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# Public Policy on Physician-Assisted Suicide: Reasons for Retaining the Ban

by B. Andrew Lustig

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*Physician-assisted suicide and active euthanasia have become the focus of a mainstream discussion that exemplifies central tensions in an ongoing societal drama. At its core, the debate implicates values that play out, invariably in tension, across our collective lives. This essay asserts that we need a set of reflections and attendant policy choices that capture and convey the range of values, individual and collective, personal and social, that are at stake in choices about suicide and assisted suicide.*

Despite recent challenges to the traditional legal and professional sanctions against physician-assisted suicide and active euthanasia, there are compelling reasons to retain our present public policy forbidding such practices. To be sure, we should not make light of the legitimate concerns that have galvanized the debate. Despite, or perhaps because of, the excesses of Dr. Jack Kevorkian, physician-assisted suicide and active euthanasia have become the focus of a mainstream discussion that exemplifies central tensions in an ongoing societal drama. While we celebrate pluralism and individualism, we also struggle to maintain certain shared values that are equally at the center of our national life: not just autonomy but a sense of community; not just rugged individualism but concern for those less fortunate and more vulnerable in our midst. The vulnerable, of course, include patients who endure significant clinical suffering. At its core, the debate about assisted suicide and active euthanasia implicates values that play out, invariably in tension, across our collective lives.

The arguments for retaining the traditional ban against physician-assisted suicide and active euthanasia require that we reflect upon values not easily accommodated within a single framework. One might imagine, for example, that we have adopted a "contractual" model for understanding the choices of patients and physicians. But the options of physician-assisted suicide or active euthanasia have broader implications than the model of "agreement between two consenting adults" suggests. Even in medicine, as traditionally understood, a "contractual" model does not do justice to the dynamic between physician and patient. Indeed, as the magnitude of potential harm from a patient's choice increases, we require more of patients, and of other vulnerable persons, before we acknowledge their competence or assume that they are capable of giv-

ing informed consent.<sup>1</sup> That "sliding scale" for competence determinations involves more than the "bare facts" of mere choice. We have general attitudes about the way that "reasonable people" should be willing to explore and understand the serious harm that may result from their choices.

In discussing physician-assisted suicide and active euthanasia, it is also important to belabor an obvious but often overlooked point: suicide, and *a fortiori* assisted suicide, are not, even for those who believe in nothing beyond the grave, matters of indifference. "Suicide" is not a neutral description. Generally speaking, we react to suicide, and assisted suicide as well, with a collective unease about how to judge whether someone wishing to die is competent, whether consent is a meaningful exercise or an empty formality. Suicide or assisted suicide is a person's last earthly act, his or her last earthly choice. There is something counter-intuitive about dealing with so final a choice as merely a matter of "contract."

As a matter of fact, we do not make light of that choice. Despite polls reflecting ever greater degrees of public acceptance of *assisted* suicide as an option, we generally respond to those who attempt suicide with the presumption, albeit a rebuttable one, that theirs' is not a cool, rational, competent choice; indeed, we ordinarily commit them for further observation. That involuntary commitment might seem an unwelcome response from a perspective that emphasizes respect for the so-called "private" choices of individuals. But the option of suicide carries a

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burden of proof. We do not, ordinarily, accept suicide as a "rational act" without further explanation. Our reluctance does not amount to idle meddling in others' affairs and life plans (or death plans, in this instance), to paternalism of an overweening sort. Instead, it reflects a value besides autonomy that we also take seriously: "being my brother's keeper," from a religious perspective; feeling compassion, from a humanist's perspective. From either vantage, suicide and assisted suicide demand policy reflections that are more complex and nuanced than a simple recourse to the presumption of autonomy in most cases or the presumption of incompetence in all cases. We need a set of reflections and attendant policy choices that capture and convey the range of values, individual and collective, personal and social, that are at stake in choices about suicide and assisted suicide.

