

If Physician-Assisted Suicide Is the Modern Woman's Last Powerful Choice, Why Are White Women Its Leading Advocates and Main Users?

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Women, particularly educated White women, are at the forefront of the U.S. physician-assisted-suicide legalization movement, as advocates and leaders. They also represent half of decedents by physician-assisted suicide, though they are a minority among unassisted-suicide decedents. The dominant physician-assisted-suicide narrative is framed in terms of choice. This article focuses on the rhetoric and the reality of choice in physician-assisted suicide for White women in the United States, consistent with an intersectional perspective and with attention to context. It examines the idea of choice in physician-assisted suicide in light of women's lives, and also considering dominant narratives of physician-assisted suicide and of femininity. A mix of privilege (e.g., White women's good-enough experiences with medical systems, relative to ethnic-minority women) and disadvantage (e.g., White women's economic and care challenges, given their longevity but in poor health), combined with dominant physician-assisted-suicide rhetoric (e.g., physician-assisted-suicide as a death of dignity and graceful self-determination) and dominant-femininity ideals (e.g., femininity as graceful self-abnegation), likely contribute to White women's strong participation in physician-assisted suicide. The implications for professional psychology of intersectional and contextual perspectives on physician-assisted-suicide discourses and practices are discussed.

Public Significance Statement

This article examines the rhetoric and reality of choice in physician-assisted suicide for U.S. White women. White women's strong participation in physician-assisted suicide, as advocates and decedents, may be driven by concerns about being a burden given their longevity but in poor health. It may also be reinforced by the congruence between dominant-femininity ideals and the narrative of physician-assisted suicide as a powerful and graceful death.

Keywords: women, choice, physician-assisted suicide, intersectionalities, context

Within the dominant narrative, physician-assisted suicide is about choice. The discourse of choice has also become more pervasive over time (Borgstrom & Walter, 2015; Canetto, 2003). *Compassion & Choices* is the name of the main pro physician-

assisted-suicide organization in the United States.¹ Influential books in the pro physician-assisted-suicide camp have *choice* in the title (e.g., Prado's [1998] *The Last Choice: Preemptive Suicide in Advanced Age*; Quill's [1993] *Death and Dignity: Making Choices and Taking Charge*; and Quill's [1996] *A Midwife Through the Dying Process: Stories of Healing and Hard Choices at the End of Life*). Choice is also a dominant theme in stories featured in the *Death with Dignity's* (n.d.-a, n.d.-b) website. The terms *choice* and *options* are in the title of bills that legalized

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¹ Until 2003, *Compassion & Choices* was called *The Hemlock Society*. According to Humphry (2003; quoted in Childress, 2012), one of its founders, rebranding reflected an awareness, on the part of some leaders (not him), that "much more respectable names, like. . . Compassion & Choices" were required to appeal to a large public. In a later article entitled "Farewell to Hemlock: Killed by its name," Humphry (2005) wrote about the Hemlock Society's search for a "good, prim" and non-threatening name. He reported that members felt that the name hemlock had to be dropped because of its "connotations of. . . suicide" (paragraphs 8 and 11). Similarly, in an article entitled "Patient Choice At the End of Life: Getting the Language Right," physician-assisted-suicide advocates Tucker and Steele (2007) wrote, "The language used to discuss something. . . influences how we feel about it" (p. 305).

physician-assisted suicide, for example, Vermont's "Patient Choice and Control at the End of Life;" California's and Colorado's "End of Life Option/s;" Hawaii's "Our Care, Our Choice" (Death with Dignity, n.d.-c).

In this article, I examine the rhetoric and the reality of choice in physician-assisted suicide for "White"² women in the United States. The reason for this focus is the demographics of physician-assisted suicide in the United States. In this country, White women are at the forefront of the physician-assisted-suicide movement, as advocates and leaders. For example, studies of The Hemlock Society found an overrepresentation of Whites (94% to 98%) and women (63% to 65%) among its members (Cossman, Lewers, Wilson, Fox, & Kamakahi, 2002).³ Furthermore, as of October 2018, the executive leadership and board of directors of *Compassion & Choices* (n.d.-a, Our Leadership, Executive Leadership [and] Our Board of Directors) appeared to be mostly (86%) White and (68%) female (five out of the six executive leaders appearing to be White women). Whites also represent the vast majority of decedents by physician-assisted suicide in the United States (96% in Oregon and in Washington State—the Death With Dignity Act's [DWDA] states with the longest legalization record). Half of DWDA decedents are women (48% in Oregon; 49% in Washington State). In Oregon and Washington State, DWDA decedents are also disproportionately well educated (46% in Oregon and 44% in Washington State have a college degree or higher education) and predominantly (72%) age 65 or older (Hedberg & New, 2017; Oregon Health Authority, 2018; Washington State Department of Health, Disease Control and Health Statistics Division, 2018).⁴ The equal proportion of women and men among Oregon's and Washington State's DWDA decedents is remarkable considering the significantly divergent proportion of women and men among those who die by suicide (Canetto, 1996). Nationally, the proportion of women and men among suicide decedents is 1:5 in persons aged 65 and older, that is, among individuals most likely to die of physician-assisted suicide (American Association of Suicidology, 2014).

A focus on White women in physician-assisted suicide is consistent with intersectionality theory. This theory calls for attention to the variability (in issues and experiences) that is associated with intersecting dimensions of human diversity (Mohanty, 1984). White women in the United States clearly take a unique position on physician-assisted suicide, relative to other women. An intersectional perspective in physician-assisted suicide, and specifically a focus on U.S. White women, also challenge the problematic assumption that the experiences of Whites are culturally neutral and universally generalizable.⁵

This article begins with a review of terms. It then examines ideas and practices of choice in physician-assisted suicide for White women, given their life conditions, and also considering dominant narratives of femininity, and of physician-assisted suicide. The article concludes with a discussion on the mix of privilege and oppression that may contribute to White women's strong engagement with physician-assisted suicide as a political cause and as a mode of death.

