This introduction reminds me of my favorite Jewish story. It’s about this old Jew who was trying to get from Minsk to Finsk. And he couldn’t get on the train so he had to stay overnight and he went to the inn and there was no place at the inn. But this all has to do with the introduction. So he begged and implored the innkeeper if he would let him sleep somewhere in the inn. And the guy says, “There’s no room.” So finally he says, “Well, I’ll tell ya, there’s a Russian general. He’s drunk so much that he’s probably out on his feet. You can sleep in his room. I’ll wake you up early in the morning and you have to get out of there before he wakes up.” So the old Jew sneaks in. He falls asleep. Early in the morning somebody grabs ahold of him and he jumps into his clothes, rushes down to be first in line at, at the train station, goes in for his morning ablutions, looks in the mirror, and he’s wearing the uniform of a Russian major general. And he says, “My God, they woke the wrong man.”

Now for me to come here and talk to you people in Michigan about this subject is like bringing coals to Newcastle. And it’s very, very presumptuous on my part so I approach it with a certain amount of caution. I come partly, I must say, because of my great affection for Dr. Waggoner, with whom I actually overlapped some time on the American Psychiatric Association board and I will say something further about Dr. Wagner when I
discuss the question of medical ethics. Then I now say something about how I got into this. This article that is referenced is actually the second article a group of us wrote on taking care of hopelessly ill patients, which was published in the New England Journal. The first made the proposal, which some of you may remember that with patients who are second or third stage Alzheimer’s that if they refused food and water, you did not have to automatically tube feed them and begin tube feeding. That article by itself was incredibly provocative. And I must tell you I got a number of letters accusing me of being a Nazi doctor.

The group reassembled two years later and went through much of what the AMA has been going through recently in describing the importance of terminal care. And the basic idea that the doctor’s responsibility, which is to cure those who can be cured and to ease the suffering of those who cannot and we went in at great length to emphasize the rule of double effect of which I will speak. Now we had prepared something. We all gave papers. We were going to write this paper for the New England Journal. And then the chairman of our group, a dean at Harvard Medical School and a wonderful, wonderful man said, “I want you all to know that although I’ve proposed a regime with you of titrated care to ease people’s suffering that I myself have a bottle of pills, and my wife who is a nurse has an understanding with me that if I get to this stage, she’s going to bring in the
pills so I can avoid all of this terminal care that we are proposing for patients.”

Now that was a very strange moment in these deliberations because then the doctor sitting next to him said, “You know, I have the same agreement with my wife that if she’s in this situation I’ll bring in the pills for her.” And then it turned out that those who didn’t have the plan already were very enthusiastic about it. Now it’s very strange because the standard ethical question the doctors ask, “What would you want if it was your mother?” Turns out that’s the wrong question. You should ask, “What would you want if it’s you?” Now it turned out that ten of the twelve people in this room, we were sort of the disciples without Christ. But ten of the twelve decided that that’s what they would want. And we published an article in which for the first time we said, “It might be ethical for a physician to assist in suicide.”

Now, the whole--everything we were proposing is just what the American Medical Association is now proposing of comfort care end of life. But these doctors thought, and I want to tell you, the doctors were--who is the leading person taking care of cancer patients at Mayo’s? Who is the leading person at Smith? Anderson Smith taking care of children with cancer? These were not just a group of people that were rounded up. These were very distinguished doctors taking care of terminal patients all the time. And ten of them were prepared to say, “This is what they wanted.” As it turns out, I
was not prepared to say at that point that I thought that physician-assisted suicide was ethical. Although, I am not sure that if the first question is, “What do we as doctors want for ourselves?” that everyone in this room who is a physician is prepared to go through a terminal illness and accept the comfort care that organized medicine promises us, which I believe is a very important question with which to begin the discussion.

At any rate, whatever we as doctors were pontificating about in the New England Journal of Medicine, events moved on as they do and as has happened to most of medical ethics, namely they’ve been replaced by the law so that although we still talk about medical ethics as I shall discuss, what we’re doing is mostly what the law has told us to do. Twenty years ago, most doctors did not believe in informed consent and most doctors did not tell patients they had cancers. There were polls which said, “What is your practice?” I don’t tell patients they have cancer. Now everybody tells patients they have cancer and they think this is the medically ethical correct thing to do but it did not come from medicine.

