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## PHYSICIAN-ASSISTED SUICIDE AND VOLUNTARY EUTHANASIA: SOME RELEVANT DIFFERENCES

JOHN DEIGH\*

Yale Kamisar, in a series of influential articles on physician-assisted suicide and voluntary active euthanasia, has written eloquently in opposition to legalizing these practices.<sup>1</sup> Today he revisits the first of these articles, his seminal 1958 article, *Some Non-Religious Views Against Proposed "Mercy-Killing" Legislation*.<sup>2</sup> In that paper Professor Kamisar used the distinction between the law on the books and the law in action to quiet concerns about the harsh consequences of a blanket prohibition on mercy killing.<sup>3</sup> A blanket prohibition, after all, if strictly applied, would impose criminal punishment on physicians and relatives whose complicity in bringing about the death of a patient, or loved one was justified by the dying person's desperate condition and lucid wish to die. It would impose criminal punishment, that is, on innocent people. To mitigate this difficulty, Kamisar argued that, while the law on the books rightly criminalizes all acts of mercy killing, the law in action, given the possibilities of prosecutorial forbearance and jury nullification, recognizes exceptions and thus can be relied on to protect such innocent people from criminal punishment.<sup>4</sup> Revisiting this argument, Kamisar

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<sup>1</sup> See Yale Kamisar, *Physician-Assisted Suicide: The Last Bridge to Active Voluntary Euthanasia*, in EUTHANASIA EXAMINED: ETHICAL, CLINICAL AND LEGAL PERSPECTIVES 225 (John Keown ed., 1995) [hereinafter Kamisar, *The Last Bridge*]; Yale Kamisar, *The Right to Die: On Drawing (and Erasing) Lines*, 35 DUQ. L. REV. 481 (1996) [hereinafter Kamisar, *The Right to Die*]; Yale Kamisar, *Are Laws Against Assisted Suicide Unconstitutional?* 23 HASTINGS CENTER REP. 32 (1993) [hereinafter Kamisar, *Laws Against Assisted Suicide*]; Yale Kamisar, *When Is There a Constitutional "Right to Die"? When Is There No Constitutional "Right to Live"?*, 25 GA. L. REV. 1203 (1991); Yale Kamisar, *Some Non-Religious Views Against Proposed "Mercy-Killing" Legislation*, 42 MINN. L. REV. 969 (1958) [hereinafter Kamisar, *Some Non-Religious Views*].

<sup>2</sup> Kamisar, *Some Non-Religious Views*, *supra* note 1.

<sup>3</sup> See *id.* at 970-73.

<sup>4</sup> See *id.*

now sees things differently. The hope of a middle ground between legalization and punishment without exception that the distinction had seemed to offer is, he now thinks, false.<sup>5</sup> And critical examination of other attempts to establish a similar middle ground leads him to think that they too will be unsuccessful.<sup>6</sup>

Such critical examination of ideas friendly to one's own position shows exemplary intellectual honesty. It is not easy to revisit one's earlier views and find them faulty. It is especially hard when those views are more than contributions to an academic dispute, when they are part of a national debate on major policy issues that deeply affect us all. At a time when public debate seems dominated by disingenuous hyperbole and cynical refusal to concede any truth in one's opponents' views, Professor Kamisar's interest in openly examining the difficulties in his own views, and his willingness to acknowledge their persistence, deserves our admiration and praise. It should also remind us, at a time when such salutary reminders are rare, of the important difference between advocacy and the search for truth.

Professor Kamisar has consistently taken a utilitarian approach to the question of legalization.<sup>7</sup> He expressly based the nonreligious views he advanced in his 1958 article on utilitarian arguments, and the gist of those arguments can be seen in the reasons he cites today in support of a policy of blanket prohibition.<sup>8</sup> To take a utilitarian approach means that one treats the good and bad consequences of adopting some policy (law, program, or course of action, etc.) as the only considerations arguing for or against that policy. Utilitarian arguments, in other words, are arguments to the effect that adopting a certain policy has better consequences than adopting any of its alternatives. Kamisar thus favors the legal ban on physician-assisted suicide and voluntary active euthanasia, not because he thinks either act is inherently unjust—indeed, he thinks either can be justified in

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<sup>5</sup> See Yale Kamisar, *Physician Assisted Suicide: The Problems Presented by the Compelling, Heartwrenching Case*, 88 J. CRIM. L. & CRIMINOLOGY 1121 (1998) [hereinafter Kamisar, *Physician Assisted Suicide*].