Terminology

Definitions and preferences for terms vary by position on the issues (Gordon et al., 2000). The American Medical Association

(AMA) uses the term *physician-assisted suicide* to refer to the deliberate and knowing provision, on the part of a physician, of means and/or information to enable a patient's suicide. According to the AMA, *euthanasia* occurs when someone directly and deliberately implements means (e.g., administers a lethal dose of medication) that end someone's life. The AMA opposes both practices because it views them as incompatible with the physician's role, difficult or impossible to control, and socially risky (AMA, 2008–2009). The World Medical Association (2017) also opposes physician-assisted suicide and euthanasia as unethical.

By contrast, those who support these practices tend to prefer expressions that do not include the word *suicide* (e.g., *death with dignity, medical assistance in dying, self-deliverance*; Tucker & Steele, 2007). In the Death With Dignity's website, it is stated that assisted suicide and euthanasia are "incorrect and inaccurate terms that opponents of physician-assisted dying use in order to mislead the public" (Death With Dignity, n.d.-d). A Final Exit Network lawyer was quoted as saying, "You'd be hard-pressed to find an exit guide who tosses around the term 'suicide.' They use terms like 'self-deliverance' or 'death with dignity.'" He concluded, "A lot of people in the movement just find it terribly offensive and jump through hoops to keep from using the word" he concluded⁶ (Majchrowicz, 2016, para. 20).

Opponents of physician-assisted suicide and euthanasia also have language objections. Some argue against using terms like *aid in dying* or *physician-assisted dying* in reference to physician-assisted suicide because these terms can also refer to "anything done to help a dying person," including palliative care (e.g., Chochinov, 2016; Golden & Zoanni, 2010, p. 16).

In this article, the term *physician-assisted suicide* is used. One reason is that it is the most common term in the literature and in organizations that have the most at stake in the issue, for example, the AMA. Another reason is that the terms proposed by legalization advocates are vague—and "wildly ambiguous," as a founder of The Hemlock Society⁶ put (it) (Humphry, 2006, p. A8). That the term *medical aid in dying* is unclear is supported by the findings of a Quebec study. In this study, 60% of health care providers did not realize that *medical aid in dying* (the term used in Canada to refer to physician-assisted suicide and euthanasia, both of which are legal there since 2016) involved their participation in administering lethal medications (Marcoux, Boivin, Arsenaault, Toupin, & Youssef, 2015). Terms like *death with dignity, medical assistance in dying, physician-assisted death, and self-deliverance* are used in this article in reference to the pro physician-assisted-suicide dis-

² "White" is a social, not a biological, construct (Smedley & Smedley, 2005). In a racialized society such as the United States being perceived as White has a real impact on life experiences. Therefore, in the United States, a racialized perspective is fundamental for understanding access to, use and outcomes of medical care as well as morbidity and mortality (Phelan, Link, & Tehranifar, 2010). For these reasons, "White" is a critical analytic for examining U.S. physician-assisted-suicide rhetoric and practices.

³ This study did not report membership data by sex and ethnicity.

⁴ The DWDA data from Oregon and Washington State are not articulated by sex and ethnicity, intersectionally.

⁵ A consequence of this assumption is that culture is underused as an explanation in the case of Whites and overused to make sense of issues involving other ethnic groups (Causadias, Vitriol, & Atkin, 2018).

⁶ In Final Exit Network language, *exit guide* and *mentor* are names used for "volunteers who help people end their own lives" (Majchrowicz, 2016).

course. Finally, the term *hastened death* is used here to refer to physician-assisted suicide and/or euthanasia.

White Women and Choice in Physician-Assisted Suicide

The idea of choice in physician-assisted suicide is based on a number of assumptions. One assumption is that the person considering physician-assisted suicide has the economic and social resources to access the whole range of care. Another assumption is that the individual has the power and the entitlement to make whatever care choice they want. More broadly, the idea of choice in physician-assisted suicide is based on the assumption that if coercion is not exerted, the physician-assisted-suicide decision is solely or primarily driven by individual preferences and autonomous evaluations. In this section, I evaluate the above assumptions with regard to White women. Specifically, I examine White women's choice in physician-assisted suicide in context. To start, I probe White women's lives in domains that are relevant to the decision to die of physician-assisted suicide, with attention to privilege and adversities. Next, I consider the idea of choice in light of dominant narratives of physician-assisted suicide and their connection with dominant narratives of femininity. When theory and research about White women are not available, I rely on theory and research on women in general, knowing that, as a result of being privileged by way of ethnicity, White women are likely to be included in dominant discourse and data.

Contexts of White Women's Choice in Physician-Assisted Suicide: Privilege and Adversities

Women experience more illnesses and disabilities but live longer than men. Across ethnic groups, women have higher rates of chronic illnesses and disabilities, but they live longer than men (Calasanti, 2010). White women have the second highest life-expectancy of all sex-by-ethnicity groups. In 2015, U.S. life expectancy at birth was 81.1 years for White women and 76.3 years for White men. In the same year, life expectancy was 78.1 years for Black women, 71.8 for Black men, 84.3 for Latinas, and 79.3 for Latinos (U.S. Department of Health and Human Services, 2016). White women's morbidity and mortality patterns are relevant to the physician-assisted-suicide discourse. Because White men's morbidity and longevity patterns are taken as the norm, White women's sicker and longer lives may be perceived as excessively long, and as burdensome—to their families, the medical system, and society, and to the women themselves (Canetto, 2001; Canetto & Hollenshead, 1999–2000, 2000–2001, 2002). For example, the authors of a study of The Hemlock Society argued that “the difference in life expectancy . . . may, at least in part, explain why women are more likely to be members of the Hemlock Society. That is, women may be more likely to face the question of active euthanasia” (Cossman et al., 2002, p. 47). Though this statement is not qualified in terms of ethnicity, it implicitly refers to the fact that White women outnumber White men in The Hemlock Society; and it suggests that White women may view euthanasia as a solution to their longevity “problem.”

