

DEATH WITH DIGNITY AND MENTAL DISORDER

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States and nations are grappling with physician-assisted dying and its boundaries. In the United States, euthanasia is universally prohibited, and a handful of states have sanctioned physician-assisted dying for competent adults with terminal illnesses. In Europe, access to physician-assisted dying is broader. The Netherlands, Belgium, and Switzerland permit physician-assisted dying for competent nonterminal patients, whether the cause of the patient's suffering is psychological or somatic. Indeed, all three countries allow physician-assisted dying for psychiatric patients without an underlying somatic disorder.

Still, legal scholars and bioethicists are divided over whether someone with a mental disorder should have access to physician-assisted dying. Some object to physician-assisted dying itself, while others support a right to assisted dying for people with terminal illnesses, but are unwilling to extend that right to people with mental illnesses. In this Article, I argue that when a person requests the assistance of a physician to hasten her death, our only concern should be whether she is competent to consent to physician-assisted dying. A large empirical literature has shown that mental disorder is not synonymous with incompetence. A person can be depressed and form a desire to die that we are obligated to respect.

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INTRODUCTION

In *Washington v. Glucksberg*¹ and *Vacco v. Quill*,² a coalition of terminally ill patients, physicians, and nonprofit organizations challenged the constitutionality of statutes banning physician-assisted dying in New York and Washington. As competent terminally ill adults, the respondents asserted that the Fourteenth Amendment protects their liberty interest in using lethal medications, obtained from their physicians, to hasten their deaths.³ After rulings favoring the respondents in the Second and Ninth Circuits, the Supreme Court granted certiorari and reversed.

During oral arguments in *Glucksberg*, several of the Justices pressed the respondents to articulate a principle that would limit their proclaimed liberty interest to patients who are terminally ill. “Ms. Tucker, why . . . is it limited to those on the threshold of death?” Justice Scalia inquired.⁴ “I mean suppose I have . . . terrible pain and the doctor says you’re going to be in terrible pain for ten years. . . . [T]he patient who has ten years of agony to look forward to has a more appealing case

1. 521 U.S. 702 (1997).

2. 521 U.S. 793 (1997).

3. *Glucksberg*, 521 U.S. at 708.

4. Oral Argument at 26:18, *Washington v. Glucksberg*, 521 U.S. 702 (1997) (No. 96-110), <https://www.oyez.org/cases/1996/96-110>.

than the patient who is at the threshold of death.”⁵ Justice Scalia was equally unconvinced that the right to hasten one’s death with the assistance of a physician could be limited to patients with physical illnesses:

Why should that decision, if it is competent, reasoned, and deliberated . . . be limited to physical pain? . . . [W]hat about the patient who has terrible emotional suffering in life and just says life is not worth it anymore? . . . You don’t have to be unstable to think that your life is not worth living, do you? . . . Or is the government going to make that judgment?⁶

In a unanimous decision, the Supreme Court held that hastening one’s death with the assistance of a physician is not a fundamental right protected by the Due Process Clause,⁷ nor do states offend the Equal Protection Clause by permitting competent, terminally ill patients to refuse life-sustaining treatment, but prohibiting physician-assisted dying.⁸ Declining to recognize a constitutional right to physician-assisted dying, the Court left the matter to the states.

In 1997, Oregon became the first state to legalize physician-assisted dying for terminally ill residents.⁹ Physician-assisted dying (also known as *physician-assisted suicide* or *medical aid in dying*) occurs when a physician provides a lethal medication to a patient at his request, which the patient can use to end his life.¹⁰ Although the Oregon Death with Dignity Act (“ODDA”) permits physician-assisted dying, it prohibits voluntary active euthanasia.¹¹ Voluntary active euthanasia, or simply euthanasia, occurs when someone, usually a clinician, intentionally ends a patient’s life with a lethal injection.¹²

The framework created by the Oregon Death with Dignity Act has become a blueprint for other states. Washington passed a similar statute through a voter referendum in 2008;¹³ the Supreme Court of Montana decriminalized physician-assisted dying in 2009;¹⁴ and Vermont passed a statute modeled on the Oregon Death with Dignity Act in 2013.¹⁵ Currently, six states and the District of Columbia permit physician-assisted dying including California¹⁶ and Colorado.¹⁷ According

5. *Id.* at 26:23.

6. *Id.* at 30:23.

7. *Glucksberg*, 521 U.S. at 728.

8. *Vacco v. Quill*, 521 U.S. 793, 796 (1997).

9. OR. REV. STAT. § 127.860 § 3.10 (1999).

10. Ezekiel J. Emanuel et al., *Attitudes and Practices of Euthanasia and Physician-Assisted Suicide in the United States, Canada, and Europe*, 316 JAMA 79, 80 (2016). The terms *physician-assisted dying*, *physician-assisted death*, and *physician-assisted suicide* are often used interchangeably. In this Article, however, I will generally use the term *physician-assisted dying*.

11. OR. REV. STAT. § 127.880 § 3.14 (1999).

12. Emanuel et al., *supra* note 10, at 80.

13. *See* WASH. REV. CODE § 70.245 (2009).

14. *Baxter v. Montana*, 224 P.3d 1211 (Mont. 2009).

15. VT. STAT. ANN. tit. 18, § 5281 (2013).

16. CAL. HEALTH & SAFETY CODE § 443 (West 2016).

17. COLO. REV. STAT. ANN. § 25-48-101 (2016).

to a recent Gallup poll, 73% of adults in the United States agree that “a doctor should be allowed to end a terminally ill patient’s life by painless means” if that is what the patient requests.¹⁸

Nonetheless, many scholars have argued that the moral arguments in favor of physician-assisted dying apply with equal if not greater force to people with non-terminal illnesses, who face not months but years of suffering.¹⁹ To that end, a model statute drafted by Professors Charles Baron and Dan Brock would authorize physician-assisted dying for “patients who are not likely to die from their illnesses within six months but have bodily disorders that cause intractable and unbearable suffering,” including AIDS, advanced emphysema, amyotrophic lateral sclerosis (commonly known as ALS or Lou Gehrig’s disease), multiple sclerosis, and some forms of cancer.²⁰ For supporters of physician-assisted dying, the primary arguments favoring legalization support extending the same option to patients with non-terminal medical illnesses. Others, including Ronald Dworkin, would permit some forms of physician-assisted dying for patients who are in the early stages of dementia or Alzheimer’s disease.²¹

What should we say to a person who requests a physician-assisted death owing to “terrible emotional suffering” of the kind described by Justice Scalia in *Glucksberg*? In the United States, supporters have championed physician-assisted dying as an option for a small swath of patients who suffer from terminal medical illnesses.²² In Europe, access to physician-assisted dying is broader. The Netherlands, Belgium, and Switzerland permit physician-assisted dying for competent non-terminal patients, whether the cause of the patient’s suffering is

18. Jade Wood & Justin McCarthy, *Majority of Americans Remain Supportive of Euthanasia*, GALLUP (June 12, 2017), <http://news.gallup.com/poll/211928/majority-americans-remain-supportive-euthanasia.aspx>.

19. See, e.g., Rachel D. Kleinberg & Toshiro M. Mochizuki, *The Final Freedom: Maintaining Autonomy and Valuing Life in Physician-Assisted Suicide Cases*, 32 HARV. C.R.-C.L.L. REV. 197 (1997); Katherine C. Glynn, Note, *Turning to State Legislatures to Legalize Physician-Assisted Suicide for Seriously Ill, Non-Terminal Patients after Vacco v. Quill and Washington v. Glucksberg*, 6 J.L. & POL’Y 329 (1997).

20. Charles H. Baron et al., *A Model State Act to Authorize and Regulate Physician-Assisted Suicide*, 33 HARV. J. ON LEGIS. 1, 11 (1996).

21. RONALD DWORKIN, *LIFE’S DOMINION: AN ARGUMENT ABOUT ABORTION, EUTHANASIA AND INDIVIDUAL FREEDOM* 189–90, 228 (1993); see also Paul T. Menzel & Bonnie Steinbock, *Advance Directives, Dementia, and Physician-Assisted Death*, 41 J.L. MED. & ETHICS 484, 485 (2013).

22. See, e.g., Brief for Ronald Dworkin et al. as Amici Curiae, *Washington v. Glucksberg*, 521 U.S. 702 (1997) (Nos. 95-1858, 96-110) (advocating physician-assisted dying for people with terminal illnesses, but opposing physician-assisted dying for people with non-terminal illnesses).

psychological or somatic.²³ Indeed, all three countries allow physician-assisted dying for psychiatric patients without an underlying somatic disorder.²⁴

Still, legal scholars, bioethicists, and psychiatrists are divided over whether someone with a mental disorder should have access to physician-assisted dying.²⁵ Some object to physician-assisted dying itself, while others support a right to assisted death for people with terminal illnesses, but are unwilling to extend that option to people with mental illnesses.²⁶ Professors Charles Baron and Dan Brock have said that because physician-assisted dying “requires competency, the subjective preference for death of a clinically depressed or mentally ill patient would be insufficient to qualify that patient for assisted suicide.”²⁷ As a respected palliative care physician and the named plaintiff in *Vacco v. Quill*, Dr. Timothy Quill urged the Supreme Court to recognize a constitutional right to physician-assisted dying for people with terminal illnesses.²⁸ Nonetheless, Dr. Quill maintains a sharp distinction between people with terminal illnesses and people with mental disorders: “In my primary care practice, I have also met many patients who were suicidal in the mental health sense of the word, and rest assured I have assisted none of them to die.”²⁹ The objections expressed by supporters of physician-assisted dying are understandable but mistaken.

This Article begins by describing the evolution of physician-assisted dying in the United States and its limitation to people with terminal illnesses. Part II turns to the moral arguments in favor of physician-assisted dying. Scholars who support the legalization of physician-assisted dying argue that competent adults should have the right to make important decisions about their own lives, according to their own values.³⁰ A second argument challenges the distinction between “a killing” and “a

23. *Office of Public Prosecutions v. Chabot*, Supreme Court of the Netherlands, Criminal Chamber, 21 June 1994, no.96.972, translated in JOHN GRIFFITHS ET AL., EUTHANASIA & LAW IN THE NETHERLANDS app. II, at 276 (1998); The Belgian Act on Euthanasia of May 28, 2002, reprinted in GUENTER LEWY, ASSISTED DEATH IN EUROPE AND AMERICA: FOUR REGIMES AND THEIR LESSONS, app. II at 172 (2010); Schweizerisches Bundesgericht [BGer] [Federal Supreme Court of Switzerland] Nov. 3, 2006, 2A.48/2006.

24. See *infra* Sections I.B–C.

25. For a cogent argument in favor of physician-assisted dying for people with mental illnesses, see Udo Schuklenk & Suzanne van de Vathorst, *Treatment-Resistant Major Depressive Disorder and Assisted Dying*, 41 J. MED. ETHICS 577 (2015). But see Frank Miller, *Treatment-Resistant Depression and Physician-Assisted Death*, 41 J. MED. ETHICS 885 (2015); Thomas Bilkshavn et al., *Four Reasons Why Assisted Dying Should Not Be Offered for Depression*, 14 J. BIOETHICAL INQUIRY 151 (2017).

26. Jacob M. Appel, *A Suicide Right for the Mentally Ill?: A Swiss Case Opens a New Debate*, 37 HASTINGS CTR. REP. 21 (2007).

27. Baron et al., *supra* note 20, at 11.

28. 521 U.S. 793, 798 (1997).

29. Timothy E. Quill, *Physicians Should “Assist in Suicide” When It Is Appropriate*, 40 J.L. MED. & ETHICS 57, 57 (2012).

30. See, e.g., Brief for Ronald Dworkin et al., *supra* note 22, at 5–7.

letting die.”³¹ For many proponents of physician-assisted dying, the right to determine the time and manner of one’s death, with the assistance of a physician, flows from the right to refuse life-sustaining medical treatment.³² A third argument in favor of physician-assisted dying appeals to the principle of beneficence—or the moral obligation of physicians to relieve the suffering of their patients and promote their well-being.³³

In Part III, I argue that the primary moral arguments advanced in favor of physician-assisted dying for people with terminal illnesses, and a growing number of people with non-terminal illnesses, can be extended to at least some people with mental disorders who are competent to make medical decisions. Part III focuses on people with clinical depression. A large empirical literature has shown that most people with depression—even severe depression—retain the capacity to make treatment decisions. Moreover, courts have held that competent adults with clinical depression have the right to refuse life-sustaining medical treatment. If the distinction between “a killing” and “a letting die” has no intrinsic moral significance as proponents of the moral equivalence thesis suggest, then a person who has the right to refuse life-sustaining medical treatment also has the right to choose physician-assisted dying. In Part III, I argue that the same principle applies to people with mental disorders. Supporters of physician-assisted dying have also endorsed the proposition that whether a person’s suffering is unbearable is a subjective determination that can only be made “by each patient individually.”³⁴ But if suffering is indeed subjective, then the argument from beneficence must include people with mental disorders as well.

