

4-1-2017

Rebranding Death

Angela Wentz Faulconer

Follow this and additional works at: <https://digitalcommons.law.byu.edu/jpl>

 Part of the [Medical Jurisprudence Commons](#)

Recommended Citation

Angela Wentz Faulconer, *Rebranding Death*, 31 BYU J. Pub. L. 313 (2017).

Available at: <https://digitalcommons.law.byu.edu/jpl/vol31/iss2/2>

This Article is brought to you for free and open access by BYU Law Digital Commons. It has been accepted for inclusion in Brigham Young University Journal of Public Law by an authorized editor of BYU Law Digital Commons. For more information, please contact hunterlawlibrary@byu.edu.

Rebranding Death

Angela Wentz Faulconer

In this paper, I will argue that efforts to legalize aid-in-dying or physician-assisted suicide are attempts to rebrand this sort of death as a good choice. It is common to justify physician-assisted suicide through arguments for a) relieving suffering or b) allowing individual autonomy, but I will show that the problem with these justifications is that once this type of death is judged as acceptable, it is difficult to justify limiting it to a narrow group such as the mentally competent, communicatively able, terminally ill adults designated by these legalization bills. Ultimately, we must either label many more deaths as good deaths, destigmatizing suicide, or we must reject the notion that death at the time we choose is acceptable. I will argue for the latter.

It is difficult to find neutral language to avoid prejudging the questions I want to explore in this paper: Is assisted dying suicide? Is physician-assisted suicide a good death? Is it something that should be approved and sanctioned, possibly even encouraged by the State? In an attempt to start from more neutral ground, and not to assume the conclusions I will argue for, I will discuss what I will call death at a time of one's choosing (DTC) instead of physician-assisted suicide or aid-in-dying.

I. DEATH WITH DIGNITY BILLS GIVE THE STATE'S IMPRIMATUR TO THE CHOICE TO END ONE'S LIFE BEFORE LIFE'S END

At the outset, it is important to acknowledge what motivates the death with dignity movement, the movement that champions death at a time of one's choosing. Many people fear death. Dying in pain has always been feared and new life-sustaining technologies now aggravate these fears as some of the people who would have died in the past are now maintained alive, but without being healed, without being returned to health,¹ without being returned to even a semblance

1. John Lachs, *When Abstract Moralizing Runs Amok*, in INTERVENTION AND REFLECTION 601, 602 (Ronald Munson ed., 2012). John D. Arras, *Physician-Assisted Suicide: A Tragic View*, in PHYSICIAN ASSISTED SUICIDE: EXPANDING THE DEBATE (Margaret P. Bat-

of well-being.² We dread finding ourselves ready to die, yet still being alive. We have seen others buy—through treatments such as chemotherapy, artificial ventilators, or difficult surgeries—a few more days or weeks, but at a cost that seems terrible to pay. We are afraid of suffering.³ We are also afraid of not being able to care for ourselves; we worry about dependence and embarrassment.⁴ We worry about a return to childhood, or worse, infancy.⁵ We worry about humiliation, and we fear a death without dignity.

tin, Rosamond Rhode & Anita Silvers eds., 1998) [hereinafter PHYSICIAN ASSISTED SUICIDE].

2. Most of us now believe that it is our right to refuse undesired life-sustaining measures (I owe thanks to Gert, Culver and Clouser for their helpful “refuse” v. “request” terminology). Bernard Gert, Charles M. Culver & K. Danner Clouser, *An Alternative to Physician-Assisted Suicide*, in PHYSICIAN ASSISTED SUICIDE, *supra* note 1, at 186. If we do not want our lives prolonged through artificial resuscitation or a mechanical ventilator or if we choose to forego chemotherapy, we have the right to refuse these treatments. Refusing medical treatment is not an example of what I call death at a time of one’s choosing. Instead, this term describes the result of requests for interventions to end one’s life. Some proponents of euthanasia, such as James Rachels, have argued that refusing medical treatment to prolong life is morally equivalent to a physician’s intervention to end life, and sometimes even morally preferable. James Rachels, *Active and Passive Euthanasia*, in INTERVENTION AND REFLECTION 585, 586 (Ronald Munson ed., 2012).

However, for most people it is common sense that refusing life-sustaining measures is different from requesting that action be taken to end one’s life. Daniel Callahan, *When Self-Determination Runs Amok*, in INTERVENTION AND REFLECTION, *supra* note 1, at 598. Refusing recommended surgery or chemotherapy is not the same sort of action and does not necessarily have the same intent as requesting administration of a lethal injection. *Id.*

The freedom to refuse life-sustaining measures may seem irrelevant to a discussion of DTOC. However, it is relevant here because of the widely shared fear of being kept alive by machines past the time a person wishes to resist dying. This fear often leads people to believe that legalizing DTOC is imperative because it would allow one to refuse undesired life-sustaining measures. However, this is mistaken. Legalizing DTOC for this reason is unnecessary because the debate about whether patients or their agents should be allowed to refuse medical treatment has already been settled. See *Matter of Quinlan*, 70 N.J. 10, 355 A.2d 647 (1976). It is already legal, and most of us would argue that it is also clearly moral, to allow patients to refuse life-sustaining technologies or to have them withdrawn. Every competent person already has that freedom, so this is not a reason for legalizing DTOC.

