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A FEMINIST EXPLORATION OF ISSUES AROUND ASSISTED DEATH

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I. INTRODUCTION

Although a great deal of public attention has recently been focused on issues around assisted death remarkably little of it has come from an explicitly feminist perspective. This is a serious omission at a time when legislators are feeling pressure to review and perhaps revise existing policies on assisted death, and when the policies they contemplate may have a significant negative and disproportionate impact on women. We think it is essential that there be some discussion of these issues from an explicitly feminist perspective in order to ensure that concerns about the oppression of women become part of the public debate in this controversial field.

In an effort to begin the needed debate, we shall identify and explore the central issues associated with the subject of assisted death that have particular salience from a feminist perspective. In the process, we shall also develop our own position regarding these issues. We support a limited permissive legislative policy, provided that it is sensitive and responsive to the many ways in which oppression can complicate decision-making around assisted death. We believe that oppression increases the risk of assisted death policies (both permissive and restrictive) operating to the detriment of those who are oppressed. Ultimately, the best protection against such operation may be to eliminate oppression and thereby reduce the likelihood of detrimental treatment of the most vulnerable members of society. In the meantime, however, it is essential that guidelines be drafted to prevent the detrimental treatment of the most vulnerable and devalued members of society when new policies are

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introduced or old ones are confirmed.

II. DEFINITIONS

An initial difficulty with any discussion of assisted death is that the definitions of many of the terms used in the debates surrounding this highly charged subject are themselves the focus of much controversy. Whenever the subject matter is as highly contentious and political as in this debate, it is common for proponents of the various well-defined positions on these matters to make their own views appear more attractive and those of their opponents seem especially unreasonable by claiming the authority to define the terms of the debate. (For example, in the jockeying for position that is characteristic of abortion debates, some of those in support of restrictive policies prefer to label their position "pro-life" and that of their opponents, "pro-abortion"; some defenders of a permissive abortion policy, in contrast, call themselves "pro-choice" and label the opposition "anti-choice").

In an effort to reduce possible misunderstandings in our discussion, we will first define some of our terms. We will try to do so in a way that is as non-contentious as possible and we will resist the temptation to enter into debates about terms at this stage. Wherever possible, we will choose the most neutral definition available so as to match the widest use possible. We mean simply to make explicit our assumptions by stipulating the following definitions:

1. "Feminism" — a system of thought and action grounded in the beliefs that women are subject to systemic oppression (in forms that tend to vary significantly among different groups of women) and that this oppression should be exposed and eliminated.¹

2. "Oppression" — the disproportionate reduction (not caused by nature or free choice) of the options or the freedom to choose among the options available to members of a group defined by morally irrelevant characteristics,

¹. It must be noted that feminism is not a monolithic system. There are many kinds of feminism (e.g., liberal feminism, radical feminism, and socialist feminism). See generally FEMINISM AND PHILOSOPHY: ESSENTIAL READINGS IN THEORY, REINTERPRETATION, AND APPLICATION (Nancy Tuana & Rosemarie Tong eds., 1995) (defining various forms of feminism). However, the beliefs outlined in this definition are the common threads through the diversity of feminist thought.

It must also be noted that the exposure and elimination of the oppression of women is frequently one of a number of goals for feminists. Other goals often include the exposure and elimination of the oppression of people on the basis of their race and class. See generally Kimberle Crenshaw, Demarginalizing the Intersection of Race and Sex: A Black Feminist Critique of Antidiscrimination Doctrine, in FEMINIST LEGAL THEORY: READINGS IN LAW AND GENDER 57-80 (Katharine T. Bartlett & Rosanne Kennedy eds., 1991). We find all forms of oppression problematic, thus our discussion of oppression in this paper will reflect concerns about race, class, etc.
here sex. 2

(3) “Assisted death” — death that results from an intentional act or omission of a second person. This term includes the following activities:

(a) “Withholding of life-sustaining treatment” — the failure to start treatment that has the potential to sustain the life of a person.

(b) “Withdrawal of life-sustaining treatment” — the stopping of treatment that has the potential to sustain the life of a person.

(c) “Provision of life-shortening palliative treatment” — the provision of drugs in amounts known to be likely to shorten a person’s life, but provided for the purpose of alleviating suffering. 3

(d) “Assisted suicide” — the act of intentionally killing oneself with the assistance (i.e., the provision of knowledge and/or means) of another.

(e) “Euthanasia” — an act undertaken by one person with the intention of ending the life of another person to relieve that person’s suffering where that act is the cause of death.

(f) “Voluntary” — in accordance with the wishes of a competent individual or with the wishes expressed in an advance directive 4 from a previously competent individual.

(g) “Nonvoluntary” — without the knowledge of the wishes of a competent or incompetent individual.

(h) “Involuntary” — against the wishes of a competent individual or advance directive.

III. THE NEED FOR A FEMINIST ANALYSIS

Much public attention has recently been focused on issues around assisted death. There have been a number of high profile cases in both Canada and the United States that have stirred considerable public debate, especially Rodriguez v. British Columbia 5 and Regina v. Latimer 6 in the former, and ranging from

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2. Note that characteristics may be morally relevant with respect to one set of options but not another. For example, we think that the characteristic of being a convict is morally relevant with respect to freedom of movement, but not with respect to the freedom to read. For a full discussion of the concept of oppression, see IRIS MARION YOUNG, JUSTICE AND THE POLITICS OF DIFFERENCE (1991).

3. Note that this is a subset of “palliative care,” or care aimed at the alleviation of suffering rather than cure.

4. “Advance directives” are directions given by a competent individual concerning what and/or how health care decisions should be made in the event that at some time in the future the individual becomes incompetent to make such decisions. Advance directives can be divided into two categories: instruction directives (commonly known as living wills); and proxy directives (commonly known as durable powers of attorney for health care). Instruction directives set out what and/or how health care decisions are to be made, and proxy directives set out who is to make them. See Jocelyn Downie, "Where There Is a Will, There May Be a Better Way": Legislating Advance Directives, 12 HEALTH L. CAN. 73, 73-80 (1992).


Cruzan v. Director, Missouri Department of Health\textsuperscript{7} to People v. Kevorkian\textsuperscript{8} in the latter. In addition, in the United States, several states, such as California,\textsuperscript{9} Oregon,\textsuperscript{10} and Washington,\textsuperscript{11} have held referenda on decriminalizing assisted suicide.

There is increasing pressure on legislators to revisit their policies around assisted death. Interested groups are lobbying politicians to modify the legal status of assisted death, with some pushing for more restrictive policies (or at least more effective, or more effectively enforced, restrictive policies) and others for more permissive policies. Legislators are clearly feeling the political pressure. For example, in Canada, a Special Senate Committee studied the issues for more than a year and released its report in June 1995.\textsuperscript{12} However, in spite of the vast academic literature and public debate on these issues, very little has been written or said from an explicitly feminist perspective. There are at least three important reasons to explore the issues around assisted death from a feminist perspective.

A. To Influence Policies and Precedents That Have Oppressive Implications for Women

Policies and precedents with respect to issues around assisted death are currently being set in many countries. Many of these policies and precedents may have oppressive consequences for women. Yet, feminists are having little input into the formation of these policies and precedents. Since feminism provides a framework for recognizing the oppressive potential of many public policies, we believe that it is important to explore the issues around assisted death from an explicitly feminist perspective.