Part III addresses the objections that have been raised by bioethicists who oppose physician-assisted dying for people with psychiatric disorders, over and above objections related to competence. A vocal chorus of bioethicists oppose physician-assisted dying for people with mental disorders on the ground that physician-assisted dying should be limited to people with incurable medical conditions. However, a strict incurability requirement would exclude many patients for whom the same bioethicists think physician-assisted dying ought to be permissible. Part IV turns to the Oregon Death with Dignity Act. A prudent approach to implementing the proposal I have described would be to build on the procedural safeguards embedded in the Oregon Death with Dignity Act. With its emphasis on competence, an argument of the kind I have described necessarily points even

31. James Rachels, *Active and Passive Euthanasia*, 292 NEW ENG. J. MED. 78 (1975) (observing that the distinction between “a killing” and “a letting die” “itself has no moral importance”).

32. Baron et al., *supra* note 20, at 5.

33. Timothy E. Quill, Bernard Lo & Dan W. Brock, *Palliative Options of Last Resort: A Comparison of Voluntarily Stopping Eating and Drinking, Terminal Sedation, Physician-Assisted Suicide, and Voluntary Active Euthanasia*, 278 JAMA 2099, 2102 (1997).

34. Marcia Angell, *The Quality of Mercy*, in PHYSICIAN-ASSISTED DYING: THE CASE FOR PALLIATIVE CARE AND PATIENT CHOICE 15, 19 (Timothy E. Quill & Margaret P. Battin eds., 2004).

beyond people with mental disorders. In Part V, I turn to cases involving people, who are neither mentally ill, nor medically ill, but simply “tired of life.”

I. THE LAW OF PHYSICIAN-ASSISTED DYING

A. *Physician-Assisted Dying in the United States*

Suicide and assisting suicide were common law crimes in the American Colonies, punishable by an ignominious burial and forfeiture of the decedent’s estates and chattels to the Crown.³⁵ Early American courts largely followed English common law and regarded suicide as murder or *felo de se*.³⁶ “Self-murder,” Sir William Blackstone observed, was among the most serious crimes, for “the suicide is guilty of a double offence; one spiritual, in invading the prerogative of the Almighty . . . the other temporal against the King,” who retains an interest in the health of his subjects.³⁷ Nonetheless, by the end of the eighteenth century, most of the Colonies abolished forfeiture and ignominious burial as punishments for suicide.³⁸ The reason for this modification, it seems, was not a shift in social attitudes toward suicide, but rather a growing concern that the harsh penalties of the common law fell upon “the innocent offspring of the offender,” rather than the offender himself.³⁹ Courts and state legislatures continued to regard assisting a suicide as a crime well into the twentieth century.⁴⁰

Before the 1950s, whether patients had a right to die or whether physicians could assist them without violating moral prohibitions was not a concern.⁴¹ Patients who were permanently unconscious died from infections and dehydration.⁴² By the 1950s, however, advances in medical technology greatly improved the prospects of patients who were dying or critically ill.⁴³ Yet for elderly and terminally ill patients, the medical technology boom of the mid-twentieth century was a mixed blessing. Medical innovation fostered a technological imperative or a belief among hospitals and physicians that they should use all of the medical treatments and technologies at their disposal to preserve human life, no matter how small the benefit or high the cost to patients and their families.⁴⁴ However, in a series of cases beginning with *Matter of Quinlan*,⁴⁵ patients and their surrogates secured the right to refuse life-sustaining medical treatment. In *Matter of Quinlan*, the New Jersey Supreme Court held that the right to refuse life-sustaining medical treatment stems from the right to

35. Thomas J. Marzen et al., *Suicide: A Constitutional Right?*, 24 DUQ. L. REV. 1, 63 (1985).

36. *Id.* at 60–61.

37. *Id.* at 62–63.

38. *Id.* at 66–67.

39. *Id.* at 68.

40. *Id.* at 71–81.

41. HENRY R. GLICK, *THE RIGHT TO DIE: POLICY INNOVATION AND ITS CONSEQUENCES* 13 (1992).

42. DANIEL HILLYARD & JOHN DOMBRINK, *DYING RIGHT: THE DEATH WITH DIGNITY MOVEMENT* 5 (2001).

43. *Id.* at 14.

44. GLICK, *supra* note 41, at 17–18.

45. 355 A.2d 647 (N.J. 1976).

privacy.⁴⁶ Several years later, in *Cruzan v. Director, Missouri Department of Health*, the U.S. Supreme Court indicated that the right to refuse unwanted medical treatment could be inferred from its prior decisions.⁴⁷

By the early 1990s, the focus of the right-to-die movement began to shift from establishing a right to refuse life-sustaining medical treatment—now firmly established by *Quinlan* and *Cruzan*—to legalizing physician-assisted dying. Physicians and patients argued that state interference in medical decision-making at the end of life intruded impermissibly on patient privacy and choice, leaving patients to die “inch by inch.”⁴⁸ However, early efforts to secure a right to physician-assisted dying failed.

Ballot initiatives to legalize physician-assisted dying and active euthanasia—dubbed physician aid in dying by supporters—were defeated in Washington (1991) and California (1992).⁴⁹ Polls showed that while voters generally supported laws that would allow physicians to write prescriptions for lethal medications to patients with incurable illnesses, voters were wary of euthanasia and unnerved by ambiguous references to “aid in dying.”⁵⁰ Opponents of the ballot initiatives in Washington and California seized upon voters’ concerns and the absence of adequate procedural safeguards in the reform proposals to fight the initiatives.⁵¹

Proponents of the right-to-die movement in Oregon crafted the Oregon Death with Dignity Act carefully, with the losses in Washington and California in mind.⁵² Right-to-die advocates abandoned early drafts of the Oregon Death with Dignity Act, which would have allowed doctors to administer lethal doses of medication to their patients directly.⁵³ In the same way, Oregon reformers distanced themselves from radical members of the Hemlock Society, who advocated access to physician-assisted death, not only for people with terminal illnesses, but also for patients with chronic illnesses who were “hopelessly ill.”⁵⁴ In November 1994, voters in Oregon passed the Oregon Death with Dignity Act by a slim margin of 51% to 49%.⁵⁵ An injunction delayed the implementation of the Oregon Death with Dignity Act until October 1997. Later that year, voters defeated a ballot measure to repeal the Oregon Death with Dignity Act, making Oregon the first state to legalize physician-assisted dying.⁵⁶

46. *Id.* at 663.

47. 497 U.S. 261, 278 (1990).

48. HILLYARD & DOMBRINK, *supra* note 42, at 15.

49. *Id.* at 10.

50. *Id.* at 36–37.

51. *Id.* at 57–58.

52. *Id.* at 80.

53. SUSAN STEFAN, RATIONAL SUICIDE, IRRATIONAL LAWS 141 (2016).

54. HILLYARD & DOMBRINK, *supra* note 42, at 82.

55. GUENTER LEWY, ASSISTED DEATH IN EUROPE AND AMERICA: FOUR REGIMES AND THEIR LESSONS 126 (2010).

56. *Id.*

In the United States, supporters of physician-assisted dying have championed physician-assisted dying as an option for patients who are suffering from terminal illnesses.⁵⁷ In Europe and Canada, access to physician-assisted dying is far broader.

B. The Netherlands

The Dutch Penal Code prohibits euthanasia and assisted suicide;⁵⁸ however, since the early 1980s, Dutch courts have recognized a necessity defense to criminal liability.⁵⁹ In *Schoonheim*, the first euthanasia case to reach the Dutch Supreme Court, the defendant's 95-year-old patient repeatedly pleaded with him to end her life.⁶⁰ When Dr. Schoonheim acceded to her request, he was charged with violating the Dutch Criminal Code. Reversing the Court of Appeals, the Dutch Supreme Court held that the Court of Appeals failed to consider whether the defendant acted in a circumstance of overmacht or necessity, given the patient's "unbearable suffering," her "increasing loss of personal dignity," and the risk that she might not be able to die in a "dignified manner" given her decline.⁶¹ The Supreme Court remanded *Schoonheim* to a lower court for further findings and Dr. Schoonheim was acquitted.⁶²

Ten years later, in *Office of Public Prosecutions v. Chabot*, the Dutch Supreme Court held that the necessity defense is available even when patients experience psychiatric suffering without an identifiable somatic cause.⁶³ Echoing *Schoonheim*, the Court reasoned that "rendering assistance with suicide, like performing euthanasia, can be considered justifiable" if the defendant "acted in a situation of necessity."⁶⁴ "In particular, a doctor may be in a situation of necessity if

57. See, e.g., Brief for Ronald Dworkin et al., *supra* note 22, at 19.

58. Article 293 of the Dutch Penal Code prohibits intentionally terminating "the life of another person at that other person's express and earnest request." Article 294 provides that "[a] person who intentionally incites another to commit suicide" or "assists in the suicide of another" is guilty of a serious offense. Amendments to Articles 293 and 294, pursuant to the 2002 Termination of Life on Request and Assisted Suicide (Review Procedures) Act, provide that prohibited behavior, "shall not be punishable if it has been committed by a physician who has met the requirements of due care as referred to in Article 2." LEWY, *supra* note 55, app. I, at 168.

59. See, e.g., Postma, *Nederlandse Jurisprudentie* 1973, no. 183: 558 (holding that patients may be given large doses of medication to relieve their pain, even though doing so may hasten the patient's death if patients are "incurably ill"; their suffering is "mentally or physician unbearable"; they have expressed the wish to die, and the person who carries out the request is their treating physician).

60. Schoonheim, Supreme Court of the Netherlands, Criminal Chamber, 27 November 1984, nr 77.091 [*Nederlandse Jurisprudentie* 1985, no. 106], translated in GRIFFITHS ET AL., *supra* note 23, app. II, at 322.

61. GRIFFITHS ET AL., *supra* note 23, at 328.

62. *Id.*

63. Supreme Court of the Netherlands, Criminal Chamber, 21 June 1994, no.96.972, translated in GRIFFITHS ET AL., *supra* note 23, app. II, at 329. For further commentary on *Chabot* see generally John Griffiths, *Assisted Suicide in the Netherlands: The Chabot Case*, 58 MOD. L. REV. 232 (1995).

64. GRIFFITHS ET AL., *supra* note 23, at 333.

he has to choose between the duty to preserve life and the duty as a doctor to do everything possible to relieve the unbearable and hopeless suffering . . . of a patient committed to his care.”⁶⁵ The notion that a psychiatric patient cannot voluntarily request assistance with suicide “is as a general [legal] proposition incorrect,” the Court observed.⁶⁶ Nonetheless, when the cause of the patient’s suffering is not a somatic disorder, the Court emphasized that trial courts must determine whether an assisted suicide was justified with exceptional care.⁶⁷ Although Dr. Chabot consulted many independent experts, none of them actually examined his patient. Without testimony from an independent medical expert who actually examined Mrs. Bosscher, the lower court could not conclude that Dr. Chabot made a justifiable choice in response to an unavoidable conflict of duties.⁶⁸

In 2002, the Termination of Life on Request and Assisted Suicide (Review Procedures) Act—also known as the Euthanasia Act—codified Dutch jurisprudence on euthanasia.⁶⁹ The Euthanasia Act permits physicians to assist their patients with suicide or euthanasia when physicians follow certain guidelines or due care criteria. Under the Euthanasia Act, the physician must: (i) “be satisfied that the patient’s request is voluntary and well considered;” and (ii) “be satisfied that the patient’s suffering is unbearable with no prospect of improvement.”⁷⁰ The physician must also inform the patient of his or her prognosis, and “together with the patient” reach the conclusion that “there is no reasonable alternative to the patient’s situation.”⁷¹ Further, the patient’s physician must consult at least one additional independent physician, who can confirm that the due care criteria have been satisfied.⁷² However, even if the consulting physician disagrees with the treating physician, the treating physician may decide to grant the patient’s request nonetheless.⁷³ The treating physician may also decide to consult another independent physician; however, the physician must submit written reports from each independent physician to the Regional Review Committee.⁷⁴ Physicians who receive requests for euthanasia often find consulting physicians through SCEN—Support and Consultation on Euthanasia in the Netherlands—a network of physicians created by the Royal Dutch Medical Association to improve the quality of euthanasia and physician-assisted suicide.⁷⁵

65. *Id.*

66. *Id.*

67. *Id.* at 335.

68. *Id.* at 336.

69. LEWY, *supra* note 55, at 26–27.

70. REGIONAL EUTHANASIA REVIEW COMMITTEES, RTE, CODE OF PRACTICE 6 (2015).

71. *Id.*

72. *Id.*

73. *Id.* at 17.

