Dying people, their families, and their physicians are all vulnerable to unruly psychological forces unleashed by the imminent prospect of death. The success of the contemporary reformist claim that death can be subject to rational control depends on the capacity of vulnerable people to tame these unruly forces. The reformist claim, moreover, rests not simply on the possibility of individual self-control by dying people and their families and physicians but also on the capacity of formal institutional actors—judicial or administrative agency regulators—to exert rationalized bureaucratic control to protect dying people against previous patterns of social and medical abuse. The reformist claims, however, have rested essentially on the assertions that rationality is good and that most people are fundamentally rational in this as in all matters. (Judge Richard Posner, for example, has formulated a complex calculus purporting to demonstrate the rationality of deliberations about suicide—including “that the availability of physician-assisted suicide increases the option value of continued living”—in a way that unintentionally and even comically illustrates the psychological implausibility of this ratiocination.) The ideals of scientific rationalism themselves would seem to require some empirical validation of this claim; but almost no systematic research has been carried out.

There is, however, evidence that casts indirect light on the question. The most illuminating recently accumulated data are from a research project carried out between 1989 and 1994, known by the acronym SUPPORT (Study to Understand Prognoses and Preferences for Outcomes and Risks of Treatments), the most extensive study ever done of hospitalized dying patients and their professional caretakers. The goal of this project was to test the possibility of improved implementation of the first phases of the reformist efforts regarding end-of-life care, that is, the right of dying people or their surrogates to refuse life-prolonging medical treatment and the campaign to popularize advance directives—so-called “living wills” and appointment of health care proxies by mentally competent individuals to specify their future wishes regarding medical treatment, against the possibility that they might become unable to exercise those choices. Generously funded by a $30 million foundation grant, the SUPPORT researchers closely monitored some nine thousand patients in two separate phases, so as to obtain a controlled study of the extent to which informed, collaborative choices could be facilitated for patients and physicians about end-of-life treatments. The first phase was a so-called naturalistic study of the current use of DNR (“do not resuscitate”) orders, provision of pain palliation, and explicit discussion and shared decision making about treatment alternatives between professionals and terminally ill patients or their families. At the conclusion of this phase, the researchers found that “physicians did not know what patients wanted with regard to resuscitation, even though these patients were at high risk of cardiac arrest. Orders against resuscitation were written in the last few days of life. Most patients who died in the hospital spent most of their last days on ventilators in intensive care. . . . Except for the comatose, more than half of the patients . . . were reported (by the patient or a family member) to have substantial pain” in the last days of their lives.

The researchers then convened focus groups to explore the reasons for these results and to identify possible correctives that would enhance the possibilities of patient self-determination. In these focus groups, a rationalistic explanation was most prominently offered: “many physicians claimed to be eager to improve care and decision making for the seriously ill, but they maintained that improvements took too much time and they often did not have the needed information about prognosis and patient preferences.” The SUPPORT researchers accordingly designed the second phase of their study “to reduce those time-and-information barriers.” For this phase, the researchers implemented an intensive intervention for one group of patients—“frequent reports” entered in the patients’ records from a sophisticated computer model of prognoses for survival and from interviews with patients and their families “anchored . . . by specially trained and committed nurses who spent all their time counseling patients and families, convening meetings with
physicians and others, eliciting preferences, making plans for future contingencies, and ensuring that the best possible information about prognosis and preferences was available to the care team.” For a concurrent control group, no new interventions were provided but, as in the first naturalistic phase, treatment provision and decision making were closely monitored.

The results of this second phase were stunning: the intensive intervention changed almost nothing. The extensive provision of information about prognoses and patient preferences, the counseling of patients and their families to elicit preferences and engage in future planning, and the continuous communication by specially trained nurses with the professional care team about these matters—that is, implementation of the most intensive mechanisms imaginable to the researchers to promote rational decision making based on accurate prognoses and to actively elicit patient choices to guide professional treatment—had zero impact on the provision of end-of-life medical care. Between the first and second phase of the SUPPORT study, and between the experimental and control groups in the second phase, there was essentially no difference regarding the timing of DNR orders, the accord between physicians and patients regarding DNR, the time spent in an intensive care unit or on a ventilator before death, the extent of untreated pain in the last days before death, and the resource use for dying patients.

