WHOSE LIFE IS IT ANYWAY?

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It is nevertheless arguable that the right to live entails the right to shape one’s life, and this right in turn entails the opportunity, if one wishes, to bring one’s existence to an end.

- Laurence Tribe (1978)¹

At the heart of liberty is the right to define one’s own conception of existence, of meaning, of the universe, and the mystery of human life.

- Planned Parenthood v. Casey (1992)²

It is indecent to live longer—to go on vegetating in coward dependence on physicians and medications, after the meaning of life...has been lost, ought to prompt a profound contempt in society.

- Friedrich Nietzsche (1888)³

INTRODUCTION

Since biblical times, a debate over voluntary euthanasia has raged, in various incarnations unabated.⁴ There is no realistic prospect that the

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⁴ “Euthanasia,” from the Greek for “easy death,” is “the act or practice of killing or permitting the death of hopelessly sick or injured individuals... in a relatively painless way for reasons of mercy.” Merriam-Webster’s Collegiate Dictionary (11th ed. 2003). For a brief but informative introduction to the definition and issues in voluntary euthanasia, see Robert Young, Voluntary Euthanasia, in Stanford Encyclopedia of Philosophy (Edward N. Zalta ed., Summer 2005) available at http://plato.stanford.edu/entries/euthanasia-voluntary/ (last visited July 29, 2005) [hereinafter Stanford Encyclopedia] (The ancient Greeks and Romans did not consider life worth preserving at any cost. Suicide was tolerated. The Stoics and the Epicure-
debate will disappear in the near future. Every new discovery in medical technology promises hope for a few wishful patients struggling to live, but at the same time provides ammunition for opponents of euthanasia. Accordingly, "the same medical technology that effects these miraculous cures and gives hope to the afflicted can also sustain biological existence over many years for patients who are, or will soon be, clinically dead." Looming in the background and always ready at a moment's notice are the "rapid reaction forces" of the pro-life and pro-choice camps. Given an opportunity the advocates both for and against voluntary euthanasia are ready and willing to engage in yet another all-or-nothing epic battle, hoping for a swift and decisive victory, while most of the time anticipating protracted and nondescript exchanges. Viewed in this light, the "right to die" campaign is a long-term engagement, not a one-time encounter. In this regard, the debate resembles more the Vietnam War, with shifting intellectual terrain to be negotiated, than a WWII battle, with distinctive mental territory to be won. The whole

ans approved of suicide when a person no longer cared for his life. In the sixteenth century, Thomas More approved of suicide for those who had become burdensome as a result of "torturing and lingering pain to himself and/or the community." In the 1970s and 1980s a series of court cases in the Netherlands culminated in an agreement between the legal and medical authorities that excused physicians from prosecution for assisting a patient to die as long as certain guidelines were strictly adhered to). See also Jennifer M. Scherer & Rita J. Simon, Death and Dying in Historical Perspective, in EUTHANASIA AND THE RIGHT TO DIE 1-13 (1999); Michael M. Uhlman, Western Thought on Suicide: From Plato to Kant, in LAST RIGHT: ASSISTED SUICIDE AND EUTHANASIA DEBATED 11-44 (Michael M. Uhlman ed., 1998) ("Without question, the most powerful influence on Western thought about suicide is Christian theology, which originates in the Jewish Scripture's account of the creation of man in God's image.").

5 Uhlman, supra note 4, at 1 ("During the next decade, assisted suicide and euthanasia could well become the dominant social and moral issue in the United States.").

6 Additionally, it is often the case that these promises of medical technology, due to various externalities—including their experimental basis, the availability of medical expertise and resources, as well as their general expense—are not made available to all struggling patients. See John Kilner, WHO LIVES AND WHO DIES 4-5 (1990). (While dialysis for chronic kidney patients was made available in 1946, by 1960, only 800 people were receiving hemodialysis as compared with 10,000 who were suitable candidates for what was then a very expensive treatment. In the 1990s only 1,000 to 2,000 hearts were available each year for transplant needs of upwards of 32,000 to 75,000 patients. At Stanford University alone, 750 ideal candidates died each year for lack of a heart donor).

7 Uhlman, supra note 4, at 2.

8 It was Vietnamese General Vo Nguyen Giap who made the revealing observation about the nature of the Viet Minh War with the French, and his observation equally applied to the Vietnam War: "The enemy will pass slowly from the offensive to the defensive. The blitzkrieg will transform itself into a war of long duration. Thus, the enemy will be caught in a dilemma: He has to drag out the war in order to win it and does not possess, on the other hand, the psychological and political means to fight a long-drawn-out war." Gerald L. Atkinson,
“right to life” saga is a remake of *All Quiet on the Western Front* with characters taken out of *Old Man and the Sea*. There is plenty of pain and suffering to go around for the foot soldiers of euthanasia—from frustrated patients to tormented doctors—but there is also an abundance of courage and perseverance in the patients, in the hearts of the doctors, and in the minds of advocates, that is too awesome to fathom with our conventional wisdom and much too inspiring to capture with our limited vocabulary.


> The enemy morale has not broken—he apparently has adjusted to our stopping his drive for military victory and has adopted a strategy of keeping us busy and waiting us out (a strategy of attracting our national will). He knows that we have not been, and he believes we probably will not be, able to translate our military successes into the ‘end products’ [that count]—broken enemy morale and political achievements by the [Government of South Vietnam]. . . . Whatever my hopes, I concluded the prognosis is bad that the war can be brought to a satisfactory conclusion within the next two years. The large-unit operations probably will not do it; negotiations probably will not do it. While we should continue to pursue both of these routes in trying for a solution in the short run, we should recognize that success from them is a mere possibility, not a probability.


9 Erich Maria Remarque, *All Quiet on the Western Front* (Ballantine Books; Reissue Edition, March, 1987) (This book is about a senseless war—WWI—taking the lives and limbs of many young people without any reason or purpose such that when death came to them it became a personal relief and final escape.). The prologue to the film said it all in not so many words: “This story is neither an accusation nor a confession, and least of all an adventure, for death is not an adventure to those who stand face to face with it. It will try simply to tell of a generation of men who, even though they may have escaped its shells, were destroyed by the war . . . .” *All Quiet on the Western Front* (Universal Pictures 1930) (emphasis added). As with those young people who had gone to war in the novel, the terminally ill who have to do battle with a terminal illness will be permanently scared. To many, death promises a much quicker relief than being alive.

10 Ernest Hemingway, *Old Man and the Sea* (Charles Scribner's Sons, 1952) (a fisherman named Santiago struggles in the face of adversity, with dignity and grace). As Santiago says, “[M]an is not made for defeat. . . . A man can be destroyed but not defeated.” *Id.* at 103.

11 When Paul Baumer, the narrator in *All Quiet on the Western Front*, finally died in October 1918, “his face had an expression of calm, as though almost glad the end had come.” Sparknotes, http://www.sparknotes.com/lit/allquiet/terms/channel_1.html (last visited Oct. 9, 2006). (*Quoting Remarque, supra note 9*). The war ended the next month. The terminally ill patients face the same fate and play similar roles in the war for “right to die.” When the war is won, their fates might eventually be seen as casualties of war.
On the surface the debate appears to be simple and straightforward. It involves two fundamental questions focusing on the power of society versus the rights of individuals—society’s asking “how far do we go to save a life?” versus an individual patient’s query asking “how much autonomy do I have to live the life I wanted?” However, the issues involved deep down are as complicated as they are morally divisive, intellectually contentious, and emotionally wrenching. As the “right to life” scholar Uhlman writes, the issues are:

What is the value of human life? When does life cease, and what are our obligations when it does? By what moral license may a human being claim the right to end his own life, and what moral duties fall upon doctors or others who are asked to assist him? What, indeed, is the purpose of medicine, and to what extent should the doctor-patient relationship be regulated? Should the law guide or follow behaviors in this area, and who should decide, courts or legislatures?

On a similar point, “[t]o think about these matters is to confront some of the central questions of human condition: belief in God and immortality of the soul, the nature of moral and legal obligation, and the origin of one’s duties to neighbor and self, to name only a few.” To these questions no agreement is in sight.

This Article represents a continuation and extension of the physician-assisted suicide (PAS) and euthanasia debate. The Article contains a constructed dialogue between a terminally-ill cancer patient suffering great pain and wishing to die a peaceful and dignified death, and a humanistic doctor personally and professionally committed to saving life, who refuses to participate in PAS. This Article is organized into four parts. Part I, Methodology, explains in detail how and why I organized the materials and structured the presentation in the manner I chose. Part II, Context of Debate, consists of two sections—Section A provides a brief overview of the concepts and arguments involved in the “right to die” debate, while Section B addresses the issue of “why is euthanasia controversial?” Part III, The Right to Die Debate, provides a

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13 Uhlman, supra note 4, at 1.

14 Id. at 11.
constructed interactive dialogue between a doctor and a patient on a range of issues raised by the “right to die” decision—from the “meaning of life” to “absolute rule v. variegated circumstances” to “the problem with the AMA Code of Ethics,” and so forth. The dialogue begins with a brief statement of facts and circumstances of the case, pinpointing the dilemmas facing Patient A and Doctor A. For philosophical and stylistic reasons, in Part IV I offer a “postscript” instead of a summary or conclusion.

I. Methodology

It is neither the purpose of this Article to break new ground,15 nor to adduce additional evidence for or against PAS. This has been attempted elsewhere.16 In fact, many of the arguments presented by my hypothetical Patient A and Doctor B have been made before with much more eloquence, persuasiveness and authority.17 In its essence, this Arti-

15 See F. M. Kamm, Morality, Mortality (1996).
Article is a reassessment of the old and a *prospecting*\(^{18}\) of the new. It is a free-flowing piece of random thoughts rather than a meticulous arrangement of organized thinking; spontaneity is what I sought. The enterprise at hand, while not lacking in intellectual challenge, scholarly appeal, or academic rigor, has a most modest agenda: to create conducive conditions for new and creative ideas to emerge in the process of reexamining, reinterpreting, and renewing understanding of old ideas.\(^{19}\)

It is further hoped that if such ideas are favorably received, explored, cultivated, and expounded upon they will some day take root and blossom, creating different schools of thought in the near term and making possible a radical paradigm shift in the long term. As such, this Article is as much about taking stock of existing ideas as it is about exciting new thinking and *suggesting* different approaches. I use "exciting" and "suggesting" to highlight my ultimate purpose in writing: I want to create an opportunity for my readers to rethink their established positions on the range of "right to die" issues; to critically reflect upon basic assumptions of received values with an eye towards discovering viable alternatives and different possibilities.\(^{20}\)

It is not my intention to find flaws in my readers' arguments and posit fault with their thinking; much less to get them to agree or disagree with me. Individuals have to come to terms with their own reflective and considered judgments.\(^{21}\) Thus, while there are points and counterpoints in the body of the dialogue, there is no definitive answer provided at the end; while the essay has a long introduction, it has no true conclusion. The protocol used in this debate, and the style adopted in the presentation, reflects and reinforces the central thesis of this essay—ethical discourse in general, and euthanasia debate in particular, is an exploratory and tentative process to engage in, and not a purposive

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\(^{18}\) I use "prospecting" to call attention to the efflorescent quality of new ideas, ever so fragile, always suggestive and mostly tentative. Such incubating ideas are a poor match for established ideas and unworthy opponents of existing ideals.

\(^{19}\) Few people know what are the necessary and sufficient conditions that are conducive to the cultivation of creative ideas. Some likely candidates are: an open debate structure; non-directive, non-imposing and non-threatening style of argumentation; critical analysis of ideas; promotion of diversity of ideas; welcoming of input.

\(^{20}\) Most of our knowledge about the social world is derived from tradition (e.g., constitutional norms), authority (e.g., religion) and convention (e.g., popular opinion). Earl Babbie, *Human Inquiry and Science*, in *The Practice of Social Research* (7th ed. 1995).

\(^{21}\) This is consistent with enlightened education philosophy: the discovery of knowledge is a process, not outcome. Knowledge cannot be imposed by others but must be discovered by individual self.
and definitive outcome to arrive at. Consistent with all other search for knowledge—presumptuously called truth seeking—this debate is an intellectual exercise that is always arriving, never arrived. The most we can hope for is a better understanding of our own thinking through the appreciation of others' arguments.\(^{22}\)

In truth, the search for answers in the "right to die" debate, as with many other controversial issues that split our communities, should begin with and end by looking inward within ourselves—using others only as a sounding board and reflective mirror. In this regard it is instructive to revisit the social and political satire *The Wonderful Wizard of Oz*.\(^{23}\) The book speaks of four characters—Dorothy, Scarecrow, Tin Woodsman, and Cowardly Lion—who all desperately desire to acquire from the Wizard of Oz characteristics they find themselves lacking.\(^{24}\) In the end, though, they are told by the Wizard that such qualities were in them all along.\(^{25}\) This story informs us of how people often come to look at an issue, or resolve problems, based on figments of their own imaginations. More often than not, our opinions have everything to do with who we are, where we come from, and what we want. As observed by Littlefield:

As each of our heroes enters the throne room to ask a favor the Wizard assumes different shapes, representing different views toward national leadership. To Dorothy he appears as an enormous head, 'bigger than the head of the biggest giant.' An apt image for a naive [sic] and innocent little citizen. To the Scarecrow he appears to be a lovely, gossamer fairy, a most appropriate form for an idealistic Kansas farmer. The Woodman sees a horrible beast, as would any exploited Eastern laborer after the trouble of the 1890's. But the Cowardly Lion, like W. J. Bryan, sees a 'Ball of Fire, so fierce and glowing he could scarcely bear to gaze upon it.' Baum then provides an additional analogy, for when the Lion 'tried to go nearer he singed his whiskers and he crept back tremblingly to a spot nearer the door.'\(^{26}\)

\(^{22}\) To appreciate is more than to understand. To appreciate is to understand completely and accept instinctively. "Appreciate" is defined as: "1.a: To grasp the nature, worth, quality, or significance of . . . b: to value or admire highly . . . c: to judge with heightened perception or understanding . . . d: to recognize with gratitude." MERRIAM-WEBSTER'S COLLEGIATE DICTIONARY (11th ed. 2003).


\(^{24}\) Id.

\(^{25}\) Id.

In the ultimate analysis, "right to die" issues and arguments are more than objective facts and scientific truth to be uncovered. Rather, they are socially constructed, culturally defined, and politically mandated.

Finally, one admission is in order. I am keenly aware that I can never be as objective and neutral in my approach to "right to die" issues as I would like. For example, by structuring the debate in a certain way—by prioritizing some issues and emphasizing certain arguments—I am involved in setting the agenda and structuring arguments that can influence the course of thinking before it has time to take shape. As a self-appointed mediator of such a controversial debate I have assumed a very delicate and important role. Such a role, if not handled properly with sincerity of purpose, sensitivity to latent concerns, and dexterity with controversial issues, might lead to stifling of ideas, obfuscation of issues and frustration of consensus building. In sum, notwithstanding my good intention, I could be doing more harm than good.

The impetus for writing this Article results from three personal observations, gathered in just a few years of research and teaching:

First, I have had occasion to observe elsewhere that "[k]nowledge never rests, people do." We should not allow ideas and concepts to get old, if only because old ideas are, ipso facto, bad ideas. Ideas and concepts can only maintain maximum utility and continued vitality as materials of people's intellectual terrain and communication tools for people's discourse when they are being constantly tested in the marketplace of ideas through deep reflection, critical examination and robust discussion. In the "right to die" debate many of the ideas and arguments, such as balancing the state's interest in preserving life and individual autonomy, are old ones, desperate for reexamination.

Second, I have on another previous occasion made the observation that, "[t]he truth of an assertion, is inversely proportion [sic] to one's


28 Kam C. Wong, Lecture Notes (September 1987) (Lecture notes from the University of Louisville) (on file with author). I made this statement to lament our inability as knowledge acquirers to catch up with knowledge creation. Our understanding of matters grows incrementally. Knowledge, however, expands exponentially.
conviction therein.”29 Simply put, the more we believe in any one thing, the less likely that the thing we believe in is true. This is not difficult to explain. Our belief in things transforms us into advocates of those ideas. This, in turn, detracts from the continued search for new ideas. Ideology is science’s worse enemy. As observed by Ardrey:

[t]he grand escapade of contemporary man can be denied neither excitement nor accomplishment. Out of our dream of equality we have lifted masses from subjection, moved larger masses into slavery. We have provided new heroes, new myths, new gallantries; new despots, new prisons, new atrocities. Substituting new gods with old, we have dedicated new altars, composed new anthems, arranged new rituals, pronounced new blessings, invoked new curses, and erected new gallows for disbelievers. We have reduced sciences to cults, honest men to public liars.30

Idealists, of whom ideologues are the worse kind, advocate and defend pre-ordained ultimate truths—liberty, equality, justice—which they believe to be natural, universal, absolute, and self-evident, in their single-minded and relentless pursuit to realize that truth. Conversely, science seeks to discover as it questions and challenges the illusive, moving, transforming, and faceless truth. However, both enterprises are always arriving, never arrived. For an idealist, truth can only be admired at a distance, never confronted up close. Perfection is not for the secular soul. Ideal, like romance, once attained, loses its mystic lure and driving passion. Struggling for ideological, purity is its own reward. In practice this means the destruction of all lesser truths. Ideology re-invigorates itself, like a vampire sucking blood. For the scientist, science is a never-ending project of proposing and rebutting. Worse yet, since no one has seen the truth, one is rightfully skeptical of having found it. Thus in the face of an ideological challenge, the scientist’s experience encompasses vast amounts of genuine self-doubt before a scientist is able to regain her composure and forge ahead with a critique of her challengers. But the self-assured—or possibly self-consumed—idealist misinterprets the scientist’s gestures of self-doubt as implicit affirmation of his superior position, leading him to deem the scientist an unworthy opponent.

29 Kam C. Wong, Lecture Notes (September 1987) (Lecture notes from the Chinese University of Hong Kong) (on file with author).
In the “right to die” debate there are more complacent followers than inspiring leaders. Most people prefer comfortable personal conviction to disturbing objective truth. This Article hopes to provide a much-needed opportunity to examine our long-held beliefs, including prejudices, myths, and ideologies. However, the reader must ultimately take the initiative to come to terms with his or her own beliefs about whether or not to support the patient’s “right to die.”

Third, I hope this essay can help to make the public aware of the complexity of the issues involved. For the general public, there is a tendency to simplify the issue as a matter of right or wrong, and for advocates to dichotomize the issue as a case between black and white. The fact of the matter is, for an issue as significant, controversial, and complicated as the debate over life and death, truth does not come in neat packages. The temptation is to bring premature closure to the debate as a result of economy (“new ideas are not practical”) or inevitability (“we need to do something, now”). The tendency is to structure the discussion in order to control the discourse, if not the outcome.

At a personal level, this Article is written in memory of my mother, who died in 1975 after a ten-year struggle with cancer. My mother might have passed away, but the memory of her dying days lives with me. Though covered up in nicely adorned academic attire and polished with smart looking scholarship, at its core this Article lays bare a troubled soul and disturbed mind.

Here the debate takes the form of a dialogue being conducted between terminally ill Patient A and his doctor, B, concerning whether Patient A should be allowed to commit suicide himself or obtain PAS. The Article seeks to anchor the debate in a more realistic setting by taking into account the context of the debate, the background of the parties, and the circumstances of the situation. In so doing it invites the readers to actively participate in the debate, first as the doctor and then as the patient, before coming up with his or her own opinion as an impartial juror.

