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Gender, Feminism, and Death: Physician-Assisted Suicide and Euthanasia

Susan M. Wolf

The debate in the United States over whether to legitimate physician-assisted suicide and active euthanasia has reached new levels of intensity. Oregon has become the first state to legalize physician-assisted suicide, and there have been campaigns, ballot measures, bills, and litigation in other states in attempts to legalize one or both practices.¹ Scholars and others increasingly urge either outright legalization or some other form of legitimation, through recognition of an affirmative defense of "mercy killing" to a homicide prosecution or other means.²

Yet the debate over whether to legitimate physician-assisted suicide and euthanasia (by which I mean active euthanasia, as opposed to the termination of life-sustaining treatment)³ is most often about a patient who does not exist—a patient with no gender, race, or insurance status. This is the same generic patient featured in most bioethics debates. Little discussion has focused on how differences between patients might alter the equation.

Even though the debate has largely ignored this question, there is ample reason to suspect that gender, among other factors, deserves analysis. The cases prominent in the American debate mostly feature women patients. This occurs against a backdrop of a long history of cultural images revering women's sacrifice and self-sacrifice. Moreover,

dimensions of health status and health care that may affect a patient's vulnerability to considering physician-assisted suicide and euthanasia—including depression, poor pain relief, and difficulty obtaining good health care—differentially plague women. And suicide patterns themselves show a strong gender effect: women less often complete suicide, but more often attempt it.⁴ These and other factors raise the question of whether the dynamics surrounding physician-assisted suicide and euthanasia may vary by gender.

Indeed, it would be surprising if gender had no influence. Women in America still live in a society marred by sexism, a society that particularly disvalues women with illness, disability, or merely advanced age. It would be hard to explain if health care, suicide, and fundamental dimensions of American society showed marked differences by gender, but gender suddenly dropped out of the equation when people became desperate enough to seek a physician's help in ending their lives.

What sort of gender effects might we expect? There are four different possibilities. First, we might anticipate a higher incidence of women than men dying by physician-assisted suicide and euthanasia in this country. This is an empirical claim that we cannot yet test; we currently lack good data in the face of the illegality of the practices in most states⁵ and the condemnation of the organized medical profession.⁶ The best data we do have are from the Netherlands and are inconclusive. As I discuss below, the Dutch data show that women predominate among patients dying through euthanasia or administration of drugs for pain relief, but not by much. In the smaller categories of physician-assisted suicide and "life-terminating events without . . . request," however, men predominate. And men predominate too in making requests rejected by physicians. It is hard to say what this means for the United States. The Netherlands differs in a number of relevant respects, with universal health care and a more homogeneous society. But the Dutch data suggest that gender differences in the United States will not necessarily translate into higher numbers of women dying. At least one author speculates that there may in fact be a sexist tendency to discount and refuse women's requests.⁷

There may, however, be a second gender effect. Gender differences may translate into women seeking physician-assisted suicide and euthanasia for somewhat different reasons than men. Problems we know to be correlated with gender—difficulty getting good medical care generally, poor pain relief, a higher incidence of depression, and a higher rate of poverty—may figure more prominently in women's motivation. Society's persisting sexism may figure as well. And the long history of valorizing women's self-sacrifice may be expressed in women's requesting assisted suicide or euthanasia.

The well-recognized gender differences in suicide statistics also suggest that women's requests for physician-assisted suicide and euthanasia may more often than men's requests be an effort to change an oppressive situation rather than a literal request for death. Thus some suicidologists interpret men's predominance among suicide "completers" and women's among suicide "attempters" to mean that women more often engage in suicidal behavior with a goal other than "completion."⁸ The relationship between suicide and the practices of physician-assisted suicide and euthanasia itself deserves further study; not all suicides are even motivated by terminal disease or other factors relevant to the latter practices. But the marked gender differences in suicidal behavior are suggestive.

Third, gender differences may also come to the fore in physicians' decisions about whether to grant or refuse requests for assisted suicide or euthanasia. The same historical valorization of women's self-sacrifice and the same background sexism that may affect women's readiness to request may also affect physicians' responses. Physicians may be susceptible to affirming women's negative self-judgments. This might or might not result in physicians agreeing to assist; other gender-related judgments (such as that women are too emotionally labile, or that their choices should not be taken seriously) may intervene.⁹ But the point is that gender may affect not just patient but physician.

Finally, gender may affect the broad public debate. The prominent U.S. cases so far and related historical imagery suggest that in debating physician-assisted suicide and euthanasia, many in our culture may envision a woman patient. Although the AIDS epidemic has called attention to physician-assisted suicide and euthanasia in men, the cases that have dominated the news accounts and scholarly journals in the recent renewal of debate have featured women patients. Thus we have reason to be concerned that at least some advocacy for these practices may build on the sense that these stories of women's deaths are somehow "right." If there is a felt correctness to these accounts, that may be playing a hidden and undesirable part in catalyzing support for the practices' legitimation.

Thus we have cause to worry whether the debate about and practice of physician-assisted suicide and euthanasia in this country are gendered in a number of respects. Serious attention to gender therefore seems essential. Before we license physicians to kill their patients or to assist patients in killing themselves, we had better understand the dynamic at work in that encounter, why the practice seems so alluring that we should court its dangers, and what dangers are likely to manifest. After all, the consequences of permitting killing or assistance in private encounters are serious, indeed fatal. We had better understand what distinguishes this from other forms of private violence, and other

relationships of asymmetrical power that result in the deaths of women. And we had better determine whether tacit assumptions about gender are influencing the enthusiasm for legalization.

Yet even that is not enough. Beyond analyzing the way gender figures in our cases, cultural imagery, and practice, we must analyze the substantive arguments. For attention to gender, in the last two decades particularly, has yielded a wealth of feminist critiques and theoretical tools that can fruitfully be brought to bear. After all, the debate over physician-assisted suicide and euthanasia revolves around precisely the kind of issues on which feminist work has focused: what it means to talk about rights of self-determination and autonomy; the reconciliation of those rights with physicians' duties of beneficence and caring; and how to place all of this in a context including the strengths and failures of families, professionals, and communities, as well as real differentials of power and resources.

The debate over physician-assisted suicide and euthanasia so starkly raises questions of rights, caring, and context that at this point it would take determination *not* to bring to bear a literature that has been devoted to understanding those notions. Indeed, the work of Lawrence Kohlberg bears witness to what an obvious candidate this debate is for such analysis.¹⁰ It was Kohlberg's work on moral development, of course, that provoked Carol Gilligan's *In A Different Voice*, criticizing Kohlberg's vision of progressive stages in moral maturation as one that was partial and gendered.¹¹ Gilligan proposed that there were really two different approaches to moral problems, one that emphasized generalized rights and universal principles, and the other that instead emphasized contextualized caring and the maintenance of particular human relationships. She suggested that although women and men could use both approaches, women tended to use the latter and men the former. Both approaches, however, were important to moral maturity. Though Gilligan's and others' work on the ethics of care has been much debated and criticized, a number of bioethicists and health care professionals have found a particular pertinence to questions of physician caregiving.¹²

Embedded in Kohlberg's work, one finds proof that the euthanasia debate in particular calls for analysis in the very terms that he employs, and that Gilligan then critiques, enlarges, and reformulates. For one of the nine moral dilemmas Kohlberg used to gauge subjects' stage of moral development was a euthanasia problem. "Dilemma IV" features "a woman" with "very bad cancer" and "in terrible pain." Her physician, Dr. Jefferson, knows she has "only about six months to live." Between periods in which she is "delirious and almost crazy with pain," she asks the doctor to kill her with morphine. The question is what he should do.¹³

The euthanasia debate thus demands analysis along the care, rights, and context axes that the Kohlberg–Gilligan debate has identified.¹⁴ Kohlberg himself used this problem to reveal how well respondents were doing in elevating general principles over the idiosyncrasies of relationship and context. It is no stretch, then, to apply the fruits of more than a decade of feminist critique. The problem has a genuine pedigree.

The purpose of this chapter thus is twofold. First, I explore gender's significance for analyzing physician-assisted suicide and euthanasia. Thus I examine the prominent cases and cultural images, against the background of cautions recommended by what little data we have from the Netherlands. Finding indications that gender may well be significant, I investigate what that implies for the debate over physician-assisted suicide and euthanasia. Clearly more research is required. But in the meantime, patients' vulnerability to requesting these fatal interventions because of failures in health care and other background conditions, or because of a desire not to die but to alter circumstances, introduces reasons why we should be reluctant to endorse these practices. Indeed, we should be worried about the role of the physician in these cases, and consider the lessons we have learned from analyzing other relationships that result in women's deaths. What we glean from looking at gender should lead us to look at other characteristics historically associated with disadvantage, and thus should prompt a general caution applicable to all patients.

My second purpose is to go beyond analysis of gender itself, to analysis of the arguments offered on whether to condone and legitimate these practices. Here is where I bring to bear the feminist literature on caring, rights, and context. I criticize the usual argument that patients' rights of self-determination dictate legitimization of physician-assisted suicide and euthanasia, on the grounds that this misconstrues the utility of rights talk for resolving this debate, and ignores essential features of the context. I then turn to arguments based on beneficence and caring. It is no accident that the word "mercy" has figured so large in our language about these problems; they do involve questions of compassion and caring. However, a shallow understanding of caring will lead us astray, and I go on to elaborate what a deep and contextualized understanding demands. I argue that physicians should be guided by a notion of "principled caring." Finally, I step back to suggest what a proper integration of rights and caring would look like in this context, how it can be coupled with attention to the fate of women and other historically disadvantaged groups, and what practical steps all of this counsels.

This chapter takes a position. As I have before, I oppose the legitimization of physician-assisted suicide and euthanasia.¹⁵ Yet the most important part of what I do here is urge the necessity of feminist analysis of this issue. Physician-assisted suicide and euthanasia are difficult problems on which people may disagree. But I hope to persuade that

attending to gender and feminist concerns in analyzing these problems is no longer optional.

Gender in Cases, Images, and Practice

The tremendous upsurge in American debate over whether to legitimate physician-assisted suicide and euthanasia in recent years has been fueled by a series of cases featuring women. The case that seems to have begun this series is that of Debbie, published in 1988 by the *Journal of the American Medical Association* (JAMA).¹⁶ JAMA published this now infamous, first-person, and anonymous account by a resident in obstetrics and gynecology of performing euthanasia. Some subsequently queried whether the account was fiction. Yet it successfully catalyzed an enormous response.

The narrator of the piece tells us that Debbie is a young woman suffering from ovarian cancer. The resident has no prior relationship with her, but is called to her bedside late one night while on call and exhausted. Entering Debbie's room, the resident finds an older woman with her, but never pauses to find out who that second woman is and what relational context Debbie acts within. Instead, the resident responds to the patient's clear discomfort and to her words. Debbie says only one sentence, "Let's get this over with." It is unclear whether she thinks the resident is there to draw blood and wants that over with, or means something else. But on the strength of that one sentence, the resident retreats to the nursing station, prepares a lethal injection, returns to the room, and administers it. The story relates this as an act of mercy under the title "It's Over, Debbie," as if in caring response to the patient's words.