The existence of an advance directive, moreover, made no difference regarding the medical treatment actually provided at the end of life. The SUPPORT intervention succeeded in ensuring that every advance directive completed by a patient was entered in the patient’s medical record, but the directives “had no effect on decision making.” In particular, physicians were no more likely to enter DNR orders for patients who had expressed this preference in their advance directives than for others who had not indicated any advance preference.

When the results of the SUPPORT study were first reported and received widespread publicity, the commonly offered explanation for this disregard of advance directives was that physicians, through neglectful inattentiveness or willful arrogance, were ignoring the wishes of their patients. Even the press release issued by the American Medical Association—not an organization likely to be attracted to physician bashing—gave this characterization to the research results as initially published in its journal. This was not, however, what the SUPPORT data demonstrated. The fact was that most patients were reluctant to discuss advance directives with their physicians, even when they themselves had completed the directives; and physicians did not initiate conversation about them. (Only 12 percent of the patients had discussed the directives with their physicians in the course of writing them, and only 42 percent had mentioned them at any time thereafter.) For patients who had completed advance directives (even in response to the intensive counseling provided by the special-duty SUPPORT nurse), it seemed as if they had participated in an empty ritual—a gesture performed because it seemed “the thing to do” when asked, but which they themselves ignored in actual practice.

As Dr. Joanne Lynn, one of the principal SUPPORT researchers, subsequently observed: “As we worked with the press, over and over we explained that the problem was much more difficult than that doctors did not hear their patients’ requests; it was that no one was talking about these subjects. This was clearly not as good a story, and it was often not written. What showed up was the mistaken notion that patients could not get a hearing.” To portray physicians as ignoring the demands and pleadings of their patients was a “better story,” I believe, because it was more comforting to believe in the thwarted possibility of self-control than to acknowledge helpless passivity in the face of the looming injustice of death. News reporters and the general public—those who viewed the SUPPORT data at a safe distance themselves from death—held fast to the comforting image of terminally ill people determined to take control of their own destiny and wrongfully obstructed by resistant physicians (a more plausible target for sustaining the belief that evil can be corrected than to castigate death itself). Yet for those people in the SUPPORT study who were close to death—the actually dying patients and their attending physicians—this image of self-control offered no comfort; it perhaps even seemed irrelevant. If the patients and physicians were intent on holding to their wish for self-control in the imminent presence of death, the preferred strategy appears to have been silence, a mutual refusal to talk about its possibility.

The SUPPORT data do not demonstrate that end-of-life care satisfied the preferences of patients or their families; in particular, it is hard to imagine that the documented existence of untreated and unnecessary pain during the last few days of life was consistent with patient or family wishes. What the data do suggest is the weakness of the self-determination principle as a protection for terminally ill patients. Even with the continuous assistance of trained counselors and the provision of extensive information, only the paper formalities of patient self-determination were affected; as the reality of death came closer, choice was an ineffective instrument to protect patients against unnecessary suffering. This was not because patients’ attempts to exercise choice were
The Second Circuit Court of Appeals held that it was irrational and therefore unconstitutional for New York state to forbid physician-assisted suicide while it permitted patients to direct their physicians to withdraw life-prolonging treatment. In his opinion for the court, Judge Roger Miner stated,

Physicians do not fulfill the role of “killer” by prescribing drugs to hasten death any more than they do by disconnecting life-support systems. Likewise, “psychological pressure” can be applied just as much upon the elderly and infirm to consent to withdrawal of life-sustaining equipment as to take drugs to hasten death. There is no clear indication that there has been any problem in regard to the former, and there should be none as to the latter.¹⁴

Judge Miner thus ignored the extensively available empirical evidence that many physicians view their actions as somehow “murderous” in disconnecting life-support systems;¹⁵ and he ignored the inadequacy of any systematic data exploring beliefs among “the elderly and infirm” about whether they felt “psychological pressure.”¹⁶

Recent research about use of medical resources for end-of-life care has demonstrated that age alone appears to be a significant determinant, with much fewer high technology expenditures for people over eighty than for younger people with the same specific disease diagnoses.¹⁷ This age differential may reflect patients’ wishes or sensible medical determinations that the greater frailty of elderly patients warrants less aggressive interventions than for younger patients—or it may result from inappropriate “psychological pressure” and discriminatory attitudes toward elderly people. Judge Miner’s airy dismissal of any concerns on this score—any worry, in particular, that elderly disabled people would be specially vulnerable targets for physician-assisted suicide or would have difficulty resisting pressures to volunteer for it—has no adequate empirical basis.

