

Of Assisted Suicide and “The Philosophers’ Brief”*

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I

The Harvard Classics edition of great papers in the history of science reprints a version of Hippocrates’ famous Oath that includes the following passage:

I will follow that system of regimen which, according to my ability and judgment, I consider for the benefit of my patients, and abstain from whatever is deleterious and mischievous. I will give no deadly medicine to any one if asked, nor suggest any such counsel; and in like manner I will not give to a woman a pessary to produce abortion. With purity and with holiness I will pass my life and practice my Art. I will not cut persons labouring under the stone, but will leave this to be done by men who are practitioners of this work. Into whatever houses I enter, I will go into them for the benefit of the sick, and will abstain from every voluntary act of mischief and corruption; and, further, from the seduction of females or males, of freemen and slaves. Whatever, in connection with my professional service, or not in connection with it, I see or hear, in the life of men, which ought not to be spoken of abroad, I will not divulge, as reckoning that all such should be kept secret. While I continue to keep this Oath unviolated, may it be granted to me to enjoy life and the practice of the art, respected by all men, in all times. But should I trespass and violate this Oath, may the reverse be my lot.¹

Graduates of American medical schools take some professional oath, most at commencement. The oath traditionally attributed to Hippocrates is not commonly used, but many swear some variant of it. And some medical graduates still pledge to observe the bans on physician-assisted

* Thanks are due to Maura Ryan for bibliographic suggestions and for illuminating conversations about the arguments of this article and to David Hollenbach, George Mavrodes, Scott Moore, David Solomon, Cass Sunstein, and the editors of *Ethics* for helpful comments on an earlier draft. I am also grateful to the Pew Charitable Trusts for financial support during the sabbatical on which this article was written.

1. *Scientific Papers: Physiology, Medicine, Surgery, Geology*, vol. 38 of Harvard Classics, ed. Charles W. Eliot (Cambridge, Mass.: P. F. Collier & Sons, 1910), p. 3.

suicide, physician-counseled suicide, voluntary euthanasia, and euthanasia by proxy which Hippocrates expressed so economically by the clause "I will give no deadly medicine to any one if asked, nor suggest any such counsel."²

The March 27, 1997, issue of the *New York Review of Books* reprinted "The Philosophers' Brief,"³ an amicus curiae brief filed by six distinguished moral philosophers in the Supreme Court cases *State of Washington v. Glucksberg* and *Vacco v. Quill*. This brief urged the Court to uphold decisions by courts of the Second and Ninth Circuits affirming that patients have a constitutionally protected right to secure the help of willing physicians in terminating their own lives, at least in a limited class of cases. It therefore asked the Court to affirm that patients have a protected right to secure the help of doctors who do not believe that the relevant clauses of the Hippocratic Oath express a professional obligation. The amici—the signatories of the brief—are John Rawls, T. M. Scanlon, Robert Nozick, Thomas Nagel, Judith Jarvis Thomson, and Ronald Dworkin.

The brief is not a philosophical treatise. It is, as the term 'brief' suggests, a highly compact and abbreviated set of arguments for its conclusion. It raises important philosophical issues but treats them at far less length than any one of the signatories would devote to them were they to take up those issues in an academic forum. I do not assume in what follows that the lines of thought in the brief amount to the fullest or most powerful expression of arguments these six philosophers could offer for the views their brief expresses. But precisely because the brief touches on philosophical issues and because the amici speak as philosophers while addressing the Supreme Court of the United States on a matter of great public concern, the brief touches on the relationship between philosophy and politics in a unique and important way which makes its arguments worthy of careful consideration. I shall argue, against "The Philosophers' Brief," that it would have been a mistake to find that citizens have a constitutional right to the assistance of willing physicians in terminating their lives.⁴ Before I do so, I want to take up an important preliminary matter on which I agree with its authors.

"The Philosophers' Brief," Dworkin notes, "defines a very general moral and constitutional principle—that every competent person has

2. R. D. Orr, N. Pang, E. D. Pellegrino, and M. Seigler, "Use of the Hippocratic Oath: A Review of Twentieth Century Practice and a Content Analysis of Oaths Administered in Medical Schools in the U.S. and Canada in 1993," *Journal of Clinical Ethics* 8 (1997): 377–88.

3. Ronald Dworkin et al., "Assisted Suicide: The Philosophers' Brief," *New York Review of Books* 44 (March 27, 1997): 41–47; pp. 41–42 are an introduction authored solely by Dworkin.

4. For an argument that the right to assisted suicide does not merit constitutional protection by an author who believes the practice should be legalized by democratic processes, see Cass Sunstein, "The Right to Die," *Yale Law Journal* 106 (1997): 1123–63.

the right to make momentous personal decisions which invoke fundamental religious or philosophical convictions about life's value for himself."⁵ This principle is held to support a protected right to physician-assisted suicide because "death is, for each of us, among the most significant events of life";⁶ indeed, I would add, it is so significant that to have a view about the meaning of death is to have a view, or the better part of a view, of the meaning of life. Prohibiting physician-assisted suicide in the name of some religious or moral conception of the significance of death is therefore an infringement on the ability of individual citizens to exercise the right asserted by the philosophers' "very general principle." This, the signatories say, the Constitution forbids and the government cannot legitimately do.

Thus at the heart of the brief's constitutional argument is a claim about liberal democratic legitimacy. Crudely put, the claim is that liberal democratic governments cannot legitimately prevent citizens from acting on their most fundamental liberty-interests in the name of a conception of the good which those restricted could not reasonably be expected to endorse as free equals. Various more subtle versions of this claim have been defended by several of the brief's signatories for many years, with philosophical arguments of great power and nuance. It is a claim for which I have very great sympathy. The claim with which I disagree is that denying a right to physician-assisted suicide "could *only* be justified on the basis of a religious or ethical conviction about the value or meaning of life itself."⁷ There are, I believe, other justifications available which are consistent with the core claim of the brief's constitutional argument. The challenge facing those of us who disagree with the conclusion of the brief is that of presenting them. More specifically, it is the challenge of arguing against that conclusion by appealing to what Rawls calls a "balance of political values" that we reasonably believe "can be seen to be reasonable by other citizens."⁸

II

A particularly important line of thought in the brief is its treatment of the attempt to distinguish the right to physician-assisted suicide, at issue here, from the right to the removal of life support, which the Court affirmed in *Cruzan*. During oral argument of *Glucksberg* and *Quill*, some justices tried to justify a constitutional distinction between prescribing lethal pills and removing life support by appealing to a "common sense"

5. Dworkin et al., p. 41.

6. *Ibid.*, p. 44.

7. *Ibid.*, p. 43, emphasis added.

8. John Rawls, *Political Liberalism* (New York: Columbia University Press, 1996), p. 243; cf. pp. 1–li, as well as "The Idea of Public Reason Revisited," *University of Chicago Law Review* 64 (1997): 765–807.

distinction between acts and omissions.⁹ States may forbid doctors to prescribe lethal doses of pills but not the removal of life support, these justices thought, because the former is an act which results in death while the latter merely allows natural processes to continue. But, Dworkin says, "the brief insists that such suggestions wholly misunderstand the 'common-sense' distinction, which is not between acts and omissions, but between acts or omissions that are designed to cause death and those that are not."¹⁰ Once we recognize that, Dworkin concludes, it is a short step to the claim that actions and omissions designed to cause the death of willing patients are on a par, morally speaking, and so there is no moral difference left to ground a constitutional distinction between assisted suicide and the removal of life support.

Whether this argument works depends crucially upon whether Dworkin or the unnamed justices are correct about where common sense lies and whether it supports the importance "The Philosophers' Brief" attaches to the autonomy of the willing patient. That, in turn, depends upon which of their distinctions leads to the more intuitively plausible evaluation of test cases. Settling *that* question is not an easy matter, however, for it is not clear that Dworkin's distinction yields the appropriate descriptions of cases we are supposed to evaluate. This is because it is not clear what it means to say of an act that it is "*designed* to cause death." Is an act designed to cause death if, or only if, or if and only if, the agent who performs it *intends* to cause death? What of cases where the agent merely *foresees* that death will result? Or cases in which the agent, regardless of her intentional and cognitive states, *ought* to foresee that death will result, perhaps because the act is of a type that usually causes death? It is only by overlooking these questions, it might be objected, that Dworkin is able to claim that there is no significant moral difference between a physician's assisting a suicide and her terminating life support.

A similar move is made in the brief itself, where crucial distinctions seem to be papered over by the phrase "act with death in view." Only this, it might be objected, allows the authors to conclude that

If and when it is permissible for him to *act with death in view*, it does not matter which of [the] two means [the doctor] and his patient choose. If it is permissible for a doctor deliberately to withdraw medical treatment in order to allow death to result from a natural process, then it is equally permissible for him to help his patient hasten his own death more actively, if that is the patient's express wish.¹¹

9. *Ibid.*, p. 42.

10. *Ibid.*

11. *Ibid.*, p. 45, emphasis added.

The soundness of the argument for this conclusion, like the soundness of Dworkin's argument, depends upon whether the morally relevant features of deliberately withdrawing life-sustaining treatment and assisting in a patient's suicide can be adequately captured by describing them both as acts "designed to cause death" or as acts undertaken "with death in view," or whether we need more distinctions to do the job.

