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JUST THE MEDICAL FACTS: AN ARGUMENT IN SUPPORT OF THE CONTINUED BAN ON PHYSICIAN-ASSISTED SUICIDE

JAMES J. BOPP, JR.*

Thank you very much; it is a pleasure to be here. Assisted suicide is a complex topic, as the first speaker has certainly demonstrated in his survey of opinions in ethics, morality and the law.¹ Assisted suicide is an intersection not only of those concepts, but also of medicine,² compassion,³ and society's atti-

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Mr. Bopp is the founder, and has served as President since 1984, of the National Legal Center for the Medically Dependent and Disabled. He has testified before over 25 legislative committees, and in over 15 federal congressional and administrative hearings. He has edited two books, *Restoring the Right to Life: The Human Life Amendment* (1984), and *Human Life and Health Care Ethics* (1985). He has authored over 40 law review articles and has filed over two dozen briefs on constitutional issues in the United States Supreme Court. Mr. Bopp is also Editor-in-Chief of *Issues in Law & Medicine*, a quarterly law journal addressing medical and legal issues.

In 1987, Congress appointed Mr. Bopp to the Biomedical Ethics Advisory Committee, which advises Congress on ethical issues arising from the delivery of healthcare, and biomedical and behavioral research. From 1984 to 1987, Mr. Bopp served on the President's Committee on Mental Retardation, which advises the federal government on appropriate public policies to protect people with disabilities from discrimination, and to gain full access to American society. In addition, he has served as General Counsel for the National Right to Life Committee since 1978.

¹ See Mon. John A. Alesandro, Esq., *Is There a Constitutional 'Right to Die'?*, 12 ST. JOHN'S J. LEGAL COMMENT. 634 (1997) (presenting discussion of physician-assisted suicide during panel discussion at St. John's University School of Law on April 4, 1997).

² See James J. Bopp, Jr., *Preface*, 12 ISSUES L. & MED. iii, iii (1996) (surveying various concepts linked to physician-assisted suicide); *Brief of the Attorney General in Washington v. Glucksberg in the United States Supreme Court*, 12 ISSUES L. & MED. 295, 315 (1996) (comparing ideal medical treatment to reality of existing medical practices); Charles J. Dougherty, *The Common Good, Terminal Illness, and Euthanasia*, 9 ISSUES L. & MED. 151, 164-65 (1993) (discussing issues of professional ethics facing physicians when confronted with legalization of physician-assisted suicide).

³ See Dougherty, *supra* note 2, at 151-52 (discussing changing face of death and its impact on dying individuals attitudes); George P. Smith, *All's Well That Ends Well: Toward a Policy of Assisted Rational Suicide or Merely Enlightened Self-Determination?*, 22 U.C. DAVIS L. REV. 275, 307-08 (1989) (addressing problem of dying with compassion and

tude toward the terminally ill and the disabled.⁴

As the law develops, particularly as it is developed by the courts, its development usually begins with the facts.⁵ That is, a properly decided court decision is inseparable from human experience. It is based upon the reality of the circumstances that the court is addressing and should, therefore, reflect that human reality. Unfortunately, it seems that the debate on physician-assisted suicide is full of false premises and misunderstandings about the process of dying and what may cause people to seek suicide.

I too, have been deeply involved in the issue of physician-assisted suicide. In 1982, I founded the Hospice of the Wabash Valley, which now serves patients in five counties in the locations surrounding where I live. I also served as chairman of the board for eight years. As you know, Hospice provides palliative care to people who are terminally ill and dying.⁶

Furthermore, in 1994, I represented and continue to represent terminally ill patients, physicians and nursing homes in the State of Oregon who have obtained a declaratory judgment that Oregon Measure 16, which would have legalized assisted suicide in Oregon,⁷ was unconstitutional.⁸ The statute deprived people

dignity that incurably disabled people face).

⁴ See Paul K. Longmore & Elizabeth Bouvia, *Assisted Suicide and Social Prejudice*, 3 ISSUES L. & MED. 141, 167-68 (1987) (discussing prejudicial assumptions of society with regard to disabled people); Leslie L. Mangini, *To Help or Not to Help: Assisted Suicide and its Moral, Ethical, and Legal Ramifications*, 18 SETON HALL LEGIS. J. 728, 734-36 (1994) (outlining American common law view of suicide); Smith, *supra* note 3, at 290-92 (discussing evolution of societal attitudes toward suicide in America).

⁵ See generally WILLIAM E. WEGNER, CLOSING ARGUMENT § 13:1 (1993-96) (noting that suggestion of critical facts essential to persuading jury); Pamela Samuelson, *Good Legal Writing: Of Orwell and Window Panes*, 46 U. PITT. L. REV. 149, 166-67 (1984) (suggesting that beginning with discussion of facts aids in effective legal argument).

⁶ See Warren L. Wheeler, *Hospice Philosophy: An Alternative to Assisted Suicide*, 20 OHIO N.U. L. REV. 755, 755 (1994) (defining hospice care as medically oriented team approach to managing pain of individuals with short life expectancy).

⁷ See *Lee v. Oregon*, 107 F.3d 1382, 1386 (9th Cir. 1997) (dismissing challenge to Oregon's Measure 16 on grounds that plaintiffs did not have standing), *cert. filed*, 65 U.S.L.W. 3783 (1997); see also Thomas Maier, *Death By Choice: Oregon Voters Back MD-Aided Suicides*, NEWSDAY, Nov. 6, 1997, at A5 (reporting that voters in Oregon approved law allowing prescription of life-ending drugs to terminally ill patients); Jeff Mapes, *Suicide Law Ruling May Shake up Fall Vote*, PORTLAND OREGONIAN, June 16, 1997, at A1 (describing opinion of James Bopp as chief attorney for Measure 16 Opponents regarding appeal to Supreme Court); Mark O'Keefe et al., *Legislators May Refer Suicide Law to Voters*, PORTLAND OREGONIAN, Mar. 1, 1997, D1 (discussing Bopp's plan to appeal to Supreme Court if Ninth Circuit refused to reconsider decision); Mark O'Keefe, *Measure 16 Foes Keep Using Courts to Stall Law*, PORTLAND OREGONIAN, Apr. 16, 1997, at B11 (discussing Bopp's reaction to Ninth Circuit's denial of reconsideration of February ruling).