There is another kind of psychological pressure which some advocates invoke as a basis for opposing legalized physician-assisted suicide—not pressure on dying individuals as such but on others, such as physicians, judges, legislators, and the general public, to expand the reach of such statutes beyond the apparently narrow category of “voluntary, imminently dying people.” This is the fear of the “slippery slope”—the inclination of a previously resisted social practice to expand beyond its proclaimed target once the initial resistance has been breached. The conjunctive disregard of this possibility and its unintended confirmation was revealed by Judge Stephen Reinhardt in his opinion for the Ninth
Circuit Court of Appeals, overturning a Washington state law that prohibited physician-assisted suicide.

Judge Reinhardt did not base his conclusion on the irrationality of the Washington statute but rather on the ground that it unduly interfered with the constitutional rights of terminally ill people to make autonomous choices about the valued duration of their lives. In the course of claiming that the state had insufficient basis for overriding an individual’s choice to hasten death, Reinhardt recited this historical account:

Step by step, the state has acknowledged that terminally ill persons are entitled in a whole variety of circumstances to hasten their deaths, and that in such cases their physicians may assist in the process. Until relatively recently, while physicians routinely helped patients to hasten their deaths, they did so discreetly because almost all such assistance was illegal. However, beginning about twenty years ago a series of dramatic changes took place. Each provoked the type of division and debate that surrounds the issue before us today. Each time the state’s interests were ultimately subordinated to the liberty interests of the individual, in part as a result of legal actions and in part as a result of a growing recognition by the medical community and society at large that a more enlightened approach was essential.

The first major breakthrough occurred when the terminally ill were permitted to reject medical treatment. The line was drawn initially at extraordinary medical treatment because the distinction between ordinary and extraordinary treatment appeared to some to offer the courts an objective, scientific standard that would enable them to recognize the right to refuse certain medical treatment without also recognizing a right to suicide or euthanasia. That distinction, however, quickly proved unworkable, and after a while, terminally ill patients were allowed to reject both extraordinary and ordinary treatment. For a while, rejection of treatment, often through “do not resuscitate” orders, was permitted, but termination was not. This dividing line, which rested on the illusory distinction between commission and omission (or active and passive), also appeared for a short time to offer a natural point of repose for doctors, patients and the law. However, it, too, quickly proved untenable, and ultimately patients were allowed both to refuse and to terminate medical treatment, ordinary as well as extraordinary. Today, many states also allow the terminally ill to order their physicians to discontinue not just traditional medical treatment but the artificial provision of life-sustaining food and water, thus permitting the patients to die by self-starvation. Equally important, today, doctors are generally permitted to administer death-inducing medication, as long as they can point to a concomitant pain-relieving purpose.\(^\text{18}\)

Judge Reinhardt offered no causal explanation for this “step by step” progression, only noting that each step “provoked . . . division and debate” and that “the liberty interests of the individual” repeatedly pre-

vailed over “the state’s interests,” which signified “growing recognition” of a “more enlightened approach.” Reinhardt was clear, moreover, that the progression he discerned in this historical unfolding had not yet reached a stopping point, even with the vindication his court was awarding the plaintiffs in overturning the state statute that prohibited physician-assisted suicide.

The plaintiffs in the Ninth Circuit case had sought authorization for physicians to prescribe lethal medication to terminally ill, mentally competent patients; they did not demand that physicians be permitted directly to administer the medication. There were both principled and tactical reasons for this limitation of the plaintiffs’ claim. The principled reason was that patient self-administration of lethal medication is an added protection to assure the voluntariness of the act and to provide clear opportunity for patients to have second thoughts.\(^\text{19}\) The tactical consideration was that voters in both Washington and California had defeated a referendum proposal in 1992, by a margin of 55 to 45 percent, that would have authorized direct physician administration of lethal medication, so-called “voluntary euthanasia”; though contemporaneous voter disapproval would not legally bar a court from declaring a contrary constitutional entitlement, most judges would be more hesitant.\(^\text{20}\) (This shift among advocates of physician-assisted suicide toward the more modest version was not limited to litigation; the 1994 referendum proposal put forward in Oregon was itself limited to physician prescriptions, and this proposal was popularly approved by the slim margin of 51 to 49 percent.)\(^\text{21}\) But Judge Reinhardt was not content simply to approve physician-assisted suicide, as the plaintiffs in the case had requested. He unmistakably signaled his court’s willingness to take a next step:

[1] It may be difficult to make a principled distinction between physician-assisted suicide and the provision to terminally ill patients of other forms of life-ending medical assistance, such as the administration of drugs by a physician. We recognize that in some instances, the patient may be unable to self-administer the drugs and that administration by the physician, or a person acting under his direction or control, may be the only way the patient may be able to receive them. The question whether that type of physician conduct may be constitutionally prohibited must be answered directly in future cases, and not in this one. We would be less than candid, however, if we did not acknowledge that for present purposes we view the critical line in right-to-die cases as the one between the voluntary and involuntary termination of an individual’s life. In the first case—volitional death—the physician is aiding or assisting a patient who wishes to exercise a liberty interest, and in the other—involuntary death—another person acting on his own behalf, or, in some instances society’s, is determining that an individual’s life
should not continue. We consider it less important who administers the medication than who determines whether the terminally ill person’s life shall end.22

Reinhardt’s candor is unusual in judicial opinion writing; the more typical course is for a judge to restrict his attention to the specific claim in the case at hand rather than reaching out (though not “directly,” as Reinhardt teasingly observed) to decide an anticipated next case. But his candor does illuminate how public debate about physician-assisted suicide is likely to proceed, and specifically how the autonomy principle will expand according to its internal logic in this procession. Reinhardt’s application of the autonomy principle to justify not only physician prescription but also the “next step” of direct physician administration of lethal drugs demonstrates the underlying mechanism of the historical progression of the “right to die” during the past twenty years which he described in his opinion. His reasoning exemplifies how the “division and debate” about this issue repeatedly paused at an apparently “natural point of repose”—for example, the distinction between terminating “ordinary” and “extraordinary” care or between withholding and withdrawing treatment—but then broke loose again, driven by “the liberty interests of the individual.”

Each of these distinctions was originally intended to diminish the discomfort—and more specifically, the aggressive implication—invoked by the disputed action. Thus although professional and popular resistance to withdrawing life-prolonging treatment faded, nonetheless withholding food and water seemed somehow “murderous”—until the perception of a technological administration of “nutrition and hydration” through a nasogastric tube displaced the initial imagery of providing food and water to a helplessly starving person. Withdrawing “artificial feeding” no longer had an assaultive implication; the key transformation was not, however, in the conception of the technological character of the feeding but in the conception of the recipient of the food. The recipient was no longer a helpless starving person but an inert body “unnaturally” invaded by liquids poured through the nose rather than sustained by food entering “naturally” by mouth. The aggressive sting receded from the withholding act not simply because the nasogastric tube suddenly appeared inhumane but more fundamentally because the recipient suddenly seemed inhuman—“as good as dead,” one might say.

A similar transformation in the conception of the recipient—the transformation of a living “subject” into a lifeless “object”—lay beneath Judge Reinhardt’s rejection of the distinction between self-administered and physician-administered lethal medication. The original purpose of this distinction was also to diminish the aggressive implication of using drugs to kill people, by restricting others’ actions to the provision of the drugs and insisting that the dying person must perform the act of self-poisoning. Reinhardt rejected this distinction, however, on the ground that “the patient may be unable to self-administer the drugs and that administration by the physician . . . may be the only way the patient may be able to receive them.” He then justified this rejection on the ground that “the critical line [is] between the voluntary and involuntary termination of an individual’s life” and the question of “who administers the medication [is] less important” than “who determines whether the terminally ill person’s life shall end.” That is, according to Reinhardt, so long as the decision to take the lethal dosage is voluntarily made by the recipient, it doesn’t matter whether the actual administration is carried out by him or by someone else.

