

LIFE EVERLASTING

The religious right and the right to die

By Garret Keizer

This is the ballad of Doctor Lloyd Thompson, who may or may not have hastened a patient's death. This is a song about American secular democracy, which may be under a sentence of death, and about those forces gathering at the gallows. Most of all, this is a song about who owns your life.

Dr. Thompson will never be as well known as Timothy Quill or as notorious as Jack Kevorkian. He will be remembered, and doubtless would choose to be remembered, as a founder of one of Vermont's first hospice programs, which serves the geographical area where I happen to live and where I hope, not any time soon, to die. He also makes house calls, and therefore might have merited a ballad even without careening so close to outlawry.

The anonymous female patient who made Dr. Thompson known beyond this range of mountains was eighty-five years old, close to death, and, for reasons no one can or will tell me, on a ventilator. Her advance directives had specified that she be kept as comfortable as possible at the end of her life but that no artificial means be employed to prolong it. So either someone at the hospital had suffered a lapse of attention or the woman herself had suffered a lapse in resolve, but in either case we find Dr. Thompson in the position of "weaning" a dying patient off a machine that, in the view of her family, she should not have been on in the first place. After several failed attempts, the patient was at last weaned from the ventilator and given doses of morphine and Versed, standard medications in the palliative procedure known as "terminal sedation." To these drugs Thompson added a third, a neuromuscular blocking agent called Norcuron. The patient died soon thereafter in 2002.

In testimony before the state medical board almost a year later, Thompson conceded that his use of Norcuron had been an error in judgment but insisted that his goal in administering the drug had not been to euthanize the patient but to spare her and her family needless distress should she have regained consciousness. Thompson had treated the patient for twenty years.

Garret Keizer's latest book is *Help: The Original Human Dilemma* (HarperSanFrancisco, 2004). His last essay for *Harper's Magazine*, "World Enough and Time," appeared in the October 2003 issue.

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"She was my friend," he would say. He would not speak to me about his patient or the storm that followed her death, but I did interview him on his work for hospice in connection with a book I was writing at the time his case was decided. His comments suggest that whatever his emotional attachment to the woman, his decisions had been determined in part by his attachment to the idea that "fixing suffering is medicine's crucial job, its great heart, the thing we have always done and have forgotten in our technological interest."

After careful deliberation, the state medical board issued a public reprimand of Thompson and placed a year's probation on his medical license. Cited in its report was a minority opinion in the medical literature, according to which "the last gasps of agonal respiration are not necessary" and "the use of neuromuscular blocking agents . . . in order to allow patients to die more peacefully" ought to be acceptable "in some rare circumstances." The Board did not hold that view, however. It added that actions such as Thompson's "crode respect for human life and for the integrity of the medical profession."

The state's attorney general followed suit by announcing that Thompson would not be prosecuted for manslaughter, though he warned that doctors making similar mistakes in the future might. As reasons for his decision, he cited the doctor's full cooperation with the investigation, the wishes of the deceased woman's family, and the impossibility of proving that the neuromuscular blocking agent was the actual cause of death. He also noted that

"it would be uphill sledding to convince twelve jurors in the Northeast Kingdom, where he has practiced so well for so many years," to convict him.

Dr. Thompson was reprimanded at roughly the same time physician-assisted suicide (PAS) became the subject of a heated debate in the Vermont legislature. The president of the state's Right to Life chapter told me that she had even wondered if the doctor's case "was part of a plan to test the law," while an outspoken advocate for the "Death with Dignity" bill confided to me that some in his group were worried that Thompson's actions "would become confused with our issue." Thompson himself has never taken a public position in support of PAS or against it.

The Vermont bill, which died in committee last year and is likely to be reintroduced later this spring, is modeled closely on the Oregon Death with Dignity Act, to date the only legislation allowing for PAS in the nation. (This is not to suggest that PAS occurs only in Oregon; an estimated one in five doctors will receive a request for PAS at least once in his or her career, and 3 to 18 percent will accede. It is not known how many doctors hasten their own death through professional privilege.) Oregon's law has been in existence since 1994, when it passed its first state referendum, but has been in use only since late in 1997, when, after legal challenges, it was approved by a majority of voters for the second time. According to the law, a "capable" adult patient diagnosed as having no more than six months to live may request a lethal dose of medicine. The request must be repeated at least three times, once in writing. Two physicians must sign off on the request, and either may order a psychological evaluation of the patient. The patient must self-administer the medicine. The patient may change his or her mind at any time. Medical protocols in Oregon also prohibit doctors from raising the subject of PAS or reintroducing it once it has been raised. Doctors are free to decline any or all requests for PAS, and a private medical institution may prohibit its staff from discussing the law with its clients.