with terminal illnesses of the protection of Oregon law against assisted suicide.⁹ Furthermore, as president of the National Legal Center for the Medically Dependent & Disabled,¹⁰ I helped coordinate, as our organization was the national coordinator, the amicus curiae briefs filed in support of the anti-assisted suicide laws in New York and Washington.¹¹

There were forty-one amicus curiae briefs filed in support of the New York and Washington laws.¹² It really was an incredible array from a broad range of groups. There was a near unanimous opinion of the professional organizations representing people who minister to people who are terminally ill each and every day. These included the American Medical Association, the American Hospital Association,¹³ the American Nurses Association,¹⁴ the National Hospice Organization,¹⁵ the American

8 See *Lee*, 107 F.3d at 1386 (discussing plaintiffs' claims that Oregon's Measure 16 was unconstitutional, as violation of equal protection and due process rights under Fourteenth Amendment; free exercise of religion and freedom of association rights under First Amendment, and; statutory rights under Americans with Disabilities Act); see James Bopp, Jr. & Richard E. Coleson, *The Constitutional Case Against Permitting Physician-Assisted Suicide for Competent Adults with "Terminal Conditions"*, 11 ISSUES L. & MED. 239, 254-67 (1995) (discussing why Measure 16 is unconstitutional).

9 See OR. REV. STAT. § 127.800 (1995) (legalizing physician-assisted suicide).

10 See Frank J. Murray, *Assisted Suicide Goes to Top Court Justices Will Decide if Practice is a Right*, WASH. TIMES, Oct. 2, 1996, at A1 (quoting Bopp as stating Constitution not meant to protect doctors who play executioner); Judy Wiessler, *Right to Die/High Court to Rule On Assisted Suicide*, HOUS. CHRON., Oct. 2, 1996, at 1 (noting that Bopp, President of National Legal Center for Medically Dependent and Disabled, stated thirty-five states prohibit physician-assisted suicide, in response to Supreme Court's decision to review issue).

11 See N.Y. PENAL LAW § 125.15 (McKinney 1997) (stating that one who intentionally causes or aids another to commit suicide is liable for manslaughter in second degree); WASH. REV. CODE § 9A.36.060 (1997) (classifying promotion of suicide as Class C felony).

12 See generally Richard E. Coleson, *The Glucksberg & Quill Amicus Curiae Briefs: Verbatim Arguments Opposing Assisted Suicide*, 13 ISSUES L. & MED. 3 (1997) [hereinafter Coleson, *Verbatim Arguments*].

13 See Brief Amicus Curiae of the American Hosp. Ass'n in Support of the Petitioners at 3-4, *Washington v. Glucksberg*, 117 S. Ct. 2258 (1997), *Vacco v. Quill*, 117 S. Ct. 2293 (1997) (Nos. 96-110, 95-1858), available in 1996 WL 656278 [hereinafter AHA Brief] (contending that association supports right to refuse life-sustaining treatment, but not right to choose physician-assisted suicide).

14 See Brief Amicus Curiae of the American Med. Ass'n, et al. in Support of the Petitioners at 2-3, *Washington v. Glucksberg*, 117 S. Ct. 2258 (1997) (No. 96-110), available in 1996 WL 656263 [hereinafter AMA Brief] (arguing physician-assisted suicide is not solution for inadequate healthcare, American Nurses Association joined submission of Brief to Supreme Court).

15 See Brief Amicus Curiae of the National Hospice Org. in Support of the Petitioners at 4-5, *Vacco v. Quill*, 117 S. Ct. 2293 (1997), *Washington v. Glucksberg*, 117 S. Ct. 2258 (1997) (Nos. 95-1858, 96-110), available in 1996 WL 656338 [hereinafter Hospice Brief] (arguing that lower courts failed to appreciate that end of life is full of meaningful experiences).

Geriatric Society¹⁶ and many, many others. The sole exception from the unanimous view of the healthcare organizations was the National Student Medical Association, which filed a brief for the opposing side.¹⁷ I think that proves the old adage: Students know only enough to be dangerous.

In addition to the healthcare professions, there were organizations representing people with disabilities,¹⁸ the United States Catholic Conference,¹⁹ the National Right to Life Committee²⁰ and the Clinton Administration²¹ that all supported the notion that laws against assisted suicide should be upheld by the Supreme Court.

Many of the briefs were what we term "Brandeis briefs."²² The term was made famous by a then-lawyer, Louis Brandeis, who became a distinguished Justice of the United States Supreme Court.²³ He was purported to have filed the first brief that

¹⁶ See Brief Amicus Curiae of the American Geriatrics Soc'y in Support of the Petitioners at 3-4, *Vacco v. Quill*, 117 S. Ct. 2293 (1997) (No. 95-1858), available in 1996 WL 656290 [hereinafter *Geriatrics Brief*] (noting that Second and Ninth Circuits did not adequately consider medical realities surrounding death).

¹⁷ See American Med. Student Association and a Coalition of Distinguished Medical Professionals in Support of Respondents at 2-3, *Vacco v. Quill*, 117 S. Ct. 2293 (1997), *Washington v. Glucksberg*, 117 S. Ct. 2258 (1997) (Nos. 95-1858, 96-110) (arguing there is no clinical basis to distinguish between patients refusing life-sustaining treatment and those seeking physician-assisted suicide).

¹⁸ See Brief Amicus Curiae of the National Legal Center for the Medically Dependent & Disabled, Inc., et al. in Support of the Petitioners, *Vacco v. Quill*, 117 S. Ct. 2293 (1997), *Washington v. Glucksberg*, 117 S. Ct. 2258 (1997) (Nos. 95-1858, 96-110), available in 1996 WL 656336; Brief Amicus Curiae of Not Dead Yet and American Disabled for Attendant Programs Today in Support of Petitioners, *Vacco v. Quill*, 117 S. Ct. 2293 (1997) (No. 95-1858), available in 1996 WL 707992.

¹⁹ See Brief Amicus Curiae of the United States Catholic Conference, et al. in Support of Petitioners at 3-5, *Vacco v. Quill*, 117 S. Ct. 2293 (1997) (No. 98-1858), available in 1996 WL 656248 (arguing it is grave injustice to deprive persons of protection of homicide laws based on condition of health).