Reinhardt ignores the fact, however, that the originally proclaimed purpose of insisting on self-administered medication was to ensure its voluntary character. He treats the distinction between self and physician as irrelevant to the question of voluntariness, without explaining why it is unnecessary or no longer needed to ensure voluntariness. He would, however, be hard put to provide any such explanation. He could not argue that practical experience had demonstrated that self-administration was not a necessary protection to ensure voluntariness. In 1996, there had been no experience of any form of legalized physician-assisted suicide in the United States; the only empirical guide anywhere in the world was in the Netherlands, where physicians have effectively been authorized to administer and not merely prescribe lethal medications and where, according to Dutch governmental studies, euthanasia has been performed on nonconsenting subjects in some cases.23

Reinhardt was not, however, concerned about experience; rather, he was driven by the logic of the self-determination ideal, by the internal imagery or ethos of the ideal. The ideal image is the self-reliant individual who independently controls life’s course. For this imagery, the question of who injects a lethal medication is unimportant, even irrelevant. The crucial question, as Reinhardt said, is who decides whether to live or to die. The very idea that an individual could be so disabled that he or she could not self-administer lethal medication itself violates this image of independent self-determination. From the perspective of the ideal image, this kind of disability is a good reason for choosing death, not a basis for withholding the possibility of death.
It did not occur to Reinhardt that helplessness might undermine voluntariness, that an individual’s wish for continued life could be clouded by a disability that undermined accustomed self-confidence, even though the diagnostic label of “mental incompetence” might not clearly apply. Reinhardt did not see how the self-administration requirement could provide some measure of protection against the ambivalent inclination of many disabled people to defer to others in devaluing themselves—an ambivalence that would express itself by a passive acceptance of hastened death which they would resist if they were required to act entirely on their own volition. Reinhardt did not comprehend the self-administration requirement as a protective measure; he saw it only as a barrier (even a punishment), not a guarantee to self-determination.

Thus we have two typified individuals, on diametrically opposite sides of the conflict—both incapable of self-administering lethal drugs, but one demanding death because of disability while the other is unable to resist because of disability. Reinhardt did not, however, acknowledge that he was choosing favorites between these two individuals. If he had admitted this, the basis for choice would not have been clear-cut: who is more worthy, more suffering, more vulnerable? Reinhardt broke loose from this conundrum in the same way that Milgram’s teacher-subjects decided to follow the experimenter’s directive—by ignoring the painful cries of a learner-victim while denying that they were, in fact, making any choice in averting their attention. Just as Milgram’s subjects were helped toward this path by their preexisting inclination to prefer scientific authority, so Reinhardt was inclined to prefer strong-willed, self-reliant types for whom death was clearly preferable to prolonged disability. But in both cases the inclination was invested with such force as to make any alternative preference virtually invisible, unthinkable.

In Milgram’s experiment this initial disregard for the plausible claims of the learner-victim set the stage for escalating violence and increasingly obvious, though increasingly denied, wrongdoing—not simply wrongdoing from the perspective of an external moral observer but wrongdoing as understood by most teacher-subjects themselves (though they could not hold to this understanding in the embattled enterprise, recurring to it only in shame retrospective). In Reinhardt’s case, it is possible to see this same dynamic unleashed.

The possibility appeared in a footnote at the conclusion of Reinhardt’s rejection of the distinction between self-administered and physician-administered lethal drugs. After stating that the critical difference was between voluntary and involuntary death, rather than the identity of the person administering death, Reinhardt appended the following footnote: “In . . . ‘involuntary death,’ when the motive is benign or altruistic, we classify the act as ‘euthanasia.’ . . . We define euthanasia as the act or practice of painlessly putting to death persons suffering from incurable and distressing disease, as an act of mercy, but not at the person’s request. . . . While we place euthanasia, as we define it, on the opposite side of the constitutional line we draw for purposes of this case, we do not intimate any view as to the constitutional or legal implications of the practice. Finally, we should make it clear that a decision of a duly appointed surrogate decision maker is for all legal purposes the decision of the patient himself.”24 There is a considerable, though unacknowledged, tension in this footnote, between Reinhardt’s apparent refusal to address the merits of “involuntary death” and his endorsement of decision making by “a duly appointed surrogate.”

The tension initially appeared in the first legal ruling that propelled the “right to die” into general public attention; in the Quinlan case, the New Jersey Supreme Court found that Karen Ann Quinlan had a constitutional right to discontinue her respirator, notwithstanding her incommunicative vegetative state, by reasoning that she would have had this right if she had been mentally competent and the fact of her incompetence should not deprive her of the right. The court purported to resolve the apparent anomaly of ascribing volition to Karen Ann by requiring that the court-appointed decision maker must exercise so-called “substituted judgment,” reaching the same decision she would have reached if she had been competent to do so, while ignoring the essential indeterminacy of this criterion and obscuring the necessarily “involuntary” character of any decision made on her behalf.