To date, two states have rejected laws based on the Oregon model: Maine by referendum and Hawaii by a close vote in the state legislature. The strongest opposition has come from medical societies (such as the AMA, to which only about 30 percent of the nation's doctors belong) and religious groups, both expressing fears that have so far proved unfounded. Since 1998, only 171 people have made use of the law. PAS has not derailed progress toward good palliative care: Oregon remains a national leader in care for the dying, including the liberal use of opiates. Nor has PAS emerged as the

lesser of two evils for the disadvantaged. The typical applicant has tended to be white, well educated, and adequately insured.

But the alarms raised in America's ongoing right-to-die debate have always been characterized by a curious selectivity. You will notice, for example, how the fear of playing God operates exclusively on one side of the medical playground. Thus to help a patient end his or her life "prematurely" is playing God, while extending it in ways and under conditions that no God lacking horns and a cloven hoof could ever have intended is the mandate of "our Judeo-Christian heritage" and the Hippocratic oath. Let someone like Dr. Thompson step out of bounds to honor the spirit of his patient's advance directives, and we will be told that he is eroding respect for the medical profession. But in cases involving a medical professional who blatantly ignores such directives, we are reminded that doctors don't always have time to review patient files while making difficult decisions. They're not God, after all.

When former Attorney General John Ashcroft thrice challenged the Oregon Death with Dignity law, threatening to prosecute participating physicians under DEA regulations (a threat that now stands at the bench of the Supreme Court), nobody mentioned the dangerous course toward theocratic despotism—or rather some did mention it, though their voices were effectively drowned out by larger moral concerns, such as those occasioned by the sight of Janet Jackson's breast or a gay groom's boutonniere.

When the Vatican issued its 2004 statement against the removal of feeding tubes from vegetative patients, a development that has even conservative ethicists and devout Catholic physicians slapping their foreheads in disbelief, few commentators spoke about returning to a day, no farther back than the 1970s, when a dying patient who begged not to be intubated would have her wrists tied like those of a condemned witch so that she could not pull the instruments of salvation from her body. Instead we are told that time will be required "to reflect upon the ruling"—time that translates in concrete human terms to a slow and horrible death.

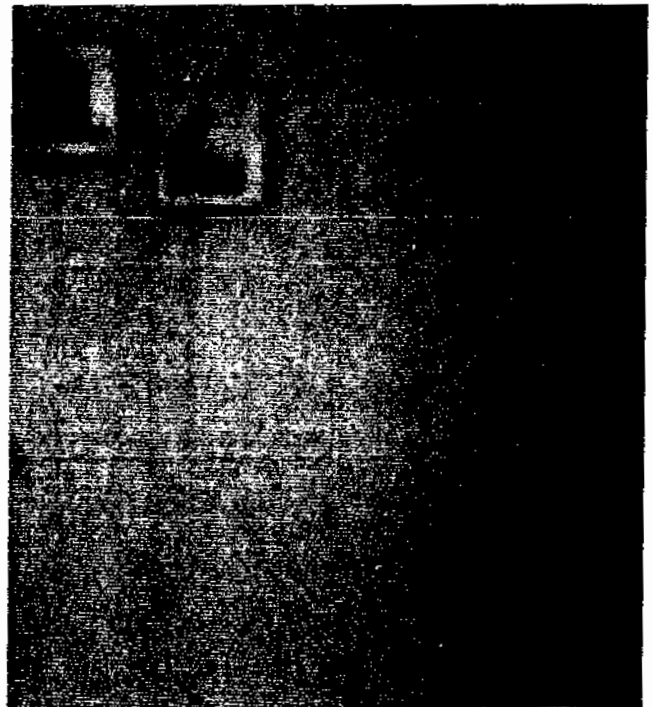
Assuming that one's life might be taken as the most private of all forms of property, one might also assume that the option for assisted suicide would resonate most powerfully with conservatives. But to make that assumption would give too much weight to ideology and too little to the psychology that informs it. The right talks about protecting life and tradition, but on some level—the level, let's say, where someone like Dr. Thompson is held up for derision—it is mostly interested in protecting pain. For two reasons.