3. Arras, *supra* note 1, at 282.

4. Paul C. McLean, *Medical Ethics: Incontinence A Fate Worse than Death? Really?*, WBUR CommonHealth, (September 9, 2016), <http://www.wbur.org/commonhealth/2016/09/09/incontinence-fate-death>.

5. See Emily B. Rubin, Anna E. Buehler & Scott D. Halpern, *States Worse Than Death Among Hospitalized Patients with Serious Illnesses*, 176 JAMA INTERNAL MED 10, 1557 (2016). It is difficult to deal with these fears rationally. A widely-reported recent study of adults age 60 and over and hospitalized with serious illnesses suggested that almost seventy percent considered incontinence as a state the same as or worse than death. *Id.* One wonders what the approximately thirteen million incontinent Americans would say about this verdict. Fifty percent of elderly adults are incontinent. Illinois Dep’t of Public Health, *Incontinence*, <http://www.dph.illinois.gov/topics-services/diseases-and-conditions/diseases-a-z-list/incontinence> (last visited Apr. 13, 2017). Are they really better off dead?

The death with dignity movement suggests a solution to our fears through the control offered by a lethal prescription. Up until now, such prescriptions have not been legal. Prescriptions and medical practices are carefully regulated by the State.⁶ Up until now, the State has not offered us control over when we die. Except in death penalty cases, the State has not taken this control for itself either. This lack of control over aspects of one's own life is hard for some to accept. Being autonomous is a priority for many. In a study of what motivated patients in Oregon to request Physician-Assisted Dying/Physician-Assisted Suicide, Ganzini, Goy and Dobscha found that patients were "more strongly motivated by the prospect of loss of autonomy," by the desire for control, than by current physical symptoms.⁷

Traditionally, taking control we would not otherwise have over our own lives, taking affirmative steps to avoid suffering or the fear of suffering, has been understood as a form of suicide. There has been a significant stigma against it. Part of this has been religious. Suicide has been seen as a wrongful death, a sin. Historically, many who committed suicide were restricted from burial in church plots.⁸ Part of this has been social. Families have been ashamed and have hidden suicide, seeing it as the failure of themselves or their loved one, keeping it out of obituaries and sometimes even out of intra-family conversation.⁹ Fortunately, as society has grown to understand more about mental illness, suicide has come to be talked about more openly and has lost some of its former stigma. We have come to feel more compassion towards the suffering that leads to these choices.¹⁰

Nonetheless, it is fair to say that suicide is still seen as a bad death, as something we would encourage those we love and those we barely know to avoid, as something that you should not do to your family. Suicide is secret. Although some do make pleas for help, in

6. Lachs, *supra* note 1, at 602.

7. Linda Ganzini, Elizabeth R. Goy & Steven K. Dobscha, *Oregonians' Reasons for Requesting Physician Aid in Dying*, 169 ARCH INTERN MED 5, 489, 491 (2009).

8. Reverend Mike Parsons, *General Synod Private Member's Motion: Canon B 38 Canon law in relation to the funerals of those who have taken their own life*, Church of England (2015), <https://www.churchofengland.org/media/2141151/gsm%201972a%20-%20pmm%20on%20canon%20b%2038.pdf>.

9. Mark E. Hastings, Lisa M. Northman & June P. Tangney, *Shame, Guilt, and Suicide*, in SUICIDE SCIENCE: EXPANDING THE BOUNDARIES, 67 (Thomas Joiner & M. David Rudd eds., 2002).

10. Reverend Mike Parsons, *Why the church should change laws on allowing suicide victims proper funerals*, Gloucestershire Live (Feb. 13, 2015), <http://www.gloucestershirelive.co.uk/church-change-laws-allowing-suicide-victims/story-26021685-detail/story.html>.

general the desire to end one's life is not something one can talk about openly, not just because of others' disapproval, but because of interference from the law.¹¹ To avoid being hospitalized, one must keep quiet. Suicide is also messy. The methods available (death by handgun, cutting an artery, hanging, or overdosing) are often undesirable,¹² likely because they are dramatic, violent, painful, and/or not always successful. Against this context, many are tempted to see legalization of death at a time of one's choosing as a solution—at least for those who qualify under the strict restrictions thought necessary in these bills—adults who are mentally competent, communicatively able, and terminally ill.¹³

Proponents see DTOC as a solution (both to loss of control and fears about death and to the difficulties of suicide) because legalizing DTOC means that the State steps in and gives permission to end one's life before it ends naturally—a) ending the fear of pain and/or loss of dignity and b) suggesting that the State sanctions one's choice. Through these bills, the State says, “You can end your life early. You can end it now. There doesn't have to be a stigma. We will call it a good death.” Speaking in the voice of the State to call it a good death might seem like a stretch, but consider that the Oregon Death with Dignity Act (upon which the other states' bills are modeled) uses the phrase “humane and dignified” eighteen times to describe death by lethal prescription.¹⁴ In this context, the restrictions put in place by bills that legalize DTOC not only make DTOC more acceptable to the public, they also make DTOC seem more acceptable for those who would consider choosing it, because death becomes something that one can qualify for, something that one can merit or not, based on one's condition. When legalized, this sort of death gains the imprimatur of the State, the State's seal of approval.

According to the State, if one meets a certain standard, reaches a certain age, is dying in a certain way (because only some conditions make a six months-until-death type prediction possible), is approved by two physicians, and jumps through the proper bureaucratic hoops,

11. E. Fuller Torrey & Mary Zdanowicz, *Outpatient Commitment: What, Why, and for Whom*, 52 PSYCHIATRIC SERV. 3, 337 (2001).