There are a number of reasons why an interactive dialogue format is best used as an heuristic device to present the issues in a “right to die” debate. First, a dialogue format lends tangible substance, thereby making the issues under discussion come to life with clarity, character, and vitality. Second, a dialogue accentuates ideas and clarifies viewpoints between contending positions and competing advocates. Third, in an essay, the author speaks to the readers directly, but in a dialogue, the
author engages the readers indirectly through the characters. Fourth, an interactive dialogue adds new dimensions for the understanding and appreciation of a problem beyond what a traditional presentation can hope to achieve. Fifth, an interactive dialogue allows the readers to become involved with the characters at a personal level and engaged with the issues as an emotional experience.31

Finally, in Part IV the Chinese professor offers a different cultural perspective of the “right to die” debate that focuses on interconnectedness, interdependency, and integrated holism, rather than the individualistic, universal, rule-based, and legal right-denominated discourse that makes up the main debate.32 In offering the Chinese professor’s speech at the end I hope to offer fresh insights in a renewed effort to understand the issues of the “right to die” debate, specifically that debates on social morality and personal ethics are culturally constructed.33

II. CONTEXT OF DEBATE

A. A Review of Basic Concepts and Fundamental Arguments

Euthanasia is the intentional killing, by act or omission, of a dependent human being, for his or her alleged benefit. Euthanasia can be categorized either as active, meaning an individual commits a specific act aimed at killing a patient, such as providing a lethal injection; or passive, meaning it occurs as a result of an omission, such as withholding or withdrawing necessary and ordinary medical care or sustenance. There is an ongoing debate over whether, morally and legally speaking, active and passive euthanasia should be treated alike.34 Additionally, euthanasia can be categorized as either voluntary or involuntary. Voluntary euthanasia occurs when a competent person consents to or requests

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31 For another example of dialogue over propriety of euthanasia at a philosophical level see Philip Berry, Euthanasia—a dialogue, 26 J. MED. ETHICS 370 (2000).
32 For a critique of our rational-right-based analysis, see generally EDWARD DE BONO, I AM RIGHT YOU ARE WRONG: FROM ROCK LOGIC TO WATER LOGIC (1990) (The brain’s understanding of problems is not logical and piecemeal but experiential and holistic, a difference Bono called rock logic vs. water logic.).
34 Robert A. Sedler, Constitutional Challenges to Bans on “Assisted Suicide”: The View From Without and Within, 21 HASTINGS CONST. L.Q. 777 (1994).
others to take his life. Involuntary euthanasia takes place when the person is either unwilling or unable to give such consent.\(^{35}\)

A person can be said to commit euthanasia when "he brings about the death of another person because he believes the latter's present existence is so bad that she would be better off dead, or believes that unless he intervenes and ends her life, it will become so bad that she would be better off dead."\(^{36}\) Euthanasia differs from murder in one important respect: while both involve the intentional killing of another human being, only the latter is done maliciously. Simply put, euthanasia is motivated by benevolence, whereas murder is driven by malevolence.\(^{37}\) A person complies in the euthanasia when he (a) suffers from terminal illness; (b) has no likelihood of cure; (c) labors under intolerable pain or unacceptably burdensome life; (d) is unacceptably dependent on others or on technology for life support; and (e) expresses an enduring, voluntary, and rational wish to die.

The euthanasia debate is also called the "right to die" debate because in the final analysis the patient is asking society, through the courts\(^{38}\) or by means of legislation,\(^{39}\) to grant him the right (with the help of doctors or significant others) to end his life in a dignified and

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\(^{35}\) See STANFORD ENCYCLOPEDIA, supra note 4.


\(^{37}\) Under the common law, murder cannot be distinguished from euthanasia because both involve the intentional taking of the life of another without consent, justification, or excuse. Malice is defined only as a guilty mind, i.e., intent, which is not justified by self-defense. Killing in pursuit of altruistic, moral or higher ends has never been recognized, save in cases of necessity to protect oneself through self-defense. To put it another way, the motive (to kill benevolently to relieve pain of others versus to kill maliciously to elicit gratification for oneself) behind why one kills is never a relevant consideration or justification for murder; it might be a good reason for lenient treatment. See Stacy L. Mojica & Dan S. Murrell, supra note 33.

\(^{38}\) See Washington v. Glucksberg, 521 U.S. 702 (1997), where four Washington physicians who occasionally treated terminally ill patients challenged the State of Washington's decision making "[p]romoting a suicide attempt" a felony, and providing that "[a] person is guilty of [that crime] when he knowingly causes or aids another person to attempt suicide." Id. at 707. The physicians argued such a law was unconstitutional in denying plaintiffs the "right to die" as a privacy choice under the Fourteenth Amendment's Due Process Clause. The plaintiffs relied in particular on Planned Parenthood of Southeastern Pa. v. Casey, 505 U.S. 833 (1992), and Cruzan v. Director, Mo. Dept. of Health, 497 U.S. 261 (1990). The Federal District Court held, and the Ninth Circuit affirmed, "that Washington's assisted suicide ban is unconstitutional because it places an undue burden on the exercise of that constitutionally protected liberty interest." Washington, 521 U.S. at 708. See also Sedler, supra note 34, at 769-80 for a discussion of how the American Civil Liberties Union litigates to secure the right to "hasten" inevitable death for terminal patients.
comfortable manner. Thus euthanasia is also called PAS. The central legal, qua moral, issue in such cases is best presented by one euthanasia lawyer in court:

This case concerns the limits that the Alaska State Constitution places on a state’s power to intrude into and control that profound, personal decision, a decision that will determine the course and length of the

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(1) An adult who is capable, is a resident of Oregon, and has been determined by the attending physician and consulting physician to be suffering from a terminal disease, and who has voluntarily expressed his or her wish to die, may make a written request for medication for the purpose of ending his or her life in a humane and dignified manner in accordance with Ore. Rev. Stat. §§ 127.800 to 127.897.

(2) No person shall qualify under the provisions of Ore. Rev. Stat. §§ 127.800 to 127.897 solely because of age or disability. In order to receive a prescription under the Death with Dignity Act, a qualifying patient must make both an oral and a written request, and reiterate the oral request at least 15 days after making the initial request.

Under the Act, the attending physician has the following responsibilities:

1. to determine whether the patient has a terminal illness;
2. to determine whether the patient is capable;
3. to inform the patient of his/her diagnosis and prognosis;
4. to inform the patient of the risks and probable result of taking the prescribed medication;
5. to inform the patient of the feasible alternatives, including comfort care, hospice care and pain control;
6. to refer the patient to a consulting physician for confirmation of the diagnosis;
7. to refer the patient to a consulting physician for a determination that the patient is capable and has acted voluntarily
8. to refer the patient for counseling if the patient may be suffering from any mental disorder, including depression, causing impaired judgment;
9. to request that the patient notify next of kin (the patient does not have to comply); and
10. to offer the patient the opportunity to rescind the request at any time.

pain of the individual’s remaining life. The question presented is whether mentally competent adults who face suffering and certain death in the near future have the right to choose to hasten their death by administering to themselves drugs prescribed by their doctor for that purpose. A second question is whether the State of Alaska may intercept that decision in an effort to ensure that such persons must remain alive, regardless of their wishes, until the ravages of disease reach their ultimate, painful conclusion.40

In more simple terms, “[t]he right question is whether an absolute ban on the physician-prescribed medications by a terminally ill person to hasten that person’s death, if and when the person chooses to do so, is an undue burden on the person’s due process interest.”41

There are four arguments in support of legalizing PAS: the mercy argument,42 the argument from the patient’s right to self-determination,43 the economics argument,44 and the reality argument.45 Conversely, there is a variety of arguments against legalizing PAS, including the argument that medical doctors will not be able to tell those who truly wish to end their lives from those who are merely depressed,46 the

41 Sedler, supra note 34, at 780-81.
42 This is also known as the compassion argument. It holds that we should be sensitive to the pain and suffering of terminally ill patients. This is a humanistic argument, and can be both emotional and effective.
43 This argument can be based on both principles of patient empowerment and privacy of choice issue. The argument encompasses three ideas: 1) that the patient knows best; 2) that the patient should be responsible; and 3) that the patient should have the ultimate say as a matter of principle. This is a rational and philosophical argument fitting for an individualistic society. See Sedler, supra note 34.
44 This is a utilitarian, cost benefit, rational choice argument. This argument presupposes two things: that people are rational, and that people are similarly endowed (hedonistic) and uniformly disposed (utilitarian). This moves the focus of the debate from the subjective (what patient/doctor really thinks best) to the objective (what society should be thinking). The utility curve can be drawn at the individual level (“Is it worth $10,000 to buy another day of painful existence?”) or the societal level (“Is it worth spending millions of dollars to save one dying person in light of how that money could be elsewhere used?”). The critical question is whether an economic theory can accommodate irrational instincts and affective properties, commonly called humanity.
45 This is a theory versus practice argument. People will keep on doing what they do, notwithstanding any public debate.
argument that PAS is subject to abuses and cannot be easily or effectively regulated, the slippery slope argument, the occasional miracle argument, the sanctity of life argument, the dilution of doctor/patient trust argument, and the argument that doctors should follow their own consciences and social morality.

B. Why is Euthanasia Controversial?

The "right to die" debate arouses heated public discussion and tumultuous private exchanges, which can be realized in various forms,
from litigation to political rallies. It possesses the ability to galvanize opposing advocates and attracts controversial discussion and relentless debate, for good reason.

First, “right to die” issues make for great public debate material. The issues are clearly framed in black and white theoretical terms and provocatively denominated with absolute moral principles. Because they are framed in black and white terms, they accentuate differences and sharpen the debate, making mutual understanding and individual concession all but impossible. Because the debate is immersed in moral principles, the issues are emotionally laden, affording no incentive to compromise and still less ground for settlement. Settlement is not a viable option without compromising one’s integrity. A “take no prisoners” approach with a zero-sum mentality informs the debaters and structures the exchanges with predictable results and a foregone conclusion.


52 Alan Meisel, Managed Care, Autonomy, and Decisionmaking at the End of Life, 35 Houston L. Rev. 1393, 1402 (1999) (“[M]ore than one hundred . . . cases litigated . . . resulting . . . in a consensus about end-of-life decisionmaking. The essentials of this consensus are that competent patients have the right to refuse medical treatment even if that refusal will result in the patient’s death . . .”).

53 For an historical account of the “right to die” movement from one of its leader, see Derek Humphry & Mary Clement, Freedom to Die: People, Politics, and the Right to Die Movement (1998); see also Rebecca C. Morgan, Freedom to Die: People, Politics, and the Right to Die Movement, 40 Santa Clara L. Rev. 609 (2000).

54 John D. Arras, Physician-Assisted Suicide: A Tragic View, in Physician Assisted Suicide: Expanding the Debate 279-300 (Margaret P. Battin et al., eds., 1998) (noting that “PAS poses a ‘tragic choice’ for society in the sense that whichever policy we embrace, there are bound to be victims.”) Arras examines two slippery slope arguments used against PAS and suggests that the alleviation of social and medical deficiencies would circumvent most PAS requests.

55 Francis Dominic Degnin, Levinas and the Hippocratic Oath: A Discussion of Physician-Assisted Suicide, 22 J. Med. & Phil. 99 (1997) (How is it that well educated and intelligent physicians, committed strongly and compassionately to the care of their patients, argue ada-
Second, there is a gross lack of agreement on “right to die” issues, including what values and principles are at stake; how key concepts and theory are to be defined and understood; and how principles might be incorporated in policy, law, and practice, within the medical profession, legal community, and social realm. Before the debate can reach an answer as to what constitutes necessary and sufficient conditions for PAS, it must first answer questions like whether differences in opinions should be resolved by majoritarian consensus or scientific verification.

It seems that everyone has an opinion on matters of life and death, regardless of how well informed on the issues they are, but at the same time no one is willing to listen, much less agree. For example, the majority of medical doctors have all but conceded the inevitability of PAS as a practical matter, if not as a proper recognition of existing moral concerns. This stance, however, is not shared by all medical professionals. Further, there can also be differences of opinions between physicians of different nations regarding these issues. The differences

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56 As Moreno observed: “how can we hope to resolve problems such as whether doctors may assist in suicide if there are so many ideas about the purpose of life, or of reducing waste of health care resources if there are so many ideas about what accounts as waste?” JONATHAN D. MORENO, DECIDING TOGETHER 10 (1995).

57 Id at 13 (scientific truth is inimical to political consensus).


59 Neil Abramson et al., EUTHANASIA AND DOCTOR-ASSISTED SUICIDE: RESPONSES BY ONCOLOGISTS AND NON-ONCOLOGISTS, 91 S. MED. J. 637, 640-42 (1998) (Both oncologists and non-oncologists in Florida were opposed to euthanasia. Both groups preferred better pain control and improved quality of life rather than euthanasia. Both groups admitted to participating in passive euthanasia. Both groups ventured little support for active euthanasia and doctor-assisted suicide. However, should the acts of euthanasia and doctor-assisted suicide become legalized, more non-oncologists than oncologists would agree to participate.); Linda Ganzini et al., ATTITUDES OF OREGON PSYCHIATRISTS TOWARD PHYSICIAN-ASSISTED SUICIDE, 153(11) AM. J. PSYCHIATRY 1469, 1470-74 (1996) (The author surveyed Oregon psychiatrists after passage, in November 1994, of Oregon’s ballot measure legalizing PAS for terminally ill persons. Two thirds agreed with PAS under some circumstances. One half favored legalization.).

60 Dick L. Willems et al., ATTITUDES AND PRACTICES CONCERNING THE END OF LIFE: A COMPARISON BETWEEN PHYSICIANS FROM THE UNITED STATES AND FROM THE NETHERLANDS, 160 ARCHIVES INTERNAL MED. 63, 63 (2000) (Physicians from Oregon and from the Netherlands were interviewed using the same instrument and compared using the same questions. “American physicians found eu-
of ideas and conflating of opinions are both a reflection and reinforce-
ment of a still larger intellectual-political terrain that preoccupies our
mindset in the post-modernist society. Post-modernist thinking is ob-
sessed with debunking established myths by being critical, if not cynical,
of traditional values, and dismissive, if not destructive, of entrenched
ideas and ideals, in the relentless pursuit of emerging ideas and the zeal-
ous promotion of boundless pluralistic discourse. In the process, consen-
sus, which was once a virtue to be embraced, is now deemed a vice.
And truth, once a goal to arrive at, is now a pitfall to avoid.

Third, the current lack of agreement on “right to die” issues is
occurring at a time when the medical profession is losing much of its
institutional prestige and moral authority. Physician-centered paternal-
ism is increasingly being replaced by patient self-determination. Doct-
ors’ professional privileges are abruptly being challenged by patients’
civil rights.61 Doctors’ motives and medical opinions are being increas-
ingly questioned and challenged by their patients.62 All this has resulted
from a noticeable and irreversible decline in the quality and meaningful-
ness of the patient-doctor relationship.63

Fourth, the “right to die” implicates a number of disciplines with
different disciplinary protocols, scholarly traditions, intellectual styles
and philosophical foundations. This makes meaningful cross-discipline
discussion difficult, and an integrative solution impossible.64

Fifth, improvement in living conditions, better preventive health
care and dramatic development of medical technology extends life to
beyond what is “natural.” This extension of the average life-span can
have the net effect of prolonging personal agony and draining limited
social resources.

Sixth, euthanasia is a reality we have to learn to deal with; there is
no escaping it.65 Euthanasia, especially in its passive form, is prevalent

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61 Derek Humphry & Mary Clement, Freedom to Die: People, Politics, and the
62 President’s Advisory Comm’n on Consumer Protection & Quality in the Health Care
Industry, Participation in Treatment Decisions, in Consumer Bill of Rights and Responsi-
2006).
63 Id. at 35-37.
64 Moreno, supra note 56.
65 Arras, supra note 54, at 279-300 (“PAS poses a ‘tragic choice’ for society in the sense that
whichever policy we embrace, there are bound to be victims.”).
and generates huge medical, social, moral and legal problems.\textsuperscript{66} It is exacerbated by the "don't ask/don't tell" mentality often adopted by society. Surveys show that doctors routinely engage in euthanasia, with or without a patient's expressed preference or articulated consent.\textsuperscript{67}

Seventh, "right to die" issues are real life concerns, not just a conjured up intellectual debate. The resolution of such issues will have a material influence and impact on important life choices. Issues of life and death affect us all in a very personal and inevitable way. The real and substantial possibility of living with excruciating pain as a result of terminal illness or incapacitating injury is never too far from our minds. The news media is replete with stories of freak accidents and catastrophes, sufficient for us to realize our own vulnerability even in the comfort of our own homes.\textsuperscript{68}

Eighth, the "right to die" debate goes to the core of our existence. It involves the freedom to choose and decide who we are and what we want to do. As Dr. Aycke Smook properly observed; "[a]utonomy in decision making is a fundamental issue in our society."\textsuperscript{69}

Ninth, "right to die" issues are ubiquitous and refuse to go away. Just as people think they have resolved this issue, a sensational case\textsuperscript{70} or a new advance in medical technology surfaces that promises to stir our restless emotion and prick our beguiled conscience. Thus, notwithstanding explicit criminal laws against suicide and euthanasia, people will continue to commit euthanasia and the state will continue to find


\textsuperscript{67} Michael J. Kelleher et al., \textit{Euthanasia and Related Practices Worldwide}, 19 \textit{CRISIS} 109, 109-115 (1998) ("Despite the obvious international importance of euthanasia, very little is known about the extent of its practice, whether passive or active, voluntary or involuntary. This examination is based on questionnaires completed by 49 national representatives of the International Association for Suicide Prevention (IASP), dealing with legal and religious aspects of euthanasia and physician-assisted suicide, as well as suicide.").


\textsuperscript{69} Aycke Smook, M.D., Address at the Royal Society of Medicine in London: The Dutch Way (Nov. 1999).

excuses to accommodate these actions. For example, in 1999, a widow was sentenced to only two years of probation by the United Kingdom’s Exeter Crown Court for her attempted murder of her husband, who had long suffered from dementia and Parkinson’s disease. Similarly, in 1999, Dr. David Moore was found not guilty of murder for giving pain-killing drugs, which had the effect of hastening death, to his patients.

Tenth, there is a great contradiction in our public policy towards euthanasia that cannot be easily explained or reconciled in comparison to other accepted aspects of public policy. For example, the British Medical Association (BMA) has issued guidelines and endorsed living wills, an action which would seem to clearly reflect patients’ wish to refuse treatment. The BMA also voted in 1999 against legalizing PAS. However, this runs counter to the opinion of the British public, which overwhelmingly supports PAS. Further, the U.K. government has allowed mentally incapacitated adults to make “advance statements” and “advance directives” (basically living wills) for health care issues concerning their own well being. On December 10, 1999, Member of

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71 Gerrit van der Wal et al., Evaluation of the Notification Procedure for Physician-Assisted Death in the Netherlands, 335 New Eng. J. Med. 1706, 1706-11, 1728 (1996). In the Netherlands, a physician is required by law to report to the coroner who will then notify public prosecutors of any assisted suicide performed. Ultimately, the Assembly of Prosecutors General decides whether to prosecute. Of the 6324 cases reported during the period from 1991 through 1995, only 13 involved prosecution of the physician. Id.

72 UK: Wife Freed After Mercy Kill Attempt, BBC, March 29, 1999, http://news.bbc.co.uk/1/hi/uk/307034.stm (Mrs. Victoria Wood was given two years of probation of killing her husband).


74 See Editorials, Withdrawing or Withholding Life Prolonging Treatment: A New BMA Report Fills an Ethical Vacuum, 318 BMJ 1709 (1999). For the legislative effort based on BMA guidelines, see also Katharine Wright, Medical Treatment (Prevention of Euthanasia) Bill, 1999, Bill [12] (Eng.).


76 Peter Byrne, The BMA on Euthanasia: The Philosopher Versus the Doctor, in Medicine, Medical Ethics and the Value of Life 15-34 (1990).

77 Department for Constitutional Affairs, Consultation Paper Issued by the Lord Chancellor’s Department, Making Decisions on Behalf of Mentally Incapac-
Parliament Joe Ashton introduced the Doctor Assisted Dying Bill in the Parliament, arguing that:

The current situation is a doctor's dilemma. Drugs that alleviate pain . . . also shorten life . . . There is a huge void in the law. When does it become legal to give more drugs to alleviate pain, even though that terminates life? Some doctors will assist patients who say that they want to die with dignity, but there is no law that says that they can. The patient has no legal right to choose and the doctor has no legal right to administer more drugs. Some doctors refuse for ethical or religious reasons. Some will give only enough drugs to alleviate pain, not enough to hasten death. One doctor in the north-east has admitted that he has shortened life, as have others elsewhere. He is being investigated by the Crown Prosecution Service. One of the reasons why [one litigant] went to court was so that her doctor would be covered. . . . The religious and ethical issues are very difficult. The British Medical Association decided, without balloting its members, that it did not want a change in the law for the time being. As it stands, the law can lead to unofficial euthanasia, but the patient has no choice—no chance of being given dignity to shorten their life by four or five weeks.78

Finally, there is a large gap between the public opinion of euthanasia and the professional ethical codes and state criminal laws that forbid it. The trend is increasing in favor of establishing a “right to die.” For example, in Canada, a National Angus Reid Poll conducted in 1994 found that a majority of Canadians, 74%, approved doctor-assisted suicides for terminally ill patients who wish to end their lives.79 This was a 4% increase from the previous year. A survey of the Australian public, conducted by Roy Morgan Research Centre, showed similar results.80

78 "Mr. Joe Ashton (Bassetlaw): I beg to move, that leave be given to bring in a Bill to enable a person who is suffering distress as a result of his terminal illness or incurable physical condition to obtain assistance from a doctor to end his life; and for connected purposes." 302 PARL. DEB., H.C. (6th ser.) (1997) 1025.


