

No, we don't think our doctors are out to get us: Responding to the straw man distortions of disability rights arguments against assisted suicide

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The arguments that disability rights advocates present in opposition to legalized assisted suicide are frequently misconstrued in public debate. The goal of this paper is to identify and analyze key “straw man” fallacies about the disability rights opposition in order to clarify this position and the factors that contribute to its distortion. The author adopts a first-person perspective as a disability scholar/activist who has participated in “right to die” debates for over two decades. Three possible barriers that potentially impede comprehension of disability rights arguments are discussed. Prominent fallacies that assisted suicide proponents attribute to disability rights opponents are analyzed in relation to the dynamics of the assisted suicide debate, social views of disability and incurable illness, and available evidence. The author's position is that disability rights arguments against legalized assisted suicide contribute a complex intellectual and experience-based perspective to the debate that can illuminate immediate and distal consequences of altering public policy. © 2010 Elsevier Inc. All rights reserved.

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The first time I heard the term “straw man” was during graduate school. A classmate, whose scholarship I admired, had used it for a touch of irony in the title of a course paper. I remember nothing else about the paper, and very little about the student, but the term has stayed in the back of my mind. It moves to the front every time I hear a dismissal of the disability rights opposition to legalized assisted suicide.¹

Philosophers Robert Talisse and Scott F. Aikin [1] explain that “One commits the straw man fallacy when one misrepresents an opponent's position in a way that imputes to it implausible commitments, and then refutes the misrepresentation instead of the opponent's actual view” (p. 345).

Although evil intentions may hatch such specious refutations in some cases, other cases of “straw-manning” are reducible to something more innocent: the failure to comprehend the opponent's argument. In the 25 years that I have been involved in the right-to-die debate, I have seen both dynamics at play. Sometimes, missionaries for assisted suicide are zealous rhetoricians who strategically corrupt opposing viewpoints for easy dispatch. Often, though, proponents of legalized assisted suicide distort their opponents'

position simply because they miss the fine points of counter-arguments. I think failure of comprehension accounts for many of the straw man fallacies that disability rights opponents encounter in response to their most carefully articulated economic, political, and cultural analyses of the issues.

Dominant dynamics in the debate

Support for assisted suicide has been driven not by subtle distinctions but by strong emotions and large ideas. Fear of suffering, humiliation over needing care, and anger over threatened loss of independence are powerful emotions. Freedom, autonomy, quality of life, and control over one's body are huge concepts. Occasionally, big drama also enters the mix. Tragic case studies are presented to underscore the horror of particular lives lacking an assisted exit. Keeping the debate at this coarse level fits well with sound-bite media coverage, where complexities and subtle implications have little place. Unfortunately, gross analysis fails miserably to illuminate a phenomenon as complex as assisted suicide.

Many of the key spokespersons in favor of assisted suicide are comfortable dealing in big ideas on center stage. They are familiar with ideals such as independence, control, and freedom because they are by and large from the dominant sector of society that has had access to those experiences. Diane Coleman has characterized the leading proponents of legalized assisted suicide as “white, well-off,

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¹ Like many other disability advocates, I choose to use the term “assisted suicide” rather than “death with dignity” and other terms that euphemize the phenomenon and obscure its nature.

worried, and well” [2]. They have enjoyed a good deal of control, know exactly what they have to lose, and are determined to retain it until death. Unfortunately, viewing the world from a position of privilege may limit one’s insight into the consequences of a policy change whose greatest impact could fall on socially marginalized groups.