The important thing about these two decisions--let me speak about the second circuit opinion first because it’s very much what I had written about in my editorial--actually for the American Journal of Psychiatry. You just imagine two patients who both have had a fracture and are paralyzed. And it may be there’s a centimeter difference in where their fracture occurs and where the spinal cord is injured. One is on a respirator and the other is not.
Under the law of the United States now, the person who is on the respirator can refuse the respirator and die. The person whose injury is one centimeter lower has no treatment to refuse and therefore is that kind of problem. So, so you can argue, and I think the argument can be made, how do you distinguish those two human beings and their right to end it all?

At any rate, the second circuit made an argument saying there was no rational way to distinguish between people in those situations who needed the doctor’s help to die by some pills and somebody who could just have the treatment stopped, right? The Ninth Circuit opinion was more ambitious, more politically provocative and complicated. It went in the direction of the thinking on the right to abortion and found a new right to hasten one’s death. Now when the cases were argued before the Supreme Court, one of the first questions asked by Justice Kennedy was, “Are you asking us to outlaw - to overturn on constitutional grounds all these state laws which presently prohibit assisted suicide?”

Now, I want to emphasize to you that’s just what happened with abortion. Every state had a law against abortion and the states that had regulated and permitted it to some extent still had laws. All of those were overturned by the decision, right? Now I would say although it may be unpopular in this group, I would say the most important decision in medical ethics in this century was Roe vs. Wade. You may not know it, but in this century, most doctors went to prison for performing illegal abortions in this century.
Okay? That's the chief reason for doctors going to prison, okay? Now Michigan, the statutes that were overturned, the first is the Washington statute, that the person is guilty of promoting a suicide when he knowingly aides another person was the part of the statute that they overturned. And in New York where the law is if he intentionally aides another person to commit suicide. Now, as you know, Michigan does not have a law against it. Like many states, you did away, apparently, with the law against—that, that made committing suicide a crime. It used to be a crime. And in this—I doubt, perhaps if anyone will know whether anybody seriously thought about the problem or it’s like I actually served on the Massachusetts commission for the reform of the criminal law and they were just package deals they were made. And I’m sure no one focused on it but perhaps they did. But you have, you have both Dr. Kevorkian and Professor Kamisar so you know everything there is to know about this subject since you have the advocates on both sides. In common law, it was a crime to commit suicide and to assist in suicide. And so that’s the basis which people have tried to proceed here against Dr. Kevorkian.

A lot of the impetus for physician-assisted suicide has come from people with AIDS who are dying of AIDS and when their T-cells get to a certain level ,they would like to be able to check out. And this has become a much publicized situation where they invite people to actually be with them when they take medication and end their lives. The plaintiffs in the constitutional
cases were HIV patients, a physician with cancer herself who had metastasized to bone and she was in incredible pain. Every time she tried to move she would get fractures and so the cases are very compelling. The cases are very compelling. Who could be more understanding of their situation than a physician who’s got advanced metastasized to their bone? They know just what the medication is and they’re still asking for it. So what they are asking and the doctors in California said that the prescription of drugs to competent terminally ill patients is consistent with their best professional judgment and the standards of medical practice. So here are doctors saying, “Look, this is okay.”

Now, what basis do we have to say it is not okay? “I will give no deadly medicine to anyone if asked nor suggest any such counsel and in like manner, I will not give to a woman a pessary to produce abortion.” So the Hippocratic Oath, in my view, is built around sort of not giving physician-assisted suicide and not performing abortions I know some of you feel these subjects should be kept totally apart, but I do not think that they can be. And I don’t think it’s any mistake that, for example, of Ronald Dworkin’s book deals with those two subjects together. Now I want to point out to you that the Hippocratic Oath is not part of--it’s not enforced anywhere. Whether we took it or not, it’s not enforced by anyone. And I want to now show you the next which is the AMA’s principles of ethics. And I would say--that’s right. Now I don’t know if you can read the AMA’s principles of ethics, but
unfortunately, there’s almost nothing there to read. They have almost no content. I want to emphasize that to you. It doesn’t say anything in the principles of ethics about do no harm, for example. And although the AMA has in its newspaper and in its editorials emphasized how they told the Supreme Court that the basic tradition of medicine is do no harm, it is not in our principles of ethics. Okay?