12. Lachs, *supra* note 1, at 602.

13. H.B. 264, 2016 Gen. Sess., (Utah 2016); S.B. 128, 2015-2016 Cal. Leg., Reg. Sess. (Cal. 2015).

14. Oregon Health Authority, *Death with Dignity Act*, OREGON.GOV, <https://public.health.oregon.gov/ProviderPartnerResources/Evaluationresearch/deathwithdignityact/Pages/index.aspx> (last visited Jan. 21, 2017).

this “qualifies” one for DTOC. Death need no longer be secret nor messy. One need not disappoint one’s friends and family. There need not be shame. The person in this situation can comfort herself with the reflection that she has been approved by the State for what is stipulated to be a humane and dignified death. The State agrees that, given her condition, she should have (as labeled by the law passed in California this past summer) an “end of life option.”¹⁵ She now has State sanctioned control over her own life and death.

This control extends even to the death certificate. According to the California Medical Association, when a lethal prescription is ingested, “Physicians can list the cause of death that they feel is most accurate,” but under the law “physicians cannot list ‘suicide’” as that cause.¹⁶ The State also tells insurance companies how they are to understand these deaths: companies are barred from treating a patient’s “life, health or annuity policies any differently than death by natural causes.”¹⁷ The legalization of death at a time of one’s choosing is a rebranding of death. What had been the bad, societally unacceptable death of suicide is mandated by law to be labeled as the good, societally acceptable death of ingesting a lethal prescription under physician’s orders and with state law presiding.

It is curious that advocates of DTOC resist labeling this practice as suicide.¹⁸ This is surprising given that the most compelling reason for DTOC is to give a patient control of when she dies.¹⁹ The term “suicide” suggests that someone has taken that kind of control in choosing to end her own life. If having control over when one dies is a good thing, why should suicide be considered a bad thing? The reason is that although we may not wish to judge any specific individual who chooses to take her own life, as a society, it is still our sense that suicide is not acceptable—it is dying done the wrong way. Stepping back from the specific example of terminal illness, we do not generally consider pain, depression, or desire to be in control of when one dies as good reasons for ending one’s life, and this is why we treat the desire to kill oneself as a crisis—regardless of the reasons that seem to

15. S.B. 128, 2015-2016 Cal. Leg., Reg. Sess. (Cal. 2015).

16. Claudia Buck, *Eight things you should know as California’s new aid in dying law takes effect*, THE SACRAMENTO BEE, (June 9, 2016, 6:00 AM), <http://www.sacbee.com/news/local/health-and-medicine/article82660497.html>.

17. *Id.*

18. Robert Steinbrook, *Physician-Assisted Death—From Oregon to Washington State*, 359 NEW ENG. J. MED. 24, 2513 (2008).

19. Ganzini, *supra* note 7, at 489.

justify it in the view of the individual who considers taking that step.²⁰

II. JUSTIFICATIONS FOR DEATH AT A TIME OF ONE'S CHOOSING

In what follows, I will look at two possible justifications for legalizing death at a time of one's choosing and show that both justifications share a common problem: they justify too much. Regardless of whether we justify DTOC as a response to terrible suffering or if we justify it through an appeal to autonomy, the problem is that we end up justifying DTOC for everyone, not just those who can reasonably be thought to have less than six months to live. Let's look at DTOC as a response to suffering first. The argument is straightforward: DTOC is justified because some people suffer so terribly, so unbearably, that the merciful thing to do is to allow DTOC so that they need not bear the unbearable any longer.

Unfortunately, there are some important problems with focusing on suffering as a justification for legalizing death at a time of one's choosing. First, suffering is subjective: what may be tolerable to one person may be unbearable to another. Who is to judge another's suffering?²¹ Second, physical suffering is not the only form of suffering and may not be the worst, and third, the terminally ill do not have a monopoly on suffering, nor do the competent.

A. Suffering is Subjective

One problem with understanding suffering as the justification for legalizing DTOC is a practical one. Because suffering is subjective, it is difficult to apply as a criterion. Who is to be included and excluded? Arras and Callahan also make this point.²¹ We all know people who take to their beds, unable to function at the first sign of illness, and others who are able to function even under serious illness with little apparent impact to their daily activities. The suffering that one person can tolerate, others will find difficult to bear.²²

Some might look to medical professionals in hopes of finding a more objective basis for evaluating a patient's suffering. However, the yellow pain scale evaluation cards that dangle from every hospital ex-

20. National Suicide Prevention Lifeline, <http://suicidepreventionlifeline.org/> (last visited Apr. 8, 2017).

21. Arras, *supra* note 1, at 597.

22. *Id.*

am room testify that these hopes are misplaced. While the nurse may help her patient interpret the zero to ten pain scale, it is the patient's answers that determine the medicine ultimately prescribed.

Suffering's subjectivity means that it is impossible for the State to rank suffering from worst to least or to draw a line that designates the point below which suffering must be endured and above which DTOC ought to be offered as an option. This means that we must either legislate the impossible by drawing lines that are not just unfair but absurd, or allow each individual to decide when her own suffering is sufficient—effectively opening the choice to end one's life on the basis of suffering to everyone who suffers, which is to say, everyone.