Three barriers to comprehension

In a forum dominated by visceral feelings, vaguely defined ideals, and privileged voices, the disability rights opposition to assisted suicide has not played well—when it has been heard at all. Disability rights opponents are frequently excluded from the stage in public debate, or they find themselves participating under handicapping conditions.²

Even when disability rights activists and scholars are allowed to present their views, I have noticed three mechanisms that commonly prevent a fair hearing. The first is an intellectual barrier, or what ethicist Howard Brody [3] refers to as “short-sightedness.” Brody issued a public apology for having dismissed the well-documented arguments of disability activists in right-to-die cases such as that of quadriplegic David Rivlin, who had requested physician assisted dying, through ventilator disconnection, to escape institutional life in a nursing home. Brody admitted that in his excitement over the judge’s ruling in favor of Rivlin’s request, he saw himself as a “champion of patient’s rights” and saw disabled protesters as “busybodies” interfering in a private right to autonomy. Years later, Brody confessed to embarrassment over the limited basis of his thinking about such cases and his failure to grasp the “key lesson that disabilities advocates are trying to teach the rest of us.” Challenged to think more deeply about disability, he ended up agreeing with the advocates that Rivlin most likely had died unnecessarily, having received no reasonable options for a meaningful life.

The second barrier to comprehension is experiential. Although the disability rights arguments against legalized assisted suicide have been sophisticated and even abstract at times, they are also grounded in the life experience of people with disabilities, especially those residing at the economic and social margins. It is this combination of analytic astuteness and first-hand experience that sets off the disability rights opposition from other positions in the debate. However, knowledge from experience is difficult to transmit across an experiential divide. I should point out that

² Disability activists and scholars arguing against legalized assisted suicide have faced an uphill battle in public debate. Forum organizers often tell them that they have no standing in a matter affecting only “the terminally ill.” Accordingly, they receive outsider treatment in a debate that is ironically dominated by people who are neither disabled nor terminally ill. Spokespersons from the disability rights opposition are rarely invited to speak at public events and are told that they can express their views from the audience during Q & A. After pushing for their own inclusion, they may win token invitations to speak but then find they are given insufficient time to lay out their arguments in a program so stacked against them that even “neutral” moderators may openly dismiss their points.

by “experiential divide,” I am referring to something more complex than a disabled versus nondisabled standpoint. The kind of knowledge at issue here is imparted by very real threats to one’s life—experiences such as institutionalization, neglect, abuse, discriminatory treatment, social devaluation, and impoverished resources. Some people grasp the depths of those experiences and some do not. Well-meaning nondisabled and disabled proponents of assisted suicide, even those who express fervent support of disability rights, often fail to comprehend the depth and danger of an oppression that they have not personally experienced.³ Disability historian Paul Longmore, in challenging experientially uninformed dismissals of the danger of legalized assisted suicide, characterizes them as “naive” [4]. I will return to the idea of naiveté later in relation to safeguards.

The third barrier to comprehension involves defensiveness. Acknowledging the validity of the disability rights opposition to assisted suicide entails related acknowledgements that may be hard to confront, such as realizing the pervasiveness of social devaluation based on class, age, and disability, and recognizing the injustices of our country’s health care system, including the growing physical danger that many people experience in hospitals because of cost-cutting policies and changing values of care. To concede those points, proponents must face their own feelings about sharing resources and shouldering social responsibilities. They must deal with deeply buried fears about disability and must confront their own potential vulnerability should they become incurably ill, alone, or impoverished. On top of all those troubling insights and associated threats to peace-of-mind, proponents who truly absorb disability rights arguments against assisted suicide might have to give up cherished identities as defenders of autonomy. Just as Howard Brody has to admit every time he thinks about a lonely, dispirited, and impoverished David Rivlin giving up his right to breathe to escape a nursing home, what looks like autonomy on surface examination is often much more complicated and much less free. These are thorny realities that tempt avoidance.

Taking on the straw men

The following sections of this paper will present a list of straw man fallacies commonly used by proponents of

³ For example, attorney Andrew Batavia and historian Hugh Gallagher were two prominent individuals with disabilities who publicly supported the legalization of assisted suicide. Significantly, both denied that people with disabilities were socially oppressed (Batavia quoted in Corbet, 1997 [5]; Gallagher, 2001 [6]). According to Gallagher, “As a general proposition, American disabled citizens today are oppressed only so far as they allow themselves to be oppressed. They have the right, as they choose to exercise and demand the right, to control their bodies, their lives, and their destinies” (Gallagher, 2001, pp. 98-99 [6]). In contrast, two political progressives who identify as nondisabled, activist Ralph Nader and pro-choice U.S. Representative Jan Schakowsky, have consistently opposed the legalization of assisted suicide because of the potential for lethal discriminatory treatment of people with disabilities in health care.

legalized assisted suicide to refute the arguments of the disability rights opposition. After stating each fallacy, I will discuss it and attempt to replace some of the straw with facts. Since I am a disabled scholar and activist myself and have publicly argued against the legalization of assisted suicide, I will write in the first person when referring to disability rights opponents.