1. Policies and Precedents

Many countries are in the process of setting permissive policies and precedents on the withholding and withdrawal of life-sustaining treatment. Consider the following examples:

*Permissive policies*

The British House of Lords Select Committee on Medical Ethics recently issued a report which said that the withholding and withdrawal of life-

\textsuperscript{7} 497 U.S. 261 (1990).
\textsuperscript{9} California's Proposition 161 was defeated in November 1992.
\textsuperscript{10} 1995 OR. LAWS 3 (L.M. 16) (1995). On December 27, 1994, federal district Judge Michael Hogan enjoined the state from enforcing the law. Injunction No. 94-6467-HO.
\textsuperscript{11} The Washington Initiative 117 was written as a series of amendments to its Natural Death Act of 1979.
\textsuperscript{12} \textit{SPECIAL SENATE COMM. ON EUTHANASIA AND ASSISTED SUICIDE, OF LIFE AND DEATH: REPORT OF THE SPECIAL SENATE COMMITTEE ON EUTHANASIA AND ASSISTED SUICIDE} (1995).
sustaining treatment upon the request of a competent patient should not be illegal. In addition, the voters of the state of Oregon recently passed a referendum to decriminalize physician-assisted suicide.

*Permissive precedents*

In *Rodriguez*, the Supreme Court of Canada said that competent individuals have the right to refuse treatment even if the consequence of such a refusal is death. In *Cruzan*, the Supreme Court of the United States affirmed the right of individuals to refuse life-sustaining treatment (either directly when competent or indirectly when incompetent).

At the same time, and sometimes in the same jurisdictions, there is also a contrasting move to more restrictive policies and precedents on assisted suicide and euthanasia. For example:

*Restrictive policies*

The Canadian Special Senate Committee on Euthanasia and Assisted Suicide recently rejected calls for changes to the current legal prohibitions against euthanasia and assisted suicide. In California and Washington, referenda proposing the decriminalization of assisted suicide were defeated at the polls.

*Restrictive precedents*

In 1993, the Supreme Court of Canada held that the restrictive assisted suicide provisions of the *Criminal Code* did not breach the *Canadian Charter of Rights and Freedoms*. In 1995, the Michigan Supreme Court rejected Dr. Kevorkian’s constitutional challenge to the restrictive Michigan assisted suicide *Criminal Code* provisions and the United States Supreme Court refused to hear his appeal of that decision.

2. Possible Oppressive Consequences

Policies and precedents on assisted death may have oppressive consequences for women. Consider the following hypothetical, though not atypical,
examples:

i) A group of policy-makers is persuaded by the argument that expanding palliative care (and, in particular, palliative care provided in the home) will greatly reduce if not eliminate requests for assisted suicide and euthanasia. They therefore put in place a policy which restricts assisted suicide and euthanasia and, at the same time, calls for a massive expansion of palliative care (particularly care provided in the home). No feminists have appeared before these policy-makers and no policy-maker seems to have noticed that the burden of care of the terminally ill in the home falls disproportionately on women. Not having been sensitized to look for the specific impact of policies on women and other oppressed groups, the policy-makers do not recognize this fact. Therefore, they make no mention in their proposed policy of the need for a respite care system and other systems designed to try to prevent women from being further disadvantaged in the workplace because of the increased, and disproportionately distributed, demands of caregiving in the home. Thus, a policy that in practice will have oppressive consequences for women is implemented.

ii) A group of policy-makers are persuaded by arguments made in support of a limited permissive policy with respect to assisted death. Through guidelines, they restrict access to assisted death to those individuals deemed competent by two physicians. No feminists have appeared before these policy-makers to point out the fact that women are more often judged incompetent than men and that social biases against women have been incorporated into traditional medical competency standards. Again, the policy-makers do not recognize this fact. Therefore, they make no mention in their policy of the need for competency standards to be developed that do not unfairly disqualify women. Thus, a policy that, in practice, will have oppressive consequences for women is implemented.

3. Feminist Input

To date, assisted death has not been widely recognized as a feminist issue and an explicitly feminist analysis has not been applied to the formation of any of these permissive and restrictive policies and precedents. In support of this claim, we rely on the following facts. First, no feminist groups intervened in any of the high-profile assisted death cases in Canada or the United States. Second, although there is a vast literature on assisted death, very little has been written from an explicitly feminist perspective. Even casting a wide net (i.e., with broad criteria for inclusion), we found only five papers in a search of North American literature through 1995. It is interesting to note that only

23. Leslie Bender, A Feminist Analysis of Physician-Assisted Dying and Voluntary Active Euthanasia, 59 TENN. L. REV. 519 (1992); Alice Lind, Hospitals and Hospices: Feminist Decisions About Care for the Dying, in HEALING TECHNOLOGY: FEMINIST PERSPECTIVES 263 (Kathryn Strother Ratcliff et al. eds., 1989); Steven H. Miles & Allison August, Courts, Gender
one of the existing books on women, health care, and ethics really addresses these issues (e.g., Helen Bequaert Holmes and Laura M. Purdy,24 Susan Sherwin,25 Mary Briody Mahowald,26 Susan Wolf27). Third, no feminist groups or individuals articulating a feminist position testified before the Canadian Senate Committee or submitted written briefs.28 Thus, explicit feminist input into the setting of policies and precedents has, to date, been minimal.

B. To Combat Oppression That Produces Gender Patterns

Gender patterns are emerging in the area of assisted death that merit investigation. There are several reasons for concern. First, almost all of the legal cases involving assisted death in Canada and the United States have involved women as the individuals who would receive the assistance (either directly or through their surrogate decision-makers). The "classic" court cases in the United States involved Karen Ann Quinlan,29 Nancy Cruzan,30 and Elizabeth Bouvia.31 The "classic" court cases in Canada involved Sue Rodriguez,32 Nancy B.,33 and Mrs. Malette.34 Most of the American state appellate level cases regarding the withholding or withdrawal of life-sustaining treatment have involved women refusing treatment.35 Most of the Canadian

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24. FEMINIST PERSPECTIVES IN MEDICAL ETHICS (Helen Bequaert Holmes & Laura M. Purdy eds., 1992).
27. FEMINISM & BIOETHICS: BEYOND REPRODUCTION (Susan M. Wolf ed., 1996) is the notable exception to this trend. It includes an essay by Susan Wolf. Regrettably, it was not available until just before this article went to press.
28. It is interesting to note, however, that the British Columbia branch of REAL Women and the National Coalition of Concerned Mothers, among other strongly anti-feminist groups, did testify before the Committee. In addition to these groups, Women Alive and Women for Life, Faith, and Family submitted written briefs but did not testify.
35. Miles & August, supra note 23, at 85-86. Of the twenty-two decisions between 1976 and 1989 regarding previously competent persons without written advance directives, thirty-six percent
withholding and withdrawal cases have involved women refusing treatment (and it is interesting to note that where the Canadian withholding and withdrawal cases have not involved women, they have involved men whose autonomy was compromised and hence, like women, they can be viewed as being disempowered—one was a prisoner and two were psychiatric patients). Moreover, the majority of Dr. Kevorkian's "clients" have been women.