Well, I put that on because that’s a small university on the West coast that some of you may have heard of. And, you will see that they have, in fact, over their hospital put these ethical principles. Now I would say about that, this is part of the problem of ethics in medicine. Whose ethics? Who’s got it? Where do we stand as a group on medical ethics?

Now the line being crossed, as far as the law is concerned and as far as the AMA in their brief is concerned is this comes from the AMA’s council on judicial and ethical matters and it was first dated 1982. And those of you who were lawyers will recognize that it is very legalistic indeed. It says that we should not intentionally cause death. It’s almost like a statute. You should not intentionally cause death. Now that’s because we were then, as our group who wrote in the New England Journal of Medicine, we were welcoming the double effect. And basically the idea is that if you’re trying to ease pain and you give a huge amount of medication and the patient ends up dying, that’s alright because you did not intentionally cause death. Your intention was to ease the pain. So the AMA has accepted that. The line
being crossed in these briefs is whether you can write a prescription for a lethal dose of medication therefore. Not what Dr. Kevorkian has done, but what Dr. Quill has done. Can you use your power to prescribe a lethal dose, explain it to the patient, and give them the prescription? Now as I said, you cannot escape the connection, legally certainly. The Ninth Circuit wrapped itself in the abortion law arguments in ruling that there was a right to assisted suicide. And I want to point out that when the court dealt with abortion, it also had to deal with the Hippocratic Oath. And the way the Supreme Court did it was to say that that part about--and this is very interesting, that part about abortion was from the Pythagoreans who were a strange subset of the group of doctors at the time. And so, therefore, this should be distinguished from the rest of the Hippocratic Oath. Okay?

Now I think that Hippocrates, the Pythagoreans, and other Greeks are all going to--have all fell in the court of appeals. So the important thing for us to realize is that the law looks increasingly, in my view, and I will try to demonstrate this, increasingly disdainfully at medical ethics as a reason not to do anything for the law. In fact, in one of the most compelling arguments, the court said, “Well, what the doctors are supposed to do with informed consent is what the patient wants. So what are the doctors complaining about? They’re supposed to do what the patient wants.” Now public opinion on assisted suicide is rapidly, it seems to me and perhaps wrongly, but rapidly moving in the direction of greater and greater public acceptance.
and approval of it. The Roper poll in 1990 had 64 percent, the Harris poll had 73 percent in 1994, the Oregon Referendum actually passed in a plebiscite. The Oregon MD’s were said to be 60 percent for it. The Washington and California referenda lost but many people say that in the future they will pass again. I have 125 students who take law and medicine at Harvard Law School. Ninety percent of them favored physician-assisted suicide and they will be part of the elite class of lawyers running the country. Ninety percent of them favor physician-assisted suicide. I am told that the Michigan Medical Society recently came out opposed to it, some 56 percent but earlier polls showed that doctors in Michigan, 56 percent would prefer physician-assisted suicide to a law that was an outright ban.

Now why does the public want PAS? In my view, I’m giving you this from my reading of legal opinions and from medical writings. First, there’s a strong argument made by many doctors that many of our treatments actually prolong suffering and cause people to have a more painful death than they would otherwise have. Some of you may have read Ben Ruby’s column to that effect in the New England Journal of Medicine, that patients who would have died a relatively quick, uncomplicated death say from leukemia now go through a prolonged treatment, very painful and perhaps in the end, die a more painful death. Second of all, there is the growing recognition that we can prolong life but we cannot prolong the quality of life. And so there is a huge sense among the public of, “I’m gonna end up with some chronic
disabling disease and the doctors are gonna be able to keep me alive but they’re not gonna be able to give me what is necessary for me to enjoy life.” Then there is this horrible situation that if you work in a nursing home or visit a nursing home you discover that most of the patients are quite isolated. Many of them have--half of them in a standard nursing home have no known relative and nobody has visited them in years. This is standard sort of public nursing home. So there’s this incredible isolation. There's the dementia, of course, and the concern has been a very important part of the literature. If I don’t decide now and do it now, I’ll be incompetent to decide it then. So there’s this fear of dementia. I, I think judges are very much, when they write about this, their sense that they’re gonna be lying there naked, incontinent, dependent on people for their basic needs is a horrifying picture to them.