Fallacy No. 1: *We harbor unfounded fears that legalizing assisted suicide would embolden physicians who want to kill us.*

This is one of several straw man fallacies that could be clustered into the paranoid “They’re out to get us!” genre. We hear it in response to the disability rights analysis of flaws in proposed assisted suicide statutes. Our policy experts have astutely pointed out that these statutes shift the balance of protections in favor of physicians, who are allowed to report on their own actions under the laws and who are virtually immune to legal consequences as long as they plead “good faith” [7].

People with disabilities have more experience with physicians than most people. We know that medical mismanagement takes many forms and rarely is it flagrant or even deliberately malicious. Nonetheless, many of us have been harmed significantly by medical professionals who knew little about our lives, who thought incurable functional impairments were the worst things that could happen to a person, and who were confident they knew best. Research has shown for some time that many health professionals believe life with extensive disabilities is not worth living [8]; however, malpractice sanctions have prevented most from acting on those misconceptions. Whatever a particular doctor may have thought about the quality of our lives, she/he has known that the court could punish any physician who provided less support for our lives than for anyone else’s life.

Those of us who face disability prejudice daily know how entrenched and destructive it is. Experience has purged us of illusions about it. We know that even when the laws were more clearly on the side of protecting our lives than they are now, some doctors and nurses quietly found ways to act on their beliefs about disability and let disabled newborns, new trauma victims, and “frail” elderly individuals slip away. However, they did so under the constant threat of whistle-blowers.

In the last 30 years, whistle-blowing has quieted significantly. Laws allowing death to occur through treatment withdrawal and withholding have blurred the lines of protection for the lives of people with disabilities. Since no one wants forced treatment imposed upon him/her, these legal changes potentially had an up side. Unfortunately, as it has turned out, the laws can be applied harmfully to hasten death for people with disabilities, such as David Rivlin.⁴ Disability advocates blew the whistle for Rivlin

and other demoralized individuals with disabilities, but we found ourselves increasingly alone. Whatever their intended value might have been, laws permitting death through treatment withdrawal reinforced thinking in society and in medical settings that lives with incurable impairments are less worthy of support than other lives. Historically, these changes coincided with growing national concern over rising health care costs and with the circulation of schemes for restricting services.

I chose those last two words, “restricting services,” deliberately. Some may argue that the laws allowing refusal of treatment have nothing to do with restricting services and, instead, empower patients to determine what happens to their bodies in medical settings. Certainly, these laws were originally wrapped in autonomy arguments, but they have been applied in mostly one direction: to refuse unwanted treatment, not to secure wanted, or even needed, treatment. The bias toward restriction of services is clear to many people with disabilities facing devastating insurance denials of motorized wheelchairs, back-up ventilators, and personal assistance services. The bias is also clear when doctors, nurses, and social workers one-sidedly describe advance directives and living wills to their patients as documents that allow them to state “what measures you would *not* want taken,” and it is blatantly clear to people with extensive disabilities who are repeatedly asked by medical personnel if they have signed a “do not resuscitate” order yet.

Perhaps the bias in favor of foregoing services is most evident in the creation of the concept, “futile treatment,” which has allowed doctors to deny life-sustaining treatment—even to patients and their families who want treatment—if doctors judge the treatment ineffective or inappropriate. If anyone believes that futile treatment policies do not affect people with disabilities, consider the case of Leslie Burke, a British middle-aged wheelchair-user with a progressive neurological condition called cerebellar ataxia. Knowing that he would one day lose his ability to talk and use his muscles, Burke sought legal affirmation of the right to receive assisted nutrition and hydration until his natural death.⁵ He won his “right-to-food” from the British high court in 2004—a landmark decision celebrated by disability rights groups. However, in 2005, the decision was overturned on appeal by the General Medical Council with support from the government’s Department of Health. Summarizing the government’s position in the case, *The Times* newspaper reported: “The National Health Service should not have to give life-prolonging treatment to every patient who demands it because that would mean a crippling waste of resources, the Government said yesterday” [13].