Subsequent efforts to contain decision making for incompetent people within the apparently comforting framework of voluntary self-determination focused on lobbying for legislative enactments that authorized competent individuals to make binding advance directives or to appoint surrogate decision makers, so-called “health care proxies” to regulate any future medical interventions. Although such legislation has by now been enacted in every state, and the Congress endorsed such efforts in 1990 by requiring every hospital to inform patients of their rights under these state laws, in practice relatively few people have taken advantage of these laws.25 In the pre-Quinlan era, physicians would have confidently taken charge of medical decision making for incommunicative people; but this resolution has lost its social approbation. Accordingly, in face of the failure of most people to claim their rights to self-
determination, by 1996 the legislatures in thirty-three states had enacted specific statutes providing for the automatic default appointment of surrogate decision makers for incompetent patients (based on a prescribed scheme, typically with first preference to spouses, then adult children, then other relatives or close friends).\textsuperscript{26}

There are practical reasons favoring this legislative approach; and it is not clear that such automatic appointments would lead to abuses of trust. But this is not self-determination. When a default surrogate decision maker exercises this legislatively bestowed authority to discontinue life-prolonging medical treatment, this action would precisely fit the definition that Judge Reinhartd prescribed for "euthanasia"—that is, "an act or practice of painlessly putting to death persons suffering from incurable and distressing disease, as an act of mercy, but not at the person's request." Whatever the merits of this result, however merciful it might truly be, this involuntary "putting to death"—this "mercy killing"—is exactly what Reinhartd approved in his endorsement of surrogate decision making, just one sentence after he insisted that he was approving no such thing.

Was this a purposeful elision on his part? Did Reinhartd know about the numerous state statutes already in force that would yield this result? His careful locution, avoiding the customary phrase "mercy killing" in favor of "painlessly putting to death," itself suggests some cosmetic covering-up. But perhaps, as I am inclined to believe, his concealment was as much from himself as from others.

An argument can be made that this kind of involuntary killing should become accepted practice—that the automatic appointment of surrogate decision makers is appropriate because many people fail to anticipate the possibility that they would become incompetent and tethered to life-prolonging medical devices but that this outcome would be abhorrent to them; and, moreover, that a default surrogate should be authorized to consent to physician-assisted suicide as well as withdrawal of life-prolonging treatment because both are logically and morally equivalent ways of intentionally hastening death. This argument is disputable in both logical and moral terms; but it is not implausible. Judge Reinhartd did not, however, make this argument; he made no argument at all in favor of this result and yet slid into it without acknowledgment.

Reinhartd is not unique in his inclination toward this slippery maneuver. This is the way that public deliberation about emotionally charged issues often proceeds—the way that initial, avowedly small steps away from some previously fixed moral position make it easier, almost unno-
ticed, to take larger and then again larger steps, until the old, adamantly held position appears quite empty and completely evaporates. This progression from cautious incremental reform to ultimate wholesale repudiation—from, say, Gorbachev's glasnost to Yeltsin's revolution—is not necessarily misleading or malign. But in considering the administration of death, there are special dangers in this kind of progression.

The slippage in Judge Reinhartd's vocabulary illustrates the danger. From insisting that he was doing nothing more than protecting every individual's right to self-determination in controlling death, he moved to endorse one person's control over another person's death. This dying person is literally "out of control"; and so is Reinhartd himself. He is beyond the control of the only governing principle he is prepared to acknowledge, the principle of self-determination; but also, in a deeper way that this principle itself refuses to acknowledge, he is in the grip of death, which is in final analysis the antithesis of self-control. The slippage in his invocation of a self-controlled death ironically, even mockingly, mirrors the ultimate inability of anyone to attain this cherished goal.

The pursuit of this goal, of rational control over one's own life, is a noble endeavor. But pressed beyond sensible limits, this pursuit becomes destructive, as we have seen in the distorted impact—the suffering imposed on dying people—of the noble aspirations of medical science to exert rational control over death. Judge Reinhartd's opinion illustrates how readily the worthy ideal of individual self-determination slides toward unintentional distortions.