Further, women's wishes concerning the withholding and withdrawal of life-sustaining treatment have been treated differently than men's by American courts. In Courts, Gender and "The Right to Die," Steven Miles and Allison August examined all civil state appellate-level "right-to-die" cases involving incompetent, adult patients between 1976 and 1989. They found slightly gender-patterned results. The courts ordered continuation of life-prolonging care in two of the fourteen cases involving profoundly ill, previously competent women who did not have advance directives but made no such order in the eight similar cases involving men.

More significantly, they found seriously gender-patterned reasoning. There were twenty-two cases involving newly incompetent persons without written advance directives. In seventy-five percent of the cases involving men but only fourteen percent of the cases involving women, the courts constructed the preference for medical care from the memories and insights of family and friends. In twelve percent of the cases involving men but forty-three percent of the cases involving women, the decision was held to belong to the family/guardian. In twelve percent of the cases involving men but twenty-one percent of the cases involving women, the decision was held to be a medical matter. In zero percent of the cases involving men but twenty-one percent of the cases involving women, the decision was held to belong to the health care institution.

involved men and sixty-four percent involved women. Id.

39. Osgood & Eisenhandler, supra note 23, at 362. At least sixty-three percent of Dr. Kevorkian's "clients" have been women. Id.
40. Miles & August, supra note 23, at 85-95.
41. Id. at 85 n.3. It might be argued that Miles and August's sample size was too small to justify drawing conclusions. However, while the conclusions drawn by Miles and August are based on a small number of cases, they are not extrapolations from data on a small subset of a large set of cases. The twenty-five cases discussed in the article are all the cases, and so their conclusions about what the courts have been doing are not vulnerable to sample size criticisms.
42. Id. at 85.
43. Id. at 86.
There were three cases involving incompetent persons with written advance directives (one man and two women). The court rejected the living will of one of the women and accepted the living wills of the man and one of the women. However, even in the cases involving the acceptance of the living wills, the courts required that a higher burden of proof be met for the woman than for the man.\(^\text{44}\)

Through a careful analysis of the reasoning in the twenty-two cases involving newly incompetent persons without written advance directives, Miles and August conclude that:

[There are] four major differences in how courts speak of previously competent women's or men's moral preferences. The first difference is the courts' view that a man's opinions are rational and a woman's remarks are unreflective, emotional, or immature. Second, women's moral agency in relation to medical decisions is often not recognized. Third, courts apply evidentiary standards differently to evidence about men's and women's preferences. Fourth, life-support dependent men are seen as subjected to medical assault; women are seen as vulnerable to medical neglect.\(^\text{45}\)

They further conclude that:

Gender profoundly affects judicial analysis of the right-to-die cases. Judicial reasoning about men stresses the role of personal autonomy in these controversial decisions. Judicial reasoning about women examines the role of caregivers.\(^\text{46}\)

Feminism teaches us that oppression can be so pervasive and insidious that its components can often be difficult to recognize. Hence, whenever a gender pattern emerges, it ought to be explored to determine whether it is caused by gender oppression. If it is, then that oppression must be combated. Because gender patterns have emerged around assisted death, these patterns need to be explored to determine whether they are caused by gender oppression. If they are, then the practices and underlying assumptions giving rise to the patterns must be challenged.

C. To Avoid Oppressive Implications for Other Issues

The subject of assisted death involves a potent mix of health matters, medical involvement, individual autonomy, and life and death deliberations. In that respect, it is connected in many people's minds with other issues that affect women's social and political status, namely abortion and forced obstetrical interventions. We believe that restrictive positions on abortion and permissive positions on (i.e., legal tolerance of) forced obstetrical interventions

\(^{44}\) Id. at 91.
\(^{45}\) Id. at 87.
\(^{46}\) Id. at 91.
both contribute in very significant ways to the oppression of women in society. Thus, we are concerned about the implications of the analysis of issues around assisted death for these two related issues. It is important that feminists develop arguments that support values promoting women’s empowerment through the full range of all related issues. To empower women in one sphere, for example through a policy in assisted death, that can be used to disempower them in another, for example, abortion, would hardly count as feminist if the ultimate impact is the further entrenchment of women’s oppression.

One argument is especially salient in this regard. Consider the way in which positions on assisted death are expressed. Discussions of assisted death often involve reference to the principles of sanctity of life and autonomy.\(^\text{47}\) If, as it commonly is, a restrictive position on euthanasia and assisted suicide is expressed starkly as “the sanctity of life trumps autonomy, therefore assisted suicide and euthanasia should not be permitted,” then this position may be taken by many to imply the positions that “the sanctity of life trumps autonomy, therefore abortion should not be permitted” and “the sanctity of life trumps autonomy, therefore forced obstetrical interventions should be permitted.” Since this stark expression can be taken to prescribe not only a restrictive position on assisted death but also a restrictive position on abortion and a permissive position on forced obstetrical interventions (both positions that seriously disempower women), we believe that it is dangerous to women to allow a restrictive position on assisted death to be supported through such an expression. At the very least, a more nuanced expression of the restrictive position on assisted suicide and euthanasia is needed if negative implications for the related issues of abortion and forced obstetrical interventions are to be avoided.

Consider, also, the implications for abortion and forced obstetrical interventions of the courts’ gender-patterned reasoning about end-of-life decisions discussed in the previous section. As Miles and August note in *Courts, Gender and “The Right to Die”*:

Such gender patterned reasoning may be relevant to the debate about legal medical abortion, as well . . . . We find that women are disadvantaged in having their moral agency taken less seriously than that of men when a controversial medical decision is evaluated by a court. If this is generally true, the gender pattern in the “right-to-die” cases is more than a peephole on a troubling, but small, set of court decisions. The gender pattern is a lens which can magnify our understanding of the interaction of gender and jurisprudence.\(^\text{48}\)

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47. See generally Special Senate Comm. on Euthanasia and Assisted Suicide, *supra* note 12, at 55, 64 (discussing the principle of the sanctity of life and autonomy).

48. Id. at 92-93.
When courts have been given the scope to engage in gender-patterned reasoning, they have, historically, discriminated against women on matters involving medical care and decision-making. It is very important that we ensure that the policies and procedures governing assisted death not be developed in such a way as to invite the courts to engage in gender-patterned reasoning that may have implications not only for women's treatment in assisted death matters, but also for matters of managing or terminating their pregnancies. To guard against such policy implications, we believe that some feminists should examine the ways in which positions on assisted death are expressed, carefully examine the concepts and arguments underlying these positions, and carefully examine the reasoning patterns employed by the courts in assessing women's end-of-life decisions.