Now adding to this list of woes is the recent study by the Johnson Foundation which found that in many hospitals, the quality of comfort care for terminal patients was not getting better and that many people were in hospitals getting poor comfort care. Now Emanuel claims--now there’s a certain Harvard spin to this presentation which is not entirely a, a result of my egomania. There’s, there are the Emanuels, Ezekiel and Linda Emanuel. Ezekiel is gone to be the head of ethics for NIMH from Harvard and Linda has gone to be the vice president for ethics of the AMA. And they are organizing sort of the organized medicine’s response against physician-
assisted suicide. Ezekiel Emanuel has lots of data and he claims that the patients who want—and this is what puts it into our category, who want physician-assisted suicide are depressed, not in pain and that medicine can handle pain. But what is going on is that people become depressed.

Now if you will forgive me, I want to just describe to you the reasoning of the court and how it gets from the Cruzan decision in the Supreme Court to physician-assisted suicide. Now what happened several years ago as many of you know, the Supreme Court was—dealt with the Cruzan case and it said that a patient who was permanently unconscious, is the current language, had a right to refuse treatment. The question was whether they had also a right to refuse food and water, whether that was to count as treatment. The AMA presented a brief saying it should count as treatment. And in the concurring opinion of Justice O’Connor, she made clear that it was meant to include food and water. So then the argument goes, if you can do those things, you are in fact being given a right to hasten your own death. Now this is related to the question: How do we speak about it? Do we speak about it as physician-assisted suicide or hastening your own death? The logic chopping view of the Ninth Circuit is everybody has a right now to hasten their own death. Right? That's what Cruzan is about, the right to hasten one’s own death. So the holding in Cruzan can be read as doctor assisted suicide because you pull out the tubes and then Nancy Cruzan starves to death or dies of thirst. That’s how she dies, right? And so you’re
assisting her in that way of committing suicide. That is hastening her death by withdrawing treatment. Now the irony is that the most conservative member of the court, Justice Scalia, said, “You know, this letting Cruzan refuse treatment is nothing but suicide.” And now the liberal judges have jumped on his language and say, “Yes, that's right. You said it yourself.” And if you remember the grave digger scene in Hamlet, there’s the question of whether the water comes to you or you go to the water depends on whether you’re gonna get buried on holy ground or not, whether you’ve committed suicide or something else. The grave digger is debating whether Ophelia is going to get buried in holy ground or not. Actually, Justice Scalia rehearsed that argument in his opinion. Now the point then for this court was that Cruzan is really about hastening death and with the assistance of the doctor who removes the tubes. So then this court had to look at the standards of medical practice. And this is my reason, along with others, for talking about the disdain. They said, “First we did do not resuscitate. And that actually means letting the person die. Then we let them refuse extraordinary care.” That’s what Quinlan was about. Then we said, “There's no difference between ordinary care and extraordinary care.” That’s what Cruzan was about. Then we said, “Ease the pain and suffering even when it hastens death.” The AMA said that. So why is the AMA objecting now? This court found no ethical or legal distinction between double effect and single effect. You’re giving these drugs so that the person will ease their pain but you know the patient is going to die. That’s what
you want to happen. Indeed, I don’t know how many of you work in hospices, but if you are around hospices, basically the nurses start giving more scopolamine and whatever and they really are expecting the patient to die. There isn’t any question. They’re waiting for is it tomorrow or the next day and they’re upping the dose. And that’s what’s happening. Now you can continue to call that not intending, but that is just, I would say, pretending. Then the court said, “Pulling a plug and prescribing to allow death are legally equivalent.” I was consulted about a woman who was on a respirator that had neurosurgery. It’d gone badly. She’d been on a respirator for several years and she wanted out. And so the question was, would somebody go--some doctor go to her house and shut off the machine? She had adult children. She talked to her adult children. They all thought it was the right thing to do but they didn’t want to be the ones to shut off the machine. So they wanted a doctor to go and shut off the machine. So the doctor who had operated on her said he would shut off the machine but he wanted her to come in the hospital to shut off the machine. He didn’t want to go into her house and shut off the machine. She was living at home. Then the hospital said they didn’t want her in the hospital to have her machine shut off. Okay? So finally they went to court and under the Massachusetts law, they were told they could shut off the machine. Then with a court order the doctor who had operated her went to her home and first gave her medication. Of course he was not going to shut off the machine and just watch her suffocate. So first he gave her medication so she
wouldn’t go through the experience of feeling that she was suffocating to death. Now the critics of the AMA’s position said, “You know, doctors are already doing much worse than physician-assisted suicide in these cases. This is a woman who had a life expectancy of twenty years on her respirator. So she was not imminently dying. The court said she has a right to refuse the treatment and the doctor goes and gives her medication first so she won’t feel it and then shuts off the machine. And as you know, there is an article now in the literature about treating terminal pain patients by giving them huge doses of barbiturates to put them in barbiturate coma and then turning off the fluid and food so that they will die peacefully in their sleep which is sort of an incredibly roundabout way, again, to get to involuntary euthanasia.

