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# Sex, Suicide, and Doctors

*Gerald Dworkin*

What's purple, hangs on the wall, and whistles?  
I don't know.  
A herring.  
Herrings aren't purple.  
So, paint it purple.  
Herrings don't hang on the wall.  
Hang it on the wall.  
But, herrings can't whistle.  
No analogy is perfect. (Yiddish joke)

Paul J. Weithman's argument is a constitutional one.<sup>1</sup> Agreeing with many liberals that the state may not enforce controversial conceptions of the meaning of life on citizens who disagree, he nevertheless believes that the state may legitimately forbid physician-assisted dying. This is because there is another ground for such a ban. There are legitimate reasons for an absolute prohibition on physicians' ever intending the death of their patients. "The reasons that doctors should hold themselves to a prohibition on intentionally causing their patients' deaths are quite similar to the reasons that doctors should hold themselves to an absolute prohibition on seducing them" (p. 554).

This is an argument from analogy, and I shall argue that the two kinds of cases are sufficiently different in character that the argument fails. The case that Weithman takes to be a settled matter is the absolute prohibition on physicians' intending to seduce their patients. He presents what seems to me a completely successful argument. To show that an absolute prohibition on physicians' intending the death of their patients is required he must show that the features which explain the former prohibition hold (or at least enough of them hold) in the case of the latter prohibition.

I

What are the crucial features that Weithman refers to in the case of doctor-patient sex to buttress the absolute prohibition? I believe the following are all the relevant features he presents.

1. Paul J. Weithman, "Of Assisted Suicide and 'The Philosophers' Brief,'" in this issue, pp. 548–78. Subsequent references to this article will be given in the text in parentheses.

*Consent.*—Given the authority vested in doctors, and the vulnerability of patients, “it may be extremely difficult for patients to render genuine consent to a physician who is attempting to seduce them” (p. 555); “the same questions that arise about the genuineness of consent to a seduction arise about the genuineness of consent to sex when patients present themselves as willing to engage in it” (p. 558). In addition, the doctor may use his position of authority to manipulate the consent.

*Dangerous and inappropriate attitudes.*—“Sex can elicit strong emotions and attachments in both parties . . . these feelings can cloud a physician’s medical judgment and compromise her ability to give her patient good medical care” (p. 554).

*Harms.*—“The cost of an honest mistake, of having sex with an apparently willing patient who is in fact unable to give genuine consent, could be very high” (p. 559).

*Temptation.*—“Because patients must place themselves in positions of physical and emotional vulnerability to get medical care, doctors are placed in the way of very powerful temptations to have sex with their patients” (p. 555). Because of the strong temptations, rationalization and self-deception are “more effectively taken out of play by a stable commitment to refrain” from sex with patients (p. 556).

*Patients’ need for self-revelation.*—“Self-revelation is . . . necessary if patients are to receive proper diagnosis and treatment. But many patients may be reluctant to expose themselves to their doctors, either physically or emotionally, if they worry that their doctors may consider them potential sexual partners” (p. 556).

Having listed these important considerations, Weithman argues cogently in favor of doctors holding themselves to an absolute prohibition, and the cultivation of the appropriate dispositions, rather than leaving it to individualized judgments about the appropriateness of sexual relationships on a case-by-case basis. In addition to guarding against mistake and manipulation, there is an important value in the patient’s knowing that there is such an absolute prohibition. It fosters trust and confidence.

I shall make four general claims to show that the analogy is not sound. First, many of the features of the sexual case either are not present or are present in a significantly diminished fashion in the intending death case. Second, there is a crucial factor present in the latter that is not present in the former. Third, Weithman poses false alternatives, that is, either absolute prohibition or case-by-case judgment. Finally, since the law already protects withholding or withdrawal of treatment and alimention, and it is reasonable to believe that anybody concerned about Weithman’s features would see some of them present in these cases, the demand for an absolute prohibition in the intending death cases seems unwarranted.

## II

*Consent*

This is the feature which most obviously is present in both situations. Many of those worried about legalizing assisted dying are worried about how informed and voluntary the requests of patients for medically assisted dying will be. The authority of the doctor, and his expertise, create a risk that patients will be manipulated into consenting to death when their actual preferences are for continued life. I shall mention here two points to which I shall return. First, the worries about consent are equally valid in the case of withdrawal and withholding of treatment. Second, one response to such worries is safeguards rather than prohibition.