One argument for more distinctions begins with the fact that withdrawing ventilation is not certain to cause death. In one case study, 11 percent of those who underwent "terminal weaning" from mechanical ventilation survived and were discharged from the hospital.¹² While there may be some cases in which we would want to say that the doctors whose patients lived failed to achieve their objective, there are surely others in which the aim of withdrawing ventilation is to bring it about that the patient's life is not prolonged by unwanted medical care. Since doctors do not know ahead of time which patients will survive the withdrawal of ventilation, this may also be their objective in many cases in which withdrawal is shortly followed by death. Thus doctors may wean their patients from ventilators "with death in view," but important features of their actions are left out of account if the description stops there. Withdrawal of ventilation is often accompanied by the administration of opioids. It is sometimes alleged that these drugs cause the death of the patient through respiratory depression and that the causal connection between the opioids and the death is so close a doctor cannot but intend the death of the patient when administering them. But in fact patients who receive opioids when life support is withdrawn live on average as long as those who do not, even when those who are given the drugs receive them in large doses. This suggests that the underlying medical condition, rather than the drugs, usually determine the patient's time of death¹³ and that the reason for administering drugs may often be to insure the patient's comfort rather than to cause his death. The latter suggestion is supported by a survey of physicians' intentions reported in a recent clinical study of patients from whom life support was withdrawn.¹⁴ Because continued hydration can cause severe discomfort from fluid build-up, even the withdrawal of nutrition and hydration may plausibly be undertaken to increase the comfort of a dying patient.¹⁵ And as with

12. R. W. Carlson, M. L. Campbell, and R. R. Frank, "Life Support: The Debate Continues," *Chest* 109 (1996): 852-53; a patient is "terminally weaned" when the support provided by the mechanical ventilator is gradually decreased but the endotracheal tube is left in place.

13. William C. Wilson, Nicholas G. Smedira, Carol Fink, James A. McDowell, and John M. Luce, "Ordering and Administration of Sedatives and Analgesics during the Withholding and Withdrawal of Life Support from Critically Ill Patients," *Journal of the American Medical Association* 267 (1992): 949-53, esp. p. 949.

14. *Ibid.*, p. 953.

15. M. Andrews, T. R. Bell, S. A. Smith, J. F. Tischler, and J. M. Veglia, "Dehydration in Terminally Ill Patients: Is It Appropriate Palliative Care?" *Postgraduate Medicine* 93 (1993):

mechanical ventilation so with nutrition and hydration, the aim of withdrawal might be to bring it about that the patient's life is not prolonged by unwanted care. When this is so, the hastening of death is a foreseen but unintended consequence of withdrawal. Thus it may be a mistake to seize on either the distinction between acts and omissions or the distinction between those acts and omissions which are "designed to cause death" and those which are not. Perhaps the really interesting distinction is between those acts and omissions which are *intended* to cause death and those which are not.

There are, of course, powerful currents of philosophical thought that run contrary to this suggestion. A number of philosophers, including some of the authors of "The Philosophers' Brief," have expressed doubts about whether the distinction between the intended and the unintended but foreseen can do the moral work it is often introduced to do.¹⁶ Even if the distinction is a morally significant one, it is not clear how it is relevant to the questions at issue here. Since a doctor can neglect to save a life for the same reason he can act to end it, it is doubtful that the distinction between the intended and the unintended but foreseen can be exploited to show the significance of that between acts and omissions. Furthermore, even if some doctors withdraw nutrition and hydration without intending the death of their patients, others no doubt do intend to cause their deaths. And as Dworkin implies,¹⁷ some doctors may prescribe lethal doses of pills intending to satisfy their patients' wishes, with their patients' death as a foreseen but unintended consequence of the prescription. So even if talk of acts "designed to cause death" or acts undertaken "with death in view" is too vague for some purposes, it is not at all apparent either that the vagueness is problematic here or that dispelling it would reveal grounds for a constitutional distinction between physician-assisted suicide and the withdrawal of life support.

I want to argue that the distinction between deaths which are the intended outcome of physicians' actions and those which are the foreseen but unintended consequences is crucial to the argument about physician-assisted suicide but not for the reasons it is sometimes thought to be. Those who attach great importance to the distinction sometimes go on to argue that the wrongness of performing acts from a certain inten-

201-3, 206-8, cited at Howard Brody, Margaret L. Campbell, Kathy Faber-Langendoen, and Karen S. Ogle, "Withdrawing Intensive Life-Sustaining Treatment—Recommendations for Compassionate Clinical Management," *New England Journal of Medicine* 336 (1997): 652-57, n. 50.

16. See Judith Jarvis Thomson, "Rights and Deaths," *Philosophy and Public Affairs* 2 (1973): 146-59, sec. II; also Thomas Nagel, "War and Massacre," *Philosophy and Public Affairs* 1 (1972): 123-44, pp. 130-31.

17. Dworkin et al., p. 42; see also F. M. Kamm, "A Right to Choose Death?" *Boston Review* 22 (1997): 20-23, esp. n. 1 and accompanying text.

tion is itself at least a prima facie reason for the legislative prohibition of acts of that kind.¹⁸ I proceed differently, for whether the wrongness of an act provides such a reason is a question I leave aside. Instead I argue that doctors should cultivate a virtue centered on an absolute prohibition: a prohibition on acting from the intention of killing their patients. I then argue that the reasons physicians should observe this absolute prohibition also provide sufficient reasons for absolute legislative prohibitions on physician-assisted suicide. Those reasons are not, however, sufficient for overturning *Cruzan*. To show why physicians should honor this absolute prohibition, and later to show how the reasons for their doing so tell against legalizing physician-assisted suicide, it is useful to begin with another kind of conduct that is also forbidden by the Hippocratic Oath, the seduction of patients. The reasons that doctors should hold themselves to a prohibition on intentionally causing their patients' deaths are quite similar to the reasons that doctors should hold themselves to an absolute prohibition on seducing them.

III

One obvious moral problem with doctors' trying to seduce their patients does not attach to assisted suicide and is connected with the danger that they may succeed. Sex can elicit strong emotions and attachments in both parties. Whether the relationship between doctor and patient is enhanced or soured by their shared sexual experience, these feelings can cloud a physician's medical judgment and compromise her ability to give her patient good medical care. Since one of a physician's role-specific duties is to give good care to her patients, it seems dangerous for doctors to have sex with them. And if it is dangerous for doctors to have sex with patients they have successfully seduced, it is hard to see how it could not also be dangerous for doctors to try to seduce them. Furthermore, the intention that is presupposed by the seduction of a patient—the intention of having sex with a patient if the seduction is successful—presupposes certain affective states which have the patient as their object. The states of desire presupposed by seduction can themselves cloud medical judgment. Acting with the intention of having sex with a patient therefore presupposes attitudes that are dangerous for doctors to have.

Other moral problems are rooted in the possibility that doctors who seduce their patients will use their medical authority to do it. In virtue of their education and their expert ability to provide something that human beings value greatly, physicians enjoy a social status that gives what they say authority in a wide range of social situations. Their authority is especially great in their relationships with patients for, as the word 'patient' suggests, vulnerability is essential to that role. Patients make them-

18. See Robert P. George, *Making Men Moral* (New York: Oxford University Press, 1993), p. 190.

selves vulnerable to their doctors by exposing their bodies to them, as they must if they are to be diagnosed and properly treated. They may also expose themselves in conversation with their physicians, revealing physical infirmities and emotional states that they would not routinely share with others. Indeed the confidentiality of the doctor-patient relationship is important, and protected by the Hippocratic Oath, precisely because this form of self-revelation is necessary for patient care on the one hand but makes patients vulnerable on the other. Patients generally make themselves vulnerable to their doctors in the full expectation that their physical and verbal revelations will not be met with the affective states of desire and objectification that are presupposed by the intention to seduce them. They might well be less forthcoming if they believe that doctors have those attitudes. In positions of such vulnerability, patients may also form strong emotional attachments to their doctor which the doctor could then eroticize, and in response patients may develop a strong even if transitory desire to please their doctor or may simply be extremely compliant. Under these conditions, it may be extremely difficult for patients to render genuine consent to a physician who is attempting to seduce them. This difficulty will be especially acute if the physician, purporting to offer medical care, presents sex as a form of therapy with potentially beneficial consequences for the patient's emotional or physical well-being.

But even if the seduction of patients is morally problematic in all these ways, why should doctors *always* refrain from doing it? The correct answer begins from the claim that, just because patients must place themselves in positions of physical and emotional vulnerability to get medical care, doctors are placed in the way of very powerful temptations to have sex with their patients. Physicians could cope with the temptation by learning to make complex judgments about the appropriateness of seduction in various cases, giving in to temptation when they feel confident that they would not be exploiting their patients and refraining otherwise. Or they could cope with it by cultivating the disposition to honor an absolute prohibition on the seduction of their patients. Which of these ways of coping with the temptation is preferable depends in part upon how grave an evil would result when a physician acts on honest errors of judgment. If it is a minor matter to have sex with a patient who does not render genuine consent, then the risks that attend physicians' judging when to seduce and when not to might be acceptable. But it is plain that this is not so, and that a doctor who seduces a patient incapable of giving genuine consent can do very serious damage to the patient. The fact that even honest mistakes can have grave consequences argues in favor of doctors' holding themselves to an absolute prohibition on the seduction of their patients. This conclusion draws further support from the fact that rationalization and self-deception tend to cloud judgment in the face of strong temptation to perform an action that may be

done in some circumstances but not others. Rationalization and self-deception are more effectively taken out of play by a stable commitment to refrain from actions of that kind under *all* circumstances than by a commitment to refrain from them only under circumstances in which one ought not perform them.