The first is theological: the belief that pain holds the meaning of life. Supposedly, and demonstrably, this is a Christian idea, though if Jesus himself had believed it, he would have told the lepers to find meaning in their sores. The fact is, with even a little encouragement, most lepers do. This explains the conundrum so perplexing to the liberal mind: why hard-pressed people can vote against their own interests in support of someone like George W. Bush. How can they not see? In fact, they do see; they see from the same point of view that has led them to believe that the misery of their lives is the foundation of their integrity.

The second reason, which can always be counted on to exploit the first, is political: the belief that pain is fundamental to justice, which makes perfect sense if justice is conceived as nothing more than a system of punishments and rewards. The essence of punishment is pain. Whoever owns pain owns power.

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smokes a joint)—all are roundly condemned for their escape from “responsibility” but truly feared for their escape from jurisdiction. It is a fear with a long and traceable history. The Roman emperor Tarquin crucified the bodies of citizens who committed suicide in order to escape his tyranny. When Margaret Sanger began her campaign for birth control, she was accused of permitting women to escape their God-ordained sorrow in bearing children.

All this came home to me when we brought my wife’s mother to Vermont to die. She was soon under the care of our community hospice, whose efforts to keep her pain-free were nothing short of heroic. Still, there were hoops to be jumped through; her doctor and pharmacist—both extremely committed to her care—were among those expected to jump. The narcotic patches she applied to her skin counted as “regulated substances.” Before the hospice nurses offered to run the errand in my stead, I was required to drive thirty-five miles in order to retrieve the script in person. God forbid that it fall into “the wrong hands” (a fear that hovers over the Supreme Court as it rules on medical marijuana). With far less trouble, and far less official anxiety about wrong hands, we could have relieved Grandma’s discomfort by buying a gun and shooting her. That, you see, would have had the virtue of causing some pain all around.

It would be a gross distortion to claim that opposition to physician-assisted suicide is all religious, all from the right, or entirely motivated by some twisted need to see people pay their dues in full. But nearly all the organized opposition to PAS, and especially that of groups like National Right to Life, the Family Forum, The Center for American Cultural Renewal, and the Roman Catholic hierarchy, finds common cause in the need to halt a perceived drift toward nihilism and a disrespect for life.

Like the religious right, I believe in moral absolutes. At the very least, I believe in two that were articulated some years ago by the theologian Paul Tillich, those being “the absolute concreteness of every situation in which a moral decision is required” and “the command not to treat a person as a thing.” Presumably, the latter of these would preclude vitalizing the body of a vegetative person (of which there are at least 15,000 in this country at any given time) by plugging him into a wall like a Mr. Coffee machine, but I may be taking my absolutes too far.

In contrast, the wisdom of the right consists of knowing how to take its absolutes just far enough, which is to say never so far as to relinquish the prerogatives of wealth and power. The achievement amounts to an ethical sleight of hand. You work the trick by shifting the domain of moral absolutes to those areas of life where they least apply. You treat the gray areas of human existence as though they were black and white, the better to disguise one’s self-interested smudging of black and white to gray. You erect castles of rectitude on the frontiers of mortality in the hopes that the murder and rapine taking place in the town squares can go on undisturbed. You accept the death of a six-year-old child by aerial bombardment or economic sanctions and defend the life of a six-week-old fetus. Think of it as taking the high road in Lilliput.

From that exalted vantage point, consider Dr. Thompson’s cavalier disregard for human life. He may have hastened his patient’s death by as much as five minutes. Let’s be as reckless as he was and say five hours. But should you perchance check a mortality table, you will discover that life expectancy at birth is roughly five years shorter for an African-American baby than for a white baby. This is true for both genders. In the interests of brevity we will not go into the life expectancies of Creoles born downstream from Louisiana power plants or Pacific Islanders born on former

nuclear test sites or country kids born in the back hollows of Dr. Thompson's practice.