²⁰ See Brief Amicus Curiae of the National Right to Life Comm. in Support of Petitioners at 1-2, *Washington v. Glucksberg*, 117 S. Ct. 2258 (1997) (No. 96-110), available in 1996 WL 656315 (finding that right to suicide has not been properly formulated in history and tradition of nation).

²¹ See Brief for the United States as Amicus Curiae Supporting Petitioners, *Vacco v. Quill*, 117 S. Ct. 2293 (1997) (No. 95-1858); Brief for the United States as Amicus Curiae Supporting Petitioners, *Washington v. Glucksberg*, 117 S. Ct. 2258 (1997) (No. 96-110).

²² See generally BLACK'S LAW DICTIONARY 188 (6th ed. 1990) (defining "Brandeis brief" as "[f]orm of appellate brief in which economic and social surveys and studies are included along with legal principles and citations which takes its name from Louis D. Brandeis, former Associate Justice of Supreme Court").

²³ See Sanford Levinson, *Fan Letters: Holmes & Frankfurter: Their Correspondence, 1912-1934*, 75 TEX. L. REV. 1471, 1483 (1997) (discussing Brandeis as inventor of "Brandeis brief" who was extremely fact-oriented, as evidenced by his opinions while Supreme Court Justice). See generally BLACK'S, *supra* note 22, at 188 (noting "Brandeis brief" takes its name from Louis D. Brandeis, former Associate Justice of Supreme Court, who used this tactic while practicing law).

sought to advise a court of the societal consequences of a potential ruling by setting forth extensive relevant facts, outside the record that the court has before it, to inform and assist judges in coming to a correct result.²⁴ Such briefs often play a major role in the decisions that courts make.²⁵

You will hear, and have heard, from many lawyers about the law. I have chosen this morning not to focus on the law, but on the medical facts about suicide, as set forth in the amicus curiae briefs filed with the Supreme Court.²⁶ Many of the excerpts from these briefs will be published in a forthcoming edition of a journal about law and medicine which I edit. In this talk, I will try to consolidate what I think are the principal medical facts that these briefs point out, and that provide the basis for an informed discussion of how the law should deal with this important issue.

The first medical fact: Using modern medical techniques, pain can be successfully controlled.²⁷ According to the brief of the American Medical Association, the Second Circuit's decision²⁸ rested in substantial part on the assumption that there is a growing number of terminally ill patients who die protracted and painful deaths,²⁹ that absent physician-assisted suicide, these

²⁴ See generally Imad D. Abyad, *Commercial Reasonableness in Karl Llewellyn's Uniform Commercial Code Jurisprudence*, 83 VA. L. REV. 429, 450 (1997) (stating that "Brandeis briefs" may be received through testimony of expert witnesses); G. Edward White, *The American Law Institute and the Triumph of Modernist Jurisprudence*, 15 LAW & HIST. REV. 1, 1 (1997) (noting that "Brandeis brief" designed to incorporate arguments that legal rules should reflect social context into decisions).

²⁵ See BLACK'S, *supra* note 22, at 82 (noting such briefs often are submitted at request of courts).

²⁶ See, e.g., AMA Brief, *supra* note 14, at 2-3, *Washington v. Glucksberg*, 117 S. Ct. 2258 (1997) (No. 96-110) (arguing physician-assisted suicide is not solution for inadequate healthcare); AHA Brief, *supra* note 13, at 3-4, *Washington v. Glucksberg*, 117 S. Ct. 2258 (1997), *Vacco v. Quill*, 117 S. Ct. 2293 (1997) (Nos. 96-110, 95-1858) (contending that association supports right to refuse life-sustaining treatment, but not right to choose physician-assisted suicide); Geriatrics Brief, *supra* note 16, at 3-4, *Vacco v. Quill*, 117 S. Ct. 2293 (1997) (No. 95-1858) (noting that Second and Ninth Circuits did not adequately consider medical realities surrounding death).

²⁷ See, e.g., Susan R. Martyn & Henry J. Bourguignon, *Physician-Assisted Suicide: The Lethal Flaws of the Ninth and Second Circuit Decisions*, 85 CAL. L. REV. 371, 399-400 (1997) (noting that since pain and suffering frequently can be controlled in majority of cases, it is only sense that patient has lost control that causes him or her to want to end life).

²⁸ See *Quill v. Vacco*, 80 F.3d 716, 718 (2d Cir. 1996) (holding that physicians may prescribe drugs for mentally competent patients to self-administer if they seek to end their lives during final stages of terminal illness), *rev'd*, 117 S. Ct. 2293 (1997).

²⁹ See AMA Brief, *supra* note 14, at 5-6, *Washington v. Glucksberg*, 117 S. Ct. 2258 (1997) (No. 96-110) (finding that it was implicit in Second Circuit's decision that those requesting suicide do so to avoid excruciating pain); Coleson, *Verbatim Arguments*, *supra* note 12, at 9.

patients are condemned to face unmitigated torture before they die.³⁰ "Implicit in the [court's] holding [are] the view[s] that [many of] those who request suicide do so to avoid excruciating pain and that health care professionals can do nothing compassionate in response other than" to assist in suicide.³¹

The Court cites no evidence, says the American Medical Association, to support these views.³² In fact, available information demonstrates that these views are mistaken.³³

There is no evidence that increasing numbers of patients are dying in severe pain. To the contrary, "[t]he potential for management of pain has recently improved both through the development of better techniques and through enhanced care delivery through hospice and palliative care efforts."³⁴ . . . The pain of most terminally ill patients can be controlled through[out] the dying process without heavy sedation or anesthesia . . . Given the increasing ability to control pain, it is not surprising that, [contrary to the Second Circuit's assumption,] the demand for physician-assisted suicide does not come principally from those seeking relief from physical pain. A recent study of such requests in Washington State found that . . . severe pain . . . was [not] a common patient concern, suggesting that intolerable physical symptoms are not the reason most patients request physician-assisted suicide or euthanasia.³⁵

Second medical fact: Suicidal requests result from depression.³⁶ "Depression is the single factor found to be a significant

³⁰ See AMA Brief, *supra* note 14, at 5-6, *Washington v. Glucksberg*, 117 S. Ct. 2258 (1997) (No. 96-110) (discussing fallacy that physicians' only compassionate response to extreme pain is suicide); Coleson, *Verbatim Arguments*, *supra* note 12, at 9.

