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PHYSICIAN-ASSISTED DEATH

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Physician-assisted death is not a new invention. Voluntary euthanasia and physician-assisted suicide were commonly practiced in ancient Greece and Rome to spare people of high social rank from prolonged suffering. The Hippocratic Oath, with its stance against physician-assisted death, represented a minority opinion among Greek physicians at the time it was written (Brogden 2001).

In modern times, the topic of physician-assisted death has gained prominence in the United States owing in part to the publicized deaths assisted by Dr. Jack Kevorkian and in part to Americans' general concerns about suffering painful, slow, and undignified death under medical care that appears to be able to prolong dying but not necessarily living (Benoliel and Degner 1995; Lattanzi-Licht and Connor 1995). At the core of the controversy concerning physician-assisted death is the individual's right to choose death versus society's obligation to protect its most vulnerable members from hastened and not completely voluntary death. The debate is often restricted to cases involving persons with terminal illnesses, but sometimes it is expanded to include people whose quality of life has become "unbearable" (Girsh 2000; Koch 2000; Ogden 2000).

DEFINITION OF PHYSICIAN-ASSISTED DEATH

The term *physician-assisted death* may be used to refer to euthanasia or to physician-assisted suicide. *Euthanasia*, a word from ancient Greek, can be translated as "a good death." Euthanasia can be active or passive and may be voluntary, involuntary, or nonvoluntary. In passive euthanasia, the patient does not receive life-supporting therapy, and this often results in the patient's death. In involuntary passive euthanasia, the patient refuses life-supporting therapy or such therapy is withdrawn at the patient's request. Involuntary passive euthanasia occurs when life-supporting therapy is withheld or withdrawn against the

patient's wishes. If the patient's preferences are not known and the illness has progressed to a point where communication with the patient is no longer possible, withholding or withdrawal of life-supporting therapy is considered to be nonvoluntary euthanasia. In active euthanasia, by contrast, the physician performs an active intervention with the intent of ending the patient's life. If the patient requests that intervention, the euthanasia is voluntary; if the patient does not want to die, it is involuntary; and if the patient's wishes are unknown, it is nonvoluntary.

Although one could argue that taking a person off life-support could be considered an active intervention, the primary distinction between passive and active euthanasia is the *intention* to end a person's life (Sulmasy 2000; Kass and Lund 1996). If a person does not die after life-support has been removed, the intervention would not be deemed a failure. However, if a person continues to live after active euthanasia has been performed, the procedure would be considered unsuccessful. Finally, in physician-assisted suicide, the physician actively provides the patient with the means to end his or her life, usually by prescribing or providing a lethal dose of a medication that the patient independently ingests. In such a case, the physician might or might not be present at the time the patient decides to die.

Voluntary passive euthanasia is a legal and generally accepted practice in the United States. In 1990, the U.S. Supreme Court granted competent adults the right to refuse medical treatment. In the same year, the U.S. Congress passed the Patient Self-Determination Act, which requires all hospitals that receive federal funding to inform patients of their rights to demand or refuse medical treatment. Physician-assisted suicide and active euthanasia, however, are much more controversial. In 1997, the U.S. Supreme Court ruled that there is no constitutionally protected right to physician-assisted suicide but left it to the individual states to regulate physician-assisted death. To date, physician-assisted suicide is legal only in the state of Oregon, and active euthanasia remains illegal throughout the United States. In the Netherlands and Belgium, physician-assisted suicide and active euthanasia are legal

under certain conditions, and in Switzerland assisted suicide is prosecuted only if the person who assisted in the suicide acted for selfish reasons. In this chapter, I use the term *physician-assisted death* to refer only to physician-assisted suicide and active euthanasia, with primary emphasis on physician-assisted suicide.

ARGUMENTS IN FAVOR OF PHYSICIAN-ASSISTED DEATH

Most people in the United States support physician-assisted death under two conditions: that it is voluntary and that the patient has a terminal or incurable illness. According to data from the General Social Surveys (surveys with a national U.S. probability sample conducted almost every year by the National Opinion Research Center), the proportion of U.S. residents who support the right of a person to end his or her own life if that person has an incurable disease increased from 39% in 1977 to 63% in 1998. During the same period, the proportion of people who agree that physicians should be allowed by law to end the life of a person with an incurable disease if the patient and the family request it increased from 62% to 71% (Davis and Smith 2000). These data indicate that U.S. residents support active voluntary euthanasia even more than they support physician-assisted suicide. Similarly, in a 1996–97 study of 988 terminally ill patients, Emanuel, Fairclough, and Emanuel (2000) found that 60% were in favor of physician-assisted suicide or euthanasia for a person with an incurable disease, even though only 11% had seriously thought about physician-assisted suicide or euthanasia for themselves. Relief from suffering and the maintenance of self-determination and control at the end of life are the arguments most often cited in favor of physician-assisted death.

Relief From Suffering

Many people are afraid of having to suffer excruciating pain and prolonged agony at the end of life and of being forced to continue an existence that has lost all meaning. If death is inevitable, physician-assisted death might provide the “good death” that otherwise appears to be impossible (Girsh 2000). Indeed, in their study of terminally ill patients, Emanuel, Fairclough, and Emanuel (2000) found that those with pain, substantial caregiving needs, and depressive symptoms were most likely to contemplate physician-assisted suicide or euthanasia. Yet emotional suffering might be more salient than physical suffering (Girsh 2000; Quill et al. 1998). In follow-up interviews conducted with their terminally ill respondents 2 to 6 months after their initial interviews, Emanuel et al. found that only those patients with depressive symptoms and those who experienced shortness of breath had changed their minds and started to contemplate physician-assisted suicide and euthanasia, whereas

increased pain or a decline in physical functioning did not lead to the desire for a hastened death. On the other hand, 50% of the patients who initially reported considering physician-assisted suicide or euthanasia were no longer doing so 2 to 6 months later. This suggests that patients’ desires for physician-assisted suicide and euthanasia might not be particularly stable, and that therapeutic interventions designed to alleviate symptoms of depression and dyspnea might reduce requests for physician-assisted death.

Self-Determination and Control

The second major argument for physician-assisted death is that a person should have the right to choose a quick and painless death if he or she has an incurable illness and there is no hope for a recovery (Girsh 2000; Lenzer 1999). Many sick people are afraid that a progression of their disease will rob them of their dignity and mental faculties, and they do not want to become completely dependent on others. They prefer to die at a time of their choosing rather than witness their own terminal decline and a loss of self (Lavery et al. 2001).