IV. A FEMINIST ANALYSIS OF THE ISSUES AROUND ASSISTED DEATH

Before entering into a feminist analysis of issues centering around assisted death, it is necessary to set out and explain two limits on the scope of our discussion. The non-feminist arguments against and in favor of a permissive policy with respect to assisted death have been thoroughly canvassed elsewhere and we will not duplicate those efforts here. In addition, we will focus only on voluntary assisted suicide and euthanasia. We limit our focus in this way for two reasons. First, the current debate about policies regarding assisted death is primarily focused on voluntary assisted suicide and euthanasia. Nonvoluntary withholding and withdrawal of life-sustaining treatment and the provision of life-shortening palliative treatment are widely accepted. Involuntary withholding and withdrawal of life-sustaining treatment, the provision of life-shortening palliative treatment, assisted suicide, and euthanasia are widely rejected. We take no exception to either of these widely accepted positions. What remains controversial is nonvoluntary and voluntary assisted suicide and euthanasia. However, the arguments in favor of nonvoluntary assisted suicide and euthanasia are somewhat different from the arguments in favor of voluntary assisted suicide and euthanasia and, in our view, are not particularly feminist. Since the focus of this paper is on a

51. Id. at 100 (noting that involuntary euthanasia is considered "unacceptable" by most).
feminist analysis of issues around assisted death, and since the acceptance of voluntary assisted suicide and euthanasia is the less controversial of the two remaining forms of controversial assisted death (and hence is likely to be the first, if not only, step on the path toward a more permissive policy), we shall focus on voluntary assisted suicide and euthanasia. The issue of nonvoluntary assisted suicide and euthanasia must remain the topic for a separate paper.

That said, we shall first make explicit our own argument in support of a limited permissive policy with respect to voluntary assisted suicide and euthanasia. Then we will consider a number of arguments against a permissive policy which we think involve special concerns for feminists and, hence, merit detailed discussion. Finally, we will explain the shape that a permissive policy must take if it is to be sensitive to feminist concerns and we will provide a theoretical basis for such a policy.

A. A Feminist Case in Support of a Limited Permissive Policy

The principal argument in favor of a permissive policy is one of respect for autonomy. Respect for autonomy requires that the choices freely made by an informed and competent individual be respected by others regardless of the consequences for the individual, so long as the choices do not harm others.53

Respect for autonomy supports a limited permissive policy with respect to assisted suicide and euthanasia in the following way:

i) If an individual is competent, then that individual should be free to do or not to do whatever she wishes (as long as the act or omission will not harm others). As long as assisting the act of suicide or euthanizing does not harm anyone other than the individual who is freely acting or being acted upon, then the state should not interfere. This means that, for competent individuals, voluntary assisted suicide and euthanasia should be permitted.

ii) If an individual is incompetent but, when competent, expressed her wishes with respect to assisted suicide and euthanasia, then her surrogate should follow those wishes and again voluntary assisted suicide and euthanasia should be permitted.

We believe that health care decisions, especially those associated with the beginning and end of life, are of such fundamental concern to the person whose life is most directly affected that it is essential to allow her the authority to decide such matters. Restrictive state policies that limit the ability of an individual to choose assisted death falsely presume that the state is in a better position than the individual to determine if continued life is a benefit to her.

53. Obviously, respect for autonomy must be balanced against other concerns (e.g., harm to others). If a great deal of harm will befall others, it may be the case that the failure to respect autonomy will be morally justified. However, we believe that it is important not to build a limit concerning levels of harm into the definition of respect for autonomy.
They violate autonomy in a very deep way on a matter that is of fundamental interest to many individuals.

We believe that the principle of respect for autonomy establishes a strong *prima facie* case in favor of a permissive policy with respect to assisted suicide and euthanasia. At this point, therefore, we shift our attention to the arguments against a permissive policy. While there are many arguments in the literature that oppose a permissive policy with respect to voluntary assisted suicide and euthanasia, we do not find any sufficiently persuasive to justify such a profound intrusion into personal autonomy. We do, however, find that a number of the objections raise special concerns when they are considered from a distinctly feminist perspective. Hence, we shall now explore the objections that give us pause as feminists in order to understand how to respond to these concerns by developing a position sensitive to oppression.

B. **Arguments Against a Limited Permissive Policy**

1. **Slippery Slope**

   The slippery slope argument is commonly expressed in the following terms. If society allows assisted suicide and euthanasia, then there will inevitably be a slide toward the bottom of a slippery slope, and many clearly unacceptable practices will become prevalent. For example, it is feared that we will soon find ourselves unable to prevent involuntary euthanasia of the elderly, the disabled, and other vulnerable individuals. Once it is allowed that one particular life is not worth living and can be deliberately terminated, then there will be no good reason to claim that the lives of the disabled, the elderly, and other vulnerable people are worth living. In order to prevent such an undesirable result, all lives must be valued and assisted suicide and euthanasia must not be permitted. The notorious death camps of Nazi Germany are typically offered as examples of human inability to avoid descent along this objectionable slope.

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54. We should acknowledge here that autonomy is a concept about which many feminists have expressed serious reservations. We share many of these reservations but do not believe that the solution to the problems with autonomy is to abandon the concept. Rather, we believe that the solution is to reconceptualize autonomy. Much more will be said about this feminist reconceptualization of autonomy in section V of this paper.


Before responding to the specific use of the slippery slope argument in this context, it should be noted that a parallel slippery slope argument can be presented to those who use it in the euthanasia debate: if we do not respect autonomous decisions about euthanasia, soon we will not respect any autonomous decisions about the withholding and withdrawal of life-sustaining treatment, and then we will lose respect for all autonomous decisions about medical treatment of any sort. Ignoring autonomy here could lead to gross abuses of autonomy elsewhere, therefore, we ought to respect autonomy in the field of voluntary assisted suicide and euthanasia. Slippery slope arguments can cut many ways.

We should note, also, that if slippage from voluntary euthanasia to nonvoluntary or involuntary euthanasia is possible, then slippage is also possible down the slope from voluntary to nonvoluntary and involuntary withholding and withdrawal of life-sustaining treatment and provision of life-shortening palliative treatment. Yet, voluntary forms of these latter assisted death practices have already been accepted by the courts and are widely accepted (and expected) in North America. Many patients, families, and health care providers take for granted the freedom to comply with patient requests to stop life-sustaining treatment and to provide pain relief at the levels necessary to be effective. The changes in current practice that would be required if such withholding and withdrawal of life-sustaining treatment were to be prohibited or if limitations were imposed on the provision of palliative care are both extensive and intolerable. Yet, if the danger of the slippery slope does not prevent permitting these practices (and we do not think that it should), then it should not prevent permitting assisted suicide and euthanasia.

As noted above, though, the principal focus of most opponents of a permissive policy is on the more contentious cases of assisted suicide and euthanasia. We shall, then, concentrate specifically on the use of slippery slope arguments in this context. It is important to appreciate that slippery slope arguments come in two forms, logical and psychological. In the interest of analytical clarity, we shall examine each type independently.