The lack of relationship to the patient; the failure to attend to her own history, relationships, and resources; the failure to explore beyond the patient's presented words and engage her in conversation; the sense that the cancer diagnosis plus the patient's words demand death; and the construal of that response as an act of mercy are all themes that recur in the later cases. The equally infamous Dr. Jack Kevorkian has provided a slew of them.

They begin with Janet Adkins, a 54-year-old Oregon woman diagnosed with Alzheimer's disease.¹⁷ Again, on the basis of almost no relationship with Ms. Adkins, on the basis of a diagnosis by exclusion that Kevorkian could not verify, prompted by a professed desire to die that is a predictable stage in response to a number of dire diagnoses, Kevorkian rigs her up to his "Mercitron" machine in a parking lot outside Detroit in what he presents as an act of mercy.

Then there is Marjorie Wantz, a 58-year-old woman without even a diagnosis.¹⁸ Instead, she has pelvic pain whose source remains undetermined. By the time Kevorkian reaches Ms. Wantz, he is making little

pretense of focusing on her needs in the context of a therapeutic relationship. Instead, he tells the press that he is determined to create a new medical specialty of "obitiatry." Ms. Wantz is among the first six potential patients with whom he is conferring. When Kevorkian presides over her death there is another woman who dies as well, Sherry Miller. Miller, 43, has multiple sclerosis. Thus neither woman is terminal.

The subsequent cases reiterate the basic themes.¹⁹ And it is not until the ninth "patient" that Kevorkian finally presides over the death of a man.²⁰ By this time, published criticism of the predominance of women had begun to appear.²¹

Kevorkian's actions might be dismissed as the bizarre behavior of one man. But the public and press response has been enormous, attesting to the power of these accounts. Many people have treated these cases as important to the debate over physician-assisted suicide and euthanasia. Nor are Kevorkian's cases so aberrant—they pick up all the themes that emerge in "Debbie."

But we cannot proceed without analysis of Diane. This is the respectable version of what Kevorkian makes strange. I refer to the story published by Dr. Timothy Quill in the *New England Journal of Medicine*, recounting his assisting the suicide of his patient Diane.²² She is a woman in her forties diagnosed with leukemia, who seeks and obtains from Dr. Quill a prescription for drugs to take her life. Dr. Quill cures some of the problems with the prior cases. He does have a real relationship with her, he knows her history, and he obtains a psychiatric consult on her mental state. He is a caring, empathetic person. Yet once again we are left wondering about the broader context of Diane's life—why even the history of other problems that Quill describes has so drastically depleted her resources to deal with this one, and whether there were any alternatives. And we are once again left wondering about the physician's role—why he responded to her as he did, what self-scrutiny he brought to bear on his own urge to comply, and how he reconciled this with the arguments that physicians who are moved to so respond should nonetheless resist.²³

These cases will undoubtedly be joined by others, including cases featuring men, as the debate progresses. Indeed, they already have been. Yet the initial group of cases involving women has somehow played a pivotal role in catalyzing reexamination of two of the most fundamental and long-standing prohibitions in medicine. These are prohibitions that have been deemed by some constitutive of the physician's role: above all, do no harm; and give no deadly drug, even if asked. The power of this core of cases seems somehow evident.

This collection of early cases involving women cries out for analysis. It cannot be taken as significant evidence predicting that more women may die through physician-assisted suicide and euthanasia; these individual cases are no substitute for systematic data. But to understand

what they suggest about the role of gender, we need to place them in context.

The images in these cases have a cultural lineage. We could trace a long history of portrayals of women as victims of sacrifice and self-sacrifice. In Greek tragedy, that ancient source of still reverberating images, "suicide . . . [is] a woman's solution."²⁴ Almost no men die in this way. Specifically, suicide is a wife's solution; it is one of the few acts of autonomy open to her. Wives use suicide in these tragedies often to join their husbands in death. The other form of death specific to women is the sacrifice of young women who are virgins. The person putting such a woman to death must be male.²⁵ Thus "[i]t is by men that women meet their death, and it is for men, usually, that they kill themselves."²⁶ Men, in contrast, die by the sword or spear in battle.²⁷

The connection between societal gender roles and modes of death persists through history. Howard Kushner writes that "Nineteenth-century European and American fiction is littered with the corpses of . . . women. . . . [T]he cause was always . . . rejection after an illicit love affair. . . . If women's death by suicide could not be attributed to dishonor, it was invariably tied to women's adopting roles . . . assigned to men."²⁸ "By the mid-nineteenth century characterizations of women's suicides meshed with the ideology described by Barbara Welter as that of 'True Womanhood. . . .' Adherence to the virtues of 'piety, purity, submissiveness and domesticity' translated into the belief that 'a "fallen woman" was a "fallen angel." . . .²⁹ Even after statistics emerged showing that women completed suicide less often than men, the explanations offered centered on women's supposedly greater willingness to suffer misfortune, their lack of courage, and less arduous social role.³⁰

Thus, prevailing values have imbued women's deaths with specific meaning. Indeed, Carol Gilligan builds on images of women's suicides and sacrifice in novels and drama, as well as on her own data, in finding a psychology and even an ethic of self-sacrifice among women. Gilligan finds one of the "conventions of femininity" to be "the moral equation of goodness with self-sacrifice."³¹ "[V]irtue for women lies in self-sacrifice. . . ."³²

Given this history of images and the valorization of women's self-sacrifice, it should come as no surprise that the early cases dominating the debate about self-sacrifice through physician-assisted suicide and euthanasia have been cases of women. In Greek tragedy only women were candidates for sacrifice and self-sacrifice,³³ and to this day self-sacrifice is usually regarded as a feminine not masculine virtue.

This lineage has implications. It means that even while we debate physician-assisted suicide and euthanasia rationally, we may be animated by unacknowledged images that give the practices a certain gendered logic and felt correctness. In some deep way it makes sense to

us to see these women dying, it seems right. It fits an old piece into a familiar, ancient puzzle. Moreover, these acts seem good; they are born of virtue. We may not recognize that the virtues in question—female sacrifice and self-sacrifice—are ones now widely questioned and deliberately rejected. Instead, our subconscious may harken back to older forms, reembracing those ancient virtues, and thus lauding these women's deaths.

Analyzing the early cases against the background of this history also suggests hidden gender dynamics to be discovered by attending to the facts found in the accounts of these cases, or more properly the facts not found. What is most important in these accounts is what is left out, how truncated they are. We see a failure to attend to the patient's context, a readiness on the part of these physicians to facilitate death, a seeming lack of concern over why these women turn to these doctors for deliverance. A clue about why we should be concerned about each of these omissions is telegraphed by data from exit polls on the day Californians defeated a referendum measure to legalize active euthanasia. Those polls showed support for the measure lowest among women, older people, Asians, and African Americans, and highest among younger men with postgraduate education and incomes over \$75,000 per year.³⁴ The *New York Times* analysis was that people from more vulnerable groups were more worried about allowing physicians actively to take life. This may suggest concern not only that physicians may be too ready to take their lives, but also that these patients may be markedly vulnerable to seeking such relief. Why would women, in particular, feel this?

Women are at greater risk for inadequate pain relief.³⁵ Indeed, fear of pain is one of the reasons most frequently cited by Americans for supporting legislation to legalize euthanasia.³⁶ Women are also at greater risk for depression.³⁷ And depression appears to underlie numerous requests for physician-assisted suicide and euthanasia.³⁸ These factors suggest that women may be differentially driven to consider requesting both practices.

That possibility is further supported by data showing systematic problems for women in relationship to physicians. As an American Medical Association report on gender disparities recounts, women receive more care even for the same illness, but the care is generally worse. Women are less likely to receive dialysis, kidney transplants, cardiac catheterization, and diagnostic testing for lung cancer. The report urges physicians to uproot "social or cultural biases that could affect medical care" and "presumptions about the relative worth of certain social roles."³⁹

This all occurs against the background of a deeply flawed health care system that ties health insurance to employment. Men are differentially represented in the ranks of those with private health insurance,

women in the ranks of the others—those either on government entitlement programs or uninsured.⁴⁰ In the U.S. two-tier health care system, men dominate in the higher-quality tier, women in the lower.

Moreover, women are differentially represented among the ranks of the poor. Many may feel they lack the resources to cope with disability and disease. To cope with Alzheimer's, breast cancer, multiple sclerosis, ALS, and a host of other diseases takes resources. It takes not only the financial resource of health insurance, but also access to stable working relationships with clinicians expert in these conditions, in the psychological issues involved, and in palliative care and pain relief. It may take access to home care, eventually residential care, and rehabilitation services. These are services often hard to get even for those with adequate resources, and almost impossible for those without. And who are those without in this country? Disproportionately they are women, people of color, the elderly, and children.⁴¹

Women may also be driven to consider physician-assisted suicide or euthanasia out of fear of otherwise burdening their families.⁴² The dynamic at work in a family in which an ill member chooses suicide or active euthanasia is worrisome. This worry should increase when it is a woman who seeks to "avoid being a burden," or otherwise solve the problem she feels she poses, by opting for her own sacrifice. The history and persistence of family patterns in this country in which women are expected to adopt self-sacrificing behavior for the sake of the family may pave the way too for the patient's request for death. Women requesting death may also be sometimes seeking something other than death. The dominance of women among those attempting but not completing suicide in this country suggests that women may differentially engage in death-seeking behavior with a goal other than death. Instead, they may be seeking to change their relationships or circumstances.⁴³ A psychiatrist at Harvard has speculated about why those women among Kevorkian's "patients" who were still capable of killing themselves instead sought Kevorkian's help. After all, suicide has been decriminalized in this country, and step-by-step instructions are readily available. The psychiatrist was apparently prompted to speculate by interviewing about twenty physicians who assisted patients' deaths and discovering that two-thirds to three-quarters of the patients had been women. The psychiatrist wondered whether turning to Kevorkian was a way to seek a relationship.⁴⁴ The women also found a supposed "expert" to rely upon, someone to whom they could yield control. But then we must wonder what circumstances, what relational context, led them to this point.

What I am suggesting is that there are issues relating to gender left out of the accounts of the early prominent cases of physician-assisted suicide and euthanasia or left unexplored that may well be driving or limiting the choices of these women. I am not suggesting that we

should denigrate these choices or regard them as irrational. Rather, it is the opposite—that we should assume these decisions to be rational and grounded in a context. That forces us to attend to the background failures in that context.

Important analogies are offered by domestic violence. Such violence has been increasingly recognized as a widespread problem. It presents some structural similarities to physician-assisted suicide and especially active euthanasia. All three can be fatal. All three are typically acts performed behind closed doors. In the United States, all three are illegal in most jurisdictions, though the record of law enforcement on each is extremely inconsistent. Though men may be the victims and women the perpetrators of all three, in the case of domestic violence there are some conceptions of traditional values and virtues that endorse the notion that a husband may beat his wife. As I have suggested above, there are similarly traditional conceptions of feminine self-sacrifice that might bless a physician's assisting a woman's suicide or performing euthanasia.