³¹ AMA Brief, *supra* note 14, at 5-6, *Washington v. Glucksberg*, 117 S. Ct. 2258 (1997) (No. 96-110) (addressing issue of physicians' response to severe pain); Coleson, *Verbatim Arguments*, *supra* note 12, at 9.

³² See AMA Brief, *supra* note 14, at 6, *Washington v. Glucksberg*, 117 S. Ct. 2258 (1997) (No. 96-110) (arguing that there is no evidence supporting view that increasing numbers of patients die in severe pain); Coleson, *Verbatim Arguments*, *supra* note 12, at 9.

³³ See AMA Brief, *supra* note 14, at 6, *Washington v. Glucksberg*, 117 S. Ct. 2258 (1997) (No. 96-110) (noting that management of pain has improved with better techniques and advanced technology).

³⁴ *Id.* (discussing development of improved pain management) (quoting AMA Council on Scientific Affairs, *Good Care of the Dying Patient*, 275 JAMA 474, 475 (1996)).

³⁵ AMA Brief, *supra* note 14, at 6, *Washington v. Glucksberg*, 117 S. Ct. 2258 (1997) (No. 96-110) (discussing reasons why patients commonly seek to commit suicide); Coleson, *Verbatim Arguments*, *supra* note 12, at 9-10.

³⁶ See Bopp & Coleson, *supra* note 8, at 242 (stating that most people seeking suicide suffer from depressive illness, or some other psychiatric or emotional problem); Herbert

predictor of the desire for death.”³⁷ What are we talking about when we talk about depression? We are not talking about the term as we commonly use it; that is, being in a sad mood. What we are talking about is the psychiatric illness of depression, which triggers suicidal wishes. It is a psychiatric illness that renders one incapable of rational decision making.³⁸ It is often triggered by major negative life events, such as a divorce, death, loss of a job, loss of a family member, or the onset of a terminal illness.³⁹

Depression arising from such causes is, to a large extent, treatable with both therapy and drugs.⁴⁰ Depression can be diagnosed by a series of symptoms: Sleep disturbance; interest loss; feelings of guilt or worthlessness; energy decrease; concentration loss; appetite change; psycho-motor changes; and suicidal ideation.⁴¹ Generally, these are symptoms relating to a depres-

Hendin, *Suicide and the Request for Assisted Suicide: Meaning and Motivation*, 35 DUQ. L. REV. 285, 285 (1996) (noting close to ninety-five percent of individuals who seek suicide have diagnosable psychiatric illness); Susan M. Wolf, *Physician-Assisted Suicide in the Context of Managed Care*, 35 DUQ. L. REV. 455, 466 (1996) (finding that most patients who seriously prepare for euthanasia or physician-assisted suicide are depressed).

³⁷ AMA Brief, *supra* note 14, at 9, *Washington v. Glucksberg*, 117 S. Ct. 2258 (1997) (No. 96-110) (noting that anxieties during serious illnesses are complicated by depression); Coleson, *Verbatim Arguments*, *supra* note 12, at 11.

³⁸ See Ruth Macklin, *Some Problems in Gaining Informed Consent from Psychiatric Patients*, 31 EMORY L.J. 345, 365 (1982) (noting that patients suffering from depression are unable to make rational decisions about treatment); G. Steven Neeley, *Chaos in the "Laboratory" of the States: The Mounting Urgency in the Call for Judicial Recognition of a Constitutional Right to Self-Directed Death*, 26 U. TOL. L. REV. 81, 89 (1994) (discussing case where physician would not honor suicide request because patient was depressed, therefore irrational).

³⁹ See, e.g., Jane L. Dolkart, *Hostile Environment Harassment: Equality, Objectivity, and the Shaping of Legal Standards*, 43 EMORY L.J. 151, 225 (1994) (noting that sexual victimization puts women at higher risk for clinical depression); Debbie S. Holmes, *Marital Privileges in the Criminal Context: The Need for a Victim Spouse Exception in Texas Rule of Criminal Evidence*, 28 HOUS. L. REV. 1095, 1117 (1991) (finding that natural disasters and personal disasters, such as assault and rape, trigger post-traumatic stress disorder, or depression).

⁴⁰ See Stanley S. Herr et al., *No Place to Go: Refusal of Life-Sustaining Treatment by Competent Persons with Physical Disabilities*, 8 ISSUES L. & MED. 3, 22 (1992) (reporting that patients who are depressed may be treated if accurately and promptly diagnosed); Nancy J. Osgood, Ph.D., *Assisted Suicide and Older People—A Deadly Combination: Ethical Problems in Permitting Assisted Suicide*, 10 ISSUES L. & MED. 415, 427 (1995) (noting that depression is treatable by antidepressant drugs, electroconvulsive therapy, support groups and psychological therapies); Ronald L. Wisor, *Community Care, Competition and Coercion: A Legal Perspective on Privatized Mental Health Care*, 19 AM. J.L. & MED. 145, 167 (1993) (explaining that depression and schizophrenia can both be successfully treated with medication and therapy).

⁴¹ See generally Amiram Elwork, *Depression's Devastation: Occupational Stress Can Contribute to Depression*, 56-MAY OR. ST. B. BULL. 39, 39 (1996) (noting symptoms of depression include sadness, fear of rejection and failure, guilt and anger); Elizabeth Emmett, *Depression: Research Sheds Light On a Dark Illness*, 31-FALL ARK. LAW. 4, 4

sive mood. One survey indicates that ninety-five percent of those who attempt suicide have the psychiatric illness of depression.⁴²

The American Medical Association went further in discussing this issue.⁴³ "In this regard, those with terminal or chronic illness are no different than others who express suicidal wishes. Most who commit suicide suffer from depression or some other diagnosable psychiatric illness, which generally is treatable."⁴⁴ Thus, it is because of the depression, not particularly the terminal illness, that suicidal attempts occur. One survey, reported in one of the briefs,⁴⁵ said that of all attempted suicides in the United States, only two to four percent involve people who actually are terminally ill.⁴⁶ This suggests, once again, that any life event can trigger episodes of suicidal tendencies. The American Medical Association concluded that:

While severe chronic or terminal illness is a risk factor for suicide, 'only a small percentage of terminally ill or severely ill patients attempt or commit suicide' . . . [These] patients are similar to physically healthy individuals who contemplate suicide they 'are usually suffering from a treatable mental illness, most commonly depression.'⁴⁷

The American Suicide Foundation argued in its brief:

No sound scientific or clinical basis exists for distinguishing

(1996) (stating that those suffering from depression live in world of gray, feeling hopeless, numb or suicidal); David R. Price & Paul R. Leeshaley, Ph.D., *Defending Claim of Postconcussion Syndrome*, 62 DEF. COUNS. J. 589, 593 (1995) (noting that depression is both symptom of other illnesses and illness in and of itself).