What I find especially interesting is the way in which the cold-blooded calculation that launches an invasion in which thousands of children suffer and die is imaginatively transferred to decisions seldom undertaken without struggle and seldom concluded without remorse. The woman who deliberates, procrastinates, and prays late into the night over discontinuing her comatose grandmother's life support is reconceived as an inheritance-mongering opportunist, rubbing her fly-like hands together in the expectation of getting granny's insurance policy five minutes and a potential lawsuit sooner. The family doctor who ventures to ask if there are instances when a too-literal adherence to the Hippocratic vow to "do no harm" might in itself be a form of harm is recast (see the National Right to Life propaganda video *Death as a Salesman*) as a hypodermic-wielding assassin, making his house calls on apprehensive old ladies with the remorseless efficiency of a cruise missile. And let us not forget Turbo Slut, meticulously scheduling her multiple abortions between manicures and reruns of *Sex and the City*.

The cool devils of the war room and the think tank are thus fictitiously excoriated and driven out to possess the swine, namely those put-upon people who face extraordinary dilemmas with ordinary resources, people who, in my experience as a rural minister running some of the same roads as Dr. Thompson, are seldom cool and almost never calculating, though they can sometimes be astonishingly brave. To slander their moral courage in defense of moral dogmatism is one of the shabbier tactics of the right. Another is to prey on the fear of consequence that comes naturally to people who live a put-upon life. With the help of some homiletic oratory, put-upon people can be led

D to believe that even a democracy is not governed by universal suffrage so much as by an implacable logic. One misstep, and down to hell we go.

Dr. Ira Byock, who describes himself as a "life-long progressive" and who has recently taken charge of the Palliative Care Program at Dartmouth-Hitchcock Medical Center with a goal no less ambitious than that of "changing the world," says that PAS laws are really "an apology for a failed medical system." Byock advocates a change that he considers "more controversial than assisted suicide," which is to require medical residents to do a rotation in palliative care and pain management at least half as long as the roughly 200 hours many now do in obstetrics (though most of them will never deliver a baby in future practice). As things stand now, he says, "physicians can graduate and be licensed and really have almost no training in pain management," a factor not without relevance to the estimated 50 million Americans who live with acute and chronic pain.

As with other medical professionals who oppose PAS, some of Byock's objections derive from his sense of a doctor's proper role. "If society is hell-bent on legalizing pre-emptive death," he says, "I suggest that they give it to another profession. I would nominate the judiciary." But while such a transfer might satisfy some members of the medical community, it would hardly satisfy the religious right or those disability groups that have emerged as its staunchest allies on this issue. Groups like Not Dead Yet view any laws for assisted death as a threat to the very existence of the disabled. At least they claim to. After reading some of their literature, I suspect that what they see is not so much a threat as an insult. "Death with Dignity" becomes a loaded term in the presence of Life with Disability. Complaints about the "indignities" of terminal illness—loss of control over bathroom functions, complete lack of mobility—are naturally going to seem offensive to those who have struggled to assert their dignity under similar conditions.

And yet it was not that long ago that something like a cochlear implant, an operation that permits some deaf people to hear, was viewed as an insult by the deaf community. In fact, it was not that long ago that the sight of the disabled themselves was viewed as an insult to the tastes and digestions of

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the self-appointed "normal" community. I confess to having a hard time discerning the moral distinction between keeping someone alive, keeping someone deaf, and keeping someone out of sight, all in the name of someone else's sensitivities; and when a disability activist says of the decision to allow Terri Schiavo to die (a decision that for a time seemed possible only if Governor Jeb Bush died too), "This is not compassion; it's contempt," I want to say, "She is not a person to you; she is a precedent." A thing.

I am even more skeptical when PAS is opposed in the name of the poor. If, as Dr. Johnson so memorably told us, "patriotism is the last refuge of a scoundrel," then the hovels of the poor are often where a scoundrel runs for cover after his flag blows off. One hears, for example, that the reason farmers in my community should not receive a fair price for their milk is that it will then be too expensive for poor people to afford. Similarly, the reason we should not have an option for PAS is because it might tempt us to kill off poor people. How about we kill off poverty with a mandatory living wage and a truly progressive income tax?

