

NOW IS THE MOMENT TO REFLECT: TWO YEARS OF EXPERIENCE WITH OREGON'S PHYSICIAN-ASSISTED SUICIDE LAW

Susan R. Martyn and Henry J. Bourguignon

In November of 1994, Oregon voters approved Measure 16, the Death with Dignity Act, making Oregon the first state to legalize the practice of physician-assisted suicide. Three years later, the law went into effect. Today, Professors Martyn and Bourguignon take a comprehensive look at the substance and operation of this controversial statute.

The authors begin by looking to Oregon and the state's assessment of the law as set forth in two reports from the Oregon Department of Human Resources. The authors focus on the first cases of physician-assisted suicide as documented by these reports, noting the scarcity of information available relating to these early cases. Professors Martyn and Bourguignon emphasize that all the restrictive elements of the state law, the law's supposed teeth, are vague, elastic concepts, subject to personal interpretation by physicians. The Oregon statute depends upon and requires physicians to determine such elusive factors as whether the patient is competent, is acting voluntarily, is suffering pain, or is terminally ill. The authors stress that, inevitably, these physicians, not their patients, will effectively make the decision about assisted suicide. Physician-assisted suicide will become just one more remedy prescribed by physicians, not a choice about dying made by individual patients.

Susan R. Martyn is a Professor of Law at the University of Toledo College of Law, and an Adjunct Professor of Law and Medical Humanities, Medical College of Ohio at Toledo.

Henry J. Bourguignon was Professor of Law and Distinguished University Professor and is now Professor Emeritus at the University of Toledo College of Law.

The authors review each component of the law, analyzing the objectives of the law in light of recent experience with its operation. The authors then explore issues of competency and voluntariness and confront the complexities of determining what constitutes "terminal illness" and physician "assistance." Finally, the authors reach the conclusion that it is impossible to document and monitor physician-assisted suicide in a manner that ensures the law's limits are not violated. They recommend that other states consider Oregon's experience and refrain from enacting similar laws.

I. Introduction

Legal development, like biology, knows no spontaneous generation. Some precedent can always be found for each new statute or judicial decision. The law moves forward, looking back. But there are moments in legal development that are uniquely pregnant with change. One thinks of the passage, after long and anguished debate, of the Civil Rights Act of 1964.¹ Though surely having roots which had survived years of American racial turmoil, the Civil Rights Act undoubtedly marked a clear, fresh beginning.

The Oregon Death with Dignity Act² marks just such a turning point in American law. The legal possibility of physician-assisted suicide has now been introduced into the law of one state. The Oregon health authorities have issued two reports on the first two years of the law's operation. Now is the moment to pause and think carefully through the full ramifications of this law. Should this Oregon law serve as a model for other states to adopt? Should the results of the first two years of assisted suicides assure citizens in Oregon and other states that the novel experiment has reliably and safely achieved its purpose? Or should the Oregon law be rejected and repudiated as far too dangerous in contemporary American society?

This article takes a full and detailed look at the first two years of physician-assisted suicide in Oregon. The flaws in the Oregon law and the canyon-like gaps in our understanding of the operation of the law cry out for a prudent and wary study of the first year of the law's applicability. Physician-assisted suicide is not just another legal experiment; its introduction as a morally and legally acceptable form of ending lives has abruptly changed the law's age-old orientation. This

1. 42 U.S.C. § 2000 (2000).

2. OR. REV. STAT. §§ 127.800–897 (1997). The passage of the statute and the subsequent court challenges to it are briefly recounted by Simon M. Canick, Note, *Constitutional Aspects of Physician-Assisted Suicide After Lee v. Oregon*, 23 AM. J.L. & MED. 69 (1997); and Patrick M. Curran, Jr., Note, *Regulating Death: Oregon's Death with Dignity Act and the Legalization of Physician-Assisted Suicide*, 86 GEO. L.J. 725 (1998).

new Oregon legalized practice calls for a thorough examination of the law's two-year history and of the trajectory of the law into the future.

In June 1997 the Supreme Court, in cases from the states of Washington and New York, unanimously agreed that there is no general, constitutionally protected right to the assistance of a physician to commit suicide.³ In the Supreme Court cases concerning physician-assisted suicide, however, Justices O'Connor and Souter explicitly looked to state legislatures as better able to craft a careful legal framework which would allow assisted suicide in a few, clearly limited cases and would protect the many vulnerable persons from suicide or euthanasia in all other cases.⁴ Justice Souter, in explicitly calling for a remand to the legislatures, insisted that courts lacked the capacity to resolve the many factual, moral, and legal uncertainties involved in the controversy over assisted suicide. He continued,

Legislatures, on the other hand, have superior opportunities to obtain the facts necessary for a judgment about the present controversy. Not only do they have more flexible mechanisms for factfinding than the Judiciary, but their mechanisms include the power to experiment, moving forward and pulling back as facts emerge within their own jurisdictions.⁵

Justice O'Connor pointed out that "[s]tates are presently undertaking extensive and serious evaluation of physician-assisted suicide and other related issues."⁶ Justice Souter referred in his opinion to "state regulation with teeth."⁷ This suggests the possibility that a state law could allow physician-assisted suicide in a precisely defined number of cases. Such a state law would have teeth that would protect persons who lack capacity, who suffer from depression or other mental illness, or those who might be subject to undue influence, coercion or other vulnerability, from being subjected to physician-assisted suicide or euthanasia. The idea sounds attractive, even noble: a state statute, designed with accuracy and sensitivity, which would have the teeth to prevent likely abuses.

3. See Susan R. Martyn & Henry J. Bourguignon, *Physician-Assisted Suicide: The Supreme Court's Wary Rejection*, 31 U. TOL. L. REV. (forthcoming 2000).

4. Parts of the present article have previously appeared, prior to the Supreme Court's two decisions, as an article by the authors, *Physician-Assisted Suicide: The Lethal Flaws of the Ninth and Second Circuit Decisions*, 85 CAL. L. REV. 371 (1997).

5. *Washington v. Glucksberg*, 521 U.S. 702, 788 (1997) (Souter, J., concurring).

6. *Id.* at 737 (O'Connor, J., concurring).

7. *Id.* at 785 (Souter, J., concurring).

Yet Oregon, by what it has said and by what it has failed to say in the first two years, has shown convincingly that any physician-assisted suicide law will create the possibility for serious and widespread abuse. This article can be summarized simply—the Oregon assisted-suicide law has no teeth.

Prior to the Supreme Court's 1997 decisions, Oregon, by direct initiative, had already enacted the nation's first law to permit and regulate physician-assisted suicide.⁸ The law did not go into effect until the end of 1997, after the two Supreme Court decisions. Shortly after the law went into effect, a task force of professionals organized by Oregon Health Sciences University published a guidebook for caregivers, which explained and fleshed out the bare-bones structure of the law.⁹ The first reported deaths under the law took place in 1998 and the Oregon Department of Human Resources issued its report on the first year's experience in February 1999.¹⁰ A second report followed in February 2000.¹¹ This article will comment on the fairly meager amount of information supplied by the Department of Human Resources. It is best to begin by considering the first case of assisted suicide in Oregon under the physician-assisted suicide law, for which there are few details, and by summarizing the sparse details of the Department of Human Resources Reports. The heart of this article will examine one by one and in detail the restrictions on physician-assisted suicide in the Oregon law, the supposed teeth in the law.

II. The First Documented Case

Mrs. A, the first documented case of legal physician-assisted suicide in Oregon, was in her mid-eighties and suffered from advanced

8. In November 1994, the voters of Oregon, by the initiative process, approved Measure 16, The Death with Dignity Act, OR. REV. STAT. §§ 127.800–.897. The implementation of the law was delayed by litigation and a referendum to the voters to consider repeal of the law. After the repeal effort was defeated, the law went into effect in November 1997. The first year of the law's operation was 1998.

9. See THE OREGON DEATH WITH DIGNITY ACT: A GUIDEBOOK FOR HEALTH CARE PROVIDERS (Kathleen Haley & Melinda Lee eds., 1998) [hereinafter OREGON GUIDEBOOK].

10. See CENTER FOR DISEASE PREVENTION & EPIDEMIOLOGY, DEPARTMENT OF HUMAN RESOURCES, OREGON'S DEATH WITH DIGNITY ACT: THE FIRST YEAR'S EXPERIENCE (1999). [hereinafter THE FIRST YEAR'S EXPERIENCE]. The same results are also presented in Arthur Chin et al., *Legalized Physician-Assisted Suicide in Oregon—The First Year's Experience*, 340 NEW ENG. J. MED. 577 (1999).

11. See Amy D. Sullivan et al., *Legalized Physician-Assisted Suicide in Oregon—The Second Year*, 342 NEW ENG. J. MED. 598 (2000) [hereinafter *Second Year Report*].

breast cancer which had apparently spread to her lungs.¹² The reports of her death are incomplete and based on sources with biases in favor of or against assisted suicide. As with the state's official report on all the cases of assisted suicide in 1998 and 1999, the information is sketchy and inadequate—the Oregon law shrouds physician-assisted suicide behind a thick veil of secrecy.

The first two physicians to whom Mrs. A talked about assisted suicide, one her personal physician and some other physician, both refused to assist her in ending her life.¹³ It appears that one or both of the physicians thought that Mrs. A was depressed and that her decisionmaking capacity was impaired.¹⁴ The medical director of Compassion in Dying, an advocacy group in favor of physician-assisted suicide, had two telephone conversations with Mrs. A and also with her son and daughter.¹⁵ From the telephone contacts he called into question the medical opinion of the physician who had concluded Mrs. A suffered from depression.¹⁶ This physician admitted that at the time of his telephone interviews, Mrs. A was not bedridden or suffering great pain and was largely able to take care of herself.¹⁷ The medical director referred Mrs. A to a physician who in turn had Mrs. A interviewed by a consulting physician and a psychiatrist.¹⁸ These three physicians concluded that Mrs. A qualified for physician-assisted suicide under the Oregon law.¹⁹ The new attending physician then, with the assistance of a pharmacist, provided Mrs. A with the mixture of barbiturates which she took to end her life.²⁰

The identity of the physicians who finally examined Mrs. A and assisted her suicide are not known. We do not know on what basis

12. See Herbert Hendin et al., *Physician-Assisted Suicide: Reflections on Oregon's First Case*, 14 ISSUES L. & MED. 243, 244 (1998); Testimony of Diane Coleman, Executive Director of Progress Center for Independent Living, Cook County Ill. and founder of Not Dead Yet, Before the House Judiciary Committee, Constitution Subcommittee, July 14, 1998, Federal News Service; see also Brad Cain, *Woman is First to Use Suicide Law*, DALLAS MORNING NEWS, Mar. 26, 1998, at 3a; Kim Murphy, *Death Called First Under Oregon's New Suicide Law*, L.A. TIMES, Mar. 16, 1998, at 1A; Timothy Egan, *First Death Under Assisted Suicide Law*, N.Y. TIMES, Mar. 26, 1998, at 14A; *Shopping for Suicide*, DETROIT NEWS, Apr. 26, 1998, at B6.

13. See Hendin et al., *supra* note 12, at 244.

14. See *id.*

15. See *id.*

16. See *id.* at 245.

17. See *id.* at 246.

18. See *id.*

19. See *id.*

20. See *id.*

they concluded that she was not depressed despite the opinion of one or two other physicians. We do not know how they determined that she had the decisionmaking capacity to choose assisted suicide or that she was acting in a voluntary manner, not subject to undue influence, or that she was terminally ill. We do not know how well-trained the physicians or the psychiatrist were in diagnosing competence or mental illness or depression. We do not know whether any of the physicians tried to alleviate her real and pressing concerns.

It is known, however, that Mrs. A expressed a concern about being artificially fed.²¹ Yet, in an edited audiotape released by Compassion in Dying after her death, the physician who certified that she had capacity and that her decision was voluntary did nothing to assure her that she had the power to prevent tube feeding.²² The tape fails to provide any evidence that the physician tried to find alternatives to suicide that might meet Mrs. A's needs and calm her anxieties.²³ Instead, the same physician listed for her in a summary manner the alternative choices she could make, such as hospice support, chemotherapy, or hormone therapy.²⁴ It appears that no time was taken to explore with her the reasons why she chose assisted suicide or rejected other options.²⁵

The people of the State of Oregon might have expected some adequate analysis by the state's Department of Human Resources of the death of Mrs. A and of the others who received physician assistance in their suicides in the first two years of the new law's operation. However, they can derive little helpful insight into the actual operation of the physician-assisted suicide law in 1998 or 1999 from the reports issued by the Department. The First Year Report indicates that twenty-three persons in the state, including Mrs. A, were reported to the Department to have received prescriptions for lethal medications.²⁶ The report concludes: "Of these twenty-three persons, fifteen died after taking their lethal medications, six died from their underlying illness, and two were alive as of January 1, 1999."²⁷ In the sec-

21. *See id.* at 247.

22. *See id.*

23. *See* Kathleen Foley & Herbert Hendin, *The Oregon Report: Don't Ask, Don't Tell*, 29 HASTINGS CENTER REP. 37, 40-41 (1999).

24. *See* Hendin et al., *supra* note 12, at 247.

25. *See id.*

26. *See* THE FIRST YEAR'S EXPERIENCE, *supra* note 10, at 4.

27. *Id.* One person died in 1999. *See Second Year Report, supra* note 11, at 599.

ond year, thirty-three people received prescriptions and twenty-seven died after taking the medication.²⁸

Both the reports provide bare statistical summaries. In the first year, the median age of the twenty-one people who ingested a legal dose was sixty-nine; all twenty-one were white, fifty percent were male. In the second year, the median age was seventy-one, ninety-six percent were white, and fifty-nine percent were male.²⁹ Only five of the twenty-one (thirty-one percent) had a psychiatric or psychological consultation in year one. Ten (thirty-seven percent) were referred to a psychologist in year two.³⁰ Both reports implicitly assured the people of Oregon that all of the persons provided with a prescription for a lethal dose of medication had been considered “capable” or competent, had acted voluntarily, were terminally ill, and that all the physicians’ reports had fully complied with the law.³¹

Throughout this article we will refer to these reports, to glean some further shreds of information on the actual working of the physician-assisted suicide law. But vast areas of silence frustrate anyone’s ability to assess what really occurred. The Department of Human Resources naively accepts the factual accuracy of the scant reports sent to the Department by the physicians involved in each case. This article raises numerous questions that the Department failed to ask or failed to answer. It arranges the questions under a few crucial headings relating to the terms of the “teeth” in the assisted suicide law in Oregon. In the end, we conclude that a frightening pall of ignorance and silence conceals and obscures vastly more than it reveals about the first two year’s of physician-assisted suicide in Oregon.

III. The Questions Which Should Have Been Addressed in the Oregon Reports

The key operative provision of the Oregon assisted suicide law states:

An adult who is capable, is a resident of Oregon, who has been determined by the attending physician and consulting physician to be suffering from a terminal disease, and who has voluntarily expressed his or her wish to die, may make a written request for

28. See *Second Year Report*, *supra* note 11, at 599.

29. See *id.* at 600.

30. See *id.* at 601.

31. See *id.* at 603.

medication for the purpose of ending his or her life in a humane and dignified manner.³²

The Oregon law, as well as draft laws proposed for other states, attempts in general to assure a right to physician-assisted suicide only for: (1) a competent or “capable” person, (2) who voluntarily seeks help in dying, (3) is terminally ill, (4) is suffering, and (5) receives assistance from a physician in dying.³³ These are the “teeth” the State seeks to place in its regulation.

On its face, the Oregon law does not seem to make physician-assisted suicide available to every person who is deeply upset over losing a lover or a job, or to every person who is suffering from some emotional or psychological problem, or to every person with a serious, but not terminal illness, or to every person pressured by family or medical insurer to accept the suicide option.³⁴ A careful analysis of the complexity of the five elements of the Oregon law, however, demonstrates that each is not a fixed line, but rather a continuum. Each element of the law calls for a subjective assessment by the physician. The new, ragged, and blurry line created by the law is untenable and unenforceable. The supposed teeth in the law have no bite at all.

A. Was the Patient Capable?

The Oregon law uses the word “capable” to attempt to restrict assisted suicide to competent patients.³⁵ It defines capacity as the

32. OR. REV. STAT. § 127.805 (1997). The full statute is reproduced at OR. REV. STAT. §§ 127.800–.995 (1997).

33. *See id.* § 127.805.