⁴² Hendin, *supra* note 36, at 285 (noting close to ninety-five percent of suicide victims had diagnosable psychiatric illness in months before death); see also *Abstracts*, 12 ISSUES L. & MED. 325, 327-28 (1996) (noting that ninety-five percent of suicide victims are suffering from psychiatric illness, and most suffer from depression).

⁴³ See Brief of American Med. Ass'n at 8-10 (discussing why most patients commit suicide); Coleson, *Verbatim Arguments*, *supra* note 12, at 11-12.

⁴⁴ *Id.* at 9 (addressing root of suicidal tendencies in patients with terminal illnesses); Coleson, *Verbatim Arguments*, *supra* note 12, at 11.

⁴⁵ See *id.* at 10 (discussing connection between terminal illness and suicide); Coleson, *Verbatim Arguments*, *supra* note 12, at 12.

⁴⁶ See Edward J. Larson, *Prescription for Death: A Second Opinion*, 44 DEPAUL L. REV. 461, 468-69 (1995) (discussing major studies that agree that only two to four percent of suicide victims are struggling with terminal illness) (citing David C. Clark, "Rational" Suicide and People with Terminal Conditions or Disabilities, 8 ISSUES L. & MED. 147, 151 (1992)); Osgood, *supra* note 40, at 427 (noting percentage of suicide victims with terminal illness is only two to four percent).

⁴⁷ AMA Brief, *supra* note 14, at 10, *Washington v. Glucksberg*, 117 S. Ct. 2258 (1997) (No. 96-110) (discussing link between terminal illness and suicide) (quoting New York Task Force, *When Death is Sought: Assisted Suicide and Euthanasia in the Medical Context*, 271 JAMA 1786, 9, 13 (1994)).

suicidal patients with terminal conditions from other suicidal patients; treatable, reversible mental disorders, usually of a depressive nature, characterize both. Both groups are ambivalent about the desire to die; both suffer from extreme anxiety and cognitive impairments; both have excessive needs for control, most dramatically expressed by controlling the time and place of their death. In both groups depression interferes with their decision-making ability.⁴⁸

Medical fact number four: In elderly and ill patients it is difficult to determine if a patient is competent or depressed.⁴⁹ The American Geriatric Society addressed this issue:⁵⁰

The seriously ill commonly have deficits in cognitive and emotional functioning[,] which change over relatively short periods of time and correlate strongly with suicide inquiries. Many elderly patients and dying cancer patients experience delirium, a syndrome in which they are confused, unable to maintain attention, and unable to master new information. Most episodes are not detected in usual care. Likewise, depression is common, serious, and often undetected and untreated. Depression, delirium, and mood disorders strongly correlate with [risk of] suicide. Indeed, most cancer patients now committing suicide have discernible psychiatric illness . . . [that] strongly corresponds with risk of suicide. Treatment of depression substantially alters an initial inclination to refuse life-sustaining treatment Excluding [depressed] patients from access to [physician-assisted suicide] would be essential, but that turns out to be quite diffi-

48 Brief Amicus Curiae of the American Suicide Foundation at 3, *Washington v. Glucksberg*, 117 S. Ct. 2258 (1997) (No. 96-110), available in 1996 WL 665436 (arguing that distinction between patients refusing life-sustaining treatment and choosing physician-assisted suicide is not supported by evidence); Coleson, *Verbatim Arguments*, *supra* note 12, at 13.

49 See generally Robert A. Burt, *Constitutionalizing Physician-Assisted Suicide: Will Lightning Strike Thrice?*, 35 DUQ. L. REV. 159, 174 (1996) (noting that distinguishing between profound sadness and clinical depression is difficult); Edward R. Grant & Paul B. Linton, *Relief or Reproach?: Euthanasia Rights in the Wake of Measure 16*, 74 OR. L. REV. 449, 531-32 (1995) (addressing problem of characterizing patients as clinically depressed); Danuta Mendelson, *Historical Evolution and Modern Implications of Concepts of Consent to, and Refusal of, Medical Treatment in the Law of Trespass*, 17 J. LEGAL MED. 1, 48-49 (noting that law presumes every adult is competent to make medical decisions until proven otherwise); Thomas F. Schindler, *Assisted Suicide and Euthanasia: Ethical Dimensions of the Public Debate*, 72 U. DET. MERCY L. REV. 719, 720 (1995) (discussing various problems with drawing lines in determining who should be given right to physician-assisted suicide).

50 Geriatrics Brief, *supra* note 16, at 22-23, *Vacco v. Quill*, 117 S. Ct. 2293 (1997) (No. 95-1858) (discussing problems with determining whether patients with terminal illness are competent); Coleson, *Verbatim Arguments*, *supra* note 12, at 62-64.

cult. Most depression, just like most delirium, is not recognized or treated in current practice. The risks of involving persons with diminished capacity in [physician-assisted suicide] are substantial.⁵¹

Medical fact number five: Elderly and ill patients are subject to undue influence and coercion and many will not seek assisted suicide voluntarily.⁵² The American Geriatric Society also addressed this issue:⁵³

Proponents of a constitutional right to [physician-assisted suicide] expect the practice to be limited to persons who are acting voluntarily, without undue influence or coercion. The image is that of an independent, capable person thoughtfully evaluating his or her options, unaffected by biased third parties or other circumstances. This is so far from the experience of dying as to be fanciful. Dying persons are often very weak, prone to strong emotions, and vulnerable to the suggestions, expectations, and guidance of others. In this context, pressure or encouragement from family, friends, and caregivers may cloud or overwhelm the patient's independent judgment and thus amount to inappropriate coercion.⁵⁴

Medical fact number six: Pressure to contain healthcare costs will cause people to seek suicide.⁵⁵ The American Medical Asso-

51 Geriatrics Brief, *supra* note 16, at 22-23, *Vacco v. Quill*, 117 S. Ct. 2293 (1997) (No. 95-1858) (addressing issue of competence as it relates to patients with terminal illness seeking physician-assisted suicide); Coleson, *Verbatim Arguments*, *supra* note 12, at 63-64.