From what I read about Leslie Burke, he did not demonize individual physicians or believe they were eager for his early death. Neither did he feel assured, however,

⁴ A disability rights analysis of such cases can be found in many sources, including Coleman (1992) [9], Johnson (1989) [10], and Longmore (1987 [11], 1991) [12].

⁵ I prefer the term “assisted nutrition and hydration” in place of the oddly inaccurate and biased but ubiquitous term “artificial nutrition and hydration.”

that his life would be supported and his treatment wishes heeded in medical settings. He knew that medical practice and health care allocation policies had already moved in a direction biased against supporting expensive and dependent lives. I suspect he will not feel better if the push for legalized assisted suicide succeeds in his country. When countless people with disabilities die every day from treatment withdrawal, in a legal procedure that is now so routine that it rarely reaches a court, when our lives are weighed in terms of the resources we consume, and when the law protects our right to refuse life-sustaining treatment but not our parallel right to request it, it is reasonable to believe that things will get worse when doctors are given more license to judge the hopelessness of incurable conditions and more impunity to act on their judgments.

I am personally acquainted with many persons with disabilities who oppose assisted suicide, yet I do not hear any of us voicing fears about cold-blooded doctors out to get us. We are, in fact, much more frightened by the doctors who are out to help us but who see our lives as burdensome and who know little about options that make life with disability valuable. We know that the misplaced pity and pessimism of such doctors is reinforced by the medical institutions surrounding them, the policies that guide them, the health care funding system that rewards them for holding costs down, and the prevailing culture that influences their thinking about disability. That constitutes a formidable amount of bias against our lives. We not only understand this intellectually but we feel it daily in response to the way we are treated now in comparison to how we were treated before the “right to die” campaign.

Fallacy No. 2: *We are afraid that families will pressure vulnerable disabled people to commit assisted suicide because of money or because the families want to be free of burdens.*

This version of the “They’re out to get us” straw man fallacy manages concurrently to malign our families and to trivialize our deep concerns about the economic and social pressures associated with long-term illness and disability. In a for-profit health care system, even the best insurance does not insulate families against the mounting price of health services in the United States, and families with less than the best insurance can be crushed by out-of-pocket charges for long-term health care. Home health services, although often less expensive than nursing home placement, are rarely covered completely, leaving families financially drained in short order. The options are unjust and tragic. If families want to remain intact and avoid institutionalizing a loved one with an incurable condition, they must choose between bankruptcy and the stress of providing personal assistance services (and sometimes even nursing care) on their own, on top of their usual responsibilities. Consider how that feels to the individual needing services. Not many people in our individualistic culture want to be reliant on family members for personal assistance. Nor do they want to see their families impoverished

by the cost of hiring assistants out-of-pocket. In our current social system, people with incurable conditions are morphed into burdens simply because they experience changes in their health and functioning that are part of being human.

Most disability rights advocates who oppose legalized assisted suicide are not afraid that our families are out to get us. We are afraid that a society that refuses to expect and to provide for incurable conditions will abandon us *and* our families after we are no longer of apparent value to society. That prediction is not a paranoid fantasy or a groundless anxiety. The social and economic pressure to institutionalize incurably ill and disabled individuals plays out across our country everyday, often leading to premature deaths from complications of institutional treatment. Insidiously, there are no laws explicitly requiring nursing home placement; the system is simply set up to push people there by default. In this context, if assisted suicide gains wider legal reach, it will have a deadly double effect. It will not only advance the idea in our culture that it is reasonable for certain people to be helped to a hastened death, but it will also offer an alternate destination, assisted suicide, for socially abandoned individuals floating down the river toward the nursing home. The former effect is potentially more deadly than the latter. Expanding our culture’s comfort with letting go of “suffering” people will ultimately lead to less support for our lives—whether it involves an antibiotic that is withheld, a ventilator that is withdrawn, or a message about being a burden that takes away one’s will to live. The decriminalization of assisted suicide has already begun to increase the broken body count far beyond countable incidents of assisted suicide.