34. Oregon physicians report that they grant only about one in every six requests and that about one in ten requests actually result in a suicide. *See* Linda Ganzini et al., *Physicians’ Experiences with the Oregon Death with Dignity Act*, 342 *NEW ENG. J. MED.* 557 (2000) [hereinafter *Physicians’ Experiences*].

35. Other proposed physician-assisted suicide laws also attempt to assure that only competent patients obtain the help of a physician in committing suicide. For example, the proposed *Model State Act to Authorize and Regulate Physician-Assisted Suicide*, drafted by Charles H. Baron et al., 33 *HARV. J. ON LEGIS.* 1, 27 (1996), states as one condition for physician-assisted suicide:

(3) [T]he patient has made a request of the responsible physician to provide medical means of suicide, which request is (A) not the result of a distortion of the patient’s judgment due to clinical depression or any other mental illness; (B) represents the patient’s reasoned choice based on an understanding of the information that the responsible physician has provided to the patient . . . concerning the patient’s medical condition and medical options . . .

See also Comment, *An Illinois Physician-Assisted Suicide Act: A Merciful End to a Terminally Ill Criminal Tradition*, 28 *LOY. U. CHI. L.J.* 763, 823 (1997):

2) a “competent patient” means a patient who is:

ability “in the opinion of the patient’s attending physician or consulting physician . . . to make and communicate health care decisions to health care providers.”³⁶ The law does not specify, however, how capacity determinations should be made. It instead relies on physicians to apply whatever clinical tests of capacity they deem appropriate. The best test for decisionmaking capacity, as the Oregon law seems to acknowledge in its definition, dovetails with the law of informed consent by focusing on the patient’s capacity to understand disclosure of relevant information and to communicate a personal choice.³⁷ At a minimum, this means that a seriously ill patient should understand not only his own medical condition, or diagnosis, but also the likely progress of the disease, prognosis, and the health care options available to treat it or to alleviate any pain or suffering. It also means that the person can evaluate possible outcomes as better or worse by comparing them to a framework created by that person’s individual values and goals.³⁸

It is often difficult to determine whether a patient is truly capable of making a life-and-death decision. No clear, simple litmus test exists to determine patient capacity or competence, in large part because, both in law and in medicine, decisionmaking capacity is a continuum.³⁹ The Oregon law seems to recognize the difficulty of assur-

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- i) conscious;
 - ii) capable of understanding his terminal diagnosis;
 - iii) capable of understanding his available alternatives to assisted suicide;
 - iv) capable of understanding that he is requesting assistance in suicide;
 - v) capable of understanding his own death; and
 - vi) able to clearly communicate health care decisions.

36. OR. REV. STAT. § 127.800(6) (1997).

37. See Uniform Health-Care Decisions Act § 1(3), 9 U.L.A. 312 (Supp. 1999) (“‘Capacity’ means an individual’s ability to understand the significant benefits, risks, and alternatives to proposed health care and to make and communicate a health-care decision.”).

38. See PRESIDENT’S COMM’N FOR THE STUDY OF ETHICAL PROBLEMS IN MED. & BIOMEDICAL & BEHAVIORAL RESEARCH, MAKING HEALTH CARE DECISIONS 45 (1980); see also James L. Werth Jr. et al., *Requests for Physician Assisted Death: Guidelines for Assessing Mental Capacity and Impaired Judgment*, 6 J. PSYCHOL. PUB. POL’Y & L. (forthcoming 2000).

39. For an exploration of the complexity of legal tests for competence, see John Parry, *Incompetency, Guardianship, and Restoration*, in THE MENTALLY DISABLED AND THE LAW 369, 371–78 (Samuel Jan Brakel et al. eds., 3d ed. 1985); cf. John Parry, *A Unified Theory of Substitute Consent: Incompetent Patients’ Right to Individualized Health Care Decision-Making*, 11 MENTAL & PHYSICAL DISAB. L. REP. 378, 379 (1987) (“[U]nfortunately, the definition of incompetency is of equal or greater complexity than substitute decision-making itself.”).

ing competence by requiring a counseling referral if the attending physician or consulting specialists think the patient is suffering from a psychiatric disorder or depression.⁴⁰ However, misunderstanding, psychological problems, depression, or coercion short of a diagnosable disorder do not require such a consult.

An Oregon multidisciplinary task force prepared a thoughtful guidebook designed to advise physicians about the new assisted suicide law.⁴¹ The Guidebook recommended that attending physicians refer all patients who request physician-assisted suicide for a psychiatric consult.⁴² “Given this diagnostic uncertainty and the gravity of the decision regarding physician-assisted suicide, it is strongly encouraged that the attending physician seek consultation from a clinical psychologist or psychiatrist in all cases.”⁴³ The Oregon Guidebook for implementing the Death with Dignity Act also acknowledged that personal bias, value systems, or philosophical beliefs of physicians can influence their judgment about patient capacity: “Mental health professionals who are either strong proponents or opponents of this Act may have difficulty objectively evaluating patients and should consider declining.”⁴⁴

The Guidebook makes clear that even those extensively trained to assess capacity recognize the inherent difficulty of doing so. A recent survey of Oregon psychiatrists and psychologists indicates that a mere six percent of these mental health professionals felt confident they could determine whether some mental or emotional problem was distorting the judgment of a person who requested assisted suicide, if they consulted with the patient only once.⁴⁵ They felt more confident only if they could assess capacity over a longer period of time.⁴⁶

Furthermore, the Guidebook emphatically insisted that a general description of the patient’s diagnosis, prognosis, treatment options, risks, and alternatives are not sufficient to obtain the patient’s “informed decision” under the Oregon law. When discussing physician-assisted suicide,

[t]he physician is not given the option of providing a general description and then asking the patient if more detail is desired. The

40. See OR. REV. STAT. § 127.825 (1997).

41. See OREGON GUIDEBOOK, *supra* note 9.

42. See *id.* at 22.

43. *Id.* at 22, 47.

44. *Id.* at 30.

45. See *id.* at 30.

46. See *id.*

attending physician must provide that detail as a matter of course; without it, there is no “informed decision.” . . . [Informed consent] requires no less than a detailed discussion of all elements of the patient’s “informed decision.”⁴⁷

Informed consent, the Guidebook recognizes, is based on what the patient understands and communicates, not on what the physician says.

The reports by the Oregon Department of Human Resources on the first two years of experience with the law ignored the wise and prudent suggestions of Oregon’s own Guidebook. The reports were based on specific information sent to the Department which “documents compliance with the law.”⁴⁸ This documentation by the attending physician involved completion of either a long form or a short form.⁴⁹ The short form provided no information at all about the patient’s competence, but merely authorized the Department to study the relevant portions of the patient’s medical records for itself.⁵⁰ The Oregon Department, by tolerating this short form, encouraged physicians who assist a suicide to adopt the gingerbread man approach—catch-me-if-you-can. The short form thrusts the entire burden of detecting noncompliance with the law on the Department. The long form, however, demands only slightly more from the attending physician. This long form (two pages) documenting the attending physician’s compliance merely provided a preprinted box for the physician to check—“determination that the patient is capable.”⁵¹ No documentation is required to show how the physicians determined the person’s capacity, what questions were asked and how well they were understood or answered, how much time was spent discussing the elements of informed consent or determining competence, on how many different occasions, or whether the patient’s judgment was clouded by medication, disease, depression, or mental illness. Despite the explicit statement in the Oregon Guidebook, the Department was completely satisfied if the attending physician merely checked in preprinted boxes that:

the patient was fully informed of: (check boxes) (a) his or her medical diagnosis; (b) his or her prognosis; (c) the potential risks

47. *Id.* at 49.

48. THE FIRST YEAR’S EXPERIENCE, *supra* note 10, at 2.

49. The various forms are reproduced in OREGON GUIDEBOOK, *supra* note 9, at 65–67.

50. *See id.* at 67.

51. *Id.* at 65.

associated with taking the medication to be prescribed; (d) the probable result of taking the medication to be prescribed; (e) the feasible alternatives, including, but not limited to, comfort care, hospice care and pain control.⁵²

These neatly marshaled checks give no indication at all of what the patient actually understood. A mere check on the form, or even the filing of the short form that does not even raise these questions, satisfies the Department that the physician has complied with the law.

The Department, in its reports, indicated that it also contacted the attending physicians, that is, those who wrote the lethal prescription for the forty-four patients, either by telephone or in person to ask further questions.⁵³ The Department apparently did not even attempt to ask further questions about the capacity determination. The Department's report describes the types of questions pursued orally as follows:

[Prescribing] physicians were asked to confirm whether the patient took the lethal medications, and were then asked a series of questions to collect data not available from the physician reports [the long or short forms] or death certificate (e.g., insurance status, end-of-life care, end-of-life concerns, medications prescribed, and medical and functional status at the time of death).⁵⁴

Neither study attempted to make contact with either the consulting physicians or psychiatric consultants. In the second year, the Department conducted interviews with family members of individuals who took lethal doses of medication about one year after the death.⁵⁵ No questions about the capacity of the patient were pursued.⁵⁶ The Department, based on this hollow data, admits that only fifteen of the sixty-eight prescription recipients had a psychiatric or psychological consultation,⁵⁷ yet nonetheless assured the people of Oregon that "all patients were ultimately determined to be capable in the context of the Death with Dignity Act. All physician reports were in full compliance with the law."⁵⁸

52. *Id.* at 66.

53. THE FIRST YEAR'S EXPERIENCE, *supra* note 10, at 3.

54. *Id.*; see also *Second Year Report*, *supra* note 11, at 599.

55. See *Second Year Report*, *supra* note 11, at 599.

56. See *id.*

57. See *id.* at 601.

58. THE FIRST YEAR'S EXPERIENCE, *supra* note 10, at 4-5. The *Second Year Report*, *supra* note 11, at 603, is a bit less glib: "As best we could determine, all the physicians who provided assistance complied with the provision of the Death with Dignity Act."

After the first two years of the Oregon law's operation, thirty-seven physicians have reported assisting patients to die, and every single one of these doctors either checked the box stating that the patient was capable or else told the Department to discover for itself from the patient's medical records whether the patient was competent. Yet, in the Second Year Report the Department admits that, because it reports any cases of noncompliance to the State Board of Medical Examiners, "noncompliance is difficult to assess."⁵⁹ Was there any remote likelihood that attending physicians, however sensitive and caring, would indicate on the form that the patient was possibly incompetent to make the request for assisted suicide? The meaningless, futile information supplied by physicians who checked the box "determination that patient is capable," along with similarly empty information supplied orally by the physicians, led the Department to conclude that there was full compliance by physicians in all forty-three cases of assisted suicide.

In reaching this conclusion, the Department noted that "many patients (27/43 or 63%) had to ask more than one physician for a prescription for lethal medication."⁶⁰ The Second Year Report explains this finding by pointing out that "[m]any physicians in the state are not willing to provide assistance with suicide."⁶¹ Yet, the same study cited for the proposition that "many physicians" are not willing to assist a suicide found that fifty-five percent of Oregon physicians support the law and "fifty-one percent were willing to prescribe lethal medication for a terminally ill patient."⁶² In fact, only twenty-nine percent of the physicians who refused to prescribe a lethal dose of medication did so because they were not willing, in any case, to offer the option. At the same time, thirty-seven percent of the requests from patients were rejected either because the patient did not meet the legal criteria or because the physician was unwilling to provide the prescription based on the subjective factors of the case.⁶³ Despite these findings, the Department never questioned whether these physicians refused the prescriptions because they questioned the capacity of their patients.⁶⁴

59. *Second Year Report*, *supra* note 11, at 603.

60. *Id.*

61. *Id.*

62. *Physicians' Experiences*, *supra* note 34, at 557, 558–61.

63. *See id.*

64. *See Second Year Report*, *supra* note 11, at 603.

Both reports' neglect of a major safeguard in the Oregon law may suggest that such determinations are relatively easy to make or, perhaps, that they are unimportant. The latter supposition seems completely inconsistent with the law itself. The former explanation, that capacity determinations are fairly routine, stands in stark contrast to clinical reality. Mrs. A's situation is far closer to the typical scenario. The fact that at least three different physicians initially assessed her capacity and came to different conclusions shows just how difficult and complex determinations of patient decisionmaking capacity or competence can be.⁶⁵ In practice, capacity to make a decision is not a single, easily isolatable scientific fact like the boiling point of water or the patient's blood pressure. Sensitive and conscientious physicians can arrive at different conclusions.

Clinical assessments of capacity call for a thoughtful, thorough, time-consuming, and necessarily subjective evaluation by the physician, who faces the reality that patients can be more or less competent and, capable at one moment and not another, competent for some decisions, but not others. The difficulty of making capacity determinations in patients suffering from serious illness is compounded by the medical, psychological, and social vulnerability of such persons. Indeed, several factors inherent in the typical assisted suicide case make it far more difficult to reliably evaluate the patient's competence.

First, the rate of depression among terminally ill patients appears to be "much higher than would be expected in the general population."⁶⁶ Recent studies indicate that fully two-thirds of those requesting assisted suicide suffer from depression.⁶⁷ Second, seriously ill patients often require powerful medications which can distort the patient's thoughts and feelings. "For many patients, the progression of disease will result in the impairment of decisionmaking capacity, either from the effects of the disease itself or those of drug treatment."⁶⁸ Third, seriously ill patients may also suffer physical and mental disability, have short attention spans, or find it difficult to concentrate.⁶⁹ They may have difficulty hearing or thinking through

65. See *supra* notes 12–20 and accompanying text.

66. James Henderson Brown et al., *Is It Normal for Terminally Ill Patients to Desire Death?*, 143 AM. J. PSYCHIATRY 208, 210 (1986).

67. See Foley & Hendin, *supra* note 23, at 39.

68. David Örentlicher, *From the Office of the General Counsel: Physician Participation in Assisted Suicide*, 262 JAMA 1844, 1845 (1989).

69. See OREGON GUIDEBOOK, *supra* note 9, at 31.

complex subjects. Though they may nod or reply acceptance, they may have forgotten some vital facts or misunderstood what has been said. Though some physicians might question their decisionmaking capacity, others might readily accept their capacity, as happened with Mrs. A.⁷⁰

Further, the words of a seriously ill patient spoken to a family member or doctor—"Would you help me to end it all?"—carry no assurance that they accurately reflect the patient's personal, authentic, autonomous self. In addition to problems created by the physical and mental challenges such patients face, the competency determination also must depend on physicians who can be tempted to base their assessments on whether the patient decides to accept the treatment the doctor or family members consider appropriate in the situation.⁷¹ If doctors or family members, like some judges, are horrified at the sight of a patient reduced "to a childlike state of helplessness, diapered, sedated, [and] incontinent,"⁷² they are likely to conclude that the patient is competent when he has requested assistance in dying. The physician's own fear of being in such a condition herself may color her view of what the patient might competently find to be an intolerable existence.

Physicians, psychiatrists, and psychologists, like anyone else who deals with a seriously ill, mentally or physically disabled patient can all too easily conclude that the patient's request for assisted suicide is reasonable and therefore competent. The greatest threat is that persons with mental or physical disabilities or depression, especially those who burden others, will readily be found competent to request

70. See Michael McGonnigal, *This Is Who Will Die When Doctors Are Allowed to Kill Their Patients*, 31 J. MARSHALL L. REV. 95, 114 (1997).

71. See, e.g., R. Sean Morrison et al., *When Too Much Is Too Little*, 335 NEW ENG. J. MED. 1755, 1759–80 (1996); see also D. Don Welch, *Walking in Their Shoes: Paying Respect to Incompetent Patients*, 42 VAND. L. REV. 1617, 1625–28 (1989); cf. S. Van McCrary & A. Terry Walman, *Procedural Paternalism in Competency Determination*, 18 J. L. MED. & HEALTH CARE 108, 112 (1990) (discussing the paternalistic presumption of incompetency for patients who refuse to consent to recommended treatment); Wendy M. Margolis, Comment, *The Doctor Knows Best?: Patient Capacity for Health Care Decisionmaking*, 71 OR. L. REV. 909, 916–17 (1992) (explaining that frequently doctors believe they have obtained "informed consent" when they merely inform the patient of the procedure they will administer).