52 See Larson, *supra* note 46, at 473-74 (noting that states raised interest in preventing undue influence in defense of statutes prohibiting physician-assisted suicide); Edward J. Larson, *Seeking Compassion in Dying: The Washington State Law Against Assisted Suicide*, 18 SEATTLE U. L. REV. 509, 514-15 (1995) (noting that ageism could lead physicians to accept that elderly patients have desire to commit suicide without sufficient investigation of motives). See generally Clifton B. Kruse, Jr., *Contracts to Devise or Gift Property in Exchange for Lifetime Care—Latent and Insidious Abuse of Older Persons*, 12 PROB. L.J. 1, 16 (1994) (defining undue influence as "moral coercion, importunity which cannot be resisted, or immoral solicitation causing one to do what is contrary to his or her actual desires").

53 See Geriatrics Brief, *supra* note 16, at 23-24, *Vacco v. Quill*, 117 S. Ct. 2293 (1997) (No. 95-1858) (addressing issue of undue influence in context of care and financial considerations); Coleson, *Verbatim Arguments*, *supra* note 12, at 64-65.

54 Geriatrics Brief, *supra* note 16, at 23-24, *Vacco v. Quill*, 117 S. Ct. 2293 (1997) (No. 95-1858) (discussing problem of undue influence on patients seeking physician-assisted suicide); Coleson, *Verbatim Arguments*, *supra* note 12, at 64.

55 See Richard M. Doerflinger, *Conclusion: Shaky Foundations and Slippery Slopes*, 35 DUQ. L. REV. 523, 528 (1996) (noting that freedom to provide people with lethal drugs is overly convenient solution for solving healthcare problems); Robert L. Kline, *Give Me Liberty and Give Me Death: Assisted Suicide as a Fundamental Liberty Interest*, 6 B.U.

ciation also addressed this issue:⁵⁶

Pressure to contain health care costs exacerbates the problem. Even if, as one would expect, health care insurers would consciously seek to avoid suggesting to patients or physicians that they consider financial costs in making a decision to hasten death, the continuing pressure to reduce costs can only constrain the availability and quality of palliative care and support services that patients and families need. These limitations on the availability of proper care clearly can place pressure on patients to express a wish for suicide that they might not otherwise feel.⁵⁷

Moreover, poor and minority individuals are at the greatest risk of receiving inadequate care.⁵⁸ Thus, they feel the greatest pressure to request physician-assisted suicide.

Medical fact number seven: Offering suicide reaffirms feelings of worthlessness in patients.⁵⁹ Here the American Geriatric Society argued as follows:

Many persons consider suicide or wish for early death while they are angry or suffering. Since persons feeling worthless often test others to see whether these views are shared, encountering agreement actually functions to affirm the denigration of value [that person feels for his life].

To offer [physician-assisted suicide] at this time does not merely offer an option but also affirms feelings of worthlessness.

PUB. INT. L.J. 527 (1997) (discussing Ninth Circuit's dismissal of argument that health-care system will deny disadvantaged people adequate healthcare, but will fund programs for them to commit suicide); Martyn & Bourguignon, *supra* note 27, at 422 (taking detailed look at healthcare payers' effect on use of physician-assisted suicide).

⁵⁶ See AMA Brief, *supra* note 14, at 13-14, *Washington v. Glucksberg*, 117 S. Ct. 2258 (1997) (No. 96-110) (addressing issue of healthcare costs in connection with physician-assisted suicide); Coleson, *Verbatim Arguments*, *supra* note 12, at 52-53.

⁵⁷ AMA Brief, *supra* note 14, at 13-14, *Washington v. Glucksberg*, 117 S. Ct. 2258 (1997) (No. 96-110) (discussing link between inadequate healthcare and pressure to seek physician-assisted suicide); Coleson, *Verbatim Arguments*, *supra* note 12, at 52.

⁵⁸ AMA Brief, *supra* note 14, at 8, *Washington v. Glucksberg*, 117 S. Ct. 2258 (1997) (No. 96-110) (noting that centers serving predominantly minority patients are more likely to have inadequate pain treatment available); Coleson, *Verbatim Arguments*, *supra* note 12, at 10.

⁵⁹ See Tom L. Beauchamp, *The Justification of Physician-Assisted Deaths*, 29 IND. L. REV. 1173, 1200 (1996) (discussing how pejorative connotations of suicide may limit patient's options and apply unnecessary pressure to seek suicide). See generally Smith, *supra* note 3, at 380-81 (noting society's view that suicide is choice recognizing worthlessness of life); Mark Strasser, *Assisted Suicide and the Competent Terminally Ill: On Ordinary Treatments and Extraordinary Policies*, 74 OR. L. REV. 539, 584 (1995) (discussing possibility that patient's suicide may be classified as patient's only hope).

ness or devaluation. Since, when comfortable and comforted, most patients feel that this was an unexpectedly important time, encouraging supportive care and discouraging suicide seems well within the purview of wise public policy.⁶⁰

Medical fact number eight: Assisted suicide undermines the trust patients have in healthcare providers.⁶¹ Here, an association representing some one-thousand nursing homes gave their opinion:⁶²

Many medical ethicists have written that introducing physician-assisted suicide into the physician-patient relationship will seriously undermine patients' trust that physicians are committed to preserving life, which is at the core of the relationship. This breakdown of trust has even more drastic effects on the relationship between [nursing homes] and the people they serve. Unlike the selection of a doctor, the choice to enter a nursing home or other facility for the aging entails a fundamental life shift—uprooting one's home and placing large areas of one's life into the hands of others. Many seniors choose to make this move even when their physical state does not make it necessary because they view it as beneficial; they can trust in a facility's mission of preserving life and health when they entrust their lives to it. One of this nation's most vulnerable populations relies on [nursing homes] to show a compassionate commitment to life at one of its most trying yet precious moments. Especially if residents feel that the choice will be subtly forced upon them, physician-assisted suicide will threaten this relation-

⁶⁰ Geriatrics Brief, *supra* note 16, at 8-9, *Vacco v. Quill*, 117 S. Ct. 2293 (1997) (No. 95-1858) (addressing issue of reaffirming feelings of worthlessness in patients suffering from illness who seek physician-assisted suicide); Coleson, *Verbatim Arguments*, *supra* note 12, at 17.