Fallacy No. 3: *We fail to differentiate the Nazi annihilation of disabled people from compassionate assisted dying.*

This fallacy belongs to the “We just can’t understand the difference” genre. I have heard this fallacy hurled derisively by proponents of assisted suicide whenever disability rights opponents reference the history of euthanasia. In most cases, well-read opponents have merely pointed out the historical interplay of economic stress, competition for resources, cultural representations of disability, social values regarding productivity and quality of life, and civic ideals regarding valid citizenship. They have presented evidence of how these forces interact in stepwise progression to undermine public support for people who need help and resources to live. I have noticed that these analyses are often too smart for the room. As soon as Nazi Germany is mentioned as an extreme case illustrating these dynamics, many proponents of assisted suicide protest what they frame as a facile analogy from the Nazis to the contemporary right-to-die movement. This has occurred so predictably that some disability advocates now remind each other not to mention the Nazis if they want their analyses to be heard at all.

Although there are some frightening parallels between the progression toward euthanasia in Nazi Germany and

aspects of the contemporary right-to-die juggernaut in the United States, thoughtful opponents of assisted suicide are fully aware of differences between the two campaigns. One difference is particularly troubling. The Nazi attack on costly “unproductive” humans was so explicit and sweeping, and it was so contiguous with Hitler’s murderous racial cleansing, that most of the world could readily recognize and oppose its menacing dynamics. In contrast, the contemporary right-to-die campaign has been so stealthily clad in the language of free choice, dignity, and rationality that much of the world fails to comprehend its social selfishness and public danger. What future generations will conclude about the relative horrors of “life unworthy of life”⁶ versus “death with dignity”⁷ may depend on what happens to current and future initiatives to legalize assisted suicide in the United States.

Fallacy No. 4: *When we express concerns that legalized assisted suicide will lead to involuntary deaths, we are confusing voluntary requests for medical assistance to die by one’s own actions with involuntary euthanasia.*

Here is another example of the “We just can’t understand the difference” fallacy. Whether it stems from naiveté or arrogance, this straw man myth reveals how much power proponents of assisted suicide believe they have to control the forces they wish to set in motion. Need for control is a common theme among those who want to legalize assisted suicide and those who seek it. Research on assisted suicide requesters, in fact, suggests that many are control-seekers who cannot accept losing physical independence. Engineering their own deaths is a means to wrest some control back from nature [14,15].

In matters of public policies that regulate the life and death conduct of doctors, however, no person is an island. Changes in public policy encompass all citizens. What control-seekers want for their own peace of mind may work out quite well for them in the context of privilege and choice. However, they cannot determine how it will work out for their neighbors who reside outside that context. They have no idea how legalized assisted suicide will interact with race, age, disability, class, gender, insurability, and other dimensions of disadvantage and social devaluation. They have no basis for determining how “voluntary” one’s choices really are in those contexts.

Most proponents of assisted suicide give short shrift to questions of real-life consequences for other people. They talk about rights and freedoms in their pure form rather than looking at what actually happens in the untidy, impure real world. They assume that safeguards will take care of all that. In their lives, protections have always worked for them. They apparently cannot conceive of a situation in

which their careful armchair planning would not be sufficient for everyone.