72. This is the frequently quoted language used by the Ninth Circuit in its opinion, *Compassion in Dying v. Washington*, 79 F.3d 790, 814 (9th Cir. 1996) (en banc). It should be noted that incontinence, sedation, and helplessness are not necessarily indications of terminal illness.

assistance in suicide.⁷³ Because all seriously ill patients are in some ways disabled, their suicidal requests can seem reasonable to the healthy physician or family member. A psychologist, who is personally disabled and has worked for years with disabled and suicidal persons, has written:

Lacking an informed perspective and harboring intense fears of becoming disabled, the public, including judges, ethicists, and media reporters, [as well as physicians] takes such complaints [i.e. communications of suicidal intent] at face value and looks no further for their significance. Such people readily conclude that the disabled person's wish to die is reasonable because it agrees with their own preconception that the primary problem for such individuals is the unbearable experience of a permanent disability (and/or dependence on life aids). If permanent disability is the problem, death is the solution. In this analysis, the wish to die is transformed into a desire for freedom, not suicide. If it is suicide at all, it is "rational" and, thereby, different from suicides resulting from emotional disturbance or illogical despair.⁷⁴

Depression, the major precursor of suicidal intent, often worms its way into serious illnesses and, especially among the elderly, can remain undiagnosed and untreated.⁷⁵ In fact, clinical studies now indicate that depression is the only factor that predicts suicidal intent or ideation.⁷⁶ Indeed, Oregon physicians report that they recognized symptoms of depression in twenty percent of patients who sought suicide assistance.⁷⁷

73. Of course, some patients with physical disabilities are fully competent to make their own decisions. But even fully competent disabled individuals may be subject to societal coercion because they are not provided the support or options which make life a desirable option. "What is salient to the moral conception of coercion is that the range of options has been unfairly, arbitrarily, or unjustifiably limited [for persons with disabilities], not by hard facts and physical laws, but by human beliefs, decisions, actions, and policies." Jerome E. Bickenbach, *Disability and Life-Ending Decisions*, in *PHYSICIAN ASSISTED SUICIDE: EXPANDING THE DEBATE* 123, 125 (1998); see also Anita Silvers, *Protecting the Innocents from Physician-Assisted Suicide*, in *PHYSICIAN ASSISTED SUICIDE: EXPANDING THE DEBATE*, at 133-48.

74. Carol J. Gill, *Suicide Intervention for People with Disabilities: A Lesson in Inequality*, 8 *ISSUES L. & MED.*, 37, 39 (1992). This author wrote to oppose termination of treatment for persons with disabilities, not explicitly to oppose the even more threatening risk of physician-assisted suicide.

75. See *NEW YORK STATE TASK FORCE ON LIFE & THE LAW, WHEN DEATH IS SOUGHT: ASSISTED SUICIDE AND EUTHANASIA IN THE MEDICAL CONTEXT* 32-33 (1994) [hereinafter *NEW YORK TASK FORCE*].

76. See Ezekiel J. Emanuel et al., *Euthanasia and Physician-assisted Suicide—Attitudes and Experiences of Oncology Patients, Oncologists and the Public*, 347 *LANCET* 1805, 1908 (1996).

77. See *Physicians' Experiences*, *supra* note 34, at 559.

Depression tends to accompany the transient stress or mental crisis generated by the shock, disbelief, anger, or perceived helplessness that often inheres in the stark reality of serious illness.⁷⁸ Fear of an unknown but even more painful future can impel a critically ill patient to think of death as a preferable alternative.⁷⁹ Typically, these initial stress reactions do not result in sustained desires for suicide;⁸⁰ ordinarily, depressed terminally ill patients respond to personal intervention or clinical treatment.⁸¹ This may partially explain why suicide rarely occurs among such persons.⁸² It also helps us understand why at least one physician apparently thought Mrs. A was depressed.

These factors become far more complex when the person experiencing depression comes from an ethnic or cultural tradition unfamiliar to the attending physician.⁸³ They become compounded further when we add organic mental dysfunction, or the strong effects of medication, which seriously ill patients may experience, and which may impair their judgment and make it impossible to remain free from outside influence while thoughtfully weighing the alternative choices.⁸⁴ “In many cases, a patient who requests euthanasia or as-

78. See generally Leslie Hartley Gise et al., *Medical Psychiatric Rounds on a Gynecologic Oncology Service: End-Stage Cervical Carcinoma in a Jehovah's Witness Refusing Treatment*, 11 GEN. HOSP. PSYCHIATRY 372 (1989) (interview with end-stage cancer patient demonstrating her feelings of depression, anger, and anxiety generated by her deteriorating condition); Nancy J. Osgood, *Environmental Factors in Suicide in Long-Term Care Facilities*, in SUICIDE AND THE OLDER ADULT 98 (Anton A. Leenars ed., 1992) (discussing, as a factor contributing to depression, the “loss” attending illness and declining health).

79. See IRA BYOCK, *DYING WELL: PEACE AND POSSIBILITIES AT THE END OF LIFE* 44 (1997).

80. See, e.g., John R. Peteet, *Depression in Cancer Patients: An Approach to Differential Diagnosis and Treatment*, 241 JAMA 1487, 1487 (1979) (describing symptoms of depression seen in cancer patients and noting that diagnosis is not typically accompanied by “persisting . . . suicidal ideation”).

81. See Leonard R. Derogatis et al., *The Prevalence of Psychiatric Disorders Among Cancer Patients*, 249 JAMA 751, 757 (1983).

82. See William Breitbart & Steven D. Passik, *Psychiatric Aspects of Palliative Care*, in OXFORD TEXTBOOK OF PALLIATIVE MEDICINE 607 (1st ed. 1993); Peter M. Levine et al., *Mental Disorders in Cancer Patients: A Study of 100 Psychiatric Referrals*, 42 CANCER 1385, 1387 (1978) (explaining that suicide is “uncommon among patients with cancer”).

83. See, e.g., Byron J. Good et al., *The Interpretation of Iranian Depressive Illness and Dysphoric Affect*, in CULTURE AND DEPRESSION 369 (Arthur Kleinman & Byron J. Good eds., 1985); ARTHUR KLEINMAN, SOCIAL ORIGINS OF DISTRESS AND DISEASE: DEPRESSION, NEURASTHENIA, AND PAIN IN MODERN CHINA (1986); Edward L. Schieffelin, *The Cultural Analysis of Depressive Affect: An Example from New Guinea*, in CULTURE AND DEPRESSION, *supra*, at 101.

84. See Norman G. Levinsky, *The Purpose of Advance Medical Planning—Autonomy for Patients or Limitation of Care?*, 335 NEW ENG. J. MED. 741 (1996).

sisted suicide may have undiagnosed major clinical depression or another psychiatric disorder that prevents him or her from formulating a rational, independent choice.”⁸⁵

As already mentioned, these concerns explain why the Oregon Guidebook for health care providers deems a clinical psychiatric or psychological evaluation necessary in every case to rule out the possibility that a suicide request results from any one of these factors.⁸⁶ Yet, ignoring Oregon’s own guidebook, only fifteen of the forty-three persons (about one-third) whom physicians in Oregon assisted to end their lives were given psychological consultations.⁸⁷ This serious omission is briefly passed over in the Department’s report as if utterly insignificant. To make matters worse, although physicians report that twenty percent of patients seeking lethal prescriptions exhibit symptoms of depression, the same physicians found ninety-three percent competent to make medical decisions.⁸⁸ While it is possible that all the patients who sought suicide assistance were carefully evaluated by competent and caring physicians, it is far more likely that many more should have been referred for further consultation. Moreover, even in the cases where psychological consultations were sought, both reports document only this fact and fail to indicate the nature of the assessment made.⁸⁹ There is no suggestion that there was any opportunity for more than one meeting with the patient, even though only six percent of psychiatrists and psychologists in Oregon felt confident they could adequately determine decisionmaking capacity in a single ses-

85. NEW YORK TASK FORCE, *supra* note 75, at 89. The report, with great sensitivity, also states later:

Care and support for terminally and chronically ill patients also impose serious burdens on family members and other caregivers. The burdens are both financial and emotional. Family members may be drained by these demands or may conclude, based on their own perspective, that the patient’s life is no longer worth living. Out of this benevolence, or from sheer frustration or exhaustion, family members may suggest or encourage the patient to accept assisted suicide or euthanasia. Motivated by a sense of guilt or abandonment, many patients will feel that they have no choice once the option is presented. Indeed, if assisted suicide and euthanasia are widely available, patients may feel obligated to consider these options to alleviate the burden their illness and continued life imposes on those closest to them.

Id. at 124.

86. See *supra* notes 42–44 and accompanying text.

87. See *Second Year Report*, *supra* note 11, at 601.

88. See *Physicians’ Experiences*, *supra* note 34, at 559.

89. See THE FIRST YEAR’S EXPERIENCE, *supra* note 10, at 4–5; see also *Second Year Report*, *supra* note 11, at 601.

sion with the patient.⁹⁰ The Department never asked how physicians not specially trained in assessing competence could make the determination in two-thirds of the cases without a psychological consultation.

Oregon law and regulations compound these problems by requiring no specific training or ability of the physician who determines capacity. As the Oregon Guidebook makes clear, physicians in general, including those in Oregon, have difficulty diagnosing depression in their patients.⁹¹ Only specialists who are accustomed to interacting with seriously ill, physically and mentally disabled patients, and who can remain emotionally detached from the decision, should perform capacity determinations. Such lengthy evaluations will seldom be available to many suicidal patients, especially those who lack mobility, health insurance, money, or time. This necessary expenditure of time, effort, and money may provide the best explanation why only fifteen of the forty-three patients, in the first two year's experience, were referred to psychiatrists or psychologists for consultation.

Furthermore, even if an extensive psychiatric assessment was undertaken for each patient, different physicians using the same criteria will often disagree about the patient's capacity.⁹² For complex political, professional, and moral reasons, competence exists in the eye of the beholder. For some mental health professionals, too careful scrutiny of mental competency might seem to invade the personal space they feel is necessary for the exercise of human freedom. Some believe that they should maintain professional distance as a means to screen off their own personal bias.⁹³ Others prefer to engage a patient and listen to her story to avoid the dehumanizing influence of psychological testing and to create an opportunity for shared empathy, which might encourage a person to express her real motivations.⁹⁴

The Oregon law compounds this problem by, understandably, allowing health care workers who object to physician-assisted suicide to refuse to participate in the Oregon program.⁹⁵ Those who are will-

90. See OREGON GUIDEBOOK, *supra* note 9, at 30.

91. See *id.* at 31.

92. See Susan R. Martyn & Henry J. Bourguignon, *Physician's Decisions About Patient Capacity: The Trojan Horse of Physician-Assisted Suicide*, 6 J. PSYCHOL. PUB. POL'Y & L. (forthcoming 2000).

93. See Werth et al., *supra* note 38.

94. See Stuart J. Youngner, *Bureaucratizing Suicide*, 6 J. PSYCHOL. PUB. POL'Y & L. (forthcoming 2000).

95. See OR. REV. STAT. § 127.885(4) (1997). Only 56% of Oregon psychiatrists

ing to provide a competency assessment or other medical advice are often those who are already convinced that physician-assisted suicide is appropriate for some seriously ill patients. Their acceptance of assisted suicide as reasonable, in general, will render them more likely to accept a particular seriously ill patient's request as competent. In the case of Mrs. A, it appears likely that the advocacy group, Compassion in Dying, readily located physicians who were accepting of assisted suicide. Not surprisingly, she was found competent. The fact that sixty-one percent of patients did not receive a prescription from the first physician they asked but eventually obtained it from another physician further demonstrates the physician-shopping option generated by the Oregon law.⁹⁶

All this is to say that physicians in Oregon who view assisted death as an acceptable option for a particular patient will more likely find that person to have the decisionmaking capacity to request that option. Similarly, patients can seek out physicians who seem most in tune with the result they desire, as apparently Mrs. A and her family did. Given this and other problems, it is easy to imagine how a patient, suffering mental or physical disabilities, weakened by illness, sedated by medication, frightened by an uncertain future, worried about the financial costs of continued treatment, or completely dependent on health care providers and caregivers, might ask for suicide assistance. In addition, it is equally easy to understand how physicians, family members, and medical staff, fearful of ever facing similar mental and physical disabilities for themselves, can read such a cry of frustration or fear as a competent call for assisted suicide.

The case of *Lane v. Candura*⁹⁷ deftly illustrates the subjectivity inherent in competency determinations. Mrs. Candura, an elderly diabetic patient, was depressed over the recent death of her husband.⁹⁸ She at first consented and then refused to consent to the amputation of her gangrenous leg.⁹⁹ She was lucid on some matters and confused on others, cooperative with some medical personnel but hostile to others,

support implementation of the Act. Of those Oregon psychiatrists opposed to the Act, 72% would refuse to perform an evaluation required by the Act. Among psychologists in Oregon, only 36% are willing to perform these evaluations. See OREGON GUIDEBOOK, *supra* note 9, at 30.

96. See *Second Year Report*, *supra* note 11, at 601.

97. 376 N.E.2d 1232 (Mass. App. Ct. 1978).

98. See *id.* at 1233.

99. See *id.*

and vacillating in her decision.¹⁰⁰ The trial court concluded that she was not competent to refuse the life-sustaining operation,¹⁰¹ but the court of appeals disagreed.¹⁰² Two psychiatrists, associated with each other in practice, examined her and reached opposite conclusions.¹⁰³ When the second psychiatrist was asked by the trial court to account for the difference of clinical opinion, he said of his associate, "I think it is just a personal philosophy type of thing."¹⁰⁴

This case illuminates the "hidden world of values" that often becomes a determining factor for physicians as they judge patient capacity.¹⁰⁵ Moral qualms about suicide easily can influence a clinician's assessment. Professional views about proper clinical distance can affect the nature and quality of information on which the mental health professional relies. Political views about everything from rights of personal liberty to responsibility for others, as well as the proper allocation of ever-scarce medical resources, can also color a capacity determination. Physicians, aware of the prevalence of depression among those who request suicide, will understandably be reluctant to certify capacity without extensive evaluation. Those who favor assisted suicide or are unaware of these clinical realities will likely ignore the complexity of the suicide wish of many persons.¹⁰⁶

Most frightening of all, at precisely the time the Oregon law should require more of professionals, it demands far less. The law waters down the usual standard of due care for medical professionals to near meaningless proportions. In its place, the Oregon law provides that "[n]o person shall be subject to civil or criminal liability or professional disciplinary action for participating in good faith compliance with [the Oregon physician-assisted suicide statute]."¹⁰⁷ This means that a physician who mistakenly but honestly believes a person to be competent (or terminally ill or acting voluntarily) is shielded from any legal accountability by the state statute. Physicians would only be subject to liability under this standard only if someone can

100. *See id.* at 1234.

101. *See id.* at 1233.

102. *See id.* at 1236.

103. *See id.* at 1235.

104. *Id.* at 1235 n.5.

105. *See* Youngner, *supra* note 94.

106. *See* Robert A. Burt, Commentary, 4 J. PSYCHOL. PUB. POL'Y & L. (forthcoming 2000).

107. OR. REV. STAT. § 127.885(1) (1997).

prove bad faith, or wrongful motivation.¹⁰⁸ Honest physicians who are negligent or incompetent receive nearly absolute protection from their own mistakes. The “teeth” that appear in the law cloak negligent medical practice with legal immunity even where the negligence results in the patient’s suicide.¹⁰⁹ Patients, however, who are no longer available to complain, lose nearly all legal protection. Oregon citizens should be entitled to professionally competent capacity determinations, but Oregon’s assisted suicide law actually promotes incompetent, hurried, and less than complete evaluations.

It should be of no surprise then that a mere check of a box on a preprinted form for the Oregon Department of Human Resources reveals nothing about the decisionmaking capacity of the patients who sought help in committing suicide. The Oregon Department has in practice concluded that such determinations matter little because, absent fraud or proof of bad faith, no physician who makes them can be held legally accountable. Capacity determinations, which appear to be a major safeguard in the Oregon law, in practice, amount to nothing more than a perfunctory check of a box or a filing of the short, catch-me-if-you-can form.