Clearly, there are limits to the analogy. But my point is that questions of choice and consent have been raised in the analysis of domestic violence against women, much as they have in the case of physician-assisted suicide and active euthanasia. If a woman chooses to remain in a battering relationship, do we regard that as a choice to be respected and reason not to intervene? While choosing to remain is not consent to battery, what if a woman says that she "deserves" to be beaten—do we take that as reason to condone the battering? The answers that have been developed to these questions are instructive, because they combine respect for the rationality of women's choices with a refusal to go the further step of excusing the batterer. We appreciate now that a woman hesitating to leave a battering relationship may have ample and rational reasons: well-grounded fear for her safety and that of her children, a justified expectation of economic distress, and warranted concern that the legal system will not effectively come to her aid. We further see mental health professionals now uncovering some of the deeper reasons why some women might say at some point they "deserve" violence. Taking all of these insights seriously has led to development of a host of new legal, psychotherapeutic, and other interventions meant to address the actual experiences and concerns that might lead women to "choose" to stay in a violent relationship or "choose" violence against them. Yet none of this condones the choice of the partner to batter or, worse yet, kill the woman. Indeed, the victim's consent, we should recall, is no legal defense to murder.

All of this should suggest that in analyzing why women may request physician-assisted suicide and euthanasia, and why indeed the California polls indicate that women may feel more vulnerable to and

wary of making that request, we have insights to bring to bear from other realms. Those insights render suspect an analysis that merely asserts women are choosing physician-assisted suicide and active euthanasia, without asking why they make that choice. The analogy to other forms of violence against women behind closed doors demands that we ask why the woman is there, what features of her context brought her there, and why she may feel there is no better place to be. Finally, the analogy counsels us that the patient's consent does not resolve the question of whether the physician acts properly in deliberately taking her life through physician-assisted suicide or active euthanasia. The two people are separate moral and legal agents.⁴⁵

This leads us from consideration of why women patients may feel vulnerable to these practices, to the question of whether physicians may be vulnerable to regarding women's requests for physician-assisted suicide and euthanasia somewhat differently from men's. There may indeed be gender-linked reasons for physicians in this country to say "yes" to women seeking assistance in suicide or active euthanasia. In assessing whether the patient's life has become "meaningless," or a "burden," or otherwise what some might regard as suitable for extinguishing at her request, it would be remarkable if the physician's background views did not come into play on what makes a woman's life meaningful or how much of a burden on her family is too much.⁴⁶

Second, there is a dynamic many have written about operating between the powerful expert physician and the woman surrendering to his care.⁴⁷ It is no accident that bioethics has focused on the problem of physician paternalism. Instead of an egalitarianism or what Susan Sherwin calls "amicalism,"⁴⁸ we see a vertically hierarchical arrangement built on domination and subordination. When the patient is female and the doctor male, as is true in most medical encounters, the problem is likely to be exacerbated by the background realities and history of male dominance and female subjugation in the broader society. Then a set of psychological dynamics are likely to make the male physician vulnerable to acceding to the woman patient's request for active assistance in dying. These may be a complex combination of rescue fantasies⁴⁹ and the desire to annihilate. Robert Burt talks about the pervasiveness of this ambivalence, quite apart from gender: "Rules governing doctor-patient relations must rest on the premise that anyone's wish to help a desperately pained, apparently helpless person is intertwined with a wish to hurt that person, to obliterate him from sight."⁵⁰ When the physician is from a dominant social group and the patient from a subordinate one, we should expect the ambivalence to be heightened. When the "help" requested is obliteration, the temptation to enact both parts of the ambivalence in a single act may be great.

This brief examination of the vulnerability of women patients and their physicians to collaboration on actively ending the woman's life in a way reflecting gender roles suggests the need to examine the woman's context and where her request for death comes from, the physician's context and where his accession comes from, and the relationship between the two. We need to do that in a way that uses rather than ignores all we know about the issues plaguing the relations between women and men, especially suffering women and powerful expert men. The California exit polls may well signal both the attraction and the fear of enacting the familiar dynamics in a future in which it is legitimate to pursue that dynamic to the death. It would be implausible to maintain that medicine is somehow exempt from broader social dynamics. The question, then, is whether we want to bless deaths driven by those dynamics.

All of this suggests that physician-assisted suicide and euthanasia, as well as the debate about them, may be gendered. I have shown ways in which this may be true even if women do not die in greater numbers. But exploring gender would be incomplete without examining what data we have on its relationship to incidence. As noted above, those data, which are from the Netherlands, neither support the proposition that more women will die from these practices, nor provide good reason yet to dismiss the concern. We simply do not know how these practices may play out by gender in the United States. There is no good U.S. data, undoubtedly because these practices remain generally illegal.⁵¹ And the Dutch data come from another culture, with a more homogeneous population, a different health care system providing universal coverage, and perhaps different gender dynamics.⁵²

The status of physician-assisted suicide and euthanasia in the Netherlands is complex. Both practices remain criminal, but both are tolerated under a series of court decisions, guidelines from the Dutch medical association, and a more recent statute that carve out a domain in which the practices are accepted. If the patient is competent and contemporaneously requests assisted suicide or euthanasia, the patient's suffering cannot be relieved in any other way acceptable to the patient, a second physician concurs that acceding to the request is appropriate, and the physician performing the act reports it to permit monitoring and investigation, then the practices are allowed.

Dutch researchers have been reporting rigorous empirical research on the practices only in the past several years.⁵³ The team led by Dr. Paul van der Maas and working at governmental request published the first results of their nationwide study in 1991.⁵⁴ They found that "medical decisions concerning the end of life (MDEL)" were made in 38 percent of all deaths in the Netherlands, and thus were common. They

differentiated five different types of MDEL's: non-treatment decisions (which are neither physician-assisted suicide nor active euthanasia) caused 17.5 percent of deaths; administration of opiod drugs for pain and symptomatic relief (which would be considered active euthanasia in the United States if the physician's intent were to end life, rather than simply to relieve pain or symptoms with the foreseeable risk of hastening death) accounted for another 17.5 percent; active euthanasia at the patient's request (excluding the previous category) accounted for 1.8 percent; physician-assisted suicide (in which the patient, not physician, administers the drugs) covered 0.3 percent. Finally, there was a category of "life-terminating events without explicit and persistent request" accounting for 0.8 percent. In more than half of these cases, the patient had expressed a desire for euthanasia previously, but was no longer able to communicate by the time a decision had to be made and effectuated.

Women predominated in all of these categories except for the two rarest, but not by a great deal.⁵⁵ Thus, the ratio of females to males is 52:48 for euthanasia,⁵⁶ the same for death from drugs for pain and symptomatic relief, and 55:45 for non-treatment decisions.⁵⁷ This is against a background ratio of 48:52 for all deaths in the Netherlands.⁵⁸ However, in the much smaller categories of physician-assisted suicide and "life-terminating events without explicit and persistent request," men predominated by 68:32 and 65:35 respectively.⁵⁹ Why would men predominate in these two categories? In the case of physician-assisted suicide, the researchers suggest that we are talking about younger, urbanized males who have adopted a more demanding style as patients⁶⁰ and may be seeking control.⁶¹ Perhaps women, in contrast, are more often surrendering to their fate and relinquishing control to the physicians whom they ask to take their lives. Unfortunately, the researchers do not venture an explanation of why males predominate in the category of people who die from "life-terminating events without explicit and persistent request." This is numerically the smallest category, and one that should not occur at all under the Dutch guidelines because these are not contemporaneously competent patients articulating a request. Thus the numbers may be particularly unreliable here, if there is reluctance to report this illicit activity. Finally, the researchers report that more males than females made requests for physician-assisted suicide and euthanasia that physicians refused (55:45).⁶²

What can we learn from the Dutch data that is relevant to the United States? There are causes for caution in making the cross-cultural comparison. There may be fewer reasons to expect a gender difference in the Dutch practices of euthanasia and physician-assisted suicide (as we would define these terms, that is, including the administration of drugs for pain relief and palliation, when the physician's purpose is to

end life). First, the Netherlands provides universal health care coverage, while the United States's failure to provide universal coverage and tolerance of a two-tier health care system differentially disadvantages women (and other historically oppressed groups), leaving them with fewer means to cope with serious illness and more reason to consider seeking death. Second, the Netherlands presents greater homogeneity in race and ethnicity.⁶³ Again, this means that the United States presents more opportunities for and history of oppression based on difference. Third, we have to wonder whether elderly women in the United States face more difficulties and thus more reason to consider physician-assisted suicide and euthanasia than those in the Netherlands. A significant number in the United States confront lack of financial resources and difficulties associated with the absence of universal health coverage. Older women in the United States may also find themselves disvalued. "[T]here is evidence that the decision to kill oneself is viewed as most 'understandable' when it is made by an older woman."⁶⁴ Finally, it is worth speculating whether gender dynamics differ in the Netherlands.

Apart from that speculation, the differences in Dutch demographics and health care would be reasons to expect no gender differential in the Netherlands in the practices we are examining. The fact that we nonetheless see something of a gender difference in the case of most deaths intentionally caused by a physician at the patient's request should heighten our concern about gender differences in the United States. Given the general illegality of euthanasia and physician-assisted suicide currently in this country, decent data would be difficult to gather. Yet there seems to be reason to attend to gender in what studies we can do, and in our analysis of these problems. Studies planned for Oregon, the one American jurisdiction to legalize physician-assisted suicide so far, should surely investigate gender.

Attending to gender in the data available from the Netherlands, in the images animating the American debate, and in the cases yielding those images thus suggests that our customarily gender-neutral arguments about the merits of physician-assisted suicide and euthanasia miss much of the point. Though one can certainly conceive of a gender-neutral practice, that may be far from what we have, at least in the United States, with our history and inequalities.

Equally troubling, our failure thus far to attend to gender in debating these practices may represent more than mere oversight. It may be a product of the same deep-rooted sexism that makes the self-destruction of women in Greek tragedy seem somehow natural and right. Indeed, there is something systematic in our current submerging of gender. The details left out of the usual account of a case of assisted suicide or euthanasia—what failures of relationship, context, and resources have

brought the woman to this point; precisely why death seems to her the best remaining option; what elements of self-sacrifice motivate her choice—are exactly the kind of details that might make the workings of gender visible.

They are also the kind of details that might make the workings of race, ethnicity, and insurance status visible as well. The sort of gender analysis that I have pursued here should also provoke us to other analyses of the role played by these other factors. To focus here on just the first of these, there is a long history of racism in medicine in this country, as vividly demonstrated by the horrors of the Tuskegee Syphilis Study.⁶⁵ We now are seeing new studies showing a correlation between race and access to cardiac procedures, for instance.⁶⁶ Although analysis of the meaning of these correlations is in progress, we have ample reason to be concerned, to examine the dynamic at work between patients of color and their physicians, and to be wary of expanding the physician's arsenal so that he or she may directly take the patient's life.

This sort of analysis will have to be detailed and specific, whether exploring gender, race, or another historic basis for subordination. The cultural meaning, history, and medical profession's use of each of those categories is specific, even though we can expect commonalities. The analysis will also have to pay close attention to the intersection, when a patient presents multiple characteristics that have historically occasioned discrimination and disadvantage.⁶⁷ How all of these categories function in the context of physician-assisted suicide and euthanasia will bear careful examination.

Probably the category of gender is the one we actually know most about in that context. At least we have the most obvious clues about that category, thanks to the gendered nature of the imagery. We would be foolish not to pursue those clues. Indeed, given grounds for concern that physician-assisted suicide and euthanasia may work in different and troubling ways when the patient is a woman, we are compelled to investigate gender.