74. *Id.*

75. Marike Catharina Jansen-van der Weide et al., *Implementation of the Project ‘Support and Consultation on Euthanasia in the Netherlands’ (SCEN)*, 69 HEALTH POL’Y 365 (2004).

When Dutch physicians perform euthanasia, they are required to notify the local pathologist, who will then report the case to one of five Regional Euthanasia Review Committees (“RTEs”).⁷⁶ If the RTE decides that the physician has satisfied due care requirements, it will close the case.⁷⁷ If the committee determines that the physician has not complied with one or more due care criteria, the committee must notify the Public Prosecution Service and the Health Inspectorate.⁷⁸ The prosecutor and health inspector have the authority to determine whether the doctor should be prosecuted.⁷⁹

A *Code of Practice*, published jointly by the Regional Euthanasia Review Committees, provides insight into how the RTEs interpret key provisions of the Euthanasia Act. The *Code* also illustrates a decidedly Dutch perspective on physician-assisted dying. For example, to comply with the requirements of the Euthanasia Act, physicians must be satisfied that patients are competent to make decisions, insofar as they are able to understand both their diagnosis and prognosis as well as the consequences of their decision.⁸⁰ Patients must make the request themselves; however, unlike the Oregon Death with Dignity Act, Dutch law does not require a written request. A verbal request is sufficient.⁸¹ Nor does the Euthanasia Act require more than one request for euthanasia or prescribe an interval between requests. Instead, according to the *Code of Practice*, “the physician must be satisfied that the request is unequivocal and consistent,” although “a request need not . . . have persisted for a long time in order to be granted.”⁸²

Further, the attending physician must establish that the patient’s request is free from undue influence. The *Code of Practice* encourages physicians to exercise caution if, for example, a relative becomes too involved in the patient’s decision.⁸³ Although the possibility that greedy relatives will force vulnerable patients into physician-assisted suicide has been a source of consternation in the United States,⁸⁴ the Dutch accept that a patient might request euthanasia partly “because he feels he is a burden to others.”⁸⁵ If so, “the request may not necessarily be involuntary.”⁸⁶ Indeed, data collected by the Departments of Health in Oregon and Washington has

76. REGIONAL EUTHANASIA REVIEW COMMITTEES, *supra* note 70, at 7.

77. *Id.*

78. *Id.*

79. *Id.*

80. *Id.* at 11.

81. *Id.*

82. *Id.*

83. *Id.*

84. See, e.g., Herbert Hendin & Kathleen Foley, *Physician-Assisted Suicide in Oregon: A Medical Perspective*, 106 MICH. L. REV. 1613 (2008).

85. REGIONAL EUTHANASIA REVIEW COMMITTEES, *supra* note 70, at 11.

86. *Id.*; see also Brief for Ronald Dworkin et al., *supra* note 22 (“Even people who are dying have a right to hear, and if they wish, act on what others might wish to tell or suggest or even hint to them, and it would be dangerous to suppose that a state may prevent this on the ground that it knows better than its citizens when they should be moved by or yield to particular advice or suggestion in the exercise of their right to make fateful personal decisions for themselves.”).

shown that, for many patients, a desire not to be a burden on friends, family, or caregivers is a common concern.⁸⁷

Pursuant to Dutch law, the physician must also establish that the patient's suffering is "unbearable, with no prospect of improvement."⁸⁸ However, physicians are encouraged to assess suffering against the backdrop of the patient's life and ultimately, from the patient's point of view. "What is bearable for one patient may be unbearable for another. This depends on the individual's perception of his situation, his life history and medical history, personality, values and physical and mental stamina. It is therefore important to consider the patient's 'biography' when assessing his suffering."⁸⁹

Finally, upon informing the patient of her prognosis, both the physician and patient must conclude that "there is no reasonable alternative" to euthanasia.⁹⁰ According to the Dutch, whether there is a reasonable alternative to euthanasia depends on whether there is a favorable balance between benefits and burdens from the patient's perspective, "given the number of treatments the patient has already undergone," possible side effects of treatment, and "the patient's age and mental stamina."⁹¹ Patients may refuse treatment and their refusal "need not necessarily preclude granting a request for euthanasia."⁹²

C. Other Jurisdictions

In Belgium, a physician who performs euthanasia does not commit a criminal offense if the patient is legally competent and in a "medically futile condition of constant and unbearable physical or mental suffering" arising from a serious illness or accident.⁹³ In Belgium, as in the Netherlands, both physician-assisted dying and euthanasia are permitted.⁹⁴ Moreover, both countries permit

87. OR. HEALTH AUTH. PUB. HEALTH DIV., OREGON DEATH WITH DIGNITY ACT DATA SUMMARY 2016, at 10 (2017) [hereinafter ODDA DATA SUMMARY 2016] <http://www.oregon.gov/oha/PH/PROVIDERPARTNERRESOURCES/EVALUATIONRESEARCH/DEATHWITHDIGNITYACT/Documents/year19.pdf> (finding that 42% of patients who received lethal medications through the Oregon Death with Dignity Act reported the burden on family, friends and caregivers as an end of life concern); WASH. ST. DEP'T OF HEALTH, 2016 DEATH WITH DIGNITY ACT REPORT: EXECUTIVE SUMMARY 8 (2017), <https://www.doh.wa.gov/Portals/1/Documents/Pubs/422-109-DeathWithDignityAct2016.pdf> (51% of Washington Death with Dignity Act patients reported the burden on family, friends and caregivers as an end-of-life concern in 2016).

88. The Dutch Termination of Life on Request and Assisted Suicide Act, § 2(1)(b), *reprinted in* LEWY, *supra* note 55, app. I, at 162.

89. REGIONAL EUTHANASIA REVIEW COMMITTEES, *supra* note 70, at 14.

90. The Termination of Life Act § 2(1)(c)–(d).

91. REGIONAL EUTHANASIA REVIEW COMMITTEES, *supra* note 70, at 15.

92. *Id.* at 16.

93. The Belgian Act on Euthanasia of May 28, 2002, § 1, *reprinted in* LEWY, *supra* note 55, at 172–73.

94. Lieve Thienpont et al., *Euthanasia Requests, Procedures and Outcomes for 100 Belgian Patients Suffering from Psychiatric Disorders: A Retrospective, Descriptive Study*, 5 *BMJ OPEN* 1 (2015); LEWY, *supra* note 55, at 18.

ethanasia in cases of intolerable suffering arising either from a psychiatric condition or a medical ailment.⁹⁵

In Switzerland, euthanasia is prohibited.⁹⁶ However, assisted suicide is only punishable if assistance is rendered with “selfish motives”; for example, a pecuniary interest in the victim’s death.⁹⁷ In *Haas v. Switzerland*, the Swiss high court held that people with “incurable, permanent, severe psychological disorders” have a right to end their lives with assistance of a physician.⁹⁸ The *Haas* court distinguished between a person whose desire to die is a symptom of a treatable mental disorder and someone with a long-standing mental disorder who has made a rational or well-considered choice to end his or her life.⁹⁹ “It cannot be denied,” the court observed, “that an incurable, long-lasting, severe mental impairment . . . can create a suffering out of which a patient would find his [or] her life . . . not worth living anymore.”¹⁰⁰

In *Carter v. Canada*, the Canadian Supreme Court held that an absolute prohibition against physician-assisted death infringes the right to life, liberty, and security of the person—rights protected by the *Canadian Charter of Rights and Freedoms*.¹⁰¹ In a unanimous decision, the Court struck down portions of the Canadian Criminal Code insofar as they prohibit physician-assisted dying for a competent adult who “(1) clearly consents to the termination of life and (2) has a grievous and irremediable medical condition (including an illness, disease, or disability) that causes enduring suffering that is intolerable to the individual in the circumstances of his or her condition.”¹⁰² In doing so, *Carter* also opened a door to

95. Although Belgian and Dutch euthanasia laws are similar, there are some small procedural differences. In Belgium, a request for euthanasia must be “voluntary, well-considered[,] and repeated.” The Belgian Act on Euthanasia of May 28, 2002, § 3, reprinted in LEWY, *supra* note 55, at 172. In contrast to the Netherlands, Belgian law requires at least one month between the patient’s request and performing euthanasia. *Id.* at 174. Belgian law mandates a consultation from an independent physician who is required to examine the patients and confirm that he or she meets the criteria for euthanasia. *Id.* at 173. If the patient does not have a terminal illness, in contrast to the Netherlands, the patient’s treating physician must consult a second physician who can determine whether the patient meets the criteria for euthanasia. *Id.* at 174. For a comparison of Belgian and Dutch law see Tinne Smets et al., *The Medical Practice of Euthanasia in Belgium and the Netherlands: Legal Notification, Control and Evaluation Procedures*, 90 HEALTH POL’Y 181 (2009).

96. GRIFFITHS ET AL., EUTHANASIA AND LAW IN EUROPE 470 (2008).

97. *Id.*

98. Bundesgericht [Bger] [Federal Supreme Court of Switzerland] Nov. 3, 2006, 2A.48/2006.

99. Appel, *supra* note 26, at 21.

100. Derek Humphry, *Swiss Approve Assisted Suicide for the Mentally Ill*, ASSISTED-DYING BLOG (Feb. 1, 2007), <http://assisted-dying.org/blog/2007/02/01/swiss-approve-assisted-suicide-for-the-mentally-ill>.

101. *Carter v. Canada* (Att’y Gen.), [2015] 1 S.C.R. 331 (Can.).

102. *Id.* at 390, para. 127. Nor must a person accept medical treatment in order to demonstrate that his or her condition is “irremediable.” *Id.*

the possibility that a person with a mental disorder might also have a constitutional right to access physician-assisted death.¹⁰³

In *Canada (Attorney General) v. E.F.*, a 58-year-old woman from Alberta sought judicial approval for physician-assisted suicide based on a mental disorder.¹⁰⁴ The woman, known only as E.F., had been diagnosed with conversion disorder.¹⁰⁵ Conversion disorder is a psychiatric condition in which patients present with neurological symptoms (such as blindness, paralysis, and numbness) that cannot be explained by a medical diagnosis, but are almost always preceded by a psychological stressor.¹⁰⁶ E.F.'s application was granted and upheld by a unanimous Alberta Court of Appeal.¹⁰⁷ A few weeks later, E.F. died with the assistance of a physician.¹⁰⁸

Notwithstanding the appellate court decision in *Canada v. E.F.*, “and in contrast to what some commentators thought was the plain meaning of *Carter*,” in June 2016, the Canadian Parliament announced that the country’s new law would limit medical assistance-in-dying (“MAiD”) to adults with incurable illnesses.¹⁰⁹ In Canada, MAiD includes both administering a lethal substance to a patient directly upon his request (voluntary active euthanasia) and prescribing a lethal substance to a patient so that he may administer the substance himself (physician-assisted dying).¹¹⁰ In order to access MAiD, the patient must be: (i) eligible for government funded healthcare in Canada;¹¹¹ (ii) a mentally competent adult, 18 or older;¹¹² and (iii) have a “grievous and irremediable medical condition.”¹¹³ The statute defines the term *grievous and irremediable medical condition* as “an advanced state or irreversible decline”¹¹⁴ that causes “enduring physical or psychological suffering.”¹¹⁵ It must also be the case that the patient’s death is “reasonably foreseeable,”¹¹⁶ a provision interpreted by the government to mean that the person’s

103. Barbara Walker-Renshaw & Margot Finley, *Will the S.C.C.’s Decision on Physician-Assisted Death Apply to Persons Suffering from Severe Mental Illness?*, 36 HEALTH L. CAN. 74, 78 (2016).

104. 2016 ABCA 155 (Can.).

105. Paul S. Appelbaum, *Should Mental Disorders Be a Basis for Physician-Assisted Death?*, 68 PSYCHIATRIC SERVS. 315 (2017).

106. AM. PSYCHIATRIC ASS’N, DIAGNOSTIC AND STATISTICAL MANUAL OF MENTAL DISORDERS: DSM-IV-TR 492–93b (4th ed. text rev. 2000); *see also* AM. PSYCHIATRIC ASS’N, DIAGNOSTIC AND STATISTICAL MANUAL OF MENTAL DISORDERS: DSM-5, at 309–13 (5th ed. 2013).

107. *E.F.*, 2016 ABCA 155.

108. *Alberta Woman at Centre of Assisted-dying Debate Ends Her Life in Vancouver*, CBC NEWS (June 4, 2016), <http://www.cbc.ca/news/canada/calgary/alberta-woman-assisted-death-1.3616594>.

109. Appelbaum, *supra* note 105, at 316.

110. An Act to Amend the Criminal Code and to Make Related Amendments to Other Acts (medical assistance in dying), S.C. 2016, c. 3, 241.1(a)–(b) (Can.).

111. *Id.* at 241.2(1)(a).

112. *Id.* at 241.2(1)(b).