Decisionmaking capacity or competence is not a single fixed point but rather a continuum. The complex and subtle problems involved in evaluating capacity undermine the possibility that patient competence can be relied upon as providing teeth in a legal regulation that prevents the killing of temporarily or permanently incapacitated patients. The point is not that all patients are incompetent to request physician-assisted suicide. The crucial risk is that those who lack capacity because of mental disability, confusion, depression, or because they are dependent or in an impoverished situation will have their expressions of anguish interpreted as competent requests for assisted suicide. Unfortunately, this risk of a superficial or hasty capacity determination is much more certain to materialize in Oregon because physicians are legally protected from their own incompetence.

108. See, e.g., *Ellis v. Springfield Women’s Clinic, P.C.*, 678 P.2d 268, 270, *rev. denied*, 683 P.2d 91 (Or. Ct. App. 1984); see also *Perry v. St. Francis Hosp.*, 886 F. Supp 1551, 1556–60 (D. Kan. 1995) (discussing the meaning of a similar good faith immunity provision in the Uniform Anatomical Gift Act).

109. See *Lee v. Oregon*, 891 F. Supp. 1429 (D. Or. 1995), *rev’d on other grounds*, 107 F.3d 1383 (9th Cir.), *cert. denied sub nom. Lee v. Harclerod*, 522 U.S. 927 (1997).

B. Did the Patient Make a Voluntary Request?

If determining whether a request for physician-assisted suicide has been made by a competent patient is complex and problematic, it is even more difficult to assure that such a choice is voluntary. Capacity and voluntary action often overlap. In practice, many of the factors, such as depression, which influence whether a patient has the capacity to choose, also can affect whether a patient is making a voluntary decision. Other patients may feel compelled to end their lives because they lack real alternatives due to inadequate medical treatment or personal support.¹¹⁰ Voluntary action, like capacity, is not a single fixed point, but a continuum; patients can be more or less under the influence of other persons or circumstances, more or less autonomous in making a decision.

The Oregon law requires that the patient “voluntarily expressed his or her wish to die,”¹¹¹ but nowhere does the law define “voluntary.” As used in other proposed assisted suicide statutes, voluntary means free of coercion, fraud, or undue influence.¹¹² The requirement that a person act voluntarily was intended to add teeth to the Oregon law by guarding against outside pressure. In reality, however, be-

110. See OREGON GUIDEBOOK, *supra* note 9, at 5, 31. Cf. McKay v. Bergstedt, 801 P.2d 617 (Nev. 1990) (thirty-one-year-old mentally competent person with quadriplegia granted court order to remove life support when faced with imminent death of his caregiver father, but only after fully informing him of care alternatives available after his father’s death).

111. OR. REV. STAT. § 127.805; see also *id.* § 127.815(1), (3).

112. The proposed Model State Statute attempts to assure that the request for suicide is voluntary by providing:

It is lawful for a responsible physician . . . to provide a patient with medical means of suicide, provided that the responsible physician acts on the basis of an honest belief that . . .

(3) the patient has made a request of the responsible physician to provide medical means of suicide, which request . . .

has been made free of undue influence by any person; and

has been repeated without self-contradiction by the patient on two separate occasions at least fourteen days apart, the last of which is no more than seventy-two hours before the responsible physician provides the patient with the medical means of suicide.

Charles H. Baron et al., *supra* note 35, at 26–27.

The Proposed Illinois Physician-Assisted Suicide Act seeks to assure a voluntary request for suicide by requiring a counselor for the person who requested assisted suicide. The counselor must determine “whether the patient’s request for assistance in suicide is [motivated] primarily by any of the following (1) duress; (2) fraud; or (3) coercion [or by clinical depression or any other emotional or psychological disorder.]” Comment, *supra* note 35, at 825.

cause voluntary action, like capacity, exists on a continuum, the requirement remains elusive and treacherous at best.

As is often the case in the law, when lawmakers cannot deal directly with the substance of a matter, they try to surround it with procedures in the hope that these will assure the substantive result they seek. The Oregon law relies on several procedures to put teeth in the requirement that the request be voluntary. It requires two oral requests at least fifteen days apart and a properly attested written request.¹¹³ It further states that the patient always has the right to rescind the decision and must personally perform the final act of taking the prescribed lethal drug.¹¹⁴ As a final precaution, the law requires a forty-eight-hour waiting period between the written request for the lethal drug and the writing of the prescription.¹¹⁵

In addition to these procedures, the Oregon assisted suicide law attempts, by use of threat, to prevent coercion of patients. The law states, "A person who coerces or exerts undue influence on a patient to request medication for the purpose of ending the patient's life . . . shall be guilty of a Class A felony."¹¹⁶ But at the same time, the Oregon law asks physicians on a case-by-case basis to make the determination whether a person is acting voluntarily.¹¹⁷ Further, as with capacity determinations, Oregon requires only that the physician acted in good faith in concluding that the patient's request was voluntary.¹¹⁸ The law does require disclosure of some alternatives to suicide,¹¹⁹ but this disclosure ultimately need satisfy only the physician's good faith belief that disclosure was adequate and understood by the patient.¹²⁰ In all but the most extraordinary cases, subtle, negligent or reckless coercion, or influence will trigger the law's good faith defense. A physician or family member's influence therefore will remain unchecked and unreported.

The Oregon Guidebook, however, recognizes that subtle coercion, short of intentional manipulation, is the kind that most often threatens to undermine or destroy a voluntary decision.¹²¹ Not satis-

113. See OR. REV. STAT. §§ 127.810, .840.

114. See *id.* §§ 127.840, .845.

115. See *id.* § 127.850.

116. See *id.* § 127.890(2).

117. See *id.* § 127.815(1).

118. See *id.* § 127.815(6)-(7).

119. See *id.* § 127.815(1)(e).

120. See *supra* notes 107-09 and accompanying text.

121. See OREGON GUIDEBOOK, *supra* note 9, at 5-6, 51. The guidebook states:

fied with the procedural safeguards built into the statute itself, the Guidebook urges physicians not to raise the possible option of physician-assisted suicide with a patient: “We believe that the attending physician should not initiate the discussion, because if he/she does, the patient may feel pressure even though physician-assisted suicide is a legally available option.”¹²² Yet, no physician protected by the good faith immunity defense will ever be prosecuted or disciplined for suggesting to a patient that assisted suicide is an option to be considered.

The Oregon Department of Human Resources monitors this delicate issue of whether the patient’s request was voluntary by following the perfunctory statutory mandate. It asks physicians to check an appropriate box indicating that the procedural requirements of the law have been satisfied, with a place to fill in the dates of the oral and written requests.¹²³ The short form, of course, does not even require this formalistic information.¹²⁴

The Department did compile statistics comparing the assisted-suicide deaths in 1998–99 with other comparable natural deaths.¹²⁵ The Department, for instance in the First Year Report, noted that: “Persons who were divorced and persons who had never married were 6.8 times and 23.7 times, respectively, more likely to choose physician-assisted suicide than persons who were married.”¹²⁶ These findings were not repeated in the Second Year Report. There, the Department noted that “[p]atients who died by physician-assisted suicide were better educated but otherwise demographically similar to residents of Oregon with similar diseases.”¹²⁷

Clinicians tell us that many persons who request suicide are “beset with ambivalence, simply wish to reduce or interrupt anxiety, or are under the influence of drugs, alcohol, or intense pressure.”¹²⁸

“We recommend that providers refrain from exerting any influence which encourages a patient’s decision to pursue a legal prescription.”

122. *Id.* at 7.

123. This form is reproduced in OREGON GUIDEBOOK, *supra* note 9, at 65–66.

124. *See id.*

125. *See First Year’s Experience*, *supra* note 10, at 14; *Second Year Report*, *supra* note 11, at 602.

126. *Id.* at 5.

127. *Second Year Report*, *supra* note 11, at 603.

128. Tom L. Beauchamp & James F. Childress, *Moral Problems of Suicide Intervention*, in *ETHICAL ISSUES IN DEATH AND DYING* 127, 128 (Tom L. Beauchamp & Robert M. Veatch eds., 2d ed. 1996).

Further, such a person may entertain psychological rescue fantasies.¹²⁹ A “competent” and “voluntary” request for suicide actually may convey a deep desire for relief from the distressing realities currently confronting the person.¹³⁰ A psychiatrist who has studied suicidal patients for many years has written that “[t]he patient, who may have said she wants to die in the hope of receiving emotional reassurance that all around her want her to live, may find that . . . she has set in motion a process whose momentum she cannot control.”¹³¹

Mere silent acceptance of such words by family or physicians can exert undue influence on the weary and frightened patient. These dynamics explain why some commentators familiar with suicide intervention believe that “suicide cannot really be ‘chosen;’” the compulsion of human self-preservation suggests that every person retains some “hope of being saved.”¹³² A thoughtful consideration of the true meaning of some suicide requests reveals the inadequacy of the Oregon law’s procedural protections. An anguished cry for assurances, for companionship, for pain relief, spoken in the form of a suicide request, can be repeated often orally or in writing without ever being a voluntary request for assisted suicide.¹³³ “Physicians inexperienced in dealing with suicidal patients tend to take requests to die literally and concretely, failing to hear this ambivalence.”¹³⁴

Coercion or undue influence destroys a voluntary choice for suicide. In today’s world of unequal access to health care services, persons who are alone, poor, old, members of racial or ethnic minorities, or those living with mental or physical disability all too often have little real choice when told they have the clinical option of assisted suicide.¹³⁵ In addition, those who lack medical insurance have little choice if they must decide between further medical treatment that

129. See *id.* at 128.

130. See *id.* at 128–29.

131. Herbert Hendin, *Selling Death and Dignity*, 25 HASTINGS CENTER REP. 19, 23 (1995).

132. Erwin Ringel, *Suicide Prevention and the Value of Human Life*, in ETHICAL ISSUES IN DEATH AND DYING, *supra* note 128, at 144; see also Yeates Conwell & Eric D. Caine, *Rational Suicide and the Right to Die: Reality and Myth*, 325 NEW ENG. J. MED. 1100, 1101 (1991).

133. See OREGON GUIDEBOOK, *supra* note 9, at 21; HERBERT HENDIN, SEDUCED BY DEATH: DOCTORS, PATIENTS, AND THE DUTCH CURE 35–42 (1997).

134. Hendin et al., *supra* note 12, at 252.

135. See Stephanie Graboyes-Russo, Note, *Too Costly to Live: The Moral Hazards of a Decision in Washington v. Glucksberg and Vacco v. Quill*, 51 U. MIAMI L. REV. 907, 919 (1997).

they cannot afford or inexpensive assisted suicide. “[F]or certain groups, . . . financial considerations are so predominant as to be coercive.”¹³⁶

The Oregon Department of Human Resources report states, “No person who chose physician-assisted suicide expressed a concern to their physician about the financial impact of their illness.”¹³⁷ Yet there was also no effort to discover whether or how thoroughly physicians discussed this issue with the patients. It is not a question that most physicians ordinarily raise or that most patients ordinarily volunteer with physicians. The family of one patient who received suicide assistance told a newspaper that the patient did not want her financial resources to be devoured by her medical care.¹³⁸

Some financial coercion is inherent in nearly all forms of health care today. For example, the Oregon Medicaid Plan will pay for physician-assisted suicide as a medical service for Medicaid recipients,¹³⁹ but it denies payment for some health care costs of seriously ill patients if the treatment is not included in the prioritized list of conditions and treatments covered for 270,000 indigent residents.¹⁴⁰ The Oregon prioritized plan, which is based on the necessity of rationing health care, necessarily has a financial incentive to endorse and encourage physician-assisted suicide, because this will always be less expensive than lengthy palliative care.¹⁴¹

136. *Id.*

137. THE FIRST YEAR’S EXPERIENCE, *supra* note 10, at 8; *see also Second Year Report*, *supra* note 11, at 603. All who died were insured, although some spent their own funds on some medical expenses, such as prescription medication.

138. *See* Foley & Hendin, *supra* note 23, at 41.

139. *See* Graboyes-Russo, *supra* note 135, at 919–20.

140. *See* Richard M. Doerflinger, *Conclusion: Shaky Foundations and Slippery Slopes*, 35 DUQ. L. REV. 523, 529 (1996); W. John Thomas, *The Oregon Medicaid Proposal: Ethical Paralysis, Tragic Democracy, and the Fate of a Utilitarian Health Care Program*, 72 OR. L. REV. 47, 91–105 (1993); *Oregon Lets State Pay for Suicides*, N.Y. TIMES, Feb. 27, 1998, at A6. Oregon’s prioritized plan for health care services for the indigent necessarily relies “on judgment- and value-based decisionmaking,” and “cannot be derived from scientific evidence on effectiveness, outcomes, and cost.” OFFICE OF TECHNOLOGY ASSESSMENT, CONGRESS OF THE U.S., EVALUATION OF THE OREGON MEDICAID PROPOSAL (1992).

141. The Oregon Health Plan requires a hospice benefit that must not exclude “core hospice services.” OREGON GUIDEBOOK, *supra* note 9, at 11. However, this hospice benefit does not cover all Oregonians, especially the working poor, nor do all health plans in Oregon offer comprehensive hospice services as an alternative to physician-assisted suicide. *See generally* Nelson Lund, *Two Precipices, One Chasm: The Economics of Physician-Assisted Suicide and Euthanasia*, 24 HASTINGS CONST. L.Q. 903 (1997).

Another form of undue influence is allowed under the Oregon law, even though the Guidebook recommends against it. The mere mention of suicide as a legally sanctioned clinical option by a trusted physician could overwhelm the spirit of the already frightened and depressed patient.¹⁴² Seriously ill persons become even more vulnerable as they become more dependent on health care providers. The right to die could well be perceived by such a person as a duty to die, an obligation to relieve the stress of relatives and friends or alleviate the burdens of medical costs.¹⁴³ “Patients who are enfeebled by disease and devoid of hope may choose assisted suicide not because they are really tired of life but because they think others are tired of them.”¹⁴⁴ True voluntary choice and personal autonomy could be lost if the patient, increasingly dependent on caregivers, in pain, exhausted from illness, or worried about the lingering suffering of family members or burdensome costs of continued health care, is offered a quick way out by his doctor or family. Furthermore, communication by even the most well-intentioned physician can be skewed where religious or cultural differences in expression cloud or change meaning.¹⁴⁵ All these factors can create coercion or undue influence.

The suicide option in the Oregon law creates undue influence in a more subtle manner as well, by changing the social perception of legitimate behavior. The small number of terminally ill patients who in the past voluntarily fought for the right to kill themselves with the aid of a physician, may soon be followed by numerous vulnerable patients who, once offered the option of suicide by a trusted physician, must fight to justify their continued existence. For the mentally or physically disabled, including those who are terminally ill, the mes-

142. See generally Orentlicher, *supra* note 68, at 1884–85.

143. A recent survey of Oregon physicians found that 93% thought patients might request assisted suicide because of a concern they will be a burden on others. See Melinda A. Lee et al., *Legalizing Assisted Suicide—Views of Physicians in Oregon*, 334 NEW ENG. J. MED. 310, 312 (1996). Interestingly, a poll indicates that oncologists, cancer patients, and the general public believe that assisted suicide is least justifiable in situations where patients feel their existence burdens others. See Ezekiel J. Emanuel et al., *supra* note 76, at 1809.

144. Orentlicher, *supra* note 68, at 1884, 1885.

145. See generally ETHNIC VARIATIONS IN DYING, DEATH AND GRIEF: DIVERSITY IN UNIVERSALITY (Donald P. Irish et al. eds., 1993) (discussing variations in experience, expression, and understanding by African Americans, Mexican Americans, Hmong, and Native Americans, as well as principles and orientations of Jewish, Buddhist, Islamic, Quaker, and Unitarian beliefs).

sage of physician-assisted suicide in Oregon is plain: “[T]here are lives which the state has little or no interest in saving.”¹⁴⁶

Enforcing the legal requirement that the decision is voluntary is impossible. At a minimum there should be assurances that a seriously ill person understands the health care options available to her. These may include alternative, and perhaps better, palliative treatments for physical and mental suffering, care in alternative facilities or at home, continued life in a debilitated state for a period of time, foregoing life-sustaining treatments, or death, caused by her own hands with the direct aid of a physician. In fact, Oregon physicians report that when these alternatives were made available, nearly one-half of patients changed their mind, as compared with only fifteen percent of those who receive no information or referral to alternative care.¹⁴⁷ Moreover, understanding alternatives to suicide also requires that the alternatives, such as improved pain management or hospice care, are made easily accessible for a trial period of time by the person weighing a decision.¹⁴⁸ Although Oregon physicians report *offering* palliative alternatives to nearly ninety percent of patients who request a lethal dose of medication, they report *implementing* such an intervention in only about one-half of all patients who seek lethal prescriptions.¹⁴⁹

Given the unique setting of the terminally ill patient, however, it will often be difficult and expensive for Oregon to assure that physicians fully provide all the information in an understandable form. Furthermore, the law does not require disclosure of other common alternatives that might be elected by a patient who is seriously ill, such as foregoing medical interventions or care in facilities other than hospice.