Feminism and the Arguments

Shifting from the images and stories that animate debate and the dynamics operating in practice to analysis of the arguments over physician-assisted suicide and euthanasia takes us further into the concerns of feminist theory. Arguments in favor of these practices have often depended on rights claims. More recently, some authors have grounded their arguments instead on ethical concepts of caring. Yet both argumentative strategies have been flawed in ways that feminist work can illuminate. What is missing is an analysis that integrates notions of physician caring with principled boundaries to physician ac-

tion, while also attending to the patient's broader context and the community's wider concerns. Such an analysis would pay careful attention to the dangers posed by these practices to the historically most vulnerable populations, including women.

Advocacy of physician-assisted suicide and euthanasia has hinged to a great extent on rights claims. The argument is that the patient has a right of self-determination or autonomy that entitles her to assistance in suicide or euthanasia. The strategy is to extend the argument that self-determination entitles the patient to refuse unwanted life-sustaining treatment by maintaining that the same rationale supports patient entitlement to more active physician assistance in death. Indeed, it is sometimes argued that there is no principled difference between termination of life-sustaining treatment and the more active practices.

The narrowness and mechanical quality of this rights thinking, however, is shown by its application to the stories recounted above. That application suggests that the physicians in these stories are dealing with a simple equation: given an eligible rights bearer and her assertion of the right, the correct result is death. What makes a person an eligible rights bearer? Kevorkian seems to require neither a terminal disease nor thorough evaluation of whether the patient has non-fatal alternatives. Indeed, the Wantz case shows he does not even require a diagnosis. Nor does the Oregon physician-assisted suicide statute require evaluation or exhaustion of non-fatal alternatives; a patient could be driven by untreated pain, and still receive physician-assisted suicide. And what counts as an assertion of the right? For Debbie's doctor, merely "Let's get this over with." Disease plus demand requires death.

Such a rights approach raises a number of problems that feminist theory has illuminated. I should note that overlapping critiques of rights have been offered by Critical Legal Studies,⁶⁸ Critical Race Theory,⁶⁹ and some communitarian theory.⁷⁰ Thus some of these points would be echoed by those critiques.⁷¹ Yet as will be seen, feminist theory offers ways to ground evaluation of rights and rights talk⁷² in the experiences of women.

In particular, feminist critiques suggest three different sorts of problems with the rights equation offered to justify physician-assisted suicide and euthanasia. First, it ignores context, both the patient's present context and her history. The prior and surrounding failures in her intimate relationships, in her resources to cope with illness and pain, and even in the adequacy of care being offered by the very same physician fade into invisibility next to the bright light of a rights bearer and her demand. In fact, her choices may be severely constrained. Some of those constraints may even be alterable or removable. Yet attention to

those dimensions of decision is discouraged by the absolutism of the equation: either she is an eligible rights bearer or not; either she has asserted her right or not. There is no room for conceding her competence and request, yet querying whether under all the circumstances her choices are so constrained and alternatives so unexplored that acceding to the request may not be the proper course. Stark examples are provided by cases in which pain or symptomatic discomfort drives a person to request assisted suicide or euthanasia, yet the pain or discomfort are treatable. A number of Kevorkian's cases raise the problem as well: Did Janet Adkins ever receive psychological support for the predictable despair and desire to die that follow dire diagnoses such as Alzheimer's? Would the cause of Marjorie Wantz's undiagnosed pelvic pain been ascertainable and even ameliorable at a better health center? In circumstances in which women and others who have traditionally lacked resources and experienced oppression are likely to have fewer options and a tougher time getting good care, mechanical application of the rights equation will authorize their deaths even when less drastic alternatives are or should be available. It will wrongly assume that all face serious illness and disability with the resources of the idealized rights bearer—a person of means untroubled by oppression. The realities of women and others whose circumstances are far from that abstraction's will be ignored.

Second, in ignoring context and relationship, the rights equation extols the vision of a rights bearer as an isolated monad and denigrates actual dependencies. Thus it may be seen as improper to ask what family, social, economic, and medical supports she is or is not getting; this insults her individual self-governance. Nor may it be seen as proper to investigate alternatives to acceding to her request for death; this too dilutes self-rule. Yet feminists have reminded us of the actual embeddedness of persons and the descriptive falseness of a vision of each as an isolated individual.⁷³ In addition, they have argued normatively that a society comprised of isolated individuals, without the pervasive connections and dependencies that we see, would be undesirable.⁷⁴ Indeed, the very meaning of the patient's request for death is socially constructed; that is the point of the prior section's review of the images animating the debate. If we construe the patient's request as a rights bearer's assertion of a right and deem that sufficient grounds on which the physician may proceed, it is because we choose to regard background failures as irrelevant even if they are differentially motivating the requests of the most vulnerable. We thereby avoid real scrutiny of the social arrangements, governmental failures, and health coverage exclusions that may underlie these requests. We also ignore the fact that these patients may be seeking improved circumstances more than death. We elect a myopia that makes the patient's

request and death seem proper. We construct a story that clothes the patient's terrible despair in the glorious mantle of "rights."

Formulaic application of the rights equation in this realm thus exalts an Enlightenment vision of autonomy as self-governance and the exclusion of interfering others. Yet as feminists such as Jennifer Nedelsky have argued, this is not the only vision of autonomy available.⁷⁵ She argues that a superior vision of autonomy is to be found by rejecting "the pathological conception of autonomy as boundaries against others," a conception that takes the exclusion of others from one's property as its central symbol. Instead, "If we ask ourselves what actually enables people to be autonomous, the answer is not isolation but relationships . . . that provide the support and guidance necessary for the development and experience of autonomy." Nedelsky thus proposes that the best "metaphor for autonomy is not property, but childrearing. There we have encapsulated the emergence of autonomy through relationship with others."⁷⁶ Martha Minow, too, presents a vision of autonomy that resists the isolation of the self, and instead tries to support the relational context in which the rights bearer is embedded.⁷⁷ Neither author counsels abandonment of autonomy and rights. But they propose fundamental revisions that would rule out the mechanical application of a narrow rights equation that would regard disease or disability, coupled with demand, as adequate warrant for death.⁷⁸

In fact, there are substantial problems with grounding advocacy for the specific practices of physician-assisted suicide and euthanasia in a rights analysis, even if one accepts the general importance of rights and self-determination. I have elsewhere argued repeatedly for an absolute or near-absolute moral and legal right to be free of unwanted life-sustaining treatment.⁷⁹ Yet the negative right to be free of unwanted bodily invasion does not imply an affirmative right to obtain bodily invasion (or assistance with bodily invasion) for the purpose of ending your own life.

Moreover, the former right is clearly grounded in fundamental entitlements to liberty, bodily privacy, and freedom from unconsented touching; in contrast there is no clear "right" to kill yourself or be killed. Suicide has been widely decriminalized, but decriminalizing an act does not mean that you have a positive right to do it and to command the help of others. Indeed, if a friend were to tell me that she wished to kill herself, I would not be lauded for giving her the tools. In fact, that act of assistance has *not* been decriminalized. That continued condemnation shows that whatever my friend's relation to the act of suicide (a "liberty," "right," or neither), it does not create a right in her sufficient to command or even permit my aid.

There are even less grounds for concluding that there is a right to be killed deliberately on request, that is, for euthanasia. There are reasons

why a victim's consent has traditionally been no defense to an accusation of homicide. One reason is suggested by analogy to Mill's famous argument that one cannot consent to one's own enslavement: "The reason for not interfering . . . with a person's voluntary acts, is consideration for his liberty. . . . But by selling himself for a slave, he abdicates his liberty; he foregoes any future use of it. . . ." ⁸⁰ Similarly, acceding to a patient's request to be killed wipes out the possibility of her future exercise of her liberty. The capacity to command or permit another to take your life deliberately, then, would seem beyond the bounds of those things to which you have a right grounded in notions of liberty. We lack the capacity to bless another's enslavement of us or direct killing of us. How is this compatible then with a right to refuse life-sustaining treatment? That right is not grounded in any so-called "right to die," however frequently the phrase appears in the general press.⁸¹ Instead, it is grounded in rights to be free of unwanted bodily invasion, rights so fundamental that they prevail even when the foreseeable consequence is likely to be death.

Finally, the rights argument in favor of physician-assisted suicide and euthanasia confuses two separate questions: what the patient may do, and what the physician may do. After all, the real question in these debates is not what patients may request or even do. It is not at all infrequent for patients to talk about suicide and request assurance that the physician will help or actively bring on death when the patient wants;⁸² that is an expected part of reaction to serious disease and discomfort. The real question is what the doctor may do in response to this predictable occurrence. That question is not answered by talk of what patients may ask; patients may and should be encouraged to reveal everything on their minds. Nor is it answered by the fact that decriminalization of suicide permits the patient to take her own life. The physician and patient are separate moral agents. Those who assert that what a patient may say or do determines the same for the physician, ignore the physician's separate moral and legal agency. They also ignore the fact that she is a professional, bound to act in keeping with a professional role and obligations. They thereby avoid a necessary argument over whether the historic obligations of the physician to "do no harm" and "give no deadly drug even if asked" should be abandoned.⁸³ Assertion of what the patient may do does not resolve that argument.

The inadequacy of rights arguments to legitimate physician-assisted suicide and euthanasia has led to a different approach, grounded on physicians' duties of beneficence. This might seem to be quite in keeping with feminists' development of an ethics of care.⁸⁴ Yet the beneficence argument in the euthanasia context is a strange one, because it asserts that the physician's obligation to relieve suffering permits or even commands her to annihilate the person who is experiencing the

suffering. Indeed, at the end of this act of beneficence, no patient is left to experience its supposed benefits. Moreover, this argument ignores widespread agreement that fears of patient addiction in these cases should be discarded, physicians may sedate to unconsciousness, and the principle of double effect permits giving pain relief and palliative care in doses that risk inducing respiratory depression and thereby hastening death. Given all of that, it is far from clear what patients remain in the category of those whose pain or discomfort can only be relieved by killing them.

Thus this argument that a physician should provide so much "care" that she kills the patient is deeply flawed. A more sophisticated version, however, is offered by Howard Brody.⁸⁵ He acknowledges that both the usual rights arguments and traditional beneficence arguments have failed. Thus he claims to find a middle path. He advocates legitimation of physician-assisted suicide and euthanasia "as a compassionate response to one sort of medical failure," namely, medical failure to prolong life, restore function, or provide effective palliation. Even in such cases, he does not advocate the creation of a rule providing outright legalization. Instead, "compassionate and competent medical practice" should serve as a defense in a criminal proceeding.⁸⁶ Panels should review the practice case by case; a positive review should discourage prosecution.

There are elements of Brody's proposal that seem quite in keeping with much feminist work: his rejection of a binary either-or analysis, his skepticism that a broad rule will yield a proper resolution, his requirement instead of a case-by-case approach. Moreover, the centrality that he accords to "compassion" again echoes feminist work on an ethics of care. Yet ultimately he offers no real arguments for extending compassion to the point of killing a patient, for altering the traditional boundaries of medical practice, or for ignoring the fears that any legitimation of these practices will start us down a slippery slope leading to bad consequences. Brody's is more the proposal of a procedure—what he calls "not resolution but adjudication," following philosopher Hilary Putnam—than it is a true answer to the moral and legal quandaries.