Women have fewer economic resources than men, particularly in late adulthood. Throughout their lives, women have fewer economic resources than men. To start with, in the United

States, women are less likely to be in the paid workforce than men. When they are, they are paid less and receive fewer work benefits than men. Women also have more interrupted work histories and are more likely to work part time than men (mainly related to their greater caregiving responsibilities). Both patterns contribute to their lower wages. For these reasons, as well as other biases and discrimination (e.g., women's lesser access to capital), women are less likely to accumulate the resources they need in late adulthood. Women are also more likely than men to rely on publicly funded health insurance, such as Medicare and Medicaid. Furthermore, women are more likely than men to live alone—particularly following divorce or widowhood. When they are ill, older women are less likely than older men to be cared for by family members or at home, even when they are married. In addition, more women than men live in nursing homes (Canetto, 2001, 2018; Emanuel et al., 1999; Hooyman, 2014; Jecker, 1991).

White women fare better economically than ethnic-minority women, across the lifespan. For example, in 2009, a much smaller percentage of White women (8.2%) than Black women (21.8%) were poor. One reason is that White women's earnings are higher than those of Black women, despite the fact that White women spend less time in the labor force. In addition, White women are more likely to marry and to stay married than Black women. Therefore, White women, through the life span, including in later adulthood, are more likely than Black women to rely on economic resources that they have accumulated through marriage rather than individually (see Addo & Lichter, 2013, for a review). A consequence of the latter situation is that older White women may view themselves, and may be perceived by others, as less entitled to their financial assets.

Even though White women are privileged in terms of economic resources, relative to Black women, they face significant financial, social, health, and care challenges, relative to White men, particularly in late adulthood—the time of life when physician-assisted suicide tends to take place. It is perhaps this mixture of White privilege and gender oppression that contributes to older White women viewing themselves, and being viewed by others, as rational when they express a wish to hasten their death. White women have long, good-enough lives, it may be argued. If their life quality deteriorates when they are older, as related to illnesses and widowhood, and they have met or exceeded White male life expectancy, why stay? An example of this perspective can be found in writings by Girsh, a founder of The Hemlock Society, and a psychologist. Girsh (2002) argued that women's right-to-die activism is “rational” and “reasoned” because women know that they

live longer than men, that there will be fewer caregivers for them, that women compose two-thirds of the demented [sic] population, and that they are more likely to wind up in a nursing home. For these reasons, they believe there IS [sic] a need to EXPAND [sic] the choices for how they as women—and all people—die. (p. 289)

As noted earlier, though Girsh's statement is not qualified in terms of ethnicity, it is about White women outnumbering White men in The Hemlock Society. Girsh seems to think that (White) women's advocacy for, and pursuit of, physician-assisted suicide

is “rational” given their limited access to caregiving when older and sick.

Women are viewed and treated as less deserving of resources than men, including by the medical system. Everywhere in the world, women’s lives are devalued. Millions of women are missing from the world population as a result of such devaluing. For example, in several countries (e.g., China), many fewer girls than boys are born as a result of prenatal sex-selection interventions that favor males. In various parts of the world, women are dispossessed and even killed when they become widows (Canetto, 2018).

With regard to medical care, and in the United States, women receive more but worse quality care than men. For example, women are less likely than men to be taken seriously when they report physical symptoms. They are also less likely to receive appropriate medical care, especially when they need expensive diagnostics and therapeutic interventions but also when they experience pain. These biases have been documented across a range of medical situations, including kidney dialysis and transplantation, cardiovascular disease, joint-replacement surgery, and critical care. For example, women are less likely than men to receive life-supporting treatments when in intensive care units, even at the same level of illness severity at admission (Kent, Patel, & Varela, 2012; McMurray et al., 1991). According to McMurray and colleagues (1991), care disparities at the disadvantage of women are fueled by biases about women’s social contribution and entitlement. One such bias is that women do not deserve the same high-cost care that men receive because they do not contribute economically to their family and society as much as men do.

The devaluing of women’s lives has implications for the discourse and practice of physician-assisted suicide. With regard to physicians’ role in physician-assisted suicide, a lifetime of exposure to ideologies that devalue women will no doubt impact physicians’ judgment of women’s assisted-suicide requests—as it biases their every other decision about women. To be clear, physicians are not uniquely biased against women. Everybody is. The problem is that physicians have the power to make life-and-death decisions based on those biases, and with the authority of the profession (Kass & Lund, 1996).

Physician-assisted suicide is by far the least-expensive intervention physicians can approve for a seriously ill person.⁷ Having been exposed to biased views of women’s social contribution and entitlement (including the normalizing of women’s self-effacement), physicians may be especially prone to judge as sensible women’s assisted-suicide requests and to forgo assessing the mental health of female petitioners, even when the requests seem driven by burden concerns (Canetto, 2011; Wesley, 1993). It is to be noted that, in the United States, concerns about being a burden are not a disqualifying condition for physician-assisted suicide. Because women are especially likely to have those concerns, objectively and subjectively, choice in hastened death may be uniquely compromised for women. In addition, physicians may more readily endorse White women’s requests for assisted suicide than say, Black women’s, because White women have more economic resources and higher social status, and are therefore assumed to be less vulnerable to renouncing to life because of economic or

social pressures. Vulnerability however is a complex issue, as will be discussed later.

Women have less entitlement to resources, including to medical care, than men. Women perceive themselves to be less entitled to resources than men. This has been related to cultural ideologies that legitimize women having fewer resources than men (O’Brien, Major, & Gilbert, 2012) and that valorize women’s abnegation and self-effacement (Wolf, 1996). Women and entitlement research findings that are relevant to physician-assisted suicide include the finding that older women are less likely than older men to express a preference for life-sustaining or life-prolonging care (e.g., Arber, Vandrevalla, Daly, & Hampson, 2008; Bookwala et al., 2001). In terms of reasons for this female preference, concerns about being a burden are dominant, consistent with women’s socialized tendency to put others before themselves (e.g., Arber et al., 2008).