The logical slippery slope argument can be most readily addressed. It takes the following form: if we allow assisted suicide and euthanasia, we will not be able to draw any meaningful distinction between acceptable and unacceptable killings, and, hence, we will inevitably slide toward the bottom of the slope (i.e., toward allowing involuntary euthanasia and thus the killing of demented patients, mentally handicapped humans, indigent humans, and any other group deemed to be "unfit" for continued existence). However, as with all logical slippery slopes, there is a fairly simple response. If there is a

58. See generally SPECIAL SENATE COMM. ON EUTHANASIA AND ASSISTED SUICIDE, supra note 12, at 37-46.
morally significant difference between the evaluation of life at the top of the slope and the evaluation of life at the bottom of the slope then we have the materials necessary for erecting a barrier on the slope. Or, if there are good reasons for allowing the activities at the top and these reasons are not present at the bottom, then the descent is not logically necessary. Since we can distinguish between different evaluations (for example, evaluations of the value of life made by the subject and evaluations of the value of life made by another person), we can avoid the logical slippery slope even if we allow assisted suicide and euthanasia. As long as we make clear that the judgment of whether or not a life is worth continuing can be made only by the person whose life is at issue and we retain a firm criterion of voluntariness, the horrors of involuntary assisted death disappear. Free and informed consent can function as the barrier on the slope defined by criteria of voluntary choice, rather than external evaluations of quality of life.

The psychological slippery slope argument is more difficult. The argument here is that "once certain practices are accepted, people shall in fact go on to accept other practices as well. This is simply a claim about what people will do, and not a claim about what they are logically committed to." Clearly, this is the more problematic version of the slippery slope for advocates of assisted suicide and euthanasia. The question of whether people would in fact move to involuntary euthanasia if they moved to voluntary assisted suicide and euthanasia is an empirical one; that is, it requires an empirical investigation that has not yet been done (and perhaps cannot be done without a trial period of legal voluntary assisted suicide and euthanasia). Certainly, there are many reasons to doubt the validity of the Nazi experience as an appropriate test, since the death camps were created under a totalitarian regime with little concern for individual autonomy.

A more useful model is that provided by current practice in the Netherlands where a permissive policy is in place. Unfortunately, there are conflicting interpretations of the relevant data emerging from the Netherlands, so the necessary empirical facts are contested. Some people claim that the available data do indeed demonstrate a descent down a slippery slope. However, there are at least two responses to this claim. First, it seems that this claim is based upon misunderstandings of the Dutch data. Proponents of the psychological slippery slope argument cite a recent and comprehensive Dutch study and claim that it revealed that approximately one thousand deaths per year result

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60. Paul J. Van der Maas et al., Euthanasia and Other Medical Decisions Concerning the End of Life, 22 HEALTH POL'Y 669 (1991).
from nonvoluntary euthanasia.\textsuperscript{61} However, this number actually reflects the number of deaths resulting from "life-terminating acts performed without the patient's explicit request" (LAWER) and this category includes deaths resulting from the following: "1 intensification of the treatment of pain and symptoms with a minor shortening of the patient's life as its side-effect. 2 to discontinue or never to commence a life-prolonging treatment. 3 active termination of life at a moment when vital functions already have begun to fail. 4 active termination of life at a moment when the vital functions are still undamaged."\textsuperscript{62} This number, therefore, includes the withholding and withdrawal of life-sustaining treatment and the provision of life-shortening palliative treatment when the patient's wishes are not or cannot be known or are known and are being followed but the letter of the law with respect to documenting consent is not being followed. It is important to recognize that many thousands of deaths occur in North America every year as a result of what the Dutch study calls LAWER, despite existing restrictive legislation against euthanasia. Hence, LAWER deaths cannot be attributed to a slippery slope following a permissive policy. One thousand LAWER deaths in the Netherlands provides no evidence of a descent down a slippery slope.

Second, one can respond that \textit{even if there has been slippage in the Netherlands}, this does not prove that the slide down the psychological slope is \textit{necessary}. The slide could be entirely due to the system in place in the Netherlands,\textsuperscript{63} which is a system that few, if any, people endorse as a system for Canada or the United States. With a different permissive system there might not be any slippage. It is possible to introduce voluntary assisted suicide and euthanasia and then monitor it closely. If there is any sign of slippage down the slope from voluntary to involuntary, then the activities in question can be recriminalized. The dangers of the psychological slippery slope can, therefore, be guarded against within a permissive policy.

Nevertheless, we do think that there are feminist reasons to be concerned about a psychological slippery slope (particularly with respect to the elderly and people with disabilities). Oppressed people are generally undervalued in society. Those whose lives are least valued are most likely to be vulnerable to nonvoluntary (and contrary to the individual's best interests) or involuntary euthanasia if there is any slide down that slope. Further, the general devaluing


\textsuperscript{62} \textit{The Netherlands Ministry of Welfare, Health and Culture, Medical Practice with Regard to Euthanasia and Related Medical Decisions in the Netherlands: Results of an Inquiry and the Government View}, VDB 92-034, 5 (on file with the \textit{Saint Louis University Public Law Review}).

\textsuperscript{63} \textit{See generally} \textit{Special Senate Comm. on Euthanasia and Assisted Suicide, supra} note 12, at 115-48.
of the lives of oppressed people may make such slippage more likely, at least with respect to members of oppressed groups. We believe that there is a danger that members of oppressed groups could be placed at increased risk of harm under permissive policies. Since oppression exposes its victims to a heightened risk of particular forms of violence and exploitation, its combination with a permissive policy on assisted death might be very dangerous. We believe that this danger must be acknowledged and guarded against by being especially vigilant against involuntary and some cases of nonvoluntary assisted death, especially when dealing with individuals who are members of oppressed groups.

However, we believe that it is possible to provide the necessary protection through the guidelines governing a permissive policy on assisted death so long as this danger is acknowledged and guarded against. Moreover, in contrast to current practice, we would include the withholding and withdrawal of life-sustaining treatment and the provision of life-shortening palliative treatment in these guidelines, because oppression raises similar risks of harm with these practices as well. Hence, with respect to any form of voluntary assisted death, when an individual belongs to an oppressed group, it should be made especially clear that the decision to shorten her life is: a) one that she supports; or b) if she is no longer competent, one for which she has previously indicated support.

In sum, we do see a slippery slope risk of harm, but we do not see this risk as grounds for rejecting a permissive policy. Rather, we see it as a factor that requires specific attention in the development of guidelines for a permissive policy.

2. Competence

It is often argued that it is very difficult to assess the competence of dying individuals; their capacity to make autonomous decisions can be compromised by grief, fear of dying, illness, or by the treatments they are receiving for their illness. Proponents of this argument generally suggest that some (if not all) of the individuals who express a wish for assisted suicide or euthanasia are incompetent because individuals who are sufficiently ill to qualify for assisted suicide or euthanasia are likely to have had their competence eroded by pain, disease, drugs, etc.64 It is true that pain, drugs, and disease can impair competence. However, at least three responses can be made to this argument.

First, it must be remembered that competence is not an all-or-nothing concept. That is, one may at any one time be competent to make some decisions and not competent to make others. Even if an individual's competence is compromised by her condition, she might be or become

competent to make a decision about the value or disvalue of continued existence to her. In addition, one's competence can vary over time.

Second, the existence of some individuals who have been rendered incompetent by pain, drugs, or disease does not justify concluding that all individuals with similar pain, drugs, or disease are not competent. Even if some individuals are incompetent because of pain, drugs, or disease, not all individuals will be.