What Brody's analysis does accomplish, however, is that it suggests that attention to method is a necessary, if not sufficient, part of solving the euthanasia problem. Thus we find that two of the most important current debates in bioethics are linked—the debate over euthanasia and the debate over the proper structure of bioethical analysis and method.⁸⁷ The inadequacies of rights arguments to establish patient entitlement to assisted suicide and euthanasia are linked to the inadequacies of a "top-down" or deductive bioethics driven by principles, abstract theories, or rules. They share certain flaws: both seem overly to ignore context and the nuances of cases; their simple abstractions

overlook real power differentials in society and historic subordination; and they avoid the fact that these principles, rules, abstractions, and rights are themselves a product of historically oppressive social arrangements. Similarly, the inadequacies of beneficence and compassion arguments are linked to some of the problems with a "bottom-up" or inductive bioethics built on cases, ethnography, and detailed description. In both instances it is difficult to see where the normative boundaries lie, and where to get a normative keel for the finely described ship.

What does feminism have to offer these debates? Feminists too have struggled extensively with the question of method, with how to integrate detailed attention to individual cases with rights, justice, and principles. Thus in criticizing Kohlberg and going beyond his vision of moral development, Carol Gilligan argued that human beings should be able to utilize both an ethics of justice and an ethics of care. "To understand how the tension between responsibilities and rights sustains the dialectic of human development is to see the integrity of two disparate modes of experience that are in the end connected. . . . In the representation of maturity, both perspectives converge. . . ." ⁸⁸ What was less clear was precisely how the two should fit together. And unfortunately for our purposes, Gilligan never took up Kohlberg's mercy killing case to illuminate a care perspective or even more importantly, how the two perspectives might properly be interwoven in that case.

That finally, I would suggest, is the question. Here we must look to those feminist scholars who have struggled directly with how the two perspectives might fit. Lawrence Blum has distinguished eight different positions that one might take, and that scholars have taken, on "the relation between impartial morality and a morality of care:" ⁸⁹ (1) acting on care is just acting on complicated moral principles; (2) care is not moral but personal; (3) *caré* is moral but secondary to principle and generally adds mere refinements or supererogatory opportunities; (4) principle supplies a superior basis for moral action by ensuring consistency; (5) care morality concerns evaluation of persons while principles concern evaluation of acts; (6) principles set outer boundaries within which care can operate; (7) the preferability of a care perspective in some circumstances must be justified by reasoning from principles; and (8) care and justice must be integrated. Many others have struggled with the relationship between the two perspectives as well.

Despite this complexity, the core insight is forthrightly stated by Owen Flanagan and Kathryn Jackson: "[T]he most defensible specification of the moral domain will include issues of both right and good." ⁹⁰ Martha Minow and Elizabeth Spelman go further. Exploring the axis of abstraction versus context, they argue against dichotomizing the two and in favor of recognizing their "constant interactions." ⁹¹ Indeed,

they maintain that a dichotomy misdescribes the workings of context. "[C]ontextualists do not merely address each situation as a unique one with no relevance for the next one. . . . The basic norm of fairness—treat like cases alike—is fulfilled, not undermined, by attention to what particular traits make one case like, or unlike, another."⁹² Similarly, "[w]hen a rule specifies a context, it does not undermine the commitment to universal application to the context specified; it merely identifies the situations to be covered by the rule."⁹³ If this kind of integration is available, then why do we hear such urgent pleas for attention to context? "[T]he call to context in the late twentieth century reflects a critical argument that prevailing legal and political norms have used the form of abstract, general, and universal prescriptions while neglecting the experiences and needs of women of all races and classes, people of color, and people without wealth."⁹⁴

Here we find the beginning of an answer to our dilemma. It appears that we must attend to both context and abstraction, peering through the lenses of both care and justice. Yet our approach to each will be affected by its mate. Our apprehension and understanding of context or cases inevitably involves categories, while our categories and principles should be refined over time to apply to some contexts and not others.⁹⁵ Similarly, our understanding of what caring requires in a particular case will grow in part from our understanding of what sort of case this is and what limits principles set to our expressions of caring; while our principles should be scrutinized and amended according to their impact on real lives, especially the lives of those historically excluded from the process of generating principles.⁹⁶

This last point is crucial and a distinctive feminist contribution to the debate over abstraction versus context, or in bioethics, principles versus cases. Various voices in the bioethics debate over method—be they advocating casuistry, specified principlism, principlism itself, or some other position—present various solutions to the question of how cases and principles or other higher-order abstractions should interconnect. Feminist writers too have substantive solutions to offer, as I have suggested. But feminists also urge something that the mainstream writers on bioethics method have overlooked altogether, namely, the need to use cases and context to reveal the systematic biases such as sexism and racism built into the principles or other abstractions themselves. Those biases will rarely be explicit in a principle. Instead, we will frequently have to look at how the principle operates in actual cases, what it presupposes (such as wealth or life options), and what it ignores (such as preexisting sexism or racism among the very health care professionals meant to apply it).⁹⁷

What, then, does all of this counsel in application to the debate over

physician-assisted suicide and euthanasia? This debate cannot demand a choice between abstract rules or principles and physician caring. Although the debate has sometimes been framed that way, it is difficult to imagine a practice of medicine founded on one to the exclusion of the other. Few would deny that physician beneficence and caring for the individual patient are essential. Indeed, they are constitutive parts of the practice of medicine as it has come to us through the centuries and aims to function today. Yet that caring cannot be unbounded. A physician cannot be free to do whatever caring for or empathy with the patient seems to urge in the moment. Physicians practice a profession with standards and limits, in the context of a democratic polity that itself imposes further limits.⁹⁸ These considerations have led the few who have begun to explore an ethics of care for physicians to argue that the notion of care in that context must be carefully delimited and distinct from the more general caring of a parent for a child (although there are limits, too, on what a caring parent may do).⁹⁹ Physicians must pursue what I will call "principled caring."

This notion of principled caring captures the need for limits and standards, whether technically stated as principles or some other form of generalization. Those principles or generalizations will articulate limits and obligations in a provisional way, subject to reconsideration and possible amendment in light of actual cases. Both individual cases and patterns of cases may specifically reveal that generalizations we have embraced are infected by sexism or other bias, either as those generalizations are formulated or as they function in the world. Indeed, given that both medicine and bioethics are cultural practices in a society riddled by such bias and that we have only begun to look carefully for such bias in our bioethical principles and practices, we should expect to find it.

Against this background, arguments for physician-assisted suicide and euthanasia—whether grounded on rights or beneficence—are automatically suspect when they fail to attend to the vulnerability of women and other groups. If our cases, cultural images, and perhaps practice differentially feature the deaths of women, we cannot ignore that. It is one thing to argue for these practices for the patient who is not so vulnerable, the wealthy white male living on Park Avenue in Manhattan who wants to add yet another means of control to his arsenal. It is quite another to suggest that the woman of color with no health care coverage or continuous physician relationship, who is given a dire diagnosis in the city hospital's emergency room, needs then to be offered direct killing.

To institute physician-assisted suicide and euthanasia at this point in this country—in which many millions are denied the resources to cope with serious illness, in which pain relief and palliative care are by all

accounts woefully mishandled, and in which we have a long way to go to make proclaimed rights to refuse life-sustaining treatment and to use advance directives working realities in clinical settings—seems, at the very least, to be premature. Were we actually to fix those other problems, we have no idea what demand would remain for these more drastic practices and in what category of patients. We know, for example, that the remaining category is likely to include very few, if any, patients in pain, once inappropriate fears of addiction, reluctance to sedate to unconsciousness, and confusion over the principle of double effect are overcome.

Yet against those background conditions, legitimating the practices is more than just premature. It is a danger to women. Those background conditions pose special problems for them. Women in this country are differentially poorer, more likely to be either uninsured or on government entitlement programs, more likely to be alone in their old age, and more susceptible to depression. Those facts alone would spell danger. But when you combine them with the long (indeed, ancient) history of legitimating the sacrifice and self-sacrifice of women, the danger intensifies. That history suggests that a woman requesting assisted suicide or euthanasia is likely to be seen as doing the "right" thing. She will fit into unspoken cultural stereotypes.¹⁰⁰ She may even be valorized for appropriate feminine self-sacrificing behavior, such as sparing her family further burden or the sight of an unaesthetic deterioration. Thus she may be subtly encouraged to seek death. At the least, her physician may have a difficult time seeing past the legitimating stereotypes and valorization to explore what is really going on with this particular patient, why she is so desperate, and what can be done about it. If many more patients in the Netherlands ask about assisted suicide and euthanasia than go through with it,¹⁰¹ and if such inquiry is a routine part of any patient's responding to a dire diagnosis or improperly managed symptoms and pain, then were the practices to be legitimated in the United States, we would expect to see a large group of patients inquiring. Yet given the differential impact of background conditions in the United States by gender and the legitimating stereotypes of women's deaths, we should also expect to see what has been urged as a neutral practice show marked gender effects.

Is it possible to erect a practice that avoids this? No one has yet explained how. A recent article advocating the legitimation of physician-assisted suicide, for example, acknowledges the need to protect the vulnerable (though it never lists women among them).¹⁰² But none of the seven criteria it proposes to guide the practice involves deeply inquiring into the patient's life circumstances, whether she is alone, or whether she has health care coverage. Nor do the criteria

require the physician to examine whether gender or other stereotypes are figuring in the physician's response to the patient's request. And the article fails to acknowledge the vast inequities and pervasive bias in social institutions that are the background for the whole problem. There is nothing in the piece that requires we remedy or even lessen those problems before these fatal practices begin.

The required interweaving of principles and caring, combined with attention to the heightened vulnerability of women and others, suggests that the right answer to the debate over legitimating these practices is at least "not yet" in this grossly imperfect society and perhaps a flat "no." Beneficence and caring indeed impose positive duties upon physicians, especially with patients who are suffering, despairing, or in pain. Physicians must work with these patients intensively; provide first-rate pain relief, palliative care, and symptomatic relief; and honor patients' exercise of their rights to refuse life-sustaining treatment and use advance directives. Never should the patient's illness, deterioration, or despair occasion physician abandonment. Whatever concerns the patient has should be heard and explored, including thoughts of suicide, or requests for aid or euthanasia.

Such requests should redouble the physician's efforts, prompt consultation with those more expert in pain relief or supportive care, suggest exploration of the details of the patient's circumstance, and a host of other efforts. What such requests should not do is prompt our collective legitimation of the physician's saying "yes" and actively taking the patient's life. The mandates of caring fail to bless killing the person for whom one cares. Any such practice in the United States will inevitably reflect enormous background inequities and persisting societal biases. And there are special reasons to expect gender bias to play a role.

The principles bounding medical practice are not written in stone. They are subject to reconsideration and societal renegotiation over time. Thus the ancient prohibitions against physicians assisting suicide and performing euthanasia do not magically defeat proposals for change. (Nor do mere assertions that "patients want it" mandate change, as I have argued above.)¹⁰³ But we ought to have compelling reasons for changing something as serious as the limits on physician killing, and to be rather confident that change will not mire physicians in a practice that is finally untenable.