Consistent with the principle of self-determination and control, physician-assisted death should be completely voluntary, both on the side of the patient and on the side of the physician (Girsh 2000; Lenzer 1999; Quill et al. 1998). Nobody should be pressured to engage in physician-assisted death, and patients should be free from depression when they make requests for such services. Patients should continue to have the right to request treatment even if that treatment is considered medically futile. Furthermore, no physician or health care provider should be forced to take part in physician-assisted death.

ARGUMENTS AGAINST PHYSICIAN-ASSISTED DEATH

Arguments against physician-assisted death revolve around ethical, moral, and religious considerations. In addition, some who oppose physician-assisted death make the “slippery slope” argument—that is, they are concerned that the legalization of physician-assisted suicide for terminally ill patients (a) might give way to active euthanasia and physician-assisted suicide for chronically ill persons and those who suffer from psychological distress, and (b) might pressure members of vulnerable populations into seeking early death.

Ethical, Moral, and Religious Considerations

Many physicians feel that it is unethical, morally wrong, and against the Hippocratic Oath to end a patient’s life intentionally, even if the patient requests it. According to the American Medical Association’s Code of Medical Ethics, physician-assisted death contradicts the physician’s

role as a healer (Kass and Lund 1996). Furthermore, patients might not be able to trust their doctors completely if doctors have the power to take their patients' lives, particularly in a climate of cost-saving incentives for physicians.

Moreover, physician-assisted suicide might place an undue moral and ethical burden on patients' family members and friends (Emanuel, Fairclough, and Emanuel 2000). For example, if a physician is not present at the time of a patient's suicide attempt, the patient might ask a family member or friend to help with the preparation and administration of the lethal medication. If death then does not come quickly, the family member or friend might also feel compelled to take steps to accelerate the dying process, such as by placing a plastic bag over the patient's head (Ogden 2000). A survivor who participates in such actions might suffer feelings of guilt and a prolonged and complicated bereavement process (Miller and Meier 1998).

Most religions also condemn physician-assisted suicide and active euthanasia. Life is considered to be a gift from God, and as such it is sacred. It is not for human beings to decide when life is no longer worth living if death does not come swiftly and naturally. It is permissible only for a patient to forgo or terminate a treatment that is unlikely to cure or benefit the patient but causes an extreme burden for either the patient or the community (Alexander 2000; Hai and Husain 2000; Kavesh 2000; Rowell 2000). This position is clearly in stark contrast to the argument for autonomy and control at the end of life. For many Christians, Jews, and Muslims, the sanctity of life and the sovereignty of God are absolute and override any individual's desire to end his or her life prematurely (Alexander 2000; Hai and Husain 2000; Kavesh 2000). As Rowell (2000) notes, according to the beliefs of most religions, "human freedom does not extend to a right to bring about our death at a time or in a manner specified by us" (p. 159).

Furthermore, caring for the terminally ill is an important practice in the lives of religious persons. They are asked to provide care that is not only restricted to the physical needs of the dying person but also addresses existential and spiritual needs, such as the meaning of suffering and death. This, in turn, can strengthen the relationship and the emotional bond between patient and caregiver. From a religious perspective, care for the dying is not primarily a burden; rather, it is an opportunity for the caregiver to develop compassionate love and to grow spiritually by sharing another person's pain and suffering and by providing selfless service to a person in need. The dying patient, on the other hand, might learn to find meaning in suffering, vulnerability, and dependency and to accept and give selfless love. In this context, physician-assisted death is seen as depriving terminally ill persons and their caregivers of a chance for spiritual growth and a deeper understanding of life (Alexander 2000; Koch 2000).

The Slippery Slope Argument

Many who oppose physician-assisted death are concerned that the legalization of physician-assisted suicide for the terminally ill might lead to the acceptance of physician-assisted suicide for the chronically ill, the disabled, and the psychologically distressed, as well as to the acceptance of active euthanasia for people whose quality of life appears to be extremely low but who do not have the capability to choose for themselves (Brogden 2001). If physician-assisted suicide is to be restricted to terminally ill patients, physicians need to be able to predict with a certain amount of accuracy how long a patient with a life-threatening illness is expected to live. Yet, in a 1999 study of Oregon physicians, Ganzini et al. (2001) found that 27% of physicians who had received requests for physician-assisted suicide and who were willing to prescribe lethal medications were not confident that they could predict whether a patient had a life expectancy of 6 months or less.

Those who make the slippery slope argument also point out that if unbearable suffering is the main reason for the legalization of physician-assisted suicide, it is not clear why such practices should be restricted to those who suffer physical symptoms at the end of life. Chronically ill and disabled people might suffer just as much as or even more than people with terminal illnesses, and they typically have to endure their suffering much longer (Lenzer 1999). For example, illnesses such as ALS, multiple sclerosis, AIDS, and neurological diseases progress slowly and can take years to lead to death. If physician-assisted suicide were to become legal, it is not clear how it could be justified for patients with severe pain and a life expectancy of less than 6 months but denied for patients with equally severe physical symptoms but the "wrong" kind of disease (Caplan, Snyder, and Faber-Langendoen 2000; Kamisar 1996). In fact, 75% of the people Dr. Kevorkian helped to die did not suffer from terminal illnesses (Roscoe et al. 2001).

Moreover, "suffering" might be more of an indicator of psychological distress than of physical pain, although there might be a certain reciprocal relationship between the intensity of pain and the experience of psychological distress (Drickamer, Lee, and Ganzini 1997; Holstein 1997). A quadriplegic, for instance, might suffer little physical pain but feel unable to bear the dependency and helplessness that such a life entails. Would it be fair to deny depressed and distraught patients the option of ending their lives (Kamisar 1996)? Indeed, supporters of physician-assisted death in the Netherlands argue that physical *and* mental suffering should be considered valid criteria for physician-assisted death (Koch 2000).

Furthermore, some individuals may not be able to ingest lethal doses of medication on their own, either because their illnesses have progressed to a point where swallowing is difficult or because they regurgitate the medication. Would it be fair to deny such people the option of physician-assisted suicide solely on the basis of their

physical incapability? An alternative solution might be to offer active voluntary euthanasia. In fact, in the Netherlands, euthanasia is preferred to physician-assisted suicide because it is considered to be the safer and more reliable way to induce death (Brogden 2001; Groenewoud et al. 2000).

Finally, if only voluntary physician-assisted death is permissible, would this not mean that people who appear to suffer from physical or mental anguish but are no longer able to communicate their preferences for physician-assisted suicide or euthanasia would be denied physician-assisted death? If mental competence is a prerequisite of physician-assisted death, will not people be forced to choose death earlier rather than later if there is the possibility that their illness might eventually rob them of their capacity to decide (Caplan et al. 2000)? Legal permission to practice nonvoluntary euthanasia could be perceived as a solution to these problems.