By contrast, research finds that Blacks express a preference to receive all the care that they can get (Wicher & Meeker, 2012). This preference has been interpreted as an indication of Blacks’ healthy distrust toward medical systems that fail to provide them with adequate care (Institute of Medicine [US] Committee on Understanding and Eliminating Racial and Ethnic Disparities in Health Care, Smedley, Stith, & Nelson, 2003) and that have also been blatantly abusive (e.g., the 40-year-long Tuskegee syphilis “experiment”; the 1970s’ involuntary sterilization practices; Dula & Williams, 2005; King & Wolf, 1998; Wicher & Meeker, 2012). In a review of studies of African Americans’ end-of-life preferences, Wicher and Meeker (2012) noted, “African Americans do not trust they will get the care they need or want. They believe that . . . this care will be denied to them for financial reasons even when medically indicated” (p. 53). Withholding of care is what Blacks already get. Their concern therefore is getting enough care, not excessive care, argued Dula and Williams (2005) in an article addressing the unbearable whiteness of the physician-assisted-suicide legalization movement. Another issue relevant to Blacks’ medical care preferences is that they have a shorter life-expectancy than Whites. Therefore, voluntarily giving up on opportunities to stay alive does not make sense to many Black older adults, according to Dula and Williams.

It is unknown how experiencing a mix of privilege and oppression (e.g., as a White woman) versus multiple oppressions (e.g., as a Black woman) may relate to end-of-life-care concerns and pref-

⁷ According to information available on the *Death with Dignity’s* (n.d.-e) website (section “How much does the medication cost?”), medication cost varies depending on protocol, with the following as estimates: “Pentobarbital in liquid form cost about \$500 until about 2012, when the price rose to between \$15,000 and \$25,000. The price increase was caused by the European Union’s ban on exports to the US because of the drug being used in capital punishment, a practice that is illegal and deemed deplorable there; many international pharmaceutical companies don’t export the drug to the United States for the same reason. Users then switched to the powdered form, which cost between \$400 and \$500. The dose of secobarbital (brand name Seconal) prescribed under death with dignity laws costs \$3,000 to \$5,000. Due to the increase in the cost of Seconal, alternate mixtures of medications has been developed by physicians in Washington state. The phenobarbital/chloral hydrate/morphine sulfate mix produces a lethal dose that is similar in effect to Seconal. The cost of this alternate mix is approximately \$450 to \$500. A second alternative, consisting of morphine sulfate, Propranolol (Inderal), Diazepam (Valium), Digoxin and a buffer suspension costs about \$600.”

ferences, because most end-of-life studies do not examine intersectionalities. The limited research suggests that similarities in end-of-life concerns and preferences may be greater by ethnicity than by sex. For example, in a study of priorities about end-of-life care, older White women and men's especially valued choices. By contrast, older Black women and men expressed concerns about past inequities and what these inequities might mean for current care (Duffy, Jackson, Schim, Ronis, & Fowler, 2006).

Though there is no direct evidence on the role of entitlement in White women's physician-assisted-suicide choices, it is easy to see how low entitlement may contribute to their involvement with physician-assisted suicide, for example, considering White women's longevity, morbidity, and unmet care needs as well as their good-enough experiences with a medical system that promises gentle deliverance (Canetto, 2001, 2011; Canetto & Hollenshead, 1999–2000). In this regard, this statement about women's Hemlock Society membership is relevant: Women "are far more likely to become care givers than men" and they outlive men, which "may lead women to seek other options [when they need caregiving] . . . of which the Hemlock Society is one" (Cossman et al., 2002, p. 47). Though this statement is not qualified in terms of ethnicity, it is about White women—because it refers to the fact that women outnumber men among the overwhelmingly White membership of The Hemlock Society.

Contexts of White Women's Choice in Physician-Assisted Suicide: Femininity and Physician-Assisted Suicide Narratives

Self-deliverance is about self-determination, autonomy, being in control, and asserting one's rights. Self-determination, autonomy, and being in control are key themes in the pro physician-assisted-suicide narrative. On the Compassion & Choices website, it is stated that the second and third principles of care are self-determination and autonomy. Autonomy is described as follows: "Decisions about end-of-life care begin and end with the individual" (Compassion & Choices, n.d.-b). On the Death With Dignity website, it is said that legalization allows "the freedom to control . . . [one's] own ending. Most people who obtain medications under these laws value being able to make their own decisions" (Death With Dignity, n.d.-f). Vermont's act is called "Patient Choice and Control at the End of Life" (Death with Dignity, n.d.-c). *Final Exit's* (n.d.-a) core belief is in "an individual's right to self determination" (para. 3). Compassion & Choices' Doctors for Dignity is described as a network of physicians supporting patients' autonomy at the end of life (Compassion & Choices, 2017b). In a recent *Compassion & Choices'* annual report (2017a), Mary, a supporter, is introduced as someone who "would want things on her own terms" (p. 26). Pamela's story, on the Death with Dignity's website, is entitled "Control Over My Death": "[I]t is important to choose the way we die as it is to choose the way we live," she says (Death With Dignity, n.d.-g). Given the emphasis on autonomy in the prophysician-assisted-suicide discourse, it is perhaps not surprising that loss of autonomy is the concern endorsed by most (91%) Oregon DWDA decedents (Hedberg & New, 2017) and by most (87%) Washington State DWDA decedents (Washington State Department of Health, Disease Control and Health Statistics Division, 2018). Consistent with this theme, the distinctive characteristics of Oregon's DWDA petitioners, relative to matched controls

who did not pursue a DWDA death, were independence and self-reliance (as well as hopelessness and depression; Smith, Harvath, Goy, & Ganzini, 2015).

The language of rights also dominates the pro physician-assisted-suicide discourse. The Death with Dignity movement was known as the Right to Die movement. *The Right to Die* is the title of Humphry and Wickett's (1986) book. Some organizations still use right-to-die language and present hastened death as a fundamental human right. For example, Final Exit Network advocates for people's "human right to choose to end their lives when they judge their quality of life to be unacceptable" (Final Exit Network, n.d.-b, para. 1). Final Exit Network's website describes hastened death as "the human and civil rights cause of this century, just as women's suffrage was in the 20's, racial rights in the 60's, and rights of the disabled in the 90's" (Final Exit Network, n.d.-c, para. 1). However, right-to-die language is increasingly being replaced by right-to-assisted-dying language. For example, the theme of the 2018 conference of The World Federation of Right to Die Societies was "#assisteddying: Human rights in the 21st century" (The World Federation of Right to Die Societies, n.d.). Similarly, on the Death with Dignity website, in a testimonial entitled "A Fundamental Human Right," Page Williams stated, "I would like the right to have the gift of medical aid in dying for myself . . . I believe that this is a fundamental human right" (Death with Dignity, n.d.-g).