<sup>6</sup> *Id.* at 1122.

<sup>7</sup> See, e.g., Kamisar, *Some Non-Religious Views*, *supra* note 1, at 974; Kamisar, *The Right to Die*, *supra* note 1, at 517-18.

<sup>8</sup> See, e.g., Kamisar, *Physician Assisted Suicide*, *supra* note 5, at 1123-24, 1129-33, 1133-36.

certain compelling, heart-wrenching cases—but because the adverse social consequences of legalizing these acts would outweigh the benefits.<sup>9</sup> Or what comes to the same thing, he favors the legal ban, despite the hardships and tragedies it creates in these compelling, heart-wrenching cases, because he thinks the social consequences of legalization would be worse.

What are these adverse social consequences? What leads Kamisar to think that legalization would be worse than keeping the ban? What speaks in its favor is that legalization would end the cruelty of denying dying people whose suffering and humiliation is great, who are lucid and rational, and who truly wish to die the humane means of escaping their misery that medicine can supply. These are the ban's primary victims, and Kamisar readily acknowledges their victimization.<sup>10</sup> Nevertheless, he maintains that however many of them there are—and he thinks there are actually relatively few—there are potentially many more victims of legalization.<sup>11</sup> These potential victims are the dying patients whose relatives or physicians would, if physician-assisted suicide and voluntary active euthanasia were legal, try to pressure them into opting for assisted suicide or euthanasia. The danger in these cases is that if the patients yielded to the pressure their physicians or relatives placed on them, they would then likely be consenting unfreely or irrationally and thus losing their lives unjustly. Legalization, in other words, would put many dying people at risk of losing their lives unjustly, and this risk would be realized in sufficiently many cases, Kamisar believes, as to overshadow the fewer cases of dying people for whom legalization would be a godsend. What is more, once we realize that those whom legalization would make especially vulnerable to unjust loss of life would be disproportionately found among society's weakest adult members, the poor, the old, and the chronically ill, the shadow this loss casts over the benefits of legalization will appear even larger and darker.<sup>12</sup>

This then is the main utilitarian argument that Kamisar advances to support his position. As the quotes and citations he gives in his discussion of that position suggests, the argument is

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<sup>9</sup> *Id.*

<sup>10</sup> *Id.*

<sup>11</sup> See Kamisar, *The Last Bridge*, *supra* note 1, at 246.

<sup>12</sup> *Id.*

commonly made by other opponents of legalization. It is also clear from these quotes, as well as from Kamisar's exposition, that he and other prominent opponents of legalization see no need, when making this argument, to distinguish between physician-assisted suicide and voluntary active euthanasia. Indeed, they explicitly conflate the two rather than treat them separately. The methods of utilitarianism, however, caution against such conflation. One might of course think that it is harmless since the two practices are, after all, just different ways of doing the same thing, different ways of aiding people in realizing their wish to die.<sup>13</sup> But that one can describe either practice in the same way is not, on a utilitarian approach, sufficient to justify conflating them. One must show instead that the risks and advantages of legalizing one would be the same as those of legalizing the other, for only then would the utilitarian calculation of the consequences yield the same result in either case. Since Kamisar does not consider the question of whether the risks and advantages are the same in either case, his argument may not have the same force as an argument against legalizing physician-assisted suicide that it has as an argument against legalizing voluntary active euthanasia. Fidelity to the utilitarian approach requires that we see whether it does.

Suspicion that the argument's force differs with the case centers on the premiss that the victims of legalization would be far more numerous than the victims of keeping the ban. This is a strong premiss. Indeed, if it were the argument's only quantitative consideration, as it appears to be, one would have to interpret it as claiming, in effect, that the disparity in the size of the two classes of victims was so vast that no other quantitative

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<sup>13</sup> Alternatively, one might think it is harmless because there is no intrinsic moral difference between voluntary active euthanasia and assisted suicide. Thus Dan Brock writes, "If there is no significant, intrinsic moral difference between the two, it is also difficult to see why public or legal policy should permit one but not the other; worries about abuse or about giving anyone dominion over the lives of others apply equally to either." Dan Brock, *Voluntary Active Euthanasia*, 22 HASTINGS CENTER REP. 10, 10 (1992). Brock's reasoning, however, is fallacious. Though two types of action may have the same intrinsic moral quality, differences in the manner or circumstances in which the two are typically performed can result in differences in the likely consequences of legally permitting them, and these differences may then imply that arguments against legalization of one type are stronger (e.g., because the adverse consequences of legalization are worse) than arguments against legalization of the other. The considerations I offer below are meant to substantiate this general point with regard to voluntary active euthanasia and physician assisted suicide.