The value of observing an absolute moral prohibition derives support from another argument as well. It is extremely important that patients feel they can expose themselves to their doctors because self-revelation is, as I mentioned earlier, necessary if patients are to receive proper diagnosis and treatment. But many patients may be reluctant to expose themselves to their doctors, either physically or emotionally, if they worry that their doctors may consider them potential sexual partners or regard them as objects of sexual desire. Patients will be much more confident that they can reveal themselves if it is generally believed that doctors hold themselves to an absolute prohibition on seducing their patients than if it is thought that they give the possibility careful consideration. The value of observing this absolute moral prohibition therefore derives from the importance of two distinct but related functions the prohibition plays in the practice of medicine. First, committing themselves to honoring the prohibition enables physicians to cope with a potentially powerful temptation to have sex with patients who may be incapable of genuine consent. Second, it grounds patients' confidence that doctors will not accede to this temptation and exploit them if they place themselves in the vulnerable position they must assume if they are to receive the care they need.

That an absolute prohibition on the seduction of patients fulfills these functions explains why the Hippocratic Oath included the prohibition in the first place. One function of an oath not to do something is that it provides the agent with a special reason not to do it, a reason which differs in kind from any that may be furnished by the inadvisability or the moral wrongness of doing it.¹⁹ Now the clause of the Oath which prohibits seduction does not prohibit a doctor from having sex with his unconsenting or unwilling patients, for X successfully seduces Y only if X brings about in Y a willingness to have sex with X. A prohibition on non-consensual sex—on rape—would presumably be either redundant or ineffective, since the reasons provided by rape's obvious wrongness are themselves so compelling that no one otherwise willing to disregard them would be deterred by having vowed not to do it. To get at the reasons for including a prohibition on seduction, we have to see why it

19. See the brief but very illuminating remarks of Thomas Scanlon, "Promises and Practices," *Philosophy and Public Affairs* 19 (1990): 199–226, pp. 223 ff. Whether the reasons provided by an oath *substitute* for other of the agent's reasons or *supplement* other reasons which remain in force is an interesting question but one I cannot pursue here. On substitutional and supplementary reasons generally, see Joseph Raz, "Authority and Justification," *Philosophy and Public Affairs* 14 (1985): 3–29.

might be thought useful to provide physicians with a special reason not to do it.

The Hippocratic Oath is a *professional* oath. As such, one of its functions is to impose certain role-specific duties that attend the practice of that profession and provide those who swear the oath with a special reason to honor them. I have suggested that the doctor's duty to refrain from seducing patients under all circumstances is paradigmatically role specific, for the reasons that I have brought forward to show that doctors should *never* seduce their patients depend upon special features of the doctor-patient relationship. Incorporating this prohibition into a professional oath—the Hippocratic Oath—reminds doctors of this and stresses the importance of observing it. The practice of taking some form of the Oath upon graduation forces those beginning their medical careers to acknowledge these role-specific duties and to impose special reasons on themselves to honor them. It provides that reminder at one of the most significant points in a physician's life and forces her to recall that in taking the Oath she is joining a profession which has long tried to honor the standards she is pledging to observe. Among the role-specific duties the Oath imposes is the obligation not to induce or attempt to induce in one's patients the willingness to have sex with their doctor. It seems especially important to do this if, as I suggested, physicians are in the way of a particularly strong temptation to seduce their patients because of the physically and emotionally vulnerable positions in which patients must put themselves to receive care.²⁰

A second reason for including an absolute prohibition in the Oath is that swearing the Oath is itself a public act. As such, it furnishes grounds for public trust in the medical profession, and it contributes to patients' confidence in the intentions of their doctors. This confidence is on much firmer ground when patients believe their doctors are committed to absolute prohibitions on seduction than when they believe doctors will make up their minds about whether seduction is acceptable over the course of their treatment. Since public confidence in the medical profession is necessary if patients are to turn to doctors for treatment, an Oath that includes an absolute prohibition on the seduction of patients provides one of the prerequisites of good care. The function of the Oath in securing this public trust is hinted at near the end of that part of the Oath I quoted earlier. There the physicians pledging it say, "While I continue to keep this Oath unviolated, may it be granted to me to enjoy life and the practice of the art, *respected by all men, in all times*" (my emphasis). This might be thought a plea to the gods to whom the Oath is ostensibly addressed, asking that they bestow a reward in return for the

20. For the thought that the prohibitions of the Hippocratic Oath respond to what I have called the "role-specific temptations" of physicians, I am indebted to Leon Kass, "Why Doctors Must Not Kill," *Commonweal* 118 (1991): 472–76, particularly p. 474.

physician's fidelity to the Oath. But it also suggests the recognition that public respect and public trust are natural consequences of serving the public in an honorable way. The prohibition on seduction is therefore included in the Hippocratic Oath precisely because that prohibition plays the two related roles in medical practice that I appealed to in justifying the prohibition.

So far I have focused on one kind of action that typically proceeds from an intention to have sex with a willing patient—those in which the physician attempts to induce in the patient that willingness to have sex with the doctor.²¹ I have done so because the Hippocratic Oath explicitly mentions actions of that kind. Now consider not a patient in whom the doctor must induce a willingness to have sex but one who appears willing to have sexual relations with his physician. Indeed consider patients who appear urgently to desire it and do so because they think sex with their doctors an important part of their medical, say their psychiatric, treatment. Faced with such patients, may doctors act from the intention of giving them what they want?

It is clear that the reasons why it is dangerous for doctors to consider seducing their patients tell against their having sex with their antecedently willing patients as well. Whether sex improves or sours the doctor-patient relationship, it can give rise to affective states that impede the doctor's ability to give good medical care. Furthermore, the same questions that arise about the genuineness of consent to a seduction arise about the genuineness of consent to sex when patients present themselves as willing to engage in it. There is the danger that such patients are doing what they believe their doctor wants them to do rather than acting from a genuine desire of their own. There is the danger that patients' ability to think clearly about the implications of their decision is clouded by the differences in power between patient and physician. There is the danger that any discussion in which the doctor attempts to determine the genuineness of the patient's willingness and consent will also be one in which what the doctor says and what the doctor concludes about the patient's state of mind will be colored by the doctor's desire to have sex with the patient. Finally special concerns about genuine consent arise when the patient thinks of sex with the doctor as legitimate medical care and when the physician reinforces this attitude by discussing doctor-patient sex in therapeutic terms. Under these circumstances the patient may be disposed to actions which he would not choose to engage in if he thought of sex otherwise. Whether this indicates that the patient's free choice is compromised is at least open to question, as it is at least an open question whether the physician has a responsibility to persuade the patient that doctor-patient sex is not a form of medical

21. I say "typically" because X might have reasons to seduce Y with the intention of breaking off at the last moment; cf. Albert Camus, *The Stranger* (New York: Vintage, 1954), p. 40.

treatment. These questions are particularly pressing if the patient conceives of sex with the physician as treatment for a condition, psychological or physical, from which he desperately seeks relief or escape.

In the case of the antecedently willing patient as in the case of seduction, the dangers of doctors' acting on the intention of having sex with their patients are sufficiently great that physicians should observe an absolute prohibition on acting from that intention. By the nature of their work physicians are placed in the way of a powerful temptation to have sex with their patients. The cost of an honest mistake, of having sex with an apparently willing patient who is in fact unable to give genuine consent, could be very high indeed. Therefore doctors need to protect themselves and their patients against the possibility of honest mistakes; they also need to minimize the danger of their own rationalization and self-deception. This is better done, I suggested, by doctors' holding themselves to an absolute prohibition on sex with their patients than by doctors' exercising their judgment case by case. Because patients must feel confident that they can expose themselves to their doctors physically and emotionally if they are to receive good care and because public confidence in the medical profession is better secured by an absolute moral prohibition, doctors should hold and be generally known to hold themselves to such a prohibition. In the case of the antecedently willing patient as in the case of the seduced one, these considerations would explain including a blanket prohibition on doctor-patient sex in the Hippocratic Oath. Codes of medical conduct and some versions of the Oath include just such a blanket prohibition.²²

IV

Having shown why physicians should hold themselves to an absolute prohibition on acting from the intention to have sex with their willing patients, let me now consider acting on the intention to take the lives of their willing patients. Note first that the same questions about the genuineness of consent that arise when patients seem antecedently willing to have sex with their doctors arise when patients ask their doctors' assistance in terminating their lives. There is an obvious danger that patients' ability to think clearly about the implications of a decision to terminate their lives is clouded by the differences in power between patient and physician. Despite significant shifts toward greater recognition of patient autonomy in the practice of medicine, these differences have not been erased. Insofar as they stem from disparity of education, wealth, and social standing, they will bulk especially large in a doctor's relationship with the poor and the otherwise marginalized. Insofar as they stem from the

22. See American Medical Association (AMA), Council on Ethical and Judicial Affairs, "Sexual Misconduct in the Practice of Medicine," *Journal of the American Medical Association* 266 (1991): 2741–45, nn. 2–4 and accompanying text.

physician's medical expertise, they will be an especially salient feature of the doctor-patient relationship when the patient is desperately or terminally ill. They therefore pose the danger that any discussion in which the doctor attempts to determine the genuineness of the patient's willingness and consent will also be one in which what the doctor says and what the doctor concludes about the patient's state of mind will be colored by the doctor's view that the patient would be better off if her life were over. They pose the danger that patients who choose to end their own lives are doing what they believe their doctor wants them to do, rather than acting from a genuine desire of their own.