Self-determination, autonomy, being in control, and asserting one's rights are powerful frameworks for women, given women's history of disenfranchisement, especially about their bodies. Autonomy in medical decisions, however, is more of a concern for Whites than, for example, for Blacks (Dula & Williams, 2005). It is, in many ways, an expression of privilege to have autonomy as a priority in medical decisions. When under threat, connecting with trusted others may be critical for survival. The framing of hastened death as a human right, and connecting it to women's reproductive rights, may also particularly appeal to White women. An audience of White women may be implicit in the following statement by Girsh (2002): "Having fought for choice for women in voting, reproductive rights, property ownership . . . [women] certainly know what they're doing when they fight for the right to have assistance in dying" (p. 289). One reason is that, in the dominant discourse, reproductive rights have been equated with the right to reduce one's fertility via access to contraceptives and legal, safe abortion. For Black women, reproductive concerns include the right to have children and the right to a safe pregnancy and delivery.⁸ Black women's reproductive concerns, however, have not been at the forefront of the dominant reproductive-rights discourse. Therefore, the dominant reproductive-rights discourse likely has mixed resonance for Black women. Taken together, this evidence suggests reasons why White women may come to feel that the hastened-death movement speaks about their concerns, aspirations, and values, in their language and with their stories—and why White women may be particularly drawn to it.

Medical aid in dying is the modern and rational way to death. In the pro physician-assisted-suicide discourse, medical aid in dying is the modern and rational way to death. It is about

⁸ Black women have 3 to 4 times the rates of maternal mortality of White women (Villarosa, 2018).

being informed and logical; clear-headed, lucid, and matter-of-fact; pragmatic, free-thinking, and sophisticated; sane and sensible; enlightened and progressive; noble and brave (e.g., Angell, 2014; Friedman, 1997; Girsh, 2002; Humphry, 2000). By contrast, opposition to physician-assisted suicide is viewed as a sign of irrationality, ignorance, and superstition—"the forces of intellectual darkness," as Humphry (2000) put it (p. 2). Those who are against physician-assisted suicide are perceived as imposing their religious dogma on others. For example, Girsh (2001) argued that "mythology" and "superstitious beliefs about dying" are at the foundation of the opposition to physician-assisted suicide (p. 8).

There are many examples of physician-assisted suicide being presented as a rational death for modern women. In the (predominantly White-readership) fashion magazine *Vogue*, physician-assisted suicide has been framed as an opportunity, literally, "One last choice," for women (Friedman, 1997, p. 158). Similarly, on the *Death with Dignity's* website, in a testimonial entitled "Designing the Experience of Death" (*Death with Dignity, n.d.-i*), a fashion designer recounted how, via the DWDA, she designed a "noble and brave" death for her mother. Advice columnist Landers promoted the establishment of death clinics as an alternative to long-term care. She called the idea "a sane, sensible, civilized alternative to existing in a nursing home, draining family resources, and hoping the end will come soon" (cited in Landers, 1993, para. 1).

Rational and brave are powerful words for women because they are rarely used to describe them. Their association with physician-assisted suicide is disquieting. For context, it is important to remember that White men's high suicide rates, for example, in Western Europe and in the United States, have, for a long time, been attributed to their being rational and courageous. Historically, women and other "primitive" people (as anybody who was not an educated White man was viewed, for example, by Durkheim) were considered incapable of the deliberate renunciation of life that is suicide. This übermensch theory of suicide fell apart when it became known that in China, women, particularly rural women, had the highest suicide mortality (see Canetto, 2008, for a review). In the current pro assisted-suicide discourse, women demonstrate rationality and courage when they fight for, and pursue a hastened death. The framing of physician-assisted suicide as a rational death may be particularly meaningful for White women because, as a result of White privilege, they are encouraged to aspire to, and may identify with dominant values, as compared to Black women, who having been stereotyped as unfit for those values (Nelson, Cardemil, & Adeoye, 2016; Purdie-Vaughns & Eibach, 2008), may have learned to reject them.

Death with dignity is about poise and propriety. In the advocacy discourse, physician-assisted suicide is presented as a way to prevent the so-called indignities of aging, and also the physical and emotional messiness and unpredictability of nonhastened dying. Physician-assisted suicide is promised to be a poised, disciplined, clean death; a death with a predictable course; a death that can be scheduled and announced; a death that can be preceded by a properly planned funeral reunion, spirited or solemn, with family and friends. In the pro discourse, physician-assisted suicide is also said to avoid the physical and emotional messiness and the uncertainties of unassisted suicide. In sum, in the pro discourse, a physician-assisted suicide is framed as a death that minimizes the

inconveniences, for family and friends, of a nonhastened death or an unassisted suicide.

The dominant femininity discourse is also full of references to poise. Good women are proper, controlled, and disciplined. In life, as in death, they do not make demands, draw attention to themselves, or make a mess. They live and exit from life quietly and unobtrusively (Canetto, 2001; Canetto & Hollenshead, 1999–2000; Kohm & Brigner, 1998; Wolf, 1996).

Examples of dominant-femininity-decorum themes in the physician-assisted-suicide narrative can be found in various sources. For example, Dunshee, a founder of *Compassion in Dying*, wrote, in *Vogue* magazine, about a woman whose assisted suicide she witnessed: "She met me at the door holding a vacuum cleaner . . . [She] was doing a final housecleaning . . . [She also] had mouthwash on her nightstand . . . to use after she swallowed the barbiturates mixed in applesauce" (Friedman, 1997, p. 165). A journalist for Australia's *The Canberra Times* wrote, "For the well-organized housewife . . . [a hastened death] is . . . [the ultimate] tidy solution" (Verlander, 1997, p. 16).