At any rate, the court looked at all this and said, “We can’t see the difference between acts of omission and acts of commission. We’re not talking about assisting suicide, rather terminally ill hastening death by refusing a treatment.” Now the Ninth Circuit also looked at our medical literature and the pleadings of the plaintiffs and said, “First we’re making criminals out of compassionate physicians.” Right? Dr. Quill being an example. You all know about Dr. Quill. I’ll say a few words later on if--now the truth of the matter is that physician-assisted suicide and voluntary euthanasia have been done for centuries and there are many descriptions in the literature. There happens to be a very moving description of Sigmund Freud’s doctor performing voluntary euthanasia on Freud after Freud asked for it after he’d
suffered for years from cancer of the jaw. And he says, “You know, doctor, you promised me that when I got there you would do this. I’ve gotten there. Do it.” And the doctor did it. So Emanuel had written an article earlier on before he got on this particular kick, which I think was true that doctors all over America were doing all sorts of things like physician-assisted death, voluntary euthanasia and so forth. And there was really an information problem. If you could get to the right doctor, you could find a doctor who would do what you wanted. And so there’s the question of what is this slippery slope that people are talking about? We’re already doing everything. There is no risk to the integrity of the profession.

If you look at doctors who oppose assisted suicide, you find they do not give ethical reasons. They give their own personal religious reasons. And so doctors who are opposed to suicide are usually Catholic or they live in small towns and are fundamentalist Protestants. They are not objecting to these things on the basis of their ethics. Now Yale Kamazar has written that one can object to it on non-religious grounds and I agree with him. But that is not the reason that doctors give. And then I quote from the Ninth Circuit, “Twenty years ago the AMA contended that performing abortions violated the Hippocratic Oath. Today it claims that assisting the terminally ill patients to hasten their death does likewise. The AMA’s contention had no constitutional weight then and it has none now.” Most doctors can readily
adapt to a changing legal climate and if you look at abortion, we certainly did.