*Harms*

Here again the parallels are present. If a patient is manipulated into choosing death when she would prefer to live, it is a serious harm. Once again the two points I mentioned under *Consent* are relevant.

*Dangerous Attitudes*

Here we find our first divergence. Sexual attraction and erotic fantasies and drives are a central part of all our lives. It is often inappropriate and demeaning to entertain sexual fantasies about those with whom we are engaged in professional relationships. Such thoughts can interfere with our ability to deal with professional problems in a thoughtful way. Note that all this is true even for those who are persons of good will, with no intent to injure or harm others.

But contemplating aiding a patient in dying, thinking about whether such patients are suitable for such assistance, thinking of them as persons who would be better off dead rather than alive, are not ever-present attitudes. And to claim that they are inappropriate ways of regarding patients is to beg the questions at issue.

Again consider the statements that Weithman makes about sexual desire and the force of eroticization: "In positions of . . . vulnerability, patients may also form strong emotional attachments to their doctor which the doctor could then eroticize, and in response patients may develop a strong even if transitory desire to please their doctor" (p. 555). These claims rely on the initial presence of strong erotic drives and their consequences for those in dependent positions. There is nothing comparable in the case of assisted suicide.

*Temptation*

The clearest divergence of features concerns temptation. In the sexual case given that patients are in positions of physical and emotional vul-

nerability, “doctors are placed in the way of very powerful temptations to have sex with their patients” (p. 555). Weithman attempts to make the analogy via a corresponding temptation: “Because of their work and training, doctors are also in the way of a temptation to end the lives of their terminal patients” (p. 560). Here we simply disagree. I believe that all the evidence is that if doctors have a temptation it is to do everything humanly (inhumanly?) possible to save the lives of their patients. Indeed it is because in succumbing to such a temptation doctors overtreat the terminally ill that so many people are fearful of what awaits them at the end. If one looks back at the resistance of the medical profession to accepting the idea of allowing patients to withdraw from existing life support—something we now think of as having the status of tradition—the most common moral objection was that this was to “abandon the patient.”<sup>2</sup>

Indeed, evidence for the real temptation is to be found in studies that Weithman himself cites in footnote 33. What these studies show is that doctors ignore the clearly expressed wishes of their patients not to receive medical care under certain conditions, and that when a clinical intervention was designed to attempt to change this situation (having nurses talk to the doctors about the wishes of their patients), this failed to change the situation.<sup>3</sup> It is precisely because the temptation is to do anything to avoid the death of the patient that we must find ways of guarding against it.

### *Self-Revelation*

Again, the idea that if doctors are permitted to assist willing patients in dying such patients will be less willing to reveal important information about themselves is much less plausible in this context than in the sexual one. It is unlikely that patients will be reluctant to reveal their true feelings about, say, their bodies because they worry about being considered a potential object of assisted dying.

So far I have claimed that a number of the crucial features which justify the ban on sexual relationships with doctors do not apply to the case of assisted dying. I now want to argue that there is a crucial disanalogy, that is, a feature present in the latter case that is not present in the former. What is different is what is at stake in imposing the prohibition. What are the costs that come with the prohibition?

In the case of the prohibition on sex with patients, doctors and patients will have to find alternative sexual partners or, at least, wait until

2. The most common legal objection was that this was equivalent to homicide.

3. See Alfred F. Connors, Neal V. Dawson, Norman A. Desblens, et al., “A Controlled Trial to Improve Care for Seriously Ill Hospitalized Patients: Study to Understand Prognoses and Preferences for Outcomes and Risks of Treatments,” *Journal of the American Medical Association* 274 (1995): 1591–98.

the doctor-patient relationship is ended.<sup>4</sup> This may be inconvenient, or in some cases unfortunate, but it certainly does not weigh heavily against the kinds of dangers that Weithman presents. But in the case of assisted dying what is at stake is the possibility of avoiding great pain, indignity, and discomfort. What is at stake is the ability of the dying patient to determine the kind of death she will have. The interests at stake plausibly generate a moral claim to assistance—if not a right. No such claim is credible in the case of sexual partners.

Weithman is aware of this objection (n. 51). He attempts to defend the analogy by saying that just as patients may find alternative sex partners, they may find other ways of “determining the time and manner of their deaths.”<sup>5</sup> Well, yes. They can use a gun or jump from windows. They can read *Final Exit* and hope that the barbiturates they take do not leave them in a state of coma rather than death.<sup>6</sup> They can find compassionate relatives or friends to take the risks of being prosecuted. The nature of the alternatives in each case—sex, assisted dying—do not seem at all comparable. Doctors as a class are not singled out as privileged sexual partners. Doctors as a class are singled out as privileged aids in dying in virtue of their understanding of patients’ prognoses, their responsibility to alleviate pain and suffering, their (in the best case) history of interaction with the patients, and prior communications with their patients about their wishes.