B. Physical Suffering Is Not the Only Suffering

Another problem with justifying death at a time of one's choosing through suffering is that physical suffering is not the only (or necessarily even the worst) type of suffering. Like physical suffering, mental suffering too, can be hard to heal from. It too can leave us unable to pursue the activities we once enjoyed.²³ Mental suffering too can make life feel not worth living.²⁴ It can feel unbearable. If we seek to relieve those who suffer, then if physical suffering is a justification for DTOC, mental suffering ought to be as well. Again though, the problem is that this opens the option of DTOC to almost everyone.

C. The Terminally Ill and the Competent Do Not Have a Monopoly on Suffering

Finally, note that the terminally ill and the competent do not have a monopoly on suffering. One does not need to be terminally ill to suffer. Bills to legalize DTOC contain many safeguards that limit it to a narrow category of people (mentally competent adults, able to communicate, terminally ill and within six months of death, etc.).²⁵ Although these safeguards may make us more comfortable with the bills because they restrict their scope, they undermine the bills' log-

23. Mayo Clinic Staff, *Diseases and Conditions: Depression (major depressive disorder): Symptoms*, Mayo Clinic, <http://www.mayoclinic.org/diseases-conditions/depression/basics/symptoms/con-20032977> (last visited Jan. 21, 2017).

24. *Id.*

25. S.B. 128, *supra* note 15; H.B. 264, *supra* note 13.

ic.²⁶ If end-of-life suffering justifies legalizing DTOC, it makes sense that profound middle or beginning-of-life suffering should justify DTOC as well. If suffering is what makes choosing death acceptable, then one's life expectancy ought to be irrelevant.²⁷

This is not all—just as there are many that suffer who are not terminally ill—there are many who suffer who are not cognitively competent.²⁸ Unfortunately, terrible suffering is not limited only to those from whom we can secure consent. If suffering alone were reason to condone DTOC, then suffering might also be reason enough to condone ending the lives of children who are suffering (but who have not reached the age of majority) as has happened in Belgium,²⁹ or to end the lives of Alzheimer's patients who are suffering but mentally incompetent. However, most of us find these conclusions unacceptable. If this is what prioritizing suffering means, these arguments suggest a problem with our priorities. We do not sanction juvenile and incompetent adult euthanasia because we do not see suffering alone as sufficient for sanctioning death.

There are several problems with justifying the legalization of DTOC as a response to suffering. The main point is that human suffering is vast and sufferers are legion. If terrible suffering by itself sufficed to justify DTOC, then DTOC would need to be offered as an option to many. However, as a society, we reject this idea. When a young person undergoes surgery and doctors struggle to get his pain under control afterwards, no one would see ending his life as an option he ought to be offered. When people suffer from painful, debilitating chronic (as opposed to terminal) illnesses for which there is no cure, we do not see ending such a person's life as the appropriate course. The reason DTOC bills tend to be heavily restricted—for example, to specific classes of sufferers (aged to adulthood and competent) or to people under certain circumstances or suffering from certain conditions (within six months of death, those suffering from ALS but not those from Alzheimer's, for example)—is because in fact most of us do not see suffering by itself as reason for ending someone's life. Suffering alone does not condone DTOC.

26. Daniel Callahan, *When Self-Determination Runs Amok*, in INTERVENTION AND REFLECTION, *supra* note 2, at 599; Arras, *supra* note 1, at 283.

27. *Id.*

28. Callahan, *supra* note 2 at 600; Daniel Callahan, *Ad Hominem Run Amok: A Response to John Lachs*, 5 J. OF CLINICAL ETHICS, no. 1, 1994, at 14.

29. See Rory Watson, *Belgium Extends Euthanasia Law to Children*, BRITISH MED. J. at 348 (2014).

But if suffering alone does not provide justification for DTOC, what does? The other main argument for State sanction of DTOC is from individual control or autonomy. It is worth noting that the experience of Oregon (where DTOC has now been legal for almost twenty years) suggests that most people who request life-ending prescriptions do so not because of current and unbearable suffering, but because they hope to control when and how they die.³⁰

The argument from individual control, or autonomy, fits nicely with the justifications based on suffering that were insufficient on their own. Why would it be the appropriate province of the State (or anyone else) to decide who has suffered more, which type of suffering is more difficult, or when suffering justifies death? Because the individual is the one who must live with the suffering or have his life ended, the individual is the one who should have control, the one who should have the final say over whether death is the right choice for him or not. This argument suggests that the individual must have autonomy over his own life, including when and how he dies. Rather than prioritizing suffering, this view prioritizes autonomy.

John Stuart Mill advocates for this view of autonomy in *On Liberty*.³¹ Because he has two views about autonomy and its relationship with the State which may or may not be consistent with each other, I will distinguish them by calling the first view autonomy₁ and the second view autonomy₂. In arguing for autonomy₁ he explains that individual autonomy must be prioritized because it is “[t]he only freedom which deserves the name . . . that of pursuing our own good in our own way.”³² If a person believes that his own best good is to end his life, it appears Mill would support such a choice because “over himself, over his own body and mind, the individual is sovereign.”³³ The State has no license to interfere with his sovereignty, the individual’s control over his own body and mind, unless there is a “harm to others.”³⁴ Mill says we cannot interfere with a person even if we think in exerting this control over his own life (and one assumes, death) he is harming himself, for his “own good, either physical or moral, is not a sufficient warrant.”³⁵

30. Ganzini, *supra* note 7, at 491.

31. See generally, JOHN STUART MILL, *ON LIBERTY* (1863).

32. *Id.* at 29.

33. *Id.* at 23.