80 The Right of the Individual or the Common Good? Report of the Inquiry by the Select Committee on Euthanasia, Legislative Assembly of the Northern Territory, Table 4.4, p. 62 (May 1995).
III. The "Right to Die" Debate

A. The Facts

Patient A is suffering from an incurable form of cancer, a degenerative disease of the sort that has become a common cause of death in contemporary times.\textsuperscript{81} There is little chance of recovery, and he is given no more than a year to live. Additionally, he is suffering great pain as a result of his condition. In his own words:

I have a large cancerous tumor which is wrapped around the right carotid artery in my neck and is collapsing my esophagus and invading my voice box. The tumor has significantly reduced my ability to swallow and prevents me from eating anything but very thin liquids in extremely small amounts. The cancer has metastasized to my plural [sic] cavity and it is painful to yawn or cough. . . . In early July 1994 I had the [feeding] tube implanted and have suffered serious problems as a result. . . . I take a variety of medications to manage the pain. . . . It is not possible for me to reduce my pain to an acceptable level of comfort and to retain an alert state. . . . At this time, it is clear to me, based on the advice of my doctors, that I am in the terminal phase of this disease. . . . At the point at which I can no longer endure the pain and suffering associated with my cancer, I want to have drugs available for the purpose of hastening my death in a humane and certain manner. I want to be able to discuss freely with my treating physician my intention of hastening my death through the consumption of drugs prescribed for that purpose.\textsuperscript{82}

Patient A has an insurance policy worth $30,000, redeemable upon his death. The hospital bills run $100 a day. His wife is having a baby and needs $10,000 to pay for the medical treatment associated with her pregnancy. His son needs $10,000 in order to attend college. Lastly,

\textsuperscript{81} See President's Commission for the Study of Ethical Problems in Medicine and Biomedical and Behavioral Research, Deciding to Forgo Life-Sustaining Treatment: A Report on the Ethical, Medical and Legal Issues in Treatment Decisions (1983) ("Between 1900 and the present, the causes of death have changed dramatically: communicable diseases have declined sharply while chronic degenerative diseases have become more prominent."). By 1976 the leading causes of death were heart disease, cancer and cerebrovascular disease, all illnesses which are progressive for some years before death. Department of Health, Education and Welfare, Facts of Life and Death 31-33 (1978). More significantly, in 1978 over 50% of the population died of an illness diagnosed at least twenty-nine months in advance. Lewis Thomas, Dying as Failure, 447 ANNALS AM. ACAD. POL. & SOC. SCI. 1, 1-2 n.8 (1980).

\textsuperscript{82} Pain cannot be adequately described except through visualization and empathy. Patient A's personal declarations come from the court file of Quill v. Vacco, 521 U.S. 790 (1997).
his house will be repossessed tomorrow unless he pays off a $10,000 personal loan. The hospital is experimenting with a new drug that, if successful, may cure all cancerous persons. The experiment needs patients like A, but it is expected that the drug will not be ready to be successfully tested for a year and certainly not earlier than six months. There is a 50% chance that the drug will be proven effective, but the drug also has known side effects.

Additionally, bear in mind that the American Medical Association has found that one of the many reasons that terminal patients are not effectively responding to treatments is because the patients lose their wills to live. There have been public outcries from some quarters, especially Catholics, about the medical profession not exercising independent judgments in stopping patients from killing themselves. The Pope, in fact, issued a stern statement condemning the practice.

Human rights activists and the ACLU have denounced the practice of not allowing one to make up one’s mind about one’s body. Should A be able to obtain prescribed drug to kill himself? Should killing oneself


84 This position is best summed up by Pope John Paul II: “Man, therefore, possesses life as a gift, of which he cannot consider himself the owner however; for this reason, he cannot feel he is the arbiter of life, whether his own or others.” Pope John Paul II, Address to Midwives (January 26, 1980), in 72 ACTA APOSTOLICAE SEDIS 84, 84-88 (1980). However, what makes people skeptical is that God’s command not to take life allows for certain exception: self-defense, accidental killing, just war and deserved capital punishment. The Second Vatican Council does not say what euthanasia means. Pius XII addressed the issue obliquely when he considered the issues of pain-relieving drugs causing death and the use of artificial respiratory device to continue life:

Every form of direct euthanasia, that is to say, the administration of narcotics in order to procure or to hasten death, is immoral because it is a claim to dispose directly of life. . . . One lays claim to a right of direct disposition whoever one wills the shortening of life as an end or as a mean.

. . . .

Natural reason and Christian moral say that man (and everyone entrusted with the care of his fellow man) has the right and duty, in case of serious illness, to take the treatment necessary for the preservation of life and health. . . . But his duty normally obliges one only the use of ordinary means (according to the circumstances of persons, places, epochs and culture), i.e. of means that do not impose any extraordinary burden on oneself or on some else . . .

Pius XII, Address to doctors and surgeons in response to questions of anesthetists (February 24, 1957), in 49 ACTA APOSTOLICAE SEDIS 129, 129-47, 1027-33 (1957).

85 Motion and Memorandum for ACLU Foundation of Oregon, Inc. as Amicus Curiae, Oregon v. U.S. Attorney General, Civil No. CV-01-1647-JO (D.Or.).
be against the law? These questions properly raise a “right to die” issue. Consider the following dialogue.

**B. The Meaning of Life**

Patient A: I want to die. My reasons are as follows: (1) I cannot tolerate the pain anymore;\(^8^6\) you could not possibly understand the pain since it is not occurring to yourself.\(^8^7\) (2) I do not want to be a burden to my family, relatives and friends.\(^8^8\) (3) If I die, I can be liberated, physically and psychologically.\(^8^9\) (4) It is costing me too much to live. (5) If I die,


\(^8^7\) The pain one experiences depends on one’s pain threshold and tolerance. According to the International Association for the Study of Pain, http://www.iasp-pain.org/terms-p.html#Pain (last visited Oct. 23, 2006), pain is defined as “[a]n unpleasant sensory and emotional experience associated with actual or potential tissue damage, or described in terms of such damage. Note: Pain is always subjective. Each individual learns the application of the word through experiences related to injury in early life.” That said, pain and suffering can be effectively managed and tolerably lived with; such a fact provides a compelling argument against taking one’s life. However, since pain is personal, it cannot be talked away unless the suffering is willing, ready and prepared to do so mentally. In the case of cancer, 80-90% of pain can be relieved with oral analgesics and adjuvant, about 10-20% can be difficult to treat. See J. Sykes, R. Johnson & G.W. Hanks, *ABC of Palliative Care: Difficult Pain Problems*, 315 BMJ 867, 867 (1977). Most pain in cancer responds at least partially to opioids. Pain that is inadequately relieved is due to opioid analgesics dosage causing intolerable side effects. The most common intolerable cancer pain is neuropathic pain, i.e., pain from damages of nervous tissue produced by cancer infiltrating or compressing tissue damaged. \(^\text{Id.}\)

\(^8^8\) Ezekiel J. Emanuel et al., *Understanding Economic and Other Burdens of Terminal Illness: The Experience of Patients and Their Caregivers*, 132 Annals Intern Med. 451, 451-53, 455-56 (2000) (The researchers interviewed terminally ill patients and caregivers in six randomly selected U.S. sites, Worcester, Massachusetts; St. Louis, Missouri; Tucson, Arizona; Birmingham, Alabama; Brooklyn, New York; and Mesa County, Colorado, to ascertain the causes and consequences of economic and non-economic burden on caretakers of terminal patients. 34.7% of patients had substantial care needs. Patients who had substantial care needs were more likely to report that they had a subjective sense of economic burden. Patients with substantial care needs were more likely to consider euthanasia or PAS. Caregivers of these patients were more likely to have depressive symptoms.); see also M.H. Cantor, *Strain among Caregivers: A Study of Experience in the United States*, 23 Gerontologist 597 (1983); L.K. George & L.P. Gwyther, *Caregiver Well-Being: A Multidimensional Examination of Family Caregivers of Demented Adults*, 26 Gerontologist 253 (1986); K. Siegel et al., *Caregiver Burden and Unmet Patient Needs*, 68 Cancer 1131 (1991); B.J. Berkman & S.E. Sampson, *Psychosocial Effects of Cancer Economics on Patients and Their Families*, 72 Cancer 2846 (1993); E.J. Emanuel et al., *Assistance from Family Members, Friends, Paid Care Givers and Volunteers in the Care of Terminally Ill Patients*, 341 New Eng. J. Med. 956 (1999).

\(^8^9\) The major problem with terminally ill patients is one of length of life versus quality of life. For the life experience of one terminal patient, see Ruth Picardie, *Before I Say Goodbye: Recollections and Observations from One Woman’s Final Year* (2000).
I can give life and perpetuate my legacy and realize my dream through my children. (6) If I die, I can secure my family from poverty. (7) If I die, I can assure a better future for my son. (8) If I die, my organs can be harvested and used to save many other lives. (9) If I die, I can realize my own identity. (10) If I die I can make a personal statement about the right to a "meaningful life." (11) If I die, I can set an example to another, use myself as a test case, and protest government policy.  

These thoughts I have are shared by many persons in the same situation as me—recent Oregon studies show that, after two years of experience with the Death with Dignity Act, terminal patients share many of my concerns.  

I have considered this for a long time. This is not a rash judgment. I understand that you have an obligation to me as a medical professional, as well as a burning sympathy regarding my plight, but if you care for me, please understand my situation, identify with my goal, and empathize with me as a person. Please help me in achieving what I want by doing any of the following: (1) put me to sleep forever; (2) give me the advice and/or the medications so that I can do it myself with painless ease; (3) let me do it and don't stop me from dying.

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90 Miles Little, Assisted Suicide, Suffering and the Meaning of a Life, 20 THEORETICAL MED. & BIOETHICS 287, 287 (1999) (decisions regarding life and death should be grounded "in concepts of the meaning of life").


92 Most terminally ill persons have a lot of time to think about their own predicament. I refer you to the comments of one doctor regarding dealing with his patient's decision to end her life:

While I was reviewing the instructions again as the protocol required [per the Oregon Death with Dignity Act], my patient interrupted me and asked, "Excuse me, are you saying that I have to take all of these [death medications]?" There was not a hint of anxiety or indecision in her voice. There was complete understanding, anticipation, almost exhilaration. She was fully engaged in the discourse, in the planning.

Doctor B: Life is always precious, and I do not think you should die.\footnote{If the disagreement stops at a discourse level, this is fine. However, more often than not, the doctors are able to prevail over their patients and against their wishes because of their superior knowledge and elevated social position in the medical exchange relationship. The patient needs the doctor's medical knowledge and skills. The doctor expects and gets deference and compliance in return. A study shows that when 1,400 doctors and nurses at five major hospitals were asked about their treatment routines of terminally ill patients, a full 70% of the resident doctors admitted to over-treating such patients against their conscience. See Jane E. Brody, \textit{Doctors Admit Ignoring Patients' Wishes}, N.Y. TIMES, May 24, 1989, at A1. Dutch doctors admitted to killing thousands without the patients' knowledge or consent. In 1991, the Remmelink Report, the first official government study of the practice of euthanasia in the Netherlands, a sample of 8681 cases, shows that doctors actively killed patients without the patients' knowledge or consent in 1040 cases (12%) and doctors administered lethal morphine overdose without the patients' explicit consent in 4941 cases (56.9%). \textit{See Remmelink Report: Euthanasia Results in the Netherlands—Number of Cases in 1990} (1991), http://www.euthanasia.com/hollchart.html (last visited Aug. 1, 2005).} I can give you more painkillers or even put you to sleep for a while,\footnote{Doctor B's position—save life and improve quality of life—is well represented in the profession. \textit{See Abramson et al., supra note 59.} However, there are vocal, strong and vibrant dissenting voices. For example, in 1988 ten doctors associated with major medical schools and hospitals declared "it is not immoral for a physician to assist in the rational suicide of a terminally ill person." Sidney H. Wanzer et al., \textit{The Physician's Responsibility toward Hopelessly Ill Patients: A Second Look}, 320 NEW ENG. J. MED. 844, 848 (1989).} or I can put you in palliative care\footnote{In practice, palliative care "affirms life and regards dying as a normal process; neither hastens nor postpones death; provides relief from pain and other distressing symptoms; integrates the psychological and spiritual aspects of care; offers a support system to help patients live as actively as possible until death; and offers a support system to help patients' family cope during the patient's illness and their own bereavement." \textit{See Bill O'Neill & Marie Fallon, ABS of Palliative Care. Principles of Palliative Care and Pain Control}, 315 BMJ 801, 801-04 (1997). In seeking to help terminal patients to manage pain, palliative care workers recognize that pain is not only physical in origin but also has emotional, social, and cultural roots. A broad definition of pain includes: physical pain (symptoms, adverse effects of treatment); anger (bureaucratic bungling, delays in diagnosis, unavailable physicians, uncommunicative physicians, failure of therapy, friends who do not visit); anxiety (fear of hospital or nursing home, fear of pain, worry about family and finances, fear of death, spiritual unrest, uncertainty about future); depression (loss of social position, loss of job prestige and income, chronic fatigue, sense of helplessness, disfigurement). \textit{Id.}} or a hospice home.\footnote{"Hospice poll finds majority would not opt for assisted suicide." International Anti-Euthanasia Task Force, http://www.iaetf.org/iua5.htm#6 (last visited Aug. 1, 2005). A recent Gallup Poll commissioned by the National Hospice Organization found that, while the American public is sharply divided on whether PAS should be legalized, the majority of those questioned said that they would not choose PAS for themselves. In fact, 70% of adults indicated that, if terminally ill, they would "seek a hospice program of care until death occurs naturally." 62% of adults said that they would pursue "curative treatment." Only about one-third (35%) indicated that they would ask their physician to end their life. Press Release, National Hospice Organization, http://www.internationaltaskforce.org/iua5.htm, (last visited Oct. 3, 2006). Other studies} I regret not taking the time to talk to you earlier and make you understand more about...
these options. Please give us another opportunity to understand each other.97 I will do whatever I can to make your last days as comfortable as possible.98

Patient A: I thought doctors are supposed to be value neutral.99 They are there to serve my needs and not there to dictate what I should want.100

have shown that hospice care is a meaningful alternative to terminal patient and is effective in reducing PAS:

Options such as palliative care at home that significantly improve quality of life and make euthanasia less attractive are currently only available to those who can privately subsidize healthcare services. If an emphasis is placed on community-based initiatives and well-supported self-help, then there would be less inequality of healthcare and the voluntariness of choices, including euthanasia, would be more equal for all people under the healthcare system.

Michael Burgess, Commentary to Michael Stingl, Euthanasia and Health Reform in Canada, in SPECIAL SECTION: EUTHANASIA AND PUBLIC POLICY, 7 CAMBRIDGE Q. HEALTHCARE ETHICS 363-366 (1998); see also John Hubert & Susan Sherwin, Commentary to Michael Stingl, Euthanasia and Health Reform in Canada, in SPECIAL SECTION: EUTHANASIA AND PUBLIC POLICY, 7 CAMBRIDGE Q. HEALTHCARE ETHICS 366-70 (1998); (request for euthanasia is affected by healthcare system reform); Courtney S. Campbell et al., Conflicts of Conscience: Hospice and Assisted Suicide, 25 HASTINGS CENTER REP. 36-43 (1995) (The success of legalized PAS challenged the identity and integrity of hospice leading to its demise and disuse. identity and integrity. "In the wake of Measure 16, Oregon hospice programs must develop practical policies to balance traditional commitments not to hasten death and not to abandon patients with dying patients' legal right to request lethal prescriptions.").

97 Jack Coulehan, The Man with Stars Inside, 126 ANNALS INTERNAL MED. 799, 799 (1997) ("Public opinion polls show that a large percentage of persons in the United States currently favor the legalization of professionally assisted death. . . . The movement toward assisted death reflects inadequate palliative care, poor patient-physician communication, [and] great confusion about the right to refuse treatment.").

98 Lonnie R. Bristow, A Statement on Physician-Assisted Suicide, Statement before U.S. House of Representatives' Committee on the Judiciary, Subcommittee on the Constitution, April 29, 1996 ("physician must strive to understand the various existential, psychological, and physiological factors that play out over the course of terminal illness and must help the patient cope with each of them.").

99 Francis J. Beckwith & John F. Peppin, Physician Value Neutrality: A Critique, 28 J.L. MED. & ETHICS 67 (2000). The concept of Physician Value Neutrality (PVN) is that the physicians when treating the patient must keep their values—religious, political, or moral—out of the patient-physician relationship, lest they suborn the value choice of the patient. The development of PVN is influenced by four separate but related scientific, philosophical, and psychological traditions: political liberalism (state should not impose comprehensive doctrine of whatever kind), natural scientism (scientists should suspend personal feelings and attitudes), logical positivism (value and morals are metaphysical and meaningless), and psychoanalysis (psychoanalysts should be neutral and act as a mirror). Id. at 68-69.

Doctor B: Yes, but I also have a duty to save your life and not harm you. I cannot see how trying to save lives—my job—could be interfering with your value choice. More specifically, how is talking you out of suicide superimposing my values on yours?

Patient A: Everything we do in life involves value choices: choosing to jog evidences prioritizing a healthy lifestyle; similarly, choosing to sleep late evidences a love for midnight hours. When it comes to life and death, I need to be able to make unfettered choices. I am trying to make three value statements: (1) As a person, I should have free choice; (2) My choice should neither be unfettered nor, worse, overruled; and, (3) I prefer to die on my own terms. These are all value-laden propositions. Do you see my point? Do you not agree?

Doctor B: In that case, I concede that Physician Value Neutrality is a myth. Neither the state nor the medical profession can afford to be value neutral. Even by refusing to intervene in matters pertaining to patients' health, we can be making decisions of great consequence.

Patient A: It certainly is not true that discourses over the “right to die” are similar in tone, content and intensity for all time and with different cultures. More often than not, ancient people accepted the reality of death as part of a dynamic life process, facing it with poise and serenity. In modern times, some people accept death with a sense of realism, viewing death as inevitable but not to be hastened. These people embrace death as the ultimate reprieve after a long, arduous journey. Still others look to death as an honor, an event to anticipate and work toward. These people achieve their identity through death, such as a mother who risks her life to save her child, or Marines who die to save

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101 This is an “intrinsic value,” i.e. one related to the status of being a person. See C. J. Dougherty, Ethical Values at Stake in Health Care Reform, 268 JAMA 2409-13 (1992).

102 This is an “instrumental value,” i.e. one that helps achieve an intrinsic value. Id.


104 Francis J. Beckwith & John F. Peppin, Physician Value Neutrality: A Critique, 28 J.L. MED. & ETHICS 67 (2000). (PVN is flawed in logic and impossible to attain. The medical profession should get away from PVN and take a stance of moral issues of the day. The patients are entitled to know where the medical profession stands.).

their buddies.\textsuperscript{106} You see, people's right to take life away is variously interpreted. For example, in ancient times, suicide was widely and openly practiced. Hindu wives voluntarily sacrificed themselves at the funeral rites of their dead husbands,\textsuperscript{107} and, in China and Japan, people commit suicide in lieu of being disgraced.\textsuperscript{108}

In Western civilizations, especially within the philosophical community, self-destruction was acceptable, though not venerated.\textsuperscript{109} For example, Plato made provisions for suicide under the following circumstances:

(1) when one's mind is morally corrupted and one's character can therefore not be salvaged, (2) when the self-killing is done by judicial order, as in the case of Socrates, (3) when the self-killing is compelled by extreme and unavoidable personal misfortune, and (4) when the self-killing results from shame at having participated in grossly unjust actions.\textsuperscript{110}

The Epicurean philosophers, who were preoccupied with sensitivity and emotion, equated happiness with being free from pain.\textsuperscript{111} Thus, Cicero observed:

\textsuperscript{106} I was told by my Marine sergeant: "Marines do not die for their country. They die for their unit and buddies." I have worked with Gurkha Soldiers from Nepal ("The Bravest of the brave", http://rip.physics.ukn.edu/Nepal/NPE.html#13) who believed that if and when they die in war they will have realized their life goal of being a good soldier in serving the British Crown. Similarly, the kamikaze (suicide) bomber pilots believed that they were serving the Japanese emperor when they plunged to their death.


\textsuperscript{108} "In the world of the warrior, seppuku was a deed of bravery that was admirable in a samurai who knew he was defeated, disgraced, or mortally wounded." \textsc{Stephen Turnbull}, \textit{Samurai: The World of the Warrior} (2005), (Chapter 4 available at http://ospreysamurai.com/samurai_death2.htm) (last viewed Oct. 30, 2006). \textit{See also} Vivien W. Ng, \textit{Ideology and Sexuality: Rape Laws in Qing China}, 46(1) \textsc{J. ASIAN STUD.} 57, 60 (1987) (Females who were raped in imperial China were expected to kill themselves for losing her virtue). \textit{See also} \textit{Confucianization of the Law: A Study of Speech Crime Prosecution in China}, 11(3) \textsc{MURDOCH U. ELEC. J. L.} (2004) (In Imperial China, senior officials were not sentenced to death but allowed to take their own lives if punishment is required. This was aimed at preserving their self-respect and individual dignity).

\textsuperscript{109} \textit{Ancient and Classical Views of Suicide, in Stanford Encyclopedia, supra note 4.}

\textsuperscript{110} \textit{Id.}

a strong and lofty spirit is entirely free from anxiety and sorrow. It makes light of death . . . It is schooled to encounter pain by recollecting that pains of great severity are ended by death . . . (pain) lie within our own control: we can bear them if they are tolerable, or if they are not, we may serenely quit life’s theatre, when the play has ceased to please us.\textsuperscript{112}

The Stoics were even more insistent that people live by their own decree.