\textbf{You Anoint My Head}

The deep roots of ambivalence toward chosen death are apparent in the first recorded treatment of assisted suicide in the Western cultural tradition—that is, in the death of King Saul as recounted in the first and second books of Samuel. Two inconsistent versions of Saul's death appear in Samuel. Here is the first version, at the conclusion of the first book:

[T]he Philistines were battling against Israel, and the men of Israel fled before the Philistines, and they fell slain on Mount Gilboa. And the Philistines followed hard upon Saul and his sons, and the Philistines struck down Jonathan and Abinadav and Malkihua, the sons of Saul. And the battle went heavy against Saul, and the archers, the bowmen, found him, and he quaked with fear of the archers.

And Saul said to his armor bearer, "Draw your sword and run me through
with it, lest these uncircumcised come and run me through and abuse me.” But the armor bearer did not want to do it because he was very frightened, and Saul took the sword and fell upon it. And the armor bearer saw that Saul was dead, and he, too, fell upon his sword, and he died with him.

And Saul died, and his three sons and his armor bearer, and all his men as well, together on that day.\(^{27}\)

The second book of Samuel shifts the scene to David’s encampment, after his own successful battle against the Amalekites, another enemy of Israel. Here is the second version of Saul’s death, as David learned of it:

And it happened after the death of Saul, when David had returned from striking down Amalek, that David stayed in Ziklag two days. And it happened on the third day that, look, a man was coming from the camp, from Saul, his clothes torn and earth on his head. And it happened when he came to David, that he fell to the ground and did obeisance. And David said to him, “From where do you come?” And he said, “From the camp of Israel I have gotten away.” And David said to him, “What has happened? Pray tell me.” And he said, “The troops fled from the battle, and also many of the troops have fallen and died, and also Saul and Jonathan his son died.”

And David said to the lad who was telling him, “How do you know that Saul died, and Jonathan his son?” And the lad who was telling him said, “I just chanced to be on Mount Gilboa, and, look, Saul was leaning on his spear, and, look, chariots and horsemen had overtaken him. And he turned around behind him and saw me and called to me, and I said, ‘Here I am.’ And he said to me, ‘Who are you? And I said to him, ‘I am an Amalekite.’ And he said to me, ‘Pray, stand over me and finish me off, for the fainting spell has seized me, for while life is still within me…’ And I stood over him and finished him off, for I knew that he could not live after having fallen. And I took the diadem that was on his head and the band that was on his arm, and I have brought them here to my lord.”

And David took hold of his garments and tore them, and all the men who were with him did so, too. And they knelt and they wept and they fasted till evening for Saul and for Jonathan his son and for the Lord’s people and for the house of Israel because they had fallen by the sword.

And David said to the lad who had told him, “From where are you?” And he said, “The son of an Amalekite sojourner am I.” And David said to him, “How were you not afraid to reach out your hand to do violence to the Lord’s anointed?” And David called to one of the lads and said, “Come forward, stab him.” And he struck him down, and he died. And David said to him, “Your blood is on your own head, for your mouth bore witness against you, saying ‘I was the one who finished off the Lord’s anointed.’”\(^{28}\)

One consistency shines through these conflicting accounts—that Saul asked for assistance in hastening his death and that his motives for this request appeared reasonable and even praiseworthy. Indeed, the first book of Samuel recounts that when the Philistines found Saul’s body, they cut off his head and stripped him of his armor and carried his decapitated body to their city where they impaled it on a temple wall;\(^{29}\) Saul was clearly correct in anticipating that if the Philistines had found him still alive, they would have tortured him horribly (and thereby put added indignity on Israel by this treatment of its king). There is no criticism to be found in the Biblical account of Saul’s wish for a hastened or an assisted death. Even the second version of his death at the hands of an Amalek youth had its own implied justification, since Saul had lost God’s favor and his kingship because he had failed to implement God’s specific commandment to kill all the Amalekites.

The Biblical criticism is focused instead on those whom Saul asked, or apparently asked, to speed his death. Of Saul’s armor bearer, we know only that he was struck with fear by Saul’s request, but we are not told the source of that fear. As to the Amalek youth, he may not actually have killed Saul but instead encountered his dead body and stripped it of royal emblems to seek some reward from David, the putative successor. But we clearly do know that the Amalek felt no inhibition in claiming to have acceded to Saul’s request; he must indeed have calculated that this account would receive heightened favor in David’s eyes.