113. *Id.* at 241.2(1)(c).

114. *Id.* at 241.2(2)(b).

115. *Id.* at 241.2(2)(c).

116. *Id.* at 241.2(2)(d).

death is predicted to occur “in the not too distant future.”¹¹⁷ So construed, the statute appears to exclude people like E.F., who request physician-assisted death, owing only to a psychiatric condition, and in the absence of a somatic disease.

D. Empirical Evidence

The Netherlands and Belgium have a long history of euthanasia and physician-assisted suicide, however, only a few researchers have investigated access to physician-assisted dying among people with mental disorders. A 2016 study by Scott Kim and colleagues examined 66 case summaries of psychiatric euthanasia or physician-assisted suicide published by the Dutch Regional Euthanasia Review Committees between 2011 and 2014.¹¹⁸ Researchers found that although most patients had a depressive disorder (55%),¹¹⁹ the clinical profiles of euthanasia and assisted-suicide patients included personality disorders (52%),¹²⁰ anxiety and post-traumatic stress disorder (42%),¹²¹ psychotic disorders (8%),¹²² eating disorders (3%),¹²³ and cognitive impairment (3%).¹²⁴ Most patients had more than one diagnosis and many had extensive clinical histories.¹²⁵

Kim and colleagues also found that a large majority of psychiatric patients who received euthanasia or a physician-assisted death were women (76%).¹²⁶ “[T]he ratio of women to men was 2.3 to 1, which is the reverse of the suicide ratio of women to men in the Netherlands and almost identical to the ratio of women to men attempting suicide.”¹²⁷ The authors hypothesize that “the availability of [euthanasia or assisted suicide] renders the desire to die in women psychiatric patients more effective.”¹²⁸ Finally, in 18 of the 66 cases reviewed, euthanasia was performed by a physician who the patient had not met before; and in most of those cases, the procedure was performed by a physician who was “affiliated with the End-of-Life Clinic, a mobile euthanasia practice.”¹²⁹

A retrospective study by Lieve Thienpont of 100 Belgian psychiatric patients who requested euthanasia paints a similar clinical picture.¹³⁰ In Belgium the term *euthanasia* includes both intravenous administration of a lethal drug, as well

117. *Medical Assistance in Dying, Glossary*, DEP’T OF JUSTICE, GOV’T OF CAN., <http://www.justice.gc.ca/eng/cj-jp/ad-am/glos.html> (last visited Feb. 15, 2017); see also Jocelyn Downie & Justine Dembo, *Medical Assistance in Dying and Mental Illness Under the New Canadian Law*, J. ETHICS MENTAL HEALTH 1, 2 (2016).

118. Scott Kim et al., *Euthanasia and Assisted Suicide of Patients with Psychiatric Disorders in the Netherlands 2011 to 2014*, 73 JAMA 362 (2016).

119. *Id.* at 364.

120. *Id.*

121. *Id.*

122. *Id.* at 365.

123. *Id.*

124. *Id.*

125. *Id.* at 364.

126. *Id.*

127. *Id.* at 366.

128. *Id.*

129. *Id.* at 365.

130. See Thienpont et al., *supra* note 94, at 1–3.

as oral administration of a lethal drug by the patient.¹³¹ As in the Netherlands, the most common diagnoses among Belgian psychiatric patients who requested euthanasia due to mental suffering were depression (58%) and personality disorder (50%).¹³² And, as in the Netherlands, women were overrepresented among psychiatric patients who requested euthanasia, as well as the subgroup of patients who actually received euthanasia.¹³³ In the Belgian study, 77 women and 23 men requested euthanasia, and 26 women and 9 men received euthanasia.¹³⁴

II. THE ETHICS OF PHYSICIAN-ASSISTED DYING

In the United States, supporters of physician-assisted dying have championed it primarily as an option for competent adults with terminal illnesses; however, the primary moral arguments in favor of physician-assisted dying extend beyond people with terminal illnesses to people with non-terminal illnesses and people with mental disorders.

A. Three Moral Arguments in Favor of Physician-Assisted Dying

1. Autonomy

The moral arguments in favor of legalizing physician-assisted dying for people with terminal illnesses are familiar. The first is an argument from autonomy. The autonomy argument holds that competent adults should have the right to make important decisions about their own lives, according to their own values. In *The Philosophers' Brief*,¹³⁵ six eminent moral and political philosophers led by Ronald Dworkin urged the Supreme Court to uphold the circuit court decisions in *Glucksberg* and *Quill*, largely on the ground that “the Constitution protects a sphere of autonomy in which individuals must be permitted to make certain decisions for themselves.”¹³⁶ Echoing the Ninth Circuit, the philosophers reasoned that the right to choose the time and manner of one’s death is part of the right to make intimate decisions, a right recognized by the Supreme Court in *Planned Parenthood v. Casey* and protected by the Due Process Clause.¹³⁷ A blanket prohibition on physician-assisted dying, no less than a total prohibition of abortion, would impose one answer to profound questions about the mystery of human life on all individuals.¹³⁸ “In a free society, individuals must be allowed to make those decisions for themselves.”¹³⁹

An essential element of the liberal case for physician-assisted dying is the belief that, within limits, states should remain neutral between competing conceptions of a good life. “Different people, of different religious and ethical beliefs, embrace very different convictions about which way of dying confirms or

131. *Id.* at 1.

132. *Id.* at 6.

133. *Id.* at 4–5.

134. *Id.*

135. Brief for Ronald Dworkin et al., *supra* note 22.

136. *Id.* at 8.

137. *Id.* at 8–9.

138. *Id.* at 6–7.

139. *Id.* at 5.

contradicts the value of their lives.”¹⁴⁰ When faced with imminent death, “[s]ome fight against death with every weapon their doctors can devise,” while “[o]thers will do nothing to hasten death even if they pray it will come soon.”¹⁴¹ Others, including the patient–plaintiffs in *Glucksberg* and *Quill*, want to end their lives when they believe that continuing would “disfigure rather than enhance the lives they [have] created.”¹⁴² According to *The Philosophers’ Brief*, none of these different attitudes about death and dying should be imposed “by the fiat of government, on people who reject it.”¹⁴³

2. *The Moral Equivalence Thesis*

A second argument in favor of legalizing physician-assisted dying relies on a moral equivalence thesis. Defenders of the moral equivalence thesis argue that the distinction between a killing and a letting die, itself, “has no moral importance.”¹⁴⁴ In a seminal paper, philosopher James Rachels defends the moral equivalence thesis by inviting us to consider a pair of contrasting cases.¹⁴⁵ In the first case, Smith, who will inherit a large fortune if anything happens to his six-year-old cousin, drowns his cousin in a bathtub and arranges the scene to look like an accident.¹⁴⁶ In the second case, Jones, who will also inherit a fortune if anything happens to his cousin, sneaks into the bathroom to drown the child, but to his delight, finds the child face down in the water. As Jones watches, the child drowns and Jones does nothing.¹⁴⁷ Smith killed his cousin, while Jones merely let him die. If, by itself, the distinction between a killing and a letting die were morally significant, we should conclude that Jones’s behavior was less morally reprehensible than Smith’s, yet Rachels suspects that few of us want to say that. After all, suppose Jones were to plead: “I didn’t do anything wrong. I just watched him drown. I didn’t kill him.” As Rachels writes, “if letting die were in itself less bad than killing, this defense should have at least some weight. But it does not.”¹⁴⁸

From this, Rachels and others draw two conclusions. The first is that a killing is no worse, per se, than a letting die.¹⁴⁹ The claim here is not that most *actual* killings are no worse than the typical letting die. “Obviously, if we compare an ordinary murder—say a man killing his wife out of jealousy—with the actions of a physician who humanely permits a suffering patient to die, the murder is much worse.”¹⁵⁰ Instead, Rachels argues that the difference between killing and letting die

140. *Id.* at 7.

141. *Id.*

142. *Id.*

143. *Id.*

144. Rachels, *supra* note 31, at 78.

145. *Id.* at 79.

146. *Id.*

147. *Id.*

148. *Id.*

149. *Id.*

150. James Rachels, *Killing and Letting Die*, in *ENCYCLOPEDIA OF ETHICS* 947, 948 (L.C. Becker & C.B. Becker eds., 2001). As Rachels notes, most killings involve other factors—the murderer’s motive and the absence of consent—which account for our different moral reactions to those cases, aside from one person causing the death of another. *Id.* at 948.

does not itself make a difference to the moral assessment of the actions.¹⁵¹ Building upon that argument, Rachels contends that if “killing is not in itself any worse than letting die,” then voluntary active euthanasia, in which a physician brings about a patient’s death through a lethal injection, is no worse than passive euthanasia, or simply letting the patient die.¹⁵²

Ronald Dworkin advances a similar argument. In *The Philosophers’ Brief*, Dworkin and colleagues alluded to *Cruzan*, where the Supreme Court was willing to assume for the sake of argument that the Constitution protects the right of a competent person to refuse life-sustaining hydration and nutrition.¹⁵³ If a doctor may terminate life-support when that is what the patient requests, then according to the amici, “a state may not prohibit doctors from deliberately using more direct and often more humane means to the same end when that is what a patient prefers.”¹⁵⁴

For opponents of physician-assisted dying, on the other hand, the distinction between killing and letting die is a meaningful one. In *Vacco v. Quill*, the U.S. Supreme Court held that the State of New York did not violate the Equal Protection Clause by permitting terminally ill patients to refuse life-sustaining medical treatment while prohibiting assisted dying¹⁵⁵ owing in large part to the common-sense distinction between actions and omissions.¹⁵⁶ According to a unanimous Court, the distinction between physician-assisted dying and withdrawing life-sustaining treatment was not only logical but certainly rational, and grounded in widely recognized principles of causation and intent.¹⁵⁷ “[W]hen a patient refuses life-sustaining medical treatment, he dies from an underlying fatal disease or pathology,” Chief Justice Rehnquist reasoned, but when “a patient ingests lethal medication prescribed by a physician, he is killed by that medication.”¹⁵⁸ In the same way, the Chief Justice asserted that when a physician withdraws medical treatment or provides palliative care, his purpose and intent are only to ease his patient’s pain, even though his actions may hasten his patient’s death.¹⁵⁹ By contrast, “[a] doctor who assists a suicide, however, must, necessarily and indubitably, intend that the patient be made dead.”¹⁶⁰

Still, an argument along these lines is not without its problems. When patients refuse life-sustaining medical treatment, the underlying illness is sometimes the cause of death; but, often, death results from dehydration, starvation, or an

151. *Id.*

152. Rachels, *supra* note 31, at 80.

153. Brief for Ronald Dworkin et al., *supra* note 22, at 10; *Cruzan ex rel. Cruzan v. Dir., Mo. Dep’t of Health*, 497 U.S. 261, 262, 279 (1990).

154. Brief for Ronald Dworkin et al., *supra* note 22, at 12. For a thoughtful criticism of this aspect of *The Philosopher’s Brief*, see generally Paul J. Weithman, *Of Assisted Suicide and “The Philosophers’ Brief,”* 109 ETHICS 548 (1999).

155. 521 U.S. 793, 797 (1997).

156. *Id.* at 800.

157. *Id.* at 801.

158. *Id.*

159. *Id.* at 802.

160. *Id.* at 803 (quotations omitted).

otherwise treatable complication.¹⁶¹ Nor is it plausible to claim that death is unintended when patients are sedated into a coma to relieve pain *and* artificial hydration and nutrition are withheld.¹⁶² The purpose of sedation at the end of life is to relieve the patient's suffering; however, "the additional step of withholding fluids is not needed to relieve pain," but is instead "typically taken to hasten the patient's wished-for death."¹⁶³ When physicians remove life-sustaining medical treatment, we sometimes describe the process as "letting nature take its course," however, physicians are often intimately involved in each step of the process—a process that, for physicians, can be the source of considerable anguish.¹⁶⁴

3. Beneficence

A third argument in favor of physician-assisted dying appeals to the principle of beneficence—the moral obligation of physicians to relieve the suffering of their patients and promote their well-being. As a palliative care physician, and the named defendant in *Vacco v. Quill*, Dr. Timothy Quill has spoken forthrightly about the value of palliative care for patients who are dying, as well as its limitations. According to Dr. Quill: "Palliative care, if applied with skill and expertise, can address most, but not all, end-of-life suffering."¹⁶⁵ Some patients experience "particularly vexing pain that does not respond to standard treatments" despite the best efforts of their clinicians.¹⁶⁶ For some patients, other symptoms including nausea, vomiting, weakness, breathlessness, and loss of bodily functions can be worse and harder to alleviate than physical pain.¹⁶⁷ Moreover, as bioethicist Marcia Angell writes: "The problem is not just pain."¹⁶⁸ Modern medicine has not devised a cure for the existential suffering and despair sometimes felt by patients who are dying.¹⁶⁹

Patients who are dying sometimes choose to hasten their deaths by refusing life-sustaining medical treatment, or through a process known as voluntarily stopping eating and drinking ("VSED"). However, for some patients, "either no life-sustaining treatment is available to be forgone or forgoing such treatment will result

161. Quill et al., *supra* note 33, at 2102.

162. *Id.* at 2101.