The Stoics asserted that virtue alone is good, vice alone evil, and that all else is absolutely indifferent. Poverty, sickness, pain, and death, are not evils. Riches, health, pleasure, and life, are not goods. A person may commit suicide, for in destroying his life he destroys nothing of value.\textsuperscript{113}

Thus, Seneca openly advocated suicide:

If one death is accompanied by torture, and the other is simple and easy, why not snatch the latter? Just as I shall select the ship when I am about to go on a voyage . . . so I shall choose my death when I am about to depart from life.\textsuperscript{114}

To him, quality of life is much more important the quantity of life.

For mere living is not a good, but living well. Accordingly, the wise man will live as long as he ought, not as long as he can. . . . It is not a question of dying earlier or later, but of dying well or ill. And dying well means escape from the danger of living ill.\textsuperscript{115}

Doctor B: I cannot deal with the ancient past or distant people, but only with what is presently confronting. I only know that every life is precious and that my work entails saving lives.\textsuperscript{116} Every effort must be


\textsuperscript{114} Seneca. \textit{Ad Lucilium Epistulæ Morales}. (Richard M. Gummere trans., William Heinemann, 1918) (available at http://www.molloy.edu/academic/philosophy/sophia/Seneca/epistles/ep70.htm).

\textsuperscript{115} Steven Neeley, \textit{The Constitutional Rights to Suicide} (L. Peer Lang ed., 1994).

\textsuperscript{116} This is to point out that the practice of medicine is a pragmatic profession more given to doing than thinking, achieving rather than pontificating.
made to prolong life, by technology if possible, and by law if required. Life has no more meaning in death.

Patient A: But doctor, what is living without life? How can I feel pleasure if I am asleep? If I rely on painkillers but remain strapped to my bed I do not live a full life. Painkillers can thus become as adverse as pain itself. Have you looked into my eyes lately? I have lost that magic glow. What is living without the spirit of life?

Doctor B: I agree that life is more than blood cells and bone marrow, but, by the same token, life is not purely physical. It has other larger dimensions and multiplex manifestations: a lover’s kiss, a heroic deed, a painful event endured. It is better to have loved and lost than never to have loved at all.

Patient A: No more. No more. Life should be treated like a good party. It should end at just the right time, not a minute less or a second more. What makes a party memorable are the good moments, not the bad. I have had a full life; I have no regrets.

117 Common effects of opioids toxicity include sedation, nausea and vomiting, constipation, dry mouth, agitating, hallucinations, confusion, and myoclonic jerks. See Bill O’Neill & Marie Fallon, _ABC of Palliative Care: Principles of Palliative Care and Pain Control_, 315 BMJ 801-04 (1997).

118 The gist of the issue is to ascertain the meaning of life. “Life, meaning of” _Routledge Encyclopedia of Philosophy_, Version 1.0 (1998). In context, the debate surrounds the issue whether life has meaning beyond those assigned by society and/or accepted by the public; alternatively, whether life has intrinsic values that transcend its utility function to the individual or society.

Central concerns that come under the topic include questions about whether life has a purpose, whether life is worthwhile, and whether people have any reason to live, independently of their specific circumstances and interests. . . . We can search for purposes, reasons, values that are acceptable from points of view external to ourselves, or we can restrict our attention to the realm of desires and goals found in our psyches or our communities, indifferent to possible perspectives beyond the human.

_Id._ The meaning of life cannot be discussed away from the inevitability of death. To some, life is meaningless precisely because death is inevitable. See A. Schopenhauer, _On the Suffering of the World, in The Will to Live: Selected Readings of Arthur Schopenhauer_ (1967) (Life is miserable and meaningless. Suicide is a proper way out.).

119 Decision of life and death should be viewed in the totality. Two salient and dominant variables can be identified. Moments in life are defined as a continuum of life process with a past, present, and future. Events of experience are defined as living experience of one kind or another and include doing nothing. Totality of (meaning of) life incorporates every aspect of life experience (aggregation of all events as one big experience) and all moments of life (aggregation of all moments as one big moment of life), i.e., every thing and anything we do while living. The problem with judging the meaning of life is that there is a tendency for all of us (habits of thinking, capacity of mind, limitation of language) as conditioned by culture (Christianity asks that we forgo now for the future, and Chinese family preached we should honor the past) to pay
C. The Problem with Professional Judgment

Doctor B: Personally, I empathize with your plight. As a friend, I respect your decision. Professionally, however, I cannot agree with it.\textsuperscript{120} Patient A: I respect your view, which is to say I understand it. Your colleague Dr. Timothy Quill of Rochester, New York, was also against PAS. But he finally relented to a dying patient’s plea for help, stating:

I wrote the prescription with an uneasy feeling about 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

\textsuperscript{120} Doctor B’s dilemma resulted from a conflict between his personal values and the patient’s life goals. Doctor B’s reflection on his own experience is instructive:

That evening was a nightmare for me. I had observed my patient while she was receiving her medication. She had shown determination, positive emotion, almost joy as she listened intently to my reiteration of the instructions. I was certain now that she would act on the opportunity, and my intellect and my soul re-engaged in battle. Was my role as physician now expanding into executioner? What was so difficult about this? I had helped many patients die by withholding life support and even by withdrawing it. What was different here? What about my original premises that this was not right for the population at large? And, if I felt that way, why then should it be right for the individual? I recognized only later that my patient’s goal was to be released from a life that had robbed her of her independence and dignity; at the same time, my goal was to retain a foothold in a life that was now challenged by a “calling”.

I did not choose to hear.

had left, and to maintain her dignity and control on her own terms until her death. 121

Doctor B: I share in Dr. Timothy Quill's anguish. I probably would have done the same, given the unique circumstances. However, an exception to a rule does not disqualify the rule itself; not relenting to PAS might still be right.

Patient A: Dr. Quill's dilemma is not unique at all. While I do not think that Dr. Quill's anguish alone is ground for supporting PAS, I think we should take serious note, especially when Dr. Quill's dilemma is widely and strongly felt. Physical pain causes people to feel pain, which causes psychological trouble and, in turn, anguish. We should not let doctors shoulder our society's ethical dilemmas without the proper tools.

Doctor B: Well said, but you should still heed my advice.

Patient A: First, you hardly know me. You are the eighth doctor to have come into my life since my illness, and the fifth since I was moved to intensive care. You have seen me but for a few minutes each day, you know me only through my medical record, which is to say that you don't know me personally. As such, you will be making decisions about me as a "case," not an individual. Be honest to me and truthful to yourself; when you leave this hospital, you leave me and my problems tucked away in a little file cabinet in the general office. 122 Realistically,

121 Timothy Quill, Death and Dignity: A Case of Individualized Decision Making, 324 New Eng. J. Med., 691, 691-94 (1991) (Diane, a middle aged business woman, mother and wife, was diagnosed with acute myelomonocytic leukemia. She would have a 25% chance of remission if she chose to undergo painful and drawn-out chemotherapy. She declined and wanted a PAS. Dr. Quill was conflicted. She was referred to the Hemlock society. She returned from Hemlock soliciting pain-relievers and intending to commit suicide should the pain prove intolerable.).

122 Questions loom as to the nature of the relationship a doctor ought to share with a patient prior to dispensing counsel. In an interview on NBC Dateline, Dr. Kevorkian suggested that a review of the patient's medical record is sufficient, evidencing an intent to treat a decision to die as solely a medical decision on the record, and not a socio-medical, problem. "Who said the relationship should be intimate? I'm a medical doctor. I can review records, and I can see patients, and I can examine them. Who says I've got to learn what their family history is, and who their children are, and what they did 50 years ago? Who said I have to know that?" Dateline: Kevorkian on the Record (NBC Television Broadcast Aug. 25, 1996), http://www.rights.org/deathnet/dateline.html (last visited Aug. 1, 2005). According to records compiled by Detroit Free Press, Kevorkian did not always know most of his patients intimately: "Who were the 47 people who asked Jack Kevorkian to help them die? . . . Kevorkian was in contact with 3 of them for more than a year, with 14 for less than a year, and with 11 for less than three months. He was in touch with 4 of them for less than a month before they died, and 1 less than two
you will never understand me unless you have experience what I have, complete with illness, pain, and death knocking at my door.

Doctor B: I am a medical doctor, not a social worker. I am ill-trained to deal with your social and emotional needs. If you want someone to talk to, you can always get better service from a social worker or a psychologist. There are other aspects of our relationship you fail to mention. I am not only your doctor, I am everyone’s doctor. I cannot spend all the time with you. That would be unrealistic and unjust.

Patient A: I understand that there are allocation of resources problems and distributive justice issues. As to your claim that you are a medical doctor, trained in medicine, and lack social or psychological expertise, I have two observations to make. First, it does not take graduate school training to acquire social and human skills. All it takes is sensitivity and consideration. Social work schools produce researchers and administrators, not good social workers. Second, cancer is a medical problem, but how we relate to cancer patients is a personal and social problem. Most of the time, I feel isolated socially and deprived emotionally. I am being treated like a medical object. This hurts me more than my physical pain. Overnight I was transformed from a productive member of a society with a healthy socialized self, to a medical case file to be processed and disposed of. Perhaps I will not ask you for PAS if I feel warm and cared for as I should, in the real world I came from.

weeks and 1 for less than a day. The rest could not be determined. Kevorkian met with 17 of them for the first time on the day he helped them die. 11 others met with him twice and at least 7 had three or more sessions leading up to the final one. The rest could not be determined."

http://www.freep.com/suicide/index1.htm (last visited Aug. 1, 2005). The more disturbing and controversial issue is whether, and to what extent, the McDonaldization of the health care system contributes to unnecessary PAS as a result of the lack of personal understanding, humanistic insight and meaningful communication between the caregivers and patients. How many lives can we otherwise save: “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.” Leslie Bender, A Feminist Analysis of Physician-Assisted Dying and Voluntary Active Euthanasia, 59 Tenn. L. Rev. 520-40 (1992).

Here the doctor is alluding to the problem of burn out by professionals who otherwise get too personally involved with the plight of students. As a legal aid lawyer and manager for five years (1977-82), I was taught to maintain a professional relationship with my clients. Some legal aid lawyers are burdened with tremendous guilt for not being able to help with the life circumstances of the clients. Legal aid staff ends up quitting because they feel traumatized by the experience of not being able to help in a helping business. The advice from experienced legal aid professionals, was to leave work in the office and treat clients as case files.
D. Absolute Rule v. Variegated Circumstances

Doctor B: From the perspective of society, your thinking is not justified.\textsuperscript{124} Anyone will, and should, prefer life to death, no matter how wrenching life is.\textsuperscript{125}

Patient A: I have a very simple question: how can one universal rule, noble though it obviously is, be suitably applied to different people, diverse circumstances, and variegated situations?\textsuperscript{126} An effective solution to any problem must reflect the complexity of the problem being studied. For example, police officers exercise tremendous discretion in their rounds of duty in order to make universal law fit with particularistic situations they encounter in the street, from pregnant ladies speeding to hospitals, to emotional spouses fighting each other.\textsuperscript{127} These are not viewed as criminal activities, but rather are medical emergencies and family crises. Even courts of law must have equity powers to allow them

\textsuperscript{124} Sociologists have reminded us of the importance of role in the functioning of society. ROBERT K. MERTON, The Role-Set: Problems in Sociological Theory, 8 BRIT. J. SOCIOLOGY 106 (1957), available at http://www.sociosite.net/topics/texts/merton_roleset.php. In the "right to die" debate, involved and implicated parties—patient, family, doctor, society—have different roles and associated responsibilities. In regards to issues of life and death, parties in their respective roles bring to bear different values, assumptions, perspectives, points of view, and, in the final analysis, evaluation and judgment. As a social friend, the doctor is there to provide emotional support. As a medical professional, the doctor is there to provide medical advice. The more doctors understand, the less they can be expected to disassociate themselves from their patients' "subjective" feelings. The difficulty here is that the doctor assumes multiple roles and takes on conflicting functions. Moreover, doctors' roles change as society evolves. For a discussion of the role and responsibility of doctors in terminal cases, see Brian C. Kalt, Death, Ethics, and the State, 23 HARV. J.L. & PUB. POL'y 487 (2000) ("The god-like status of doctors has fallen in the past few decades at the same time, paradoxically, as doctors' powers to sustain life have increase."). Society, through courts, has placed the responsibility of caring for sick and dying members of the society in the hands of doctors with the "ethical integrity of the medical profession" (EIMP) doctrine. The doctrine arrived with Superintendent v. Saikewicz, 370 N.E.2d 417 (Mass. 1977). Medical doctors are also involved in defining death. A Definition of Irreversible Coma: Report of the Ad hoc Committee of the Harvard Medical School to Examine the Definition of Brain Death, 205 JAMA 337 (1968).

\textsuperscript{125} It goes without saying that concept of "worthy" life and "unworthy" death is perceived and acted upon differently as informed by individual experience (e.g. religious belief) and as socio-cultural forces. JAPANESE AND WESTERN BIOETHICS: STUDIES IN MORAL DIVERSITY, (Kazumasa Hoshino ed., 1997).

\textsuperscript{126} Christine K. Cassel & Diane E. Meier, Morals and Moralism in the Debate over Euthanasia and Assisted Suicide, 323(11) NEW ENG. J. MED. 750-52 (1990) (The authors argued that the medical profession's strict prohibition on PAS fails to take into account the perspective, needs, values, and welfare of patients or acknowledge the limits of medicine in sustaining life and managing pain.).

to ignore laws and seek justice.\textsuperscript{128} Discretionary judgment, not the blind enforcement of rules, makes the world go round. Besides, rules, with no compassion, become tyrannical.

Doctor B: But we must have rules to guide our actions, protect the weak, help the meek, and constrain the ruthless! I am afraid that, if I take your words and allow patients and doctors to define what is, or is not, acceptable, we will have anarchy.

Patient A: Anarchy, I fear not. Abuse will happen from time to time, only because we are all too human. Education and spontaneous order is the best control. Furthermore, there are two propositions made above that are objectionable: one factual and one philosophical. By claiming that “anyone will prefer life,” you are trying to make a general factual statement about what most people want, which is objectionable on two grounds. First, as a factual statement, it is certainly not true in most or all instances that, given a choice, most people prefer life. Many sick people, in fact, would prefer to die. When the Hemlock Society published a do-it-yourself suicide manual in 1991—appropriately named \textit{Final Exit: The Practicalities of Self-deliverance and Assisted Suicide}—it became a \textit{New York Times} best-seller overnight, and remained there for months.\textsuperscript{129} Moreover, even healthy people opt for death. Marines are not only willing to die to defend their country but also to maintain the ideals of honor and tradition. Cigarette smokers and racecar drivers all knowingly put their lives at risk to realize life in their own terms.\textsuperscript{130} At a macro and statistical level, there is data to show that most physicians, nurses,\textsuperscript{131} victims and general public\textsuperscript{132} approve of PAS, which is repeat-

\textsuperscript{128} A.V. DICEY, AN INTRODUCTION TO THE STUDY OF LAW OF THE CONSTITUTION 381 (10th ed., 1979) (equity, which originally meant the discretionary, not arbitrary, interference of the Chancellor, for the avowed and often real purpose of securing substantial justice between the parties in a given case).

\textsuperscript{129} DEREK HUMPHREY, FINAL EXIT: THE PRACTICALITIES OF SELF-DELIVERANCE AND ASSISTED SUICIDE (1991) [Hereinafter \textit{Final Exit}] (Derek Humphery, founder of the right-to-die Hemlock Society, provides instructions for the terminally ill on subjects such as cyanide poisoning, hoarding sleeping pills, “self-deliverance via the plastic bag,” and even a how-to for farewell notes. Humphery’s book’s popularity testifies to people’s wish to be able to manage their last days.).

\textsuperscript{130} This position is best captured in Tennyson’s often misquoted line “Tis better to have loved and lost, Than never to have loved at all.” ALFRED LORD TENNYSON, IN MEMORIAM, xxvii, Stanza 4, \textit{reprinted in} ALFRED LORD TENNYSON, IN MEMORIAM, MAUD, AND OTHER POEMS (Kessinger, 2004) (1833).

\textsuperscript{131} J. Beder, LEGALIZATION OF ASSISTED SUICIDE: A PILOT STUDY OF GEROELOGICAL NURSES, 24 J. GERONTOLOGICAL NURSING 14-20 (1998) (Nurses were divided in their support of legalization of
edly borne out in the United States,\textsuperscript{133} (Michigan,\textsuperscript{134} Washington,\textsuperscript{135} Wisconsin\textsuperscript{136} Hawaii\textsuperscript{137}) Canada,\textsuperscript{138} Australia,\textsuperscript{139} and The Nether-

PAS for all ages (46 in favor, 54 opposed). There is much stronger support for legalization when applied to the elderly (58 in favor, 42 opposed).

\textsuperscript{132} L. Seidlitz et al., \textit{Attitudes of older people toward suicide and assisted suicide: an analysis of Gallup Poll findings}, 43 J. AM. GERIATRICS SOC. 993-98 (1995) ("In comparison with survey findings of physicians and the general population, a relatively smaller percentage (41\%) of these older respondents believe that physician-assisted suicide should be legalized." Research based on a random sample of 802 adults in the United States (541 women and 261 men) aged 60 years and older.).

\textsuperscript{133} A USA Today/CNN/Gallup poll conducted in April of 1996 showed that 75\% of Americans favored PAS with only 22\% opposed. USA Today, Apr. 12, 1996.

\textsuperscript{134} J.G. Bachman et al., \textit{Attitudes of Michigan Physicians and the Public Toward Legalizing Physician-Assisted Suicide and Voluntary Euthanasia}, 334(5) NEW ENG. J. MED. 303-309 (1996) (The survey involved the stratified sampling of 1,600 physicians (with a return rate of 74\%) and 1348 adults (with a return rate of 76\%) in Michigan between 1994 and 1995 on their attitude towards the role of physicians in assisted suicide cases. "Asked to choose between legalization of physician-assisted suicide and an explicit ban, 56 percent of physicians and 66 percent of the public support legalization, 37 percent of physicians and 26 percent of the public preferred a ban, and 8 percent of each group were uncertain. When the physicians were given a wider range of choices, 40 percent preferred legalization, 37 percent preferred "no law" (i.e., no government regulation), 17 percent favored prohibition, and 5 percent were uncertain. If physician-assisted suicide were legal, 35 percent of physicians said they might participate if requested—22 percent would participate in either assisted suicide or voluntary euthanasia, and 13 percent would participate only in assisted suicide.").

\textsuperscript{135} A.L. Back AL et al., \textit{Physician-Assisted Suicide and Euthanasia in Washington State. Patient Requests And Physician Responses}, 275 JAMA 919-25 (1996) (An anonymous, random survey of 828 physicians who returned questionnaires (57\% on random sample (25\%) of primary care physicians and all physicians in selected medical subspecialties in Washington State) shows that, in 1996, 12\% of responding physicians received one or more explicit requests for PAS, and 4\% received one or more requests for euthanasia. These physicians provided 207 cases descriptions. The diagnoses most often associated with requests were cancer, neurological disease, and AIDS. The patients were most concerned with loss of control, being a burden, being dependent on others for personal care, and loss of dignity. Physicians provided assistance more often to patients with physical symptoms. Physicians infrequently sought advice from colleagues. Of 156 patients who requested PAS, 38 (24\%) received prescriptions, and 21 of these died as a result. Of 58 patients who requested euthanasia, 14 (24\%) received medication and died.). G.L. Weiss, \textit{Attitudes of College Students About Physician-Assisted Suicide: The Influence of Life Experiences, Religiosity, and Belief in Autonomy}, 20 DEATH STUD. 587-99 (Nov-Dec. 1996) (Personal interviews at a four-year university showed that most students accept and approve of PAS. Key predictors of this attitude are student's level of religiosity and belief in autonomy as a philosophical principle.).

\textsuperscript{136} J. Hare & D. Skinner, \textit{End-Of-Life Care: An Explanation for Wisconsin Citizens' Attitudes Toward Legalization of Physician-Assisted Suicide}, 98(6) WIS. MED. J. 39-43 (1999) (In Wisconsin, a bill similar to Oregon's "Death With Dignity Act" was introduced in the 1993-94, 1995-96 and 1997-98 legislative sessions. A sample consisting of 1,368 Wisconsin adults from western Wisconsin was surveyed. A majority of respondents (57\%) supported the legalization of PAS.).
This data leads to the conclusion that life may not be the most important consideration in matters of life and death. Doing away with absolutes, which are rare, the issue becomes one of personal and situational judgment, which is relative to the people, time, place, and situations involved. Ultimately, judgment is most likely formed by socio-cultural and personal experience. Therefore, it would be prudent to provide college courses on managing life and death, replete with discussions on the meaning of life, and how to face death.