Disability rights opponents of legalized assisted suicide understand the difference between voluntary and involuntary, but we know that such distinctions are ideal rather than real for too many people. For one thing, voluntary decisions imply choice or access to options. When I enroll participants in my research studies, my university institutional review board requires me to ensure that their participation is voluntary. I am obligated to inform participants of all reasonable alternatives to their participation in my study and to do all I can to make sure that they are not under any pressure to enroll in the research because they have inadequate access to other options (e.g., cannot afford alternate programs or safer treatments). The standard for voluntariness that I must heed as a researcher is more stringent than the requirements of Oregon’s assisted suicide law. Doctors who receive requests to die are only required to make good faith efforts to inform requesters of their options and to rule out obvious sources of coercion, such as scheming relatives and mental illness. Doctors are not required to know about all reasonable alternatives to death as a solution to functional loss, much less hold a thorough discussion of community resources. Doctors provide medical information and most know little about the options that make life worth living for people who need assistance to live. The Oregon law does not require them to become culturally competent about disability options, nor does the law require doctors, or anyone else, to provide access to those options. No one is required to intervene and unstack the deck against living with illness and disability in our society. If requesters die believing that their only options are a nursing home, the degrading imposition of their intimate needs on family, taking their chances on the help of strangers, or death, how is that voluntary?

Several proponents of assisted suicide have pushed back on that question. Just because the deck is stacked against living with illness and disability, they assert, does not negate one’s capacity to make a free choice among available alternatives. Who are disability advocates, they ask, to force someone to live against her/his will in such a world? How paternalistic they must be to think they know better than the individual about what is right for her/him! My response has several parts. First, we are not endorsing force to make people live, but, rather, demanding that society stop forcing people to die if they wish relief from the socially created indignity of needing help. I am inviting health professionals to help us lift this crushing weight from incurably ill people before helping them out of their misery. Second, some of us may very well know more than the individual about what is right for her/him—not because we are paternalistic but because most people know very little about meaningful life with incurable impairments. We have seen so many individuals despair in the face of lost independence or body changes and then have a change of heart when offered meaningful

⁶ Life Unworthy of Life [16] (*Lebensunwerten Lebens*) was a concept embraced by Nazi leaders to describe individuals and groups who were unfit to live, including people with disabilities.

⁷ This is the euphemistic synonym for physician-assisted suicide used in the Oregon law, *Death with Dignity Act*, enacted in 1997.

choices and a counterviewpoint on disability. It makes us wonder how many of these requesters would want lethal prescriptions if they were given alternate ways to have self-determination in living until the last moments.

Last, I always find it ironic when assisted suicide proponents view disability advocates as interlopers in these matters. As other articles in this journal issue report, most requesters of assisted suicide fear loss of independence, the end of participation in meaningful activities, and burdening others. Many of us who experience disability, who have thought about it deeply, and who have advocated for others with incurable conditions know much more about such things than the average person. Moreover, many of us have had closer encounters with dying than the average person. We are at least as well-equipped to understand the needs of assisted suicide requesters as are most of the public figures who speak on their behalf. It is also ironic that assisted suicide lobbyists who call us paternalistic for worrying about the unmet needs of assisted suicide requesters see nothing paternalistic about doctors sitting in judgment over who shall be allowed to die and who does not qualify.

In addition to questioning just how “voluntary” assisted suicide will be for many individuals who have restricted options, we must also consider the indirect impact of legalization upon people who have never volunteered to die. Legalizing assisted suicide changes medical practice—period. Many of us who spend a lot of time in medical settings believe that authorizing doctors to help people take their lives and allowing doctors to gatekeep that “service” will erode the quality of health care for people with disabilities and incurable illnesses. Doctors cannot comply with assisted suicide law unless they agree that people whom they judge to be terminally ill have lives less worthy of full protection than other people’s life. Legal experts have already explained how impossible it will be to contain the expansion of this law to groups beyond those originally defined. Even more troublesome to me than legal expansion is cultural expansion.

The notion that people with “permanent” conditions do not always merit the same type, quality, or amount of health care as less “hopeless” patients has taken root in medical training and clinical practice over the last two decades. Every week, I hear another person with a disability recount a disturbing interaction with a physician, nurse, or other health professional who clearly transmitted the view that life with a disability is inherently burdensome. It does not feel safe to have one’s life in the hands of someone who views that life as unfortunate, maybe even tragic or unfair. As doctors increasingly engage in withdrawing ventilators, stopping antibiotics, and withholding food and water in cases of nonterminal disability as well as terminal illness, it is understandable that their attitudes may deteriorate toward those of us who use technology and significant human support to live. As nurses are given more responsibilities, more monitors to tend, and less time to personally engage with patients in the managed care setting, patients

with disabilities who need more time and assistance are *personae non gratae*. Arguably, health professionals have always viewed life with extensive disabilities as burdensome, given their trained commitment to health and normative functioning. However, they have never expressed it as consistently and as openly as they do now. It is as though a threshold has been lowered in the culture of health care, thus permitting freer expression of skepticism about the viability of our lives.