Mrs. A’s case provides a good example of such a missed opportunity. When she expressed a concern about being artificially fed, the physician who certified her voluntary decision ignored her fear.¹⁵⁰ He

146. Stephen L. Mikochik, *Assisted Suicide and Disabled People*, 46 DEPAUL L. REV. 987, 998 (1997).

147. See *Physicians’ Experiences*, *supra* note 34, at 557.

148. The availability of a choice to receive life insurance benefits before death, often referred to as “living benefits,” may enable patients to pay for such care. Federal law now requires life insurers to offer living benefits as an option for terminally ill policy holders. See 5 U.S.C. § 8714d (2000). See generally Andrew L. Lee, Note, *Living Benefits: A Right of the Terminally Ill*, 2 B.U. PUB. INT. L.J. 55 (1992) (discussing features of living benefits).

149. See *Physicians’ Experiences*, *supra* note 34, at 559–60.

150. See Hendin et al., *supra* note 12, at 247.

then recited the statutory list of alternatives without explaining how any of them might alleviate her concerns.¹⁵¹ His methodology seemed to confirm what she apparently believed—the only way to relieve her anxiety was to convince a physician that she needed drugs to kill herself. Because apparently her fears of artificial feeding were not alleviated, was her decision to seek assisted suicide voluntary?

As Mrs. A's case illustrates, the summary disclosure of a statutory suicide alternatives list does nothing to address an individual's real concerns. To make matters worse, the attending physician, acting in good faith, may not request a psychiatric or clinical consultation to determine whether the dying person has been overtly or subtly coerced. Such a psychiatric evaluation was ignored in nearly two-thirds of the cases of assisted suicide in 1998 and 1999. Even if psychiatric consultation is required, the law assures that the psychiatrist or psychologist has immunity for all acts performed in good faith.¹⁵² Even negligent psychiatric conclusions cannot be successfully challenged in court.

In other contexts, courts look to various external, objective criteria to determine whether, for instance, a criminal defendant's confession was voluntary¹⁵³ or that a testator's will was executed voluntarily, that is, without undue influence.¹⁵⁴ Voluntary choice and action in both of these legal contexts has led to numerous disputes and conflicts. Yet, if a physician in Oregon states that a seriously ill patient voluntarily sought assisted suicide, no legal basis exists to challenge the statement or to prevent subtle coercion from the physician or family.

151. *See id.*

152. *See* OR. REV. STAT. § 127.885 (1997).

153. *See* JOSEPH D. GRANO, CONFESSIONS, TRUTH, AND THE LAW 59–83 (1993); Laurence A. Benner, *Requiem for Miranda: The Rehnquist Court's Voluntariness Doctrine in Historical Perspective*, 67 WASH. U. L.Q. 59, 92–119 (1988); Yale Kamisar, *What Is an 'Involuntary' Confession? Some Comments on Inbau and Reid's Criminal Interrogation and Confessions*, 17 RUTGERS L. REV. 728 (1963); Stephen J. Schulhofer, *Reconsidering Miranda*, 54 U. CHI. L. REV. 435, 436–53 (1987).

154. *See* Mary Louise Fellows, *In Search of Donative Intent*, 73 IOWA L. REV. 611, 621–22 (1988); Milton D. Green, *Fraud, Undue Influence and Mental Incompetency*, 43 COLUM. L. REV. 176, 179–80 (1943); Alexander M. Meiklejohn, *Contractual and Donative Capacity*, 39 CASE W. RES. L. REV. 307, 367–72 (1989).

C. Is the Patient Suffering from a Terminal Disease?

Oregon law has reserved physician-assisted suicide for patients suffering from a “terminal disease.”¹⁵⁵ It defines “terminal disease” as “an incurable and irreversible disease that has been medically confirmed and will, within reasonable medical judgment, produce death within six (6) months.”¹⁵⁶ This requirement represents another attempt by the Oregon legislature to put teeth in the restrictions on physician-assisted suicide. Once again, this factor actually contributes to an inherently ill-defined, and therefore unenforceable, requirement. The dying process, like competence and whether a person acts voluntarily, is a continuum and seldom will a physician be able to state with precise accuracy when the end point will occur.

The Oregon Guidebook recognizes the difficulty of determining whether the patient’s illness will lead to death within six months. The Guidebook reminds physicians: “[s]everal studies indicate there is inherent inaccuracy in predicting the course of a patient’s illness and exact timing of expected death. Despite this challenge, attending physicians are called upon to use their best judgment in making such predictions.”¹⁵⁷ The law was not written to permit physicians to assist the suicide of persons who might be experiencing physical pain or psychological suffering if they are not also near death.

155. OR. REV. STAT. § 127.805. The proposed Model State Act requires terminal illness only as one basis for allowing physician-assisted suicide. The proposed Act states that:

It is lawful for a responsible physician . . . to provide a patient with medical means of suicide, provided that the responsible physician acts on the basis of an honest belief that . . . (2) the patient has a terminal illness or an intractable and unbearable illness. “Intractable and unbearable illness” is defined as “a bodily disorder (1) that cannot be cured or successfully palliated, and (2) that causes such severe suffering that a patient prefers death.”

Baron et al., *supra* note 35, at 25–26.

The proposed Illinois Act requires that the patient be terminally ill, but gives no time limit to restrict the definition:

“[T]erminally ill” means: i) the patient suffers from a disease or other physical condition that will eventually result in that patient’s death, except that “condition” does not mean a) mere advanced age; or b) the fact that the patient is currently alive. ii) For the purposes of this Act, a patient’s death need not be imminent for that person to be considered “terminally ill.”

Comment, *An Illinois Physician-Assisted Suicide Act*, 28 LOY. U. CHI. L.J. 763, 822 (1997).

156. OR. REV. STAT. § 127.800(12) (1997).

157. OREGON GUIDEBOOK, *supra* note 9, at 22.

The reports by the Department of Human Resources on the forty-three assisted suicides in 1998–99 provide no information at all on the patients' terminal illness. The Second Year Report does comment, however, that "[o]ne patient used the prescription more than 6 months after it was written (247) days."¹⁵⁸

The long form which physicians could use to supply information to the Department does not even ask whether the patient was suffering from a terminal illness. The short form asks no questions at all.¹⁵⁹ The long form does give physicians a space where they can state the prognosis of the patient's illness. This provides an opportunity for some physicians to express the view that the patient would die of the present illness within six months.¹⁶⁰

If terminal illness was intended to restrict access to physician-assisted suicide in Oregon, the Department's reports indicate that it immediately became lost and forgotten. Was Mrs. A, the first case of assisted suicide in the State, terminally ill? Did any physician make any effort to state with accuracy that her life expectancy was less than six months? She certainly was very sick with advanced breast cancer, yet she had been doing aerobic exercises until just two weeks prior to her request for assisted suicide.¹⁶¹ She could no longer exercise or work in her garden, but she could get out of bed and take care of her house.¹⁶² Her case, like that of another person described in the Second Year Report who ingested the lethal medication more than eight months later, demonstrates that the Oregon law relies on physicians to estimate that a person will die within six months. As with determinations of a patient's capacity and whether the person is acting voluntarily, Oregon law requires only the good faith evaluation of terminal illness. Absent an intentional misrepresentation, the physician's negligent assessment or guess about life expectancy suffices to qualify a person for assisted suicide.

Many will recall that, after the long ethical and legal debate about removing Karen Quinlan from a respirator, which all observers expected would surely lead to her death in a short time, she breathed on her own and lived for another nine years without the respirator.¹⁶³

158. *Second Year Report*, *supra* note 11, at 599.

159. See OREGON GUIDEBOOK, *supra* note 9, at 65–67.

160. See *id.* at 65.

161. See Hendin et al., *supra* note 12, at 245.

162. See *id.*

163. See Hannah C. Kinney et al., *Neuropathological Findings in the Brain of Karen*

The timing of death, with its silent footsteps, often lies beyond the prognosticating power of modern medical science. The point is that what was intended as a restriction on access to assisted suicide is in practice hardly a restriction at all. Little wonder the report by the Department of Human Resources completely ignored this aspect of the Oregon law.

Further, Oregon's definition of "terminal disease" is a standard borrowed from the Medicare guidelines for hospice care.¹⁶⁴ This concept of dying presumes death from cancer or AIDS, where patients experience a relatively predictable terminal phase lasting a few weeks or months.¹⁶⁵ Yet, as Dr. Joanne Lynn points out, the majority of Americans do not die from cancer (whose patients make up eighty percent of those who use hospice), but from organ system failure, such as heart or lung disease.¹⁶⁶ The timing of death from these various diseases cannot be accurately predicted because death occurs from arrhythmia or infection that occurs suddenly during a long period (usually years) of chronic illness.¹⁶⁷

Finally, the number of patients deemed terminally ill from a physician's point of view will depend not only on time but also on statistical probability. "For every patient who would be [deemed terminally ill] if the criterion were a probability of less than 10 percent of living for an additional six months, thousands [more] would be eligible if the threshold probability were 50 percent."¹⁶⁸ If we define "terminally ill" to include everyone with less than a fifty percent chance of living six months, "most of the frail elderly in nursing homes" would be considered terminally ill.¹⁶⁹

Ann Quinlan, 330 NEW ENG. J. MED. 1469, 1469 (1994).

164. See Joanne Lynn, *Caring at the End of Our Lives*, 335 NEW ENG. J. MED. 201, 201 (1996). Hospice care emphasizes interdisciplinary therapeutic services designed to comfort persons with terminal illness. Hospice emphasizes pain control and other palliative support rather than services designed to cure disease or disability. See *id.*

165. See *id.*

166. See Joanne Lynn & Anne M. Wilkinson, *Quality End-of-Life Care: The Case for a MediCaring Demonstration*, 19 BIFOCAL 1 (1998).

167. See *id.* at 1.

168. Lynn, *supra* note 164, at 201–02. "Predicting that a condition is 'terminal' within any specific time period or opining on the 'imminence' of death has been very difficult for the medical profession. . . . Distinguishing between serious illnesses, life-threatening conditions, and terminal illnesses is frequently difficult for physicians and nearly impossible for the legal community." *In re Guardianship of Browning*, 543 So. 2d 258, 268 (Fla. Dist. Ct. App. 1989).

169. Lynn, *supra* note 164, at 202.

These factors explain why a recent study of Oregon physicians found that fifty percent “were not confident that they could predict that a patient had less than six months to live.”¹⁷⁰ Estimates of when a particular patient will die are difficult to make. Physicians usually can recognize the signs that a patient is near death, in the sense that death from natural causes will occur within a few hours or perhaps days.¹⁷¹ However, beyond this, it is often extremely difficult for doctors to identify any meaningful definition of terminal illness.¹⁷² Oregon law provides no remedy, but instead exacerbates this problem by blanketing an incompetent but honest misdiagnosis of “terminal illness” with legal immunity. It is even conceivable that a physician could incompetently, but perhaps in good faith, interpret “terminal disease” to mean that a person recently diagnosed with the early stages of Alzheimer’s disease, which ultimately will be terminal, can be assisted with suicide as she struggles to absorb the first shattering diagnosis.¹⁷³ Given the variety of interpretations that even well-qualified physicians can use to determine when a patient is “terminally ill,” this requirement does not supply any teeth for the Oregon law.

170. Lee, *supra* note 148, at 312.

171. See Jonathan Gavrin & C. Richard Chapman, *Clinical Management of Dying Patients*, 163 W.J. MED. 268, 268 (1995).

172. See Lee, *supra* note 148, at 312. Of course, physicians unaccustomed to treating dying patients may be unfamiliar with this problem. This may explain why a survey of Michigan physicians found that doctors with “the least contact with terminally ill patients were the most likely to support the legalization of assisted suicide.” Jerald G. Bachman et al., *Attitudes of Michigan Physicians and the Public Toward Legalizing Physician-Assisted Suicide and Voluntary Euthanasia*, 334 NEW ENG. J. MED. 303, 308 (1996).

173. When Jack Kevorkian helped Janet Adkins commit suicide, she had been diagnosed with Alzheimer’s disease and feared for her future. But when she received doctor assistance for her suicide, she was 54 years old, not in imminent danger of death, and not suffering pain. She had played tennis just a few days before her death. See *People v. Kevorkian*, 534 N.W.2d 172, 173–74 (Mich. Ct. App. 1995), *app. denied*, 549 N.W.2d 566 (Mich. 1996), *cert. denied*, 519 U.S. 928 (1996). Of course, Kevorkian, a pathologist, was probably not competent to independently confirm her diagnosis or to discover whether she was depressed. At any rate, his limited contact with her did not allow time for him to undertake such examination. See *id.*; see also TOM L. BEAUCHAMP & JAMES F. CHILDRESS, *PRINCIPLES OF BIOMEDICAL ETHICS* 237–38 (1979). Some suggest that medical advocates for assisted death, like Kevorkian, will be most often successful with vulnerable women. See Stephanie Gutmann, *Death and the Maiden: Dr. Kevorkian’s Woman Problem*, NEW REPUBLIC, June 24, 1996 at 20. Others point out that Kevorkian’s primary goal has always been the use of tissue from newly dead bodies for medical experimentation. See Robert A. Burt, *Choosing Death: For Oneself/For Others*, in *PATIENT’S RIGHTS* 63, 80–82 (Lotta Westerhäll & Charles Phillips eds., 1994).

D. Was the Patient Experiencing Physical Pain or Psychological Suffering?

Many proponents of physician-assisted suicide presume that it is needed to avoid intolerable suffering. For some, the more traditional line between letting a patient die (termination of treatment) and killing (assisted suicide or euthanasia) has seemed inhumane and difficult to maintain in the face of long-lasting, unbearable pain.¹⁷⁴ Indeed, a patient in Oregon who wishes to request assisted suicide must be “suffering from a terminal disease.”¹⁷⁵ It is not clear from the statute, however, whether any kind of pain or suffering is intended as a limitation on the availability of physician-assisted suicide. Apparently a terminally ill person could request assisted suicide even if she were not suffering or even if her pain could be alleviated. Pain and suffering, like capacity, voluntary action, and the estimation of terminal illness, consist of a widely varied range of physical and mental conditions, a continuum, not some fixed point which can be precisely determined by a lab test.

Under Oregon law, the attending physician must inform the patient of: “The feasible alternatives [to assisted suicide], including, but not limited to, comfort care, hospice care and pain control.”¹⁷⁶ The Oregon Guidebook discusses at some length the meaning and availability of comfort care, palliative care, and hospice.¹⁷⁷ It states: “The goals of symptomatic palliative therapy are to achieve comfort, to manage symptoms, and to improve the quality of life.”¹⁷⁸

Far too often, physicians have been remiss in failing to provide adequate palliative care. To “palliate” means to “eas[e] without curing.”¹⁷⁹ Palliative care, which is also often referred to as comfort care, is intended to relieve the symptoms of a disorder and improve a patient’s quality of life.¹⁸⁰ It is not restricted to controlling physiological

174. See, e.g., TIMOTHY E. QUILL, *A MIDWIFE THROUGH THE DYING PROCESS* (1996).

175. OR. REV. STAT. § 127.805 (1997).

176. *Id.* § 127.815 (2)(e).

177. See OREGON GUIDEBOOK, *supra* note 9, at 10–13.

178. *Id.* at 10.

