led to heroics, to violent interventions, and to prohibitions against acting in furtherance of dying people's needs when those needs are to die. If we use feminist ethics to reconceive of death as a process of dying in particularized people's lives and we come to understand the role of medicine as caring for rather than prolonging life, where caring can include multiple ways of responding to dying peoples' needs, our legal system can make spaces in its laws to legitimize rather than punish or wink at that kind of compassionate, caring medical response.

FOOTNOTES:

n1 "But in this world nothing can be said to be certain, except death and taxes." Letter from Benjamin Franklin to Jean Baptiste Le Roy (Nov. 13, 1789), in 10 THE WRITINGS OF BENJAMIN FRANKLIN, at 68 (Albert H. Smyth ed., 1905).

n2 Some people have sought immortality through cryopreservation or cryonics. For example, Thomas Donaldson, along with Alcor, a cryonics organization, unsuccessfully petitioned California courts to permit Donaldson to have his head cryonically suspended before his death and to protect Alcor from prosecution for assisting suicide. *Donaldson v. Van de Kamp*, 4 Cal. Rptr. 2d 59 (Cal. Ct. App. 1992); see Miles Corwin, Tumor Victim Loses Bid to Freeze Head Before Death, L.A. TIMES, Sept. 15, 1990, at A28; Cynthia Gorney, Cryonics and Suicide: Avoiding 'the Slippery Slope,' WASH. POST, May 1, 1990, at D6. The cryonics movement began 30 years ago when Robert Ettinger published THE PROSPECT OF IMMORTALITY (1961). See Laura Wisniewski, Cryonics Groups Pin Their Hopes on the Big Chill, TORONTO STAR, May 5, 1991, at B6. The title of Ettinger's book indicates the objective of this movement. In 1990, there were already 13 complete bodies and 13 heads in cryonic suspension at three cryonics centers. See Maria Goodavage, Man Pins His Hopes on a Frozen Future; De-Animated -- Not Dead, USA TODAY, Sept. 25, 1990, at 6A. Because it is very expensive to freeze a whole body (about \$ 100,000-120,000), most participants choose to freeze only their heads (at a cost of \$ 28,000-35,000) in liquid nitrogen at 320 degrees Fahrenheit below zero. They hope they can be thawed and cured in the future when there will be the technology to regenerate bodies from the head's remaining cell tissues or to attach other bodies. Corwin, supra.

n3 See Patients Self-Determination Act, Omnibus Budget Reconciliation Act of 1990, § 1866(a)(1), 42 U.S.C.A. § 1395cc(a)(1) (West 1992); *Cruzan v. Missouri Dep't of Health*, 110 S.Ct. 2841 (1990); *Bouvia v. Superior Court*, 225 Cal. Rptr. 297 (Cal. Ct. App. 1986); *Bartling v. Superior Court*, 209 Cal. Rptr. 220 (Cal. Ct. App. 1984); *In re Estate of Longeway*, 549 N.E.2d 292 (Ill. 1989); *In re Lawrance*, 579 N.E.2d 32 (Ind. 1991); *Care and Protection of Beth*, 587 N.E.2d 1377 (Mass. 1992); *Guardianship of Jane Doe*, 583 N.E.2d 1263 (Mass. 1992); *Brophy v. New Eng. Sinai Hosp.*, 497 N.E.2d 626 (Mass. 1986); *In re Farrell*, 529 A.2d 404 (N.J. 1987); *In re the Guardianship of L.W.*, 482 N.W.2d 60 (Wis. 1992); HASTINGS CENTER OF NEW YORK, GUIDELINES ON THE TERMINATION OF LIFE-SUSTAINING TREATMENT AND THE CARE OF THE DYING (1987); PRESIDENT'S COMMISSION FOR THE STUDY OF ETHICAL PROBLEMS IN MEDICINE AND BIOMEDICAL AND BEHAVIORAL RESEARCH, DECIDING TO FOREGO LIFE-SUSTAINING TREATMENT: A REPORT OF THE ETHICAL, MEDICAL, AND LEGAL ISSUES IN TREATMENT DECISIONS (1983); COUNCIL ON ETHICAL AND JUDICIAL AFFAIRS OF THE AMER. MEDICAL ASS'N, GUIDELINES FOR WITHHOLDING OR WITHDRAWING LIFE PROLONGING MEDICAL TREATMENT (1986); George P. Smith, All's Well That Ends Well: Toward a Policy of Assisted Rational Suicide or Merely Enlightened Self-Determination?, 22 U.C. DAVIS L. REV. 275, 329 n.392 (1989) (listing several Natural Death Acts); Allan Parachini, The California Humane and Dignified Death Initiative HASTING CENTER REP. Jan.-Feb. 1989, at 10-12 (special supp.).