Then the court goes on to say, “And furthermore, if you don’t want to do it, you don’t have to do it. We’re not forcing anyone to do it.” Now at this point, I want to deal with the question of, could this be regulated? I told you about the kind of cases that were presented to the Supreme Court but I want to remind you of the cases. First, you all know Dr. Kevorkian’s first and most famous patient that we know of which was Janet Atkins. And Janet Atkins was in early stage senility. She could still beat her thirty year old son at tennis but she couldn’t remember the score, right? Now I want to tell you I play tennis with people all the time who can’t remember the score. It’s a question of whether it’s their age or--it’s a great temptation to cheat but I don’t--they don’t usually think it’s a reason that they want off if they can play tennis, right? Now she was actually in a clinic in Washington which treated people. She was unhappy with it but she is a long way from the test case of somebody who’s got advanced metastasized to bone marrow and can’t move in their bed without breaking a bone, right? That is a long way. Now Dr. Quill’s famous case was a woman who developed leukemia. She had a one chance in four of a five year cure and she refused it with consultation with Dr. Quill. Okay? So she had decided not to take it and then she was dying the less painful death that people die from leukemia. And at that point Dr. Quill went over and he actually wrote a prescription, as
you know, for a lethal dose, explained to her that this would be a lethal dose in a sort of double talk and then signed the death certificate saying that she had died from leukemia. Now I don’t object to Dr. Quill doing this morally as a human being. But I do think it’s rather asinine to then write it up in the New England Journal of Medicine and wave it in people’s face and not expect the prosecutors to attempt to prosecute him, particularly since he lied on the death certificate. I don’t think doctors are supposed to lie on the death certificate, right? So I can understand he was trying to avoid a conflict, but I don’t think this is quite the way to go about it. At any rate, I want to emphasize that this was not a patient then who we, from our treatment, had cause to suffer. She was dying the way people have died for centuries from leukemia or other diseases. So now I give that as an initial statement about the problem of regulation. Could we really regulate? These are the cases—if you look at the cases Dr. Kevorkian has done, could we regulate?

Now what is the role of psychiatry in this? I wanted to say a few words about that. In the Ninth Circuit and as I will show you, the expectation was that physicians, psychiatrists would determine whether a patient’s request to hasten death is rational and competent or motivated by depression or other mental illness or instability. So what is the concern that everyone has is the concern about irrational suicide and the psychiatrists that are supposed to check the people out that they’re not irrationally suicidal. There’s been
much debate about what model statutes should provide in this respect. Dr. Kevorkian thought that every patient should be screened by a psychiatrist. He has written up some material, actually, and calls for everyone to be evaluated by a psychiatrist. And it’s my understanding that he has a psychiatrist who is now assisting him. Dr. Quill thought it would be up to the primary practitioner to decide and the language of the various statutes goes all over the place. There are now many of these statutes. I just give you a sample of them to give you a sense of what role the psychiatrist might play. Could I have the next transparency?

Now let me just emphasize to you as a clinical matter that there are these huge problems of overlap in our DSM-IV criteria for depression, for major depression and the symptoms of terminal illness. Three--as psychiatry has become more biological, three of our categories involve weight loss, sleep disturbances, and fatigue. These were all things that patients who have terminal illness will have. Now complicating the picture and I think quite interestingly complicated, oncologists are routinely now prescribing tricyclics for all their patients. And a very interesting development in oncology. They think that tricyclics one, help patients to sleep. Second, they keep them from losing weight and maybe as a side effect, they lift their depression. That’s how they tell patients. I’m gonna give you this mediation. It’ll help you to sleep. It’ll keep you from losing weight and it might even cheer you up. Some also prescribe Ritalin. So you would be
evaluating a patient who is already on medication. Now even as a further clinical problem, I want you to know that the MacArthur study has shown that most depressed patients are competent on all tests of competency to make medical decisions. So even if you decide someone is depressed that does not mean they are not incompetent. The only test which has been proposed is the question of whether they appreciate what they’re doing. And I would say we have no reliable basis for determining whether somebody’s feelings of hopelessness when they have cancer and they have a few months to live is irrational or rational. And we certainly, I don’t think, can claim to have that wisdom. So now there are--for our profession, for psychiatrists as part of medicine, we--in the atmosphere of managed care, do we now become like the competency gatekeeper? They call us in and if we say the person is competent, we give them the stamp of approval and then they get to commit suicide. Is that ethical? Is that how we--should we play that role? Or shouldn’t we prefer to do--well, if I’m a doctor and I’m called as a consultant, I want to give a trial of treatment. I want to try some other anti-depressants. I don’t want to just say, “Yes,” or, “No.” And I’m the gatekeeper for suicide. This is a serious ethical problem within the profession about how they would go about that. And if you compare what we have said about participation in capital punishment with participation in this, you will see the incredible discrepancy.
Now, I want to now tell you about the Oregon Death with Dignity statute which was passed in 1994 by the voters. That provides that no professional organization, association or health care provider shall censure any doctor who does it. So the basic thing I would like to convey to you is if these laws pass, we are out of the loop. Nobody cares what we think. Now we might hire Yale Kamazar and say, “We have a right, some Constitutional right to condemn these people.” But the statute forbids us from admonishing our colleagues if they do it even. So I want you to see how far out of the field of play we have gotten. We would be unable to sanction our own members. The AMA would not be able to throw somebody out of the AMA. They might be able to throw them out of the American, but they couldn’t throw them out of the Oregon. Or they certainly couldn’t do anything that would affect their economic livelihood in any way.

