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GUEST ESSAY

There Are Ways to Die With Dignity, but Not Like This

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Jordanna Kalman

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By **L.S. Dugdale**

Dr. Dugdale is a physician and an ethicist at Columbia University and the author of the book "The Lost Art of Dying: Reviving Forgotten Wisdom."

Early in my medical career, I was shocked to learn that intensive care units are full of patients who never expect to leave the hospital alive. Facing advanced disease and collapsing organ systems, they rely on the miracles of modern technology to pump their hearts, help them breathe, close their wounds and filter their blood for as long as possible.

Many patients and their families understandably wish to delay death. Others find the experience torturous: the ever-mounting costs, the endless cycle of interventions, the literal and figurative sterility of the hospital environment. Some doctors and nurses secretly wonder whether these practices are in the best interests of their patients. I am one of them.

Some years ago, I began to advocate a revival of the medieval practice of *ars moriendi*, or the art of dying — a more accepting, less fearful, more community-based approach to the end of life. I believe that in many cases, it is wise to forgo life-extending interventions for the sake of a higher quality of life and a better death.

Given my views, you might expect that I would celebrate the Medical Aid in Dying Act recently passed by the New York State Assembly and now awaiting action in the New York State Senate. But this bill, like similar legislation that facilitates dying in places such as Oregon and Canada, is not about dying well. It is about relieving society — government, medical systems, even families — of the responsibility to care for those who need the most help: the mentally ill, the poor, the physically disabled.

The New York bill defines “aid in dying” as a medical practice. If a patient qualifies, a doctor can prescribe a lethal dose of drugs that the patient may self-administer to end his or her life. Labeling this a medical practice confers a kind of legitimacy on what is also called, more accurately, physician-assisted suicide.

When it comes to conventional suicide, it’s no secret that people who suffer from depression are at greater risk. There is no reason to think that depression is any less of a factor when it comes to physician-assisted suicide. Yet the New York bill, which is modeled on the Death With Dignity law enacted in Oregon in 1997, does not even require a mental health professional to screen patients for depression unless one of the doctors involved determines that the patient’s judgment may be impaired by a psychiatric or psychological disorder.

This is a major oversight that fails to protect depressed people from making flawed decisions. Depression is not just a mood; it distorts perception, often convincing people that their lives are worthless, their loved ones are better off without them and death is their only option. When people intervene to prevent a conventional suicide attempt, they do so because they believe such thoughts are not expressions of a person's true will but rather symptoms of an illness.

Oregon collects data on assisted suicides in the state, and those numbers should prompt concern about depressed patients. In 2024, for example, most people who received assisted suicide prescriptions in Oregon had terminal cancer — a group known to be at high risk for depression. Yet of the 607 Oregonians who received lethal prescriptions that year, only three were referred for psychological or psychiatric evaluation. (Research has shown that depression is a diagnosis that many doctors are prone to miss.)

This is troubling because depression remains a highly treatable illness. If we fail to properly screen terminally ill patients for depression, we risk letting the illness — not the individual — make the decision to end a life.

There is also a concern about the vulnerability of those with physical disabilities, who are accustomed to having to prove that their lives have value. Disability advocates often worry that this burden will only increase once there's a legitimate pathway to ending lives deemed not worth living. The New York bill tries to respond to these concerns by prohibiting anyone from qualifying for assisted suicide solely on the basis of age or disability. Instead the patient must have a terminal illness or condition, with a prognosis of six months or less to live.

But in practice a prognosis is not always a straightforward affair, especially when it comes to the most vulnerable patients. As a doctor who has cared for many patients with disabilities, I know how easily a prognosis of six months can become a reality — especially if a patient stops treatment. A person with intractable seizures becomes terminal if she discontinues her anti-epileptic medicines. So does someone reliant on artificial nutrition if she stops her feeds. A brittle diabetic who stops taking insulin quickly becomes terminal.

In this light, to claim that people with disabilities are protected by the New York bill is disingenuous. The bill may prevent them from qualifying for assisted suicide solely because of their disabilities, but disability can become a terminal condition by choice — or despair.

Supporters of medical aid in dying often invoke the importance of preserving personal autonomy. Last year, the No. 1 end-of-life concern that recipients of assisted suicide in Oregon cited was loss of autonomy. This is understandable: Those whose physical condition is rapidly deteriorating may see death as preferable to a life over which they have no control.

But lack of autonomy is not unique to end-of-life situations; it is often an everyday reality for the disabled and the poor. We don't want to offer people assisted suicide for just any loss of autonomy.

Here, the experience of Canada, which since 2016 has allowed eligible adults to request medical assistance in dying, is worrisome. In 2023, 432 Canadians who received assisted suicide said they required but did not receive disability support services. More disturbing still, nearly half of the nonterminal patients who received assisted suicide did so at least in part because of loneliness. One man sought assisted death as a result of homelessness, then changed his mind after a GoFundMe campaign helped him find shelter. What began as a right to die when death is "reasonably foreseeable" seems to have evolved into the possibility of a hastened death for almost any form of suffering.

This is not a compassionate policy — not in Canada, not in Oregon and not, should the bill become law, in New York. Instead of investing in the infrastructure of support for the lonely, the depressed, the disabled and the poor, we offer them a prescription for death. We call it autonomy, but it's abandonment.

The art of dying well cannot be severed from the art of living well, and that includes caring for one another, especially when it is hard, inconvenient or costly. It is not enough to offer the dying control. We must offer them dignity — not by affirming their despair but by affirming their worth. Even when they are suffering. Even when they are vulnerable. Even when they are, in worldly terms, a burden.

<https://www.nytimes.com/2025/05/11/opinion/medical-aid-dying-new-york.html?searchResultPosition=1>

It never ceases to amaze how people cannot resist intruding into other people's most intimate spaces to act out their own moral issues. To insist that no one should have the right to MAiD till society provides the full panoply of proper supports and treatments is shameless. We know this will never happen. In a globe given to greed, wealth will always be skewed away from such things. To say that sufferers must wait till justice comes is pathetic. And to hold out that no one should be depressed, and can be made "undepressed" is bizarre, given pain, suffering, and human failures in humane humanity. TJB