n4 I am particularly concerned about three aspects of the gender dynamics and power hierarchies that must be considered in analyzing dilemmas about decisions to end life. First, I am concerned that, thus far, only women have requested

assisted death, or at least, the only publicized cases involve women. This may be because women are socialized differently from men and find it easier to ask for help. Additionally, or alternatively, women may find it more unbearable to make significant others suffer from watching their slow, debilitating death. Or women may feel uncomfortable being "cared for" because their socialization usually requires them to be caregivers. Second, there are severe race, gender, and class-based biases in access to health care that must be accounted for in this analysis. Finally, women are primarily the caretakers of the ill and elderly in our society -- as nurses, in families, and as health care aides. We also must examine how altering rules about physician assistance in dying affects the experiences, power, roles, and needs of these women.

n5 Timothy Quill, *Death and Dignity: A Case of Individualized Decision Making*, 324 *NEW. ENG. J. MED.* 691-94 (1991).

n6 *Id.* at 693.

n7 B.D. Colen, *On Death and Dying -- MD Who Aided in Suicide Aims to Humanize Debate*, *NEWSDAY*, Aug. 11, 1991, at 3.

n8 *Id.*

n9 Kevorkian named his crude, jury-rigged contraption Thanatron, but his lawyer defense team suggested he rename it the "Mercy Machine" for trial. Ron Rosenbaum, *Angel of Death: The Trial of the Suicide Doctor*, *VANITY FAIR* May 1991, at 147. Kevorkian now refers to his machines as "mercytron." What is in a name? See *infra* note 21-27 and accompanying text.

n10 *Case Against 'Dr. Death' Dropped After MI Judge Throws Out Charge*, 7 *MED. ETHICS ADVISOR* 13-16 (1991).

n11 Judge Alice Gilbert of the Oakland County Circuit Court in Michigan, before whom one facet of Kevorkian's case was heard, described Dr. Kevorkian as having "a propensity for media exposure and seek[ing] recognition through bizarre behavior." *Kevorkian Told: Hands Off Machine!* 4 *DOCTOR'S PEOPLE NEWSLETTER* 2(1) (March 1991). His lawyers have appealed her decision to enjoin use of his machines and chastised the judge for her moralizing and "unprofessional attack" on Dr. Kevorkian. *Permanent Ban Against Assisted Suicide Appealed*, *UPI*, Feb. 22, 1991, available in *LEXIS*, *Nexis Library*, *UPI File*.

n12 Isabel Wilkerson, *Opponents Weigh Action Against Doctor Who Aided Suicides*, *N.Y. TIMES*, Oct. 25, 1991, at A10; Eric Harrison, *"Dr. Death" Arrested in 2 Women's Suicides*, *L.A. TIMES*, Feb. 6, 1992, at A15.

n13 *Kevorkian Chronology*, Gannett News Service, Feb. 5, 1992, available in *LEXIS*, *Nexis Library*, *Gannett File*. In May 1992, Kevorkian assisted Susan Willilams's death by giving her canned carbon monoxide. Al Koski, *'Dr. Death' Strikes Again*, *UPI*, May 16, 1992, available in *LEXIS*, *Nexis Library*, *UPI File*.

n14 *Washington Citizens for Death with Dignity* led the movement for passage of Initiative 119, which provided for "aid in dying" as a right of terminally-ill, mentally competent patients. Joyce Price, *Ire Over Prosecution Helps 'Right-to-Die' Bill*, *WASH. TIMES*, May 13, 1991, at A4; Merle S. Goldberg, *The Right to be Right; Ethics Issues Grow in Number and Complexity*, *WASH. TIMES*, June 3, 1991, at M3.

n15 Jane Gross, *The 1991 Election: Euthanasia; Voters Turn Down Mercy Killing Idea*, *N.Y. TIMES*, Nov. 7, 1991, at B16.

n16 Janny Scott, *Suicide Aid Focus Turns to California*, *L.A. TIMES*, Nov. 7, 1991, at A3.