Special concerns about genuine consent arise when the patient thinks of the termination of her life as legitimate medical care and when the physician reinforces this attitude by discussing the termination of life in those terms. Under these circumstances the patient may be disposed to actions which he would not choose to perform if he conceived of death differently. Questions about the ability to render genuine consent are particularly pressing if the patient conceives of the termination of life as treatment for a condition from which he desperately seeks relief. This is not itself to say that doctors should refuse to discuss the termination of life as a form of medical treatment, still less that they are responsible for presenting the patient a range of conceptions of termination from the medical to the traditionally religious. It is merely to point out that when a person who exercises great power in the life of a terminally ill patient discusses death with her in therapeutic terms at one of the most significant and vulnerable moments of her life, there is the danger that she will accede to her physician's wishes rather than act on well-formed desires of her own. In this case, as in the case of seduction and sex with the antecedently willing patient, the crucial question is whether these dangers are great enough that doctors should hold themselves to an absolute moral prohibition on acting from the intention of ending their patients' lives.

One of the arguments for honoring an absolute prohibition on doctor-patient sex turned on my claim that by the nature of their work, physicians are placed in the way of a powerful temptation to have sex with their patients. This heightens the danger that physicians may deceive themselves about what their patients want, or that they will rationalize sex with their patients. These dangers are better averted and the role-specific temptation is better withstood, I suggested, by doctors' commitment to an absolute moral prohibition than it would be by their trying to judge case by case. Because of their work and training, doctors are also in the way of a temptation to end the lives of their terminal patients. As one doctor has written,

Physicians get tired of treating patients who are on their way down—"gorks," "gomers," and "vegetables" are only some of the

less than affectionate names they receive from the house officers. . . . [Many doctors] tend to regard every dying or incurable patient as a failure, as if an earlier diagnosis or a more vigorous intervention might have avoided what is, in truth, an inevitable collapse. The enormous successes of medicine these past fifty years have made both doctors and laymen less prepared than ever to accept the fact of finitude.²³

Thus doctors trained to heal the sick can easily find those who resist their efforts a standing reminder of their limitations and of the limitations of their profession. None of us likes such reminders and it is natural to want to be free of them. In the case of physicians, the strength of this natural desire can be augmented by a role-specific temptation to end the lives of their patients, a temptation posed by the relationship of vulnerability into which the patient has entered with the doctor and by the doctor's expertise at dispensing drugs which she knows can be lethal to her patient. Doctors are also in the way of this temptation because their professional role is embedded in an economy which increasingly places constraints and pressures on their practice, at least in the United States. The imperatives of cost containment, which inevitably filter down to individual medical practitioners, and the scarcity of resources that could be devoted to nonterminal patients provide obvious incentives to hasten a patient's death or to persuade her to hasten her own. Here as in the case of doctor-patient sex, the question is how best to deal with a natural desire and role-specific temptation to do what everyone agrees they sometimes should not: act from an intention to end the lives of apparently willing patients. Should they learn to make complicated judgments on a case-by-case basis, or should they commit themselves to observing an absolute prohibition on acting from this intention?

It is granted all around that even an honest mistake—acting in good conscience to terminate the life of an apparently willing person who really did not wish to die or who was incapable of genuine consent—would result in a very grave evil, one against which it is extremely important to protect patients. The need for the strongest protection against such mistakes itself tells in favor of doctors' holding themselves to an absolute moral prohibition. This conclusion also draws support from another consideration. Strong temptation often seeks the help of self-deception and rationalization in support of a decision to do what one should not. A physician's temptation to end the life of a patient whose death he should not hasten, or to induce in an antecedently unwilling patient a desire to hasten her own, invites him to deceive himself about the patient's antecedent unwillingness and his hold over the patient. It also

23. Kass, pp. 473 and 476; see also Richard A. McCormick, S.J., "Euthanasia or Allowing to Die: Ethical Distinctions" (unpublished manuscript, University of Notre Dame), p. 19.

invites him to rationalize this behavior. Clearly it is easier for a physician to rationalize hastening a death he should not if there are cases in which he may act from the intention of ending the lives of his patients, for alleged similarity with these latter cases provides the rationale for his actions in the former. Just as clearly, the physician will find it easier to rationalize these actions—he will find it easier to convince himself that they were for the good of his patients—if there is a medical rationale available. It will be easier, that is, if he comes to regard the prescription of lethal dosages as a legitimate medical treatment for the willing and terminally ill. Honoring an absolute prohibition takes this possibility out of play.

Still another reason for doctors to hold themselves to an absolute prohibition is that doing so better secures public confidence in the medical profession. People will seek medical help and make the candid personal disclosures necessary for good care only if they are secure in the confidence that their physician intends their best interests. Those who fear that their doctor will regard them as a burden, will conceive a desire to hasten their deaths, or will try to persuade them to hasten it should they develop a terminal illness may have great difficulty believing their doctor intends their best interests. They may well avoid seeking the medical care they need, particularly if they fear they have a serious illness in the first place. The requisite confidence may once have been secured by patients' knowledge of physicians with whom they had long-standing relationships. But recent trends in the managed delivery of health care and Americans' increasing mobility have made such relationships increasingly rare. It is therefore increasingly important that patients have grounds for confidence in the medical profession as a whole, since they cannot be assumed to know the physician who happens to be treating them. Furthermore, it is vitally important to secure the confidence of those who have no regular relationship with a physician because they do not have the resources to secure adequate medical care. This disturbingly large segment of the American population is composed in part of those whose experience suggests that their society regards them as burdens even when they are healthy. This segment of the population needs special assurance that they will not be regarded as dispensable when they are not.

I cannot undertake a detailed discussion of the qualities of character that make a good physician, but even the most rudimentary treatment of this matter would note that medicine is a craft or "art" with practices, opportunities, and temptations that are unique to it. The fact that diseases of all kinds are the matter of various branches of scientific research can tempt physicians to think of themselves as scientists and their patients as, in the first instance, objects of their scientific inquiry. The fact that patients typically know far less about their own conditions than their doctors do can tempt physicians to think that patients should be subject

to their paternalistic control. The fact that patients pay them for their services can, conversely, tempt physicians to regard their patients as consumers whom it is their job to satisfy. It can also tempt them to abdicate responsibility for challenging their patients' expressed preferences or to mistake challenging those preferences for illegitimately overriding them. The fact that their patients are often suffering great pain can tempt doctors to be too involved with their patients or too distant from them.²⁴ Clearly the good physician must treat her patients in the face of these temptations and more.

Some medical ethicists think that the good physician should avoid the temptation to have sex with patients by observing a "taboo" on sexual relations with those who come to them for medical care.²⁵ It is better, I believe, to say that because doctors are placed in the way of this temptation, they should cultivate a virtue—a coherent, ordered, and stable family of intellectual and emotional dispositions—of choosing well with respect to doctor-patient sex. Perfect possession of the relevant virtue, if it could be attained, would be accompanied by what John McDowell calls "silencing," a state of character in which there is nothing the agent regards as a reason to act against the virtue. Physicians should aim at, and be known to aim at, a state of character in which there is nothing they regard as a reason to have sexual relations with their patients, a state of "renunciation, without struggle, of something which in the abstract [they] would value highly."²⁶ Among the public roles played

24. See generally Mary Vachon, *Occupational Stress in the Care of the Critically Ill, the Dying and the Bereaved* (New York: Hemisphere Publishing, 1987).

25. Kass, p. 474.

26. John McDowell, "Are Moral Requirements Hypothetical Imperatives?" *Proceedings of the Aristotelian Society* (1978), pp. 13–29, p. 27. There may seem to be something paradoxical about the suggestion that a virtue should be centered on or associated with an absolute prohibition. Virtue theories typically accord a preeminent role to the cultivation of practical wisdom. They do so, it might be thought, because good actions proceed from properly conducted practical deliberation about the circumstances of an action and its probable consequences. Good action, on this view, requires just the sort of reasoned flexibility that is precluded by adherence to absolute prohibitions. This is why many contemporary defenses of virtue theory oppose it to the rigidity of rule-based theories of morality. There is, however, no paradox in asserting that a person's virtuous character depends in part upon her honoring absolute prohibitions. The thought that there is depends upon an unduly restricted conception of virtue theory. Thus as one would expect, absolute prohibitions occupy a central place in the powerful and richly detailed virtue theory of Thomas Aquinas. It is important that Aquinas's arguments for the claim that it is always wrong to perform an act of a given sort typically turn on the claim that acts of that kind are contrary to one or another of the virtues. Furthermore, in Aquinas's view, the virtuous agent does not exercise practical reason to determine whether she may act against a putatively absolute prohibition in the case at hand. Rather she exercises it to determine whether the action she is considering is, under the circumstances, of a type governed by the absolute prohibition in question. Aquinas's famous discussion of whether an agent who takes another's property in desperation violates the absolute prohibition of theft is exemplary in this regard; see *Summa theologiae* II-II,66,7 ad 2. Finally, though I cannot argue the point here, I would

by the Hippocratic Oath and by codes of professional conduct is that of giving this conception of medical virtue public expression, so that physicians develop a conception-dependent desire to live up to it and have, and are generally known to have, special reasons to do so.²⁷

Physicians should also attempt to cultivate a virtue which precludes their regarding *anything* as a reason to act from the intention of ending their patients' lives. Perfect possession of *this* virtue, could it be attained, would preclude honest mistakes in which physicians help to hasten the deaths of those who seem capable of consent but are not. It would also foreclose the possibility of rationalization. The rationalization of impermissible action depends upon being able to stretch an available rationale for an act the agent may perform to cover those she should not. If there is nothing a doctor regards as a reason for helping a patient to end her life, there will be no rationale available for the stretching. The general knowledge that physicians strive to cultivate this virtue thus provides a basis for the necessary public confidence in the medical profession.