34. *Id.*

35. *Id.*

III. DIFFICULTIES WITH JUSTIFYING DTOC THROUGH ARGUMENTS FOR AUTONOMY

The idea that we should acknowledge and respect the autonomy that every competent individual rightly has over her own life and affairs is a powerful justification for legalizing death at a time of one's choosing. However, I will argue that there are three autonomy-related considerations that suggest we must not legalize DTOC: 1) allowing individuals to alienate their autonomy betrays the purposes of autonomy, 2) prioritizing autonomy has unacceptable consequences, and finally, 3) labeling this use of autonomy as a good death harms those with disabilities and chronic pain.

A. Allowing Individuals to Alienate their Autonomy Betrays the Purposes of Autonomy

The first autonomy-related reason for not legalizing DTOC is that allowing someone to alienate her autonomy betrays the purposes for which the State grants autonomy. John Stuart Mill is famous for his autonomy₁ view which suggests that the only reason for interfering with another person's autonomy is to prevent harm to others.³⁶ However, as both Gerald Dworkin and Craig Carr have pointed out, a careful reading of *On Liberty* raises another reason for interfering with autonomy.³⁷ This is the view I will call autonomy₂. In discussing whether someone should be able to sell himself into slavery, Mill explains that "the reason for not interfering, unless for the sake of others, with a person's voluntary acts, is consideration for his liberty."³⁸ Someone who sells himself into slavery "defeats, in his own case, the very purpose which is the justification of allowing him to dispose of himself . . . The principle of freedom cannot require that he should be free not to be free. It is not freedom, to be allowed to alienate his freedom."³⁹

On this view, the State gives freedom not for freedom's sake, but for freedom's fruits. Autonomy is desirable because it allows a competent adult to choose her own life plan, not just because she knows

36. *Id.*

37. Gerald Dworkin, *Paternalism*, in INTERVENTION AND REFLECTION, *supra* note 1, at 65; CRAIG L. CARR, POLITY: POLITICAL CULTURE AND THE NATURE OF POLITICS 81 (2007).

38. MILL, *supra* note 31, at 198.

39. *Id.* at 198–99.

better than others what pursuing her good looks like, but also because what she has chosen *is* the good because it is what she has chosen for herself (this is also characteristic of Mill's autonomy₁).

One need not accept every detail of Mill's conception of the good to agree that autonomy is valuable and that, as autonomy₂ suggests, the State has an important role in protecting it. Fortunately, most people guard their autonomy jealously and resist threats to it. However, in situations of desperation, people sometimes do give up their autonomy. An individual who seeks to commit herself to permanent servitude in order to secure some gain for a family member is an example of a person who seeks to alienate her autonomy. Mill's autonomy₂ suggests that it is the role of the State to step in to protect her. Another example of someone seeking to alienate her autonomy is the individual who seeks to end her own life. When life ends, autonomy ends. Thus, rather than promoting DTOC, the State should step in to protect patients.

One might argue that it is not right for the State to interfere with the autonomy of the terminally ill by prohibiting medical professionals from helping those who seek to end their lives. After all, the case in which a terminally ill person ends his life is different than the case in which someone else ends his life. A person who is not terminally ill may have years of decisions and opportunities for self-direction ahead of him if he does not end his life early. A person who is terminally ill does not have this—regardless of whether he acts or asks others to act to end his life. One might conclude that when a terminally ill person ends his life there is less impact to autonomy and, therefore, less reason for the State or anyone else to interfere.

But this is not a wholly satisfactory response. Although terminal patients are dying, they are not dead. Even with a vastly reduced slate of choices, there are still choices to be made. It is true that the terminal patient cannot implement a plan of life and hope to realize his conception of the good over the next twenty years. But for those who value autonomy, it is worth recognizing that the terminal individual does have decisions to make about his last few days and months. How will he react to his own predicament? With anticipation? Anger? Silence? Tears? Will he dissolve into self-pity or shake his fist at the universe? Or look forward to peace at last? What will his last interactions with friends and family be? Will he leave words of wisdom or memories of amusing eccentricity? Will he express gratitude for medical workers or complain? Perhaps both? Will he live out his own

conception of the good in the months he has left, abandon it, or re-forge something new?

Many see one's last days as especially important. Of course, people who choose to end their lives early also have last days. One can argue that when a terminally ill patient chooses an earlier death he makes a final and important use of his autonomy. One could argue that in doing so, he exercises his autonomy rather than alienating it. Consider the case of Brittany Maynard.⁴⁰ Maynard was the twenty-nine year old woman credited with shifting public opinion in California and across the nation when she released videos explaining her decision to end her life after her terminal cancer diagnosis in 2014. In the videos, Maynard argued that she did not want to die, she wanted to live.⁴¹ However, because the doctors could not help her to live, she wanted them to help her to die on her own terms.⁴² One could argue that Maynard made a final and important use of her autonomy by choosing to seek help in ending her life at a time of her choosing. Through these final choices she lived out her conception of the good, a good in which living with and dying from brain cancer had no part.

One can make the same argument about a woman who sells herself into slavery. She, too, makes a final and important use of her autonomy by deciding that she can best live out her conception of the good by sacrificing her freedom to help a family member. We can best understand Mill's comments on selling oneself into slavery not to mean that such a decision does not count as an exercise of autonomy—it seems obvious that it is—but instead as an exercise of autonomy that the State should not allow, because the State's role is to foster autonomy and to oppose practices that end or reduce it.