n17 *Id.*; see also *supra* note 14.

n18 Proposed measures in the United States are often compared to those in the Netherlands, where doctor assisted death, or voluntary active euthanasia, is excused, if strict guidelines are followed. In the Netherlands, the courts and medical societies have established guidelines for when active, voluntary

euthanasia by physicians will be legally justified (that is, not subject to criminal prosecution). See generally, John Horgan, *Science and the Citizen: Death with Dignity*, 264 *SCI. AM.* 17 (1991). The Royal Dutch Pharmacists Association has published a ten-page pamphlet explaining the most sensible ways for physicians to offer their patients "death on request." Michael Specter, *Thousands of Dutch Choose Euthanasia's Gentle Ending*; U.S. Physicians Debate *Death on Request*, *WASH. POST*, Apr. 5, 1990, at A1. Doctors' death-assisting conduct is evaluated after the fact by local prosecutors who determine if the guidelines, which refer to things like repeated patient requests, medical consultations, and interminable suffering, were complied with, in which case no prosecution follows or a finding of not guilty will be entered. See *id.* When doctors fail to follow guidelines but death assistance is compassion motivated, a guilty verdict without punishment may result. See *id.* For a carefully detailed examination of the development of active voluntary euthanasia in the Netherlands, see *Wainey*, *infra* note 21 at 653-64. Many commentators have suggested that the United States follow a model similar to that in the Netherlands. See, e.g., George Garbesi, *infra* note 21. It would be unfair, however, to represent the Dutch system as without serious dissent. Because of the tensions involved, Ineke Stinissens, a 47 year old woman who had been comatose for 15 years because of an overdose of anesthesia during childbirth, was forced to starve to death for 11 days after her feeding tubes were removed. Galina Vromen, *Patient's Starvation Death Intensifies Dutch Mercy-Killing Row*, *The Reuter News Reports*, Jan. 20, 1990, available in LEXIS, Nexis Library, Reuter File. Her husband spent years in court trying to get her nursing home to let her die, but when a court finally agreed to let her tubes be disconnected, it refused to order doctors at her convalescent home to end her life. *Id.* Issues of euthanasia are affecting political coalitions in the Netherlands.

n19 DEREK HUMPHRY, *FINAL EXIT: SELF-DELIVERANCE AND ASSISTED SUICIDE FOR THE DYING* (1991).

n20 For a comprehensive compilation of resources, see Smith, *supra* note 3; DON V. BAILEY, *THE CHALLENGE OF EUTHANASIA: AN ANNOTATED BIBLIOGRAPHY ON EUTHANASIA AND RELATED SUBJECTS* (1990).

n21 One of the most difficult parts of discussing this issue is naming the subject area. The names used for this phenomenon are wide-ranging, and each label shapes the discussion in a particular way. Institute of Medical Ethics Working Party on the Ethics of Prolong Life and Assisting Death, *Viewpoint: Assisted Death*, 336 *LANCET* 610, 611 (Sept. 8, 1990) [hereinafter *Viewpoint: Assisted Death*]; see also MARTHA MINOW, *MAKING ALL THE DIFFERENCE* (1990) (discussing the power of naming and labeling and its effects on our thinking). Theorists of physician-assisted death have recognized the relevance of naming by using varieties of labels: Physician-or doctor-assisted death, *Viewpoint: Assisted Death*, *supra*; rational suicide, Stephen A. Newman, *Euthanasia: Orchestrating "The Last Syllable of . . . Time,"* 53 *U. PITT. L. REV.* 153, 161 (1991); euthanatic rational suicide, Shari O'Brien, *Facilitating Euthanatic, Rational Suicide: Help Me Go Gentle Into That Good Night*, 31 *ST. LOUIS U. L.J.* 655 (1987); assisted suicide, George C. Garbesi, *The Law of Assisted Suicide*, 3 *ISSUES L. & MED.* 93, 93-111 (1987), H. Tristram Engelhardt, Jr. & Michele Malloy, *Suicide and Assisting Suicide: A Critique of Legal Sanctions*, 36 *SW. L.J.* 1003 (1982), Victor G. Rosenblum & Clarke D. Forsythe, *The Right to Assisted Suicide: Protection of Autonomy or an Open Door to Social Killing?*, 6 *ISSUES L. & MED.* 3 (1990); mercy-killing, James S. Goodwin, *Mercy Killing: Mercy for Whom?*, 265 *JAMA* 326 (1991); perimortal initiatives, Count D. Gibson, *Perimortal Initiatives: Issues in Foregoing Life-Sustaining Treatment, Suicide, and Assisted Suicide*, 3 *ISSUES L. & MED.* 29 (1987); timing-of-death decisions, Sandra Segal Ikuta, *Dying at the Right Time: A Critical Legal Theory Approach to Timing-of-Death Issues*, 5 *ISSUES L. & MED.* 3, 3-66 (1989); life-shortening palliative care, Donald G. Casswell, *Rejecting Criminal Liability for Life-Shortening Palliative Care*, 6 *J. CONTEMP. HEALTH L. & POL'Y* 127 (1990); aid-in-dying, *Model Aid-in-Dying Act*, 75 *IOWA L. REV.* 125 (1989); enlightened self-determination, George P. Smith, II, *All's Well That Ends Well: Toward a Policy of Assisted Rational Suicide or Merely Enlightened Self-Determination?*, 22 *U.C. DAVIS L. REV.* 275 (1989); arranged or negotiated deaths, Catherine Shaffer,