Third, it is possible for individuals who are competent to anticipate future incompetence and set forth their wishes in advance directives. The problem of incompetence caused by pain, drugs, or disease can thus be circumvented in at least some cases (assuming one accepts the legitimacy of advance directives). In addition, the competence argument applies as much to individuals consenting to the withholding or withdrawal of life-sustaining treatment or the provision of life-shortening palliative treatment as it does to assisted suicide and euthanasia. If it does not block accepting the former, why should it block accepting the latter? The same pressures on competence are present in situations in which individuals request the withholding or withdrawal of life-sustaining treatment or the provision of life-shortening palliative treatment, as in situations in which individuals request assisted suicide or euthanasia. If one wishes to use the competence argument against assisted suicide and euthanasia, one has to explain why it is relevant in assisted suicide and euthanasia but not in the withholding and withdrawal of life-sustaining treatment and the provision of life-shortening palliative treatment. We do not believe that this can be accomplished.

Nevertheless, it is important to note that competency is of particular concern when the individuals are women or members of other oppressed groups. Competency standards are typically constructed around the paradigm of members of the most dominant social groups, and they are often biased against members of oppressed groups.

There are problems with respect to competence that particularly plague women. First, competence is often linked to ideals of rationality, but women are more likely than men to be seen as irrational when they are perfectly rational. As Genevieve Lloyd has shown, the very concept of rationality is usually constructed in opposition to the traits that are stereotypically assigned to women (e.g., by requiring rational agents to be objective and emotionally

65. We assume, for the purposes of this paper, that respect for advance directives should be legally required. The debate about this issue is beyond the scope of this paper. See Downie, supra note 4.

66. See Miles & August, supra note 23.
It is important to consider the criteria used to evaluate competency to eliminate gender or other forms of bias that allow this standard to be used to discriminate against the oppressed.

A second, and more complicated, matter is that oppression can contribute to circumstances that make it difficult for women to be fully competent to act autonomously. Oppression tends to rob its victims of some of the necessary traits for exercising autonomy well, such as self-esteem and self-knowledge. While the traditional literature focuses on ways in which internal forces like mental illness can compromise competence, feminism suggests we also pay attention to the subtler ways in which oppression can undermine a person's ability to make decisions in accordance with her own interests or values. Diana Meyers argues that the socialization that most women experience fails to develop the skills necessary for full autonomy, leaving them only minimally autonomous, rather than medially or fully autonomous. It seems, then, that there are reasons for believing that gender socialization reduces women's levels of competency for autonomous decision-making and that it is essential that such discrimination be changed by helping girls and women develop the necessary autonomy skills to improve their levels of competency.

This, however, is not an argument against the use of competency criteria, nor is it an argument for believing that those who are oppressed are insufficiently competent to make autonomous choices about assisted suicide or euthanasia. It is, rather, an argument that suggests the importance of developing oppression-sensitive standards of competency and of paying attention to promoting the development of autonomy-competency in all people, especially those who are subject to oppression.

3. Voluntariness

The concern here is that individuals may not always be acting voluntarily when they make requests for assisted death. For example, it seems plausible to believe that many individuals will see themselves as being a burden on their loved ones or on society in general, and they may feel pressured into choosing an earlier death. Others may be vulnerable to financial or other sorts of pressures that virtually coerce them into consenting to assisted death. Such circumstances suggest that these requests for assisted death are not fully free.

Although this is a legitimate concern, there are several responses to it. First, the fact that an individual is concerned with the well-being of others is

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not evidence that she is not acting voluntarily. People may quite voluntarily
choose to end their lives rather than bankrupt their families in an effort to
prolong a painful existence. Criteria of voluntariness demand that such
individuals be acting in accordance with their own values, not that they be
acting in accordance with their own self-interest, narrowly defined.

In addition, some individuals may see themselves as a burden on their
loved ones or society and jump off a bridge, but that has not led to calls for the
recriminalization of attempted suicide. Why should assisted death be treated
differently? Another response is to suggest that this problem may dissolve in
the face of a sensitive regulatory scheme (one that, for example, includes an
extensive assessment of the voluntariness of a request for an assisted death).
Further, the consistency argument mentioned earlier must be recalled here. The
voluntariness argument applies as much to individuals consenting to the
withholding or withdrawal of life-sustaining treatment or the provision of life-
shortening palliative treatment as it does to assisted suicide and euthanasia. It
does not block accepting the former so it should not block accepting the latter.

Nevertheless, there are reasons for feminists to be concerned about
voluntariness requirements. One reason is that women seem especially prone
to self-sacrifice. As a result, they may be at particular risk of being manipulat-
ed into accepting early death rather than burdening others. After all, part of the
gender socialization for women is towards self-sacrifice and self-abnegation.

Moreover, as noted above, there are reasons to worry that many women are
lacking the requisite autonomy skills to make truly voluntary choices about
these matters. In general, women are raised to be docile and compliant, to fit
into others’ life plans rather than to define their own. They are often deprived
of the opportunity of controlling their reproductive lives, their sexual lives,
their economic lives, and their political lives. They may well be lacking in
opportunities to make autonomous, i.e., suitably voluntary, choices for
themselves, and, hence, not have had the opportunity to develop the necessary
autonomy skills.

However, such a situation cannot be effectively addressed by depriving
them of one more opportunity to exercise autonomy. Putting further
restrictions on the lives of those already limited by oppressive social structures
will neither reduce their oppression nor improve their autonomy skills. Rather,
we need to develop more sensitive measures for evaluating the requisite
standards of voluntariness and more democratic means of promoting the
development of needed autonomy skills. We shall make some suggestions on
these matters in Part V.

4. Home/Palliative Care

Some people claim that assisted suicide and euthanasia should not be
legalized because there are better ways of meeting the concerns that motivate
an interest in assisted death. They suggest that many individuals seek an early
death because they want to escape from the expense and alienation of a
prolonged dying process in hospital. Some argue that most of the requests for
assisted suicide and euthanasia would not be made if there were more home
care and other forms of palliative care available. In their view, increasing these
alternative options will dramatically decrease the demand for assisted suicide
and euthanasia; the number of remaining cases (i.e., of individuals who cannot
be helped by home care or palliative care options) will become so small that
the harms of permitting assisted suicide and euthanasia will then outweigh the
benefits.

However, this argument ignores the fact that the development of home care
and palliative programs is likely to take time. Therefore, while the
harm/benefit ratio may change in the future, the benefits of permitting assisted
suicide and euthanasia outweigh the harms now and will for some time to
come. If and when these alternative options become widely available, then the
issue might be revisited. In the meantime, however, assisted suicide and
euthanasia should be permitted.

Moreover, this argument fails to acknowledge the heavy burden such
programs place on volunteer labor. In overlooking the opportunity costs for the
volunteers involved and for society in general, these arguments tend to obscure
and devalue volunteer labor. Since most palliative and home care volunteers
are women, such arguments reflect a typical pattern in which the types of labor
traditionally done by women are valued less highly than the types of labor
typically done by men. Repeating and reinforcing this familiar pattern further
contributes to the oppression of women.

These arguments also usually overlook the fact that home care is not
always an option. Sometimes an individual’s condition is such that it requires
hospitalization. Further, some people have no homes to return to or their
homes are dangerous for them and are not the safe and comforting spaces
imagined by policy-makers. Not all homes have someone present who can help
to provide care. For example, while most elderly men tend to have wives at
home who can care for them, many elderly women are widowed and alone.
Although individuals who have comfortable homes and supportive family and
friends may well prefer to be at home, many others will be better off in
institutions. We must not develop a model based on the resources available to
those who are greatly advantaged, without paying careful attention to the needs
and opportunities available to less privileged members of society.