In the name of fairness, justice, compassion, and mercy, the legalization of physician-assisted suicide for the terminally ill could easily be extended to the chronically ill, the disabled, and the mentally distraught. It also might lead to the legalization of active voluntary euthanasia for people who are unable to take their own lives and the legalization of active nonvoluntary euthanasia for patients who are no longer capable of deciding for themselves.

Another concern of those who make the slippery slope argument is that members of vulnerable populations—such as severely ill elderly persons and poor persons as well as disabled persons—might feel pressured to ask for physician-assisted suicide rather than continue with lives of dependency, suffering, and hardship (Koch 2000). In short, there is concern that the “right to die” might turn into the “duty to die” (Alexander 2000; Brogden 2001; Hardwig 1997; Osgood 2000). Even if individuals are not openly subjected to pressure to end their lives, once the *option* of physician-assisted suicide is available, people whose quality of life has deteriorated considerably might not have the strength to ask for continuing care and treatment if death appears to be the more rational and less burdensome alternative. For example, in a survey of elderly patients and their relatives, Koenig, Wildman-Hanlon, and Schmader (1996) found that approximately 60% of the older patients were against physician-assisted suicide in cases of terminal illness, whereas almost 60% of their family members supported it. In addition, the family members were not very successful in predicting the patients’ preferences or in agreeing among themselves about what the patients’ preferences would be. If terminally ill patients and their family members do not discuss end-of-life decisions and preferences openly, older terminally ill patients might feel inclined to choose physician-assisted suicide if it were legal and some family members expressed support for it in order to relieve the family of emotional and economic burden (Brogden 2001; Osgood 2000). Interestingly, in their sample of terminally ill patients, Emanuel, Fairclough, and Emanuel (2000) found

that older respondents and those who felt appreciated by others were less likely to consider physician-assisted suicide or euthanasia, but patients with substantial care needs were more likely to do so. In a follow-up study, these researchers found that the former caregivers of deceased patients were more likely to support the hypothetical case of a terminally ill person who desired euthanasia to avoid being a burden to his or her family if they felt that their own caregiving experiences had adversely affected their lives. By contrast, African American and religious caregivers and those who experienced social support were less likely to favor euthanasia in the above hypothetical scenario.

The economic incentives for individuals to choose physician-assisted death are quite strong (Alexander 2000; Brogden 2001; Osgood 2000). Physician-assisted suicide and euthanasia are much cheaper than the costs of continuing care, for families, insurance companies, and society. In a medical climate that is characterized by skyrocketing costs for advanced technological treatments and an aging population with prolonged years of disability and illness on the one hand and strong incentives for physicians to save on medical expenditures on the other, physician-assisted suicide and euthanasia would be the ultimate cost-saving tools (Miller and Meier 1998). Although physician-assisted suicide would be voluntary, some individuals, particularly older adults who have become sick, disabled, and dependent, might feel guilty and selfish for using up valuable resources and asking to be cared for if they have the legal option to end their lives and thus relieve relatives, physicians, and society from financial, physical, and/or emotional burden (Brogden 2001; Osgood 2000).

In a society that does not provide universal health care and long-term care for its citizens, the legalization of physician-assisted suicide might mean that people are given the option to die but not the option to be healed and to be cared for when they are ill (Brogden 2001; Caplan et al. 2000; Kamisar 1996). Not surprisingly, African Americans, the poor, and people with less education, who often lack access to adequate health care services before they become eligible for Medicare at the age of 65, tend to endorse the legalization of physician-assisted suicide in much smaller numbers than do white Americans and those with a higher income and better educational background (Emanuel, Fairclough, and Emanuel 2000; Koenig et al. 1996; Mouton 2000).

RECENT EXPERIENCES WITH PHYSICIAN-ASSISTED DEATH

In Western industrialized societies, only Belgium, the Netherlands, and the U.S. state of Oregon have legalized the practice of physician-assisted death. Although physician-assisted death has not been formally legalized in Switzerland, since 1942 assisted suicide by a physician or another person has been prosecuted only if the person who

assisted acted out of selfish motives. In Belgium, physician-assisted death was legalized on May 16, 2002, following the legalization of physician-assisted death in the Netherlands on April 10, 2001, after more than a decade of tolerance for the practice. In Oregon, physician-assisted suicide—but not euthanasia—became legal on October 27, 1997. The practice of physician-assisted death in the Netherlands and in Oregon has been extensively documented and studied, and both cases are closely watched, particularly with regard to the slippery slope argument, as discussed above.

The Case of the Netherlands

Until 2001, physician-assisted suicide and euthanasia were illegal in the Netherlands, although both procedures had been tolerated for more than a decade and were not criminally prosecuted when the following four conditions were met: (a) The patient's request was voluntary, well considered, and persistent; (b) the patient judged his or her suffering as unbearable and without any hope for improvement in repeated discussions with the primary physician; (c) an independent physician confirmed that the patient's suffering was permanent and incurable; and (d) the prescribing physician submitted a full report to the coroner after the patient's death (Koch 2000; Ogden 2000). On April 10, 2001, the Netherlands formally legalized physician-assisted suicide and active euthanasia under the above-stated conditions.

In the Netherlands, the availability of physician-assisted suicide and euthanasia is not restricted to terminally ill persons who suffer incurable pain. Many older adults and AIDS patients choose physician-assisted death before they suffer the loss of autonomy, control, and dignity that often accompanies the progression of illness (Koch 2000). Unbearable and hopeless suffering might also be defined as psychological pain, as the case of Nettie Boomsma shows. Boomsma was a clinically depressed 50-year-old divorced social worker who had lost both of her children. She was allowed to commit physician-assisted suicide in 1991 after refusing intensive psychological counseling and therapy. Although this case was considered controversial in the Netherlands, a spokesperson for the Justice Ministry there defended the decision by referring to a person's right to choose death even in the absence of a terminal illness or insurmountable physical pain (Koch 2000).

It appears that in the Netherlands the legal status of physician-assisted suicide has led to voluntary active euthanasia, and euthanasia for the terminally ill has led to euthanasia for the chronically ill and those who suffer psychological distress (Brogden 2001). In some cases, euthanasia has been performed without the patient's explicit and persistent request (van der Maas et al. 1991, 1996). However, the incidence of such cases did not increase between 1990 and 1995. In 1990, 0.8% of all deaths in the Netherlands occurred through euthanasia without the patient's explicit and persistent request, compared with 0.7% of all deaths in 1995. Moreover, in more

than half of those cases the decision to perform euthanasia had been discussed with the patient at an earlier stage of the illness, or the patient had expressed the desire for euthanasia at an earlier time in case of excruciating suffering. In other cases, the patient was no longer able to communicate his or her wishes (van der Maas et al. 1991, 1996).