It is not physician-assisted suicide that poses the greatest threat to the poor and the disabled but physician-assisted eternal life: the desire of the old and the rich to avoid death at any cost, especially if the cost can be passed on to another generation or another continent. The worldwide trade in organs—nine farmers in the Indian village of Rentachintala selling their kidneys to pay off debts to the pawnbrokers who lend them money to buy seed—is but one of the more egregious examples. The trade in ultra-desirable "fresh" human ova is likely to emerge as another. We already know the countries and the classes from which they're going to be harvested.

Is anything more indicative of the vast chasm that exists between rich and poor, between a minority in surfeit and a majority in woe, than the fact that a few should lobby for deliverance from high-tech medical care while millions clamor for the basics of a first aid kit? It is a well-known statistic that with less than 5 percent of the world's population, Americans consume a quarter of the world's nonrenewable energy. It is considerably less well-known that within that all-consuming sliver, per capita federal spending on the elderly exceeds the amount spent on children by a ratio of 11 to 1. When I was younger and more romantic I could imagine serving the poor by dying in a revolution. Now it seems as though the most truly revolutionary thing I could do is simply to die.

Not that I would ever say so to someone young, romantic, and depressed. In such cases I usually quote a line I believe is from Lenin: "The first duty of a revolutionary is to stay alive." Nevertheless, I see the Oregon Death with Dignity law as a truly revolutionary development, one that opposes fundamentalism in its two most virulent forms.

I do not mean the Christian and the Islamic but rather the religious and the technological, of which biotechnology is perhaps the most messianic strain. Both forms have gawdy notions of paradise—with rewards ranging from seventy-two virgins to fifty-seven varieties of cyborg—and a narrow appreciation of free will. Only one choice will save us: We must obey every stricture that passes for "traditional morality" or we must adopt every monstrosity that passes for "progress." The zealots of both schools have disturbingly gleeful ways of describing the fate of infidels who resist either the words of prophecy or the wonders of hastened evolution.

In its dogged insistence on finitude, the Right to Die movement opposes not only the glib certainties of fundamentalism but also its penchant for apocalypse. This world doesn't have to end, it says, and I don't especially want it to; rather, I must end, and I prefer to do that on my own terms. I respect the rights of others to believe in such categories as "will of God" and "state of the art," but I utterly reject the notion that the two are one and the same.

Of course, some would argue that the emerging discipline of palliative medicine shares that same rejection. Palliative medicine takes as its cardinal principles that death is an integral part of life and that care does not have to

consist of cure. In short, that we must embrace our mortality. Unfortunately, that view always seems to translate as an embrace of palliative medicine. And I have to admit that there are things I fear about that latter embrace.

I fear, for one thing, that palliative medicine will eventually absorb and subordinate the grass-roots hospice movement. In other words, I fear that the nurses who came to take care of my mother-in-law will soon go the way of the midwife, whose name is now most likely to decorate the shingle of an obstetrical practice, like the sign of a mermaid outside a pub owned and operated by a pair of gents. I also fear the totalitarian mindset that goes with expertise, a fear I find justified by the tone of scorn directed at supporters of PAS. "There's a control issue in all this," says Lisa Szczepaniak, a palliative-care nurse and administrator at Dartmouth. Psychiatrist Herbert Hendin sounds a similar note in *Seduced by Death* when he says that advocates for a hastened death are "often depressed people with inordinate needs for control." I do not think I am especially depressed or controlling, but I do hold to the rule of thumb that whenever specialists of any kind begin to talk in unison about your "control issues," it is a good idea to note the location of the exits.

Finally, I fear the culture of coercive intimacy that thrives in the presence of illness: that impertinent need not only to identify a person's control issues but also to ritualize her life process, to appropriate her narrative, to make an identity of her disease ("Congratulations, you are now a breast cancer survivor") and a circus of

her death. It is the hug you're going to get, big guy, whether you want one or not.

