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The Individual, the Community, and Physician-Assisted Suicide

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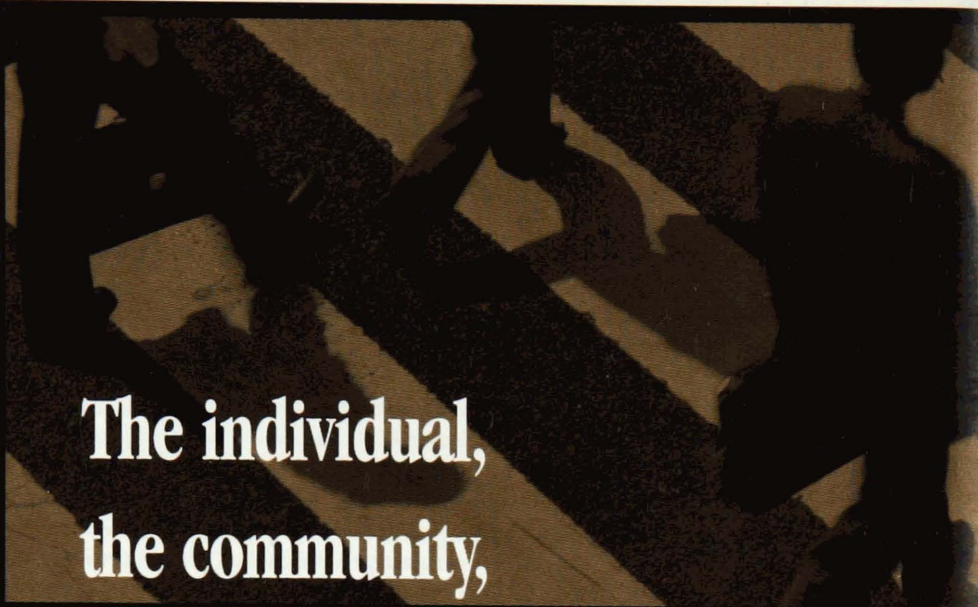
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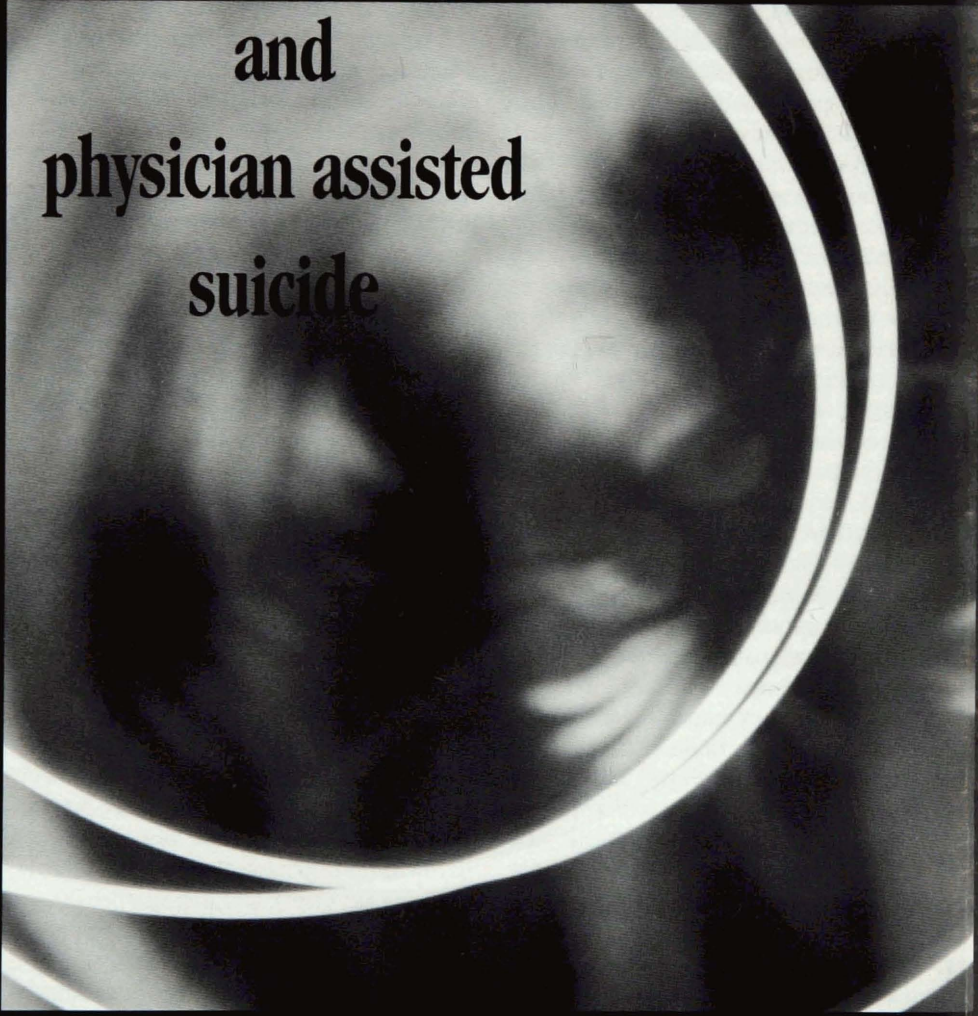
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**The individual,
the community,
and
physician assisted
suicide**