In 1990, active voluntary euthanasia accounted for approximately 1.8% of all deaths in the Netherlands, whereas physician-assisted suicide was reported in about 0.3% of all deaths (van der Maas et al. 1991). The comparable figures for 1995 were 2.4% and 0.3%, respectively (van der Maas et al. 1996). Euthanasia takes place more often than physician-assisted suicide in the Netherlands because it is considered a safer and more successful method of delivering death (Brogden 2001). For example, researchers who analyzed cases of physician-assisted suicide and euthanasia performed in 1990–91 and 1995–96 in the Netherlands found that complications and problems with completion of the procedure were reported in 7% and 16%, respectively, of all physician-assisted suicide cases, but only in 3% and 6%, respectively, of all euthanasia cases. Furthermore, in 18% of all physician-assisted suicide cases, euthanasia had to be performed to induce death (Groenewoud et al. 2000). The problems most commonly associated with physician-assisted suicide were the patient's inability to take the lethal medication and the patient's vomiting after ingesting the lethal drug. Most of the problems reported with euthanasia involved difficulties in inserting an intravenous catheter and spasm or myoclonus. For 19% of all physician-assisted suicides and 10% of all euthanasia cases, the time from the administration of the first lethal medication to the patient's death was longer than the reporting physician had expected it to be, with a median duration of 3 hours.

Voluntary euthanasia allows those patients to end their lives who have the desire to die but would be unable physically to swallow lethal doses of medication and keep the medication in their stomachs (Groenewoud et al. 2000). For the Dutch, this is a question of general fairness. People should have the right to decide for themselves when life is no longer worth living, be it for physical or psychological reasons, and they should have access to professional help to make the death-inducing procedure as safe and effective as possible (Koch 2000). In fact, most physicians in the Netherlands are willing to perform active euthanasia or physician-assisted suicide, and slightly more than 50% have already done so. Only 12% would refuse to engage in active euthanasia or physician-assisted suicide (van der Maas et al. 1996).

In the Netherlands, younger patients seek euthanasia and physician-assisted suicide more often than do older patients (van der Maas et al. 1991, 1996). Patients whose deaths resulted from euthanasia or physician-assisted suicide in 1990 listed the following concerns when asked about their decisions to end their lives: 57% feared a loss of dignity, 46% mentioned unworthy dying, 46% mentioned pain, 33% did not want to be dependent on others,

and 23% were tired of life (van der Maas et al. 1991). Interestingly, only 5% of the patients mentioned pain as the sole reason to end their lives. Contrary to common beliefs, it appears that psychological factors play a larger role in end-of-life decisions than do physical factors.

To date, the Netherlands probably provides the best conditions for the availability of physician-assisted death (Koch 2000; van der Maas et al. 1996). The Dutch have access to universal health care and long-term care services, and many Dutch people have long-standing relationships with family physicians who make house calls and are trained to listen to patients' concerns in regard to end-of-life issues. In the Netherlands, individuals have no need to consider physician-assisted death for economic or care reasons. Home and hospice care, medications, life-supporting therapies, and hospital stays are all covered equally and without additional costs to patients or their families. Without these provisions, even the Dutch might hesitate to legalize physician-assisted suicide and active euthanasia. Corneliss-Claussen, a psychologist and member of the Dutch Voluntary Euthanasia Society, cautions that "if the socioeconomic circumstances in a country are different, and if there are lots of financial problems with getting good care, the people should be very, very, very careful about introducing these possibilities [of physician-assisted death]" (quoted in Koch 2000:292).

The Case of Oregon

In 1994, 51% of Oregon voters approved the Death With Dignity Act, a citizens' ballot initiative. This act would have allowed a person with a life expectancy of less than 6 months to obtain a physician's prescription for a lethal dose of medication with the intent of ending his or her own life in a humane and dignified manner. The implementation of the Death With Dignity Act, however, was delayed by legal proceedings. In 1997, 60% of Oregon voters rejected a measure that would have repealed the Death With Dignity Act, and on October 27, 1997, Oregon became the first U.S. state to legalize physician-assisted suicide. The act does not require any physician or health care system to take part in physician-assisted suicide. On March 24, 1998, a woman with terminal breast cancer became the first person to die after receiving a physician's prescription for lethal medication under the Oregon Death With Dignity Act.

The Oregon law states that only a person diagnosed with a terminal illness and a life expectancy of 6 months or less can request physician-assisted suicide. Moreover, the patient must be 18 years or older, a resident of Oregon, and mentally capable of making health care-related decisions. For a physician to be protected from criminal prosecution for prescribing a lethal dose of medication, the physician and patient must meet the following additional requirements (Oregon Department of Human Services 2001):

- The patient must make at least two oral requests and one written request to the prescribing physician for the lethal

medication. In addition, the oral requests must be made at least 15 days apart, and the written request must be witnessed by at least two persons.

- The prescribing physician must inform the patient of available alternatives to physician-assisted suicide, including hospice and palliative care.
- Two physicians (the prescribing physician and a consulting physician) must confirm (a) the patient's terminal diagnosis and prognosis, (b) that the patient is mentally capable of making end-of-life decisions, and (c) that the patient's judgment is not clouded by any depressive disorder. If one of the two physicians suspects that the patient might suffer from depressive symptoms, the patient is required to be evaluated by a psychologist or psychiatrist.
- The prescribing physician must ask the patient to inform his or her next of kin of his or her desire to commit physician-assisted suicide. However, the patient is not required to comply with that request.
- The physician must report the prescription for lethal medication to the Oregon Health Division.

From 1998 through 2002, 129 people (16 in 1998, 27 each in 1999 and 2000, 21 in 2001, and 38 in 2002) died in Oregon after ingesting lethal medication provided by physicians under the protection of the Death With Dignity Act (Hedberg, Hopkins, and Kohn 2003; Hedberg, Hopkins, and Southwick 2002; Oregon Department of Human Services 2001; Sullivan, Hedberg, and Hopkins 2001). Physician-assisted suicide accounted for 0.06% of all deaths in Oregon in 1998, 0.09% of all deaths in 1999 and 2000, 0.07% of all deaths in 2001, and 0.13% of all deaths in 2002. In 1998, the persons who committed physician-assisted suicide in Oregon were more likely to be never married or divorced and less likely to be married than were Oregon residents who died of similar causes. They were also more likely to have expressed concern to their physicians about loss of autonomy and control of bodily functions as a consequence of their illness, but they were less likely to be completely disabled and bedridden than were persons in a matched control group of patients similar in age, underlying illness, and date of death. There were no significant differences between the two groups in regard to sex, race, or education level (Chin et al. 1999). In 1999 and 2000, the persons who engaged in physician-assisted suicide were not demographically different from Oregon residents who died of similar causes with the exception of education level. In both years, individuals who were at least college graduates had a higher likelihood of seeking physician-assisted suicide than did those with less education (Sullivan, Hedberg, and Fleming 2000; Sullivan et al. 2001). In 2001, the people who committed physician-assisted suicide were again more likely to be college graduates, but they were also more likely to be female and divorced than were Oregon residents who died of similar causes (Oregon Department of Human Services 2002). Overall, the 129 patients who died as a result of

physician-assisted suicide from 1998 through 2002 were more likely than Oregon residents who died of similar causes during that time frame to be younger, divorced, and college graduates (Oregon Department of Human Services 2003).