Similar to medical culture, the general public has become more accepting of the idea of “pulling the plug,” and the disease-of-the-week does not have to be terminal. This trend is reflected in diverse facets of popular culture, from online opinion polls to soap operas. As initiatives for legalized assisted suicide have advanced, active measures to bring about death have taken their place in popular culture right alongside treatment withdrawal. Our culture’s growing comfort with the reasonableness of dying for people with incurable conditions is ominous for “incurables” who have fought hard for inclusion and equal treatment in the public sphere. I believe that policy changes permitting doctors to judge some people’s lives as deserving of assisted termination will lower the public threshold for expressing and acting on disability prejudice. Once it becomes legal to remove protections of human life based on physical condition, relations between society and people with disabilities are profoundly altered. The consequences will be subtle, indirect, and hard to trace back to the moment that unleashed them. No safeguards in assisted suicide laws can protect us from the distal effects of tearing down long-standing sanctions that have historically buffered us from bigotry.

Fallacy No. 5: *We egocentrically believe that dying people have the same experiences and issues as we do. We fail to see that a disability caused by a terminal disease is different from life-long disability.*

Actually, this version of the “We just can’t understand the difference” fallacy could go further than it does to differentiate between experiences of disability. It would be more accurate to say that each *personal* experience of disability is unique. No two individuals have the same personal experience of disability anymore than they might have the same personal experience of race or gender. However, that does not negate the fact that there are many common features in the *social* experience of disability. In other words, people with disabilities have a lot in common with respect to the way they are treated in society.

It is the way people with disabilities are treated and regarded socially that leads anyone to feel ashamed if they need help to use a toilet. It is the stigma of disability that strikes fear into the heart of individuals who can no longer live independently or appear “normal.” It is the economics and social arrangements of disability that transform ill people into family burdens or nursing home inmates. Perhaps most important of all to recognize is that it is this constellation of disability experiences that is pressuring

terminally ill people toward assisted suicide, according to available evidence.

Proponents of legalized assisted suicide have told me that even if it were true that many of the problems of terminal illness were disability-related problems, the point is irrelevant because a dying person who becomes disabled in their eighties cannot be expected to adapt to life with a disability. In response, I would like to raise a question that seems to repulse most proponents of assisted suicide: Where is your empirical evidence? I doubt if any disability rights opponent of legalized assisted suicide expects a dying person to suddenly adopt a proud disability identity, but we do believe that anyone can benefit potentially from interventions to reduce the impact of disability oppression. We believe that the hypothetical eighty-year-olds who are dying might respond quite meaningfully to informed efforts to alleviate their disability-related concerns, just as many terminally ill people change their mind about suicide when their depression is addressed [15]. Anyone at any age can benefit from measures to enhance her/his self-determination, including dignified professional assistance at home, respectful responses to one's everyday preferences, companionship or privacy as desired, and reassurance that the changes of aging and illness do not reduce one's humanity and worth. To dismiss these efforts as futile because the individual is near the end of life has no empirical foundation and raises questions about the commitment of assisted suicide proponents to the genuine self-determination of people with terminal illnesses.

Fallacy No. 6: *We believe that the legalization of assisted suicide would unleash a tidal wave of disabled people requesting death.*

This “hysterical belief” fallacy is similar in many ways to the “They’re out to get us!” genre. In both cases, proponents attribute extreme ideas to us because they either fail to grasp or refuse to engage with the nuances of our position. Although we believe that people who request assisted suicide may have much in common with others who attempt suicide, and although “copy-cat suicide” is a serious phenomenon, we do not fear assisted suicide contagion.