⁶¹ See generally Donald G. Casswell, *Rejecting Criminal Liability for Life-Shortening Palliative Care*, 6 J. CONTEMP. HEALTH L. & POL'Y 127, 141 (1990) (discussing patient's reliance upon medical practitioners in administration of palliative care); Martyn & Bourguignon, *supra* note 27, at 399-400 (discussing problems of implementing physician-assisted suicide from medical prospective); Kenneth R. Thomas, *Confronting End of Life Decisions: Should We Expand the Right to Die?*, 44-MAY FED. LAW. 30, 36 (1997) (addressing problem that physician-assisted suicide could undermine any confidence patients might have in palliative care).

⁶² See Brief Amicus Curiae of the American Ass'n of Homes & Services for the Aging, et al. in Support of the Petitioners at 1, *Vacco v. Quill*, 117 S. Ct. 2293 (1997), *Washington v. Glucksberg*, 117 S. Ct. 2258 (1997) (Nos. 95-1858, 96-110), available in 1996 WL 656324 (representing over five thousand non-profit facilities that provide housing and healthcare to over one million aging and disabled); Coleson, *Verbatim Arguments*, *supra* note 12, at 67-68.

ship and poison the environment in which long-term care and services are provided.⁶³

Medical fact number nine: Assisted suicide will replace palliative care for patients.⁶⁴ The American Medical Association argued that "the demand for physician-assisted suicide does not come principally from those [patients who are in actual and untreatable] physical [pain at the very end of life]".⁶⁵ Rather, the requests come from those patients who are healthy, chronically ill, or terminally ill—and are depressed.⁶⁶ Those patients are seeking relief from future pain, loss of dignity, or unduly burdening their families.⁶⁷ Once physician-assisted suicide becomes available, many patients, whose needs could have been met through appropriate palliative care, will be directed instead toward physician-assisted suicide.⁶⁸

Medical fact number ten: Holland's experience with assisted suicide reveals the difficulty in complying with guidelines.⁶⁹ The American Suicide Foundation examined a series of guidelines

63 See Brief Amicus Curiae of the American Ass'n of Homes & Services for the Aging, et al. in Support of the Petitioners at 21, *Vacco v. Quill*, 117 S. Ct. 2293 (1997), *Washington v. Glucksberg*, 117 S. Ct. 2258 (1997) (Nos. 95-1858, 96-110) (addressing issue that physician-assisted suicide may ultimately undermine patients' confidence in physicians); Coleson, *Verbatim Arguments*, *supra* note 12, at 67-68.

64 See generally James K. Rogers, *Punishing Assisted Suicide: Where Legislators Should Fear to Tread*, 20 OHIO N.U. L. REV. 647, 656-57 (1994) (addressing concern that legalizing physician-assisted suicide will discourage proper counseling and palliative care).

65 See AMA Brief, *supra* note 14, at 13-14, *Washington v. Glucksberg*, 117 S. Ct. 2258 (1997) (No. 96-110) (discussing source of most requests for physician-assisted suicide); Coleson, *Verbatim Arguments*, *supra* note 12, at 9.

66 See AMA Brief, *supra* note 14, at 13-14, *Washington v. Glucksberg*, 117 S. Ct. 2258 (1997) (No. 96-110) (addressing problem that many suicide requests come from depressed individuals); Coleson, *Verbatim Arguments*, *supra* note 12, at 11.

67 See AMA Brief, *supra* note 14, at 8, *Washington v. Glucksberg*, 117 S. Ct. 2258 (1997) (No. 96-110); Coleson, *Verbatim Arguments*, *supra* note 12, at 10-11.

68 See Hospice Brief, *supra* note 15, at 17, *Vacco v. Quill*, 117 S. Ct. 2293 (1997), *Washington v. Glucksberg*, 117 S. Ct. 2258 (1997) (Nos. 95-1858, 96-110), Coleson, *Verbatim Arguments*, *supra* note 12, at 15.

69 See L. Paul Hudgins, *To Live or Die: Creating a Choice of Medically Assisted Suicide in Michigan's Proposed Law*, 8 T.M. COOLEY L. REV. 609, 633-34 (1991) (setting forth proposed guidelines for regulating assisted suicide in Michigan); Leon R. Kass & Nelson Lund, *Physician-Assisted Suicide, Medical Ethics and the Future of the Medical Profession*, 35 DUQ. L. REV. 395, 412-13 (1996) (noting that reports of euthanasia in Holland show that there were 2,300 voluntary euthanasia cases, 400 cases of physician-assisted suicide and over 1,000 cases of involuntary euthanasia in 1990 alone). *But see* Catherine L. Bjorck, *Physician-Assisted Suicide: Whose Life is it Anyway?*, 47 SMU L. REV. 371, 395-96 (1994) (setting forth detailed guidelines in place in Holland regarding physician-assisted suicide and arguing that this proves acceptance of physician-assisted suicide is feasible).

that currently exist in Holland for legal assistance in suicide.⁷⁰ These include, among others, that the request for euthanasia must come from the patient, and must be entirely free and voluntary.⁷¹ The patient must be experiencing intolerable suffering and euthanasia must be a last resort.⁷²

The American Suicide Foundation commented on the practice of euthanasia in Holland as follows:

In practice, however, most of these guidelines are routinely violated. As discussed previously, the principle of voluntariness is compromised by the mental state that characterizes these patients, and the undue influence of physicians and family members. The criterion of "intolerable suffering" has been stretched, with the approval of the Dutch Supreme Court in the case of Dr. Chabot, to include cases where there is absolutely no physical illness and where the mental suffering itself might well have been treatable. The criterion of terminal illness was abandoned by the Dutch on the ground that cases of chronic illness could involve a situation of "necessity" equal to those of terminal illness. In general, the logic of permitting euthanasia in one set of circumstances inevitably leads to acceptance of euthanasia in other circumstances where the "equities" appear to be similar.⁷³

As the American Medical Association concluded about the Holland experience, "[t]he study of euthanasia and physician-assisted suicide commissioned by the Dutch government showed that approximately one in four cases of euthanasia did not qualify as voluntary under the guidelines."⁷⁴

⁷⁰ See Brief Amicus Curiae of the American Suicide Found. in Support of the Petitioners at 17-18, 21-22, *Washington v. Glucksberg*, 117 S. Ct. 2258 (1997) (No. 96-110), available in 1996 WL 665436 [hereinafter *Suicide Brief*] (setting forth series of criteria fashioned through Dutch court decisions and guidelines by prosecutors of Royal Dutch Medical Association); Coleson, *Verbatim Arguments*, *supra* note 12, at 79-80.