In Oregon, complications associated with physician-assisted suicide appear to be less frequent than in the Netherlands. Vomiting after ingestion of the lethal medication occurred in only 4 of the 129 physician-assisted suicide cases that took place between 1998 and 2002, and seizures were not reported in any of the cases. The interval between the ingestion of the lethal dose and the time of death ranged from 4 minutes to 37 hours, with a median of 30 minutes (Hedberg et al. 2002; Oregon Department of Human Services 2003; Sullivan et al. 2001).

Most Oregon patients who ended their lives through physician-assisted suicide from 1998 through 2002 stated in conversations with their physicians that they were concerned about a loss of autonomy (75.94%; total average = 85%), a decreasing ability to participate in activities that make life enjoyable (69.84%; total average = 79%), and a loss of control of bodily functions (47–78%; total average = 58%). Only 2 of the 16 patients (12%) in 1998 mentioned concerns that they might be a burden to their family, friends, and caregivers; in 1999, 7 of the 27 patients (26%) mentioned this concern; in 2001, 4 of the 17 patients (24%) on whom data are available mentioned it; and in 2002, 14 of the 38 patients (37%) mentioned it; but in 2000, 17 of the 27 patients (63%) brought up this concern. Worries over inadequate pain control and the financial implications of their treatment appeared to be less relevant. Only 6–30% (total average = 22%) of the patients voiced any concerns over inadequate pain control, and only 3 of the 129 patients who died as a consequence of physician-assisted suicide between 1998 and 2002 expressed any concern about the financial implications of their treatment (Oregon Department of Human Services 2002, 2003; Sullivan et al. 2001).

In contrast to public perception in the United States, and comparable to the case of the Netherlands, the occurrence or fear of agonizing pain does not seem to be the primary reason patients in Oregon with terminal diagnoses have chosen physician-assisted suicide. Rather, psychological and social issues have been more important. Patients who choose physician-assisted suicide are most afraid that they will become dependent on others and lose their autonomy and control.

It is interesting to note that the legalization of physician-assisted suicide in Oregon has had the positive side effect of improving end-of-life care in that state (Cassel and Demel 2001). In 1993, only 21% of all Oregon deaths occurred under the care of hospice, compared with an estimated 36% in 2000. Moreover, from 1997 through 2000, the use of morphine for medical purposes increased by 50% (Steinbrook 2002). Correspondingly, in a survey of Oregon physicians in 1999, 30% reported that they had increased their numbers of hospice referrals since 1994,

76% stated that they had improved their knowledge of the use of pain medication at the end of life, and 69% reported that they had tried to improve their recognition of depressive symptoms in terminally ill patients (Ganzini et al. 2001).

In the same survey, 51% of the responding physicians said that they supported the legalization of physician-assisted suicide, whereas 31% opposed it. Yet, in contrast to the Netherlands, only 34% of the Oregon physicians stated that they were willing to prescribe a lethal dose of medication for a terminally ill patient; 46% were unwilling to do so, although only 30% said that they believed physician-assisted suicide is unethical or immoral. The data from this survey also showed that 14% of physicians had increased their willingness to participate in physician-assisted suicide from 1994 to 1999, and only 8% were less willing to do so in 1999 than they were in 1994 (Ganzini et al. 2001). This suggests that the acceptance of physician-assisted suicide might increase among physicians in Oregon the longer the Death With Dignity Act is in effect.

ALTERNATIVES TO PHYSICIAN-ASSISTED DEATH

Hospice and Palliative Care

Hospice care is often mentioned as an alternative to physician-assisted death. Founded in 1967 in England by Dame Cicely Saunders, the hospice movement has grown into a \$1.5–\$2 billion industry with more than 2,500 care providers in the United States (Beresford 1997; Lattanzi-Licht and Connor 1995). Hospice care is generally available for people with a life expectancy of 6 months or less who have decided to forgo curative treatment in favor of comfort care (Cassel and Demel 2001). As Lattanzi-Licht and Connor (1995) describe it, hospice “is a coordinated interdisciplinary program of pain and symptom control and supportive services for terminally ill persons and their families. A hospice program addresses physical, emotional, social, and spiritual needs. . . . It is a return to a more human, family-oriented philosophy of care aimed at controlling symptoms and improving the quality of life for individuals with a terminal illness” (p. 143). Ideally, hospice care does not consist only of symptom control and pain relief but also helps dying patients and their families to achieve closure and find meaning and purpose in dying (Connor 1998).

It is surprising to note, however, that 73–92% (total average = 83%) of the patients who decided to end their lives through physician-assisted suicide from 1998 to 2002 in Oregon were also receiving hospice care (Oregon Department of Human Services 2002, 2003; Sullivan et al. 2001). This suggests that hospice might not be the ultimate solution for everyone. Furthermore, we do not know how well the hospice philosophy of physical, emotional,

social, and spiritual care can be realized in individual cases, and hospice care is not available for chronically ill and disabled persons with life expectancy of more than 6 months.

Many physicians argue that palliative care and better pain control should be offered to every patient, independent of the type and progression of the illness (Cassel and Demel 2001; Quill et al. 1998). In most cases, pain is treatable or can at least be alleviated to a point that it is no longer unbearable. Death is accepted if it is a consequence of increased pain medication, the so-called double effect, but the intention of the physician is only to relieve suffering and pain, and not to cause death (Kass and Lund 1996; Quill, Lee, and Nunn 2000). However, as the case studies of the Netherlands and Oregon have shown, patients opt for physician-assisted death less often because of unbearable pain than out of the fear of losing autonomy and control. Suffering tends to result from a combination of physical symptoms, pain, and concerns about psychosocial, existential, and spiritual issues (Holstein 1997; Quill and Byock 2000).