163. *Id.*

164. *Id.*; Miles J. Edwards & Susan Tolle, *Disconnecting a Ventilator at the Request of a Patient Who Knows He Will Then Die: The Doctor's Anguish*, 117 ANN. INTERN. MED. 254, 256 (1992) ("We each experienced a wave of disquieting emotion, feelings that we had killed this patient who would have otherwise continued to live connected to the ventilator. We knew intellectually that he had the legal and ethical right to refuse this medical treatment, but the gravity of his decision and our participation haunted us.").

165. Quill, *supra* note 29.

166. *Id.* at 58.

167. Angell, *supra* note 34, at 19; *see also* Baron et al., *supra* note 20, at 11 ("[W]e realized that whether one's suffering is sufficiently unbearable to make death preferable to continued life is an inherently subjective determination on which people differ, and for which no standard should be imposed on everyone.").

168. Angell, *supra* note 34, at 15.

169. *Id.* at 15, 19.

in a prolonged, unbearable, and inhumane dying process.”¹⁷⁰ VSED can take one to three weeks to result in death, depending on the patient’s clinical condition, or longer if the patient continues to consume fluids in small amounts.¹⁷¹ For such patients, proponents argue that “more active means of hasten death are necessary,” and are supported by the very same values that underpin all healthcare decision-making; namely, the importance of promoting the patient’s well-being and respecting their right to self-determination.¹⁷²

The literature on physician-assisted dying is filled with stories of patients who took their own lives when they felt they had been abandoned by the medical profession.¹⁷³ To that end, Dr. Quill contends that physicians have a moral obligation to see their patients (and the families of their patients) all the way through the dying process. “The principle of nonabandonment represents a continuous caring partnership between physician and patient. This relationship may begin in health or in sickness, may last through a potential recovery or adjustment . . . and often continues until the patient dies.”¹⁷⁴ Importantly, however, non-abandonment involves an open-ended commitment to problem-solving between doctor and patient over time.¹⁷⁵ Physicians are independent moral agents in Dr. Quill’s view, to be sure,¹⁷⁶ but by maintaining an “artificial distinction” between killing and letting die, he argues that the medical profession has effectively “turn[ed] its back” on patients and caregivers “in order to keep its intentions pure.”¹⁷⁷

B. Soft Paternalism

Scholars who support physician-assisted dying argue that competent adults should have the right to make important decisions about their own lives.¹⁷⁸

170. Baron et al., *supra* note 20, at 5.

171. Quill et al., *supra* note 33, at 2099–2100.

172. Baron et al., *supra* note 20, at 4–5.

173. See, e.g., DEREK HUMPHRY, FINAL EXIT: THE PRACTICALITIES OF SELF-DELIVERANCE AND ASSISTED SUICIDE FOR THE DYING (1991) (describing various suicide methods); see also Laurence H. Tribe, Brief of Respondents at 4–5, *Washington v. Glucksberg*, 521 U.S. 702 (1997) (No. 96–110) (noting that each of the physician–plaintiffs “feels a professional responsibility” to honor the request of competent, terminally ill patients to hasten their impending death; yet they have refrained from doing so to avoid criminal prosecution. “As a result, the physicians have witnessed their patients suffer terrible ordeals,” including a patient who “suffocated herself by securing a plastic bag over her head.” Another patient “enlisted one of his family members to help him climb over a bridge railing to jump to his death.”).

174. Timothy E. Quill & Christine K. Cassel, *Nonabandonment: A Central Obligation for Physicians*, in *PHYSICIAN-ASSISTED DYING: THE CASE FOR PALLIATIVE CARE & PATIENT CHOICE*, *supra* note 34, at 24.

175. *Id.*

176. *Id.* at 35.

177. TIMOTHY E. QUILL, DEATH AND DIGNITY: MAKING CHOICES AND TAKING CHARGE 108 (1993).

178. See, e.g., DWORKIN, *supra* note 21; GERALD DWORKIN ET AL., EUTHANASIA AND PHYSICIAN-ASSISTED SUICIDE (FOR AND AGAINST) 3 (1998); Thomas Preston et al., *The Role of Autonomy in Choosing Physician Aid in Dying*, in *PHYSICIAN-ASSISTED DYING: THE CASE FOR PALLIATIVE CARE AND PATIENT CHOICE*, *supra* note 34, at 39.

Nonetheless, they acknowledge that states have legitimate interests in preventing citizens from acting upon rash, unstable, uninformed, or coerced decisions to hasten their deaths. Dworkin writes:

[*The Philosophers' Brief*] recognizes that people may make such momentous decisions impulsively or out of emotional depression, when their act does not reflect their *enduring convictions*; and it therefore allows that in some circumstances a state has the constitutional power to override that right in order to protect citizens from mistaken but irrevocable acts of self-destruction.¹⁷⁹

The position taken by Dworkin and colleagues is a form of soft paternalism. Soft paternalism holds that government interventions into self-regarding harm are justified when—and only when—intervention is necessary to determine whether the person concerned is acting voluntarily.¹⁸⁰ John Stuart Mill offers a classic example: suppose you are hiking through the woods when you see a man approaching a bridge. If you know the bridge to be unsafe, and you are unable to communicate with him, then according to Mill, you may “seize him and turn him back without any real infringement of his liberty; for liberty consists in doing what one desires” and you may presume that “he does not desire to fall into the river.”¹⁸¹ If, however, you inform him of the risk, and he chooses to proceed anyway, you must let him cross, for as Mill writes, the possibility that he might harm himself supplies good reason for “remonstrating with him,” but not for “compelling him or visiting him with any evil in case he does otherwise.”¹⁸² In the same way, assisted-dying advocates argue that while states may regulate physician-assisted dying, they may not prevent competent, terminally ill adults from demonstrating “through whatever reasonable procedures the state might institute—even procedures that err on the side of caution—that their decision to die is indeed informed, stable and fully free.”¹⁸³

How far does this principle extend? At age 59, Craig Ewert was diagnosed with amyotrophic lateral sclerosis—commonly known as ALS or Lou Gehrig’s disease.¹⁸⁴ ALS is a progressive neurodegenerative disease that destroys the nerves in the brain and the spinal cord.¹⁸⁵ ALS begins with muscle weakness; as the disease

179. Ronald Dworkin et al., *Assisted Suicide: The Philosophers' Brief*, N.Y. REV. BOOKS (Mar. 27, 1997) (emphasis added), <http://www.nybooks.com/articles/1997/03/27/assisted-suicide-the-philosophers-brief/>.

180. JOEL FEINBERG, HARM TO SELF: THE MORAL LIMITS OF THE CRIMINAL LAW 12 (1986).

181. JOHN STUART MILL, ON LIBERTY 95 (Elizabeth Rapoport ed., Hackett 1978) (1859).

182. *Id.* at 9.

183. Brief for Ronald Dworkin et al., *supra* note 22, at 3.

184. *The Suicide Tourist*, PBS: FRONTLINE (Mar. 2, 2010), <http://www.pbs.org/wgbh/pages/frontline/suicidetourist/etc/script.html> (television broadcast transcript).

185. Nat’l Inst. of Neurological Disorders and Stroke, *Amyotrophic Lateral Sclerosis (ALS) Fact Sheet*, NAT’L INST. OF HEALTH (Jan. 8, 2018), <https://www.ninds.nih.gov/Disorders/Patient-Caregiver-Education/Fact-Sheets/Amyotrophic-Lateral-Sclerosis-ALS-Fact-Sheet>.

progresses, patients lose their ability to speak, move, and eventually breathe.¹⁸⁶ ALS is fatal and there is no cure. In 2006, Ewert traveled to Switzerland to end his life.¹⁸⁷ “If I go through with it, I die, as I must at some point,” Ewert said.¹⁸⁸ “If I don’t go through with it, my choice is essentially to suffer and to inflict suffering on my family, and then die, possibly in a way that is considerably more stressful and painful than this way. I’ve got death. I’ve got suffering and death.”¹⁸⁹ As between death and prolonged suffering on the one hand, and death on the other, Ewert chose death.¹⁹⁰ A growing number of scholars have argued that the moral arguments in favor of physician-assisted dying apply with equal (if not greater) force to someone like Craig Ewert, who faces not months but years of suffering.¹⁹¹

Others would permit some forms of medical aid-in-dying for people who are in the early stages of dementia or Alzheimer’s disease.¹⁹² Alzheimer’s disease is a progressive disease of the brain that slowly erodes the ability to form new memories and carry out simple tasks.¹⁹³ In the early stages of Alzheimer’s disease, patients experience mild memory loss and confusion.¹⁹⁴ Patients with moderate Alzheimer’s disease have trouble dressing, bathing, and toileting. In late stage Alzheimer’s, “the brain is no longer able to tell the body what to do.”¹⁹⁵ Patients lose the ability to speak, walk, sit, and swallow.¹⁹⁶ When doctors told 65-year-old Sandy Bem that Alzheimer’s disease would eventually “steal her ability to read, write and recognize people,” like Craig Ewert, Bem decided to end her life.¹⁹⁷ “I want to live only for as long as I continue to be myself,” she said.¹⁹⁸

According to Professor Norman Cantor, the case for preemptive suicide in cases of Alzheimer’s disease or similar forms of dementia rests primarily on the

186. *Id.*

187. *The Suicide Tourist*, *supra* note 184.

188. *Id.*

189. *Id.*

190. *Id.*

191. *See generally* Felicia Ackerman, *Assisted Suicide, Terminal Illness, Severe Disability, and the Double Standard*, in *PHYSICIAN ASSISTED SUICIDE: EXPANDING THE DEBATE* (Margaret P. Battin et al. eds., 1998); Baron et al., *supra* note 20, at 5 (advocating the legalization of physician-assisted suicide for patients with terminal illnesses or unbearable pain); Kleinberg & Mochizuki, *supra* note 19, at 216–24 (arguing that due process requires access to physician-assisted suicide for both terminally ill and non-terminally ill patients).

192. *See, e.g.*, DWORKIN, *supra* note 21.

193. Nat’l Inst. on Aging, *Alzheimer’s Disease: Fact Sheet*, NAT’L INST. OF HEALTH, NIH Publication No. 16-AG-6423 (2016), <https://www.nia.nih.gov/health/alzheimers-disease-fact-sheet>.

194. Menzel & Steinbock, *supra* note 21, at 486.

195. *Id.*

196. *Id.*

197. Alex Spiegel, *How A Woman’s Plan to Kill Herself Helped Her Family Grieve*, NPR (June 23, 2014), <http://www.npr.org/sections/health-shots/2014/06/23/323330486/how-a-womans-plan-to-kill-herself-helped-her-family-grieve>.

198. Robin Marantz Henig, *The Last Day of Her Life*, N.Y. TIMES (May 14, 2015), <https://www.nytimes.com/2015/05/17/magazine/the-last-day-of-her-life.html>.

“prospective indignity associated with mental decline,” rather than physical pain.¹⁹⁹ “My aversion,” Cantor writes, “is not based on prospective emotional distress and suffering,” but rather grounded “in my abhorrence of reduced mental functioning to a degree I deem intolerably demeaning.”²⁰⁰ As an academic, Cantor notes that both his “personal satisfaction and self-image have flowed largely” from his intellectual pursuits.²⁰¹ If Alzheimer’s disease left him unable to “understand and process information” with the acuity to which he has become accustomed, like so many others Cantor fears that Alzheimer’s disease would “soil” or “degrade” his memory in the minds of his survivors.²⁰² “My own preference, at least after a definitive diagnosis of Alzheimer’s is received, is never to reach the mentally debilitated stage at which I am no longer in charge of my fate. Rather,” he writes, “I plan to engineer my self-deliverance . . . while I am still competent to do so.”²⁰³ To that end, Cantor argues that people with Alzheimer’s disease should have the right to determine the time and manner of their deaths, either preemptively or through an advance directive.²⁰⁴

Still, scholars who support physician-assisted dying for people with terminal and non-terminal illnesses have stopped short of supporting assisted dying for people with mental disorders. Professors Charles Baron and Dan Brock have said that because their proposed model statute to legalize physician-assisted dying “requires competency, the subjective preference for death of a clinically depressed or mentally ill patient would be insufficient to qualify that patient for assisted suicide.”²⁰⁵ Elsewhere, Professor Brock has argued in favor of legalizing not only physician-assisted dying, but voluntary active euthanasia for people with terminal or non-terminal illnesses who are too weak to administer lethal medication on their own.²⁰⁶ Brock bases the case for physician-assisted dying and voluntary active euthanasia on individual interest in autonomy or self-determination.²⁰⁷ Still, he hastens to add, “[t]he value of exercising self-determination presupposes some minimum of decision-making capacities or competence, which thus limits the scope of euthanasia supported by self-determination; it cannot justifiably be administered, for example, in cases of dementia or treatable clinical depression.”²⁰⁸

Objections based on the presumption that people with mental disorders are incompetent to decide to hasten their deaths are based on outmoded beliefs about the relationship between mental disorder and competence. As I will demonstrate in

199. Norman L. Cantor, *My Plan to Avoid the Ravages of Extreme Dementia*, HARVARD LAW BLOG: BILL OF HEALTH (Apr. 16, 2015), <http://blogs.harvard.edu/billofhealth/2015/04/16/my-plan-to-avoid-the-ravages-of-extreme-dementia/>.