The value of doctors' honoring an absolute prohibition on acting from an intention to end the lives of their patients, like that on acting from an intention to have sex with their patients, depends upon the two roles the prohibition plays. First, committing themselves to the prohibition enables physicians to cope with a potentially powerful temptation to end the lives of patients who may appear willing but are incapable of genuine consent. Second, it grounds patients' confidence that doctors will not accede to this temptation. And as a prohibition on the seduction of patients is included in the Hippocratic Oath because the prohibition protects patients and grounds their confidence so, by parity of reasoning, the inclusion of prohibitions on "giv[ing] deadly medicine to any one if asked" and "suggest[ing] any such counsel" can be similarly explained.

conjecture that the emergence of casuistry as a theory of moral reasoning in the early modern period is best explained by the fact that thinkers like Aquinas had assigned practical reason precisely the task I have just described. For the compatibility of virtue theory with absolute prohibitions, see generally Joseph Boyle, "Natural Law and the Ethics of Traditions," in *Natural Law Theory: Contemporary Essays* ed. Robert P. George (New York: Oxford University Press, 1992), pp. 3–30. For an attempt to accommodate an absolute prohibition on lying within a Thomistic theory of the virtues but without Aquinas's theological presuppositions, see Alasdair MacIntyre, "Truthfulness, Lies and Moral Philosophers: What Can We Learn from Mill and Kant?" in *Tanner Lectures on Human Values*, vol. 16 (Salt Lake City: University of Utah Press, 1995), pp. 307–62. On the emergence of casuistry with explicit reference to Aquinas's discussion of theft, see Edmund Leites, ed., *Conscience and Casuistry in Early Modern Europe* (New York: Cambridge University Press, 1988), p. 7.

27. As the American Medical Association's "Code of Medical Ethics" says: "The Oath of Hippocrates (Christianized in the tenth or eleventh century A.D. to eliminate reference to pagan gods) has remained in western civilization as an expression of ideal conduct for the physician"; see *Code of Medical Ethics: Current Opinions with Annotations* (Chicago: American Medical Association, 1994). On conception-dependent desires, see Rawls, *Political Liberalism*, pp. 82 ff.

I have not derived an absolute prohibition on *doctors'* acting from the intention of ending the lives of their patients from a more general prohibition on *anyone's* acting from the intention of taking life or taking innocent human life. Instead I have treated the virtue of honoring this prohibition as a role-specific one, the point of which is connected with certain features of the social institution in which that role is defined. Those features include the differences in power between physicians and patients, the dangers that attend treating the termination of life as medical care, and the presence of what I have called "role-specific temptations." I have adopted this approach because it highlights the functions, including the social function, of this absolute prohibition. While I cannot pursue the matter here, I believe that the sort of functions to which I have drawn attention are a significantly underexplored and ill-understood part of the rationale for many categorical moral prohibitions. Any systematic defense of them that neglects their importance in removing grounds for rationalization, their connection with social roles, and their place in the maintenance of the social practices in which those roles are embedded thereby overlooks crucial reasons for observing them.

Of course not all practices are worth maintaining in their traditional forms. Changing circumstance and heightened moral awareness show some practices to be in need of revision or rejection. The contemporary physician's ability to prolong the lives of patients who would have died from their conditions even a couple of decades ago might suggest the need to modify traditional prohibitions in order to maintain the dignity of patients. And, it might be added, the need continually to reassess the viability of traditional prohibitions is shown by the history of the medical oath to which I have referred so often. Few medical school graduates now take the oath Hippocrates wrote²⁸ and some medical school classes compose their own. Changes in the medical oath reflect this continual reassessment of medical practice and some may explicitly enjoin it, as when the Harvard medical class of 1994 vowed to "advance [their] profession by seeking new knowledge and by reexamining the ideas and practices of the past." Among the ideas they intend to reexamine is presumably the absolute moral prohibition on hastening the deaths of their patients, since they did not pledge to observe it.²⁹

I have not said, however, that the medical oath written by Hippocrates is authoritative with respect to doctors who have not sworn it or that it reflects the most accurate and current self-understanding of the medical profession in America. I have argued only that the best explanation of its inclusion of certain moral prohibitions is that those prohibitions

28. See n. 2 above.

29. "The Oath of the Class of 1994," on file with the Office of Student Affairs, Harvard Medical School, Cambridge, Mass.

play the functions I have claimed that they do. The conclusion that physicians should observe those prohibitions is supported by a separate argument which turns on the importance of the functions the prohibitions serve and not the inclusion of those prohibitions in the Oath.

V

How do those functions ground a *legislative* prohibition on physician-assisted suicide?

A state-enacted ban on physician-assisted suicide removes the danger that physicians will assist in the suicide of a patient who seems competent but is not, that they will inadvertently pressure a patient into making the decision to terminate her life, or will rationalize hastening the death of a patient by assimilating the case to one in which consent is clear. A ban also goes some way to inculcating in doctors a disposition not to act on the intention of causing the death of their patients. Insofar as that disposition affects physicians' behavior, it too reduces the risk of mistakes. Clearly the state has a very strong interest in preventing the assisted suicide of patients who are incapable of consent or who appear genuinely willing to terminate their lives when in fact they are not. States therefore have some interest in using the law to encourage a virtue that precludes this.

States also have a strong interest in preventing doctors from acceding to the role-specific temptation to end the lives of their patients. It might be thought that patients are much more likely to fall into the hands of physicians who accede to the temptation to *overtreat* them, subjecting them to intubation, sedation, and other measures their patients regard as extreme if not intolerable. But the claim that physicians are tempted to overtreat patients near the end of life is not incompatible with the claim that they are also tempted to terminate the lives of their patients. It may be that the very patients on whom physicians have lavished all that modern medicine has to offer are those whose lives physicians are most tempted to end when their efforts prove to be of no avail.

The risks that doctors may make mistakes or succumb to temptation, while important, are not sufficient grounds for a categorical legal ban on physician-assisted suicide. The provision of adequate basic health care to all citizens is, as Rawls points out, a demand of basic justice.³⁰ The importance of adequate health care gives the state a strong interest in regulating it, not only to hold providers to accepted medical standards but also to ground public confidence in the medical profession. For without publicly accessible grounds for confidence, many patients may not take advantage of the care that is available to them. The state's interest in making health care available therefore implies an interest in its making publicly available the reasons patients have to trust their doctors.

30. Rawls, *Political Liberalism*, p. lix.

Publicly known legal prohibitions on physician-assisted suicide, like publicly known regulation of the quality of medical care, serve this state interest. This is because legalizing physician-assisted suicide or according it constitutional protections would create the public perception that doctors act from the intention of causing the deaths of their patients and because that public perception would undermine public confidence in the medical profession.

The public perception would be created in part by the fact that in practice, physicians would regularly discuss assisted suicide with their patients as a form of medical care for terminal illness.³¹ In discussing it as a form of care, it will be virtually impossible for them not to discuss it as a form of care which they will purposefully undertake to provide at the patient's request. The perception will also be created by the fact that if physician-assisted suicide were legalized or received constitutional protection, then the same status would have to be extended to two forms of euthanasia. It would have to be extended to cover the administration of drugs to patients who tried but failed to end their own lives under assisted-suicide statutes. Assisted-suicide proponent Derek Humphry, speaking of the assisted-suicide statute on which Oregon residents voted in 1994, said, "The new Oregon way to die will only work if in every instance a doctor is standing by to administer the coup-de-grâce if necessary."³² It would also have to be extended to the prescription and administration of lethal drugs to competent and consenting patients whose condition renders them unable to administer them to themselves. Therefore even if doctors participating in physician-assisted suicide did not intend to cause the deaths of their patients, the legalization or protection of physician-assisted suicide would inevitably result in the extension of this status to cases in which physicians do act, and are known to act, from that intention. The protection of this second form of euthanasia is not a slide down a slippery slope from physician-assisted suicide. To continue the metaphor, it is better regarded as a lateral move across a

31. According to a 1990 study, 50 percent of Dutch physicians "suggest" physician-assisted suicide to their patients. See Herbert Hendin, "Correspondence," *New England Journal of Medicine* 336 (1997): 1385, citing Paul J. van der Maas, J. M. van Delden, and Loes Pijnenborg, "Euthanasia and Other Medical Decisions Concerning the End of Life," *Health Policy* 22 (1992): 1-262. One reason for thinking the percentage would be higher in the United States than in the Netherlands is connected with the requirements of informed consent. Some hospital counsels warn that if physician-assisted suicide were legalized here, staff physicians at American hospitals would be required to present assisted suicide as an option to the terminally ill in order to obtain their informed consent to any treatment of their condition. Or at least, they warn that physicians would be required to do so in the absence of prohibition by a legislatively imposed "gag rule"; the model statute cited at n. 34 below does not contain any such rule. It may even be that worries about informed consent account for the high incidence of discussion of physician-assisted suicide between Dutch doctors and their patients. I am grateful to Maura Ryan for these points.

32. Derek Humphry, Letter to the Editor, *New York Times*, quoted in *New York Times* (October 26, 1997), sec. 1, p. 19.

level plain, a move that would surely be made in the name of granting extremely infirm patients protection equal to that enjoyed by those who are arguably worse candidates for suicide because they are at least able successfully to swallow or inject lethal drugs themselves.