Though many look to Mill's autonomy₁ as reason to legalize death at a time of one's choosing, Mill's autonomy₂ provides us with an understanding of why we should oppose legalization of DTOC. Allowing individuals to alienate their autonomy betrays the State's purpose for granting autonomy. The State should not promote this by rebranding death.

40. CBS News, *Brittany Maynard Doesn't "Want to Die"*, CBS NEWS, (Oct. 14, 2014, 7:00 AM), <http://www.cbsnews.com/news/brittany-maynard-dying-with-dignity-before-cancer-takes-her-life/>.

41. *Id.*

42. *Id.*

B. Prioritizing Autonomy Has Unacceptable Consequences

Craig Carr calls the tension in Mill's autonomy₁ and autonomy₂ the "freedom paradox".⁴³ Because choices (death at a time of one's choosing is an example) often "close the doors to alternative possibilities . . . it is difficult to distinguish between the exercise of autonomy and its alienation."⁴⁴ He suggests that it is inconsistent for Mill and others like him to call for the State to interfere with the autonomy of individuals who threaten to alienate their own autonomy. The problem is that prohibiting someone from alienating his autonomy requires limiting that autonomy.⁴⁵ How can the State maximize autonomy as Mill desires and limit autonomy at the same time? Even if this is consistent, is it desirable? To what degree should autonomy be prioritized?

Mill's arguments for individual autonomy and control are appealing because the type of unfettered freedom he describes is something we desire from the time we are two-year-olds. His suggestion that each of us understands better than anyone else what form our own happiness takes is intuitively appealing. However, we must be cautious about what it means to prioritize individual autonomy. If we focus on autonomy₁ which means not taking Mill's selling-oneself-into-slavery passage into account (because it is unclear how much State regulation Mill is calling for and how much he is willing to accept), Mill appears to advocate for a society different and far more hands off than our own. Contra Mill, our State does sometimes interfere with the liberty of its citizens for their own good. For example, Gerald Dworkin points out that we do not allow dueling.⁴⁶ We restrict gambling.⁴⁷ We cap loan interest rates and do not allow certain types of contracts.⁴⁸ Additionally, we will not let regular people self-diagnose their own strep throats and start taking penicillin. Blood pressure medication is not available over the counter. In addition, up to this point, we have also not allowed citizens to choose to end their lives (apart from the small number of states that have become exceptions).

If, as Mill's autonomy₁ suggests, autonomy is our most important

43. CARR, *supra* note 37, at 81.

44. *Id.* at 82.

45. *Id.* at 81.

46. Dworkin, *supra* note 37, at 61.

47. *Id.*

48. *Id.* Note that several of these restrictions might be consistent with Mill's autonomy₂ if they are understood as attempts to discourage individuals from alienating their autonomy.

consideration, then rebranding DTOC makes sense because rebranding all suicide makes sense. Not limiting the individual's autonomy means allowing suicidal friends to decide for themselves whether life is worth living. On this view, it is inappropriate to interfere with someone else's decision that it is the right time for his life to end. On Mill's view it is acceptable to remonstrate, reason with, and seek to persuade one's friend, but it is not acceptable to compel him or to physically prevent him from carrying out his intent if it does not harm others.⁴⁹ On Mill's autonomy₁ view, when the State legalizes medical assistance in ending a life, this is a way of supporting personal autonomy. Ultimately, if allowing individuals their autonomy is the most important thing, then the question of how or how much those individuals suffer is irrelevant as is the question of whether the person is terminally ill.⁵⁰ When autonomy is the preeminent consideration, what matters is whether an individual has made the decision to end his life and whether he has the will to carry that decision out.

For many of us, the idea that we cannot interfere with a friend's intent to take his own life functions as a *reductio ad absurdum* to the idea that we should prioritize individual autonomy above everything else. Making autonomy the preeminent consideration results in unacceptable consequences. When someone expresses interest in ending his own life, we beg and we plead, but we do not stop there. We call on the police or the hospital or anyone who might successfully intercede. Under the most exigent circumstances, we are willing to involve the hospital and the police because we believe, contra Mill, that coercion, not just persuasion, is appropriate. If prioritizing autonomy means that we should not do this, then we should not prioritize autonomy.

Mill's autonomy₁ arguments can be used to justify legalizing death at a time of one's choosing. However, to reach this conclusion, one must bite a bullet. There is no reason to restrict the scope of Mill's autonomy₁ arguments to the terminally ill or even to the seriously suffering. Employing Mill's arguments for individual autonomy, one justifies not just DTOC for someone who is already dying, but any competent adult's decision to end her life because that seems right to her. On this view, suicide is acceptable regardless of one's level of suffering or life-expectancy. Prioritizing autonomy means

49. MILL, *supra* note 31, at 23.

50. Arras, *supra* note 1 at 283.

that it is not the content of the choice or one's reasons for choosing that is prioritized, but choice itself. For those who are willing to bite this bullet, if legalizing DTOC does not harm others, then it is difficult to offer reasons why it should not be legalized.