An essential part of successful palliative care, therefore, is the doctor-patient relationship. To alleviate suffering, physicians should be allowed and encouraged to take the time to truly listen to patients and caregivers, not only to their reports of physical symptoms but also to their concerns and to their expressions of fears, hopes, and desires (Holstein 1997; Quill 2001; Tulsky, Ciampa, and Rosen 2000). For example, a study of terminally ill patients and their caregivers found that caregivers of patients whose physicians listened to the caregivers' concerns and opinions about the patients' illness and treatment were less likely than other caregivers to be depressed and to report that caregiving had an adverse effect on their personal lives (Emanuel, Fairclough, Slutsman, et al. 2000). Yet, because physicians might lack the appropriate training and might not have the necessary skills or patience to listen attentively, successful palliative care might require the same kind of multidisciplinary teams of physicians, nurses, social workers, and spiritual advisers as does hospice care (Quill et al. 1998; Tulsky et al. 2000).

Wong and Stiller (1999) suggest that loss of meaning might be the primary source of a patient's suffering and the request for physician-assisted death at the end of life. They argue that a sole focus on *physical* symptoms is insufficient to relieve suffering. Instead, palliative care needs to include palliative counseling, which addresses end-of-life issues and the meaning of suffering and death. Through palliative counseling, people who are dying might learn to find dignity and meaning in their lives even if they have lost their autonomy and have become dependent on others. Hence physical and emotional suffering at the end of life might not only be a problem of the individual but might also indicate a failure of society and the community to provide adequate physical, emotional, and social support (Holstein 1997; Rowell 2000; Wong and Stiller 1999).

Terminal Sedation and Voluntary Refusal of Nutrition and Fluids

Not all suffering at the end of life can be relieved by palliative care. For people who suffer excruciating pain, unbearable shortness of breath, or other symptoms that cannot be eased by comprehensive palliative care, terminal sedation might be the best legally available alternative to physician-assisted death (Quill et al. 1998). In terminal sedation, the patient is sedated until he or she loses consciousness. Without artificial nutrition and other life-prolonging interventions, death tends to follow quickly (Quill et al. 2000).

The main difference between active euthanasia and terminal sedation is the intent to relieve intolerable pain and suffering rather than to end the patient's life, although the act of sedating the patient might hasten death (Quill and Byock 2000). However, the success of terminal sedation depends only on easing the patient's suffering and not on the death of the patient. The patient is given only enough medication to achieve and maintain unconsciousness, and no additional medication is administered to expedite death (Quill et al. 2000). By contrast, if active euthanasia does not lead to the death of the patient, the intervention is considered a failure. Yet, because terminal sedation and active euthanasia in practice might be differentiated only by the *intention* of the physician, terminal sedation should be considered an intervention of "last resort" and applied only after all other palliative care options have been exhausted (Quill et al. 1998). The patient must be fully informed about the consequences of the procedure, and his or her consent must be completely voluntary. If the patient is not competent to make an informed decision but suffering appears to be extreme and persistent, the physician should consult the patient's advance directives and discuss the patient's wishes and values with family members and the health care team before terminal sedation is initiated (Quill and Byock 2000).

Voluntary refusal of nutrition and fluid is another legal alternative to physician-assisted death for patients with terminal or incurable illnesses who insist on ending their lives. The voluntary cessation of eating and drinking is a self-determined and autonomous act on the part of the patient, yet, in contrast to physician-assisted death, it does not require direct intervention by a physician to end the patient's life (Brogden 2001; Miller and Meier 1998). The advantage of this alternative is that the patient does not have to ask a physician or family members to participate in the delivery of death, and so potential ethical or moral dilemmas are avoided (Quill and Byock 2000). Furthermore, death comes gradually, giving the patient enough time to change his or her mind (Miller and Meier 1998). The physical discomforts associated with the cessation of eating and drinking can be treated with palliative care, although hunger appears to be rare after an initial period of fasting, and symptoms of dry mouth and throat can be alleviated through assiduous mouth care (Quill and

Byock 2000). On the contrary, prolonged fasting is often accompanied by mild euphoria. The disadvantage of this course of action is that the dying process can take several days or even weeks, and the patient might suffer from confusion or delirium in the later stages of the process (Quill and Byock 2000).

Quill and Byock (2000) suggest the following clinical guidelines for terminal sedation and voluntary refusal of nutrition and fluid: First, the patient has been diagnosed with a terminal illness. Second, the patient has received comprehensive palliative care, but suffering is still severe and persistent. Third, the patient is not under psychological or spiritual distress. In general, terminal sedation and voluntary refusal of nutrition and fluid should be used only in extreme circumstances and when all other interventions to relieve the patient's suffering have failed.

Universal Health Care and Long-Term Care

As long as universal health care and long-term care are not provided in the United States, it might be difficult to argue that people would not feel pressured to request physician-assisted death if it became legally available (Brogden 2001; Koch 2000). Although only three of the persons who have engaged in physician-assisted suicide in Oregon so far have said that the "financial implications of the treatment" they faced were a factor, approximately one-third of the people who have committed physician-assisted suicide since the implementation of the Death With Dignity Act have mentioned relieving the burden on family, friends, and caregivers as one reason to end their lives (Oregon Department of Human Services 2003).

A possible alternative to physician-assisted death might be to provide government-sponsored financial, social, and emotional assistance to patients and to family members who care for terminally ill and disabled persons at home (Emanuel, Fairclough, Slutsman, et al. 2000). A patient who feels appreciated rather than a burden to the family and whose physical and psychosocial needs are adequately addressed will rarely consider physician-assisted suicide or euthanasia (Brogden 2001; Emanuel, Fairclough, and Emanuel 2000). Hospice-type care should be available not only for the terminally ill who have decided to forgo all further curative treatment, but for all persons with long-term care needs. This might take the form of professional help by health care providers and social workers who periodically visit the patient and his or her family at home, respite for family caregivers, and adult day-care centers. Furthermore, caregivers should not be forced to give up their jobs, thus losing their income and their own health insurance, if they decide to care for terminally ill and physically dependent relatives at home. Rather, under the provision of universal long-term care, family caregivers could be subsidized for their caregiving work and covered under a

government-sponsored health insurance program such as Medicare.

CONCLUSION

Given the issues at stake, it is likely that the legalization of physician-assisted death will remain controversial. Although many cite untreatable and unbearable pain as the primary reason for the legalization of physician-assisted suicide, experiences in the Netherlands and in Oregon have shown that only a minority of patients who end their lives through physician-assisted suicide or active euthanasia mention unbearable pain and concerns over inadequate pain control as their primary motivation.