You also suggested that people should, as a matter of principle, cling to life. With this, I cannot agree. As a general observation, there is a strong argument that life has no intrinsic value except use value to the individual and society. More specifically, I surmise that, when you suggested that people should hold on to life "at all cost," you might be

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137 Kathryn L. Braun, Do Hawaii Residents Support Physician-Assisted Death? A Comparison of Five Ethnic Groups, 57(6) HAWAI I MED. J. 529-34 (1998) (A survey of 250 adults in five ethnic groups—Caucasian, Chinese, Filipino, Hawaiian, and Japanese—on questions about PAS showed what 52% said yes, 19% said perhaps, and 29% said no. PAS is less supported by Filipinos and Hawaiians. PAS is also less supported by Catholics and more by college graduates.).

138 Peter Singer et al., Public Opinion Regarding End-of-Life Decisions: Influences of Prognosis, Practice, and Process, 41 SOCIAL SCIENCE AND MEDICINE 15, 17-21 (1995) (A study in 1995 found that 85% of respondents approved of halting life-sustaining treatment for a competent patient unlikely to recover; 66% approved of euthanasia for a competent patient unlikely to recover; and 55% approved of assisted suicide). See also Kinsella, T. Douglas & Marie J. Verhoef, Assisted Suicide: Opinions of Alberta Physician, 18 CLINICAL & INVESTIGATIVE MED. 406-12 (1995) (A stratified random sample (n = 2,002) was drawn from all Alberta physicians. Fifty-five percent believed that assisted suicide should remain a criminal offence, whereas 18% did not, and 27% were uncertain.).

139 In 1996, the Roy Morgan Research Centre, which has conducted surveys of Australians' opinions on PAS since 1946, compared the answers it had received over the years to the question, "If a hopelessly ill person, experiencing unrelievable suffering, with absolutely no chance of recovering, asks for a lethal dose, so as not to wake again, should a doctor be allowed to give a lethal dose, or not?". While only 47% answered in the affirmative in 1962, in more recent years a vast majority of the participants have answered (78% in 1993 and 76% in 1996). See South Australian Voluntary Euthanasia Society (SAVES), Public Opinion Polls, The Right to Choose: The Case For Legalising Voluntary Euthanasia, http://www.saves.asn.au/resources/handbook/ rrc4.htm.

140 Willems et al., supra note 60 (Based on a sample of 152 physicians from Oregon and 67 from the Netherlands, the research found that American physicians found euthanasia less acceptable than their Dutch counterparts.).

141 People learn to be healthy at school but are not taught about the most fundamental aspects of life—to marry, create babies, and ultimately die. People learn to deal with all of these important issues from a process of haphazard socialization and accidental acculturation, which may or may not bear scrutiny and analysis in a court of rational analysis and prudent judgment.
restating Ronald Dworkin’s argument that life is worth preserving because people have to respect life as a matter of course. Taking life demeans the life process. If that is your argument, according to Dworkin, you should want to promote the essence of life, not its degenerated form.

Doctor B: You asked me to step into your shoes. Would you do the same? As a medical doctor, I have pledged to save lives. I dare say that no right-minded doctor makes it a career to kill patients. This is incompatible with their personal disposition and professional ethos. Please come over here and look at the AMA “Code of Medical Ethics” on PAS with me:

2.211 Physician Assisted Suicide. Physician assisted suicide occurs when a physician facilitates a patient’s death by providing the necessary means and/or information to enable the patient to perform the life-ending (e.g., physician provides sleeping pills and information about the lethal dose, while aware that the patient may commit suicide). It is understandable, though tragic, that some patients in extreme duress—such as those suffering from a terminal painful, debilitating illness—may come to decide that death is preferable to life. However, allowing physicians to participate in assisted suicide would cause more harms than good. Physician assisted suicide is fun-

\[142\] RONALD DWORKIN, LIFE DOMINION (1993) (Human life has an intrinsic, innate value. It is ipso facto sacred. Government has a detached responsibility as a matter of constitutional duty and legal right to protect and promote life as a legitimate state interest.).

\[143\] The definition of life and death is affected by how it contributes to social functioning. For example, it has been observed that: “If, however, more organs are needed for transplantation than can be legally obtained, the question whether the benefits conferred by transplantation justify the risk associated with broader ‘definition’ of death should be addressed directly.” Alexander Morgan Capron & Leon R. Kass, A Statutory Definition of the Standard for the Determination of Human Death: An Appraisal and a Proposal, in MELVIN I. UROFSKY & PHILIP E. UROFSKY, THE RIGHT TO DIE 5-40, 20, n.72 (Garland Publishing, 1996).

\[144\] For the impact of legalizing PAS on the medical profession and society, see End of Life Decisions—Views of the BMA, British Medical Assoc. (June 2002) available at http://www.bma.org.uk/ap.nsf/Content/Endoflife-Physicianassistedsuicide. See also, Margaret A. Drickamer, Melinda A. Lee & Linda Ganzini, Practical Issues in Physician-Assisted Suicide, 126(2) ANNALS OF INTERNAL MEDICINE 146-151 (1997), available at http://www.annals.org/cgi/content/full/126/2/146. See also Willems et al., supra note 60 (Notwithstanding differences in attitude towards PAS, both American and Dutch doctors are equally willing to dispense with death-hastening drugs to relieve pain, with the former more inclined to do so in cases when a patient expressed concern about becoming a family burden.) See also Doctor Assisted Dying, House of Commons Hansard Debates (Dec. 10, 1997) available at http://www.publications.parliament.uk/pa/cm199798/cmhansrd/v0971210/debtext/71210-25.htm. (Under current U.K., Doctors are forced to administer life shortening drugs to relieve patients’ pain and suffering).
 fundamentally incompatible with the physicians' role as a healer, would be difficult or impossible to control, and would pose serious social risks.145

Patient A: You are most wrong in this regard. I expect my doctors to do the right thing, and not to just follow orders blindly or to apply rules inappropriately. It is inconceivable to think that the AMA does not allow you to hasten an inevitable death, thereby reducing pain and suffering. After all, not all doctors believe in saving life. There are many doctors who are willing to terminate the lives of suffering patients as part of their medical service, of whom Dr. Kevorkian is the most famous.146 By 1997, he had killed, or assisted in the suicide of, a total of

145 Declaration of Geneva, 1948 - The Medical Code of Ethics. Adopted by the 2nd General Assembly of the World Medical Association, Geneva, Switzerland, September 1948, and amended by the 22nd World Medical Assembly in Sydney, Australia, August 1968 and the 35th World Medical Assembly, Venice, Italy, October 1983 and the 46th WMA General Assembly, Stockholm, Sweden, September 1994 and editorially revised at the 170th Council Session, Divonne-les-Bains, France, May 2005: "AT THE TIME OF BEING ADMITTED AS A MEMBER OF THE MEDICAL PROFESSION: I SOLEMNLY PLEDGE to consecrate my life to the service of humanity; I WILL GIVE to my teachers the respect and gratitude that is their due; I WILL PRACTISE my profession with conscience and dignity; THE HEALTH OF MY PATIENT will be my first consideration; I WILL RESPECT the secrets that are confided in me, even after the patient has died; I WILL MAINTAIN by all the means in my power, the honour and the noble traditions of the medical profession; MY COLLEAGUES will be my sisters and brothers; I WILL NOT PERMIT considerations of age, disease or disability, creed, ethnic origin, gender, nationality, political affiliation, race, sexual orientation, social standing or any other factor to intervene between my duty and my patient; I WILL MAINTAIN the utmost respect for human life; I WILL NOT USE my medical knowledge contrary to the laws of humanity, even under threat; I MAKE THESE PROMISES solemnly, freely and upon my honour." The Second General Assembly of the World Medical Association 1948. http://www.donoharm.org.uk/gendecl.htm Council on Ethical and Judicial Affairs of the American Medical Association, Code of Medical Ethics; Current Opinions with Annotations, 2.035 Futile Care; American Medical Association, Chicago, Illinois (1994) as discussed in note 12 in C. Lee Par
mley: Ethical Consideration in End-Of-Life Medicine: The Internet Journal of Emergency and Intensive Care Medicine. 3 (2) 1999. ("Physicians are not ethically obligated to deliver care that, in their best professional judgment, will not have a reasonable chance of benefiting their patients. Patients should not be given treatments simply because they demand them. Denial of treatment should be justified by reliance on openly stated ethical principles and acceptable standards of care... not on the concept of "futility," which cannot be meaningfully defined."). http://www.ispub.com/ostia/index.php?xmlFilePath=journa ls/jilhe/vol1n1/ethics2.xml.

47 people from all over the country. Unlike you, Kevorkian adopted a high profile to champion his cause, doctors’ ability to engage in “medicide.”

Hero to some, horror to others, Dr. Jack Kevorkian has forced the debate over assisted suicide upon an entire society simply by doing it, again and again and again. While helping at least 47 people die, Kevorkian has scoffed at the law, scorned elected and religious leaders and won over juries.

In pursuing his crusade against “meaningless” living, Kevorkian reminded us what life and humanity really means.

E. Are There Absolute Moral Values and Universal Human Rights?

Doctor B: But I have taken an oath not to kill. It is unethical for me to do so.

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149 Historically, the accepted code of ethical conduct for doctors has been the Hippocratic Oath. Hippocrates was a Greek physician in the fourth century B.C. who taught that diseases have natural causes and can therefore be studied and often cured. As a result of his writings and teaching, he was christened “the father of medicine.” The most famous document attributed to Hippocrates is the Hippocratic Oath, which served as a model of professional conduct for those seeking to practice medicine ethically. One portion of the oath reads: “I will neither give a deadly drug to anybody if asked for it, nor will I make a suggestion to this effect.” On the origin and development of the Hippocratic oath, see NIGEL M. DE S. CAMERON, THE NEW MEDICINE: LIFE AND DEATH AFTER HIPPOCRATES (1992).

150 Medical ethics is concerned with professional obligations of physicians, as spelled out in the medical profession (such as AMA) code of conduct and as elaborated by professional practice to the particular patient and larger society. Medical ethics is implicated in every aspect of what the doctors do, from keeping patient confidences to respecting his autonomy. “Medical Ethics” ROUTLEDGE ENCYCLOPEDIA OF PHILOSOPHY, Version 1.0 (1998). Medical ethics in the U.S. has come under increased scrutiny as a result of technological and social advances. Advances in medical technology, e.g. the invention of dialysis machines and discovery of DNA, call into question a doctor’s role. Social changes, e.g., the public’s increased support for PAS, have transformed the dynamics of the doctor-patient relationship from one of blind dependence to one of informed cooperation.
Patient A: But you have also taken an oath to take care of the medical needs and respect the dignity and autonomy of your patients. As a doctor, you have multiple obligations. No one single principle should trump other equally worthy considerations.

Doctor B: I am starting to get confused. Are you telling me that there is no universal truth?

Patient A: As I said and intimated, as a philosophical proposition and moral principle, there is nothing wrong in asserting that life should be preserved, but problems arise in defining the term “life.” For example, the question of when life begins or ends is not as simple as it appears. Similarly, and of more concern, no country has treated life as an absolute. Even in the Bible, the commandment “thou shall not kill” is subject to exceptions and reservations, such as self-defense, unintentional killing and capital punishment. Our sentiments towards life have changed over time. Our attitude in the U.S. towards “mercy killing” has changed drastically between 1950, 1973 and 2000. In 1950 and 1973 it was asked: “When a person has a disease that cannot be cured, do you think doctors should be allowed by law to end the patient’s life by some painless means if the patient and his family request it?” In 1950, only 36% answered affirmatively to this question, compared to 53 percent in 1973. The breakdown of these statistics is equally striking. Among adults under thirty years of age, the approval figure is 67 percent. It is noteworthy too that only 46 percent of the Catholics interviewed said they disapproved. Forty-eight percent approved and 6 percent were unsure, meaning that not even a majority of Catholics voiced disapprobation of mercy killing. These survey results are subjected to varying interpretation in the hands of able advocates or zealous ideologues. There are of course major reliability concerns. Notwith-

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151 Martyn Evans, Death Rites: Law and Ethics at the End of Life 1-11 (Robert Lee & Derek Morgan eds., 1994).
153 Pamela Paul, To Live or Die, American Demographics, Nov 1, 2002, available at http://www.findarticles.com/p/articles/mi_m4021/is_2002_Nov1/ai_93089472 For actual Gallup Poll Data, see Gallup Brain, available at http://brain.gallup.com/search/ (search “When a person has a disease that cannot be cured, do you think doctors should be allowed by law to end the patient’s life by some painless means if the patient and his family request it?”).
154 Paul, supra note 153.
155 Id.
standing, the idea and principles you hold of life are neither absolute, nor universal, nor unchanging.

Doctor B: You assert that there are no absolute, universal and unchangeable moral principles. What about justice, equality and human rights? Can we not agree that human lives are to be preserved, not killed?

Patient A: The discourse over "right to life" is but a battle ground for still-larger principles of universality and durability of human rights. On a larger intellectual compass, when it comes to human rights, my position is the same. Human rights are not absolute. Human right activists and democracy champions talk about the importance of human rights, freedom and democracy as universal and fundamental moral principles. I agree that these are important ideals deserving attention. However, human rights should not remain our exclusive, or even dominant, concern. In our debate over human values, we also need to think about cultural exchange, and not simply imposition of our values on other autonomous individuals or sovereign nations. While I personally believe that human rights are very important, there is a compelling case to be made against the imposition of ones' values, conceptions of human rights included, on other individuals and nations. Let me explain.

My assumption is that there are many values worthy of human pursuit; e.g., freedom from starvation, personal integrity, filial piety, social responsibilities and loyalty to one's country. In this regard I have four observations to make. First, it is obviously true that not all values are created equal. For example, material goods pale alongside moral and spiritual ones. Second, it is also clear that no single value, moral principles included, is so fundamental as to absolutely overshadow others at all times, in all places, and in all situations. Even the taking of innocent human lives can at times be justified in the name of stopping a greater evil. Third, judging values in context goes well beyond merely determining which moral principles should apply in a given decision making frame. Many values are involved. Most of them are in conflict and priorities must be set. The challenge is, given a set of ranked values,

\[\text{156 "Not so (respect for life as universal). In the classical Chinese tradition in which I was brought up, we are taught respect for parents, respect for teachers, respect for ancestors and for duly constituted authority, but the conception of respect due to the individual human beings as such does not exist in that culture." Basil Mitchell, The Value of Human Life, in Peter Byrne, Medicine, Medical Ethics and the Value of Life 34-47 (1990).}\]
national priorities and limited resources, prioritizing. Fourth, the rankings of values in the abstract are so loaded with conditions and disclaimers as to be of little use when applied to real-life situations. Indeed, they might create problems even in a theoretical multi-value matrix decision making set. Should I kill one to save the lives of many or possibly to improve the welfare of all? If not, then what right do we have, as a civilized government, to build a highway which, after all, kills? Are the traffic fatalities not victims of a government’s conscious policy choice, to develop highways instead of airports? Do we not call them casualties of human progress?

I am not arguing here for value relativity. Nor am I promoting situational ethics. I am advocating value pluralism. By value pluralism, I simply mean that there are many more human values which give meaning to life and happiness to people than the principles of justice, freedom, equality, and democracy. Put it in another way, a country can hold other enduring values—love for family, loyalty to friends, duty to society—and still deserve our admiration and respect. A benevolent dictator is better to many than starvation and chaos. If you doubt this, talk to the ones who are suffering, not some observers 6,000 miles away. In a national emergency, individual and human rights give way to law and order concerns.

Human rights advocates argue that human rights are so fundamental that all other values pale in comparison. While this argument has surface appeal and is emotionally satisfying, a moment of critical reflection shows that this does not conform to our understanding of how human values are formed, adopted, and evolved. First, human rights

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157 However, in Buddhist thought the principle of respect for life must be understood within the context of other aspects of Buddhism teaching as well as other precepts. Different traditions within Buddhism balance the concern for respect for life with concern with doing the “most compassionate action.” Kevin WM. Wildes, S.A., Sanctity of Life: A Study in Ambiguity and Confusion, in JAPANESE AND WESTERN BIOETHICS 89-101 (Kazumasa Hoshino ed., 1997).

158 Tom L. Beauchamp, Comparative Studies: Japan and America, in JAPANESE AND WESTERN BIOETHICS 25-47 (Kazumasa Hoshino ed., 1997). I came to my observation here—similar values but differentially ranked (individually and in conjunction with others) and variously applied (taking up contextual importance)—quite independent of Beauchamp’s work. But Beauchamp’s work—narrow morality (universal principles) and broad morality (differential application)—share one thing in common with mine, i.e. “the principles upon which men reason in morals are always the same; though the conclusions which they draw are different.” Id. at 27. For a discussion of moral objectivism and indeterminacy, see Russ Shafer-Landau, Ethical Disagreement, Ethical Objectivism and Moral Indeterminacy, 54 PHIL. & PHENOMENOLOGICAL RES. 331-44 (1994) (available at http://www.ku.edu/-philos/faculty/Shafer-Landau/DISAGREE.html).
advocates deem it "self-evident" that human rights—life, liberty and the pursuit of happiness\textsuperscript{159}—are fundamental in nature, universal in application, and apparent to all. All human beings should and must subscribe to the same set of human rights values—in content, importance, and, when compared with other values, priority. There are no exceptions or deviations. Nothing could be further from the truth. Human values, as with beauty, are in the eyes of the beholder. Likewise, there are many ways to discover human values; as many as there are individuals on this earth.

On a theoretical plane, Kant’s categorical imperatives\textsuperscript{160} or Bentham’s utilitarianism\textsuperscript{161} are good starting points in order for one to discover individual or social values, but these are not final. Ontological and teleological validation of value choices are not exhaustive.

In more practical terms, rational analysis and positive thinking are not the only, nor even the best, tools to determine the contour and correctness of human values. Indeed, I venture to guess rational analysis is ill-suited to the investigation of value matters which are, after all, more instinctual than cognitive, and more emotive than logical. We love humanity with our heart, and appreciate life with our soul, not with a computer and a brain. In the end, spiritual enlightenment, per-

\textsuperscript{159} The Declaration of Independence para.1 (U.S. 1776).

\textsuperscript{160} Immanuel Kant, \textit{GROUNDWORK OF THE METAPHYSIC OF MORALS} (J.K. Patton trans., Harper Perennial 1965) ("Act only according to that maxim by which you can at the same time will that it would become a universal law."). Kant made this observation when applying his categorical imperative to suicide:

\begin{quote}
If a man is reduced to despair by a series of misfortunes and feels wearied of life, but is still so far in possession of his reason that he can ask himself whether it would not be contrary to his duty to himself to take his own life, he should ask himself a question. He should inquire whether the maxim of his action could become a universal law of nature. His maxim is: From self-love I adopt it as a principle to shorten my life when its longer duration is likely to bring more evil than satisfaction. It is asked then simply whether this principle founded on self-love can become a universal law of nature. Now we see at once that a system of nature of which it should be a law to destroy life by means of the very feeling whose special nature it is to impel to the improvement of life would contradict itself, and therefore could not exist as a system of nature; hence the maxim cannot possibly exist as a universal law of nature, and consequently would be wholly inconsistent with the supreme principle of all duty.
\end{quote}

\textit{Id.}

\textsuperscript{161} "By the principle of utility is meant that principle which approves or disapproves of every action whatsoever, according to the tendency which it appears to have to augment or diminish the happiness of the party whose interest is in question: or, what is the same thing in other words, to promote or to oppose that happiness." \textsc{Jeremy Bentham}, \textit{An Introduction to the Principles of Morals and Legislation} 14 (Batoche Books, 2000)(1781).
sonal feelings, human experience, and collective wisdom can all play a part in one's endless value search.

Second, human rights belong to each and every individual, and are not monopolized by one ideological camp. Most certainly, values, of which human rights are an integral part, are not beholden to the intellectually bright, militarily strong, economically wealthy, or culturally rich. As nations, as communities, as families, and as individuals, we all subscribe to a set of values. Each of us is equally capable of finding a set of values suited to our taste. All of us are equally endowed as moral agents. It is apparent that no one country—no matter how big, how strong, how rich, and how enlightened—can monopolize the creation of desirable values, much less be the net exporter of virtues.\(^{162}\)

Third, national values, as with one’s moral compass, do not come prepackaged. They are a combined and integrated product of personal make-up, cultural heritage, social consensus, economic circumstances, and even accidental events. In sum, values are a sum total of human existence; wants, needs, phobia, remembrance, dreams, and hopes. Once formed, they are a given fact of nationhood and are seldom right or wrong in the abstract or in total.

Fourth, values are formed experientially, experimentally, naturally, and incrementally, more so than cognitively, absolutely, positively and dramatically. Historical accidents and national happenstance have as much to do with a country’s value formation as do rational discourse and reflective policy. Much of the values Americans take for granted are rooted in the manner by which the United States found liberation, independence, and an individuality as a result of rebellion against British rule. Conversely, the Chinese people have sought refuge in paternalism and collectivity because of their historical embracing of the teachings of Confucius.