The widely held belief that doctors intentionally take the lives of their patients would have profound implications for doctor-patient relationships as well as for the way subsequent generations of Americans approach their deaths. Courts and legislatures should be reluctant to reach a decision with such far-reaching social implications in response to problems in health care delivery that could be less drastically remedied. Among these are the problems that pain management is often inadequate and that advance directives and do not resuscitate (DNR) orders are routinely ignored so that many patients are treated with extreme measures against their will.³³ These have no doubt given momentum to the movement for physician-assisted suicide and constitute sources of pressure on patients to choose a suicide they otherwise might not. Some model statutes permitting physician-assisted suicide address the inadequacy of pain management in the hopes that no one will choose assisted suicide because her pain cannot be relieved and that all patients will receive better palliative care, but they do not address the second problem.³⁴ It would be both perverse and socially irresponsible to protect patients' right to terminate their lives in the name of autonomy so long as there is no solution to physicians' disregard for their patients' autonomy as it is expressed in their advance directives, a disregard that helps to create the very circumstances in which some find suicide desirable.

Note further that proponents of assisted suicide are in no position to discount changes to the doctor-patient relationship. They seek the legalization or protection of suicide assisted by *physicians*—not by a willing nurse, pharmacist, friend, or relative. Moreover, they are not concerned with the right of a patient to obtain the assistance of physicians willing to leave a gun or a noose at the bedside. They are concerned, rather, with the right of a patient to get help from a physician willing to put his medical expertise at her service in this endeavor.³⁵ This suggests that what proponents of a right to physician-assisted suicide want is the protection of a practice which patients and the public can regard as an optional part of sound medical care for the terminally ill. Quite clearly if

33. For the latter, see Hanson, Tulskey, and Danis, "Can Clinical Interventions Change Care at the End of Life?" *Annals of Internal Medicine* 126 (1997): 381–88; also "Doctors Ignoring Last Wishes of the Dying, Study Finds," *New York Times News Service* (November 22, 1995).

34. Charles H. Baron et al., "A Model State Act to Authorize and Regulate Physician-Assisted Suicide," *Harvard Journal of Legislation* 33 (1996): 1–34, see pp. 27–28. As of this writing the model statute is also available through the Deathnet homepage at <http://www.rights.org/deathnet/MSA.html>.

35. Baron et al., p. 17.

assisted suicide is to be regarded in this way, it will be because of the prestige of physicians³⁶ and because of widely held confidence in those who render their assistance. They must, it seems, be thought to have many of the traditionally valued attitudes and virtues,³⁷ which absolute moral and legal prohibitions were meant to help inculcate. They must continue to be thought of as committed to the patient's well-being and as unwilling to abandon her in distress. Thus if subsequent generations of physicians seem too willing to hasten the deaths of their patients, serious questions will arise about whether assisted suicide really is sound medical treatment after all. If they do arise and cannot be answered satisfactorily, it is questionable whether the assistance of physicians would any longer be what is wanted. Serious philosophical and sociological reflection is needed to determine what virtues physicians must have if physician-assisted suicide is to be perceived as a legitimate form of medical care for the dying. It is surely an open question in moral psychology whether those virtues can be sustained and transmitted to young doctors by a medical profession and a legal system no longer committed to the traditional prohibition on acting with the intention of ending the lives of their patients. If they cannot, then the legalization or protection of physician-assisted suicide will be self-defeating.

Still another reason for legally prohibiting physician-assisted suicide is connected to the perceptions and fears generated by grave injustices in the current system of health care delivery. Since part of what is at issue in the debate about physician-assisted suicide is the need to maintain public confidence in the medical profession, part of what is at issue is the temptation patients have reason to believe their doctors face. The well-to-do and the well-insured may have well-grounded fears that their doctors will be tempted to overtreat them. Those who have been undertreated or have not had access to care at times when they could have been restored to health are unlikely to fear overtreatment when their deaths are imminent. Instead, the experience of minorities, the poor, and the uninsured may ground the opposite fear.

It is a well-known fact that undermedication for pain discriminates by age, race, gender,³⁸ and therefore, quite probably, by wealth as well. While model statutes permitting physician-assisted suicide may require that patients be given the best palliative care before they receive a physi-

36. According to a Harris poll released April 28, 1997, more Americans regard medicine as a "very prestigious" profession than any other occupation. The poll also concludes that 87 percent of Americans regard medicine as "prestigious"—far more than any other occupation except scientist, which medicine edged out by a single percentage point. Results of the poll are on file with Louis Harris and Associates, Inc. I am grateful to the Information Services section of Harris and Associates for making their data available to me.

37. See Baron et al., pp. 5–6.

38. As the American Medical Association acknowledges; see "Brief of the American Medical Association, the American Nurses Association and the American Psychiatric Association, et al.," pp. 7–8, filed in *Vacco v. Quill*, 117 S. Ct. 2232 (1997).

cian's assistance in terminating their lives, the experience of women, the poor, and racial minorities may engender some distrust that this will be the case with them. This distrust need not be based on worries about the conscious operation of prejudice. Differences in pain management are no doubt due in large part to the fact that conscientious caregivers unconsciously discount evidence of some peoples' pain. Conscientiousness of the caregivers notwithstanding, those whose pain is discounted may well doubt whether things would be different merely because physicians would be required to sign a form indicating that they have not discounted it. This, in turn, grounds the fear of what seems a real possibility: that until this form of discrimination is demonstrably remedied, the model statutes will in fact result in women, minorities, and the poor being unfairly placed in a position in which committing suicide is the most attractive option. Members of these groups may see public approval of their social status in legal and health care systems which they think are more anxious to protect their right to do so than to address the substandard palliation that may lead them to request suicide in the first place.

To take but one example of how this might happen, American women are *less* likely than American men to receive adequate pain medication.³⁹ Studies in the Netherlands, the only country for which reliable data are available, show that Dutch women are *more* likely than Dutch men to have their requests for euthanasia and assisted suicide honored.⁴⁰ If assisted suicide were legalized in the United States, with its gender discrimination in palliative care, and the United States replicated or approximated Dutch patterns of differentially honoring requests for assisted suicide, the consequences would be very troublesome. Without knowing exactly what conception of autonomy a right to physician-assisted suicide is supposed to insure, it is hard to know whether women who request suicide after receiving inadequate palliation are ipso facto not free to do so. Even in the absence of a philosophical argument that they are not, the combination of inadequate pain management and a readiness to grant women's requests for suicide would publicly indicate that women's lives are not adequately valued and do not receive adequate protection.

The lived experience of the poor and the marginalized may ground a more general distrust of the medical profession and of the value that society attaches to their lives. A Gallup poll of older Americans found that while only 21 percent of African-American respondents thought that "a society which respects an older person's wish to commit suicide is

39. Ibid.

40. See van der Maas, van Delden, and Pijnenborg, p. 50, cited at Susan M. Wolf, "Gender, Feminism and Death," in *Feminism and Bioethics: Beyond Reproduction*, ed. Susan M. Wolf (New York: Oxford University Press, 1996), pp. 282-317, p. 313, n. 62. Wolf's essay is an outstanding feminist analysis of euthanasia and physician-assisted suicide, with special attention to the way self-sacrificial images of women in literature and culture bear on the questions at issue.

an advanced and civilized society," half again as many white respondents agreed with the statement. Thirty-seven percent of respondents with incomes under \$15,000 thought physician-assisted suicide should be legally protected, against 60 percent of respondents whose incomes were \$55,000 or more. And while 51 percent of white respondents agreed that physician-assisted suicide should be a legally protected option for the terminally ill, only 15 percent of African-American respondents concurred.⁴¹ Thus it is the poor and members of minority groups who may believe they have the most to fear from the legalization of physician-assisted suicide⁴² and in fact it is they who are most opposed to it. The state's interest in assuring that the poor and the marginalized have sufficient trust in the medical profession to seek the care they need would give it a strong interest in removing grounds for their fears by prohibiting physician-assisted suicide.

"The Philosophers' Brief" notes that "the burden is plainly on the state to demonstrate that the risk of mistakes is very high, and that no alternative to complete prohibition [of physician-assisted suicide] would adequately and effectively reduce those risks."⁴³ There is no doubt that "the burden on any state attempting to show this would be very high."⁴⁴ But since we allow other absolute legislative prohibitions when liberty interests are at stake and the burden of proof is comparably hard to meet, it is hard to see why absolute legislative prohibitions on physician-assisted suicide should be judged unconstitutional.

I presume that competent adults have a liberty interest in deciding with what other competent, consenting adults to have sexual relations,⁴⁵ yet there are cases in which we think it acceptable to impose ab-

41. Seidlitz, Duberstein, Cox, and Conwell, "Attitudes of Older People toward Suicide and Assisted Suicide: An Analysis of Gallup Poll Findings," *Journal of the American Geriatric Society* 43 (1995): 993-98, p. 996.

42. The 'may' is important for two reasons. One is that there are a number of possible explanations for Gallup's polling data. The other is that a Harris poll conducted immediately after the U.S. Supreme Court decided *Glucksberg* and *Quill* showed that a majority of those polled disagreed with the Court's decision, regardless of race or annual income. Whether the results of the poll indicate an enduring trend or merely an episodic reaction to the Court's decision can only be shown by further polling. One reason for questioning the significance of its results is that it showed those polled were equally likely to disagree with the Court's decision whether or not they were familiar with the cases decided. Unlike the earlier Gallup poll, the Harris poll surveyed adults in all age groups. Results of this poll are on file with Louis Harris and Associates, Inc. I am grateful to the Information Services section of Harris and Associates for making their data available to me and to the editors of *Ethics* for stressing the need to clarify the first of these points.