Physician-assisted death may be perceived either as the ultimate victory of personal control and autonomy over the inherently unpredictable process of dying or as the ultimate failure of society to protect its most vulnerable members and the sanctity of life. What does it say about a society if its people choose physician-assisted death when they can no longer conform to the Western ideal of autonomy and physical independence and feel that they have become a burden to others? Does this not imply that we have failed in our societal duty to care for the sick, dependent, and dying (Holstein 1997)? If physician-assisted death were to become legal, would that not send a message to people covered under the law that their lives are no longer worth living? Would they feel guilty about not wanting to end their lives if they needed a large amount of care and used up valuable resources yet had the legal right to free others of their burden? Does compassion for the dying consist in a law that allows them to end their lives at the time of their choosing, or rather in the promise not to abandon them during illness, suffering, and despair? As Holstein (1997) notes:

"Death with dignity" means more than the ability and the opportunity to make choices about our own life and death. Dignity is a socially conditioned value resting upon the belief that others hold us in high regard. "Death with dignity" should rest on the fundamental knowledge that intimates, caregivers, and even strangers think well of me and recognize me, lying in that bed, to be as fully human as they are. (P. 850)

In a society with inadequate medical care for many and limited social and economic support for patients and caregivers in need, it could be dangerous to introduce physician-assisted death as an acceptable solution to end-of-life issues (Brogden 2001; Koch 2000; Osgood 2000). Before focusing on an individual's right to choose physician-assisted death, we should guarantee that every person has access to adequate health care and long-term care, including physical, emotional, and spiritual care at the end of life (Caplan et al. 2000). Just as it takes a village to raise a child, it also takes a village to help a person die a "good death."

REFERENCES

- Alexander, Marc R. 2000. "Catholic Perspectives on Euthanasia and Assisted Suicide: The Human Person and the Quest for Meaning." Pp. 165–79 in *Cultural Issues in End-of-Life Decision Making*, edited by Kathryn L. Braun, James H. Pietsch, and Patricia L. Blanchette. Thousand Oaks, CA: Sage.
- Benoiel, Jeanne Quint and Lesley F. Degner. 1995. "Institutional Dying: A Convergence of Cultural Values, Technology, and Social Organizations." Pp. 117–41 in *Dying: Facing the Facts*, 3d ed., edited by Hannelore Wass and Robert A. Neimeyer. Washington, DC: Taylor & Francis.
- Beresford, Larry. 1997. "The Future of Hospice in a Reformed American Health Care System: What Are the Real Questions?" *Hospice Journal* 12:85–91.
- Brogden, Mike. 2001. *Geronticide: Killing the Elderly*. Philadelphia: Jessica Kingsley.
- Caplan, Arthur L., Lois Snyder, and Kathy Faber-Langendoen. 2000. "The Role of Guidelines in the Practice of Physician-Assisted Suicide." *Annals of Internal Medicine* 132:476–81.
- Cassel, Christine K. and Beth Demel. 2001. "Remembering Death: Public Policy in the USA." *Journal of the Royal Society of Medicine* 94:433–36.
- Chin, Arthur E., Katrina Hedberg, Grant K. Higginson, and David W. Fleming. 1999. "Legalized Physician-Assisted Suicide in Oregon: The First Year's Experience." *New England Journal of Medicine* 340:577–83.
- Connor, Stephen R. 1998. *Hospice: Practice, Pitfalls, and Promise*. Washington, DC: Taylor & Francis.
- Davis, James A. and Tom W. Smith. 2000. *General Social Surveys, 1972–2000* [machine-readable data file] (principal investigator, James A. Davis; director and co-principal investigator, Tom W. Smith; co-principal investigator, Peter V. Marsden; NORC ed.). Chicago/Storrs, CT: National Opinion Research Center (prod.)/Roper Center for Public Opinion Research, University of Connecticut (dist.).
- Drickamer, Margaret A., Melinda A. Lee, and Linda Ganzini. 1997. "Practical Issues in Physician-Assisted Suicide." *Annals of Internal Medicine* 126:146–51.
- Emanuel, Ezekiel J., Diane L. Fairclough, and Linda L. Emanuel. 2000. "Attitudes and Desires Related to Euthanasia and Physician-Assisted Suicide Among Terminally Ill Patients and Their Caregivers." *Journal of the American Medical Association* 284:2460–68.
- Emanuel, Ezekiel J., Diane L. Fairclough, Julia Slutsman, and Linda L. Emanuel. 2000. "Understanding Economic and Other Burdens of Terminal Illness: The Experience of Patients and Their Caregivers." *Annals of Internal Medicine* 132:451–59.
- Ganzini, Linda, Heidi D. Nelson, Melinda A. Lee, Dale F. Kraemer, Terri A. Schmidt, and Molly A. Delorit. 2001. "Oregon Physicians' Attitudes About and Experiences With End-of-Life Care Since Passage of the Oregon Death With Dignity Act." *Journal of the American Medical Association* 285:2363–69.
- Girsh, Faye J. 2000. "Voluntary Euthanasia Should Be Legalized." Pp. 69–77 in *Euthanasia*, edited by James D. Torr. San Diego, CA: Greenhaven.
- Groenewoud, Johanna H., Agnes van der Heide, Bregje D. Onwuteaka-Philipsen, Dick L. Willems, Paul J. van der Maas, and Gerrit van der Wal. 2000. "Clinical Problems With the Performance of Euthanasia and Physician-Assisted Suicide in the Netherlands." *New England Journal of Medicine* 342:551–56.
- Hai, Hamid Abdul and Asad Husain. 2000. "Muslim Perspectives Regarding Death, Dying, and End-of-Life Decision Making." Pp. 199–211 in *Cultural Issues in End-of-Life Decision Making*, edited by Kathryn L. Braun, James H. Pietsch, and Patricia L. Blanchette. Thousand Oaks, CA: Sage.
- Hardwig, John. 1997. "Is There a Duty to Die?" *Hastings Center Report* 27:34–42.
- Hedberg, Katrina, David Hopkins, and Melvin Kohn. 2003. "Five Years of Legal Physician-Assisted Suicide in Oregon." *New England Journal of Medicine* 348:961–64.
- Hedberg, Katrina, David Hopkins, and Karen Southwick. 2002. "Legalized Physician-Assisted Suicide in Oregon, 2001." *New England Journal of Medicine* 346:450–52.
- Holstein, Martha. 1997. "Reflections on Death and Dying." *Academic Medicine* 72:848–55.
- Kamisar, Yale. 1996. "The Reasons So Many People Support Physician-Assisted Suicide—and Why These Reasons Are Not Convincing." *Issues in Law and Medicine* 12:113–31.
- Kass, Leon R. and Nelson Lund. 1996. "Courting Death: Assisted Suicide, Doctors, and the Law." *Commentary* 102:17–29.
- Kavesh, William. 2000. "Jewish Perspectives on End-of-Life Decision Making." Pp. 181–97 in *Cultural Issues in End-of-Life Decision Making*, edited by Kathryn L. Braun, James H. Pietsch, and Patricia L. Blanchette. Thousand Oaks, CA: Sage.
- Koch, Tom. 2000. "End-of-Life Issues: A Disability Perspective." Pp. 285–301 in *Cultural Issues in End-of-Life Decision Making*, edited by Kathryn L. Braun, James H. Pietsch, and Patricia L. Blanchette. Thousand Oaks, CA: Sage.
- Koenig, Harold G., D. Wildman-Hanlon, and Kenneth Schmadier. 1996. "Attitudes of Elderly Patients and Their Families Toward Physician-Assisted Suicide." *Archives of Internal Medicine* 156:2240–48.
- Lattanzi-Licht, Marcia and Stephen R. Connor. 1995. "Care of the Dying: The Hospice Approach." Pp. 143–62 in *Dying: Facing the Facts*, 3d ed., edited by Hannelore Wass and Robert A. Neimeyer. Washington, DC: Taylor & Francis.
- Lavery, James V., Joseph Boyle, Bernard M. Dickens, Heather Maclean, and Peter A. Singer. 2001. "Origins of the Desire for Euthanasia and Assisted Suicide in People With HIV-1 or AIDS: A Qualitative Study." *Lancet* 358:362–67.
- Lenzer, Anthony. 1999. "Physician-Assisted Suicide: Policy Dilemmas." Pp. 281–95 in *End of Life Issues: Interdisciplinary and Multidimensional Perspectives*, edited by Brian de Vries. New York: Springer.
- Miller, Franklin G. and Diane E. Meier. 1998. "Voluntary Death: A Comparison of Terminal Dehydration and Physician-Assisted Suicide." *Annals of Internal Medicine* 128:559–62.
- Mouton, Charles P. 2000. "Cultural and Religious Issues for African Americans." Pp. 71–82 in *Cultural Issues in End-of-Life Decision Making*, edited by Kathryn L. Braun, James H. Pietsch, and Patricia L. Blanchette. Thousand Oaks, CA: Sage.
- Ogden, Russel. 2000. "End-of-Life Issues in the HIV/AIDS Community." Pp. 265–83 in *Cultural Issues in End-of-Life Decision Making*, edited by Kathryn L. Braun, James H. Pietsch, and Patricia L. Blanchette. Thousand Oaks, CA: Sage.