200. *Id.*

201. *Id.*

202. *Id.*

203. *Id.*

204. *Id.*

205. Baron et al., *supra* note 20, at 11.

206. Dan W. Brock, *Voluntary Active Euthanasia*, 22 HASTINGS CTR. REP. 10, 11 (1992).

207. *Id.*

208. *Id.* at 11.

Part III, a large empirical literature has shown that mental disorders are not synonymous with incompetence.

III. DEATH WITH DIGNITY AND MENTAL DISORDER

Consider the following case from the Netherlands, involving “Alice,” a woman in her 70s, whose request for euthanasia was granted after 30 years of unsuccessful treatment for recurrent episodes of depression:

Over the years, [Alice] usually received outpatient care. She had also been admitted to hospital a number of times for extensive, including pharmacologic, treatment, but with very limited effect. None of the treatments cured her depressive episodes completely or for a long period of time. The patient rejected new treatments, such as electroconvulsive therapy (ECT). She did not want to be admitted to a psychiatric ward again due to previous traumatic experiences

She had tried to end her life several times, the most recent attempt being a month before she died Two weeks before her death, she had stopped eating and drinking in order to hasten death. On her physician’s advice she had resumed eating and drinking in order to be clear-headed for her talk with her psychiatrist.

The patient’s suffering was primarily mental, and was caused by chronic depression. She also suffered from reduced concentration, so that she could no longer enjoy books and music Her declining physical condition was characterised by limited mobility, severe fatigue, listlessness, lack of appetite, painful joints in her hands and loss of independence. She still had close ties with her family, but she could not and did not wish to live any more.²⁰⁹

Pulitzer Prize winning author William Styron has described the melancholy clinical depression as “despair beyond despair,”²¹⁰ a nearly overwhelming feeling akin to “drowning or suffocation.”²¹¹ Unlike normal sadness, clinical depression involves a variety of changes in thinking and behavior.²¹² People who are depressed often experience cognitive symptoms such as feelings of extreme guilt or worthlessness, rumination, and problems concentrating. Depressed patients often report that their

209. REGIONAL EUTHANASIA REVIEW COMMITTEES, ANNUAL REPORT 2012, at 19 (2013).

210. WILLIAM STYRON, DARKNESS VISIBLE 63 (1992).

211. *Id.* at 17.

212. According to the DSM-5, a diagnosis of clinical depression requires evidence of the following: (1) a depressed mood for most of the day—nearly every day; or (2) markedly diminished interest or pleasure in almost all activities nearly every day for at least two weeks; and five or more of the following symptoms: (3) significant weight loss or weight gain; (4) insomnia or hypersomnia nearly every day (5) restlessness or feeling slowed down; (6) feelings of worthlessness or excessive or inappropriate guilt (which may be delusional) nearly every day; (7) impaired concentration or decisiveness nearly every day; and (8) recurrent thoughts of suicide. AM. PSYCHIATRIC ASS’N, DIAGNOSTIC AND STATISTICAL MANUAL OF MENTAL DISORDERS DSM-5, at 160–61 (5th ed. 2013).

thinking seems slower or “fuzzier” than it was before the onset of depression.²¹³ Others report a marked loss of interest in various activities that were once a source of pleasure.²¹⁴ Various somatic complaints can also accompany clinical depression. Like Alice, depressed patients sometimes complain of headaches, trouble sleeping, and changes in appetite.²¹⁵

More often than not, depression can be treated; however, studies suggest that up to one-third of people with depression do not respond to treatment.²¹⁶ Definitions of treatment-resistant depression (“TRD”) vary, but clinicians generally define TRD as major depression that does not respond to appropriate doses of at least two anti-depressant medications.²¹⁷

When a person who has been diagnosed with depression requests the assistance of a physician to hasten her death, quite naturally, we will wonder whether her request reflects her enduring convictions or a symptom of untreated mental illness. However, as fair-minded soft paternalists, our only concern should be whether the person is competent to consent to physician-assisted suicide.

A. Competence

1. What Is Competence?

Although the legal standards for assessing competence to make a treatment decision vary across jurisdictions, most courts define *competence* as a combination of some or all of the following four abilities: (i) the ability to *understand*; (ii) the ability to *appreciate* the significance of medical information; (iii) the ability to *reason*; and (iv) the ability to *communicate* a choice.²¹⁸ The first element of

213. *Depression, Bipolar Disorder Can Lead to ‘Fuzzy Thinking,’* PSYCHIATRYADVISOR (May 5, 2015), <http://www.psychiatryadvisor.com/mood-disorders/depression-bipolar-disorder-can-lead-to-fuzzy-thinking/article/412914/>. See generally Kelly A. Ryan, *Shared Dimensions of Performance and Activation Dysfunction in Cognitive Control in Females with Mood Disorders*, 138 BRAIN 1424 (2015).

214. See generally Philip Gorwood, *Neurobiological Mechanisms of Anhedonia*, 10 DIALOGUES CLINICAL NEUROSCIENCE 291 (2008).

215. Madhukar H. Trivedi, *The Link Between Depression and Physical Symptoms*, 6 PRIMARY CARE COMPANION J. CLINICAL PSYCHIATRY (Supp. 1) 12, 12, 15 (2004), <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC486942>.

216. Khalid Saad Al-Harbi, *Treatment-Resistant Depression: Therapeutic Trends, Challenges, and Future Directions*, 6 PATIENT PREFERENCE ADHERENCE 369, 369–70 (2012), <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3363299/pdf/ppa-6-369.pdf>.

217. *Id.* at 370.

218. THOMAS GRISSO & PAUL S. APPELBAUM, *ASSESSING COMPETENCE TO CONSENT TO TREATMENT* 31 (1998). This model, known as the four-abilities model, has been enormously influential, in large part because it was based on an exhaustive review of the law of informed consent, the scholarly literature on decisional capacity, commission reports, and the standards that are commonly used by courts to determine whether patients are competent to make treatment decisions. Because there has been more empirical research on the four-abilities model than any other, “the model allows a more evidence-based approach to competency assessment than do other models.” SCOTT Y.H. KIM, *EVALUATION OF CAPACITY TO CONSENT TO TREATMENT AND RESEARCH* 20 (2010). For more on the development of the four-abilities model, see generally Jessica Wilen Berg, Paul S. Appelbaum & Thomas Grisso,

competence is the ability to *understand* or comprehend information bearing on the treatment decision. The relevant body of information often includes the patient's diagnosis and prognosis, the nature of the treatment plan, the risks and benefits of treatment, and any alternatives to treatment, along with their associated risks and benefits.

Patients must also *appreciate* the meaning of the information that has been disclosed to them. Whether and to what extent a person must appreciate the significance of the medical facts that have been disclosed to him in order to qualify as competent is a hotly contested question.²¹⁹ As a general matter, appreciation concerns both the patient's ability to "form accurate beliefs" about the facts that have been disclosed to him, as well as the patient's ability to apply those facts to the treatment decision at hand.²²⁰ As I will explain in greater detail below, as a clinical construct, a failure of appreciation might capture our intuition that a person who is clinically depressed and seeks assisted suicide is not competent to make that treatment decision.

Third, competence also requires the ability to *reason* or manipulate information rationally. "This standard emphasizes patients' abilities to employ logical process" when comparing the risks and benefits of treatment options.²²¹ What is required here is not perfect rationality, but rather at least a basic ability "to reach conclusions that are logically consistent with starting premises."²²² Doing so will require an ability to weigh the risks and benefits of treatment against one's values, as well as at least a basic understanding of probabilities. For example, a person who is competent to make a treatment decision should understand what it would mean for an outcome to be more likely than not.²²³ Importantly, however, the ability to reason is distinct from the reasonableness of the patient's decision.²²⁴ Courts and scholars generally agree that an assessment of competence should focus

Constructing Competence: Formulating Standards of Legal Competence to Make Medical Decisions, 48 RUTGERS L. REV. 345 (1995). For a concise summary of other approaches to assessing decisional capacity, see Samantha Weyrauch, *Decision Making for Incompetent Patients: Who Decides and by What Standards*, 35 TULSA L.J. 765, 772–81 (2000).

219. See, e.g., Candice T. Player, *Involuntary Outpatient Commitment: The Limits of Prevention*, 26 STAN. L. & POL'Y REV. 159, 221–25 (2015); ELYN SAKS, REFUSING CARE: FORCED TREATMENT AND THE RIGHTS OF THE MENTALLY ILL 182–85 (2002). See generally Christopher Slobogin, "Appreciation" As a Measure of Competence: Some Thoughts About the MacArthur Group's Approach, 2 PSYCH. PUB. POL. & L. 18 (1996).

220. KIM, *supra* note 218, at 22.

221. Paul S. Appelbaum & Thomas Grisso, *The MacArthur Treatment Competence Study. I: Mental Illness and Competence to Consent to Treatment*, 19 LAW & HUM. BEHAV. 105, 110 (1995).

222. Paul S. Appelbaum & Thomas Grisso, *Assessing Patients' Capacities to Consent to Treatment*, 319 NEW ENG. J. MED. 1635, 1636 (1988).

223. *Id.*

224. KIM, *supra* note 218, at 24.

on the quality of the reasoning process rather than the reasonableness of the outcome.²²⁵

Fourth and finally, competence requires the ability to *communicate* a choice. A person can communicate a treatment decision, even though she is unable to do so verbally, by indicating her choice in writing or through a surrogate. Problems can arise, however, when patients are too ambivalent to make a choice or assign the task to a surrogate.²²⁶ Therefore, the ability to communicate generally requires the patient to make a stable choice.

2. Empirical Evidence

In the landmark MacArthur Treatment Competence Study, Paul Appelbaum and Thomas Grisso assessed the ability of medically ill and mentally ill patients to make treatment decisions across all four dimensions of competence.²²⁷ Patients who had been recently admitted to a hospital and diagnosed with schizophrenia, depression, or heart disease were compared to a control group of non-ill people from the community.

The MacArthur study produced several important findings. First, patients who had been hospitalized due to a mental illness manifested more deficits in performance on measures of understanding, appreciation, and reasoning than medically ill patients and non-ill patients in the comparison groups.²²⁸ Second, although the lower scores of mentally ill patients were generally attributable to patients with schizophrenia,²²⁹ most patients with schizophrenia did not score below patients who had been diagnosed with heart disease or the non-medically ill control group.²³⁰ Instead, the generally poorer performance of people with schizophrenia was attributed to a minority of patients within the group whose symptoms were most severe.²³¹

Third, researchers found that people who are severely depressed generally retained the capacity to make treatment decisions. The MacArthur study included 92 patients with mean Beck Depression Inventory scores of 30 (SD=11.4), indicating moderate to severe depression.²³² Yet only a few of them manifested

225. *Id.*; see, e.g., ALLEN E. BUCHANAN & DAN W. BROCK, DECIDING FOR OTHERS: THE ETHICS OF SURROGATE DECISION MAKING 50 (1990) (“An adequate standard of competence will focus primarily not on the content of the patient’s decision but on the *process* of the reasoning that leads up to that decision.”).

226. GRISSE & APPELBAUM, *supra* note 218, at 36.

227. Thomas Grisso & Paul Appelbaum, *The MacArthur Treatment Competence Study III: Measures of Abilities Related to Competence to Consent to Treatment*, 19 LAW & HUM. BEHAV. 149, 149–53 (1995) [hereinafter *MacArthur III*].

228. *Id.* at 169.

229. Berg, Appelbaum & Grisso, *supra* note 218, at 372.

230. *Id.* at 373 (explaining the difference between *impaired* and *adequate* performance. Most patients with schizophrenia scored in the unimpaired range on each measure of competence—“72% on understanding, 77.4% on appreciation, and 76% on reasoning”).

231. *MacArthur III*, *supra* note 227, at 169.