C. Labeling DTOC a Good Death Harms Those with Disabilities and Chronic Pain.

We are left with a final question: does State-sanctioned DTOC harm others? The answer is yes, by rebranding death in a way that harms the vulnerable in our community, particularly the dying and those with disabilities and chronic pain. This harm offers a basis for opposing bills that legalize DTOC, even for those who endorse Mill's autonomy.⁵¹

We should reject rebranding death because of the harm labeling DTOC a good death does to the dying and those with disabilities. If DTOC is legalized, some people may be pressured or may feel pressured to choose death when they are not yet ready to die. Legalizing DTOC means that not only the patient, but also her family, her doctors, her hospital, her insurance company, and her neighbors all live under a regime where ending the patient's life is an option that the State has officially sanctioned as acceptable, even "humane and dignified."⁵² This is cause for concern given that most of these parties would benefit in various ways from the patient's earlier death.⁵³ Recognizing that most people would never kill nor purposely pressure someone towards death, it is still disturbing to note that many of these incentives (not exclusively financial) run towards death. Coupled with the State giving its seal of approval to an early death, this is problematic.

Whether patients being pressured to die when not yet ready to choose death is an actual harm of legal DTOC rather than just a possible concern is a question perhaps best argued from an empirical perspective. We can look at what is actually happening in the Neth-

51. For those who find the notion that they must not interfere (other than through persuasion) with a friend's desire to end his life as a *reductio* of the notion that autonomy should be prioritized, the best arguments for legalizing DTOC (autonomy-based arguments) are already in doubt. This section simply offers additional reasons for opposing legalized DTOC.

52. Oregon Health Authority, *supra* note 14; H.B. 264, *supra* note 13.

53. Many of these ways are financial, but there are also the physical and time-related burdens of caregiving, the shame or frustration one might feel at being reminded of lingering patients one has been unable to cure, and the burden of feeling called upon to continue in compassion.

erlands,⁵⁴ where death at a time of one's choosing has long been legal, to determine an answer. Meanwhile, consider that choosing under pressure to end one's life early is just one of DTOC's possible harms.

Another important harm is sustained by the person with disabilities who may not choose death herself, but may have to live with her condition knowing that the State has decreed that death is an acceptable choice in conditions like hers. What is it like to be a person with ALS (Lou Gehrig's disease) in Oregon? What is it like when the State tells you that your condition is so terrible that death is an acceptable option? In pushing for legalization, advocates of DTOC are requesting the State's seal of approval to label this type of death as a good death, an acceptable choice. If the State gives its imprimatur, how could this not have an impact on the mindset of someone who is elderly, someone who suffers from terrible pain, or someone who must cope with a body that is not fully functional?

The harms to people with disabilities are significant. William Peace is a paraplegic who became disabled at age eighteen and has been paralyzed for over thirty years. He argues for disability awareness and against physician-assisted suicide at a blog he has named "Bad Cripple."⁵⁵ Consider his reaction to a 2013 *New York Times* article about end-of-life decisions.⁵⁶ In the article, the author described someone suffering from a serious disability. Peace later reflected:

"The descriptions of Hopkins [sic] body are deeply offensive. The not so subtle sub text is that life with a disability, especially for a vent dependent quad, is filled with pain and suffering. . . . [T]o be

54. Are more deaths being approved through DTOC laws each year? Is death being offered to an ever wider spectrum of people? A recent *Newsweek* article examined these trends in "Dying Dutch: Euthanasia Spreads Across Europe." Winston Ross, *Dying Dutch: Euthanasia Spreads Across Europe*, NEWSWEEK (February 12, 2015, 7:46 AM), <http://www.newsweek.com/2015/02/20/choosing-die-netherlands-euthanasia-debate-306223.html>. Scholars such as Daniel Callahan, Callahan, *supra* note 2, at 15, John Arras, Arras, *supra* note 1, at 299, Peter Singer, Peter Singer, *Voluntary Euthanasia: A Utilitarian Perspective*, in INTERVENTION AND REFLECTION 605, 612 (Ronald Munson ed., 2012), and Mary Warnock and Elisabeth MacDonald, MARY WARNOCK & ELISABETH MACDONALD, EASEFUL DEATH, 88 (2008), have long suggested that we look to the Netherlands as we attempt to answer these and similar questions. Callahan and Arras suggest that the answers to those questions caution against legalizing DTOC. Singer and Warnock and MacDonald disagree. Unfortunately, both the empirical research and the task of weighing competing interpretations of it are tasks that are beyond my scope here.

55. William Peace, *The NYT Infuriates Me*, BAD CRIPPLE (July 7, 2013, 1:09 PM), http://badcripple.blogspot.com/2013_07_14_archive.html.

56. *Id.*

rendered a quadriplegic is a fate worse than death. . . .”⁵⁷ Peace goes on to explain the hurt from the way a person with a disability similar to his own was described: “a plugged-in mannequin in the I.C.U., the very embodiment of a right-to-die case study” to read of the man’s “useless body,” its “incessant needs” and then once again, the man’s “inert sack of a body. . . .”⁵⁸ Peace does not think of himself that way. He has a life and a body that he values. The difficult thing for him and people like him is to live in an ableist culture that insists the burden is continually on them to show that their lives are worth living, that they are of value.⁵⁹

One might argue against these considerations by noting that Peace is but one man. Not everyone similarly situated would be offended. How many people are that severely disabled in any case? Those few unfortunate individuals must be contrasted with all those whose lives and deaths would be improved through legal DTC. However, this way of pitting the numbers in each community against the other does not work. The first reason for that is that the community of those with disabilities is not a small one and the number of those who would qualify for DTC is not large. According to the CDC:

A new report describing the percentage of adults with disabilities in the United States . . . is based on questions used for the first time in the 2013 Behavioral Risk Factor Surveillance System (BRFSS) that allow respondents to identify specific functional types of disability, such as mobility (serious difficulty walking or climbing stairs), cognitive (serious difficulty concentrating, remembering or making decisions), vision (serious difficulty seeing), self-care (difficulty dressing or bathing) and independent living (difficulty doing errands alone).⁶⁰

According to this report, in 2013 over 53 million adults living in communities in the United States had a disability.⁶¹ That is 22% of adults in the United States.⁶² If this number seems inflated because minor disabilities are included, consider that if we included only 1 in

57. *Id.*

58. *Id.*

59. *Id.*

60. Ctr. for Disease Control and Prevention, *Key Findings: Prevalence of Disability and Disability Type Among Adults – United States, 2013*, 64 MORBIDITY AND MORTALITY WKLY. REP. 777, No. 29 (July 31, 2015).