Ron Reynolds, outgoing president of the Vermont chapter of the Hemlock Society (now known as End-of-Life Choices), has worked for the Vermont Death with Dignity bill, but he is not overly impressed with its protocols. "I would take the shotgun if I had to go through all that nonsense. And it doesn't even deal with the issue of Alzheimer's. That's the most terrifying one of them all!"

Reynolds saw his wife through her six-year bout with a Parkinson's-like disease. The walls of his house are still lined with the stainless steel railings she used while she remained mobile. She died at home, in her bed, where he also slept until the end. "She was nothing when she died. She had no personality, no capacity to speak."

Like other supporters of PAS, Reynolds balks at the word "suicide." "When you think of people leaping out of the Trade Center towers, they were doing what most of us would be doing if the end of life was a God-awful mess. They could stay and be fried and fall with the building, or they could jump out the window and die when they hit the ground. It's not a choice between life and death, and that's what the right wants you to believe. It's the choice between two kinds of death or five kinds of death."

If there was anything typical of the proponents of PAS with whom I spoke, besides the conviction that their life and death decisions ought to be their own, it was their confession of uncertainty as to what they would actually do in the face of a difficult death. I took that uncertainty for a mark of courage and a sense of awe. The inability of the religious right to appreciate either is one of its many ironies, comparable to that of posting the Mosaic commandment against graven images on stylized tablets of stone. It is also ironic that a movement that locates society's best hope in the nuclear family should at the same time be so consistently cynical about a family's likelihood of ever acting in the best interests of its members. When a Missouri judge finally permitted the removal of Nancy Cruzan's feeding tube in 1990,

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"Untitled (nw6) from 'Nowhere Near,'" by Uta Barth.
Courtesy the artist, Tanya Bonakdar Gallery, New York City, and ACME, Los Angeles

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pro-life demonstrators stormed the hospital in an attempt to force-feed her. The nineteen who were arrested all gave their names as Nancy Cruzan. They ought rather to have said, "We are Nancy Cruzan's parents. We love their daughter more than they do."

It is also ironic, at least for the overwhelming majority of the religious right that identifies itself as Christian, that a religion that arguably began as a rabbinical protest against legalism should devolve to another form of legalism, technically called vitalism, which holds that if it's alive, it's a life. No scurrilously rationalist definition of a human being as an "upright featherless biped" or suchlike was ever so reductive. Similarly, it is ironic (and reductive) that a tradition that sees a human being as more than her body should give so little weight to existential suffering as a justification for PAS. Man may be a little lower than the angels, but his capacity for anguish is reckoned as only a little higher than that of raw meat. The typical argument goes: If physical pain were beyond our powers to relieve, that would be one thing, but the "pain" these death with dignity types are talking about is something else. Many of the supposedly competent patients who ask for PAS are actually depressed, and depression is treatable!

Leaving aside the questions of whether depression constitutes incompetence, or whether there is any reasonable response to terminal illness besides depression, one is amazed to see the defenders of the soul so blithe about illuminating its Gethsemanes with artificial light. Whereas it is apparently an unpardonable sin to meet one's Maker five minutes ahead of schedule, it is perfectly acceptable to show up for the appointment wearing a ludicrous smirk. Job's fundamental problem, you see, was not his estrangement from Yahweh but his ignorance of Zolof.

The reductionism of the right extends to the meaning of life itself. The defining quality of human life, as I understand it, is relationship. If there is any idea under the sun that is certifiably "Judeo-Christian," that is it. To be authentically pro-life means something more than protecting a life or my life. It means cherishing the lives of those who come after me or who, in the event

of a degenerative illness, will need to take care of me: my wife, my kid, my friends, persons whose lives are likely to be shortened by the stresses of prolonging mine.

If a Death with Dignity law comes to referendum in my state, I will vote for it. I do not know if I would ever use it myself. I remain seated through the credits of movies, even those I didn't much like, and after I've finished my drink, I chew the pulp from the lime. I suspect I'll want to stay for the duration. Perhaps I'll not mind terribly if someone offers me a hug.

But the pertinent question here is not what I will do on my deathbed but what I am prepared to permit others to do on their deathbeds—a distinction that the right is notorious for trying to blur—and on that question I am clear. I am also clear that my decision will be based less on my opposition to the right than on my reaction to a statement with which I essentially agree.