What we do fear is that the establishment of assisted suicide as clinical and public policy will reinforce social conditions that contribute to disabled people's despair. Concurrently, these changes in policy will make it more routine for health professionals to offer treatment withdrawal or, pending legal expansion, more active measures to end the lives of persons with incurable conditions. This argument does not even factor in the contribution of economic stress to the equation. It is not hysterical to believe that legalizing assisted suicide will expand the probabilities for unnecessary deaths like David Rivlin's by defining new candidates and adding new mechanisms for death to occur. Disability rights activists never cease to notice how much more attention and support the public extends to disabled people who seek death than to disabled people who seek jobs, personal assistance services, and

equal access to their community. We have every reason to believe this deadly trend will continue to threaten our people throughout the lifespan.

There are several other fallacies floating around regarding disability activists who oppose the legalization of assisted suicide. I will briefly address them in closing this discussion of straw men. We have been accused of heartlessly condemning terminally ill people to lives full of pain and suffering. In response, I will point out that palliative care experts tell us that virtually all physical pain can be adequately treated if doctors are well informed [17]. What is more significant for the assisted suicide debate is that pain has not figured prominently in actual requests for assisted suicide. The kind of social and psychological suffering that is expressed by requesters definitely calls for relief. This paper and the others in this special issue present various analyses of and potential responses to that suffering from a disability perspective. We call for a thorough examination of and support for the needs of individuals who request assisted suicide—including their need for control over life choices—rather than expeditious acquiescence to their despair.

We have also been accused of vitalism and of pressuring our brothers and sisters with incurable conditions to live because we are so staunchly pro-life. Actually, I know so few disability rights activists who are pro-life that I can count them on my one unparalyzed hand. It may be hard for many proponents of assisted suicide to grasp this, but we are not opposing assisted suicide out of personal philosophies but out of our sense of social responsibility. Although many courts have been willing to set aside the public interest in preserving life where people with incurable health conditions are concerned, we do not accept that carve-out and all the misconceptions about disability and illness it perpetuates. Our sounding of the alarm may seem paranoid or hysterical to some observers. Authorities on disability and violence say that the credibility of disabled witnesses is often questioned when they report abuse [18]. However, someone needs to speak in favor of the lives of individuals with disabilities, chronic illnesses, and even terminal conditions who may be too worn down to see the value of their own lives. Some are impoverished and burned out from a life of fighting for their rights. Some are financially comfortable but feel the constant threat that they will be invalidated by loss of independence. Some are struggling to withstand the impersonalism of hospitals or indignities of nursing homes and do so alone because social isolation is so commonly associated with both disability and advanced age. For all of them, we continue to blow the whistle.

Conclusion

In the end, those of us who oppose assisted suicide on political, economic, and cultural grounds are not afraid of the explicit and concrete menaces that proponents imagine we

fear and then scoff at us for fearing. Nonetheless, as the movement to legalize assisted suicide gains support in our country's respected institutions and organizations, my sleep is definitely disturbed. No, I am not worried about doctors eagerly lining up to kill me, or family members plotting to get me out of the way. I do not imagine that a new Hitler will order my death in gas chambers or sadistic experiments. Please do not reduce my concerns to caricatures and stereotypes.

What I fear more than premeditated malice and any scheming executioner is the distant and off-handed dismissal of my quality of life that is seeping into our culture, simultaneously reinforced by and finding expression in the assisted suicide movement. It trickles down into the attitudes of everyday folks, people regarded as harmless, even powerless. If the legalization of assisted suicide continues, I believe the rank and file will some day see nothing wrong with hastening the deaths of many people. They will stand by and do nothing to stop it and will endorse the policies and institutions that advance it—not because they are evil people but because it will no longer be evil in our culture to do so. It will be compassionate, respectful, routine. Whom do I fear? I am afraid of the TV news copywriter who describes every disabled person as suffering, and of the HMO staff person who casually denies a critically needed support with the stroke of a computer key. I am terrified by the seemingly innocuous wide-eyed little medical student who interviews me when I enter the hospital—the one who exits our meeting filled with pity and curiosity, wondering how in the world someone like me can live. I fear the legions of these unlikely villains. Call me paranoid.

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