61. *Id.* at 781.

62. *Id.* at 779.

every 4 people identified as disabled in that study, the number would still be over 13 million adults. By contrast, the group that would be able to make use of DTOC laws like Oregon's is smaller than one might suppose. Although the rate has tripled from the first years the law was in effect, only 155 prescriptions for lethal medication were written statewide in Oregon in 2014—the latest year for which statistics are available.⁶³ Whether one multiplies Oregon's number by fifty states or one thousand, the resulting number does not approach 13 million. The reasons for the small size of this number are not a mystery: as I've already noted, there are a lot of diseases and different forms of suffering that do not qualify for legal DTOC because they don't allow doctors to predict death within six months—either because the diseases are not predictable with that degree of precision or because they are not likely to result in death in a short time. There are many people who would not qualify for DTOC because they are too young (children and teenagers), too old (with age related dementia), or because they are cognitively compromised in midlife. Further, the safeguards that require jumping through the hoops of identifying willing providers, talking to specialists, presenting for multiple visits, and enduring waiting periods, select for the insured, the well-educated and the wealthy. Oregon's experience bears this out.⁶⁴

The second reason that balancing the numbers in each community against each other doesn't work is that concern for human dignity cuts both ways. Ultimately, it cannot be a numbers game. Proponents of legal DTOC are concerned for the dignity of those who are ready to die. However, the dignity of those who want to live and ask communities to judge them as having lives worthy of value, lives worthy of protection, rather than lives worthy of death, is no less important.

IV. LOOKING FORWARD

I have argued that it is harmful when the State rebrands death by labeling death at a time of one's choosing a humane and dignified death. Neither concern for suffering nor concern for autonomy suffices to justify legalizing DTOC. A state committed to the importance of autonomy should not endorse the alienation of autonomy

63. Linda Ganzini, *Legalized Physician-Assisted Death in Oregon*, 16 QUT L. REV. 76, 78 (2016).

64. *Id.* at 77–83.

that is ending one's life early. Autonomy is important, but it should not be prioritized above everything else. It does not make sense for us to suppose that we have an obligation to stand helpless when a friend threatens his own life. Instead we take action, even interfering with his autonomy if necessary to protect our friend. Further, because of the harms to the vulnerable in our society, the State must act to protect those with disabilities and chronic pain by opposing DTOC.

However, none of this means that we are excused from compassion for those who feel ready to die and seek our help in doing it. We must not honor nor promote the dignity of those who are not yet ready to die by being callous to the concerns of those who are. To avoid pitting the dignity of either group against the other there are at least two things we can do to help: 1) transform our understanding of dignity into something more inclusive and meaningful and 2) improve end of life care.

Transforming our notions of dignity is imperative. It is when we understand lives of disability and suffering as merely bad that we label DTOC deaths as good. Our understanding of what dignity means is too narrow and our (mis-) understandings of disability box people in. Felicia Ackerman raises this concern by discussing the notion of a life with dignity:

Timothy Quill [a well-known physician and proponent of DTOC] has suggested that "suicide could be appropriate for patients if they did not want to linger comatose, demented, or incontinent." . . . This sort of thinking invites a flip reply: Haven't Dr. Quill and his ilk ever heard of Depend[s]? To put the matter less flippantly, I think we need to question our society's bigoted and superficial view of human dignity, which holds that the old, ill, and disabled have less human dignity than the young and strong. Does Dr. Quill really want to endorse the view that human dignity resides in the bladder and the rectum?⁶⁵

Ackerman is right. Properly understood, dignity doesn't reflect conditions we have no control over such as bladder control or whether we need assistance simply to walk across the room. Disability will be a part of most of our lives. We must teach each other and come to accept that at the right time, learning to be dependent with grace is strength. It is part of living and it is part of dying. True dignity is ev-

65. Felicia Ackerman, *Assisted Suicide, Terminal Illness, Severe Disability, and the Double Standard*, in *PHYSICIAN ASSISTED SUICIDE: EXPANDING THE DEBATE* 151 (Margaret P. Battin, Rosamond Rhode & Anita Silvers eds., 1998).

identified by how we respond to conditions that we would not choose but cannot change.

Second, it is crucial that we improve end-of-life care in our communities. If as a community we care about end of life suffering, then we need to improve end of life care for the many, rather than giving the green light to end it all to the few who qualify, those who got sick with the diseases that happen to meet the criteria of the bill. We need to pour our resources into education and improving access to palliative care and hospice for all our citizens, so that both those who are ready to die and those who are not, those who are dying of ALS and of cancers both fast and slow, of kidney disease and of Alzheimer's, all receive comfort and care at the end of life.