consideration was necessary for carrying out the relevant utilitarian calculation—that, in particular, no comparison of the magnitudes of the harms that both types of victim would suffer was necessary. This would not be a reasonable claim, however, if only because one of the central issues in the dispute is whether the severity of the suffering and humiliation that could be averted through legalization is so great in certain cases as to justify relaxing the general prohibitions on homicide and suicide assistance. So the argument has to rest on some assumption about the relative magnitudes of the harms that both types of victim would suffer. Since Kamisar does not speak to the issue of the magnitudes of these harms, the question then is what assumption does it make the most sense to attribute to the argument.

Using Kamisar's silence on the issue as a guide, we can safely say the assumption he makes is that, given how vast the disparity in the size of the two classes of victims is, the harm the victims of legalization would typically suffer is severe enough to ensure that the relevant utilitarian calculation supports keeping the ban. This assumption may also be unreasonable. It is surely *ad hoc*. What is more important, though, for our purposes is that it makes clear the degree to which the force of his argument critically depends on the plausibility of the premiss that legalization would create a far greater number of victims than keeping the ban. We have good reason, then, to take the premiss as the focus of our suspicion that the argument's force differs according as it is advanced as an argument against legalizing voluntary active euthanasia or an argument against legalizing physician-assisted suicide. If the premiss is more plausible as a thesis about legalizing the one practice than as a thesis about legalizing the other, then the argument is correspondingly less forceful in the latter case than in the former. Why might this be so?

Well, for one thing, as a matter of common sense, killing yourself is a lot harder than having someone do it for you. Assuming this bit of common sense is correct, there is reason to suppose that people, on average, are less susceptible to being pressured into killing themselves than they are into letting someone kill them. Thus, even if we were to grant that legalizing physician-assisted suicide would put the same people at risk of losing their lives unjustly as would be put at risk by legalizing

voluntary active euthanasia (i.e., even if we were to ignore the possibility that people would be more reluctant to urge suicide than to urge accepting a lethal injection), this risk would be realized less frequently in the former case than in the latter. To be sure, we cannot even begin to estimate how frequently the risk would be realized in either case. But we can notice the error of being as confident about its being realized frequently in the case of physician-assisted suicide as we are about its being realized frequently in the case of voluntary active euthanasia. And in view of this error, it follows that the argument may appear to be as strong as an argument against legalizing physician-assisted suicide only because it has been mistaken for an argument against legalizing voluntary active euthanasia.

A second consequence of the common sense point concerns the acts of suicide and submission to euthanasia that would in fact occur as a result of legalization. One natural way to understand the thought that killing yourself is harder than having someone do it for you is that killing yourself requires firmer resolve. The element of passivity involved in your letting another perform the unpleasant task of putting you out of your misery means that your will is not as active as it would be if you performed the task yourself, and thus weakness or irresolution in the will is less likely to cause failure, less likely to cause an interruption in the lethal action. Conversely, then, a completed act of suicide warrants more confidence in its having issued from a will that was strong or resolute than does a completed act of submission to euthanasia. Accordingly, though any act by which a person deliberately hastens his or her death raises concerns about its voluntariness, there is less reason to worry, other things being equal, about the voluntariness of suicide than about the voluntariness of submitting to euthanasia. Hence, estimating that a great many people would lose their lives unjustly as the result of legalizing physician-assisted suicide would be harder to justify than a similar estimation of the number of unjust deaths resulting from legalizing voluntary active euthanasia. Here again we have reason to conclude that the utilitarian argument against legalizing physician-assisted suicide is weaker than it is against legalizing voluntary active euthanasia.

To be sure, the conclusion depends on a rule of common sense and not on the findings of empirical science. Our acceptance of it should therefore be tempered by recognition of its

unscientific basis. Were some well conducted scientific study to yield contrary evidence, the conclusion's cogency would diminish considerably, just as its cogency would be enhanced considerably, were such a study to yield confirming evidence. No such studies exist, however, and given the variables involved, none is likely to be pursued. At the same time, there are well-known studies in social psychology, like Stanley Milgram's experimental research on obedience to authority, whose results have implications for the question of whether the utilitarian argument has less force in the case of legalizing physician-assisted suicide than in the case of legalizing voluntary active euthanasia.<sup>14</sup> The implications are neither direct nor unqualified, but they are important nonetheless.