Given this “dynamic” and “dialectical” process of human value formation, it should come as no surprise to anyone to learn that human values never stop growing and evolving, changing in content and mix every minute and hour of the day. “We get wiser as we grow older” is as much a descriptive statement as it is an admonition to the young who

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are eager to live all that life has to offer in one day. Viewed in this light, the search for human values is not a discovery process but a creative journey. An individual, a people, a community, a nation-state; all are searching for an illusive and transient identity; but never arrive at an ultimate destiny. It is the process of searching for, and not the ultimate finding of, human values, which gives meaning to life.

Lastly and most significantly, values are bound by time and space, and posited within certain places, and societies. Two very important observations flow from this postulate. First, values exist within a context of history, place, people, society, and culture. There is no ahistorical, asocial or acultural value. To appreciate why Chinese rulers, and, for that matter, many Asian leaders, adopt a paternalistic attitude towards their subjects, it is necessary to consider the importance and structure of the family within Chinese history and culture. A critique of the Chinese style of government is not just an attack on Chinese current leaders but also an indictment against China’s cultural heritage in general, and the role and functions of family in particular. With so much at stake, and such complexities involved, a country passing judgment on others should be more reflective, thoughtful and considerate. It is easy to be misinformed and misjudge.

Second, values are bundled goods. The meaning and importance of a value cannot be easily extracted from the collective of values of which it forms an integral part. The surgical removal and strategic implantation of values will certainly cause political disruption, such as the wholesale abandonment of communism in U.S.S.R., which led to social unrest and political chaos, and social rejection, such as the ban on U.S.-style adversarial journalism in Singapore.

It is most difficult, if not impossible, for a person or country to transcend its intellectual horizon and value space. Cultural myopia is the norm. China calls herself “Central Kingdom” and still acts that way. Intellectual provincialism is the rule. All rationality is bounded.

Marx’s critique of the capitalistic intellectual order, that the consciousness of the mass is conditioned, controlled and dominated by

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163 Stephen E. Hanson, Reform and Revolution in the Late Soviet Context, 63 SLAVIC REVIEW 527 (2004).
ideas emulating from the economic base, is flawed, less so because it is an overbroad observation than because it is not carried far enough. Marx failed to explain convincingly why he could liberate himself from such an all-embracing ideological confine to lead the charge against capital­ism, while others could not. Rawls' Theory of Justice suffered from a similar cultural straight jacket: the just society behind "the veil of ignorance" envisioned by Rawls looked more like twentieth century Boston than traditional Indonesia or contemporary Japan.

Is it surprising to see first the Romans, then the British and now the Americans preaching the virtues of their culture to the rest of the world; through persuasion if possible (BBC, VOA, CNN) and by force (extra-territoriality, Vietnam) if necessary? Echoing Huntington, does it not appear odd that it takes the British a few hundred years to discover the essence of civilization while the Egyptians are still at a loss after 6000 years? Is it possible that the Americans find the best in government in 200 years while the Chinese keep missing them after 4,000 years?

The discovery of universal values has more to do with individual ego and national pride than any intrinsic merit associated with those values. The successful spread of values, from democracy to gay rights, reflects more upon a country’s economic strength and concomitant cultural domination, than on any inherent appeal and demonstrated goodness of certain moral principles.

Is it surprising that almost all participants of international conferences speak English, most with a U.S. accent, and wear ties and jackets? Cultural domination, albeit in subtle form, is here to stay. Singapore’s senior statesman was right when he said that Asian values are as worthy of respect—because those values tell Asians who they are.

I speak at length at my life’s end because I am obliged to come to terms with my own values. As an open-mined person, I believe in the utilities of open dialogue and the necessity of challenging established dogma, no matter how “self-evident” or entrenched. Contrary to con-

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166 JOHN RAWLS, A THEORY OF JUSTICE (1971).


temporary wisdom, the demise of communism did not mean the end of all ideological debates. Ideas are born every day by the minute. Hegel’s dialectic is alive, well, and very clearly evident. As a cross-cultured person by birth, education, marriage and work (Hong Kong, Japan, British, China, and America) I see the follies of ethnocentrism first hand. The beast of cultural imperialism is ugly, hungry and disingenuous. It looks most innocuous but is constantly feasting on our national pride and preying on our emotion. It starts with a simple but powerful premise: if it is right for me, why is it not right for others? Worse yet, if others do not believe as I do, they can be forced to.

The most effective countermeasure to this myopia is detached reflection: an open mind, a critical attitude, an introspective self, and sensitivity to, and accommodation of, others’ values. In the end, open debate, continued dialogue and forceful persuasion is more effective in changing minds than threats and coercion. Who has heard of killing a worthy idea?!

F. The Problem with the AMA Code of Ethics

Doctor B: I see I cannot change your mind. But you should still respect my belief that life is intrinsically valuable and that our profession’s credo is committed to the sanctity of life. After all, I have taken a solemn Hippocratic Oath to save life, not take it away.

Patient A: First, let me remind you that the AMA’s stance on PAS is softening. They have all but endorsed passive euthanasia. AMA President Thomas R. Reardon, MD, clearly articulated the position of the AMA as:

The American Medical Association voted today to continue to support the Pain Relief Promotion Act which would prevent the use of controlled substances in physician-assisted suicide while allowing phy-

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170 The Hippocratic school of medicine were strongly influenced by Pythagoras. The original Greek version of the Oath (as quoted by the Quill petitioners) required the followers of Hippocrates: “to teach them this art—if they desire to learn it—without fee and covenant; . . . [to] apply dietetic measures for the benefit of the sick according to my ability and judgment; . . . not [to] give to a woman an abortive remedy . . . not [to] use the knife.” See Brief of Bioethicists as Amici Curiae, Vacco v. Quill, 521 U.S. 793 (1997), Washington v. Glucksberg, 521 U.S. 702 (1997).

sicians to aggressively treat pain. The AMA also voted to work with state and national specialty societies to improve parts of the bill (H.R. 2260), which was passed by the House of Representatives in October of this year. . . . The AMA opposes physician-assisted suicide, as it is antithetical to the role of the physician as healer. We are committed to providing the best possible end-of-life care. The Pain Relief Promotion Act supports both these goals.¹⁷²

Second, as I pointed out elsewhere, a sizable minority of doctors do not subscribe to such views.¹⁷³ Lastly, I believe that others cannot dictate conscience.

Doctor B: While I respect the position taken by the AMA, I do not think the AMA speaks for us all. As you observed, group ethical norms do not replace personal judgment.¹⁷⁴ However, since the AMA is our official association and I joined voluntarily, I have a moral obligation to defer to their judgment as a member in good standing and out of respect for their collective wisdom, unless the AMA asks me to do something illegal or immoral. Moreover, the fact that some of my colleagues disagree with the AMA does not reflect upon the moral propriety of euthanasia. This is not a popularity contest. Finally, as you observe, in the ultimate analysis, moral judgment is individual and personal, not collective and social. I have a right to my belief.

G. Active vs. Passive Euthanasia

Patient A: I detect certain insincerity and doublespeak in what you have to say about the sanctity of life. My similarly situated roommate was allowed to die “naturally” some two weeks ago by refusing further medi-

¹⁷² Id.
¹⁷³ Marcia Angell, The Supreme Court and Physician-Assisted Suicide—The Ultimate Right, 336(1) NEW ENG. J. MED. 50-53 (1997) (Angell argues in favor of permitting PAS under certain circumstances, because an absolute ban is “too doctor-centered and not sufficiently patient-centered,” i.e. it fails to respect patient autonomy.). For a view in-line with the AMA position, see Kathleen M. Foley, Competent Care for the Dying Instead of Physician-Assisted Suicide, 336(1) NEW ENG. J. MED. 54-58 (1997) (The author suggests that the debate over PAS provides a “unique opportunity to engage the public, health care professionals, and the government in a national discussion of how American medicine and society should address the needs of dying patients and their families. . . . [i]f legalized, physician-assisted suicide will be a substitute for rational therapeutic, psychological, and social interventions that might otherwise enhance the quality of life for patients who are dying.”).
¹⁷⁴ Here, the doctor seems to have changed his position, which is quite common in the heat of an argument. People often argue in the alternative.
He was suffering from all kinds of complications and pain. Must I endure the same before dying? Morally, isn’t allowing the perpetuation of human suffering an abdication of your responsibility and conscience? Legally, to stop or withdraw treatment with the intention of relieving the patient’s suffering through death is no different than administering a fatal injection, since both actions ultimately achieve the same result—the patient’s death.

Doctor B: But there is a world of difference between active euthanasia and passive euthanasia. I cannot control your committing suicide. This is a fact of life. You certainly have a right to decline medical treatment on both constitutional and common law grounds. This is out of respect for the law. In such cases, I can hardly be held accountable for your own decision to kill yourself, nor should I be held responsible for diseases that take their natural course. I cannot, however, be held reprehensible for not helping you to hasten your own natural death. This would amount to the intentional killing of a person, and would amount to murder.

175 See Admiraal, Euthanasia in the Netherlands—Justifiable Euthanasia, 3 ISSUES L. & MED. 361 (1988). Passive euthanasia is defined as “the discontinuance of life sustaining means or treatment as a result of which the patient dies after a shorter or longer period.” Id. at 368-69. This includes stopping life sustaining medication, e.g., antibiotics or antiarrythmia or procedure, e.g., block transfusion.

176 The theme of “dignified exit” was discussed in the best seller by Hemlock Society, Final Exit. FINAL EXIT, supra note 129.

177 There is clear need to draw a distinction between killing and allowing to die. Lawrence O. Gostin, Drawing a Line Between Killing and Letting Die: The Law, and Law Reform, on Medically Assisted Dying, 21 J.L. MED. & ETHICS 94 (1993).


179 For a theoretical and philosophical argument that killing and letting die are morally equivalent, or Thesis E, see F. M. Kamm, supra note 15. For a review of legal literature and argument, see Thomas J. Marzen et al., Suicide: A Constitutional Right?, 24 DUQUESNE LAW REVIEW 1 (1985); see also Suicide: A Constitutional Right?—Reflection Eleven Years Later, 25 DUQUESNE LAW REVIEW 261 (1996).

180 F. M. Kamm, Physician-Assisted Suicide, the Doctrine of Double Effect, and the Ground of Value, 109 ETHICS 586, 590 (1999) (There is a difference between allowing someone to die intentionally and assisting others with such an intended cause of action.).

181 Ann Alpers & Bernard Lo, Does It Make Clinical Sense to Equate Terminally Ill Patients Who Require Life-Sustaining Interventions With Those Who Do Not?, 277 JAMA 1705-08 (1997) (The authors disagree with two U.S. Circuit Court decisions holding that, for determining legal liability in PAS cases, there is no difference between competent, terminally ill patients being kept alive on life support and competent, terminally ill patients who do not require such support.). For a contrary view, see cases when it is better to kill than let die. Helga Kuhse, Critical Notice:
Patient A: You cannot wash your hands of people dying when people need your help, particularly when you can easily help but refuse to do so. By refusing their call for help, you are prolonging their suffering and enticing them to do it themselves, which might be more painful or dangerous.

Doctor B: That is something I have long regretted happening to others. But I have no control over your own choice to end your life, even though, in the process, you will suffer the consequences, including pain associated with the process or mistake. However, the courts have consistently approved of aggressive pain management, even to the extent of killing the patient, provided that the intent is not to kill, but rather to treat.\(^{182}\) This is called the “double effect” doctrine. I hope this makes you feel better.

H. Compassion vs. Professionalism

Patient A: Are you not a human before you are a doctor? Do you not exercise your rationality as informed by your humanity, i.e., with compassion?\(^{183}\)

Doctor B: I am every bit human as you are. My role as a doctor and training as a professional, though, asks me to stand aloof from our human instincts, including blind compassion. Compassion to others, while a fine quality, can get me too emotionally involved with my client’s immediate circumstances and otherwise can make me too attached to the client’s life course and personal goals. These extra-medical considerations will color my objective judgment of what should be done in the best long-term interests of my client overall. In simpler terms, I have to stay “cool” when my patients are “hot.”

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\(^{182}\) Ann Alpers & Bernard Lo, *The Supreme Court Addresses Physician-Assisted Suicide*, 8 Archives of Family Medicine 200-05 (1999) (In June 1997, the US Supreme Court unanimously decided that competent, terminally ill patients have no general constitutional right to commit suicide or to obtain assistance in committing suicide. The Court made it clear that it is permissible for a physician to aggressively treat a patient for pain leading to death.);

\(^{183}\) Howard Brody, *Assisted Death—A Compassionate Response to a Medical Failure*, 327 New Eng. J. Med. 1384-88 (1992) (arguing that euthanasia should be viewed as a compassionate response to failure of medical service, rather than as something to be prohibited outright).
I. The Problem with Rationing Medical Resources

Patient A: You are engaging in doublespeak in another way. It is now common knowledge that doctors kill people by giving treatment to some and refusing it to others, out of the necessities of the situation or by choice through the prioritizing use of limited medical resources. In those instances, are you not actively causing the death of others in a very real sense of the word? You have a duty to help and save lives, and you could have helped if you wanted to, but, when you were asked to help, you declined to. As a result, people died. Should you not be held responsible? In those cases, and there are many of them happening everyday around the world, you are playing God, which is no different from what you are doing now.

Doctor B: What you said is very true. We often have far more demand for our services in emergency situations, as well as over-subscription of our limited medical resources in critical cases, than we can possibly supply. We are not able to treat everyone that does not deserve to die, but those decisions are forced upon us. It is a medical necessity. We try to rationalize and distribute the limited medical resources we have in an objective and equitable manner that is acceptable to the society and compatible with society’s collective interest.\textsuperscript{184}

Patient A: But what if I can demonstrate to you that I have a duty to kill myself?\textsuperscript{185}

Doctor B: There are other, more philosophical reasons that I should not help you. By helping you to die, I am sanctioning voluntary suicide and promoting involuntary ones in due course.\textsuperscript{186}

Patient A: I have little problem with legalizing suicide for whatever reasons. You should have more faith in the decisions of your fellow beings. I do not see people going out to buy drugs if they do not enjoy them, or if they do not think that the harmful effect is worth the price. If people have a natural instinct, inculcated desire, or learned habits of any-

\textsuperscript{184} Kilner, supra note 6.
\textsuperscript{185} John Hardwig et al., Is There a Duty to Die? (2000).
\textsuperscript{186} J.L. Bernat, The Problem of Physician-Assisted Suicide, 17 Semin. Neurol. 271-79 (1997) (While physicians must stop life-sustaining therapy when the therapy has been validly refused by patients, they have no similar duty to provide assistance in suicide. PAS raises three collateral issues: (1) legalization would have a negative effect on the practice of palliative care and adversely affects the quality of the physician-patient relationship; (2) legalization of voluntary euthanasia will follow the legalization of PAS; and (3) involuntary euthanasia inevitably follows the legalization of voluntary euthanasia, as has occurred in the Netherlands over the past twelve years.).
thing—drugs, sex, gambling—they will find a way to satisfy it. That is why drugs cannot be purged, nor gambling be outlawed.  

J. What Is a Rational Choice—Facts, Values, Opinions and Judgments?

Doctor B: I can see that you are getting irrational in your judgment.  

Patient A: In terms of decision-making process and justification, what do you mean by being rational? If you mean by irrational that all my choices do not conform to your expectation, either in terms of process or result, I cannot argue. However, if you mean by rational choice, a process of determination taking into account all material and relevant considerations of the decision maker, all considered judgment is rational in nature, notwithstanding disapproval by you, rejection by the learned, condemnation by the church, critique of philosophers, or their being deemed undesirable by society according to conventional standards customarily preferred, morally obtained or reasonably derived.

Doctor B: See the way you talk. It illustrates that you are very, very depressed.

Patient A: There is some truth to what you say. Most terminally ill persons have experienced some form of depression, if depression means that they are frustrated with their imposed station in life and feel helpless in the face of oppressive pain. Taking this into consideration, the person who insists on his “right to die” can hardly win. If he is lucid in his thinking and clear in his articulation, he is not a candidate for death treatment. We have to make every effort to change his mind, to talk

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187 A good reason why private morality (prostitution and homosexuality) should not be criminalized is because enforcement of moral values implicates privacy concerns. What one does in the privacy of one’s own home can hardly be policed without unduly interfering with one’s constitutionally guaranteed privacy. See Laurence H. Tribe, American Constitutional Law 934-37 (1978).

188 “Moreover, terminally ill patients who do desire suicide or euthanasia often suffer from a treatable mental disorder, most commonly depression. When these patients receive appropriate treatment for depression, they usually abandon the wish to commit suicide.” Task Force on Life and the Law (1984).

189 “Depressed patients less likely to follow doctors’ recommended course of treatment.” (Patients who are depressed are three times more likely to disregard their doctors’ instructions for recommended medical treatment than nondepressed patients. That was the finding of a comprehensive review of twenty-five studies of patients with cancer and other serious conditions.). DiMatteo Et Al., Depression is a Risk Factor for Noncompliance with Medical Treatment, 160 Archives Internal Med. 2101 (2000). For a discussion on cause and cure of depression, see Jennifer Barraclough, ABC of Palliative Care: Depression, Anxiety, and Confusion, 315 BMJ, 1365-68 (1977).
him out of it. If he is slightly depressed, a chronic condition of the terminally ill, he cannot be trusted to make such a critical decision. We have to make every effort to consider his best interests in making up his mind for him, but, before we do that, we have to declare that he is unfit permanently or unfit for the purpose. As a practical matter and a matter of strategy, experience informs that it is all too easy to call someone’s argument or thinking process irrational to underscore the correctness of your own position and otherwise gain support from others listening in. Forensically, it is certainly a common practice to dismiss your opponent’s argument as lacking in rationality loosely defined in order to bring closure to a debate with few agreements in sight.

Doctor B: You are incoherent and clearly out of your mind. I agree with you that life itself may not be the only consideration, but the desire to live is paramount. It is a well-documented fact. Ask any anthropologist, sociologist, psychologist, philosopher, or historian, and he will not disagree. Thus, I am not alone in what I have opined. Should you not defer your judgment to those who are gifted, learned, experienced, or wise?

Patient A: If your suggestion is that I should consult the gifted, learned, experienced, and wise on matters in which I feel lacking in understanding, I wholeheartedly concur. I certainly need to be informed of more alternatives and gain different perspectives on the issue. However, if you want me to defer to their opinion because these people are the depository of truth and wisdom, I cannot agree. A matter as evanescent as state of mind, and as personal as a will to live, can hardly be called fact.

190 “Spinoza said quite simply that ‘all persons who kill themselves are impotent in mind.’ And Aristotle, in his Ethics, described suicide as a failure in courage. ‘To run away from trouble is a form of cowardice and, while it is true that the suicide bravés death, he does it not for some noble object but to escape some ill.’” Daniel C. Maguire, Death, Legal and Illegal, ATLANTIC MONTHLY, February 1974.

191 Two questions are raised here: (1) Can the decision of life and death be deferred or trusted to others who are experts on life and death matters, such as a doctor? This is a question of competency. (2) Should the decision of life and death be deferred or trusted to others, in whole or in part, to family members who have to pick up after the death of a relative? This is a question of entitlement. The doctor, with medical expertise, is considered a morally competent person to intervene, if not even control, a person’s decision to kill themselves. The doctor is also given the right to interfere to save someone’s life. The victims, while not medically competent, are morally competent to define what is right or wrong; more significantly, what life is. But he is not considered a moral expert to his own situation. Nor is he until given the right to manage his own life, up to and including death. MORENO, supra note 56, at 5. (“Socrates famously derided the notion that those who are expert in one field must also be expert in another, let alone wise in a philosophical and moral sense.”).
A fact is absolute, but the will to live or die is not. More significantly, a factual statement is a descriptive statement, but whether a person should kill himself is a value judgment, a normative admonition. The fallacy of your argument is to generalize from what others are doing, a descriptive statement, to what I should do, a normative command. If I take your suggestion and follow the opinions of the crowd instinctively and not my conscience reflectively, I am afraid that I have not made a decision on the merits of the issue, other than, of course, a decision to follow others' decisions.¹⁹²

Doctor B: Even if I agree with you that life is not absolute, in this instance, your decision to kill yourself is not well-grounded. Yes, I have tried to put myself in your position. I have even gone to the extent to quantifying the decision. I have thus assigned values to each factors of pain (-5/day), days required for recovery (90), value of life during recovery (+2/day), chances of recovery given medical treatment (50/50), chances of medical breakthrough (50/50), time required for breakthrough (50/50), degree of recovery (75%), value of life after recovery (+10), life expectancy (5 yrs before relapses), chances of relapse within the first 5 years (60/40), chances of relapse after 5 years (80%), and chances of cure for relapse (uncertain to not good) to come up with a scientific decision. You see, I try to think like a rational person would think. I assume, or at least I hope, that you will think in this fashion. How can you not come to the same conclusion as do I?