Now here’s the idea that is the key idea, my contribution to all this. And I want to emphasize to you that I am not trying to change anyone’s view one way or the other. There is this great book I recommend to all of you written by Nisbet and Roth called *The Structure of Human Inference*. I think that’s the title of it and the book, which it should be required reading for all doctors and lawyers, describes one of the remarkable things is when we have some deeply held belief and we hear evidence that is equivocal, we go away even more deeply convinced of our original position where if we were rational, we would be less convinced because we would know that there is
no good evidence, right? So one of the problems of listening to all this kind of talk is everybody just hardens their pre-existing attitude. So I hope only to enlighten you. I’m not trying to push you one side or the other.

Now what has happened is that American medicine has lost its ethics. We did it partly to accommodate to legal restrictions, partly specific laws which took the lead away from us. But despite that, we had a very strong tradition of ethics which was what—those of you who know fancy words I would call a praxis. We didn’t have a theory of principles that we could look to and say, “Here, we’ve thought it all out. We’ve got all these qualifications like the lawyer’s code, but we knew what a good doctor was.” We had good doctors who were our role models who embodied excellence and compassion and caring. And they are the people from whom we learned our ethics. There were real, practical examples when you went on rounds with this person. This was an exemplar of what it was to be a physician. Those doctors are now all outliers under managed care. I mean that. That is a serious problem. They’re outliers. They gave more time and care than was economically efficient to their patients. I remember going on rounds. A lot of you probably went on rounds. Who was the guy who taught us about diabetes? John Peters, he would take us on rounds and he would start putting cotton batting on the feet of the diabetic patient who had sores and would make us all stand there and watch as he did this. So by an example, he was showing you, you know, we were all very busy but I’m showing you-
he was not a nice man. But he was showing us what being a doctor was about. That is not permitted under managed care.

The real organized medicine has written briefs in opposition to physician-assisted suicide and the Supreme Court. I’ve gone through the whole debate when the AMA came to the APA and argued that we should get on board with them and join them. I would say--Linda Emanuel came representing and she went through the entire literature and gave her reasons. I would say--now, this may be unfair. I would say that oncologists have a special view about taking care of dying patients that the rest of us don’t have. And I said to her, “Well, you know what? This sounds right but what are you gonna do with a patient who’s demented?” And, you know, basically she said, “Well, if the patient gets pneumonia I would just withhold treatment.” And, well, I understand that. That’s something one could do. It’s hardly an organized approach. I believe that oncologists increasingly are concerned about giving care but I now refer you to all the oncologists who didn’t want that care themselves and wanted to be free to take a lethal dose of medication when they got to that point.

At any rate, I would say to you, and this is part of my agony about how I stand on this is that in a strange way, the stand against physician-assisted suicide is the last stand of medicine as a profession. For agonizing, you want to know what is at the cutting edge. If we don’t control this in some way, if we don’t rally around and say, “No, we’re not going to sit.” Patients
who say they want the pills and it may be the right thing but I would say it will be the end of medical ethics. And so I see what is going on as having a political dimension to it that organized medicine is saying, “No, we’ve got to--we’ve found something we can agree to. Now, it’s not that hard. It’s not that easy to get people to agree. They have agreed on this.”