The striking lesson of Milgram's experiments is that people in general have such a strong disposition to obey authority that, with rare exception, they will follow the directives of an authority supervising their actions even when they have serious misgivings about the acts they are being told to perform. In Milgram's experiments, the subjects were told to perform acts—notably, the administering of shocks of increasing intensity to another person—that became at some point manifestly wrong and cruel. Predictably, at this point the subjects would begin to voice reluctance and raise objections to performing these acts and to ask the experimenter, the authority in the circumstances, whether they should stop. Though obviously disturbed by the course the experiment was taking, nearly every subject still yielded to the experimenter's explicit directives to continue, and went on administering shocks even as they appeared to have increasingly harmful effects on their recipient. While there is plainly no parallel between the circumstances of Milgram's experiment and those of a physician aiding a patient in realizing her wish to die, there is a common dynamic to the interpersonal relations in both situations. This dynamic consists, on the one hand, of an authority's communicating by words or deeds a judgment about the acceptability of certain actions that the recipient of the communication is in a position to perform and, on the other, of a disposition on the part of the recipient to defer his or her own

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<sup>14</sup> See STANLEY MILGRAM, *OBEDIENCE TO AUTHORITY: AN EXPERIMENTAL VIEW* (1974); see also J.M. Darley & C.D. Batson, *From Jerusalem to Jericho: A Study of Situational and Dispositional Variables in Helping Behavior*, 27 *J. PERSONALITY & SOC. PSYCHOL.* 100 (1973).

judgment to that of the authority. And it is because of this common dynamic that the results of Milgram's experiments have implications for our question.

Specifically, they imply that the presence of an approving physician when a patient is taking or being given a lethal drug will almost certainly affect the patient's view of the action, strengthening it when it agrees with the physician's and altering it when it does not. Thus, if the patient is at all hesitant about the wisdom of suicide or submitting to euthanasia, the presence of a physician communicating expectation and approval of the action will normally have a calming and reassuring effect, as the patient allows the physician's judgment to become his or her own. And because the circumstances of voluntary active euthanasia, if the practice were legalized, would presumably include, as a requirement of the law, the presence of a physician who would perforce be communicating such expectation and approval, the powerful dynamic that Milgram's experiments showed would in all likelihood be in play. Hence they would in all likelihood include a factor that created or increased the risk of a patient's submitting unfreely to euthanasia, and locating such a factor as a constant of these circumstances lends support to the assumption behind the utilitarian argument against legalizing voluntary active euthanasia that such legalization would put large numbers of people at risk of losing their lives unjustly.

By contrast, the results of Milgram's experiments do not similarly support the corresponding assumption behind the utilitarian argument against legalizing physician-assisted suicide. For the powerful dynamic the experiments showed would not necessarily or even typically be a factor in the suicides that resulted from such legalization. Indeed, it might be a factor in only a small percentage of them. The reason, put simply, is that physician-assisted suicide does not entail physician-supervised suicide. A law permitting physicians to prescribe a lethal dose of barbiturates for certain terminally ill patients, a law like the one recently enacted in Oregon,<sup>15</sup> need not require that a physician be present when the patient takes the drug. To the contrary, it

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<sup>15</sup> In November 1994, Oregon voters narrowly approved Ballot Measure 16. Measure 16, also known as the Oregon Death with Dignity Act, "allows a terminally ill adult to obtain a doctor's prescription for a fatal drug dosage for the express purpose of ending their life." *Lee v. Oregon*, 891 F. Supp. 1429, 1431 (D. Or. 1995) (permanently enjoining the Act's enforcement), *rev'd*, 107 F.3d 1382 (9th Cir. 1997).

is reasonable to suppose that many people who would avail themselves of the relief provided by such a law would arrange to die either alone or with family or friends, in the quiet of their home and at a time of their own choosing. Of course, the circumstances of physician-assisted suicide may still contain some constant factor that creates or increases the risk of an unfreely chosen suicide, but it is hard to see what it could be.<sup>16</sup> And until one is located or until it is shown that legalizing physician-assisted suicide would result in large numbers of physician supervised suicides, the assumption behind the utilitarian argument against such legalization—the assumption that such legalization would put large numbers of people at risk of losing their lives unjustly—must be taken as the expression of a generalized, which is to say, unfocused fear. The argument, therefore, finds less support in the concrete results of social science than the corresponding argument against legalizing voluntary active euthanasia.