232. *Id.* at 159.

significant impairments on any measure of competence. Only 5.4% of depressed patients scored in the impaired range on understanding; 7.6% showed impaired reasoning; and 11.9% scored in the impaired range on appreciation.²³³ Nor was there any evidence that patients with more severe depression performed more poorly than patients with less severe depression.²³⁴ In short, as the authors remark, “[m]ost hospitalized patients with serious mental illness have abilities similar to persons without mental illness for making treatment decisions.”²³⁵

More recent research has confirmed the central findings of the MacArthur study.²³⁶ For example, a 2003 study by Vollman and colleagues found that 53% of patients with schizophrenia lacked the capacity to make treatment decisions, compared to only 20% of patients who had been diagnosed with depression.²³⁷ A smaller number of studies have also investigated the decisional capacities of patients for whom electroconvulsive therapy (“ECT”) is clinically indicated. For example, a 2003 study of 40 patients with clinical depression who had been hospitalized and referred to ECT found that most patients retained the capacity to consent to ECT, despite their relatively high scores on the Hamilton Rating Scale for Depression.²³⁸ Using the MacArthur Competence Assessment Tool for Treatment (“MacCAT-T”), the same study recorded scores close to the maximum end of the scale on all four abilities related to competence and small improvements on the MacCAT-T when patients learned more about ECT.²³⁹

233. *Id.* at 158, 168 tbl.11.

234. *The MacArthur Treatment Competency Study: Executive Summary*, MACARTHUR RES. NETWORK ON MENTAL HEALTH & L. (May 2004), <http://www.macarthur.virginia.edu/treatment.html>.

235. *Id.* With respect to schizophrenia, Grisso & Appelbaum add, the results suggest that a diagnosis of schizophrenia should increase one’s attention to the possibility of deficiencies in abilities related to legal competence, but that the diagnosis itself is only moderately related to serious deficits in those abilities Such cases should be seen simply as “at greater risk” of incompetence Having identified a patient as “at risk,” additional assessment is needed [to determine the person’s actual abilities.]

MacArthur III, *supra* note 227, at 173.

236. See, e.g., David Okai et al., *Mental Capacity in Psychiatric Inpatients*, 191 BRIT. J. PSYCHIATRY 291, 291 (2007) (“Studies indicate incapacity is common (median 29%) but the majority of psychiatric in-patients are capable of making treatment decisions.”).

237. J. Vollman et al., *Competence of Mentally Ill Patients: A Comparative Empirical Study*, 33 PSYCHOL. MED. 1463, 1468 (2003).

238. Maria I. Lapid et al., *Decisional Capacity of Severely Depressed Patients Requiring Electroconvulsive Therapy*, 19 J. ECT 67, 70–71 (2003). The Hamilton Rating Scale for Depression is a 21-item questionnaire designed to indicate the severity of depression. Scores above 20 indicate severe depression. The mean scores of patients who participated in the study by Lapid was 30.35 (SD=7.17) (Range 21.0–47.0) among patients who were randomly assigned to the standard informed consent group and 31.30 (SD=8.71) (Range=14.0–42.0) among patients who were assigned to the experimental group. *Id.*

239. *Id.* at 71.

3. *The Dilemma of Appreciation*

Many studies have shown that most people with depression—even severe depression—retain the capacity to make treatment decisions. Nonetheless, critics argue that most tests of competence emphasize the cognitive dimensions of competence, paying scant attention, if any, to its affective dimensions.²⁴⁰ The problem, which Professors Harold Bursztajn and Thomas Gutheil astutely describe, is that “patients with major affective disorders can retain the cognitive capacity to *understand* the risks and benefits of a medication, yet fail to *appreciate* its benefits.”²⁴¹ In other words, one might worry that people who are severely depressed appear to be competent, using instruments like the MacCAT-T, because these instruments fail to capture something important about how depression impacts decisional capacity.

In their writing on competence, Thomas Grisso and Paul Appelbaum have said that appreciation involves two domains: “whether patients (1) acknowledge, or appreciate, that they are suffering from the disorder with which they have been diagnosed, and (2) acknowledge the consequences of the disorder and of potential treatment options for their own situation.”²⁴² Courts have sometimes held that patients were incompetent to make a treatment decision owing to a failure of appreciation, notwithstanding the patient’s ability to evince an adequate understanding of his diagnosis. In *Department of Human Services v. Northern*, for example, the Tennessee Court of Appeals held that an elderly woman was not competent to make treatment decisions because she believed that her gangrenous feet had turned black owing to soot or dirt.²⁴³ The patient understood that amputation and death were likely consequences of gangrene, but she refused to acknowledge that her feet were indeed gangrenous, despite objective evidence to the contrary.²⁴⁴

All agree that refusing medical treatment should not invariably count as incompetence or a failure to appreciate. The difficulty lies in determining when non-

240. See C.P. Leeman, *Depression and the Right to Die*, 21 GEN. HOSP. PSYCHIATRY 112, 114 (1999) (“A competence standard which is based only on gauging the patient’s abstract understanding of clinical facts, by asking the patient to repeat in her own words what she has been told about a treatment’s benefits and risks, is not enough.”); Carl Elliot, *Caring About Risks: Are Severely Depressed Patients Competent to Consent to Research?*, 54 ARCHIVES GEN. PSYCHIATRY 113, 114 (1997). See generally Thomas Hindmarch et al., *Depression and Decision-making Capacity for Treatment or Research: A Systematic Review*, 14 BMC MED. ETHICS 54 (2013).

241. Harold Bursztajn et al., *Beyond Cognition: The Role of Disordered Affective States in Impairing Competence to Consent to Treatment*, 19 BULL. AM. ACAD. PSYCHIATRY & L. 383, 383 (1991).

242. GRISSO & APPELBAUM, *supra* note 218, at 42.

243. *Dep’t of Human Servs. v. Northern*, 563 S.W.2d 197 (Tenn. Ct. App. 1978). *But see* Lane v. Candura, 376 N.E.2d 1232, 1236 (Mass. App. Ct. 1978) (upholding the right of an elderly woman to refuse an amputation of her gangrenous leg). Mrs. Candura’s decision may be unfortunate, the court observed, but in contrast to *Dep’t of Human Servs. v. Northern*, “it is not the uninformed decision of a person incapable of appreciating the nature and consequences of her act.” *Id.* at 1236.

244. GRISSO & APPELBAUM, *supra* note 218, at 42.

acknowledgment of illness or the benefits of treatment should count as a failure to appreciate. Most authors agree that evaluating appreciation should focus on patients' reasons for denying that they are ill, or patients' reasons for disavowing the benefits of treatment and whether those reasons are "substantially irrational"²⁴⁵ or—to use a term coined by Professor Elyn Saks—"patently false."²⁴⁶

Consider Alice. According to the Dutch Regional Euthanasia Committee, after 30 years of treatment, Alice "regarded her suffering as unbearable."²⁴⁷ In contrast to the woman who refused an amputation owing to a delusional belief that her gangrenous toes were merely dirty, Alice's pessimistic appraisal of electroconvulsive therapy was rooted in her prior experience.²⁴⁸ Although Alice had been hospitalized many times and received outpatient care including medication, "[n]one of the treatments cured her depressive episodes completely or for a long period of time."²⁴⁹ Nor did Alice "want to be admitted to a psychiatric ward again due to previous traumatic experiences."²⁵⁰ Alice might have changed her medications, but according to the Euthanasia Review Committee Alice was "afraid that changing her medication would have a negative effect on her depression. In the past, certain substances had induced psychosis."²⁵¹ If we have reason to believe that electroconvulsive therapy might help Alice, we might want to reason with her, but Alice's reasons for refusing ECT are not "substantially irrational," nor are they based on a "considerable distortion of reality."²⁵²

Still, the outstanding question is this—even if we agree that Alice is competent to refuse electroconvulsive therapy, is she competent to consent to physician-assisted dying? Conventional wisdom holds that the threshold for determining whether a person is competent to make a treatment decision ought to vary with the gravity of the patient's decision.²⁵³ The riskier and more irrevocable the conduct, the higher the threshold for competence that should be required. Nonetheless, the danger of a sliding scale approach is that a person can go from being competent to incompetent simply because the content of her decision changes, even though there has been no change in her ability to perform the mental tasks that

245. KIM, *supra* note 218, at 89 (proposing that patients can fail the appreciation standard when their beliefs are "substantially irrational, unrealistic, or a considerable distortion of reality" and "due to a cognitive or psychiatric condition").

246. Elyn Saks, *Competency to Refuse Treatment*, 69 N.C. L. REV. 945, 947 (1991); Slobogin, *supra* note 219, at 22 (preferring the Saks approach to defining appreciation); *see also* GRISSO & APPELBAUM, *supra* note 218, at 117 (explaining that the purpose of the appreciation assessment is "to determine whether the patient has any delusional or bizarre beliefs about the potential value, or lack of potential value, of the treatment").

247. REGIONAL EUTHANASIA REVIEW COMMITTEES, *supra* note 209, at 19.

248. *Id.*

249. *Id.*

250. *Id.*

251. *Id.*

252. KIM, *supra* note 218, at 89.

253. *See, e.g.*, BUCHANAN & BROCK, *supra* note 225, at 51–57; Paul S. Appelbaum, *Assessment of Patients' Competence to Consent to Treatment*, 357 NEW ENG. J. MED. 1834, 1836–37 (2007). *But see* Charles M. Culver & Bernard Gert, *The Inadequacy of Incompetence*, 68 MILBANK Q. 619, 633–36 (1990).

are constitutive of competence. When a person expresses an interest in physician-assisted dying, there is a way to account for the irrevocable nature of her decision, but it is not by increasing the threshold for establishing competence. A prudent approach would be to incorporate “cooling off” periods of the kind found in the Oregon Death with Dignity Act.

B. The Moral Equivalence Thesis

For proponents of physician-assisted dying, the right to determine the time and manner of one’s death with the assistance of a physician flows primarily from the right of a competent adult to make important decisions about her own life according to her own values. A second argument challenges the distinction between killing and letting die. Proponents of physician-assisted dying argue that if a doctor may terminate life-support when that is what the patient requests, “a state may not prohibit doctors from deliberately using more direct and often more humane means to the same end when that is what the patient prefers.”²⁵⁴ However, the same argument can be extended to people with mental disorders who are competent to make medical decisions.

Courts have held that competent adults have the right to refuse life-sustaining medical treatment, even when the treatment is minimally invasive, and sometimes even when there is a credible suspicion that the person’s decision might be complicated by clinical depression. In *Bouvia v. Riverside Hospital*, the California Court of Appeals held that 26-year-old Elizabeth Bouvia had the right to refuse a feeding tube, even though she would die without it.²⁵⁵ According to the hospital, Bouvia was clinically depressed and complying with her request would be tantamount to assisting a suicide.²⁵⁶ However, in a landmark decision, the Court of Appeals asserted that even if Bouvia’s true intent was to commit suicide, her intent made no difference. “If a right exists, it matters not what ‘motivates’ its exercise. We find nothing in the law to suggest that the right to refuse medical treatment may be exercised only if the patient’s *motives* meet someone else’s approval.”²⁵⁷ It was “indisputable” that Bouvia was “mentally competent,” “quite intelligent,” and understood “the risks involved.”²⁵⁸

Suicidal patients with do-not-resuscitate orders present a similar dilemma. In 2007, 26-year-old Kerrie Wooltorton of Norwich, England, drank several glasses of antifreeze and called an ambulance.²⁵⁹ Wooltorton arrived at a hospital, clutching a letter in which she indicated that she understood the consequences of her actions—

254. Dworkin et al., *supra* note 179.

255. 179 Cal. App. 3d 1127, 1137 (1986).

256. *See id.* at 1144; Robert Steinbrook & Bernard Lo, *The Case of Elizabeth Bouvia: Starvation, Suicide or Problem Patient?*, 146 ARCHIVE INTERN. MED. 161, 161 (1986).

257. *Bouvia*, 179 Cal. App. 3d at 1145.

258. *Id.* at 1143.

259. Sascha Callaghan & Christopher James Ryan, *Refusing Medical Treatment After Attempted Suicide: Rethinking Capacity and Coercive Treatment in Light of the Kerrie Wooltorton Case*, 18 J.L. & MED. 811, 811 (2011).