Now I already described to you why I thought regulation was unworkable and the AMA thinks so and I think this is one of Professor Kamazar’s argument. And I think it is a valid argument. When the abortion decision was going through the Supreme Court, Justice White said, “This is nothing but abortion on demand.” Chief Justice Burger said, “No, you’ve got that wrong. Justice Bachman has assured me that doctors know what they’re doing and doctors will regulate abortion.” Well, it turns out Justice Bachman and Justice Burger were wrong. And Justice White was right. And if you read Roe versus Wade, you’ll be amazed. You think they’re talking about doctors but what we really know is it is about choice. Now I’m all for choice. I’m not against choice, but I don’t think choice is regulated. Okay? I’ve already discussed the famous cases of Dr. Quill and Dr. Kevorkian and I don’t think on any scale of regulation, they are cases that should be given physician-assisted suicide. And yet patients like that will want it. Herbet Hendon who studied the Dutch experience is--and is a very eminent suicidologist is totally opposed to it and claims that although the Dutch report in the New England Journal of Medicine it was working
fine, he claims it’s working very badly. They do about one a year, a psychiatric patient who they give physician-assisted suicide to in Holland who we would not think had a terminal illness by any definition we use. They might have an illness that they’ll have for the rest of their lives, but we would not consider it a terminal illness. So Professor Kamazar has made the point which I think is absolutely right that there is a difference between act and omission. If you withhold a treatment, there are only so many people who die. But if you give a treatment then everybody becomes somebody who can die. There is a real distinction between physician-assisting suicide by giving a pill and taking things away. We take away things from patients and they go on living, much to our dismay day in and day out. So I think there is a distinction. This is a line that if it happened that next year 20,000 people did physician-assisted suicide, how would we feel? How would we feel as physicians if 20,000 people next year did it? Or 40,000 or more? So there is the external consequences of these decisions which Professor Kamazar can describe even more eloquently.

Now in this case that is before the Supreme Court, a group of moral philosophers submitted a brief. Among them, Professor Dworkin who is without doubt a brilliant man, and I know most of these gentlemen and I consider them all would get an introduction like Phil gave me. They argue powerfully that there has to be a right to physician-assisted suicide. I would say the first argument is the argument of autonomy. That’s what informed
consent is about. I would say autonomy is symptomatic of our society. We don’t trust anyone, therefore we want autonomy. If a guy tries anybody else, the one thing you can all agree on is autonomy. Autonomy is the chief moral value at Harvard Law School. You don’t trust anyone but you trust yourself. Autonomy rules. This is the most important value in contemporary society is autonomy. Individual choice, that’s the value [inaudible] and trumps anything else. You gonna tell me what to do? Now Dworkin also has this very brilliant but I think wrong-headed argument in which he says that the way we die should somehow be the last line in the poem of our life. It should be like--it should be a fitting end. And we don’t want to die in this demented, degraded way. And then he divides it up in terms of what he calls critical interest and experiential interest. And he says, you know, sitting in front of television is just an experiential thing. It doesn’t count. It’s not part of our critical life plan and it is possible to distinguish what is in person’s best interest and saying keeping someone alive when they’re demented to say that is in their best interest is an insult to their humanity. And then he makes another brilliant argument about the sanctity of life, to capture it away from those who believe that sanctity of life comes from religion or from God. His argument is, “I’m an atheist but I believe in the sanctity of life and the sanctity of life is from my human investment in my life. That’s what makes it sacred.” And then there is, I think, the most powerful argument in the arsenal of arguments which can only be overturned by an argument like Yale Kamazar’s which says, “But
the consequences are so terrible. And that is the idea that the state is going to make you suffer three, four, five years because they believe that life is sacred. That it is incredible tyranny for those of you who think you have to live out until you die to impose this on anyone else, that this is an odious form of tyranny. That is the last line of the Ninth Circuit argument is, well, however you say about this, the idea that you would compel somebody to go through what they’re going through for those months, that is tyranny. That is not justice. Now what is going to happen in the Supreme Court? I will say to you, I am willing to bet money that the Court overwhelmingly rejects physician-assisted suicide.

So what does that mean for the medical profession? It means that in every state, we’re gonna have proposals to change the law to allow physician-assisted suicide. And so the medical profession for the next ten years is gonna be consumed with this issue, which is going to be a matter in every state over and over again. Well, with that bad news, I’m gonna end and thank you for listening.