As a matter of policy, there are large conceptual differences between suicide as a negative right and assisted suicide as a positive right. Seneca, ever the Stoic, might celebrate suicide as the choice of a wise man. Arthur Koestler, the atheist intellectual, might seem to have chosen a "rational suicide" as his

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powers failed, as the plague of several diseases took their toll on his body and especially on his mind. Indeed, most secular philosophers argue that suicide may occasionally be a rational choice that, depending on circumstances, we could laud as praiseworthy. If they are correct in believing that "rational suicide" accurately describes a small minority of cases, then a blanket proscription of suicide is untenable on strictly secular grounds, independent of religious premises.

But the matter of assisted suicide is conceptually quite different, even on secular terms. Assisted suicide, if given legal sanction, becomes, in effect, an entitlement to another's assistance in ending one's life. The right to non-interference is extended to a right of assistance. In principle, others can honor my right to non-interference by fulfilling their duties of forbearance. But even in principle, assisted suicide, as a positive right, requires more. It requires a duty incumbent upon someone else to assist me, to provide me resources: an effective over-

dose of barbiturates or a lethal maskful of carbon monoxide or a deathtrap with lines carrying serial doses of thiopental and potassium chloride. My right requires a positive action, rather than merely a negative duty of forbearance. Even if suicide could plausibly be seen, under conditions of competency and non-harm to others as a "right," the right of assisted suicide involves a further set of claims, a different set of policy considerations. We make this sort of distinction in other areas of the law. For example, in states with the Hyde Amendment, the non-interference claim to have an abortion does not include a positive entitlement to state assistance in procuring an abortion.

"So what?" one might ask. What difference should this conceptual distinction make in crafting public policy? Why should we be troubled about providing assistance to those who wish to kill themselves? More specifically, why should we be leery of granting doctors the right to assist patients in suicide or even, when necessary, in euthanating patients at their own request? Why, since suicide has been decriminalized, should public policy resist legalizing assisted suicide?

In responding to these challenging questions, there are a number of matters that deserve attention. I would make a point about methodology here. There are two different approaches to considerations of public policy. Reflection can proceed from the broadest theoretical perspective and move to focus on concrete policy alternatives. One might proceed from a strict libertarian vision that finds government intrusion often, if not generally, unwarranted, and leaves individuals free to pursue their choices, including suicide or assisted suicide, with minimal constraints. Or one might be a Rawlsian, arguing for a contractarian vision that will have policy implications on a range of practical choices, especially those involving the distribution of resources. Both approaches exemplify what has been called "theoretical ethics."

By contrast, one can engage in what has been called "policy ethics." Here, one starts not with some abstract ethical or political vision, but with the principles and values embedded in various policies rather than grounded in any particular theological or philosophical perspective. This approach invokes principles and values already expressed by our collective choices to date, not uncritically of course, but with an eye toward prior norms that might illuminate present options.<sup>2</sup>

A "policy ethics" perspective is, I suggest, the preferable approach to take in the debate about physician-assisted suicide and active euthanasia. The principles and values underlying past social at-

titudes toward such practices can be further invoked to criticize and inform our present policy decisions. We have not, as yet, legalized assisted suicide in this country. Despite recent poll data suggesting major changes in public mood, there are clear merits to maintaining the distinction between decriminalizing suicide as an individual choice and prohibiting assisted suicide as a legally sanctioned option.

Several values already rooted in our social policy on assisted suicide merit further reflection and discussion. First, we have always paid lip service to concerns about the dangers of abuse in a socially sanctioned practice of assisted suicide. One interpretation of the Netherlands' experience may suggest that those dangers can be lessened by attention to regulation and bureaucratization; but, if Carlos

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Gomez's report on regulated death in the Netherlands is taken seriously, one might draw the opposite conclusion: that assisted death, even if highly regulated, tends to assume its own momentum.<sup>3</sup> The social sanction embedded in a policy prohibiting suicide expresses a value, concern for vulnerable persons, that is unlikely to be safeguarded to the same degree by a policy that moves from prescription to mere regulation. At the very least, Gomez's discussion should give pause to those who seem blithely optimistic about regulating death at the patient's request.