— BY PETER J. HAMMER, '89



This excerpt is adapted from the upcoming book Physician-Assisted Suicide, to be published in October 2000 and copyrighted by University of Michigan Press. The forthcoming book, edited and with an introduction by Professor of Law Carl E. Schneider, '79, incorporates papers delivered at the conference "Courting Death: A Constitutional Right to Suicide," held at the Law School in November 1997. The conference was devoted to follow-up discussion of two decisions in summer 1997 in which the U.S. Supreme Court rejected the right to physician-assisted suicide, Washington v. Glucksberg 117 S Ct 2258 (1997), and Vacco v. Quill 117 S Ct 2293 (1997). The following excerpt appears with permission from University of Michigan Press.

The conflict surrounding assisted suicide is symptomatic of a profound disequilibrium in the way society faces death and dying. The sources of this imbalance are many. Technology has drastically changed the physical setting in which dying occurs, forcing us to formulate new understandings of life and death. What it means to be alive or to be dead is no longer clear, nor is the exact moment of passage. The structure of modern medicine further contributes to the imbalance: As health care has become more institutionalized, specialized, and routinized, so has dying. Machines regulate and control life and death, maintaining heartbeats and breaths, reducing a person to a series of vital signs. Life is meted out and measured, regulated and controlled. Quantity, defined in hours, days, and years, often displaces quality as the objective to be pursued. Grieving and burial have also been reduced to commodities by a funeral industry equally committed to masking the real face of death. At the same time, the families and communities responsible for nurturing life and consoling death have been severely strained. Family structures at the nuclear and extended levels have become more fractured, and our circle of immediate friends and loved ones has become more geographically dispersed. As a consequence, death is often faced alone in a cold, technical environment, divorced from family and friends, surrounded by strangers.

The problem of assisted suicide forces us to carefully assess the meaning of death and dying (and by implication the meaning of life and living). This assessment is hard because death typically provokes more fear and denial than contemplation and reflection. The fear is of the unknown, of pain, suffering, and debility. The denial of death can be motivated as much by a sense of emptiness in life as by an actual fear of dying — or perhaps by a heightened fear of death because of a felt incompleteness in life. Still, it is clear that death retains an importance and significance that is as profound as it is unavoidable. Death is a stage in life holding many of its own lessons. Moreover, the manner in which death must be faced can influence the choices made during life, just as how we live will have implications for the manner in which we die. Death can bring us back to a sense of community, both by coalescing a group that provides support and comfort and by bringing to the fore the legacy we will leave behind, a legacy often defined in terms of the contributions we have made to others.

In our passive acquiescence to the medicalization of death and dying, it is not only death that is being denied. There is a denial of life. There is a denial of the individual as an integrated being. There is a denial of meaning and human dignity. Finally, there is a denial of community. Add to this the reality of individual human suffering, pain, disability, and dementia, and it is easy to see how recourse to suicide may look individually rational. While substantial attention has been paid to the role of pain in decisions on whether to commit suicide, similar attention has not been paid to the role of community. The issue is whether suicide is, for some, an individually rational response to death or an individually rational response to the way people are presently living and dying. The movement for assisted suicide may be symptomatic of larger problems in society and an indictment of the absence of meaningful community. Ironically, ratifying a right to assisted suicide and recognizing the ascendancy of the I-for-me rationality at the end of life may be the ultimate step in commodifying life and death and may further shift the balance away from the community and toward the increasingly isolated individual.