Physician's aid-in-dying makes dying gentle and graceful. *Gentle* and *graceful* are common terms in the pro physician-assisted-suicide discourse. Janet Good, a physician-assisted-suicide advocate whose death was hastened by Jack Kevorkian, a Michigan pathologist, described physician-assisted suicide as "gentle deliverance," "a soft landing" (Lessenberry, 1997, p. 82). *Graceful Exit* is the title of a book about "the right to control one's death" (Basta, 1996). "I Want to Go Out With Grace" is the title of a testimonial by Anne Littlewood on the *Death with Dignity's* website (*Death with Dignity, n.d.-j*).

The terms *comfortable* and *soothing* also recur in the pro physician-assisted-suicide discourse. A "focus on the individual's comfort" is *Compassion & Choices'* (n.d.-b) first principle of "care." *Come Lovely & Soothing Death* is the title of a right-to-die book (Fox, Kamakahi, & Capek, 1999).

In the dominant discourse, *graceful* and *gentle* are words associated with White and upper-class femininity—in contrast to terms like *strong* and *angry*, which are linked to Black and lower class femininity (Nelson et al., 2016). A physician-assisted-suicide advocate wrote that Maynard, a conventionally attractive, White-looking, educated, married woman who hastened her death at age 29, greatly helped the cause because she "made her story public with such grace" (Angell, 2014, para. 15). Comfortable and soothing are spa words, and spas are coded as privileged-women's spaces—though in physician-assisted suicide, the comfortable care is fatal care. Whether by coincidence or design, these conventional-femininity words may especially appeal to White, socially privileged women. These women may feel that the movement for a gentle, soft, graceful, comfortable deliverance is about, and for them.

Medical assistance in dying assures a good, peaceful death. A powerful theme in the pro physician-assisted-suicide discourse is that physician-assisted suicide is a good, peaceful death. *Compassion & Choices* (2017a) affirms its commitment to helping people "achieve a peaceful death" (p. 7). Similarly, peaceful is how physician-assisted suicide is described on the *Death with Dignity's* website. A testimonial by Jenny Cooper is entitled "To Peacefully Fall Asleep" (*Death with Dignity, n.d.-k*). One by Melissa Wood is labelled "A Peaceful Way" (*Death with Dignity,*

n.d.-l); and one by Mary Klein is called “Option of a Peaceful Death” (*Death with Dignity*, n.d.-m).

A contrast is made, in the pro physician-assisted-suicide narrative, between the peaceful death one can achieve via physician-assisted suicide and the horrific death one will likely have without it. Physician-assisted suicide is sometimes presented as a good death in comparison with the bad death that unassisted suicide would be. For example, Barbara Coombs Lee stated that Compassion in Dying was founded to provide a “peaceful” death to individuals who “were contemplating violent suicides . . . and doing all manner of horrific things to avoid . . . [a] terrible death” by AIDS (Childress, 2012, *The evolution of America’s right-to-die movement*, 1993).

In the pro discourse, what makes physician-assisted suicide a “good death” is the medical system that manages it. Physician-assisted suicide, it is emphasized, is a death that requires the permission of physicians and a prescription from a pharmacy. A medical assessment of the petitioner’s illness and of the illness’ prognosis is mandatory (at least in the United States), and presumably, the best of poisoning science drives the choice of the lethal prescription, to make the dying peaceful and to avoid complications—which, in physician-assisted suicide, means not dying quickly enough, or not dying at all and requiring other interventions for death to occur (Emanuel, Onwuteaka-Philipsen, Urwin, & Cohen, 2016).

It is interesting how, in the pro physician-assisted-suicide discourse, physicians’ involvement sanitizes the suicide. The participation of physicians as “technical dispensers of death” transforms the suicide into a medical procedure (Kass & Lund, 1996, p. 29) and strips it of its tragic dimension (Aviv, 2015). Physician-assisted suicide is a suicide that has lost its deviant, defiant connotation and its conventionally masculine edge. It is suicide by application; a medical option. Permission for it is to be obtained via a bureaucracy of oral and written petitions, forms, witnesses, and waiting periods. Physician-assisted suicide is, in many ways, a disciplined suicide; a deferential suicide; a subdued suicide; a conventionally feminine suicide (Canetto & Hollenshead, 1999–2000).

For context on this interpretation, it is important to note that, in the United States, suicide is generally perceived as a masculine act. Female suicide, in the United States, is viewed as more wrong and more foolish than male suicide. Also, women who kill themselves are seen as less well-adjusted than men who kill themselves (see Canetto, 1992, 1997, for reviews).

The theory that the medicalization of suicide that is intrinsic to physician-assisted suicide makes it more accessible to women is consistent with a diversity of data on assisted and unassisted suicide. For example, a Swiss study found that among the seriously ill, women died of physician-assisted suicide more often than men, whereas men died of suicide more than women (Steck, Egger, & Zwahlen, 2016).

The medicalization of physician-assisted suicide associated with its legalization may especially enable White women’s participation in it (Canetto, 2011). To start with, by way of ethnic privilege, the White and well-educated women who died via Oregon’s DWDA likely had some positive experiences with the medical system. In any case, they trusted physicians enough to give them the power to evaluate them regarding their interest in hastened death when they were seriously ill, concerned about losing autonomy and dignity,

and worried about being a burden.⁹ It is to be noted that the insertion in the process of physicians, who have to approve the request and prescribe the lethal means, might alter the ambivalence, momentum, and trajectory of the decision, possibly making it more likely that the wish to die is acted upon, and that the act is fatal (Canetto, 1995, 2001; Canetto & Hollenshead, 1999–2000, 2002).