Note, Criminal Liability for Assisting Suicide, 86 *COLUM. L. REV.* 348, 369, 370 (1986); consciousness, Steven Goldberg, The Changing Face of Death: Computers, Consciousness, and Nancy Cruzan, 43 *STAN. L. REV.* 659 (1991); direct and indirect euthanasia, JOSEPH FLETCHER, *HUMANHOOD: ESSAYS IN BIOMEDICAL ETHICS* 149 (1979), Robert Barry & James Maher, Indirectly Intended Life-Shortening Analgesia: Clarifying the Principles, 6 *ISSUES L. & MED.* 117 (1990); active voluntary euthanasia, Helga Kuhse, The Case for Active Voluntary Euthanasia, 14 *LAW, MED. AND HEALTH CARE* 145 (1986), Deborah A. Wayne, Note, Active Voluntary Euthanasia: The Ultimate Act of Care for the Dying, 37 *CLEV. ST. L. REV.* 645 (1989); active euthanasia, Francis Molenda, Active Euthanasia: Can It Be Justified?, 24 *TULSA L. REV.* 165 (1988).

n22 In 1939, Freud asked his doctor to inject him with sufficient drugs to kill him when he could no longer bear the suffering from incurable cancer of the jaw. Victor Cohn, An Assisted Suicide; Is it the First Step Toward Euthanasia?, *WASH. POST*, June 12, 1990 (Health), at 27.

n23 Celest Fremon, Love & Death; In His Final Interview, Just Before His Suicide, Bruno Bettelheim Explained Why He Wanted to Die, *L.A. TIMES*, Jan. 27, 1991 (Magazine), at 17.

n24 Henry Friendly; Judge Was "One of the Greatest," *CHI. TRIB.*, Mar. 13, 1986, at C8.

n25 See, e.g., ROBERT CAMPBELL AND DIANE COLLINSON, *ENDING LIVES* 8-12 (1988).

n26 The prefix "eu" means well or good and "thanatos" means death. WEBSTER'S NEW UNIVERSAL UNABRIDGED DICTIONARY 631 (2d ed. 1983).

n27 Hospice calls the people with whom they work clients instead of patients. Alice Lind, Hospitals and Hospices: Feminist Decisions about Care for the Dying, in *HEALING TECHNOLOGY* 263, 270 (Kathryn S. Ratcliff ed., 1989).

n28 See, e.g., Frances Olsen, The Sex of Law, in *THE POLITICS OF LAW* 453 (David Kairys ed., rev. ed., 1990).

n29 See, e.g., James Rachels, Active and Passive Euthanasia in *EUTHANASIA: THE MORAL ISSUES* 45-51 (Robert M. Baird & Stuart E. Rosenbaum eds., 1989).

n30 For detailed reviews of earlier cases against physicians, see Wayne, supra note 21, at 668-70 (Drs. Sander, Montemarano, Kraai, Neidjil, Barber, Hassman, Rosier and Caraccio); DEREK HUMPHREY & ANN WICKETT, *THE RIGHT TO DIE: UNDERSTANDING EUTHANASIA* (1986) 42-45 (Dr. Sander), 103-04 (Dr. Montemarano), 140-42 (Dr. Kraai) (1986); Eight Doctors On Euthanasia Charges, *HEMLOCK Q.*, Jan. 1989, at 6.