As the assisted suicide debate moves from the courthouse to the statehouse, we must re-examine the arguments that surround it to determine which elements are essential and which might bend in establishing a network of coexisting beliefs.

The I-for-me perspectives of the plaintiffs in *Glucksberg* (*Washington v. Glucksberg*, 117 S Ct 2258 [1997]) and *Quill* (*Vacco v. Quill* 117 S Ct 2293 [1997]) highlight the importance of respecting individual autonomy and self-determination, particularly as these qualities relate to engendering an appropriate sense of personal dignity and control in the face of death. Moreover, the reality of the pain and suffering experienced by these individuals must be directly confronted. The we-for-me arguments of opponents of assisted suicide remind us that the scope of individual autonomy and self-determination is necessarily circumscribed in the presence of defects in individual decision making, and that it is appropriate to place limits on personal choice when those choices have adverse effects on third persons. The we-for-us perspectives highlight the fact that the community is a collective entity with its own needs and interests. There are times when these collective interests may legitimately trump those of the individual. The community, however, must also be sensitive to the growth, development, and self-actualization of its members.

While there are positive aspects to these viewpoints, there are shortcomings to each perspective as well. The plaintiffs' claims in *Glucksberg* and *Quill* are arresting, but they have limitations. If we ask the dying why they consider suicide, they frequently speak of pain and suffering. But a number of other themes also emerge. One is a desire for control, another a desire for dignity. While the desire for control is understandable, the important question is what type of control is appropriate and how that control should be manifested.

Proponents of assisted suicide argue for control in the form of being able to individually determine the moment and manner of death. This is the type of control of a Hollywood director, a film editor, or Ronald Dworkin's author writing her life's last chapter. (R. Dworkin, *Life's Dominion: An Argument about Abortion, Euthanasia, and Individual Freedom*, Knopf, 1993). This is not the only type of individual control that can be envisioned. Being ill and dying entails an inevitable loss of control. That loss is compounded when doctors expect passive compliance with their expertise and authority. But while many aspects of dying are beyond human control, numerous other aspects are not. Individual control can be manifested in many ways short of assisted suicide. Letting people participate in what they can affect is one way for them to assert control and to assuage feelings of

helplessness and anxiety. Participation can help people distinguish those parts of dying that are controllable from those that are not, and help them to accept the inevitable loss of control they have over their bodies and existence. Dying must involve an appropriate combination of taking charge and letting go, engagement, and resignation.

Just as the desire for control requires a balanced understanding of what can and cannot be influenced, so the desire for dignity requires an understanding and acceptance of different forms of dependence. In our culture, dignity is often defined in terms of independence and self-sufficiency. A common fear among the dying is of becoming dependent upon others. Put bluntly but succinctly — "I want to be able to wipe my own butt." While every one can empathize with this sentiment, "dignity" need not be understood that way. Infants do not lack dignity because they need their diapers changed, nor must changing them be burdensome. Dignity is inherently a relational concept, defining the person with respect to her community. Illness and dying are necessarily an assault on self-sufficiency, a reminder of one's vulnerability, weakness, and dependence. As illness physically changes the person, it calls for a continual redefinition of one's self and of one's sense of dignity.

Confronting incapacity while retaining a sense of self-worth is like accepting loss of control over the uncontrollable and yet remaining engaged and retaining control of the dying process. A static image of self and concepts of dignity defined solely in terms of strength, independence, and autonomy are ill-suited to prepare a person for a protracted illness or prolonged death. Justice Stevens speaks poignantly about people's interest in influencing the memories they will leave behind, but no life is a snapshot. A life is a complex story, with many chapters and phases. Just as the concern about memories is a concern about how others see us, so the concern over dignity is at its heart a fear that our inability to accept the loss of our independence and our control over our bodies will be shared by others. Feelings of indignity are largely fears of rejection by our community. Such fears not only invite, but demand, a communal response.