By situating assisted suicide and euthanasia in a history of women's deaths, by suggesting the social meanings that over time have attached to and justified women's deaths, by revealing the background conditions that may motivate women's requests, and by stating the obvious—that medicine does not somehow sit outside society, exempt from all of this—I have argued that we cannot have that confidence. More-

over, in the real society in which we live, with its actual and for some groups fearful history, there are compelling reasons not to allow doctors to kill. We cannot ignore that such practice would allow what for now remains an elite and predominantly male profession to take the lives of the "other." We cannot explain how we will train the young physician both to care for the patient through difficult straits and to kill. We cannot protect the most vulnerable.

Conclusion

Some will find it puzzling that elsewhere we seek to have women's voices heard and moral agency respected, yet here I am urging that physicians not accede to the request for assisted suicide and euthanasia. Indeed, as noted above, I have elsewhere maintained that physicians must honor patients' requests to be free of unwanted life-sustaining treatment. In fact, attention to gender and feminist argument would urge some caution in both realms. As Jay Katz has suggested, any patient request or decision of consequence merits conversation and exploration.¹⁰⁴ And analysis by Steven Miles and Alison August suggests that gender bias may be operating in the realm of the termination of life-sustaining treatment too.¹⁰⁵ Yet finally there is a difference between the two domains. As I have argued above, there is a strong right to be free of unwanted bodily invasion. Indeed, for women, a long history of being harmed specifically through unwanted bodily invasion such as rape presents particularly compelling reasons for honoring a woman's refusal of invasion and effort to maintain bodily intactness. When it comes to the question of whether women's suicides should be aided, however, or whether women should be actively killed, there is no right to command physician assistance, the dangers of permitting assistance are immense, and the history of women's subordination cuts the other way. Women have historically been seen as fit objects for bodily invasion, self-sacrifice, and death at the hands of others. The task before us is to challenge all three.¹⁰⁶

Certainly some women, including some feminists, will see this problem differently. That may be especially true of women who feel in control of their lives, are less subject to subordination by age or race or wealth, and seek yet another option to add to their many. I am not arguing that women should lose control of their lives and selves. Instead, I am arguing that when women request to be put to death or ask help in taking their own lives, they become part of a broader social dynamic of which we have properly learned to be extremely wary. These are fatal practices. We can no longer ignore questions of gender or the insights of feminist argument.

Notes

My thanks to Arthur Applbaum, Larry Blum, Alta Charo, Norman Daniels, Johannes J. M. van Delden, Rebecca Dresser, Jorge Garcia, Henk ten Have, Warren Kearney, Elizabeth Kiss, Steven Miles, Christine Mitchell, Remco Oostendorp, Lynn Peterson, Dennis Thompson, and Alan Wertheimer for help at various stages, to the *Texas Journal on Women and the Law* at the University of Texas Law School for the opportunity to elicit comments on an earlier version, and to participants in the University of Minnesota Law School Faculty Workshop for valuable suggestions. Kent Spies and Terrence Dwyer of the University of Minnesota Law School provided important research assistance. Work on this chapter was supported in part by a Fellowship in the Program in Ethics and the Professions at Harvard University.

1. See, for example, Pamela Carroll, "Proponents of Physician-Assisted Suicide Continuing Efforts," *ACP Observer*, February 1992, p. 29 (describing state initiatives in Washington, California, Michigan, New Hampshire, and Oregon). Subsequently, Oregon voters made that state the first to legalize physician-assisted suicide. See 1995 Oregon Laws, Ch. 3, I. M. No. 16. But see also *Lee v. Oregon*, 869 F. Supp. 1491 (D. Or. 1994), entering an injunction preventing the statute from going into effect. Further legal proceedings will decide the statute's fate. For attempts to legalize physician-assisted suicide through litigation, see *Compassion in Dying v. Washington*, 850 F. Supp. 1454 (W.D. Wash. 1994), *rev'd*, 49 F.3d 586 (9th Cir. 1995); *Quill v. Koppell*, 870 F. Supp. 78 (S.D.N.Y. 1994). See also *Hobbins v. Attorney General*, 527 N.W.2d 714 (Mich. 1994).

2. See, for example, Howard Brody, "Assisted Death—A Compassionate Response to a Medical Failure," *New England Journal of Medicine* 327 (1992): 1384–88; Timothy E. Quill, Christine K. Cassel, and Diane E. Meier, "Care of the Hopelessly Ill: Proposed Clinical Criteria for Physician-Assisted Suicide," *New England Journal of Medicine* 327 (1992): 1380–84; Guy I. Benrubi, "Euthanasia—The Need for Procedural Safeguards," *New England Journal of Medicine* 326 (1992): 197–99; Christine K. Cassel and Diane E. Meier, "Morals and Moralism in the Debate Over Euthanasia and Assisted Suicide," *New England Journal of Medicine* 323 (1990): 750–52; James Rachels, *The End of Life* (Oxford, England: Oxford University Press, 1986).

3. I restrict the term "euthanasia" to active euthanasia, excluding the termination of life-sustaining treatment, which has sometimes been called "passive euthanasia." Both law and ethics now treat the termination of treatment quite differently from the way they treat active euthanasia, so to use "euthanasia" to refer to both invites confusion. See generally "Report of the Council on Ethical and Judicial Affairs of the American Medical Association," *Issues in Law & Medicine* 10 (1994): 91–97, 92.

4. See Howard I. Kushner, "Women and Suicide in Historical Perspective," in Joyce McCarl Nielsen, ed., *Feminist Research Methods: Exemplary Readings in the Social Sciences* (Boulder, CO: Westview Press, 1990), 193–206, 198–200.

5. See Alan Meisel, *The Right to Die* (New York, NY: John Wiley & Sons, 1989), 62, & 1993 *Cumulative Supplement No. 2*, 50–54.

6. See Council on Ethical and Judicial Affairs, *Code of Medical Ethics: Current Opinions with Annotations* (Chicago, IL: American Medical Association, 1994),

50–51; "Report of the Board of Trustees of the American Medical Association," *Issues in Law & Medicine* 10 (1994): 81–90; "Report of the Council on Ethical and Judicial Affairs," *Report of the Council on Ethical and Judicial Affairs of the American Medical Association: Euthanasia* (Chicago, IL: American Medical Association, 1989). There are U.S. data on public opinion and physicians' self-reported practices. See, for example, "Report of the Board of Trustees." But the legal and ethical condemnation of physician-assisted suicide and euthanasia in the United States undoubtedly affect the self-reporting and render this a poor indicator of actual practices.

7. See Nancy S. Jecker, "Physician-Assisted Death in the Netherlands and the United States: Ethical and Cultural Aspects of Health Policy Development," *Journal of the American Geriatrics Society* 42 (1994): 672–78, 676.

8. See generally Howard I. Kushner, "Women and Suicidal Behavior: Epidemiology, Gender, and Lethality in Historical Perspective," in Silvia Sara Canetto and David Lester, eds., *Women and Suicidal Behavior* (New York, NY: Springer, 1995).

9. Compare Jecker, "Physician-Assisted Death," 676, on reasons physicians might differentially refuse women's requests.

10. See Lawrence Kohlberg, *The Philosophy of Moral Development: Moral Stages and the Idea of Justice*, vol. I (San Francisco, CA: Harper & Row, 1981); Lawrence Kohlberg, *The Psychology of Moral Development: The Nature and Validity of Moral Stages*, vol. II (San Francisco, CA: Harper & Row, 1984).

11. See Carol Gilligan, *In A Different Voice: Psychological Theory and Women's Development* (Cambridge, MA: Harvard University Press, 1982).

12. Gilligan's work has prompted a large literature, building upon as well as criticizing her insights and methodology. See, for example, the essays collected in Larrabee, ed., *An Ethic of Care*. On attention to the ethics of care in bioethics and on feminist criticism of the ethics of care, see my Introduction to this volume.

13. See Kohlberg, *The Psychology of Moral Development*, 644–47.

14. On the Kohlberg–Gilligan debate, see generally Lawrence A. Blum, "Gilligan and Kohlberg: Implications for Moral Theory," in Larrabee, ed., *An Ethic of Care*, 49–68; Owen Flanagan and Kathryn Jackson, "Justice, Care, and Gender: The Kohlberg–Gilligan Debate Revisited," in Larrabee, ed., *An Ethic of Care*, 69–84; Seyla Benhabib, "The Generalized and the Concrete Other: The Kohlberg–Gilligan Controversy and Feminist Theory," in Seyla Benhabib and Drucilla Cornell, eds., *Feminism as Critique: On the Politics of Gender* (Minneapolis, MN: University of Minnesota Press, 1987), 77–95.

15. See, for example, Susan M. Wolf, "Holding the Line on Euthanasia," *Hastings Center Report* 19 (Jan./Feb. 1989): special supp. 13–15.

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

17. See Timothy Egan, "As Memory and Music Faded, Oregon Woman Chose Death," *New York Times*, June 7, 1990, p. A1; Lisa Belkin, "Doctor Tells of First Death Using His Suicide Device," *New York Times*, June 6, 1990, p. A1.

18. See "Doctor Assists in Two More Suicides in Michigan," *New York Times*, October 24, 1991, p. A1 (Wantz and Miller).

19. See "Death at Kevorkian's Side Is Ruled Homicide," *New York Times*, June 6, 1992, p. 10; "Doctor Assists in Another Suicide," *New York Times*, September 27, 1992, p. 32; "Doctor in Michigan Helps a 6th Person To Commit Suicide," *New York Times*, November 24, 1992, p. A10; "2 Commit Suicide, Aided by Michigan Doctor," *New York Times*, December 16, 1992, p. A21.