Death is tolerable for persons who are older and had a full life. A theme in U.S. life-and-death discourse is that a tolerable death occurs when the individual has had a full life. A full life is typically defined as a life that has run its typical span and has achieved narrative completion. For example, Callahan (1995) argued that death is tolerable in persons who have reached a certain age, accomplished their main life goals, and fulfilled their main life obligations: “If the person is old—say, in his 70s (and certainly by his 80s)—we . . . would not expect to find him playing football or climbing trees for recreation” (p. 166). Similarly, Emanuel (2014) wrote that he hoped to die at 75 because, by that age, he expected to “have lived a complete life” (para. 5). Incidentally, the idea that a long-enough life makes death tolerable, especially in the presence of illnesses, extends to death by suicide. Suicide is perceived as more permissible when the person is an older adult (Deluty, 1989; Uncapher & Areán, 2000) or when the person has illnesses or disabilities (Lund, Nadorff, Winer, & Seader, 2016; Stice & Canetto, 2008; Winterrowd, Canetto, & Benoit, 2017). A theme in the idea of “rational suicide among the elderly,” as Humphry (1992) called it, is also that of a completed life (p. 125).

A problem with dominant definitions of the full life is that they are often (and often implicitly) based on White men’s life expectancy and experiences. As a result, they are biased against women (Canetto & Hollenshead, 1999–2000; Jecker, 1991). For example, Callahan’s (1995) proposal of a criterion for limiting access to health care based on White male life expectancy harms White and Latina women because White and Latina women live longer than White men. Definitions of the completed life that fail to take into account of pervasive biases against women are also harmful to women. Consider the case of a middle-aged homemaker whose adult children have established independent work and family lives. Should this homemaker develop disabilities and have difficulties accessing care, might her interest in hastened death be viewed as rational because her conventionally feminine life story appears completed? Incidentally, this was the biography of several White women whose suicide was assisted by Kevorkian (Canetto & Hollenshead, 1999–2000). It was also the biography of two physically healthy, divorced women whose hastened-death request was approved in the Netherlands (Hendin, 1995) and in Belgium (Aviv, 2015). The Netherlands case involved a 50-year-old woman who had recently lost her two children. The Belgian woman had a

⁹ Concerns about autonomy, dignity, and being a burden are top reasons for hastened-death requests in the United States. For example, they were endorsed by 91%, 89%, and 44% of Oregon DWDA decedents, respectively. By contrast, inadequate pain control or concern about it was a reason reported by only 26% of Oregon DWDA decedents (Oregon Health Authority, 2018).

history of depression and had experienced a difficult relationship breakup around the time of her hastened death, at age 63.

Medical assistance in dying is about being compassionate and loving. The word *compassion* has pretty much been appropriated by the pro physician-assisted suicide camp. Compassion in Dying, according to one of its leaders, was established to provide a “compassionate” death to individuals with AIDS who would otherwise be “jumping from balconies and using guns and doing all manner of horrific things to avoid” a terrible death (Coombs Lee, in Childress, 2012, The evolution of America’s right-to-die movement, 1993). *Love* is also a word that recurs in the physician-assisted-suicide advocacy discourse. *Final Acts of Love: Families, Friends, and Assisted Dying* is the title of a book about individuals who engaged in “compassionate” killing of family and friends (Jamison, 1995). “A Demonstration of Love” is the title of Kate Staples’s story on the Death with Dignity’s website (Death with Dignity, n.d.-n).

Compassion and love are words associated with femininity. Good women are supposed to be compassionate and loving. The association of support for physician-assisted suicide with compassion and love aligns physician-assisted suicide with hegemonic femininity—and may contribute to White women’s advocacy for physician-assisted suicide.

Discussion

Choice is a powerful word for women. It is associated with the idea of self-determination—something which, through history, women have had to fight for. In the United States, the word *choice* is also associated with women’s right for self-determination about their body, and specifically about women’s reproductive rights.

In this article, I focused on what choice in physician-assisted suicide might mean for White women. My question was, if physician-assisted suicide is a powerful new option for women, as is argued in the pro discourse, why are White women its leading advocates and main users?

The novelty of my analysis is that I examined White women’s physician-assisted-suicide choices in context, and through the lenses of gender and ethnicity—in contrast to the dominant discourse, which treats these choices simply as expressions of individual preferences. My starting position was that the choices to advocate for, and/or to die of, physician-assisted suicide, like all choices, are rooted in gendered and racialized contexts and discourses, and that these contexts and discourses require examination.

The first context I attended to are facts of women’s lives that have implications for physician-assisted suicide, first, in general, and then with attention to White women. Several general facts emerged. As a group, women are less likely than men to accumulate the economic resources that they need in late adulthood. As they age, women experience serious illnesses and disabilities as well as care challenges. Furthermore, women are exposed to ideologies and practices that devalue them. One fact about White women stood out: their longevity. Therefore, when older and ill, White women may be uniquely positioned to experience themselves, and to be viewed by others, as a burden to their family and society, and also, possibly, to choose assisted suicide to avoid being a burden.

The second context I examined are dominant narratives of physician-assisted suicide and femininity. One such narrative is that physician-assisted suicide is a way for modern, sophisticated women to be in control and affirm their right for self-determination. Another, darker narrative is that physician-assisted suicide is a graceful way for sensible and proper women to relieve their families and society of the burden of their ill health and longevity. As physician-assisted-suicide advocate Girsh (2002) put it, women become physician-assisted-suicide activists to ensure that they can hasten their death when, having outlived their husbands, they do not have anybody to care for them. The modern-femininity narrative of self-determination with grace may be more compelling for White women than, for example, for Black women, because White women are expected to aspire to, and to achieve hegemonic-femininity ideals. Through the practice of being judged based on hegemonic-femininity ideals, White women may come to internalize them. Black women are excluded from hegemonic-femininity ideals (through a process of so-called intersectional invisibility; see Purdie-Vaughns & Eibach, 2008), so they may come to dismiss them, and as a result, may be less influenced by them.

Yet another narrative I examined is that of physician-assisted suicide as a medical option. To start with, I argued that the mediation of the medical system strips suicide of its agency and of its conventionally masculine connotation, transforming it into a conventionally feminine death. The fact that White women go for physician-assisted suicide, and that, for example, Black women do not, may also have to do with White women having had relatively positive experiences with medical systems. As members of a privileged group, White women (and, in particular, the educated White women who advocate for, and/or die via Oregon’s DWDA) likely interact with medical systems that, at least in part, represent their experience, values, and interests. White, educated women may therefore have some reason to trust these systems and even to worry about excessive care. By contrast, Black women, like Black men, know that the provider bias that they need to watch for is inadequate care (Dula & Williams, 2005; King & Wolf, 1998).