Patient A: It matters not that you or others do not agree with me. We are different people and no two persons are born alike, and our visible and apparent similarities in race, culture, and/or nationality should not

¹⁹² This deals with competency in decision-making concerning another person's life and death. Doctors are trained in medicine and licensed to practice the art of saving (some say killing, too). They are not trained or approved moral agents. This is unlike other institutional figures, e.g., teachers and police, who are normative standard-bearers for society. They have an obligation to set an example for another and, if need be, to promote established value and morality to the people. For a discussion, see Margaret P. Battin, Going Early, Going Late: The Rationality of Decisions About Suicide in AIDS, 19 J. MED. & PHIL. 571-94 (1994) (PAS involves four kinds of questions: (1) “Is suicide an option I want to consider?” (2) “Shall I hold out for the chance of a cure?” (3) “How shall I time my suicide?” (4) “What weight shall I give to the welfare and interests of others?” The physicians are asked to make decision on type (1) questions when in fact they should be consulted on type (3) question. On the other hand, the patient, relatives and friends are only involved in type (3) question when in fact they should engage in type (1) question.).
hide the real distance between us.¹⁹³ You were born in the United States. You had a good family, went to Yale, and are now an eminent doctor. You are also young and live in Boston, the bedrock of Eastern liberalism. I was born in Russia into a divorced family. My father was a common thief. My mother was a sales clerk. I am illiterate. We were poor, but my mother taught me to take care of the young. She has no future other than the future of the family. I came to this country when I was very young and lived through the Depression. I have worked hard and saved what I could. You see, we possess quite different personalities, and we developed under entirely different circumstances. I am not at all surprised that our mental dispositions and value preferences are so far apart.

In the end, we differ not because either one of us is irrational but because of three facts. First, our value system is quite different. As a doctor, you are sworn to preserve life; as a downtrodden patient, life is but an expendable commodity to me. You want to save life because it is intrinsically good. I want to die because life no longer holds any intrinsic value. Second, our assessments of the costs and benefits are quite different. As a doctor, every life you save provides satisfaction to your ego and professional calling, not to mention material rewards. As for me, I do not hold life to be as important. I am old. I have lived my life and experienced the opportunities along with it. Life means less to me with each passing moment. Life quickly loses its inherent attributes when one has to be force-fed or treated with various drugs that affect not only one’s body but also one’s mind. I will not live another day to prolong my existence just to gratify my desire to live. I guess the economists would describe it as the diminishing marginal return on life.¹⁹⁴ Third, our methods of calculation are quite different. As a scientist you believe in quantification; being a common person, I believe in intuition. Life and many of its associated processes cannot be easily and meaning-

¹⁹³ Blacks are less supportive of PAS. R.L. Lichtenstein et al., Black/White Differences in Attitudes Toward Physician-Assisted Suicide, 89 J. Nat’l Med. Assoc. 125-33 (1997) (In 1994, the Michigan legislature considered whether to continue a law banning PAS. 500 people in Detroit were surveyed. Majorities of both whites and blacks supported PAS, with more whites supporting PAS than blacks.). Older people are less supportive of PAS. J. Hare et al., Why Older Age Predicts Lower Acceptance of Physician-Assisted Suicide, 99 Wis. Med. J. 20-27, 46 (2000) (Overall, 57% of a sample of 1311 (rural community and an internal medicine clinic in western Wisconsin) were in support of legalization of PAS with 31% opposed. Older subjects were less supportive due to religious reasons.).

fully quantified, if at all. Mathematical formulas do not, and cannot, be made to capture the nuances of life, such as the smile of a newborn to a parent. You are a good example. So-called scientific tools cannot help us in making critical decisions at the end of the day. Good doctor, in order to help you to understand my predicament better, please answer the following questions for me:

1. What is the meaning of life to you? To me?
2. What is the value of a full life to you? To me?
3. What is the value of a life confined to a hospital bed and restricted by medical instrumentality to you? To me?
4. What is the value of a life recovered, only to be laboring under the apprehension of death and burdened by life support medications, to you? To me?
5. What is the value of my family’s lineal continuity, financial security, and educational achievement to you? To me?
6. How much do we have in common as Homo sapiens and how much do we differ as free thinking individuals?
7. Does your superior intellect allow you to identify with my dilemma emotionally?
8. Do all of your experiences with people allow you to empathize with my feelings?
9. Do the shared experiences we have as persons of the same race, culture, and nationality allow you to understand my value system and cost-benefit evaluation?

As a foundational matter, the assumption is that the whole is equal to the sum total of all its parts. See generally, MODE OF INDIVIDUALISM AND COLLECTIVISM (John O’Neill ed., 1973); see also Bender, supra note 122. “Dualistic thinking lead to either/or, self/other analysis instead of plural, multiple, variant, and contextualized analysis.” Id. at 530.

Differences in value are formed by broader and deeper considerations, e.g., national history and cultural makeup of a people. See N. Yasemin Oguz, Euthanasia In Turkey: Cultural and Religious Perspectives, 6 EUBIOS J. OF ASIAN AND INT’L BIOETHICS 170, 171 (1996) (available at http://www.csu.edu.au/learning/eubios/EJ66/EJ66P.html) (Allah controls life and death. Patients defer to him in all life vs. death decision). See Z. Guo, Chinese Confucian Culture and the Medical Ethical Tradition., 21(4) J. MED ETHICS 239 (1995) (available at http://ccbs.ntu.edu.tw/FULLTEXT/JR-MDL/guo.htm) (Historically, Chinese medical workers were, above all, moral agents. Traditional Chinese medical practices were informed by seven moral and professional principles: (1) medical workers were to supposed to value life above material goods, (2) they should care for the people wholeheartedly, (3) they should work diligently in improving their medical skills, (4) they should act with decorum, decency and politeness (e.g., they should stay away from treating female patients alone), (5) they should be respectful of local norms and customs, (6) they should treat every one who seeks help equally, and (7) they should respect other people’s achievements and abide by academic ethics.).
10. Who is more motivated to look for and consider all pertinent factors with respect to this decision, the person involved or the outside adviser?

11. Who is in the best position to know all the circumstances and choices available when making choices, the person involved or an outside adviser?

12. Can you really understand where I am coming from, or do you just think you know?

Doctor B: Have you ever considered the likely failure and related complications resulting from a botched PAS?

Patient A: I must say I have not. Please enlighten me. I suspect this is not going to influence my decision. I will tell you why. I cannot see how failure in euthanasia will make my condition any worse. I further take for granted that, if I decided to die in the doctor's hands, it is going to be a matter of time. I accept the risk of PAS failure.¹⁹⁷

Doctor B: My hands are tied. It is not that I do not want to help. It is because I cannot, for some very practical reasons and prudential considerations, such as malpractice insurance. First, as a doctor, I am ultimately responsible for the life and death of a patient under my charge. I could actually face murder charges, in addition to the loss of my license to practice as a doctor if my decision to "save life" is misconstrued in a less than favorable light. In such cases, I will be exposed to criminal liability.¹⁹⁸ Whether such an allegation has any merit, I would nonetheless have to assume the physical, emotional, and financial burden of having to defend myself.¹⁹⁹ If I should make a wrong decision in sup-

¹⁹⁷ Johanna H. Groenewoud et al., *Clinical Problems with the Performance of Euthanasia and Physician-Assisted Suicide in the Netherlands*, 342 NEW ENG. J. MED. 551-56 (2000). The authors assess the nature and extent of clinical problems (defined as "technical problems, such as difficulty inserting an intravenous line; complications, such as myoclonus or vomiting; or problems with completion, such as a longer-than-expected interval between the administration of medications and death") associated with PAS and find that complications come to 7% of assisted suicide cases. 16% experienced problems with smooth completion of medical procedure, e.g., a longer-than-expected time to death, failure to induce coma, or induction of coma followed by wakening of the patient.


¹⁹⁹ M. Feeley, *The Process Is the Punishment* (1979). (Being arrested is itself a punishment solely at the discretion of the police with no check and balance in the case of non-prosecution.). Law has also been used as a disciplinary, not punitive force.
porting your death wish, I have to live with the consequences, including administrative discipline, criminal punishment, and civil liability. Additionally, the survivors of a patient may ultimately be able to pursue civil monetary damages even where the patient was killed at its own request.\textsuperscript{200} Horrendous medical bills could be incurred, and damages for unnecessary pain and suffering could result as well.\textsuperscript{201} Alternatively, if I choose not to act, I will, at worst, be called unsympathetic.\textsuperscript{202}

K. The Problems with Paternalism

Doctor B: You implied by your questions that I am not competent, emotionally or intellectually, to make such a critical choice of life and death for you. I cannot agree. As a trained professional, I am totally objective in my judgment. As a fellow human being, I am very motivated to help a fallen comrade. By social morality, I am obligated by my professional creed to give you the best judgment I can muster. All I seek is your best interest. Are you not convinced that such compassion and professionalism will assure the making of an impartial and objective judgment based on the circumstances in which you find yourself?

\textsuperscript{200} For exposure to administrative responsibility, see Oregon's Third Annual Assisted-Suicide Report: More of the Same, IAETF UPDATE, Vol. 15, No. 1. (available at http://www.internationaltaskforce.org/iua23.htm) (Doctors found not to report questionable PAS cases in order to avoid liabilities.). For exposure to criminal liability, see Dutch Doctor Found Guilty of Murder Not Penalized, IAETF UPDATE, Vol. 15, No. 1 (available at http://www.internationaltaskforce.org/iua23.htm)(A Dutch doctor, Wilfred van Oijen, was found guilty of murdering an eighty-four-year-old patient. The woman, a patient of the accused for seventeen years, suffered from cardiac and osteoporosis problems. She had been bedridden for several months and suffered from serious neglect. The woman's daughters asked van Oijen to perform PAS. The doctor did not consult the patient and injected her with the drug alloferine, which stopped her breathing. He claimed that he was just providing the patient palliative care. A Dutch court ruled that van Oijen intentionally killed the victim but acted honorably and according to his conscience.). For an examination of liabilities under foreign (Jewish) law, see Steven H. Resnicoff, Physician-Assisted Suicide Under Jewish Law, (1998), http://www.jlaw.com/Articles/phys-suicide.html. Ron Panzer, Questionable Death, Assisted Suicide, Mercy Killing & Involuntary Euthanasia, (Jan. 2002), http://www.hospicepatients.org/questionable-death.html.


\textsuperscript{202} Wrongful Prolongation of Life Suit Dismissed In Indiana, FLEMING AND CURTIS NEWSLETTER, Vol. 7, No. 44 (May 1, 2000)(Doctor refused to carry out PAS on account of living relatives, but against living will). The Estate of Rebecca Jane Taylor v. Muncie Medical Investors, 727 N.E.2d 466 (Ind. Ct. App. 2000).
Patient A: I rejected your overture to help me in reaching an appropriate decision, primarily on two inter-related grounds.

First, your intent to help, from all I gathered, is a noble and chivalrous one. Indeed, it is a desirable character to imbue in our citizenry. There is no faster way to destroy a society than the exhibition of deliberate apathy by its members in the face of a crisis or felt needs of others and society. However, such a noble instinct is not without its corrupting tendencies and destructive impact. The impetus to help, arising as it must from a sense of superiority and well-being, will easily lead to an arrogance of power (intellectual, spiritual, physical, emotional, or economical) in the helper. Dependency creates subordination in the helped and breeds contempt in the helper.\textsuperscript{203} This will be manifested in a relationship denominated not as much by the actual needs of the one that wants help but by the needs of the one who is to help. This tendency seems to grow directly in proportion with the intensity of the willingness to help and is inversely correlated to the helplessness exhibited by the person needing help. In the end, the one being helped may be no better off; he may not get what he wants, but, rather, only what others think he wants. He may even end up worse off than before, and may get more than he bargained for such as the loss of self-respect for his own autonomy and freedom. Such has always been the pitfall of paternalistic relationships. I hope that our relationship with each other would not deteriorate to the point that we become enemies.

Secondly, may I suggest to you that your manifestation of selflessness must be qualified by the observation that your motivation to help is not altogether selfless.\textsuperscript{204} There is a certain kind of hypocrisy (and I am not suggesting for a moment that a healthy dosage of hypocrisy, such as protocols in diplomatic life, is not functional in the smooth functioning of our society) in this chivalrous gesture of yours. No one is totally,  

\textsuperscript{203} Emerson is the first to observe that power is a function of dependency in an exchange relationship. This has come to be known as “power dependency theory”. Richard M. Emerson, \textit{Power Dependence Relations}, 27 \textit{AMER. SOC. REV.} 31 (1962). (“Power Dependency Theory” postulates that the power of Actor A over Actor B is a function of B’s dependence on A for scarce outcomes. Dependence varies in two dimensions: significance of values sought and availability of alternatives.). \textit{See also} Samuel B. Bacharach & Edward J. Lawler, \textit{Power and Politics in Organizations} (Jossey-Bass eds., 1980).

\textsuperscript{204} Martin Gunderson & David J. Mayo, \textit{Altruism and Physician Assisted Death}, 18 \textit{J. MED. & PHIL.} 281-95 (1993) (There are three justifications for PAS: respect for individual autonomy, the avoidance of suffering, and the possibility of death with dignity. The rationale for PAS law is justice for the state and self-interest for the patients. If that should be the case, PAS law equally applies to non-terminal patients.).
selfless; even the Nobel Laureate, Mother Teresa, served God while serving mankind. I am not trying to be cynical. This point must be made to put the issue in perspective—by venturing out to help others, we are often motivated by a need to gratify ourselves. However the instinct is derived—via cultural customs, religion, morality, or otherwise—and whatever its substance and intensity may be is not important. The fact remains that it exists and must be explicitly reckoned with, and actively reconciled, when it comes into conflict with other more or similarly worthy principles. If we do not squarely confront the issue, we will be deluding ourselves into thinking that the interests of the helper and the helped are one and the same. No assumption could be more wrong or more dangerous. A servant cannot be trusted to serve two masters. This is not an indictment against the integrity of the servant as much as it is a realistic assessment of such relationships. The annals of trust law are laden with cautions against such divided allegiance. Our experience with others point unmistakably to that conclusion.

This perception of our relationship materially affects my assessment of the situation. I could no longer take your words for granted as necessary good for my own interest, in spite of your expressed sincerity and demonstrated benevolence. You may have desired it to be that way, but in reality your judgment is colored by your intended or unintended, conscious or unconscious self-interest.

Incidentally, you suggested that your professional training and discipline allow you to make impartial and objective judgments. This is at best only partially true, with respect to explicit personal conflicts of interests, and at worst, it is wholly false in regards to structural/inherent conflicts of interests. That your professional training and ethical code inveigh against explicit gratification of self-interest, I do not doubt. However, this still does not alleviate my articulated concern that is of a much subtle, amorphous, and nuanced kind. More significantly, the use of professional values to guard against such paternalistic practices fails at its essential purpose. It only serves to substitute one form of imposition by another.

Collaterally professional criteria, when applied to decision-making, suggests standardization of process and uniformity of results. This is a necessary consequence of the accumulation of learning and experience, and an inevitable development of the professionalization process. This is totally at odds with matters of personal choice and individual decision-making in life and death situations and by extension to other moral
choices of a private nature. The objectivity you sought in professionalism may be gained at the expense of the needed sensitivity and insight into the hearts and minds of the patients involved. Thus stated, the objective test you proposed may alienate more than help in getting to what the patient really desires or truly wants. Our blind faith in professionalism is habit-forming and in time will only serve to deprive us of the most important skills that we must have to do well in these types of helping situations, such as sensitivity and empathy.

The suggestion that professional ethical standards, if seriously developed and conscientiously applied, will assure the necessary degree of care and attention to the real interests of the patient, is debatable both in theory and in practice. In theory, the medical profession, as an interested party, can never be trusted to rise above its provincial dogmas and self-centered concerns in developing a set of standards truly neutral in nature and sufficiently objective to adequately preserve the absolute prerogative of the patient to decide. More likely, the patients' desire and choice will be subjugated to the perceived need of the medical profession to safeguard its self-anointed role as the ultimate guardians of public health. This is clearly demonstrated by the activism of the AMA in its recent campaign to prohibit the sale and distribution of various consumer goods, such as cigarettes and drugs, on account of their bad effects. In sum, the AMA cannot be trusted to put the interests of the patient before its own professional credo of saving life and helping people. Practically, this will also be manifested in half-hearted efforts by the AMA in overseeing the enforcement of any established ethical rules. Professional members are not likely to be punished if they are caught doing what the profession has taught them to do all their life: to help. Nor are they likely to cease doing what they do best—passing judgment on medical and scientific matters, because some rules say they should not. The natural tendency of one who feels that the rule is inappropriate will be to violate it in its spirit, if not its letter.

205 See MORENO, supra note 56, at 88-105.
206 Report 3 of the Council on Scientific Affairs (A-04), http://www.ama-assn.org/ama/pub/category/13635.html. ("Accordingly, the AMA: (1) encourages physicians to refrain from engaging directly in the commercial production or sale of tobacco products; (2) supports (a) development of an anti-smoking package program for medical societies; (b) making patient educational and motivational materials and programs on smoking cessation available to physicians; and (c) development and promotion of a consumer health-awareness smoking cessation kit for all segments of society, but especially for youth...").
L. Rationality By Process or By Result?

Doctor B: In the way you put it, all personal decisions, except for those that are thoughtless or arbitrary, are rational choices. I beg to differ. We might disagree with the outcome. We might disagree on values. We might even be different in intellectual endowment, spiritual attainment, and mental dispositions. But sound and rational judgment can only be made under three conditions. First, the decision-maker must have the requisite rationality to make such judgment, i.e., he must be a competent decision-maker. Second, the decision-making process must not be affected by external circumstances; he must be given the time and opportunity to reflect. Third, the decision-maker must be informed and must be given the necessary facilities to decide.

In this case, your pain has deprived you of your good sense. Your monetary difficulties at home do not give you the chance to think clearly. You are not competent to judge the medical promise of your case, both in terms of the eventual success of recovery and in terms of the degree of care-freeness associated with the recovery. In this case, I implore you to reconsider before I seek to deny your wishes altogether. This is not because I am autocratic. Quite the contrary, I want your decision to be one that is truly in your best interest. I also want to make sure that you would have made a choice which you, or any of your family members, would not regret later.

Patient A: Once again, you have judged my decision to be irrational. In the first two instances, you have attacked my decision as irrational in outcome. I have taken great pains to explain why that is not so. Now, you are concerned about the rationality of the decision-making process in general, and my ability to make rational choices in particular. This is a new argument, and by far the most potent justification of not allowing me to choose. Although I am inclined to argue that insane people should be allowed to make choices which present no harm to others, I will save that discussion for another occasion.

Before I start, I must point out that rationality and irrationality are not the objective, scientific, and behavioral phenomenon that they might first appear to be. They are both very culturally specific and community defined and also functional in content. In Russia, for example, political dissidents are routinely processed through mental institutions, and, in this country, we have occasion to read about mentally ill people who are in fact quite smart or are even considered to be geniuses. The medical definition of mental abnormality, for purposes of treat-
ment, is quite different from the legal term “insanity” for purposes of criminal sanction. In short, that which is a rational mind is not always so clearly defined and readily ascertainable in real life, as might otherwise be expected given our near-religious faith in the medical-science profession, especially in marginal cases.

This is both a definitional problem and a methodological concern. It serves to look at history to remind ourselves that it is very easy to apply negative labels to people we do not personally approve of or fail to understand adequately. Saint Joan of Arc was persecuted for being a witch. Socrates was considered a heretic. Jesus Christ was persecuted for his treasonous act in preaching faith. Conflict criminologists have repeatedly pointed out that criminals are not so much born as they are conveniently labeled. What is irrational still defies universal definition, and I do not expect one to be forthcoming in the future. After all, the definition for insanity as a viable criminal defense has been oscillating, leading to confusion, if not actually creating contradictions in judicial opinions and obfuscation in public policy pronouncements.

It is true that my mental state has been traumatized by my physical health. However, I am not insane. My pain and suffering have clearly played an important part in my determination and may indeed be a critical factor in deciding not to live. But how can I prevent the reasons for my decision to kill myself from reflecting poorly upon my decision-making process and my capabilities, especially to those with who disagree with me and who hold high opinions of life and its desserts. For them, and for you, a desire to live is paramount, and anyone who rejects that theological faith needs mental reconditioning. I have grave problems with this ipso facto approach.

In this instance, far from being irrational, I am eminently reasonable in taking the pain factor into account. Unless you automatically assume that people under pain or pressure cannot adequately take care of themselves, I cannot see how you can call their decisions irrational.

This is not to deny that, in rare circumstances, a person can be affected so greatly by pain that his mind actually deteriorates to such an extent as to actually deprive him of any ability to think. However, that is not my case.

I do not deny that I cannot make an informed judgment until I know all the facts, such as my exact chances of survival and the nature and extent of my recovery. However, in any decision-making process, the total and complete picture is never available. Being informed is a relative phenomenon and subjective state of mind. This will always be true to the extent that we are not omnipotent. There is also the critical question of being uninformed as to "what." What is relevant and material to one's decision-making is certainly very subjective and relative, both in terms of what to consider and how much significance to attach to certain factors. What is important to consider thus affects our assessment as to the completeness of any given information and the weight we associate with it. I believe I have all the facts I need to know at this juncture. I fully realize that new discoveries in medicine are not uncommon, given our achievement in the medical science field. If I die, I will miss possible salvation of my life and an end to pain. But I must make a decision at some point in time. This, to me, is the most appropriate moment.