It is interesting but not surprising to note how tracing the individual's interest in maintaining personal dignity has necessarily led us from viewing the individual in isolation to understanding the individual as a member of a community. Other emotions

and fears surrounding death — such as fears of abandonment and feelings of isolation — confirm that it is impossible to speak of the dying individual without also speaking of the living community. The individual and society are intimately interconnected. The decisions of family, friends, and the community will affect the environment in which death occurs and the levels of fear, anxiety, and meaning that are present. Coming to terms with death requires coming to terms with one's self and one's community. A discourse focusing exclusively upon individual autonomy and I-for-me rationality is insufficient unless the concept of self it engenders leads the individual back to a sense of community. The presence, attitudes, and actions of family and friends, of doctors and nurses, and healthcare providers will have as much to do with finding dignity and meaning in death as the medical condition of the dying person.

This criticism is not limited to I-for-me perspectives. Similar deficiencies can be found in the we-for-me policy arguments raised by opponents of assisted suicide. Rather than addressing the central issue of the individual's relationship to the community and the community's obligations to its members, opponents focus on decision defects and slippery-slope concerns. These are surely important, but at another level they are simply distractions, for they do not address the human dimension of the dying person's needs or the overall needs of society. Worse, these arguments are frequently a pretext to camouflage a debate that is really about social norms. Those favoring a strong norm in favor of the sanctity of life often invoke substantial and irremediable decision-making defects and a steep and inescapable slippery slope. Their opponents deprecate these concerns. The failure to address the central conflict between individual and collective rationality is not only disingenuous, it is self-defeating. Decision-defect and slippery-slope arguments involve contested, empirical claims. Empirical claims invite empirical resolution. Debate will inevitably drift toward "how" to regulate and not "whether" to regulate. In this process, a right to assisted suicide could too easily be adopted incrementally without openly addressing the underlying normative concerns.

We-for-us arguments face their own challenges and limitations. The concern over the sanctity of life can delegitimize itself if pursued so oppressively that it robs individual lives of their meaning. Any

authentic communal value must resonate in a consonant fashion with the needs of its individual members. The sanctity of life cannot be a wooden or artificial principle. To address these concerns, the Ninth Circuit advocated using a sliding scale standard to assess the value of life (in *Compassion in Dying v. Washington*, 850 F Supp 1454 [WD Wash 1994]): "[E]ven though the protection of life is one of the state's most important functions, the state's interest is dramatically diminished if the person it seeks to protect is terminally ill or permanently comatose and has expressed a wish that he be permitted to die without further medical treatment. . . . When patients are no longer able to pursue liberty or happiness and do not wish to pursue life, the state's interest in forcing them to remain alive is clearly less compelling."

Unfortunately, this analysis raises its own slippery-slope concerns. If the socially determined value of a life diminishes as people near death, how will the debates over voluntary and involuntary euthanasia, or the rationing of healthcare be affected? Eroding or chipping away at the intrinsic value society attaches to the lives of its individual members can have profound and disturbing consequences. The use of a sliding scale in which the value of a life is worth less depending on its objective circumstances motivates the opposition to the legalization of assisted suicide of many associations of handicapped and disabled people. In fairness to the Ninth Circuit, the court tries to make the sliding scale depend upon the dying person herself. The distinction between the individual's assessment of her life's value and society's assessment, however, is difficult to maintain as a practical matter and almost impossible to implement as a matter of policy. To be given legal effect, the individual's evaluation must ultimately be ratified by the state.

If the sliding-scale valuation of human life is not a good way to prevent a rigid version of the sanctity of life from burdening the dying, how should collective concerns over the intrinsic value of life be tailored to address the needs of the terminally ill? A policy that can provide a satisfactory answer to this question will effectively mediate and potentially resolve the tensions between individual and collective rationality that divide camps in the assisted suicide debate. While I do not claim to have a definitive answer to this question, a satisfactory resolution would seem to minimally include the following elements.

First, an acknowledgement that a necessary corollary to the sanctity of life is the value of compassion. A society that claims to respect the intrinsic value of life is obligated to respond compassionately to the physical and emotional needs of its dying members, including the use of aggressive palliative care when necessary to ameliorate individual pain and suffering. Respect for the sanctity of life without the corresponding value of compassion can become a hollow and potentially oppressive principle.