Beyond the concern with abuse, the practices of physician-assisted suicide and voluntary euthanasia pose challenges to the often invoked but insufficiently elaborated "integrity of medicine" as a public profession. Willard Gaylin captures the central issue at stake for medicine in the face of efforts to change policy on killing by physicians:

The very soul of medicine is on trial. For this is not one of those peripheral issues about which pluralism and relativism can be tolerated, about which a value-free stand on the substance can be hedged around with procedural safeguards to ensure informed consent or "sound decision-making." Nor is this an issue . . . that touches medicine only as a trade. This issue touches medicine at its very moral

center; if this moral center collapses, if physicians become killers or are even merely licensed to kill, the profession—and, therewith, each physician—will never again be worthy of trust and respect as healer and comforter and protector of life in all its frailty. For if medicine's power over life may be used equally to heal or to kill, the doctor is no more a moral professional but rather a morally neutered technician.<sup>4</sup>

Because society licenses medical professionals, in effect granting a monopoly to practitioners, it is shortsighted, or perhaps even perverse, to view the issue of physician-assisted suicide as simply a variant of consent between privately consenting individuals. Professional and legal prohibitions against physicians killing patients have long been central to medicine's self-understanding. Within the profession of medicine itself, therefore, a more serious and sustained discussion is needed, especially at this moment in the public debate, about what care and compassion toward terminal patients require; about the meaning of care when cure cannot be had; about providing truly effective pain relief in a climate of tertiary care that seems, only grudgingly, to be learning the lessons of effective analgesia provided in the hospice context; and about whether medicine, as a profession licensed to intervene in the name of curing and/or caring, should be allowed to assist in suicide, or even to kill a patient, in the name of that caring. Indeed, the societal irony is that public confidence in medicine is at its lowest point in the past thirty years. Yet with doctors less trusted than perhaps ever before in this culture, we are rushing headlong, it would seem, toward investing medicine with a new and awesome sort of practice—assisting in suicide, or even killing, under the guise of care.

The foregoing is not meant to suggest that I am unsympathetic to the real plight of patients—patients who may see assistance in their deaths as a release from unbearable suffering. Hard cases will be precisely that. But hard cases tend to make bad law. Exceptional cases of "mercy killing" can already be handled by our present policy. Indeed, a review of the literature on "mercy killing" indicates that present policy has a good deal more flexibility, provisions for lenient sentencing based on exculpatory conditions and so forth, than its most vocal critics suggest. And surely all of us either have heard about or can imagine a case of intractable pain that cannot, apparently, be handled by most analgesics, a case that might prove the exception to our ordinary restrictions upon medical practice.

But it is important to emphasize the last word of the previous sentence: medical *practice*. As John Rawls reminds us, there remains an obvious difference between how we justify any particular act and the warrants we invoke to justify a social practice that allows such acts in the aggregate.<sup>5</sup> Because I have taken the approach of policy ethics rather than theoretical ethics, I retain confidence in the guidance we may yet find in traditional constraints against medical killing or assistance in suicide. To assume that medicine as a public practice has no history, that it can be reduced to the private choices of consenting patients and willing individual doc-

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tors, is, I believe, to misconstrue the social understanding that we as prospective patients have of the medical profession. Practical reasons remain to be skeptical of a major shift in public policy from prescription to acceptance of doctor-assisted suicide or euthanasia. Tertiary medicine, after all, has much yet to learn about effective pain control, especially from hospice contexts. Why would we wish to cross the Rubicon to legalizing assisted suicide when the interim step of effective analgesia has been so steadily underemphasized in tertiary care? We may find ways to justify exceptional cases, where euthanasia

or assisted suicide does appear to be the caring and compassionate response to a patient's plight. But a change in our general social *policy*—a change that alters medical practice—should not be crafted quickly or adopted lightly. As William May reminds us:

The existence of exceptional cases does not itself argue for permissive laws. It is by no means clear that we should always legally permit what, under exceptional circumstances, we may feel morally obliged to do. The moral life [may] sometimes requires us to move out into a no-man's land where we cannot find full protection; [but] society would be ill-advised to provide that protection.<sup>6</sup>

To Doctor May's observation, I say, "Amen."

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