n31 Id.

n32 L. Edelstein, The Hippocratic Oath: Text, Translation and Interpretation, 19 *BULL. HIST. MED.* 1164 (1943); Hippocratic Oath, in JUDITH AREEN, ET AL., *LAW, SCIENCE AND MEDICINE* 273 (1984); see Curley Bonds, The Hippocratic Oath: A Basis for Modern Ethical Standards, 264 *JAMA* 2311 (1990) (arguing that the ancient oath's fundamentals are still applicable today).

n33 See generally CAROL GILLIGAN, *IN A DIFFERENT VOICE* (1982). Some additional works in feminist ethics on which I rely are NEL NODDINGS, *CARING* (1984); NEL NODDINGS, *WOMEN AND EVIL* 130-42 (1989); SARA RUDDICK, *MATERNAL THINKING: TOWARD A POLITICS OF PEACE* (1989); Annette C. Baier, The Need For More Than Justice, in *SCIENCE, MORALITY & FEMINIST THEORY* 41 (Marsha Hanen & Kai Nielsen eds., 1987) [hereinafter *FEMINIST THEORY*]; Lorraine Code, Second Persons, in *FEMINIST THEORY* 357; Ann Ferguson, A Feminist Aspect Theory of the Self, in *FEMINIST THEORY* 339; Marilyn Friedman, Beyond Caring: The De-Moralization of Gender, in *FEMINIST THEORY* 87; Virginia Held, Non-Contractual Society: A Feminist View, in *FEMINIST THEORY* 111; Alison Jaggar, Feminist Ethics: Projects, Problems, Prospects, in *FEMINIST ETHICS* 78 (Claudia Card ed., 1991); Carol S. Robb, A Framework for Feminist Ethics, in *WOMEN'S CONSCIOUSNESS, WOMEN'S CONSCIENCE: A READER IN FEMINIST ETHICS* 211 (Barbara Hilkert Andolsen et al. eds., 1985) [hereinafter *WOMEN'S CONSCIOUSNESS*]; Ruth L. Smith, Feminism and

the Moral Subject, in *WOMEN'S CONSCIOUSNESS* 235; Joan C. Tronto, *Women and Caring: What Can Feminists Learn About Morality from Caring?* in *GENDER/BODY/KNOWLEDGE: FEMINIST RECONSTRUCTIONS OF BEING AND KNOWING* 172 (Alison M. Jaggar & Susan R. Bordo eds., 1989); Virginia Warren, *Feminist Directions in Medical Ethics*, 4 *HYPATIA* 73 (1989); Caroline Whitbeck, *A Different Reality: Feminist Ontology*, in *BEYOND DOMINATION* (Carol Gould ed., 1983); *WHO CARES: THEORY, RESEARCH, AND EDUCATIONAL IMPLICATIONS OF THE ETHIC OF CARE* (Mary M. Brabeck ed., 1989).

n34 See, e.g., Robin Dillon, *Care and Respect*, in *EXPLORATIONS IN FEMINIST ETHICS: THEORY AND PRACTICE* 69 (Eve Browning Cole & Susan Coutrap-McQuin eds., 1992).

n35 See, e.g., *PRESIDENT'S COMM'N FOR THE STUDY OF ETHICAL PROBLEMS IN MEDICINE AND BIOMEDICAL AND BEHAVIORAL RESEARCH: DECIDING TO FOREGO LIFE-SUSTAINING TREATMENT* 26-27, 44 (1983); TOM L. BEACHAMP & JAMES F. CHILDRESS, *PRINCIPLES OF BIOMEDICAL ETHICS* 67-119, 210 (3d ed., 1989).

n36 See, e.g., Smith, *supra* note 33, at 235.

n37 Baier, *supra* note 33, at 53-56; Marilyn Friedman, *Feminism and Modern Friendship: Dislocating the Community*, in *EXPLORATIONS IN FEMINIST ETHICS: THEORY AND PRACTICE* 89 (Eve Browning Cole & Susan Coutrap-McQuin eds., 1992); Held, *supra* note 33; RUDDICK, *MATERNAL THINKING*, *supra* note 33.

n38 Baier, *supra* note 33.