Second, development of an appropriate vocabulary to operationalize the principles associated with preserving the sanctity of life in order to help guide the making of end-of-life decisions. I often prefer speaking of a "reverence for life" rather than the "sanctity" or "intrinsic value" of life, and operationalizing this principle by requiring that individual decisions be life-affirming. Choice of terminology, however, should not obscure the fact that life must remain an end in itself, and that end-of-life decisions should be made in accordance with this principle. The danger in the Ninth Circuit's sliding scale and in efforts to adopt a "quality of life" rhetoric is that both can too easily slip in directions that fail to respect life as its own end. A rhetoric grounded in reverence for life and a requirement that end-of-life decisions be life-affirming helps avoid this trap, and yet should be capable of acknowledging that the object of life and medicine is not simply the preservation of a series of vital signs.

Third, encouraging individual self-determination and empowering individuals to exercise control over their lives and medical care within a dominant ethic of reverence for life, including reverence for their own lives. Individuals should be permitted to structure a substantial range of end-of-life alternatives, including alternatives other than dying in an institutionalized medical setting. While I would empower greater individual autonomy in making end-of-life decisions, I would deny the individual the option of suicide on the ground that such an act is not life-affirming and fails to respect the intrinsic value of life that should be symmetrically held by the individual and society.

Although approaching the problem from a substantially different perspective, these principles are in general accord with the Supreme Court's results in *Cruzan v. Director, Missouri Dept. of Health* 497 US 261 (1990) and *Glucksberg*. Individuals are provided substantial freedom in denying unwanted medical care, and yet are also



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denied the right to assisted suicide. The extension of choice in one area and the denial of choice in another may appear contradictory, but it underlies an important paradox. Sometimes the exercise of individual freedom can be realized only in the presence of external constraints. The freedom is the ability to actively shape and influence the manner in which death and dying occur. The constraint is the prohibition of suicide. The individual and the community may be better able to negotiate the delicate balances these decisions require if they do so within a setting in which both the individual and the state share a mutual commitment to the sanctity of human life.

But what of the challenge of I-for-us reasoning? Is a norm prohibiting suicide but expressly acknowledging society's obligation for compassionate palliative care and otherwise permitting individuals substantial self-determination in making life-affirming end-of-life decisions consistent with the dictates of I-for-us rationality? Could that norm be embraced by the plaintiffs in *Glucksberg* and *Quill* not necessarily as a matter of individual rationality, but as part of what they could think of as collectively rational? Justification for such a norm could come from two sources. First are the aspirational arguments in favor of a symmetric commitment to the sanctity of life as an essential aspect of our definition of society. If these arguments present a persuasive picture of how we conceive of ourselves and our community, then a norm prohibiting assisted suicide could fall within the category of I-for-us norms essential to the survival and integrity of the community. The arguments against the sliding-scale value of life suggest some of the dangers associated with failing to embrace such a norm.

The second possible justification would be in terms of norms designed to facilitate individual development. A norm against assisted suicide could be justified if dying, like primary education, is an important developmental stage in life — a stage that is capable of substantively transforming individual preferences and beliefs. Death is undeniably an important stage in life, potentially no less significant than other development stages such as childhood and adolescence. Death and dying may afford unexpected opportunities and lessons for each of us, lessons that would be lost if death is short circuited or denied. This contention is not limited to the lessons inherent in the dying process. Equally important is the fact that knowledge of how

we must face death can filter back and influence decisions throughout our lives. Moreover, it is not only the dying who learn through death. The actions and decisions we make in dying teach those around us, particularly members of our family, about life and death.

If these I-for-us arguments are not persuasive, then the issue of assisted suicide is reduced to a set of empirical questions regarding the significance of various we-for-me concerns. Appropriate policy should then be based upon the assessment of state legislators about the pervasiveness of individual decision defects and the seriousness of potential slippery slope problems. The significance of resolving the debate in this manner, however, should not be lost. Assisted suicide raises important constitutive questions. Rejecting the aspiration arguments in favor of the sanctity of life involves the adoption of a different set of aspirational claims and beliefs that will equally define us as a society. My point is that in making constitutive decisions that will define who we are, we should collectively pause and give careful consideration to what we want to be.

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