- Oregon Department of Human Services. 2001. *Oregon's Death With Dignity Act: Three Years of Legalized Physician-Assisted Suicide*. Portland: Oregon Department of Human Services.
- . 2002. *Fourth Annual Report on Oregon's Death With Dignity Act*. Portland: Oregon Department of Human Services.
- . 2003. *Fifth Annual Report on Oregon's Death With Dignity Act*. Portland: Oregon Department of Human Services.
- Osgood, Nancy J. 2000. "Ageism and Elderly Suicide: The Intimate Connection." Pp. 157–73 in *Death Attitudes and the Older Adult: Theories, Concepts, and Applications*, edited by Adrian Tomer. Philadelphia: Brunner-Routledge.
- Quill, Timothy E. 2001. *Caring for Patients at the End of Life: Facing an Uncertain Future Together*. New York: Oxford University Press.
- Quill, Timothy E. and Ira R. Byock. 2000. "Responding to Intractable Terminal Suffering: The Role of Terminal Sedation and Voluntary Refusal of Food and Fluids." *Annals of Internal Medicine* 132:408–14.
- Quill, Timothy E., Barbara C. Lee, and Sally Nunn. 2000. "Palliative Treatments of Last Resort: Choosing the Least Harmful Alternative." *Annals of Internal Medicine* 132: 488–93.
- Quill, Timothy E., Diane E. Meier, Susan D. Block, and J. Andrew Billings. 1998. "The Debate Over Physician-Assisted Suicide: Empirical Data and Convergent Views." *Annals of Internal Medicine* 128:552–58.
- Roscoe, Lori A., Julie E. Malphurs, L. J. Dragovic, and Donna Cohen. 2001. "A Comparison of Characteristics of Kevorkian Euthanasia Cases and Physician-Assisted Suicides in Oregon." *Gerontologist* 41:439–46.
- Rowell, Mary. 2000. "Christian Perspectives on End-of-Life Decision Making: Faith in a Community." Pp. 147–63 in *Cultural Issues in End-of-Life Decision Making*, edited by Kathryn L. Braun, James H. Pietsch, and Patricia L. Blanchette. Thousand Oaks, CA: Sage.
- Steinbrook, Robert. 2002. "Physician-Assisted Suicide in Oregon: An Uncertain Future." *New England Journal of Medicine* 346:460–64.
- Sullivan, Amy D., Katrina Hedberg, and David W. Fleming. 2000. "Legalized Physician-Assisted Suicide in Oregon: The Second Year." *New England Journal of Medicine* 342:598–604.
- Sullivan, Amy D., Katrina Hedberg, and David Hopkins. 2001. "Legalized Physician-Assisted Suicide in Oregon, 1998–2000." *New England Journal of Medicine* 344:605–7.
- Sulmasy, Daniel P. 2000. "Voluntary Euthanasia Is Unethical." Pp. 24–32 in *Euthanasia* edited by James D. Torr. San Diego, CA: Greenhaven.
- Tulsky, James A., Ralph Ciampa, and Elliott J. Rosen. 2000. "Responding to Legal Requests for Physician-Assisted Suicide." *Annals of Internal Medicine* 132:494–99.
- van der Maas, Paul J., Johannes J. M. van Delden, Loes Pijnenborg, and Caspar W. Looman. 1991. "Euthanasia and Other Medical Decisions Concerning the End of Life." *Lancet* 338:669–74.
- van der Maas, Paul J., Gerrit van der Wal, Ilinka Haverkate, Carmen L. M. de Graaff, John G. C. Kester, Bregje D. Onwuteaka-Philipsen, Agnes van der Heide, Jacqueline M. Bosma, and Dick L. Willems. 1996. "Euthanasia, Physician-Assisted Suicide, and Other Medical Practices Involving the End of Life in the Netherlands, 1990–1995." *New England Journal of Medicine* 335:1699–1705.
- Wong, Paul T. P. and Catherine Stiller. 1999. "Living With Dignity and Palliative Care." Pp. 77–94 in *End of Life Issues: Interdisciplinary and Multidimensional Perspectives*, edited by Brian de Vries. New York: Springer.