Because of this crucial asymmetry it is important to see that Weithman has presented us with alternatives in the context of sexual relations that are not exclusive. When the harms are serious, and the benefits are of the relatively trivial kind in question, it is reasonable to choose absolute prohibitions against case-by-case judgment. What, after all, is there to judge? Whether this sexual contact would be fulfilling? If there were really important values at stake, for example, suppose we discovered that such sexual contact would cure vaginal cancer, then we would consider the possibility of case-by-case judgment qualified by safeguards. We would want an independent judgment as to the likelihood of such a cure. We would want to be sure the doctor was not making up this diagnosis to provide an excuse for sexual contact. We would want to make sure no manipulation was taking place.

4. Different professions differ as to whether this latter alternative is considered ethical. In the psychological professions it is usually prohibited because of the issue of “transference.”

5. Unlike some commentators who suggest that we ought to leave the existing law in place and rely on doctors to exercise their judgment and take the risk of prosecution—not a large one to be sure—Weithman believes that doctors should refuse to engage in such practices.

6. Derek Humphry, *Final Exit: The Practicalities of Self-Deliverance and Assisted Suicide for the Dying* (New York: Dell, 1992).

In the context of assisted dying, when the values at stake are so important, then we certainly do not want an absolute prohibition. But, because some of the features Weithman refers to are present here as well, we do not want to leave it to the doctor's judgment. What we want is a permission governed by regulation.<sup>7</sup>

A final point. Weithman says that although we must never allow doctors to intend the death of their patients this does not mean we should forbid them from terminating life support. He concedes that many of the same dangers may be present in decisions to withhold or withdraw treatment but—it is now his chance to attack analogies—says that “permitting the termination of life support does not create the same public perception that physicians are sometimes willing to cause the deaths of their patients” (p. 573).

My reply is twofold. First, if this is the public perception then it is based on mistake and confusion. When a doctor withdraws artificial nutrition and hydration, or disconnects the respirator, she does cause the death of her patient—the idea that the “disease kills the patient” notwithstanding. And if she is willing to do this, she is willing to cause the death in the sense of knowing it will happen and being prepared to go ahead nevertheless. It is also the case that when a doctor administers an overdose of morphine—intending to relieve pain—she kills the patient; doctrine of double effect notwithstanding. In particular, the practice of terminal sedation, which was explicitly approved by the American Medical Association in their brief to the Supreme Court—“For a very few patients, however, sedation to a sleep-like state may be necessary in the last days or weeks of life to prevent the patient from experiencing severe pain”<sup>8</sup>—and which is often accompanied by withholding of nutrition and hydration, can hardly lead to the perception that doctors are not willing to cause the death of their patients.

On the other side, when a doctor gives a patient the barbiturates, and explains how to use them, he does not kill the patient. That is why it is assisted *suicide*. In terms of intention, the doctor's intent might be only to provide the patient with the means to control her future, believing that such control will make it unnecessary for the patient to actually kill herself.<sup>9</sup>

7. In a recent news item I discovered that the now-familiar yield sign was first conceived of in 1939, and was introduced in its current form in 1950 in Tulsa, Oklahoma. What we want in the case of medically assisted dying is something in between the rigidity of a stop sign and leaving it to the discretion of each driver.

8. Brief of the American Medical Association, *Washington v. Glucksberg*, 117 S.Ct. 2258 (1997), p. 1376.

9. That this is not an idle wish can be seen from a recent survey of physicians in the United States. Of the patients for whom these doctors wrote lethal prescriptions 59 percent used the prescriptions to end their lives. Diane E. Meier, Carol-Ann Emmons, Sylvan Wallenstein, et al., “A National Survey of Physician-Assisted Suicide and Euthanasia in the United States,” *New England Journal of Medicine* 338 (1998): 1193–1201.

Finally, if as Weithman concedes, many of the worries about mistake and rationalization are present in the case of terminating treatment, then patients *ought* to be worried about them quite independently of the intent of the doctor. Given the existence of such worries, and given that the argument from analogy is unsuccessful, it is unclear how Weithman can uphold the right of a patient to withdraw or withhold treatment.