179. See Derek Doyle, *Palliative Symptom Control*, in *PALLIATIVE CARE* 297 (Derek Doyle ed., 1984).

180. See Cornelius J. van der Poel, *Ethical Aspects in Palliative Care*, *AM. J. HOSPICE & PALLIATIVE CARE*, May/June 1996, at 49; see also Laura S. Hitchcock et al., *The Experience of Chronic Nonmalignant Pain*, 9 *J. PAIN & SYMPTOM MGMT.* 312, 312–14 (1994).

pain alone, but also includes the amelioration of all the subjective symptoms of suffering, whether physical,¹⁸¹ psychological,¹⁸² situational,¹⁸³ or spiritual.¹⁸⁴

Even though Oregon law does not explicitly require that any kind of pain is a prerequisite to receiving physician-assisted suicide, the Department of Human Resources report on the first year of assisted suicide gathered statistics on this question. The First Year Report concluded:

More than two-thirds of the patients who chose physician-assisted suicide, were also enrolled in hospice Of the four patients who chose physician-assisted suicide, but who were not receiving hospice care, three had repeatedly refused enrollment offers. To date, lack of access to hospice care has not been associated with the decision to take lethal medications. Fear of intractable pain was also an end of life care issue not associated with physician-assisted suicide. Only one person who chose physician-assisted suicide expressed concern to her physician about inadequate pain control at the end of life.¹⁸⁵

The Second Year Report similarly noted that “[p]alliative care was available to all the patients who requested assistance with suicide, and three quarters of them received hospice care before they died.”¹⁸⁶

The report’s conclusion about pain control is perhaps suspect because it is based on oral interviews with attending physicians after

181. See, e.g., Doyle, *supra* note 179, at 265; Neil L. Schechter, *The Management of Pain Associated with Diagnostic Procedures in Children with Cancer*, in CURRENT & EMERGING ISSUES IN CANCER PAIN 371, 376–78 (C. Richard Chapman & Kathleen M. Foley eds., 1993); Gavrin & Chapman, *supra* note 171, at 268–70; Hitchcock et al., *supra* note 180, at 312–14; van der Poel, *supra* note 180, at 50.

182. See Robert A. Pearlman et al., *Insights Pertaining to Patient Assessments of States Worse than Death*, 4 J. CLINICAL ETHICS 33, 39–40 (1993); James S. Reitman, *The Debate on Assisted Suicide—Redefining Morally Appropriate Care for People with Intractable Suffering*, 11 ISSUES L. & MED. 299, 307–12 (1995) (discussing the need to recognize and alleviate despair while treating terminally ill patients); Mark D. Sullivan & Stuart J. Youngner, *Depression, Competence, and the Right to Refuse Life-saving Medical Treatment*, 151 AM. J. PSYCHIATRY 971 (1994) (suggesting the need to diagnose and treat depression in patients with serious medical illnesses before honoring a patient’s request to die).

183. See Ivan Lichter, *Communication*, in PALLIATIVE CARE, *supra* note 179, at 444, 450; Ian Thompson, *Ethical Issues in Palliative Care*, in PALLIATIVE CARE, *supra* note 179, at 461, 463.

184. See Peter W. Speck, *Spiritual Issues in Palliative Care*, in OXFORD TEXTBOOK OF PALLIATIVE MEDICINE 515 (Derek Doyle et al. eds., 1993); van der Poel, *supra* note 180, at 53; see also Alan C. Mermann, *Spiritual Aspects of Death and Dying*, 65 YALE J. BIOLOGY & MED. 137, 137–39 (1992) (discussing spiritual aspects of death which may confront the terminally ill).

185. THE FIRST YEAR’S EXPERIENCE, *supra* note 10, at 8.

186. *Second Year Report*, *supra* note 11, at 603.

the assisted suicide had been reported.¹⁸⁷ It is understandable that physicians would report that patients requested assisted suicide because of their autonomous choice rather than because of inadequate palliative care.¹⁸⁸ “[I]n numerous published studies physicians underestimated what patients were experiencing.”¹⁸⁹ The Second Year Report documents this phenomenon in Oregon. Family members of patients who died after ingesting a lethal dose of medication reported that fifty-three percent of these patients were concerned about physical suffering and that only one-third had sufficient medication to control suffering on the day before they died.¹⁹⁰ In contrast, physicians of these same patients reported that only twenty-six percent expressed concern about adequate pain control.¹⁹¹

Further, suffering can be psychological, social, emotional, or spiritual. It is difficult to know whether the physicians carefully and competently explored in detail the motivation of the patients who sought assisted suicide.¹⁹² Recall, however, that only fifteen of the forty-three received psychological consultations.¹⁹³ The Department’s reports, moreover, ask only brief questions about physical pain, assuming any other kind of suffering will not motivate persons seeking assisted suicide.¹⁹⁴ Interestingly, the Second Year Report indicates that when family members rather than physicians discussed a patient’s suffering, “they referred to dyspnea (difficulty breathing) and dysphagia (difficulty swallowing) as well as pain.”¹⁹⁵

These gaps in our knowledge might explain why the Department’s report deviates from other accounts by physicians accustomed to treating patients with severe pain. These experts routinely report that many persons with uncontrolled pain request assisted suicide.¹⁹⁶ One recent survey of physicians in the state of Washington found that

187. See THE FIRST YEAR’S EXPERIENCE, *supra* note 10, at 3; see also *Second Year Report*, *supra* note 11, at 598.

188. See *Second Year Report*, *supra* note 11, at 8–9. The report concluded, “[I]n Oregon the decision to request and use a prescription for lethal medications in 1998 appears to be more associated with attitudes about autonomy and dying, and less with fears about intractable pain or financial loss.” *Id.* at 9.

189. Foley & Hendin, *supra* note 23, at 38.

190. See *Second Year Report*, *supra* note 11, at 603.

191. See *id.* at 600.

192. See Eric J. Cassell, *Diagnosing Suffering: A Perspective*, 131 ANNALS OF INTERNAL MED. 531 (1999).

193. See *supra* note 87 and accompanying text.

194. See Foley & Hendin, *supra* note 23, at 40.

195. *Second Year Report*, *supra* note 11, at 603.

196. See Foley & Hendin, *supra* note 23, at 38.

a substantial number of patients who ask their physicians to help them die fear losing control or burdening others.¹⁹⁷ These requests commonly “dissolve with adequate control of pain and other symptoms.”¹⁹⁸ Frequently, it is not the pain itself, but pain joined with a patient’s depression or anxiety because she has a fear of losing control, which instills a desire in the patient to end her life.¹⁹⁹ Anxiety may be generated by the fear that pain will not be adequately controlled.

Over the past fifteen years, palliative care has changed.²⁰⁰ Today, “modern pain relief techniques can alleviate pain in all but extremely rare cases. Effective techniques have been developed to treat pain for patients in diverse conditions.”²⁰¹ In the last decade in particular, dramatic advances in knowledge about palliative care has occurred in at least two categories. First, huge medical and technical gains have taken place that now enable health care providers to supply a wide range of pain symptom management.²⁰² Second, progress has been realized in understanding and responding to the human suffering of dying patients beyond physical pain.²⁰³ There are now “a small but growing number of trained clinicians who have addressed

197. See Anthony L. Back et al., *Physician-Assisted Suicide and Euthanasia in Washington State: Patient Requests and Physician Responses*, 275 JAMA 919, 921–22 (1996) (reporting that 77% of the terminally ill patients surveyed were concerned about future loss of control and 75% of them were concerned about being a burden).

198. Kathleen M. Foley, *The Relationship of Pain and Symptom Management to Patient Requests for Physician-Assisted Suicide*, 6 J. PAIN & SYMPTOM MGMT. 289, 290 (1991).

199. See NEW YORK TASK FORCE, *supra* note 75, at 25. In one recent survey of American cancer patients, patients who were actually experiencing pain were more likely to find euthanasia or physician-assisted suicide unacceptable than those who were not currently in pain. See Emanuel et al., *supra* note 76, at 1809.

200. See Foley, *supra* note 198, at 289.

201. NEW YORK TASK FORCE, *supra* note 75, at 40; see also Ada Jacox et al., *New Clinical-Practice Guidelines for the Management of Pain in Patients with Cancer*, 330 NEW ENG. J. MED. 651 (1994) (stating that in 90% of cancer patients experiencing pain, “the pain can be controlled by relatively simple means”); Robert D. Truog et al., *Barbiturates in the Care of the Terminally Ill*, 327 NEW ENG. J. MED. 1678, 1679–81 (1992) (presenting certain circumstances in which the use of barbiturates by a physician intending to relieve pain, rather than to kill, is justified); Robert G. Twycross, *Where There Is Hope, There Is Life: A View from the Hospice*, in EUTHANASIA EXAMINED 141 (John Keown ed., 1995) (asserting that sufficient pain relief is almost always possible in patients with incurable cancer).

202. See Michael H. Levy, *Pharmacologic Treatment of Cancer Pain*, 335 NEW ENG. J. MED. 1124, 1124 (1996); Paul Rousseau, *Hospice and Palliative Care*, 41 DISEASE-A-MONTH 773, 776 (1995); Nathan I. Cherny & Russell K. Portenoy, *The Management of Cancer Pain*, 44 CAL. CANCER J. 262, 262 (1994).

203. See Foley, *supra* note 198, at 290.

the special needs of this population and have developed guidelines for the evaluation and treatment of pain, other symptoms, and psychological distress.”²⁰⁴

Medical gains became clear with the publication of pain guidelines for physicians by the World Health Organization in 1986.²⁰⁵ These guidelines taught clinicians to classify different levels of pain²⁰⁶ and to identify the relationship between psychological anxiety and physical symptoms.²⁰⁷ Methodologies were also suggested to assess pain and to improve communication between patients and health care providers. Today, in settings where staff is adequately trained, it is now routine to control pain fairly easily in about ninety-eight percent of all patients.²⁰⁸ Even in rare cases where pain control is more difficult, it can at least be managed by terminal sedation.²⁰⁹

These developments have sparked other initiatives. New curricular guidelines for physicians’ and nurses’ training have been devised.²¹⁰ New national and international organizations, such as the American Pain Society, the American Society of Hospice Physicians, the International Association for the Study of Pain, and the International Psycho-Oncology Society have been created.²¹¹ These and other groups have developed clinical practice guidelines intended to educate health care providers.²¹² Gradually, information about pain man-

204. *Id.*

205. See WORLD HEALTH ORG., CANCER PAIN RELIEF (1986); see also EXPERT COMM. ON CANCER PAIN RELIEF & ACTIVE SUPPORTIVE CARE, WORLD HEALTH ORG., CANCER PAIN RELIEF AND PALLIATIVE CARE 19–21 (1990).

206. See, e.g., Kathleen M. Foley, *Pain Assessment and Cancer Pain Syndromes*, in OXFORD TEXTBOOK OF PALLIATIVE MEDICINE 148, 149–51 (discussing various classifications of pain).

207. See, e.g., Hitchcock et al., *supra* note 180, at 313 (discussing effect of pain on psychological well-being).

208. See Council on Scientific Affairs, American Med. Ass’n, *Good Care of the Dying Patient*, 275 JAMA 474, 475 (1996).

209. “Certainly, no one need be in serious pain, since physicians could always relieve pain with anesthesia or profound sedation. For some, this is an unacceptable trade-off, but it is always available.” Council on Scientific Affairs, *supra* note 208, at 475; see also Levy, *supra* note 202, at 1124.

210. See, e.g., TASK FORCE ON PROF’L EDUC., INTERNATIONAL ASS’N FOR THE STUDY OF PAIN, CORE CURRICULUM FOR PROFESSIONAL EDUCATION IN PAIN (Howard L. Fields ed., 1991); Ad Hoc Comm. on Cancer Pain, American Soc’y of Clinical Oncology, *Cancer Pain Assessment and Treatment Curriculum Guidelines*, 10 J. CLINICAL ONCOLOGY 1976 (1992); see also Betty R. Ferrell et al., *Pain and Addiction: An Urgent Need for Change in Nursing Education*, 7 J. PAIN & SYMPTOM MGMT. 117, 122–23 (1992).

211. See Foley, *supra* note 198, at 290.

212. See AMERICAN PAIN SOC’Y, PRINCIPLES OF ANALGESIC USE IN THE TREATMENT OF ACUTE PAIN AND CANCER PAIN (3d ed. 1992); JUDITH H. WATT-

agement has become available to physicians in all specialties.²¹³ Physicians have learned, for example, that patients dealing with chronic pain often report it less graphically than those experiencing acute episodes.²¹⁴ Dying patients also underreport pain²¹⁵ because they misunderstand its significance or fear the consequences of further bothering the physician. Failure to explain the basis for the distress, however, may only increase anxiety, which in turn increases pain.²¹⁶

Similar strides have been made in understanding the causes and amelioration of suffering distinct from physical pain. As Eric Cassell put it:

Suffering occurs when an impending destruction of the person is perceived; it continues until the threat of disintegration has passed or until the integrity of the person can be restored in some other manner. It follows, then, that although it often occurs in the presence of acute pain, shortness of breath or other bodily symptoms, suffering extends beyond the physical. Most generally, suffering can be defined as the state of severe distress associated with events that threaten the intactness of a person.²¹⁷

For example, common fears of dying persons such as abandonment, loss of family relationships, or dying alone can be quieted.²¹⁸ Furthermore, depression and its relationship to medical decisions concerning the dying process can be treated.²¹⁹ Other studies have examined the psychological challenges faced by those caring for dying patients. Significantly, psychiatrists note that physicians can over-identify with a patient's psychological distress without recognizing the "risk of colluding with the patient's feelings of hopelessness and helplessness."²²⁰

WATSON & MARILEE IVERS DONOVAN, PAIN MANAGEMENT: NURSING PERSPECTIVE (St. Louis: Mosby Year Book 1992); Health & Pub. Policy Comm., American College of Physicians, *Drug Therapy for Severe, Chronic Pain in Terminal Illness*, 99 ANNALS INTERNAL MED. 870 (1983).

213. See Gavrin & Chapman, *supra* note 171, at 268; Jacox et al., *supra* note 201, at 651.

214. See Doyle, *supra* note 179, at 298.

215. See Foley, *supra* note 198, at 148.

216. See Bond, *Psychological Aspects of Treatment of Cancer Pain*, in PALLIATIVE CARE, *supra* note 179, at 249; Doyle, *supra* note 179, at 302-03.

217. ERIC J. CASSELL, THE NATURE OF SUFFERING 33 (1991).

218. See Nathan I. Cherny et al., *The Treatment of Suffering When Patients Request Elective Death*, 10 J. PALLIATIVE CARE 71, 73-76 (1994).

219. See Bond, *supra* note 216, at 246-49; William Breitbart & Steven D. Passik, *Psychiatric Aspects of Palliative Care*, in OXFORD TEXTBOOK OF PALLIATIVE MEDICINE 6090 (1998); Doyle, *supra* note 179, at 306-07; Sullivan & Youngner, *Depression, Competence, and the Right to Refuse Lifesaving Medical Treatment*, 151 AM. J. PSYCHIATRY 975-76 (1994).

220. Susan D. Block & J. Andrew Billings, *Patient Requests to Hasten Death*, 154

Although these advances represent a revolution in palliative care,²²¹ they are not yet available to all dying patients.²²² Some receive less than adequate comfort care measures because they lack access to health care resources.²²³ Others have insurance, but coverage may be lacking for needed interventions.²²⁴ Too many suffer because their primary care physician chooses to remain uninformed about palliative care options.²²⁵ A growing number of states are enacting intractable pain legislation to reassure physicians that adequate pain control is legally and medically required.²²⁶ Hospice care, though expanding rapidly, still does not reach all the patients who could benefit from it.²²⁷ Similarly, managed-care incentives may be needed to induce physicians to treat less attractive or less profitable groups of patients.²²⁸

Embracing legalized assisted suicide poses new challenges to these recent advancements in palliative care. Death, through physician-assisted suicide or physician-administered euthanasia, will surely end pain. Unfortunately, it also could end interest and research, as well as research funding, in palliative care. Until about a decade ago, little systematic study had been done of dying patients or their need for palliative care.²²⁹ Studies by physicians familiar with pain control for dying patients document that poor pain assessment, fear of addic-

ARCHIVES INTERNAL MED. 2039, 2044 (1994).

221. See J. Cambier, *A Modern View: Pain Today*, in THE HISTORY OF PAIN 331 (1995). “[T]he past thirty years have modified our relationship to pain more than all the previous centuries combined.” *Id.*

222. See *supra* notes 146–51 and accompanying text.

223. See Betty R. Ferrell & Hurdis Griffith, *Cost Issues Related to Pain Management: Report from the Cancer Pain Panel of the Agency for Health Care Policy and Research*, 9 J. PAIN & SYMPTOM MGMT. 221, 232–33 (1994); Foley, *supra* note 198, at 292.