Finally, this argument seems to ignore the well-entrenched gendered
division of labor which places a disproportionate share of the burden of home
care on women in our society. There are higher expectations on women than
on men to provide such care, and those who do provide home care are
penalized in the workplace for having home care responsibilities. This is not
per se a counter-argument to the home care argument, but, rather, it is a caveat that if home care is increased without acknowledging and providing a remedy for these inequities, the oppression of women will be increased.

If current trends continue and home care programs are increased, we must find ways of protecting female family members from being disadvantaged by disproportionately distributed burdens. Moreover, we must anticipate and reduce some of the burden that falls on female family members by developing programs that support them, such as respite care programs and employment protection. While we are anxious to promote the expansion of home care and other palliative care programs for those who choose them, we think it essential to insist that female family members be free to refuse to provide the necessary services.

5. Disguised Homicide

Perhaps the most serious argument against a permissive policy on assisted suicide and euthanasia is that there is a risk that such a policy will be abused. That is, acts intended to end life for an improper motive (e.g., to inherit money) will be disguised as assisted suicide or euthanasia, and, thus, acts that should be punished will go unpunished. Advocates of this argument note that motive is difficult to evaluate. How are we to accurately assess whether an individual gave someone a lethal injection to end their suffering or to hasten the receipt of an inheritance? They fear that ignoble motives will be hidden by false descriptions of mercy-killing.

Here, as with the slippery slope argument, we grant that there is some reason for concern, especially when the person whose death is at issue belongs to an oppressed group. Yet, here, too, we think the danger is exaggerated and the concern can be addressed. After all, the law already excuses some other forms of killing even though there is a similar risk of abuse of the permissive policy. For example, a person might kill someone for an inheritance and disguise it as an act of self-defense. The risk of abuse of the policy has not led to a call for finding all those who kill in self-defense guilty of first-degree murder. Why should assisted death be treated any differently?

Furthermore, we think that the best way to address these problems is to develop a sensible set of regulations governing practices of assisted death. If there are strict requirements with respect to consent, then it will be very difficult to abuse the permissive policy and disguise a killing for an ignoble motive as a legal assisted death. However, in drafting those guidelines, it is essential that the special complications of oppression be taken into account, in order to protect those who are most vulnerable under a policy of decriminalized assisted death.

It should be emphasized here that, since it is only in the presence of guidelines that these concerns can be thoroughly investigated and addressed,
we think that the oppressed will actually be better protected from danger under a permissive regime with carefully crafted oppression-sensitive guidelines than they are under a restrictive regime. A permissive policy with regulations can improve safety more effectively than a restrictive policy that drives desperate individuals to seek underground solutions to their intolerable situations.

6. Normalization

Finally, there is reason to worry that if assisted suicide and euthanasia are legalized they may also become normalized. In other words, once the legal restrictions are removed, expectations may develop that persons in certain situations should take advantage of the “opportunity” for assisted death. If we look at the history of medicine, we find countless cases where a procedure introduced to handle one set of problematic cases has quickly been extended and become the norm for all related cases. For example, in pregnancy, the use of ultrasound, electronic fetal monitors, and, increasingly, prenatal genetic diagnosis all began as procedures for exceptional cases, and each has become the normal standard of practice in treating any pregnant woman (or, in the case of prenatal diagnosis, for all women of a certain age). Similarly, cardiopulmonary resuscitation was found to work effectively at saving lives where there was an expectation that patients would fully recover, but it has become the standard practice for all patients who experience heart stoppage unless there is a standing DNR (Do Not Resuscitate) order in place. And while many practitioners and administrators welcome the use of advance directives to guide decision-making, the increased use of these instruments is leading to a state of affairs where some physicians take the absence of an advance directive as evidence that patients want everything done to prevent death. Hence, there is reason to fear that legitimization of assisted suicide and euthanasia may lead to its normalization; once assisted suicide and euthanasia become routine, individuals with poor prognoses may face expectations that they will volunteer for such options. Moreover, increased pressure to reduce health care expenditures can be expected to aggravate this problem.

We do not think that this is an insurmountable obstacle. However, it is very important to acknowledge that there is such a danger. Hence, we stress that our support of a permissive policy on assisted suicide and euthanasia is conditional on its including regulations which make it explicit that no individual should be pressured to accept assisted death or be made to feel that this is the normal and preferred response to their condition.

70. Assuming, of course, in the United States’ context, sufficient insurance coverage.
V. TOWARD A FEMINIST POLICY ON ASSISTED DEATH

Despite the objections considered, we remain supportive of a permissive policy of assisted death based on a firm commitment to a principle of respect for autonomy. However, as foreshadowed earlier, in order to address the concerns associated with oppression that have been identified, we think it essential to modify traditional interpretations of autonomy. We are especially concerned about the development of an autonomy measure that is sensitive to the many ways in which a person’s wishes may be dramatically distorted by a history of oppression. Specifically, we seek a conception of autonomy that can help provide some protection for oppressed members of society against the risk of abuse of a permissive policy governing assisted death practices and can accommodate the fact that one of the many costs of oppression is decreased opportunities to develop a high level of autonomy skills. Legislative policies regarding assisted death must be developed with an awareness of their potentially different effects on differently situated members of society.

Hence, we propose that guidelines regarding practices of assisted death be built around an ideal of autonomy that grounds social policies in a recognition of the difficulties of asserting autonomy in the face of oppression. Here we shift the discussion to a relational ideal of autonomy as the basis for analysis.71

Whereas traditional liberal interpretations of autonomy construct selves as ideally isolated, independent beings, a relational interpretation understands selves to be relationally constructed. Indeed, we reject the traditional liberal individualist conception which views the self solely as a rational, self-conscious, socially unencumbered agent,72 in favor of an understanding of the self as an essentially social being who is at least partly shaped and modified within a web of interconnected relationships. This relational understanding of the self helps us to appreciate that the various relationships in which a person finds herself all play a role, to varying degrees, in fostering or inhibiting her capacity for autonomous action. They are the context for the activities that are ultimately constitutive of autonomy (e.g., defining, questioning, revising, pursuing one’s interests and goals). Both interpersonal and political relationships (i.e., those having to do with personal interactions and those deriving from existing patterns of power, privilege, dominance, and oppression)

71. A relational interpretation of autonomy is developed in Susan Sherwin, A Relational Approach to Autonomy in Health Care (forthcoming).
influence the sort of self that a person becomes.

The exercise of autonomy involves the use of essential capacities and skills (e.g., self-knowledge, self-direction, and self-esteem) which are products of an agent's social experience and situation. Relational autonomy, then, is a capacity that is developed (and constrained) by social circumstances; it is exercised within relationships and social structures which together shape the individual and also determine others' responses to her efforts at exercising autonomy. By recognizing how a person's position within an oppressive power structure can affect her ability to develop the requisite skills for exercising autonomy effectively, we can appreciate that autonomy is a product of personal resources and skills which are themselves, at least partly, a product of structural conditions.