43. Dworkin et al., p. 46.

44. *Ibid.*

45. *Bowers v. Hardwick* may indicate the Supreme Court's refusal to recognize this interest, but Dworkin's writing suggests that he thinks citizens have it. Indeed it is precisely because he thinks citizens have this interest and the Court refused to recognize it that he thinks *Bowers* mistaken. See Ronald Dworkin, *A Matter of Principle* (Cambridge, Mass.: Harvard University Press, 1985), p. 68.

solute legislative prohibitions on some ways of pursuing this interest. For example, patients who develop strong emotional attachments to their medical or psychiatric caregivers and who wish to consummate relationships with them would find their ability to act on that interest restricted by laws which prohibit sexual relations between patients and their physicians. In spite of this, many states categorically prohibit physicians practicing psychotherapy from having sex with their patients.⁴⁶ The state of California goes further. There it is criminal for “any physician” to have sex with a patient unless that physician has referred the patient to another doctor recommended by a third-party physician.⁴⁷ Instead of imposing an absolute legislative prohibition, the California statute could have allowed doctors to have sex with their patients provided that patients sign forms stating their consent and attesting to their state of mind before they have sex with their doctors. Yet far from forswearing an absolute prohibition in favor of a requirement that patients formally signal their consent, the statute goes on to say that “in no instance shall consent of the patient or client be a defense.”⁴⁸ The rationale for absolute legislative prohibitions on sex between doctors and patients cannot be the view that doctor-patient sex is an inappropriate expression of human sexuality any more than an absolute legislative prohibition on physician-assisted suicide could be justified by the claim that suicide is an inappropriate way for human death to occur. Thus it must be that the California legislature thought that patients could be adequately protected only by a statute which includes an absolute prohibition and makes clear that patient consent is not exculpatory. Furthermore, some state statutes single out doctor-patient sex which occurs during the course of treatment and under a Michigan statute, patients are for some purposes deemed incapable of consent to doctor-patient sex that occurs under such circumstances.⁴⁹ This suggests that patients are thought especially vulnerable, and especially in need of protection, when sex with their physician is presented as a form of medical care. Finally, such laws are enacted not only to protect patients but also pursuant to the state’s interest in maintaining confidence in the integrity of the medical profession. This is clear from the legislative history of the California statute.⁵⁰

46. Richard A. Posner and Katharine B. Silbaugh, *A Guide to America’s Sex Laws* (Chicago: University of Chicago Press, 1996), pp. 111–28.

47. *Ibid.*, p. 113, emphasis added.

48. *Ibid.*

49. The purposes are prosecution for an injury resulting from sexual conduct during treatment; see 750.520b.(1)(f)(iv) of the *Michigan Criminal Code*.

50. See “Public Vulnerable to Bad Doctors, Study Says,” *Los Angeles Times* (April 16, 1989), sec. I, p. 3: “In a 100-page report, the University of San Diego’s Center for Public Interest Law asserted that a massive restructuring of the California Board of Medical Quality Assurance and the procedures it uses for disciplining physicians will have to be undertaken by the Legislature before consumers can be assured that incompetent doctors are being weeded out of the medical system.” That the story from the *Times* is included in the legis-

No doubt it would be hard to show that states can satisfy their legitimate interests only by statutes of this kind. Indeed it would be as difficult to show this as to show that states must resort to absolute legislative prohibitions on physician-assisted suicide to secure public confidence in physicians and to protect terminally ill patients to whom assisted suicide might be offered as a form of medical care. The latter statutes, like the former, categorically forbid one way of acting on a liberty interest.⁵¹ Therefore unless proponents of physician-assisted suicide are prepared to declare both burdens impossible to meet—and are prepared to argue against the California statute and other laws prohibiting physician-patient sex—they must concede that absolute legislative prohibitions on it are acceptable.

The justification for absolute legal prohibitions on physician-assisted suicide are thus the same as those that ground the importance of doctors' honoring absolute prohibitions on acting from an intention to have sex with their willing patients or to end the lives of their dying ones. The legal prohibition like these others prevents mistakes and rationalizations in the face of potentially powerful temptation and it maintains the necessary public confidence in physicians who would otherwise be thought to act from that intention. The state's interests are sufficient to warrant enacting such a prohibition. They are not, however, sufficient to warrant overturning *Cruzan*. The danger of mistakes and rationalizations in the termination of life support may be at least as great as in physician-assisted suicide. But permitting the termination of life support does not create the same public perception that physicians are sometimes willing to cause the deaths of their patients. For practical purposes, a right to physician-assisted suicide implies a right to voluntary euthanasia; there is no comparable implication to *Cruzan*. More importantly, physician-assisted suicide will be discussed as a form of medical care which physicians undertake to provide. It is doubtful that physicians discuss the termination of life support in the same terms. It is more likely to be discussed as the withdrawal of medical care from a terminally ill patient than as the last medical care that she receives.

lative history of the California statute suggests that the Legislature passed the bill at least in part in response to the study, which clearly evinced concern with public confidence in the medical profession. I am grateful to the staff of the Archives of the California State Assembly for making documents relevant to the bill's legislative history available to me.

51. It might be objected that there is a disanalogy between the cases because statutes prohibiting sexual relations between physicians and patients do not make it impossible for patients to act on their liberty interest in having sex with other competent and consenting adults. They simply forbid them to act on it with their doctors. But there is no disanalogy. Statutes prohibiting physician-assisted suicide do not make it impossible for patients to act on their alleged liberty interest in determining the time and manner of their deaths. They simply forbid one way of acting on that interest, actions which involve the help of their doctors.

VI

My argument that physicians ought never act from the intention of terminating the lives of their patients does not turn on a controversial conception of a good human life, nor does it appeal to religious or ethical claims about how human beings ought to face their deaths. Instead it appeals to special features of what the Hippocratic Oath refers to as "the art" of medicine to argue that physicians should cultivate a virtue which precludes their ever acting on that intention. One of the arguments that states may prohibit physician-assisted suicide depends upon this claim. It therefore depends upon an ethical conception of good medical practice, one that even physicians may find controversial. Despite that, courts and legislatures could adopt the arguments offered here, consistent with the principle of legitimacy at the heart of the brief's constitutional argument.

It is sometimes claimed that the form of liberalism associated with the authors of "The Philosophers' Brief" precludes public debate about substantive moral questions. This criticism is badly mistaken. Finding a constitutionally protected right to a willing physician's help in terminating one's own life would have profound and long-lasting consequences for doctor-patient relationships and for the practice of medicine. The authors' liberalism does not forbid debate about the implications of using public power one way rather than another when allegedly fundamental rights are at stake, nor does it forbid vigorous public debate about the implications of government action for private associations or professional practice. The authors' principle of legitimacy does not imply that courts and legislatures may not appeal to controversial moral claims about medical practice and virtuous physicians in deciding how to regulate assisted suicide. Neither, for that matter, does it imply that citizens and amici may not appeal to those claims in their public arguments about what courts and legislatures should do. What it does imply is that courts and legislatures may act in the name of a controversial conception of virtuous medical practice only if, first, denying protection to physician-assisted suicide is required to insure the virtuous practice of medicine and, second, the overriding importance of virtuous medical practice can itself be justified by appealing to a reasonable "balance of political values." Government should not discourage physicians from helping patients terminate their lives simply because it is morally wrong or will make them worse people. It may discourage them from doing so if permitting physician-assisted suicide would, as I have argued, harm the public interest reasonably conceived.

The arguments of this article do turn on special features of the medical profession and on the state's interest in regulating it. They therefore leave open the questions of whether suicide assisted by others should be decriminalized, or whether it would be legal and permissible to license a

branch of the pharmaceutical profession to assist the terminally ill in ending their own lives. In the last section I canvassed a number of reasons why proponents of assisted suicide are especially interested in suicide assisted by physicians. But if suggestions of this kind are put forward in the face of those reasons, the suggestions will have to be examined carefully. If the practices they propose are wrong or should be prohibited, it is for quite different reasons than those that settle the questions presented by physician-assisted suicide.

While I cannot rely on a particular ethical or religious conception of death in making those arguments, I can safely assume that many Americans adhere to such conceptions through the end of life. It is safe to assume that many Americans would regard the decision to terminate their own lives as a uniquely momentous one. It is therefore a decision that they should not be or feel forced to make. I have invoked contingent facts about current injustices in American society and American medicine and have suggested consequences that may follow legalizing or protecting physician-assisted suicide in light of them. Whether these consequences in fact follow, or are likely to follow, cannot be settled by philosophical discussion alone.⁵² If American society "were more or less well ordered," if citizens' "fundamental rights [were] guaranteed and there [were] no basic injustices,"⁵³ if all citizens enjoyed "the social bases of self-respect" and so were encouraged to accord due value to their own lives,⁵⁴ then perhaps they would be able to achieve or approximate full political autonomy.⁵⁵ If so, *perhaps* we could then be sure that choices by women, minorities, and the poor to end their own lives were autonomous in the relevant sense. And so perhaps, under those conditions, physician-assisted suicide could be justified in the name of patient or citizen autonomy. Perhaps it could be justified even if citizens merely enjoyed adequate "basic health care [and the other] essential prerequisites for a basic structure within which the ideal of public reason, when conscientiously followed by citizens, may protect the basic liberties and prevent social and economic inequalities from being excessive."⁵⁶ But we are plainly so far from realizing these conditions that the question can be safely postponed;⁵⁷ nothing in this article should be construed as implying that I think physician-assisted suicide should be permitted under conditions as favorable as that. Under prevailing conditions, I have argued, physician-assisted suicide should not be legalized or constitutionally protected.