224. See Ferrell & Griffith, *supra* note 223, at 232.

225. Doctors generally lack knowledge of effective pain management techniques and fear of addiction in patients. They also worry that pain control might be viewed as euthanasia. See Charles S. Cleeland, *Documenting Barriers to Cancer Pain Management*, in CURRENT & EMERGING ISSUES IN CANCER PAIN, *supra* note 181, at 322–24; Foley, *supra* note 198, at 291–92.

226. See, e.g., CAL. BUS. & PROF. CODE § 2241.5 (2000); COLO. REV. STAT. § 12-36-117 (1999); FLA. STAT. ch. 458.326 (1999); MINN. STAT. § 152.125 (1999); MO. REV. STAT. § 334.105 (1999); OHIO REV. CODE ANN. § 4731.052 (1999); OR. REV. STAT. § 677.470 (1997); TEX. CIV. CODE ANN. § 4495C (2000); VA. CODE ANN. § 54.1-3408.1 (Michie 1999).

227. See Lynn, *supra* note 164, at 201.

228. See Sidney D. Watson, *Medicaid Physician Participation: Patients, Poverty, and Physician Self-Interest*, 21 AM. J.L. & MED. 191, 217–19 (1995).

229. See Counsel on Scientific Affairs, *supra* note 208, at 474.

tion, fear of possible legal complications, and fear of death itself often prevent doctors from providing adequate palliative care.²³⁰

There can be no doubt that patients continue to suffer needlessly. Physicians and other health care providers must accelerate the implementation of palliative care options.²³¹ Physicians who contend that patients suffering severe pain should be allowed help in killing themselves need incentives to first implement advances in palliative care. They need to understand that they might be trying to protect themselves from further exposure to the patient's suffering and gradual decline. A dying patient provides a mirror into which few are eager to stare.

It is too early to determine what effect the Oregon option may have on the development and implementation of these palliative care advances. Clinical evidence beyond the Department's report suggests that the potential for diverting attention from palliative care advances should not be ignored. It may be that making suicide a clinical option threatens more humane care and reduces patient choice.

First, because many patients recant a suicide wish when adequately treated for pain and suffering,²³² no decision to elect suicide should be viewed as truly voluntary unless viable palliative care alternatives have been attempted. Second, current costs of palliative care span a wide spectrum.²³³ Nevertheless, none of these options can compare to the lure of cheaper costs promised by assisted suicide. In an increasingly cost-conscious health care system, physician-assisted

230. See Ronald H. Blum et al., *Factors Limiting the Use of Indicated Opioid Analgesics for Cancer Pain*, 7 AM. J. HOSPICE & PALLIATIVE CARE 31-32 (1990); Eduardo Bruera et al., *Changing Pattern in the Treatment of Pain and Other Symptoms in Advanced Cancer Patients*, 2 J. PAIN & SYMPTOM MGMT. 139 (1987); Charles S. Cleeland et al., *Pain and Its Treatment in Outpatients with Metastatic Cancer*, 330 NEW ENG. J. MED. 592 (1994); Sidney H. Wanzer et al., *The Physician's Responsibility Toward Hopelessly Ill Patients*, 320 NEW ENG. J. MED. 844, 846-47 (1989).

231. See Christine K. Cassel & Bruce C. Vladeck, *ICD-9 Code for Palliative or Terminal Care*, 335 NEW ENG. J. MED. 1232, 1233 (1996). The Health Care Financing Administration's recent approval of a diagnosis code for palliative care should facilitate such efforts. See *id.* Others suggest establishing a national commission "to explore and develop a consensus on the care and treatment of the seriously or terminally ill—a scientific commission similar to the President's Commission that in 1983 gave us guidelines about foregoing life-sustaining treatment with dying patients." Hendin, *supra* note 131, at 23.

232. See *Physicians' Experiences*, *supra* note 34, at 562. Two thirds of all suicide requests to physicians in the Netherlands are rescinded, often due to palliative interventions. Nearly the same number change their minds in Oregon when offered similar palliative alternatives.

233. See Ferrell & Griffith, *supra* note 223, at 223-33.

death, once legally and socially accepted, could become one of the only fully covered options. Third, physicians may fail to recognize that demands from patients for suicide often represent pleas for better care or reassurance that they will not be abandoned. The emergency room visit for pain control by those without primary health care providers could, under the Oregon system, result in advocacy for permanent relief, through assisted death.²³⁴

Over the past twenty years, the consistent thrust of legal developments regarding the right to forego life-sustaining medical treatment has been to enlarge the scope of individual patient control and choice. Palliative care options, including foregoing life-sustaining treatment have been developed, implemented, and multiplied as a result. Legal approval of assisted suicide as a patient right, however, risks reducing real choice and control by slowing this progress or replacing it altogether.

The proponents of physician-assisted suicide assert that patients who suffer intolerably are the most obvious candidates for this option of a quick death. Yet, the alternative of truly adequate palliative care, including options to forego life-sustaining treatment, easily can become hidden from doctors and patients alike whenever assisted suicide appears easier or less expensive. By referring to the criterion of suffering, the Oregon statute seems to acknowledge another potential restriction on physician-assisted suicide.²³⁵ However, legitimizing suicide as a remedy for suffering ignores recent advances in palliative care and creates legal incentives that may subtly or overtly encourage seriously ill patients to end pain by terminating life.

E. Was the Suicide Assisted by a Physician?

The Oregon statute assumes that assisted suicide will involve only physicians' assistance. It requires an active role for the "attending physician" defined as "the physician who has primary responsibility for the care of the patient and treatment of the patient's terminal disease."²³⁶ The attending physician is charged with the responsibility

234. One recent study documents that 42% of outpatients with pain were not given adequate pain treatment. "Patients seen at centers that treated predominantly minorities were three times more likely than those treated elsewhere to have inadequate pain management." Cleeland, *supra* note 225, at 592.

235. See OR. REV. STAT. § 127.805 (1997).

236. *Id.* § 127.800(2). The requirement for both an attending and a consulting physician to participate in the determination of a terminal disease, is in OR. REV.

of providing informed consent to the patient and with making the initial determination that the person is capable, acting voluntarily, and is terminally ill.²³⁷ The “consulting physician,” defined as “a physician who is qualified by specialty or experience to make a professional diagnosis and prognosis regarding the patient’s disease,”²³⁸ is charged with the responsibility of confirming that the patient suffers from a terminal disease, is capable, is acting voluntarily, and has made an informed decision.²³⁹ The Oregon law also sets out the possible role of mental health professionals, to whom a patient may be referred, “[i]f in the opinion of the attending physician or the consulting physician a patient may be suffering from a psychiatric or psychological disorder, or depression causing impaired judgment.”²⁴⁰

As previously pointed out, the statute further dangles the carrot of legal immunity as a means to encourage physician involvement.²⁴¹ The physician, not a family member, pharmacist, nurse, or friend, is to provide access to a lethal dose for the patient to use. However, according to Oregon law, anyone including the physician, pharmacist, nurse, family member, or others may obtain legal protection from mistaken judgments as long as she acts in “good faith.”²⁴² As emphasized above, the law states that: “No person shall be subject to civil or criminal liability or professional disciplinary action for participating in good faith compliance with [the Oregon physician-assisted suicide statute].”²⁴³

The Guidebook discusses at some length the roles of the attending and consulting physicians, as well as the roles of psychiatrists and psychologists. The Guidebook, with its usual moral sensitivity, re-

STAT. § 127.805. The Model State Act for assisted suicide also requires participation by two physicians, the “Responsible physician,” “who (1) has full or partial responsibility for treatment of a patient who is terminally ill or intractably and unbearably ill and (2) takes responsibility for providing medical means of suicide to the patient” and (3) “a consulting physician who has examined the patient and is qualified to make such an assessment that the patient is suffering from a terminal illness or an intractable and unbearable illness.” Baron et al., *supra* note 35, at 26, 29. The draft Illinois Physician-Assisted Suicide Act requires only an “assisting physician” and an “independent physician,” both of whom must be “disinterested persons” and licensed to practice as a physician. Comment, *An Illinois Physician-Assisted Suicide Act*, 28 LOY. U. CHI. L.J. 822, 824–27 (1997).

237. See OR. REV. STAT. § 127.815.

238. *Id.* § 127.800(3).

239. See *id.* § 127.820.

240. *Id.* § 127.825.

241. See *id.* § 127.885(1).

242. *Id.*

243. *Id.*

minds physicians of the need for carefully listening to what the patient really means when she requests assisted suicide: "Patients may communicate one thing, yet mean quite another. Patients frequently visit physicians with a particular symptom, yet have deeper worries that remain hidden. Eliciting hidden factors may promote healing beyond biologic treatment."²⁴⁴ However, this subtle communication of the real meaning behind suicidal requests is utterly ignored by the law and hence, also by the Oregon Department of Human Resources in its report.

The Guidebook, recognizing the ease with which the legal requirement of a second, independent physician's judgment could become perfunctory, recommends that, "the consulting physician practice outside the attending physician's practice group,"²⁴⁵ and advises that the consultant "have expertise in managing the patient's terminal disease, including palliative therapies."²⁴⁶ Yet, probably because the law itself requires neither of these practices, the Department in its report gives no indication that it attempted to find out the practice specialty of the consulting physician or whether the consulting physicians were partners or friends of the attending physicians. Any intent in the law for a truly independent second opinion concerning whether the patient was depressed, capable of deciding, acting voluntarily, or terminally ill was thereby easily bypassed.

The statistics compiled in the Department of Human Resources report highlight another aspect of physician selection. At least half of the attending physicians knew the patient requesting assisted suicide for less than six months.²⁴⁷ Sixty percent of the physicians who wrote prescriptions saw the patient only after another physician rejected that same person's request.²⁴⁸ This strongly suggests that in at least half the cases, physicians were selected because they were ready, willing, and able to assist the suicide, rather than because they were in a posi-

244. OREGON GUIDEBOOK, *supra* note 9, at 21. The Guidebook continues: Reasons underlying a request for a lethal prescription may include unrelieved pain and physical suffering, depression, feelings of isolation, emotional or spiritual crisis. Concerns about being a financial burden to self or family may also be an underlying reason. . . . Examining the meaning behind the request for a lethal prescription may lead to new physical or psychosocial interventions that might obviate the patient's desire for a lethal prescription.

245. *Id.* at 22.

246. *Id.*

247. See *Second Year Report*, *supra* note 11, at 601.

248. See *id.*

tion to understand the full complexity of the patient's values, psychological crises, beliefs, family relationships, and all the other factors which might lie behind the suicide request. As the Guidebook makes clear, writing a prescription for a lethal drug should not be treated as the same as writing a prescription for an antibiotic or antihistamine.²⁴⁹

Three possible rationales exist for relying on physicians rather than others to perform the task of suicide assistance. First, physicians may be preferred because they generally have the most clinical expertise. Doctors might be seen as the least likely to err in assessing clinical facts, such as diagnosis, prognosis, and treatment options, as well as patient capacity or whether the patient is acting voluntarily or is terminally ill. Their clinical expertise also enables them to assist death in the most humane manner possible. Further, they alone have the legal power to prescribe an appropriate drug. Second, physicians may be preferred because they are perceived to be relatively immune to conflicts of interest. Granting them legal immunity seems a small accommodation to guarantee patient autonomy. Third, it might be hoped that the social and moral role of physicians would provide a built-in protection against abuse, particularly for seriously ill and vulnerable persons. Careful scrutiny, however, reveals that none of these rationales can carry its intended weight.

There can be no doubt that most physicians are competent, morally sensitive, and dedicated to serve their patients. Yet, as to the first rationale for reliance on physicians, as we have seen, clinical expertise has its own limits.²⁵⁰ Doctors, like everyone else, make mistakes. These mistakes may be errors in clinical diagnosis, prognosis, or treatment, or they may involve inadvertent or unintentional manipulation of patient choice.²⁵¹ Errors can be compounded when a physician acts outside her particular specialty. Suicide assisted by a dermatologist, radiologist, pathologist, or ophthalmologist will have resulted from a far different clinical assessment than a suicide assisted by a family physician, internist, or oncologist. Yet under Oregon law,

249. See OREGON GUIDEBOOK, *supra* note 9, at 5–6.

250. See *supra* notes 244–49 and accompanying text.

251. See Michael J. Green et al., *Do Actions Reported by Physicians in Training Conflict with Consensus Guidelines on Ethics?*, 156 ARCHIVES INTERNAL MED. 298, 300–01 (1996). A recent study of the actions of internal medicine residents found that 29% admitted intentionally manipulating a patient to accept or reject a test or procedure, and 18% said they had discontinued life-sustaining interventions without permission from a patient or proxy. See *id.*

any of these could qualify as “attending physician” if the patient had selected them for treatment of her terminal disease.²⁵²

Further, even if suicide assistance were restricted to the physician with a primary care relationship with a patient, recall that most doctors from this group are unfamiliar with the signs of clinical depression.²⁵³ A physician who misses such a diagnosis can make assisted suicide available without eliminating a major cause of incapacity or involuntary choice. This may explain why a recent poll shows that physicians with the most experience in interacting with dying patients favor legalizing assisted suicide the least.²⁵⁴ The perverse implication is that those doctors without clinical expertise may well perform the bulk of assisted suicides (and gain legal immunity as long as they act in good faith). More than sixty percent of the attending physicians who assisted the forty-three suicides in Oregon in 1998–99 were not the first physicians approached by the patient for a prescription, yet in only fifteen of the forty-three cases (thirty-five percent) did they perceive any need for a psychological consultation.²⁵⁵

Some assert that it is possible to identify a group of physicians capable of assessing all of the clinical factors that the Oregon law has made prerequisites to assisted suicide.²⁵⁶ Yet, most physicians have no particular expertise in grasping or assessing a patient’s deeper thoughts, beliefs, values, fears, and motivations, all of which are central to understanding her true wishes.²⁵⁷ Further, physicians have their own needs and agendas, such as personal time, professional advancement, research projects, or financial incentives.²⁵⁸ Even conceding the generous devotion to their patients, which many physicians display, they often have little time to discover or the wisdom to understand the patient’s true wishes or best interests. Most physicians today do not have the type of close relationships with their patients that would enable them to distinguish the patient’s request for suicide from a cry for some other kind of help. Those who do, need more than one session with the person to approach an accurate determina-

252. See OREGON GUIDEBOOK, *supra* note 9, at 20.

253. See Gavrin & Chapman, *supra* note 171, at 270–71.

254. See Bachman et al., *Attitudes of Michigan Physicians*, 334 NEW ENG. J. MED. 308 (1996).

255. See THE FIRST YEAR’S EXPERIENCE, *supra* note 10, at 4, 17.

256. See Werth et al., *supra* note 38.

257. See WILLIAM F. MAY, *THE PATIENT’S ORDEAL* (1991) (exploring the issues of medical ethics from patients’ perspectives to provide insight for practitioners).

258. See SHERWIN B. NULAND, *HOW WE DIE* 249–54 (1994).

tion.²⁵⁹ Even then, mental health professionals themselves differ about how to accomplish this task.²⁶⁰

The Oregon law, as already pointed out, virtually eliminates any possibility of calling a physician's action into question, either by a criminal or civil suit, by granting physicians legal immunity for "good faith compliance" with the law.²⁶¹ Because "good faith compliance" is an entirely subjective norm, it means that no physician who acts honestly but incompetently in any aspect of diagnosis, prognosis, presentation of alternatives, determination of capacity and voluntary action, or providing the lethal dose of medication can be held liable or lose her license to practice medicine. This same physician's acts are further shrouded by the Oregon statute's guarantee of physician-patient confidentiality, which grants the physician another layer of protection against any prosecutor or family member who might question his suicide assistance. "If the attending physician discloses [the patient's assisted suicide request] without the patient's authorization he/she may be exposed to civil liability for invasion of the patient's privacy and breach of confidentiality."²⁶²

The Oregon Department of Human Resources has made abundantly clear that it will make no serious effort to investigate the assisted suicides that take place in the State. Some physicians may have supplied the Department with far more information about the individual assisted suicide case than what is demanded on the long or short forms. However, this information provides no reliable proof that patients were not coerced, lacking in capacity, or even that they were terminally ill. The Department, perhaps because it followed the bare bones of an inadequate and inherently unenforceable statute, seems satisfied with the minimal reports of physicians who merely check the boxes on the long form or sign the short form telling the Department to check the medical records for itself.