A relational interpretation of autonomy can help us to clarify how voluntariness standards can be adjusted to take into account the burdens of oppression. The standard approach to an assessment of whether a particular decision is an autonomous one is to ask whether there are any external forces directly interfering with the choice. For example, is a woman consenting to participate in a potentially very dangerous research project because her physician has told her that, unless she consents, he will no longer treat her as a patient?

A relational approach is much broader and asks whether there are any external or internal forces directly or indirectly interfering with the choice. We should explain what we mean by these additional elements of internal and indirect. By “internal forces interfering with choice” we mean a woman’s own desires that are grounded in the perceptions of herself and her options that have been oppressively constructed through socialization in such a way that the woman does not accurately perceive herself or her options. By “forces indirectly interfering with choice,” we mean forces that limit the set of options available to the individual. Examples of each of these kinds of forces within the context of assisted death should illustrate these definitions.

“External direct forces” — there is a power imbalance between physicians and patients and this imbalance is particularly strong between male physicians and female patients. As a result, women may be more likely than men to be pressured into decisions about assisted death by their physicians.

73. See generally Meyers, supra note 69, for a full discussion of autonomy skills.

74. “Inevitably, there is a built-in power imbalance in medical encounters: (relatively) healthy, well-educated, affluent doctors provide services to patients who are typically ill and frightened, and, often, are also poor, and lacking in education and social authority. This general difference in power between patients and physicians is further exacerbated by the fact that, most commonly, the patient is female and the physician is male. In fact, according to nearly all of the standard dichotomies supporting dominance in our culture—gender, class, race, ability status—odds are that if there is a difference between the affiliations of physician and patient, the physician is likely to
“External indirect forces” — more women than men are socially and economically disadvantaged, so conditions near the end of life are more often worse for women than for men. As a result, women may have limited options with respect to pain control and other forms of comfort care available to them. Moreover, more women than men end up on their own with no one to care for them. As a result, women may have limited options all of which are unattractive to them.

“Internal direct forces” — sexism and ageism in society cause women (especially older women) to have lower self-esteem than men. This might lead them to see their lives as having less value and to request assisted death more readily than men.

“Internal indirect forces” — since there is so much legal regulation of women’s reproduction, women are more used to having less importance attached to, and more restrictions placed upon, their bodily integrity than men. As a result, they may believe that expressing resistance to treatment that they do not want is not an option available to them.

We are now ready to consider the implications of a relational interpretation of autonomy for a permissive policy for issues around assisted death.

With regard to competence, when confronted with a request for an assisted death, courts and health care professionals should be careful not to assume that women are not rational. They should take care not to fall prey to mistakenly thinking a woman is incompetent because they believe that women are less competent than men or because they fail to understand alternative ways of reasoning (commonly associated with women) and assume incompetence in the face of such reasoning. At the same time, they must not forget that, of course, not all women will be competent to make such decisions. In cases in which women are not sufficiently rational, the response of courts and health care professionals should be to try to help them become rational. If a woman is less than sufficiently competent, the response should be to help find ways to improve her competence.

fall on the dominant side of that distinction and the patient on the subordinate side.” Id. at 1.


76. We are not concerned here with the simple biological fact that men die younger than women do and hence the biological component of a complete explanation for the fact that a greater percentage of women than men are single when they are old. Rather, we are concerned with the societal reasons for a greater percentage of women than men being single when they are old. For example, society has different expectations regarding remarriage for men and women: it is more widely accepted that widowers or divorced men “need” to remarry while widows or divorced women do not, and that older widowers or divorced men will marry younger women while older widows or divorced women will not marry younger men.

77. See Miles & August, supra note 23; see also MEYERS, supra note 69.
Furthermore, society must recognize ways in which oppression generally distorts opportunities to develop competency. It will then be better able to take the steps that are necessary to ensure that members of oppressed groups are given the opportunity to develop needed skills.

With regard to voluntariness, at a macro level, courts, policy-makers, and health care providers should strive to remove external direct forces, increase the options available to women so as to remove external indirect forces, and remove the sources of direct and indirect internal forces. This means, for example: putting in place patient empowerment programs; fighting against poverty, fighting for universal health care, and fighting for more effective and more available palliative care and other forms of comfort care; determining whether (and, if so, why) members of oppressed groups are disproportionately seeking assisted deaths; and improving respect for women’s bodily integrity.

At a micro level, courts and health care professionals should try to remove external direct forces, increase the options available to the woman so as to remove external indirect forces, and assist the woman to reconstruct her perceptions so as to remove the direct and indirect internal forces compromising her freedom. When members of oppressed groups express a desire for assisted death, they should be helped to review and evaluate their choices and be given non-directive counselling to ensure that their decisions are not grounded in low self-esteem which derives from their oppressed status or exploitation by those who traditionally exert power over them. It should further be ensured that death is indeed their preference and that they are not being coerced into this option because they lack the resources to obtain appropriate health care. If their condition can be relieved by health care and if they would prefer to receive health care, then efforts should be made to ensure access to care.

Once a best effort has been made at all of this, then the woman’s wishes should be respected no matter what others may think of the consequences for her and even if her decision seems to be in response to oppressive social conditions. We believe that we ought to fight the forces of oppression and the sources of the forces. However, we do not believe that this fight should be conducted at the expense of individual women; we should fight for women but not fight the women.

VI. CONCLUSION

In the end, it can be concluded that issues around assisted death must be addressed from an explicitly feminist perspective. Without a feminist analysis, policies and precedents around assisted death will continue to be set in the relative absence of a feminist perspective, and women will be ill-served (if not harmed) by these policies and precedents. We believe that a feminist analysis supports a permissive policy with respect to assisted death, provided that care
is taken in establishing the policy to avoid increasing (or failing to decrease) the oppression of women and members of other oppressed groups. A relational vision of autonomy provides the needed safeguards by requiring that the permissive policy be such that distortions resulting from the oppression of women and other groups be attended to and guarded against.

Ultimately, the best way to avoid the risks of harm under assisted death policies (permissive or restrictive) that are faced by members of oppressed groups is to eliminate their oppression. Meanwhile, a policy regarding assisted death, like other social policies, must account for the ways that oppression tends to complicate a person's treatment by the practice at issue. After all, as oppressed members of society, women are especially vulnerable not only to particular sorts of harm under assisted death policies, but also to inadequate health services based on insufficient data about their health needs; to falling into poverty; to being subject to domestic violence and sexual assault; to being excluded from powerful positions in politics and work; and to being assigned a disproportionate share of domestic responsibilities. In each case, the best solution is to eliminate the oppression that makes women more vulnerable to injustice and abuse. The next best solution is to design policies to reduce their vulnerability to the specific harms at issue. So, too, a truly fair and safe practice of assisted death requires eliminating the distorting effects of oppression. Only when oppression itself is fully eliminated can we be confident that our policies regarding assisted death will be fairly administered. In the meantime, we must ensure that safeguards are in place to reduce the added dangers oppression brings in the face of any policy governing assisted death, be it permissive or restrictive.

78. For example, there is not an adequate empirical basis for determining their specific health needs owing to skewed medical research practices. See Rebecca Dresser, Wanted: Single, White Male for Medical Research, 22 HASTINGS CENTER REP. 24, 24-29 (1992).