20. See "Why Dr. Kevorkian Was Called In," *New York Times*, January 25, 1993, p. A16.

21. See B. D. Colen, "Gender Question in Assisted Suicides," *Newsday*, November 25, 1992, p. 17; Ellen Goodman, "Act Now to Stop Dr. Death," *Atlanta Journal and Constitution*, May 27, 1992, p. A11.
22. See Timothy E. Quill, "Death and Dignity—A Case of Individualized Decision Making," *New England Journal of Medicine* 324 (1991): 691–94.
23. On Quill's motivations, see Timothy E. Quill, "The Ambiguity of Clinical Intentions," *New England Journal of Medicine* 329 (1993): 1039–40.
24. Nicole Loraux, *Tragic Ways of Killing a Woman*, Anthony Forster, trans. (Cambridge, MA: Harvard University Press, 1987), 8.
25. *Ibid.*, 12.
26. *Ibid.*, 23.
27. *Ibid.*, 11.
28. Kushner, "Women and Suicidal Behavior," 16–17 (citations omitted).
29. Kushner, "Women and Suicide in Historical Perspective," 195, citing Barbara Welter, "The Cult of True Womanhood: 1820–1860," *American Quarterly* 18 (1966): 151–55.
30. *Ibid.*, 13–19.
31. Gilligan, *In A Different Voice*, 70.
32. *Ibid.*, 132.
33. Loraux in *Tragic Ways of Killing a Woman* notes the single exception of Ajax.
34. See Peter Steinfels, "Help for the Helping Hands in Death," *New York Times*, February 14, 1993, sec. 4, pp. 1, 6.
35. See Charles S. Cleeland et al., "Pain and Its Treatment in Outpatients with Metastatic Cancer," *New England Journal of Medicine* 330 (1994): 592–96.
36. See Robert J. Blendon, U. S. Szalay, and R. A. Knox, "Should Physicians Aid Their Patients in Dying?" *Journal of the American Medical Association* 267 (1992): 2658–62.
37. See William Coryell, Jean Endicott, and Martin B. Keller, "Major Depression in a Non-Clinical Sample: Demographic and Clinical Risk Factors for First Onset," *Archives of General Psychiatry* 49 (1992): 117–25.
38. See Susan D. Block and J. Andrew Billings, "Patient Requests to Hasten Death: Evaluation and Management in Terminal Care," *Archives of Internal Medicine* 154 (1994): 2039–47.
39. Council on Ethical and Judicial Affairs, American Medical Association, "Gender Disparities in Clinical Decision Making," *Journal of the American Medical Association* 266 (1991): 559–62, 561–62.
40. See Nancy S. Jecker, "Can an Employer-Based Health Insurance System Be Just?" *Journal of Health Politics, Policy & Law* 18 (1993): 657–73; Employee Benefit Research Institute (EBRI), *Sources of Health Insurance and Characteristics of the Uninsured: Analysis of the March 1992 Current Population Survey*, EBRI Issue Brief No. 133 (Jan. 1993).
41. The patterns of uninsurance and underinsurance are complex. See, for example, Employee Benefit Resources Institute, *Sources of Health Insurance*. Recall that the poorest and the elderly are covered by Medicaid and Medicare, though they are subject to the gaps and deficiencies in quality of care that plague those programs.
42. Lawrence Schneiderman et al. purport to show that patients already consider burdens to others in making termination of treatment decisions, and—more importantly for this chapter—that men do so more than women. See Lawrence J. Schneiderman et al., "Attitudes of Seriously Ill Patients toward Treatment that Involves High Cost and Burdens on Others," *Journal of Clinical Ethics* 5 (1994): 109–12. But Peter A. Ubel and Robert M. Arnold criticize the

methodology and dispute both conclusions in "The Euthanasia Debate and Empirical Evidence: Separating Burdens to Others from One's Own Quality of Life," *Journal of Clinical Ethics* 5 (1994): 155-58.

43. See, for example, Kushner, "Women and Suicidal Behavior."

44. See Colen, "Gender Question in Assisted Suicides."

45. Another area in which we do not allow apparent patient consent or request to authorize physician acquiescence is sex between doctor and patient. Even if the patient requests sex, the physician is morally and legally bound to refuse. The considerable consensus that now exists on this, however, has been the result of a difficult uphill battle. See generally Howard Brody, *The Healer's Power* (New Haven, CT: Yale University Press, 1992), 26-27; Nanette Gartrell et al., "Psychiatrist-Patient Sexual Contact: Results of a National Survey. Part 1. Prevalence," *American Journal of Psychiatry* 143 (1986): 1126-31.

46. As noted above, though, Nancy Jecker speculates that a physician's tendency to discount women's choices may also come into play. See Jecker, "Physician-Assisted Death," 676. Compare Silvia Sara Canetto, "Elderly Women and Suicidal Behavior," in Canetto and Lester, eds., *Women and Suicidal Behavior*, 215-33, 228, asking whether physicians are more willing to accept women's suicides.

47. See, for example, Susan Sherwin, *No Longer Patient: Feminist Ethics and Health Care* (Philadelphia, PA: Temple University Press, 1992); Barbara Ehrenreich and Deirdre English, *For Her Own Good: 150 Years of the Experts' Advice to Women* (New York, NY: Doubleday, 1978).

48. Sherwin, *No Longer Patient*, 157.

49. Compare Brody, "The Rescue Fantasy," in *The Healer's Art*, ch. 9.

50. Robert A. Burt, *Taking Care of Strangers* (New York, NY: Free Press, 1979), vi. See also Steven H. Miles, "Physicians and Their Patients' Suicides," *Journal of the American Medical Association* 271 (1994): 1786-88. I discuss the significance of the ambivalence in the euthanasia context in Wolf, "Holding the Line on Euthanasia."

51. In an article advocating the legitimation of physician-assisted suicide, the authors nonetheless note the lack of good data on U.S. practice: "From 3 to 37 percent of physicians responding to anonymous surveys reported secretly taking active steps to hasten a patient's death, but these survey data were flawed by low response rates and poor design."-Quill, Cassel, and Meier, "Care of the Hopelessly Ill," 1381 (footnotes with citations omitted).

52. On relevant differences between the United States and the Netherlands, see Jecker, "Physician-Assisted Death;" "Report of the Board of Trustees;" Margaret Battin, "Voluntary Euthanasia and the Risks of Abuse: Can We Learn Anything from the Netherlands?" *Law, Medicine & Health Care* 20 (1992): 133-43.

53. There have been two major teams of researchers. The first, conducting research at governmental request, has produced publications including Loes Pijnenborg, Paul J. van der Maas, Johannes J. M. van Delden, and Caspar W. N. Looman, "Life-terminating acts without explicit request of patient," *Lancet* 341 (1993): 1196-99; Paul J. van der Maas, Johannes J. M. van Delden, and Loes Pijnenborg, "Euthanasia and other Medical Decisions Concerning the End of Life: An investigation performed upon request of the Commission of Inquiry into the Medical Practice concerning Euthanasia," *Health Policy* 22 (1992): 1-262; and Paul J. van der Maas, Johannes J. M. van Delden, Loes Pijnenborg, and Caspar W. N. Looman, "Euthanasia and other medical decisions concerning the end of life," *Lancet* 338 (1991): 669-74. The second team's publications

include G. van der Wal, J. T. van Eijk, H. J. Leenen, and C. Spreeuwenberg, "The use of drugs for euthanasia and assisted suicide in family practice" (Medline translation of Dutch title), *Nederlands Tijdschrift Voor Geneeskunde* 136 (1992): 1299–305; same authors, "Euthanasia and assisted suicide by physicians in the home situation. 2. Suffering of the patients" (Medline translation of Dutch title), same journal 135 (1991): 1599–603; and same authors, "Euthanasia and assisted suicide by physicians in the home situation. I. Diagnoses, age and sex of patients," same journal 135 (1991): 1593–98. More recently the latter group has published Gerrit van der Wal and Robert J. M. Dillmann, "Euthanasia in the Netherlands," *British Medical Journal* 308 (1994): 1346–49; M. T. Muller et al., "Voluntary Active Euthanasia and Physician-Assisted Suicide in Dutch Nursing Homes: Are the Requirements for Prudent Practice Properly Met?" *Journal of the American Geriatrics Society* 42 (1994): 624–29; G. van der Wal et al., "Voluntary Active Euthanasia and Physician-Assisted Suicide in Dutch Nursing Homes: Requests and Administrations," *Journal of the American Geriatrics Society* 42 (1994): 620–23.

54. van der Maas et al., "Euthanasia," *Lancet*.

55. Henk ten Have has pointed out to me that women have also predominated in the court cases on physician-assisted suicide and euthanasia in the Netherlands. Personal communication, April 1993. Ideally, those judicial opinions will be translated into English or be analyzed by someone bilingual, permitting comparison to the textual analysis of U.S. judicial opinions in Steven Miles and Alison August, "Courts, Gender, and 'the Right to Die,'" *Law, Medicine & Health Care* 18 (1990): 85–95.

56. van der Maas, van Delden, and Pijnenborg, "Euthanasia," *Health Policy*, 50.

57. van der Maas et al., "Euthanasia," *Lancet*, 671.

58. Johannes J. M. van Delden, personal communication, April 2, 1993.

59. Pijnenborg et al., "Life-terminating acts without explicit request of patient;" van der Maas, van Delden, and Pijnenborg, "Euthanasia," *Health Policy*, 50; Johannes J. M. van Delden, personal communication, April, 1993. Note that the 1991 *Lancet* article combines euthanasia, physician-assisted suicide, and "life-terminating events without explicit and persistent request," labeling the combination "euthanasia and related MDEL," and reporting a combined gender ratio of 61:39, with males predominating. See van der Maas et al., "Euthanasia," *Lancet*, 670–71. However, as I indicate in text, when you separate the three subcategories, women predominate for euthanasia.

60. Note that in *Lancet*, the researchers addressed both euthanasia and physician-assisted suicide in stating that, "Euthanasia and assisted suicide were more often found in deaths in relatively young men and in the urbanised western Netherlands, and this may be an indication of a shift towards a more demanding attitude of patients in matters concerning the end of life." van der Maas et al., "Euthanasia," *Lancet*, 673. See also Pijnenborg et al., "Life-terminating acts without explicit request of patient." However, in their subsequent *Health Policy* publication, they reported that euthanasia was *not* more often found in men, though physician-assisted suicide was. van der Maas, van Delden, and Pijnenborg, "Euthanasia," *Health Policy*, 50.

61. Johannes J. M. van Delden, personal communication, April 1993.

62. See van der Maas, van Delden, and Pijnenborg, "Euthanasia," *Health Policy*, 52.

63. Compare, for example, "Netherlands: Ethnic Minority Population to Reach One Million by 2000," *Financieele Dagblad*, March 3, 1994 (ethnic minority

population will then be 6.6 percent), with U.S. Department of Commerce, Bureau of the Census, *Statistical Abstract of the United States* 1993, 113th ed., 18 (20 percent of the 1990 population was non-white).

64. Canetto, "Elderly Women and Suicidal Behavior," 225–26 (citation omitted). I am grateful to Alta Charo for suggesting I also consider the preponderance of women in American nursing homes. See *Census of the Population, 1990: General Population Characteristics of the United States* (Washington, DC: Government Printing Office, 1992), 48 (1,278,433 women in nursing homes versus 493,609 men). On suicidal behavior, both attempted and completed, in U.S. nursing homes see Nancy J. Osgood, Barbara A. Brant, and Aaron Lipman, *Suicide Among the Elderly in Long-Term Care Facilities* (New York, NY: Greenwood Press, 1991).

65. There is a substantial literature on the Tuskegee study. See, for example, Arthur L. Caplan, "When Evil Intrudes," Harold Edgar, "Outside the Community," Patricia A. King, "The Dangers of Difference," and James H. Jones, "The Tuskegee Legacy: AIDS and the Black Community," all in "Twenty Years After: The Legacy of the Tuskegee Syphilis Study," *Hastings Center Report* 22 (Nov.-Dec. 1992): 29–40; James H. Jones, *Bad Blood: The Tuskegee Syphilis Experiment* (New York, NY: Free Press, 1981); Allan M. Brandt, "Racism and Research: The Case of the Tuskegee Syphilis Study," *Hastings Center Report* 8 (Dec. 1978): 21–28.

66. See Mark B. Wenneker and Arnold M. Epstein, "Racial Inequalities in the Use of Procedures for Patients with Ischemic Heart Disease in Massachusetts," *Journal of the American Medical Association* 261 (1989): 233–57. See also Robert J. Blendon et al., "Access to Medical Care for Black and White Americans: A Matter of Continuing Concern," *Journal of the American Medical Association* 261 (1989): 278–81; Craig K. Svensson, "Representation of American Blacks in Clinical Trials of New Drugs," *Journal of the American Medical Association* 261 (1989): 263–65.