The second possible rationale for physician assistance—freedom from conflicts of interest—builds on the first. Oregon law seems to characterize physicians as objective, fair, and compassionate evaluators, who serve at the invitation of a patient. Offering physicians legal immunity seems necessary to promote the personal autonomy of in-

259. See *supra* notes 45–46 and accompanying text.

260. See *supra* notes 92–96 and accompanying text.

261. OR. REV. STAT. § 127.885(1) (1997).

262. OREGON GUIDEBOOK, *supra* note 9, at 50.

dividual patients. Yet medicalizing suicide actually promotes the further domination of physicians over patients. Because the Oregon law depends on physicians, they become the sole arbiters of patient rights. In doing so, the law “transforms a private act (suicide) into a medical event.”²⁶³ Further, power inequalities already inherent in the doctor-patient relationship create additional conflicts. Finally, making suicide the prerogative of physicians changes their traditional social and moral role as well as enhances their power. As unregulated physician authority increases, patient autonomy disappears.

It is interesting to contrast this increased medical dependence with Oregon’s advance directive statutes.²⁶⁴ They provide citizens the right to *forego* medical treatment, thereby reducing an individual’s tie to medical technology.²⁶⁵ At first glance, the increased involvement and dependence on physicians might seem justified because physicians form a group of persons cloaked with moral trust by a society that depends on them for much of its health needs. However, the realities of physician-assisted suicide also offer a tempting diversion from the real power that they exert.

Patients and physicians are not equals. Oregon law only reinforces this inequality. The physician acts as an authority figure whose greater knowledge and experience allows her to prescribe the professionally perceived best course of action for the patient.²⁶⁶ Patients, who lack the information that their physicians possess, will be inclined to accept a prescription of death as the best alternative available, even though this is not a decision they would have made without the often unspoken guidance of a physician. As physicians come to see assisted suicide as an alternative to other forms of medical care, there exists a risk that assisted suicide will become a treatment that a doctor suggests or prescribes to a patient rather than something that is granted by the doctor only after a patient requests it. This dynamic will result in further shifts of focus from the patient to the physician. Assisted suicide will no longer be a question of patient choice, but one of the physician’s assessment of the patient’s situation.²⁶⁷

263. Tania Salem, *Physician-Assisted Suicide: Promoting Autonomy or Medicalizing Suicide?*, 29 HASTINGS CENTER REP. 30 (1999).

264. See OR. REV. STAT. § 127.510.

265. See *id.*

266. See RUTH MACKLIN, ENEMIES OF PATIENTS 24 (1993).

267. See Salem, *supra* note 263, at 32–33.

The third rationale for preferring physician assistance depends on the traditional social and moral role of doctors as guardians against abuse of seriously ill individuals. But erasing legal barriers to assisting patients with suicide changes the very doctor-patient relationship the lawmakers relied on.²⁶⁸ Once physicians assume the role of actively intervening to assist suicide or to cause death, their preexisting moral position, which depended on not harming patients, will be altered.²⁶⁹ Physicians are encouraged by the Oregon law to add assistance in death to their list of “beneficent” acts. “Doing no harm,” as required by the medical oath,²⁷⁰ no longer always involves refusing to kill. The laudable goal of involving patients in decisionmaking can easily vanish once a quick final solution appears on the legal horizon. However, naive trust in physician judgment eventually leads to further medical control over death and its discussion. Most troubling, even a doctor’s mention to a seriously ill, dependent, and suffering patient of the option that death might be hastened, will force the patient to justify her remaining existence.

The real reason physicians are preferred over others may boil down to their availability and efficient ability to carry out the lethal act. Physicians usually attend a person with a terminal illness, and they are legally and clinically able to administer the fatal drug. The Oregon voters’ hopes of greater choice necessarily included reliance upon physicians to enable it. But the Oregon law thereby transformed the private choice of an individual into additional dependence on a physician.

In reality, allowing physicians to kill sanitizes the act of assisted suicide itself. The cloak of legality carries serious social consequences. It encourages both physicians and patients to view killing as merciful and included in the category of “medically indicated” treatments. Burdening doctors with this responsibility diverts moral accountability for the act of killing away from others. Once “medicalized” killing is labeled merciful, it also will become difficult to argue that those initially not included within the law’s scope should remain ineligible for

268. See MACKLIN, *supra* note 266, at 204–06.

269. See Leon R. Kass, *I Will Give No Deadly Drug*, in *BIRTH TO DEATH: SCIENCE AND BIOETHICS* 231, 231–46 (David C. Thomas & Thomasine Kushner eds., 1996).

270. This maxim of medical ethics “at least, do no harm” has been attributed to Hippocrates. BEAUCHAMP & CHILDRESS, *supra* note 173, at 189. However, “it is not found in the Hippocratic corpus,” except by a “strained translation.” *Id.*

its benefits. Those who are incompetent or lack voluntary choice because of poverty or choice of the wrong physician certainly can suffer at least as much as the truly competent, voluntary, consenting patient who is terminally ill. If killing is lawful, merciful, and available from physicians, there seems little reason to deny it to those in such circumstances.

Unfortunately, the extension of medically assisted death to those who are not competent, not acting voluntarily, and even not terminally ill is precisely what has happened in the Netherlands, where assisted death in various forms has been tolerated legally and medically over the past twenty years.²⁷¹ Dutch doctors routinely report the degree of suffering or the perceived quality of life of a patient as the primary factor in determining when a request is granted, or unfortunately, when euthanasia is performed “mercifully” without a request.²⁷²

There is some evidence Dutch physicians, like their counterparts in Oregon, initially believed that personal autonomy, the individual rights of patients, justified euthanasia.²⁷³ As they listened compassionately to a patient’s wish to end life, they tested that person’s capacity and voluntary action by assessing the extent of the person’s disease, degree of disability, and extent of pain.²⁷⁴ The more degenerative and disabling the condition, the greater the likelihood that the physician would deem a suicide request “rational.”²⁷⁵

Once Dutch physicians accepted the notion that there were some who understandably might prefer to be killed, it became easier to presume an unspoken request from the next patient apparently suffering to the same extent.²⁷⁶ Assisted suicide and euthanasia in the Netherlands became a treatment option for physicians because they saw suf-

271. See Johannes J. Van Delden et al., *The Rummelink Study Two Years Later*, HASTINGS CENTER REP., Nov.–Dec. 1993, at 25.

272. See Loes Pijnenborg et al., *Life-Terminating Acts Without Explicit Request of Patient*, 341 LANCET 1196, 1198 (1993) (discussing Dutch cases where physicians cited “the hopelessness of the situation, the unbearable suffering, and the futility of further medical treatment” and “very poor quality of life with no chance for improvement, further treatment being futile” as reasons for mercy killings).

273. See, e.g., HENDIN, *supra* note 133, at 47–95; see also *Second Year Report*, *supra* note 11, at 600. Physicians cited loss of autonomy as the most frequent reason for requesting physician-assisted suicide.

274. See Van Delden et al., *supra* note 271, at 24.

275. See *id.*

276. See CARLOS F. GOMEZ, *REGULATING DEATH: EUTHANASIA AND THE CASE OF THE NETHERLANDS* 137 (1991).

fering patients, rather than because they believed in the voluntary choice of a competent patient.

This creep toward involuntary euthanasia and mercy killing has gone unchecked in the Netherlands, despite legal regulations similar to those in Oregon. In surveys which guarantee legal immunity, Dutch physicians report that they “grant” euthanasia to persons who do not ask, who are completely incapacitated, and in some cases, are not terminally ill.²⁷⁷ Note, that this has occurred in a country where access to health care is guaranteed and no explicit financial incentives exist to limit treatment.²⁷⁸ Despite universal health care, a benefit unheard of in America, the majority of cases where doctors intentionally shorten life in the Netherlands “remain unnotified, unchecked and invisible to justice.”²⁷⁹

A recent survey of American oncologists documents exactly the same behavior among those few American physicians who have secretly written prescriptions for patients to kill themselves and those who have used a lethal injection to kill a patient.²⁸⁰ American physicians consistently adhered to only one safeguard in deciding whether to assist patient suicides or give them lethal injections. Nearly all consistently required poor quality of life, that the patient be “severely ill—either having pain despite narcotic medications or extremely poor physical functioning.”²⁸¹

These same American physicians were inconsistent about whether the patients acted voluntarily. In fact, in fifteen percent of the cases, the patients were unaware that a family member’s request for euthanasia triggered a lethal injection.²⁸² Finally, these physicians

277. See HENDIN, *supra* note 133, at 97–126.

278. See Gerrit van der Wal & Robert J. M. Dillman, *Euthanasia in the Netherlands*, 308 BRIT. MED. J. 1346 (1994). Over 99% of all patients in the Netherlands have primary care physicians as part of extensive health care coverage provided by the government. Approximately 6300 general practitioners serve 15 million Dutch residents. Forty percent of patients die at home and no explicit financial incentives encourage family or health care providers to limit treatment. See *id.*

279. H. Jochemsen, *Euthanasia in Holland: An Ethical Critique of the New Law*, 20 J. MED. ETHICS 212, 215 (1994).

280. See Ezekiel J. Emanuel et al., *The Practice of Euthanasia in the United States*, 280 JAMA 507 (1998).

281. *Id.* at 511. The authors also concluded that “for some patients, receiving opioid analgesia and/or hospice care does not obviate the desire for euthanasia or PAS [physician-assisted suicide].” *Id.* at 513. The study did not evaluate whether these patients received effective palliative care, perhaps from the same physicians.

282. See *id.* The authors state that “these data warn that safeguards meant to ensure patient autonomy could be violated in a significant minority of cases making nonvoluntary or involuntary euthanasia a concomitant of permitting voluntary

rarely used psychiatric consultations, leading the researchers who conducted the study to worry: “The data suggest that laws like Oregon’s, which permit but do not mandate a psychiatric evaluation, may not lead to adequate detection and care of mental illness among patients requesting PAS [physician-assisted suicide].”²⁸³

Overall, this study concludes that American “physicians frequently confuse euthanasia with PAS”²⁸⁴ and that their “practices are frequently inconsistent with proposed safeguards, although having severe physical symptoms seems a strong requirement for physicians to perform euthanasia or PAS.”²⁸⁵ In other words, in practice, these physicians ignored capacity and voluntary action, occasionally listened to relatives or other third parties rather than the patient, and consistently performed euthanasia or physician-assisted suicide when they, the physicians, deemed the patient’s quality of life miserable. Death became the physician’s prescription, not the voluntary and competent choice of the patient.

IV. Conclusion

The point of this article is not to criticize either physicians or the Oregon Department of Health. The point of the article is more basic—the Oregon physician-assisted suicide law has no teeth. It imposes, in practice, no effective or enforceable restrictions on assisted suicide. The law has created the illusion for Oregon voters that it limits assisted suicide to a small number of cases. The Oregon Department of Human Resources, by its reports on the 1998 and 1999 assisted suicides, has enhanced that illusion by assuring that the law was fully complied with. There are vast gaps in our knowledge because the Oregon law itself shrouds physician-assisted suicide in silence, confidentiality, physician good faith protection, unasked questions, and a willing blindness to clinical and practical realities. It is known, for example, that forty-three assisted suicides were reported—it is not

euthanasia or PAS.” *Id.* at 511.

283. *Id.* at 512.

284. *Id.* at 513.

285. *Id.* The authors also conclude that: “even with well-crafted questions, existing data may overstate the practices of euthanasia and PAS,” that “there are some unsuccessful attempts at PAS” and that “a significant minority of physicians experience regret and emotional distress at having performed euthanasia or PAS.” *Id.*

known how many were actually performed. It is also clear that significant detail is missing from the reported cases.

This leads to the conclusion that the most troublesome aspect of the Oregon law is its deception. The face of the statute appears to allow physician-assisted suicide while attempting to protect the state's citizens from involuntary euthanasia. The "teeth" in the Oregon law, however, simply cannot hold. The Department of Health's reports about the two years of assisted suicide in Oregon beg us to ask more questions than it answers. The Department's conclusion, that the statutory requirements were complied with in forty-three cases, assures compliance only with the Oregon law's minimal requirements; thus we end up with a perfunctory recitation of inherently unenforceable criteria.

Most discussions of physician-assisted suicide envision five criteria as necessary safeguards against involuntary euthanasia. They assert that only competent, terminally ill patients who voluntarily choose to end their lives because of intolerable suffering will be granted the assistance of a physician in ending their lives. The Oregon statute pays lip service in varying degrees to all five of these "teeth." Asserting that capacity, voluntary choice, terminal illness, suffering, and physician involvement will protect dying persons is a claim that no statute can guarantee and a line no legal system can enforce.

The Oregon Department of Health's reports reveal that only two criteria, capacity and voluntary choice, have been taken seriously enough to track with any degree of care. Even then, the report demonstrates that they are impossible to monitor. The other three criteria, terminal illness, patient suffering, and physician involvement are essentially ignored by the report. Physician involvement is assumed, but suicides assisted by others remain hidden and unreported. Terminal illness also is presumed but not documented. Suffering is not an explicit statutory criterion. Nevertheless, the Department seems to acknowledge its importance by asking brief questions about physical pain. The answers confirm the conclusion sought. Physicians report that physical pain does not seem to compel patients to ask for death. This conclusion ignores both other clinical studies that disagree as well as the reports of family members, who document both uncontrolled pain and the equal or greater role psychological suffering plays in suicide requests.

The Department's report appears to rely heavily on two explicit statutory "teeth," capacity and voluntary action. It is here that the statute's deception takes a deeper plunge. On its face, the law requires a second opinion from a consulting physician and recommends a psychological referral as well. However, the Department's reports say nothing about who the consulting physicians were or how they assessed the patients, and indicates that only fifteen persons were referred for a psychological consult.

As suggested, these results demonstrate that both criteria are nearly impossible to measure. Capacity waxes and wanes, especially in seriously ill persons, where it is often complicated by depression, age, and disease status. Voluntary choice similarly gets colored by the external world of factors that influence or coerce decisions, such as insurance coverage, cost, dependency, the influence of relatives, and the fear of dying. The statutory answer, "consult and disclose," creates more problems than it solves. Consult whom? The law's answer is physicians who may or may not be competent and who most likely favor physician-assisted suicide and therefore will find it a rational competent choice. Disclose what? A statutory list of alternatives easily can bypass an individual's real concerns. Even worse, focusing on these "teeth" blatantly underestimates the immunity of physicians under the Oregon statute. The trade off of legal immunity for physician involvement allows and even invites negligent assessment of diagnosis, prognosis, and alternatives to relieve suffering.

In short, the Department's reports treat only two of five statutory criteria semiseriously and those two criteria fail as restrictions when subjected to the reality of clinical and legal scrutiny. The Department should not be considered at fault, but the law itself. This is why recognizing physician-assisted suicide in states other than Oregon will lead to similar problems. As in Oregon, it will be impossible to document whether patients who are helped to die were capable of making such a decision, acting voluntarily, terminally ill, or suffering. Some will lack capacity. Some will not be acting voluntarily. Some will not be terminally ill, and some will not be suffering. In all of these cases there will seldom, if ever, be a successful prosecution or disciplinary action because statutory immunity will be thought necessary to encourage physician involvement.

States, therefore, should be wary of adopting similar legislation. It is clear from the Dutch experience that universal access to health

care does not protect citizens from involuntary euthanasia. We know from the first two years of experience in Oregon that there was only technical and mechanical compliance with the minimal statutory prerequisites. The traditional line in law and in medicine between letting die (termination of treatment) and killing (physician-assisted suicide or euthanasia), might not always be a perfectly clear line, but it has been vastly more effective at preventing abuse over a long period of time than its alternatives ever can be.

In rare cases a terminally ill patient in unrelievable pain might competently and voluntarily request a physician's assistance in ending his life. Oregon's assisted suicide law is objectionable because it purports to apply only to these few, whereas in fact it makes assisted suicide available to the many who lack capacity, whose choice is swayed by undue influences, who are not terminally ill, or whose suffering otherwise could be ameliorated. State laws should focus on encouraging adequate palliative care instead of assisted suicide as the best hope for providing care near the end of life and protecting the vast majority of seriously ill patients from coercion, suffering, and abuses.