⁷¹ See *Suicide Brief*, *supra* note 70, at 18, 21, *Washington v. Glucksberg*, 117 S. Ct. 2258 (1997) (No. 96-110) (noting voluntary request means informed and without duress); Coleson, *Verbatim Arguments*, *supra* note 12, at 80.

⁷² See *Suicide Brief*, *supra* note 70, at 21-22, *Washington v. Glucksberg*, 117 S. Ct. 2258 (1997) (No. 96-110) (setting forth guidelines issued by Dutch minister for health); Coleson, *Verbatim Arguments*, *supra* note 12, at 81-82.

⁷³ *Suicide Brief*, *supra* note 70, at 22, *Washington v. Glucksberg*, 117 S. Ct. 2258 (1997) (No. 96-110) (discussing problem of classifying patients as those suffering "intolerable suffering") (quoting JOHN KEOWN, *EUTHANASIA, CLINICAL PRACTICE AND THE LAW* 210-16 (1994)); Coleson, *Verbatim Arguments*, *supra* note 12, at 82.

⁷⁴ *AMA Brief*, *supra* note 14, at 11, *Washington v. Glucksberg*, 117 S. Ct. 2258 (1997) (No. 96-110) (discussing difficulty in establishing adequate safeguards and procedures related to physician-assisted suicide); Coleson, *Verbatim Arguments*, *supra* note 12, at 50-51.

The American Suicide Foundation concluded its review of the Holland experience:

The public has the illusion that legalizing assisted suicide and euthanasia will give them greater autonomy. The Dutch experience teaches us that legal sanction for assisted suicide and euthanasia actually increases the power and control of doctors who can suggest or encourage it, not propose obvious alternatives, ignore patients' ambivalence about suicide, and even put to death patients who have not requested it.⁷⁵

Finally, hospice care offers compassionate and appropriate alternatives to suicide,⁷⁶ according to the brief of the National Hospice Organization:⁷⁷

The decisions below failed to appreciate that the final stage of life presents opportunities for meaningful experiences that could be lost without the State's protection of life and prevention of assisted suicide even among the terminally ill. Moreover, many terminally-ill patients seek assistance with suicide not because they cannot be cured, but rather because they cannot bear the physical pain and depression that often accompany terminal illness. These factors can almost always be ameliorated. Hospice care provides a proven, effective alternative to assisted suicide that is ideally suited to ameliorate the factors underlying the desire for suicide among the terminally ill. By emphasizing palliative care, the hospice movement has succeeded in increasing awareness in the medical community of the need to treat pain and symptom management aggressively. Furthermore, hospices understand the psychological dimension of suffering and are committed to treating the depression and fear that surround

⁷⁵ Suicide Brief, *supra* note 70, at 30, *Washington v. Glucksberg*, 117 S. Ct. 2258 (1997) (No. 96-110) (concluding that Dutch experience proves physician-assisted suicide was not appropriate solution to end-of-life problems); Coleson, *Verbatim Arguments*, *supra* note 12, at 87.

⁷⁶ See generally Martyn & Bourguignon, *supra* note 27, at 419-20 (addressing impact of physician-assisted suicide on hospice care in United States); Donald E. Spencer, *Practical Implications for Health Care Providers in a Physician-Assisted Suicide Environment*, 18 SEATTLE U. L. REV. 545, 547 (1995) (discussing hospice care as one alternative to public's limited perception of choices); Wheeler, *supra* note 6, at 760 (noting that hospice care prescribes medication to assuage pain and suffering, allowing "pain free" death).

⁷⁷ See Hospice Brief, *supra* note 15, at 4-5, *Vacco v. Quill*, 117 S. Ct. 2293 (1997), *Washington v. Glucksberg*, 117 S. Ct. 2258 (1997) (Nos. 95-1858, 96-110) (arguing hospice care provides proven, effective alternative to physician-assisted suicide); Coleson, *Verbatim Arguments*, *supra* note 12, at 14-15.

terminal illness. When patients suffering from terminal illness are given proper palliative and supportive care, the desire for assistance with suicide generally disappears. Hospices provide substantial benefits to the patients' families as well, by including them in the unit of care and by providing them with the counseling, support, and anticipatory grief work that has been proven so effective in softening the blow of a loved one's death.⁷⁸

* * *

Had the Court of Appeals understood that "[the] hospice way of dying . . . offers a middle path between two undesirable approaches in caring for the terminally-ill patient—curative, high-technology medicine on one hand, and death by euthanasia on the other hand," they never would have felt constrained by the false dichotomy represented by those two options. Hospice offers patients and their families the opportunity to deal with the pain, depression, and other experiences caused by dying and—unlike the alternative of physician-assisted suicide—[hospice] gives [patients] the opportunity to continue to live. In light of the availability of hospice care as a means to alleviate the physical and psychological suffering that underlies terminally-ill patients' desire for assistance with suicide and the potential benefits to the patients' families, the States of Washington and New York were more than justified in concluding that their interest in preserving life was just as strong during the last stage of life as it was during all of life's other stages.⁷⁹

⁷⁸ Hospice Brief, *supra* note 15, at 4-5, *Vacco v. Quill*, 117 S. Ct. 2293 (1997), *Washington v. Glucksberg*, 117 S. Ct. 2258 (1997) (Nos. 95-1858, 96-110) (summarizing effective treatment hospice care provides as alternative to physician-assisted suicide); Coleson, *Verbatim Arguments*, *supra* note 12, at 14.

⁷⁹ Hospice Brief, *supra* note 15, at 12-13, *Vacco v. Quill*, 117 S. Ct. 2293 (1997), *Washington v. Glucksberg*, 117 S. Ct. 2258 (1997) (Nos. 95-1858, 96-110) (concluding that Second and Ninth Circuits failed to fully appreciate value of hospice care in caring for patients in end stages of life) (quoting Courtney S. Campbell et al., *Conflicts of Conscience: Hospice and Assisted Suicide*, HASTINGS CTR. REP., May-June, 1995, at 36-37); Coleson, *Verbatim Arguments*, *supra* note 12, at 14-15.