67. On the intersection of race and gender, for example, see Kimberlé Crenshaw, "Demarginalizing the Intersection of Race and Sex: A Black Feminist Critique of Antidiscrimination Doctrine, Feminist Theory and Antiracist Politics," *Chicago Legal Forum* 1989: 139–67. See also Patricia Hill Collins, *Black Feminist Thought: Knowledge, Consciousness, and the Politics of Empowerment* (New York, NY: Routledge, 1991). On the intersection of race and gender in health, see Evelyn C. White, ed., *The Black Women's Health Book: Speaking for Ourselves* (Seattle, WA: Seal Press, 1990).

68. See, for example, Morton J. Horowitz, "Rights," *Harvard Civil Rights-Civil Liberties Law Review* 23 (1988): 393–406; Mark Tushnet, "An Essay on Rights," *Texas Law Review* 62 (1984): 1363–403.

69. Though there is overlap in the rights critiques of Critical Legal Studies (CLS) and Critical Race Theory, "[t]he CLS critique of rights and rules is the most problematic aspect of the CLS program, and provides few answers for minority scholars and lawyers." Richard Delgado, "The Ethereal Scholar: Does Critical Legal Studies Have What Minorities Want?" *Harvard Civil Rights-Civil Liberties Law Review* 22 (1987): 301–22, 304 (footnote omitted). Patricia Williams, indeed, has argued the necessity of rights discourse: "[S]tatements . . . about the relative utility of needs over rights discourse overlook that blacks have been describing their needs for generations. . . . For blacks, describing needs has been a dismal failure. . . ." Patricia J. Williams, *The Alchemy of Race and Rights* (Cambridge, MA: Harvard University Press, 1991), 151.

70. See, for example, Mary Ann Glendon, *Rights Talk: The Impoverishment of Political Discourse* (New York, NY: Free Press, 1991).

71. Margaret Farley has helpfully traced commonalities as well as distinctions between feminist theory and other traditions, noting that it is wrong to demand of any one critical stream that it bear no relation to the others. See Margaret A. Farley, "Feminist Theology and Bioethics," in Earl E. Shelp, ed., *Theology and Bioethics: Exploring the Foundations and Frontiers* (Boston, MA: D. Reidel, 1985), 163–85.

72. I take the term "rights talk" from Glendon, *Rights Talk*.

73. See, for example, Jean Grimshaw, *Philosophy and Feminist Thinking* (Minneapolis, MN: University of Minnesota Press, 1986), 175.

74. See, for example, Naomi Scheman, "Individualism and the Objects of Psychology," in Sandra Harding and Merrill B. Hintikka, eds., *Discovering Reality: Feminist Perspectives on Epistemology, Metaphysics, Methodology, and the Philosophy of Science* (Boston, MA: D. Reidel, 1983), 225–44, 240.

75. See Jennifer Nedelsky, "Reconceiving Autonomy: Sources, Thoughts and Possibilities," *Yale Journal of Law and Feminism* 1 (1989): 7–36.

76. *Ibid.*, 12–13.

77. See Martha Minow, *Making All the Difference: Inclusion, Exclusion, and American Law* (Ithaca, NY: Cornell University Press, 1990).

78. Another author offering a feminist revision of autonomy and rights is Diana T. Meyers in "The Socialized Individual and Individual Autonomy: An Intersection between Philosophy and Psychology," in Eva Feder Kittay and Diana T. Meyers, eds., *Women and Moral Theory* (Savage, MD: Rowman & Littlefield, 1987), 139–53. See also Elizabeth M. Schneider, "The Dialectic of Rights and Politics: Perspectives from the Women's Movement," *New York University Law Review* 61 (1986): 589–652. There is a large feminist literature presenting a critique of rights, some of it rejecting the utility of such language. See, for example, Catharine MacKinnon, "Feminism, Marxism, Method and the State: Toward Feminist Jurisprudence," *Signs* 8 (1983): 635–58, 658 ("Abstract rights will authorize the male experience of the world.").

79. See, for example, Susan M. Wolf, "Nancy Beth Cruzan: In No Voice At All," *Hastings Center Report* 20 (Jan.-Feb. 1990): 38–41; *Guidelines on the Termination of Life-Sustaining Treatment and the Care of the Dying* (Bloomington, IN: Indiana University Press & The Hastings Center, 1987).

80. John Stuart Mill, "On Liberty," in Marshall Cohen, ed., *The Philosophy of John Stuart Mill: Ethical, Political and Religious* (New York, NY: Random House, 1961), 185–319, 304.

81. Leon R. Kass also argues against the existence of a "right to die" in "Is There a Right to Die?" *Hastings Center Report* 23 (Jan.-Feb. 1993): 34–43.

82. The Dutch studies show that even when patients know they can get assisted suicide and euthanasia, three times more patients ask for such assurance from their physicians than actually die that way. See van der Maas et al., "Euthanasia," *Lancet*, 673.

83. On these obligations and their derivation, see Leon R. Kass, "Neither for Love nor Money: Why Doctors Must Not Kill," *The Public Interest* 94 (Winter 1989): 25–46; Tom L. Beauchamp and James F. Childress, *Principles of Biomedical Ethics*, 4th ed. (New York, NY: Oxford University Press, 1994), 189, 226–27.

84. See Leslie Bender, "A Feminist Analysis of Physician-Assisted Dying and Voluntary Active Euthanasia," *Tennessee Law Review* 59 (1992): 519–46, making a "caring" argument in favor of "physician-assisted death."

85. Brody, "Assisted Death."

86. James Rachels offers a like proposal. See Rachels, *The End of Life*.

87. For a summary of the debate over the proper structure of bioethics, see David DeGrazia, "Moving Forward in Bioethical Theory: Theories, Cases, and

Specified Principlism," *Journal of Medicine and Philosophy* 17 (1992): 511–40. There have been several different attacks on a bioethics driven by principles, which is usually taken to be exemplified by Beauchamp and Childress, *Principles of Biomedical Ethics*. Clouser and Gert argue for a bioethics that would be even more "top-down" or deductive, proceeding from theory instead of principles. See K. Danner Clouser and Bernard Gert, "A Critique of Principlism," *Journal of Medicine and Philosophy* 15 (1990): 219–36. A different attack is presented by Ronald M. Green, "Method in Bioethics: A Troubled Assessment," *Journal of Medicine and Philosophy* 15 (1990): 179–97. Hoffmaster argues for an ethnography driven, "bottom-up" or inductive bioethics. Barry Hoffmaster, "The Theory and Practice of Applied Ethics," *Dialogue* XXX (1991): 213–34. Jonsen and Toulmin have urged a revival of casuistry built on case-by-case analysis. Albert R. Jonsen and Stephen Toulmin, *The Abuse of Casuistry: A History of Moral Reasoning* (Berkeley, CA: University of California Press, 1988). Beauchamp and Childress discuss these challenges at length in the 4th edition of *Principles of Biomedical Ethics*.

88. See Gilligan, *In A Different Voice*, 174. Lawrence Blum points out that Kohlberg himself stated that "the final, most mature stage of moral reasoning involves an 'integration of justice and care that forms a single moral principle,' " but that Kohlberg, too, never spelled out what that integration would be. See Lawrence A. Blum, "Gilligan and Kohlberg: Implications for Moral Theory," *Ethics* 98 (1988): 472–91, 482–83 (footnote with citation omitted).

89. See Blum, "Gilligan and Kohlberg," 477.

90. Owen Flanagan and Kathryn Jackson, "Justice, Care, and Gender: The Kohlberg-Gilligan Debate Revisited," in Larrabee, ed., *An Ethic of Care*, 69–84, 71.

91. Martha Minow and Elizabeth V. Spelman, "In Context," *Southern California Law Review* 63 (1990): 1597–652, 1625.

92. *Ibid.*, 1629.

93. *Ibid.*, 1630–31.

94. *Ibid.*, 1632–33.

95. There are significant similarities here to Henry Richardson's proposal of "specified principlism." See DeGrazia, "Moving Forward in Bioethical Theory."

96. On the importance of paying attention to who is doing the theorizing and to what end, including in feminist theorizing, see Maria C. Lugones and Elizabeth V. Spelman, "Have We Got a Theory for You! Feminist Theory, Cultural Imperialism and the Demand for 'The Woman's Voice,'" *Women's Studies International Forum* 6 (1983): 573–81.

97. I have elsewhere argued that health care institutions should create processes to uncover and combat sexism and racism, among other problems. See Susan M. Wolf, "Toward a Theory of Process," *Law, Medicine & Health Care* 20 (1992): 278–90.

98. On the importance of viewing the medical profession in the context of the democratic polity, see Troyen Brennan, *Just Doctoring: Medical Ethics in the Liberal State* (Berkeley, CA: University of California Press, 1991).

99. See, for example, Howard J. Curzer, "Is Care A Virtue For Health Care Professionals?" *Journal of Medicine and Philosophy* 18 (1993): 51–69; Nancy S. Jecker and Donnie J. Self, "Separating Care And Cure: An Analysis Of Historical And Contemporary Images Of Nursing And Medicine," *Journal of Medicine and Philosophy* 16 (1991): 285–306.

100. Compare Canetto, "Elderly Women and Suicidal Behavior," finding evidence of this with respect to elderly women electing suicide.

101. See van der Maas, van Delden, and Pijnenborg, "Euthanasia," *Health Policy*, 51–55, 145–46; van der Wal et al., "Voluntary Active Euthanasia and Physician-Assisted Suicide in Dutch Nursing Homes."

102. See Quill, Cassel, and Meier, "Care of the Hopelessly Ill."

103. In these two sentences, I disagree both with Kass's suggestion that the core commitments of medicine are set for all time by the ancient formulation of the doctor's role and with Brock's assertion that the core commitment of medicine is to do whatever the patient wants. See Kass, "Neither for Love Nor Money;" Dan Brock, "Voluntary Active Euthanasia," *Hastings Center Report* 22 (Mar.-Apr. 1992): 10–22.

104. See Jay Katz, *The Silent World of Doctor and Patient* (New York, NY: Free Press, 1984), 121–22.

105. See Miles and August, "Gender, Courts, and the 'Right to Die.' "

106. While a large literature analyzes the relationship between terminating life-sustaining treatment and the practices of physician-assisted suicide and euthanasia, more recently attention has turned to the relationship between those latter practices and abortion. On the question of whether respect for women's choice of abortion requires legitimization of those practices, see, for example, Seth F. Kreimer, "Does Pro-choice Mean Pro-Kevorkian? An Essay on *Roe*, *Casey*, and the Right to Die," *American University Law Review* 44 (1995): 803–54. Full analysis of why respect for the choice of abortion does not require legitimization of physician-assisted suicide and euthanasia is beyond the scope of this chapter. However, the courts themselves are beginning to argue the distinction. See *Compassion in Dying v. Washington*, 49 F.3d 586 (9th Cir. 1995). On gender specifically, there are strong arguments that gender equity and concern for the fate of women demand respect for the abortion choice, whereas I am arguing that gender concerns cut the other way when it comes to physician-assisted suicide and euthanasia.