It is one thing to be lacking in information. It is another to have information but disagree upon its importance, and it is still a third to differ as to what is important to consider. I think our differences rest with the last two factors, and not the first. It is true that I do not have the exact information of my chance of recovery and the quality of life I might lead thereafter. But I cannot, because of this, abdicate my judgment to the doctor, unless of course, I want to. Besides, the chance of recovery, important though it may be in my thinking, is only one factor. The other factors concerning my desire to end my pain and for the good of my family are certainly of equal, if not of more importance. Of course, I should perhaps think generously of contributing my life to medical science or at least, selfishly or for reasons of family pride, allow my body to be so used, so that my name will become a household word in the annals of medical history. But these matters do not concern me now. I just want to get this ordeal over with and rest in peace. I am thus inclined to put the more immediate concerns of my family's security and my well-being above and beyond the notion of life or public
service. I have only one life to live and to give! Should I not be trusted to make that decision! Whose life is it, anyway?

In this case I am as informed as I ever will be. I do not have all the time in the world. I am certainly under tremendous pressure. It is regrettable that decisions are never made in a perfect world or in an ideal classroom situation. But then, the ideal decisions will not necessarily be a real decision, much less be perfect or right. They suffer from a lack of realism, if not being regarded as totally irrelevant.

M. The Problem of Making a Decision in a Vacuum

Doctor B: I want you to do this favor for me. Imagine that you are not suffering from all this pain and think through your decision once again. Do you not agree that you can gain so much more by staying alive? Is it not worth it to you to avoid a quick fix to such a complicated choice? You do not want to regret your decision while you are in that great beyond? This is what I really mean by rational choice.

Patient A: I would not decide to kill myself if I did not feel the pain. But in asking me to think as though I am free of the problems and ignore my painful circumstance, you have asked something totally unrealistic and artificial. First of all, life problems such as mine do not come in an encapsulated form but are always found unfolding amidst a set of evolving circumstances that are continually in flux and forever changing. This forecloses any meaningful attempt to capture a problem at a given point in time, much less to do away with certain essential elements inherent in the situation. A decision made in such a sterile and static fashion is meaningless. Second of all, imagination is a poor substitution for experience. There is a limit to what our mind can do. I cannot realistically assess a situation until and unless I am involved in that situation. That is why the common law approach to conflict resolution, which seeks to attend to the particular circumstances of each case, is more suited in providing just and equitable resolution of people’s disputes than the civil law model, which is more adapted to catering to future social needs.

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210 This raises the question of whether we can be detached and objective in evaluating things.
N. Should One Be Expected to Help Another Kill Himself?

Doctor B: If I kill you, even at your instruction, I will be a murderer, morally and legally.\textsuperscript{211} I will be an accessory to a crime if I help you die.\textsuperscript{212} Even if I do not do anything and just watch you die, I may be guilty of the crime due to omission of a legal duty. Of course, if I have consented to your death, I will be guilty of conspiracy.\textsuperscript{213} I cannot do it.

Patient A: I understand your concern. I can only ask for your help, but have no intention of forcing you to violate your religious faith, moral conviction, or legal duty.\textsuperscript{214} Though I do not believe that it is either morally or legally wrong to help relieve others from immense suffering, I

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\item[	extsuperscript{211}] Select Committee on Assisted Dying for the Terminally Ill Bill, Minutes of Evidence, 2005, H.L. Bill [17] (Gr.Brit)(letter to the Select Committee from Dr. Fiona Randall) available at http://www.publications.parliament.uk/pa/ld200405/ldselect/ldasdy/86/5020345.htm. ("Firstly, it is a central function of the law to safeguard the interests of everyone in the community, and not just the interests of a minority or an individual, however deserving, against those of the majority. Secondly, morality is much more complicated that the law could ever be. Thirdly, in treating cases of respecting refusal of treatment differently from requests for PAS and euthanasia, the law does not say that there is always a clear moral difference between the two.").
\item[	extsuperscript{212}] Dr. Quill was nearly prosecuted for assisting suicide, a crime in New York, by a Rochester area District Attorney. He suffered the threat of prosecution for four months until a grand jury refused to indict him in July 1991. B.D. Colen, \textit{On Death and Dying—MD Who Aided in Suicide Aims to Humanize Debate}, NEWSDAY, Aug. 11, 1991, at 3. For Dr. Quill's admission leading to the prosecution, see Timothy Quill, 324 NEW ENG. J. MED. 691-94 (1991).
\item[	extsuperscript{213}] In the U.S., the "right to die" (suicide) is prescribed by common law and euthanasia is provided for by legislation of various states. Thus far, only one state, Oregon, has legalized active euthanasia based on a terminal patient's persistent request. The constitutionality of suicide and euthanasia has been decided by the U.S. courts. See Washington v. Glucksberg, 521 U.S. 702 (1997) (The U.S. Supreme Court upheld Washington's ban against assisted suicide as applied to competent, terminally ill adults who wish to hasten their deaths by obtaining medication prescribed by their doctors. The Court refused to expand the liberty interest under the Due Process Clause of the U.S. Constitution to include a right to commit suicide under it, a right to assisted suicide. The state has prevailing interests in the preservation of human life, the prevention of suicide, the integrity of the medical profession, the protection of vulnerable groups, and the avoidance of a slippery slope into euthanasia.); Vacco v. Quill, 521 U.S. 793 (1997) (The U.S. Supreme Court held that the terminally ill do not have a right to PAS under the Equal Protection Clause of the U.S. Constitution. The Court also noted as important the distinction between assisted suicide and withdrawal of life-sustaining treatment, a distinction recognized by both the medical and legal professions.).
\item[	extsuperscript{214}] Martyn Gunderson, \textit{A Right to Suicide Does Not Entail a Right to Assisted Death}, 23 J. OF MED. ETHICS 51-54 (1997) (The author raised the question of whether a right to suicide invariably entitles the person to employ others to assist in the suicide. The author argued "that the permissibility of suicide does not by itself entail the permissibility of employing someone to assist in the suicide. . .nor entail the right to assisted death.").
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understand that the moral and legal order has vested interests in not condoning the killing of others. Morally, the thought of taking a life unnecessarily pollutes the mind and undermines culture. Legally, acts of killing condoned by law might create bad precedents, besides teaching people that it is alright to kill.215 But I submit that the law has no business in telling me how I should manage my own life. By killing myself, I will have hurt no one.216

O. How to Evaluate Intangibles Such as Hope and Fear?

Philosopher C: There is hope. There is a hope that you might be cured, though the chances are slight. Is that not worth waiting for?217

Patient A: Oh, what miseries have been incurred in the name of hope? I have been chasing after dreams all my life. This decision is no different from the rest, except I am older and wiser now. I am also given some statistical odds, uncommon in other life pursuits. I must say, though I relish and embrace the scientific data and very much want it to be reliable, I feel that I am deluding myself with these figures and projections. You told me that I might have a 50-50 chance of recovery if I wait one more year. I believe it only because I want to believe it, not because I believe it to be true for a moment.

The fact is, I do not want to live one more day of this miserable existence, even for another month of good health. Who is to say that

215 Thomas Cavanaugh, The Nazi! Accusation and Current US Proposals, 11 BIOETHICS 291-97 (1997) (There are some recurring concerns that legalization of PAS and voluntary active euthanasia (VAE) specifically will lead to abuse. Disputants pointed to Nazi 'euthanasia' program in which over 73,000 handicapped children and adults were killed without consent.).

216 Daniel Callahan, When Self-Determination Runs Amok, 22 HASTINGS CENTER REPORT 52-55 (1992) ("The euthanasia debate is . . . one in a long list of arguments in our pluralistic society. It is profoundly emblematic of three important turning points in Western thought. The first is that of the legitimate conditions under which one person can kill another. . . . The second turning point lies in the meaning and limits of self-determination. . . . The third turning point is to be found in the claim being made upon medicine: it should be prepared to make its skills available to individuals to help them achieve their private vision of the good life. . . . I believe that, at each of these three turning points, proponents of euthanasia push us in the wrong direction. Arguments in favor of euthanasia fall into four general categories, which I will take up in turn: (1) the moral claim of individual self-determination and well-being; (2) the moral irrelevance of the difference between killing and allowing to die; (3) the supposed paucity of evidence to show likely harmful consequences of legalized euthanasia; and (4) the compatibility of euthanasia and medical practice. [Author abstract]").

217 DWORKIN, supra note 142, at 82 (One of the stronger arguments against euthanasia is that life is full of possibilities and death is final. Legislation for "Death with Dignity" tries to deal with the problem with informed consent and a waiting period.).
my recovery will be speedy even if there is a breakthrough? Who is to say that my new life will be a full one? More importantly, would I not be subjected to a whole new set of worries, such as the worry that my hard-earned life will be subjected to the recurrence of the disease, worry about my son's education and worry about my family's financial security. Having gone through this once, I loathe the day I have to live under the shadow of death.

Philosopher C: You agree that our mind works in mysterious ways. Hope begets hope. There is more than one narrative to life and living. I implore you to have faith in yourself. That is hope in the real sense, not some distant image of castle in the sand. 218

Patient A: I can only speak from my own experience.

IV. POSTSCRIPT

A. A Different Paradigm: An Asian Perspective

A Chinese professor enters.

Chinese Professor: I have been listening to your conversation very closely and with much interest. One thing you all have forgotten is the fact that we are animals of history, culture, and habits. The right to die discourse is very much shaped by our culture and informed by history.

The case for the right to die is summed up in one neat and deceptively compelling argument: 'Whose life is it anyway? 219 In traditional China, the answer is: my parents'. 220 This gratuitous statement is neces-

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218 Brian H. Childs, The Last Chapter of the Book: Who is the Author? Christian Reflections on Assisted Suicide, in 18 J. MED. HUMANITIES 21-28 (1997) (There are many narratives to understanding life, and all of them need not be coherent and unified. Pain does not necessarily call for liberation. Suicide is neither inevitable nor the only alternative to human adversity and suffering.).

219 HARDWIG, supra note 185. In practical terms, who has a vested interest in an individual's life is important, e.g., the merging need to manage medical resources and expenditure puts the control over patient's well-being, if not even life, in the hands of HMO, and on economic, instead of medical or emotional, grounds.

220 In this regard, in traditional and imperial China, the commonly received morality is that a person's body belongs to his or her parents. This principle speaks to the idea that an individual is an integral part and necessary extension of the family as a social, moral, economic and political unit. Thus when an individual commits a wrong, the family loses face. For a contemporary view, see Vera Rich, Will the Chinese Legalise Euthanasia?, 345 LANCET 783 (1995). The dilution of traditional moral principles, the erosion of integrity of family unit, the promotion of new social morality, and the introduction of a capitalistic market structure promises to shatter the old notion (some say myth) of the body as an extension of the family philosophy.
sary to inform the readers of the ever-lurking cultural context underscor-
ing this debate.\footnote{Kazumasa Hoshino, \textit{Bioethics in the Light of Japanese Sentiments, in Japanese and Western Bioethics} 13-25 (Kazumasa Hoshino ed., 1997). The Japanese are insensitive and even reluctant to "accept the vital importance of autonomy, self-determination and individualistic freedom in decision making; all of which are indispensable valuable principles in Western bioethics." \textit{Id.} at 25.}

This self-righteous claim to life and death encompasses two lesser claims: my life is my own, and I know best what to do. The first is a natural rights argument; the second a legal privacy claims. Both of these claims are more complicated than first meets the eyes. Let me explain.

B. \textit{Taking a Life Is Everybody's Business}

Chinese Professor: I start by observing that the issue of life and death is not only just a personal problem or an individual issue. The taking of life, by abortion or suicide, affects others, near and far, past and future.\footnote{According to "U.S.A. Suicide: 1998 Official Final Data," there were 732,000 suicides from 1978 to 1998. \textit{U.S.A. Suicide: 1998 Official Final Data"}, http://www.suicidology.org/index.html (last visited Jan. 26, 2006). Each dead is survived by six related/intimately affected survivors. \textit{Id.}} As Saint Thomas Aquinas observed, "[s]econd, every part belongs to the whole in virtue of what he is. Suicide therefore involves damaging the community, as Aristotle makes clear."\footnote{St. Thomas Aquinas, \textit{The Summa Theologica}, Second Part of the Second Part, QQ 64-66 (Benziger Bros., 1947) Whether it is lawful to kill oneself? ("Secondly, because every part, as such, belongs to the whole. Now every man is part of the community, and so, as such, he belongs to the community. Hence by killing himself he injures the community. . .").} In more concrete terms, for society, it is the loss of a productive member; for the community, it is the loss of a comrade in arms; for the family, it is the loss of an intimate relation;\footnote{\textit{HARDWIG, supra} note 185. "The death of a loved one and the \textit{way} she died may rearrange the life of a family. Sometimes for decades." The author argued for a shift away from exclusively patient-focused analysis of the right to die problem. The decision of one member in the family affects all. \textit{Id.} at 2-3.} for humanity, it is the loss of a kindred spirit. Finally, for the human race, it is the severing of a vital human link.\footnote{"Feminist ethics derive from an alternative or richer conception of human nature—one that understands people's being motivated by love, friendship, responsibility, and caring rather than solely by self-interest and fear." \textit{Bender, supra} note 122.}

The individual, as a social being, has connections not only to himself, but to others.\footnote{"We don't act in a vacuum; our significant acts take place in relationship to others. A given act may be right or wrong, depending on whether it meets an obligation or violates it. The}
individual, as a human being, lives not only in the present but also in the past and future. The present is the past's hope and the future's memory. The individual, as a life form, is inseparable from the universal life forces that it helps create, maintain, and shape. It is life personified.  

most obvious obligations is a legal contract. But there are many others, often unspoken: obligations of friendship, of family, of a profession, of citizenship, of trust, and of promises to keep." BRUCE HILTON, FIRST DO NO HARM (1991). Hilton asks of Patient A to consider his obligations to others, i.e., consequence of one's action to those being affected, before one acts. This approach, while an improved (adequate?) response to the liberal conception of human nature, i.e., a social, a historical, atomistic individualism, which is informed by abstract ideological characteristics and qualities, (see, for example, Hobbes nature of man before civil society in LEVIATHAN (1651) and Rawls' original position behind the "veil of ignorance in A THEORY OF JUSTICE (1971)), is not sufficient to address the Chinese Professor's concern with a different image of human nature and social relations, as instructed by history and culture.

227 For the classical (Mills) and reformed liberal (Rousseau and now Hilton) views of the unit of social, economic, political, legal, and accounting in the liberal model is the autonomous self, whether restrictively (selfish as individual interest) or expansively (selfless as individual interest) construed and understood, see JAMES COLEMAN, FOUNDATION OF SOCIAL THEORY (Belknap Press 1998)(1990), ADAM SMITH, THE WEALTH OF NATIONS (Kathryn Sutherland ed., Oxford Univ. Press 1998)(1776), J.S. MILLS, ON LIBERTY, in ON LIBERTY AND OTHER WRITINGS (Stefan Collini ed., Cambridge Univ. Press 1989) (1859), F.A. von HAYEK, LAW, LEGISLATION AND LIBERTY, Vol. 1 & 2 (Univ. Chicago Press 1979)(1973), RICHARD A. POSNER, THE ECONOMIC ANALYSIS OF LAW (3d ed., 1986). For the Chinese Professor, it is corporate or collective holism. To the Chinese, the unit of social accounting is the whole and never the parts. The assumption is that the "part" (individual) cannot be separated from the "whole" (collective). The best analogy to make this clear is with the structure and properties of chemicals: a compound is a mixture of elements (atoms and ions) in definitive proportions, e.g., water is made up of two parts hydrogen and one part oxygen (H₂O), which maintain their own chemical properties before, during, and after mixture. A complex chemical is atoms interacting with each other to form a whole new chemical with different properties emerging. Thus to say that we are connected to others, and depending on the frame of reference—the universe, nation, society, community, organization, family or significant others—is to say that we are joined together in a larger whole, unseparated and inseparable.

This analogy, while accurate, is incomplete and far too mechanistic. When atoms interact with each other, they completely lose their own existential integrity, and they form a separate new identity as part of the new chemical. A collective of humans can group together to form a corporate whole (e.g., crowd behavior) without at the same time attenuating, much less losing, the individuals' intrinsic qualities or innate characteristics. Thus, it is correct to observe that the individual exists prior to the collective and still maintains himself after the collective is formed. It is also correct to say that individuals, after mixing together, form a whole new corporate identity, separate and distinct from the individual. This make the matter more complicated. The sublimation of the individuals into the collective whole may not be automatic or complete. Some people get sublimated more, others less. There is also the consideration that some parts of us are sublimated and others not.

How might this understanding of groups and individuals affect our analysis of a group member's "right to die"? The answer lies in the question: to what extent and in what manner can a person be said to be part of a larger group or community? More pertinent, how might it
In all, collective, humanity, and life are made up of, and informed by, the individual but transcend and outlive him.\textsuperscript{228} Thus, taking away one's life is not just simply terminating one's isolated, if autonomous, existence. Rather, it takes away a part of society, of community, of family, and of humanity. Killing a person, if done deliberately, shatters social solidarity, dilutes communal bonds, retards human development, and cheapens life. It makes for a weaker society, lesser human race, and bleaker life process.\textsuperscript{229} For the same reason, we should not have capital punishment.

More graphically, when someone is killed, a part of us dies with him. That is why we all grieve when we see people, even enemies, die.
That is why even hardened prison officials have compassion for people on death row. The human body is a public trust. The individual is not the best to judge. Much of the debate over the right to die hinges on the issue of individual competency to decide—it raises the issue of rationality. Is a terminally ill person competent to decide rationally? I submit that this is the wrong question to pose.

My argument is a simple one. Individual rationality is not the same as collective rationality, such as system rationality or social rationality. Individual rationality cannot be trusted to guide human destiny. Allowing individual rationality to steer a course for society and mankind is to open up a Pandora’s box of questions with no satisfactory answers, i.e., the same kinds of questions posed by genetic engineering, such as, what is best for society, or what is ideal for humankind?

On a more practical scale, just as we do not trust the individual police officer to determine when to use his firearm, we do not deem it appropriate for the individual to decide what is good for the collective whole. This is not to suggest that his rational judgment is not sound under the circumstances. It is to recognize the limitations of his individual rationality, which is circumscribed by self-interest and restricted by a lack of information. In practice, and in real terms, the individual can rarely be expected to rise above the occasion—the limited circumstances in which he finds himself, and the immediate situation with which he is presented. As a result, the individual is not fully informed and is not able to think about what is good for his society and for humanity. These life and death decisions require a historical memory, future vision, cultural perspective, and, more critically, holistic judgment, far beyond what an individual can hope to possess or provide. In the end, what is good for the individual may not be good for the society. What is deemed suitable for the society may not be acceptable to the individual. Such is the case when the society chooses for the terminally ill a painful life over a simple death, even when the individual has every reason to object.

Who should decide when life begins and ends, if not the individual self? I have no answer, but only an observation. It is important to realize that individual rationality does not exhaust other ways of order-

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ing social and human life. Natural selection allows the human race to mutate and survive. Collective wisdom keeps us from self-destruction. Spontaneous order regulates conduct and resolves conflicts. Human instincts are still the best way to steer us through life crisis and personal troubles. There are more intricate natural forces, more complex human dynamics, and more complicated life process at work that humble scientists, titillate philosophers, and most certainly perplex and confound individuals. Simply put, individual thinking is no match for Mother Nature at work.

**AFTERTHOUGHT**

I feel saddened as I address these issues. I have reluctantly allowed myself to be drawn into the vortex of such a no-win, heart-rending debate. My mother was terminally ill with a brain tumor for ten years. I must admit that there were times, when we were alone, that I could have hastened her death and relieved her agony by ignoring her cries for help. I did not.

When I look back, I still feel ambivalence, sometimes guilt. My human emotions drive me one way, and my rationality takes me in another. Schooling has given me an analytical mind and critical spirit but has taken away my innocence and makes me uncomfortable of trusting my emotions.

Still, during these tormenting moments, I am glad to be able to find some genuine, if fleeting, solace. I am able to feel the pain of my mother and suffering endured by my fellow human beings. I am glad that I am a human being; living the vagaries of my feelings.

231 Having someone close in one's family die has a direct impact on how one views "life and death" issues and concomitant approach of PAS. See Marcia Angell, *The Supreme Court and Physician-Assisted Suicide—The Ultimate Right. [Editorial]*, 336 New Eng. J. Med. 50-53 (1997). The author favors PAS in limited circumstances. She ends her editorial with a description of her father's suicide after receiving a diagnosis of metastasis cancer. Angell concludes that PAS "... is simply a part of good medical care." *Id.*

232 Peter Suber, Against the Sanctity of Life (1996), [http://www.earlham.edu/~peters/writing/sanctity.htm](http://www.earlham.edu/~peters/writing/sanctity.htm).