The statement to which I refer is that the issue of physician-assisted suicide is not the most important thing we have to discuss in regard to end-of-life care. One hears the statement in many forms and from many sources. It has been made repeatedly by Dr. Byock, including in his testimony before Congress in 1999, when he challenged lawmakers to "do what is needed to make [PAS] irrelevant." It was echoed by Dr. Thompson in his speech before stepping down as head of the Vermont Medical Society. He urged his colleagues not to be distracted by the PAS debate from the central problems of pain relief and enabling people to die in the place of their choosing.

These are meaningful statements by dedicated men. And although I agree with the substance of their remarks, I take exception to what they imply. The statement that physician-assisted suicide is only a distraction from the national crisis in end-of-life care betrays the very same attitude that created the crisis to begin with. It is the attitude of the expert who is always more qualified to identify your "real issue" than you are. When the New Jer-

sey Supreme Court ruled in 1976 that Karen Ann Quinlan could be removed from her respirator and allowed to die, her physicians effectively subverted the ruling by painstakingly weaning her from the machine, reattaching her whenever it seemed she would expire, until they had at last succeeded in enabling her to vegetate independently for close to ten years. Neither the courts nor the Quinlans had understood the real issue. They were only laymen, after all.

I believe that if our democracy manages to achieve a ripe old age, our descendants will view the wall of separation between church and state as of lesser historical importance than the distinction between a citizenry and a laity—a distinction we have yet to make. Indeed, our continued use of such an ecclesiastical metaphor as “layman” suggests that we have not so much separated church and state as we have joined a different church. On one level, PAS laws only serve to further that cult. They are little more than protocols for begging a doctor’s permission. We continue to make the ancient equation between a skill at reading entrails and the prerogative of pronouncing fate. But to take a longer view, PAS rests on two principles that are central to a liberal society.

The first is that we are owners of our own lives. That there is a well-defined domain, roughly coextensive with the boundaries of our own flesh, where we are permitted to have control issues. Permitted, but not obliged—and sometimes, it seems, not even inclined. Only 36 percent of Americans have living wills. In regard to death, our attitude toward physicians remains that of a coquette: we expect the doctor to order our dinner for us, reserving the right to complain if we don’t like what shows up on our plate. Or to leave him alone and in disgrace should he turn out to have ordered something not on the menu of “acceptable medical practice.”

The second principle, without which liberal individualism always devolves into preciousness, is that we are collective owners of the culture we produce collectively. The debate over PAS is not fundamentally about the Hippocratic oath or the Ten Commandments; it is about who owns the medicine. We continue to behave as though doctors invented, patented, and produced every pill they dispense. I believe doctors are the natural custodians of medicine; I do not believe that custodianship trumps citizenship—especially when a citizen grows too frail to harm anyone but herself or even to help herself, though she may know exactly how she wishes to be helped.

And one thing more regarding the relevance of a Death with Dignity law to our democracy: we are free to try it out. We are free to take a step in that direction and then to rescind or expand the step. We are in fact free to do almost anything we wish—except to avoid the issue or deny the freedom. We stand in a place of aches and wonders, with few discernible absolutes besides the necessity to choose and our evolving conviction that it is wrong to use a person as a thing. We can dare to walk on this ground of dubious footing, because we are holding one another up as best we can, and because it is we ourselves and not some deterministic logic that writes our civil laws. We can permit free speech and prosecute libel. We can maintain a military and foreswear militarism. We can, with all due respect to ethicists who claim we can do no such thing, allow abortion and disallow infanticide, and we can do so for the simple reason that it seems like the best thing to do. We can sniff out our options and pick and choose among them, a birthright generally less appreciated by a dogmatist than by a dog.

“You are gods,” says one of the Psalms, adding that we shall all die anyway. Perhaps our best defense against the dangers of playing God (chief among them being a death less merciful than we allow to dogs), as well as our best hope of a compromise with those who would adorn our public squares with scriptures graven on tablets of stone, is to sing that verse as though we truly believed it, not in the blind credulity of any fundamentalism but with an intelligence approaching faith. ■

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