But David’s accusation—“How were you not afraid to reach out your hand to do violence to the Lord’s anointed?”—evoked his own troubled relationship with, and fears regarding, Saul. On two prior occasions David could himself have killed Saul and if he had done so, his motives would have appeared entirely justified. After Saul had lost God’s favor, he knew that David had been chosen as his successor, and he repeatedly tried to kill him. After numerous murderous assaults against him, David came upon Saul alone and unprotected, relieving himself against the wall of a cave. David did not kill Saul, however, but only cut off a small piece of his cloak; yet even then, we are told, “David was smitten with remorse… and he said to his men, ‘The Lord forbid me, that I should have done this thing to my master, the Lord’s anointed, to reach out my hand against him, for he is the Lord’s anointed.’”\(^{30}\) In a second episode, David and his men came upon Saul asleep in his camp, but David restrained his men, saying “Do no violence to him! For who can reach out his hand against the Lord’s anointed and be guiltless?”\(^{31}\)

These past associations proved fatal to the Amelek youth—not simply in spite of the strong justifications for Saul’s death at his hand but because of their very strength, because of the seemingly ineluctable temp-
tation to inflict death without any remorse. As David observed, in the light of his own powerful temptations and equally powerful justifications, who can do such killing and "be guiltless"? When David erupted against the messenger who claimed to have assisted King Saul's suicide, his imprecation—"How were you not afraid to reach out your hand to do violence to the Lord's anointed?"—directly referred to his own fearfulness and self-recrimination when he had inhibited his impulse to kill Saul. In modern guise, this same transaction occurs entirely within one individual's mind in recapturing his or her mature sense of self in imminent confrontation with death, as I discussed in chapter 1. The virtual identity of the psychological processing of one's own death and one's experience of significant other deaths powerfully expresses the confusing shift between first-person and third-person perspectives that Charles Taylor identified as the central conceptual weakness in the modern sense of self. In this confusion are the roots of the psychoanalytic observation that mature individuation necessarily carries some implication of parricide, of guilt-inducing violence directed against the psychologically internalized image of one's parents.\textsuperscript{32}

In this melange of feelings induced by the confrontation with one's own death, we can see the vulnerability of modern claims for self-determined death through the lens of King David's punitive, murderous outburst against the embodiment of his own worst fears about himself. As this Biblical transaction is reenacted entirely in one individual's mind, the danger is that this guilt-ridden eruption will be aimed at oneself—that the individual will embrace death as a deserved punishment rather than, in the hopeful spirit of the contemporary reform ethos, as a calmly accepted inevitability. The struggle between these two moods will present an opening for the abuse of dying people reminiscent of discredited past practices. In the confusion of this struggle, terrible suffering can fall on dying people.

\textbf{THE DEATH PENALTY}

Surely Goodness and Mercy Shall Follow

The death penalty is the paradigmatic expression of officially sanctioned involuntary killing. There is, moreover, no pretense of mercy; it is intended as punishment, even though constitutional norms against "cruel and unusual punishment" restrain its administration. We can nonetheless discern important lessons from American efforts during the past thirty years to ensure the "rationality" and "fairness" of capital punishment that provide guidance for thinking about the administration of death more generally. The lessons emerge from the following themes that have been explored in previous chapters: that death conveys an inherent aura of wrongdoing, in persistent counterpoint to claims for its practical or moral worthiness; that suppression of this ambivalent attitude is psychologically possible but nonetheless carries considerable risk that it will erupt into actions which express the underlying sense of wrongdoing, even as it remains unacknowledged; and that rigid commitment to the "goodness" of one's motives and the coherence or "meaningfulness" of one's thinking—that is, the denial of ambivalence or confusion—is a marker for an impetus toward condoning and even escalating actual wrongdoing.

I have thus far developed these themes by focusing mainly on an effort to explain a considerable anomaly—the fact that, during the past century, the well-intentioned efforts of medical science to avert death have carried the unintended consequence of inflicting considerable suffering on many dying people. The common complaint against physicians, which erupted in public discourse around 1970, has been that their protestations of beneficence were virtually transparent masks for