A narrative that may uniquely relevant to White women’s participation in physician-assisted suicide is that a hastened death is appropriate for people who have fulfilled their main life goals and responsibilities, based on their biography. For women who spent at least some of their adult years as homemakers (typically, White women), the completed life may be defined as having children who are established in their family and work.

A conclusion of this intersectional analysis is that the facts of White women’s lives, and the dominant narratives of femininity and of physician-assisted suicide, likely direct White women toward physician-assisted suicide. Another conclusion is that these facts and narratives may support White women viewing themselves, and others viewing them as making a rational decision when they go for physician-assisted suicide. So far, these dynamics do not seem to apply to other women. In the case of physician-assisted suicide, the category of woman clearly encompasses a broad range of experiences, positions and behaviors, depending on ethnicity. This intersectional analysis also makes visible a corollary but important point: that White women’s and men’s similar rates of physician-assisted suicide obscure the different contexts of their choices. White women and men come to physician-assisted suicide via different paths, and likely for different reasons.

Implications for Theory

What might the findings of this analysis mean for theory? One interpretation they suggest is that White women “get” physician-assisted suicide and that Black women do not; that White women understand its empowering potential and, by way of White privilege, can go for it, whereas Black women do not or cannot—because they are unsophisticated, or because they need to be concerned about insufficient care and premature mortality (Dula & Williams, 2005). Once Black women and men achieve enough education, economic well-being, and power in society, this argument goes, they will join White women and men as advocates and users of physician-assisted suicide. Another interpretation is that it is Black women and men who have a sophisticated understanding of physician-assisted suicide. According to this interpretation, it is White women and men who should listen to, and learn from what Black women and men are saying about physician-assisted suicide—for example, that the principle of individual choice is neither feasible nor desirable in most medical situations, but especially when the person is seriously ill; that the concept of a generic, right-bearing agent leaves unexamined the gendered and racialized realities (of life, end-of-life, and death) that constrain choice in care; and that medical hastening of dying is not required to be compassionate toward the seriously ill or to support dignity at the end of life (e.g., Dawson, 1998; Dula & Williams, 2005).

Implications for Practice

The evidence and conclusions of this intersectional analysis of physician-assisted-suicide discourses and practices have implications for psychology’s practice. They are relevant for psychologists involved in assessment and intervention as well as psychologists whose roles are research and education. In this last section I offer examples of psychology’s practice implications (for additional intersectionality-focused practice implications, see Canetto, 2011).

In several U.S. states, licensed psychologists have a formal role in the physician-assisted-suicide process. For example, Oregon’s DWDA (n.d.) stipulates that the petitioner “be referred for a psychological examination” if either the prescribing or the consulting physician “believes that the patient’s judgment is impaired by a psychiatric or psychological disorder” (p. 1). Psychologists informed by an intersectional perspective would evaluate petitioners’ mental status and capacity in light of petitioners’ cultural and social location, not just in terms of an abstract ability to “make and communicate health care decisions” (p. 1).¹⁰ In the case of White female petitioners, psychologists should especially pursue low-entitlement beliefs and being-a-burden concerns. Meanings of femininity, disability, and assisted suicide would also be core in psychological evaluations of White female petitioners. To ensure that an intersectionalities lens is integrated in hastened-death discourse and practices, psychologists need to go beyond including intersectionalities in their evaluations of petitioners. One reason is that psychological evaluation referrals are made in very few cases. In Oregon, only 4.9% of DWDA cases were referred for an evaluation in the past 20 years, and 3.5% in 2017 (Oregon Health Authority, 2018). Another reason is that psychologists are not the sole professionals who can be called in for an evaluation. For systematic and sustained impact, intersectionalities frameworks

need to be integrated in end-of-life education and policies. To this goal, psychologists should seek to educate the general public, students, and professionals across relevant disciplines as well as policymakers about the intersectional specificities and dynamics of physician-assisted suicide and suicide. This would include educating about gendered and racialized issues in the wish to hasten one’s death and also, more broadly, about the social contexts of individual choice.

The intersectional specificities of physician-assisted suicide have implications for psychologists in research roles. These specificities call for psychologists to advocate for, and take a lead in an intersectional framing of hastened-death research. At a most basic level, it is important that hastened-death research moves beyond single demographic-category analyses (e.g., by sex or by ethnicity only), as found, for example, in annual reports by DWDA states (e.g., Oregon Health Authority, 2018). Beyond this basic level of change, the intersectional specificities of physician-assisted suicide call for research based on nuanced formulations of choice and vulnerability (Canetto, 2011; Kohm & Brigner, 1998; Krag, 2014). These are formulations that take seriously the idea that individual choices are shaped by social norms and constrained by feasibility. They also are formulations that recognize that vulnerability is not simply, and always, greater for people who experience multiple oppressions (Canetto, 2011; Krag, 2014; Purdie-Vaughns & Eibach, 2008). Unmitigated oppression, for example, by way of sexism and racism, can trigger push-back and defenses, including collective protective mechanisms and, therefore, some resilience. By contrast, a mixture of oppression and privilege may support trust, and even deference, to systems, like the medical system, that have the power to effect enormous good but also serious harm. Positioned between oppression and privilege, White women may have less choice about physician-assisted suicide than may be inferred through DWDA type of data. In the United States, an intersectional perspective on hastened-death research calls for a focus on older White women’s paradoxical assisted and unassisted-suicide choices, to understand the dynamics that contribute to their strong participation in physician-assisted suicide, as advocates and decedents, and their rarity among suicide decedents.

¹⁰ The request to die is a complex communication with multiple meanings (Canetto, 2011; Canetto & Hollenshead, 2002; Monforte-Royo, Villavicencio-Chávez, Tomás-Sábado, Mahtani-Chugani, & Balaguer, 2012; Muskin, 1998).

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