These last points highlight the importance, in dealing with the question of whether the two practices can be treated as in-

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<sup>16</sup> Kamisar, to his credit, has sought in the published research on suicide evidence of the danger he believes legalizing physician assisted suicide would create. Thus he notes that psychiatric disorder is a common feature of people who commit suicide. See Kamisar, *Laws Against Assisted Suicide*, *supra* note 1, at 38. He does not, however, explain why this fact should mean that legalization would create a greater risk of unjust loss of life among the people who suffer from such disorders. For even though legalization may lead to significantly more suicides, it does not follow that it will lead to significantly more suicides among those who have some psychiatric disorder. All that might happen is that the demographics of suicide change to include significantly more people who do not suffer from some psychiatric disorder. The point is that legalization is aimed at giving people who have good and sufficient reason to wish to die medical help in realizing that wish, and there is no reason to suppose that psychiatric disorder is a common characteristic of such people or that the law could not be written or administered in a way that precluded those whose psychiatric disorder prevented them from making rational choices from gaining assistance from a physician in committing suicide.

Kamisar also notes that there is a higher incidence of clinical depression among the elderly than among those at earlier stages of life. See *id.* But this point appears to relate only to his concern, which is central to his article, that the federal courts could not find a constitutional right to assisted suicide that was limited to terminally ill patients. It is certainly plausible that legalization would put large numbers of people at risk of losing their lives unjustly if the permission were extended to anyone, even someone in good health, who sincerely wished to die. For the purposes of the discussion here, however, we are only considering legalizing physician assisted suicide for dying people who face sufficient pain or indignity in the remaining time left to them as to make suicide a reasonable choice. It's unclear that the higher incidence of clinical depression among the elderly would significantly increase the number of people at risk of losing their lives unjustly under such legalization.

distinguishable in utilitarian arguments against their legalization, of considering how the practices would *typically* be engaged in if they were legalized. One can, to be sure, imagine physician-assisted suicides that are not significantly different from submitting to euthanasia. Assisted suicides in which the amount of assistance is so great as to reduce the patient's role to that of merely taking the very last steps, nothing more than opening a mouth, say, and intentionally swallowing a capsule placed therein by the physician are, practically speaking, equivalent to submitting voluntarily to active euthanasia.<sup>17</sup> And if such suicides were typical of the suicides that resulted from legalizing the practice, then one could not seriously object to conflating it with voluntary active euthanasia when making utilitarian arguments against their legalization. In particular, one could not seriously object to this conflation on the grounds that it is harder to kill yourself than to have someone do it for you if the typical suicide consisted in swallowing a capsule a physician had placed in one's mouth. But neither Kamisar nor, as far as one can tell, any of the prominent opponents of legalization he cites offers reasons to think that such suicides would be typical.

Moreover, there doesn't appear to be good reason to think that such suicides would be typical. For to think so, one must be convinced of two things: first that many physicians who do honor the ban on voluntary active euthanasia would see legalization of physician-assisted suicide as an invitation to circumvent it; and second, that the law could not be so written or enforced as to effectively discourage such circumvention if it were necessary. Neither proposition seems particularly compelling.<sup>18</sup> Rather, these propositions seem just as speculative as the bare conjecture that legalization would result in a great many unfreely chosen suicides. In other words, they do not appear to provide grounds on which to justify, when making utilitarian arguments against legalization, conflating physician-assisted suicide and voluntary active euthanasia that are any firmer than the conflation itself. These considerations, then, corroborate our earlier observations that utilitarian methods advise treating

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<sup>17</sup> See Kamisar, *The Last Bridge*, *supra* note 1, at 230-31.

<sup>18</sup> The law enacted in Oregon, for example, requires that the lethal medication physicians are authorized by the law to prescribe must be self-administered, and though what counts as self-administered is somewhat open, the intent is to keep the physician's assistance at a low level. *Id.* at n.124.

the two practices separately. Conflating them, as Kamisar and the prominent opponents of legalization he cites do, allows the weaker argument to pass unjustifiably for the stronger.