52. I am grateful to Cass Sunstein for urging me to emphasize this important point.

53. Rawls, *Political Liberalism*, p. 248.

54. *Ibid.*, p. 82.

55. *Ibid.*, p. 77.

56. *Ibid.*, p. lix.

57. See Michael Walzer, "Feed the Face," *New Republic* 84 (June 9, 1997): 29.

“The Philosophers’ Brief” concludes by reviewing the cases of four terminally ill patients who want legally to end their lives with the assistance of their physicians. These accounts, though greatly abbreviated, are deeply moving. I have no doubt that the authors of the brief, and other people of good will who want the court to protect assisted suicide, are motivated in large part by compassion for the suffering and the dying. Many who support this position have no doubt sat helpless at the bedsides of people they loved, watching them die protracted deaths made needlessly painful by undermedication. I have done so as well. Inadequate pain management and underfunded research into pain management are the shame of American medicine, a scandal beside which useless operations and escalating profits pale in comparison. It is a scandal which is all the worse for invidious discriminations in palliative care.⁵⁸ And it is one which the medical profession has the power to correct. If physicians are to enjoy the public trust to which I have so often appealed, it is one which they should address without fail or delay.

APPENDIX

A BRIEF RESPONSE TO PROFESSOR DWORKIN⁵⁹

I agree with Gerald Dworkin that analogies are imperfect and we must be careful about exploiting them in argument. I liken the need for an absolute prohibition on physician-patient sex to the need for one on physician-assisted suicide (PAS). Despite Dworkin’s doubts, I want to maintain that my comparison is genuinely illuminating. I cannot take up every point that Dworkin makes. Here I address two of the most important disanalogies he sees between the need for absolute prohibitions on physician-patient sex and on PAS.

Attitudes and temptations.—Physicians’ erotic attitudes toward patients and their role-specific temptation to act on them depend upon the initial presence of erotic drives. Are there drives or dispositions which could manifest themselves as “contemplating aiding a patient in dying, thinking about whether such patients are suitable for such assistance, thinking of them as persons who would be better off dead rather than alive”? I suggested one: the human disposition strongly to resent standing reminders that our best efforts have failed. This natural disposition may be strengthened by experience in physicians whose success engenders high expectations of themselves and their profession. If so, then it may be that those patients on whom physicians have expended their best efforts are also those whom physicians are readiest to believe would be suitable for assisted suicide when those efforts fail. Now let me suggest some other dispositions.⁶⁰ Care for the dying is burdensome because of the toll taken by sustained emotional investment, because the sufferings of others who care for the patient can weigh heavily upon us, because the same is true of what we imagine the sufferings of the patient to be, and because the dying tap our own anxieties about dependency, aging, and

58. See n. 38.

59. I am grateful to Maura Ryan for invaluable discussion and bibliographic advice.

60. I am indebted to Steven H. Miles, “Physicians and Their Patients’ Suicides,” *Journal of the American Medical Association* 271 (1994): 1786–88.

death. It is only natural to feel the weight of these burdens. It is only human to desire relief when they come to seem unbearable.

There is no reason to think that health professionals are exempt from these dispositions and good reason to believe they are not.⁶¹ In the Netherlands, PAS is initially suggested by the physician 50 percent of the time.⁶² This statistic and the initial presence of the dispositions to which I have pointed raise questions about whose suffering and whose views about the patient's quality of life would motivate PAS in particular cases. These questions are made all the more pressing by studies showing that physicians rate their patients' quality of life lower than the patients do.⁶³ They are driven home by some of the most forceful writing in favor of PAS. The anonymous author of the famous "It's Over Debbie" acted on an ambiguous request to end a "scene" s/he found cruel involving a patient s/he had never met.⁶⁴ Timothy Quill writes eloquently of the shame and helplessness of patients' families and of the meaninglessness he sees in some terminally ill patients' lives.⁶⁵ Were PAS legalized, physicians would be uniquely positioned to seek relief for themselves and their patients' families by suggesting suicide to the dying patient while persuading themselves that it is for the patient's good and accords with her considered desires.

Self-revelation.—These attitudes and temptations may be especially strong when terminally ill patients are those whose lives our society often undervalues in the first place. I mentioned one piece of evidence that physicians differentially (and no doubt subconsciously) discount their patients' pain: undermedication discriminates by age, gender, and race. There are also significant differences between the quality and intensity of medical care received by black and white Americans, even after differences in income and clinical characteristics are taken into account.⁶⁶ African Americans are more likely than white Americans to report that their physicians did not discuss the results of their tests or examination, explain the seriousness of their illness or injury, or inquire sufficiently about their pain.⁶⁷ One obvious worry about legalizing PAS is that undermedication and lack

61. Robert N. Butler, "Psychiatry and the Elderly: An Overview," *American Journal of Psychiatry* 132 (1975): 893–900; also Pirkko J. Clarke, "Exploration of Countertransference toward the Dying," *American Journal of Orthopsychiatry* 51 (1981): 71–77. The point is especially well put in Edmund D. Pellegrino, "Compassion Needs Reason Too," *Journal of the American Medical Association* 270 (1993): 874–75.

62. See n. 31.

63. See Richard Uhlmann and Robert Pearlman, "Perceived Quality of Life and Preferences for Life-Sustaining Treatment in Older Adults," *Archives of Internal Medicine* 151 (1991): 495–97. Another study found that physicians significantly underestimated their chronically ill patients' desire for resuscitation. See Richard Uhlmann, Robert Pearlman, and Kevin Cain, "Physicians' and Spouses' Predictions of Elderly Patients' Resuscitation Preferences," *Journal of Gerontology* 43 (1988): M115–M121.

64. "It's Over Debbie," *Journal of the American Medical Association* 259 (1988): 272.

65. See, e.g., Timothy Quill, *Death and Dignity* (New York: Norton, 1993), pp. 16, 38–39.

66. Council on Judicial and Ethical Affairs of the American Medical Association (AMA), "Black-White Disparities in Health Care," *Journal of the American Medical Association* 263 (1990): 2344–46.

67. Robert Blendon, Linda Aiken, Howard Freeman, and Christopher Corey, "Access to Medical Care for Black and White Americans," *Journal of the American Medical Association* 261 (1989): 278–81.

of information would compromise the autonomy of a choice for assisted suicide. Another is that minority patients would unfairly be placed in positions in which assisted suicide is the most attractive option. A third is parasitic on the first two: these patients may not trust physicians when they are seriously ill because they may believe that they will be put in these positions or that the autonomy of their end-of-life decisions may be compromised. At issue now is whether this distrust would be so great that, were PAS legalized, a significant number of minority patients would be afraid to reveal their symptoms to physicians when they fear they are seriously ill.

A significant number of African Americans already harbor suspicions about the medical establishment. A 1990 survey found that 10 percent of black Americans believe the AIDS virus was "deliberately created in a laboratory in order to infect black people," another 20 percent believe this could be true.⁶⁸ Suspicion born of compromised autonomy and systematic undermedication could deepen distrust that is already present. It might be argued that these additional grounds for distrust would be addressed by strict safeguards on PAS, safeguards whose scrupulous observance and enforcement would be publicly known. But distrust is not so easily eradicated once it takes root. It is, for example, extremely difficult to recruit people of color for participation in clinical medical studies despite the fact that those studies are strictly regulated. This difficulty stems in large part from distrust of the medical establishment based upon abuses in the past, most notably the Tuskegee Syphilis Study.⁶⁹ Given the memory of Tuskegee and widespread suspicion about the genesis of AIDS, it is not surprising that what is true of clinical studies generally is true of attempts to study AIDS among African Americans.⁷⁰

Perhaps safeguards on PAS would eliminate a good part of the discrimination in therapeutic and palliative care that threatens autonomy and could unfairly make suicide attractive to minority patients. Even so, the difficulty of recruiting minority participants in clinical studies of any kind shows that distrust of the medical establishment can be sustained by the collective memory of a few notorious abuses. The difficulty of conducting clinical studies of AIDS and other diseases suggests that distrust breeds fear of disclosing the symptoms of serious illness, even to those conducting studies which promise benefits for minority communities and for the participants themselves. These difficulties also show that distrust cannot be eliminated by safeguards, since those who are supposed to observe and enforce them are prominent among the objects of suspicion. I therefore worry that safeguards on PAS would not dispel the distrust that could keep minority patients from seeking the medical help they need when they fear they are seriously ill. Comparison to another case in which the need for patients' self-revelation grounds an absolute prohibition is not as misleading as Dworkin suggests. Talk of doctor-patient sex in this connection is no red herring.

68. Cited at James H. Jones, "The Tuskegee Legacy: AIDS and the Black Community," *Hastings Center Report* 22 (1992): 38-40, n. 1 and accompanying text.

69. On the difficulty and the explanation, see National Institutes of Health (NIH), *NIH Outreach Notebook on the Inclusion of Women and Minorities as Subjects in Clinical Studies*, NIH Publ. no. 94-0324-P (Bethesda, Md.: NIH), p. 13, where the Tuskegee Syphilis Study is mentioned. I am grateful to Sue Ellen Levkoff for helpful discussion of this matter.

70. Jones, p. 39, which attributes resistance to clinical studies of AIDS to the legacy of Tuskegee.