“death in 95–99% of cases and if I survive then kidney failure.”²⁶⁰ She added, however, that she did not want life-sustaining treatment, only painkillers and oxygen to relieve her discomfort.²⁶¹ Because Wooltorton was conscious when she arrived at the hospital, doctors were able to make a contemporaneous determination of competence, in addition to reading her letter. The doctors concluded that Wooltorton was competent to refuse treatment.²⁶² The hospital complied with her request, and Wooltorton died in the hospital the next day.²⁶³ After an inquest into Wooltorton’s death, the coroner issued a verdict in favor of the hospital.²⁶⁴ According to the coroner, “[Woltorton] had the capacity to consent to treatment which, it is more likely than not, would have prevented her death. She refused such treatment in full knowledge of the consequences and died as a result.”²⁶⁵ Therefore, “it would have been ‘unlawful’ for the doctor overseeing her care to intervene.”²⁶⁶

Consider the implications of *Bouvia* and Wooltorton for Alice. Suppose the Dutch Euthanasia Review Committee had denied Alice’s request for euthanasia. One year later, Alice, still clinically depressed, arrives in the emergency room complaining of acute abdominal pain. Alice has appendicitis, but refuses an appendectomy. She understands her diagnosis, the risks of surgery, and the risks of refusing treatment, but refuses treatment nonetheless. Her reasons for refusing treatment betray neither patently false beliefs, nor considerable distortions of reality. If Alice is competent, then *Bouvia* and Wooltorton suggest that Alice has the right to refuse treatment, even though doing so will lead to her death. If James Rachels is correct, then, insofar as Alice has the right to refuse life-sustaining treatment, she also has the right to elect physician-assisted suicide.

C. Beneficence

A third argument commonly advanced in favor of physician-assisted dying is what I have called the argument from beneficence or compassion. When a person who is dying and experiencing intolerable pain, competently requests a medically assisted death, supporters of physician-assisted dying argue that the person’s “well-

260. *Id.*

261. *Id.*

262. See Sheila A.M. McLean, *Live and Let Die*, 339 BRIT. MED. J. 637 (2009).

263. Rebecca Dresser, *Suicide Attempts and Treatment Refusals*, 40 HASTINGS CTR. REP. 10, 10 (2010).

264. Tim Moore, *Mental Capacity Bill: Death of Kerrie Wooltorton*, NORTHERN IR. ASSEMBLY (Oct. 28, 2015), <http://www.niassembly.gov.uk/globalassets/documents/ad-hoc-mental-capacity-bill/research-papers-for-report/11.-raise-briefing-paper---death-of-kerrie-wooltorton-28.10.15.pdf>.

265. Adam Gabbatt, *Doctors Acted Legally in “Living Will” Suicide Case*, GUARDIAN (Oct. 1, 2009), <https://www.theguardian.com/society/2009/oct/01/living-will-suicide-legal>.

266. John Bingham et al., *Family of “Living-will” Girl to Sue Hospital*, TELEGRAPH (Oct. 2, 2009), <http://www.telegraph.co.uk/news/uknews/law-and-order/6252339/Family-of-living-will-girl-to-sue-hospital.html>.

being may be best promoted by affording him that assistance.”²⁶⁷ Yet even among people with serious medical ailments the pain that causes someone to seek physician-assisted dying might not be physical.²⁶⁸ As Professor Norman Cantor writes of Alzheimer’s disease, it is instead the “prospective indignity associated with mental decline,” rather than physical pain.²⁶⁹ Supporters of physician-assisted dying are committed to the proposition that whether one’s suffering is unbearable is “an inherently subjective determination on which people differ, and for which no objective standard should be imposed on everyone.”²⁷⁰ But, if suffering is indeed subjective, then the argument from beneficence or compassion must include people with mental disorders as well.

One might wonder why an able-bodied person with a mental illness requires the assistance of a physician to hasten her death. However, in this respect, people with mental illnesses and persons in the early stages of a terminal or non-terminal illness do not differ. As I mentioned earlier, the literature on physician-assisted dying is filled with heartrending stories of people who took their own lives when they felt abandoned by the medical profession. A common method of “self-deliverance,” as it is sometimes called, involves suffocation by securing a plastic bag over one’s head.²⁷¹ “Suicide bags” also known as “exit bags” or hoods, are commonly used in conjunction with helium tanks, to prevent the sense of suffocation as the person loses consciousness.²⁷² Others consume lethal doses of barbiturates²⁷³ and in doing so bring about death through respiratory depression.²⁷⁴ Supporters of physician-assisted dying do not champion legalization because people with terminal illnesses are unable to take their own lives. Clearly, they are. Rather, as Professor Lawrence Tribe writes, the current prohibition against physician-assisted dying forces competent adults to “endure painful and undignified deaths.”²⁷⁵ The same can be said for competent adults with mental disorders who resort to taking their own lives in painful and undignified ways.

D. Objections

The primary arguments against physician-assisted dying for psychiatric patients concern the possibility that such patients are not competent to consent to

267. Robert Young, *Voluntary Euthanasia*, in THE STANFORD ENCYCLOPEDIA OF PHILOSOPHY (Edward N. Zalta ed., 2017), <https://plato.stanford.edu/entries/euthanasia-voluntary/>.

268. *The Right to Die*, ECONOMIST (June 27, 2015), <https://www.economist.com/news/leaders/21656182-doctors-should-be-allowed-help-suffering-and-terminally-ill-die-when-they-choose>.

269. Cantor, *supra* note 199.

270. Baron et al., *supra* note 20, at 11.

271. HUMPHRY, *supra* note 173, at 123.

272. *Id.* at 169.

273. *Id.* at 114.

274. ROBERT G. CARROLL, PROBLEM-BASED PHYSIOLOGY 99–100 (2010).

275. Brief of Respondents at 7, *Washington v. Glucksberg*, 521 U.S. 702 (1997) (No. 96-110).

physician-assisted dying.²⁷⁶ However, others argue that physician-assisted dying ought to be limited to people with incurable medical conditions, in part because the desire to die is likely to be unstable, particularly among psychiatric patients.²⁷⁷ Others argue that allowing physician-assisted dying for psychiatric patients fails to appreciate the “therapeutic significance of hope.”²⁷⁸ I will address each of these arguments in turn.

1. *An Option of Last Resort*

A vocal contingent of bioethicists contend that if physician-assisted dying is morally permissible at all, it is only permissible for people with “incurable” medical conditions, ideally as a “last resort” when palliative care has failed.²⁷⁹ In their view, the uncertainty of a psychiatric patient’s prognosis is sufficient to distinguish physician-assisted dying in the setting of depression from patients with incurable illnesses like cancer or amyotrophic lateral sclerosis (“ALS”) for whom medical aid-in-dying is morally permissible.²⁸⁰

For some patients, however, clinical depression is an incurable condition. Over a seven-year period, the National Institute of Mental Health conducted the Sequenced Alternatives to Relieve Depression (“STAR*D”) trial to assess the effectiveness of anti-depressants in patients with non-psychotic major depressive disorder.²⁸¹ The study enrolled 4,041 patients, ages 18–75, from 41 clinical sites around the country.²⁸² The protocol included four different levels of treatment, each testing a different anti-depressant medication or combination of anti-depressant medications.²⁸³ The outcome of interest was whether patients achieved a remission from depression, where the term remission was defined as “becoming symptom-free.”²⁸⁴ Study participants who did not achieve a remission of depressive symptoms were encouraged to proceed to the next level of treatment.²⁸⁵ Researchers also noted whether participants experienced a response to treatment, which meant that their

276. See, e.g., Baron et al., *supra* note 20, at 11.

277. See Robert A. Schoevers et al., *Physician-Assisted Suicide in Psychiatry: Developments in the Netherlands*, 49 *PSYCHIATRIC SERVS.* 1475, 1477 (1998).

278. Bilkshavn et al., *supra* note 25, at 154.

279. See, e.g., Miller, *supra* note 25, at 885; see also Bilkshavn et al., *supra* note 25, at 154–55 (arguing that the possibility of hope distinguishes clinical depression from chronic somatic disease. “[I]n certain chronic somatic conditions the disease’s progress is relentless and inexorable and any hope in recovery might be futile; in chronic depression, on the other hand, recovery or at least some relief from emotional pain might be attainable.”); Schoevers et al., *supra* note 277, at 1475 (“The assessment of treatment prognosis in psychiatry is not accurate enough to allow a final decision about incurability.”).

280. Bilkshavn et al., *supra* note 25, at 153.

281. *Questions and Answers About the NIMH Sequenced Treatment Alternatives to Relieve Depression (STAR*D) Study—All Medication Levels*, NAT’L INST. OF MENTAL HEALTH, (Nov. 2006) [hereinafter NIMH], <https://www.nimh.nih.gov/funding/clinical-research/practical/stard/allmedicationlevels.shtml>.

282. *Id.*

283. *Id.*

284. *Id.*

285. *Id.*

symptoms decreased by at least half compared to where they were at the start of the trial.²⁸⁶

On average, it took six weeks for STAR*D patients to achieve a response to treatment, and almost seven weeks for participants to achieve a remission of depressive symptoms.²⁸⁷ Although roughly one-third of patients with major depressive disorder experienced a remission from depression within their first treatment, the likelihood of remission declined with each successive treatment failure—from 36.8%, to 30.6%, to 13.7%, and ultimately to 13%, as patients progressed through treatment levels 1 through 4.²⁸⁸ “An overall analysis of the STAR*D results indicates that patients with difficult-to-treat depression can get well after trying several treatment strategies,” but according to the National Institute of Mental Health, “the odds of beating the depression diminish with every additional treatment strategy needed.”²⁸⁹

Still, critics note that at least some treatment-resistant patients might benefit from treatment. For example, Matthew Broome and Anghard de Cates write: “[I]t cannot be assumed that those with TRD and hence the absence of remission, haven’t experienced marked symptomatic benefits and alleviation of their suffering from treatments: they may, for example, move from a severe depression to a mild episode in terms of severity and still be classified as TRD.”²⁹⁰

It is probably true that at least some patients who have been classified as TRD might benefit from anti-depressant medications. Even so, the possibility of a benefit does not distinguish patients with terminal illnesses, who might also benefit from palliative care. Supporters of physician-assisted dying believe that “physician-assisted suicide should be an option for dying patients when palliative care has failed” and that, “the judgment as to whether palliation has failed [can] only be made by each patient individually, since suffering is entirely subjective.”²⁹¹ If suffering is indeed subjective and a judgment as to whether palliative care has failed can only be made by each patient individually, then the possibility that an anti-depressant might afford someone like Alice a modest benefit should not prevent her from electing euthanasia or physician-assisted suicide.

Some people, like Craig Ewert and Sandy Bem, suffer from devastating illnesses for which there is no cure. However, a strict incurability requirement would exclude many patients with serious medical illnesses, for whom most supporters of physician-assisted suicide believe physician-assisted dying is morally permissible. In a moving article published by the *New England Journal of Medicine*, Dr. Timothy Quill offers a compelling account of his decision to prescribe a lethal dose of

286. *Id.*

287. *Id.*

288. J. Craig Nelson, *The STAR*D Study: A Four-Course Meal That Leaves Us Wanting More*, 163 AM. J. PSYCHIATRY 1864, 1864 (2006).

289. NIMH, *supra* note 281.

290. Matthew R. Broome & Angharad de Cates, *Choosing Death in Depression: A Commentary on ‘Treatment-Resistant Major Depressive Disorder and Assisted Dying,’* 41 J. MED. ETHICS 586, 587 (2015).

291. Angell, *supra* note 34, at 15.

barbiturates for “Diane,” his patient of many years, who had been diagnosed with acute myelomonocytic leukemia (“AML”).²⁹² AML is curable, but only if patients are willing to undergo a grueling course of chemotherapy, whole-body irradiation, a bone marrow transplant, possible infection, and months of hospitalization for a 25% chance at a cure.²⁹³ “[T]here was something about her giving up a 25 percent chance of a long-term survival in favor of almost certain death that disturbed me,” Quill writes.²⁹⁴ Yet, Quill supplied Diane with a prescription for barbiturates and informed her of “the amount needed to commit suicide” nonetheless.²⁹⁵ “Since patients have the unequivocal right to refuse medical treatment, even if that treatment might be life-saving,” Quill reasons, “we cannot punish those who do so by not offering them treatments intended to humanize their dying.”²⁹⁶ The same approach should apply to Alice. If the possibility that Diane might achieve a long-term cure did not stop Dr. Quill from assisting her, the possibility that Alice might benefit from electroconvulsive therapy, or another round of inpatient hospitalization, or another anti-depressant—treatments she adamantly refused—should not disqualify her from euthanasia.

The case for physician-assisted dying in the setting of psychiatry might be at its zenith in cases of treatment-resistant depression; however, it would be a mistake to suggest that physician-assisted dying should *only* be available to patients with treatment-resistant depression or patients whose psychiatric conditions are otherwise irremediable. Although generally supportive of physician-assisted suicide in psychiatry, William Rooney, Udo Schuklenk, and Suzanne van de Vathorst argue that a judgment as to whether the patient’s condition is irremediable is a necessary precondition for access to physician-assisted suicide. “In instances where treatment that is highly likely to be beneficial is being refused (for instances, in the case of a recent diagnosis, or other similar circumstances) physicians would be right to refuse a request for MAiD [i.e. medical assistance in dying].”²⁹⁷ But why should that be the case? Consider the Jehovah’s Witness who is injured in a car accident and refuses a life-sustaining blood transfusion. The law allows such a person to refuse even a highly effective medical treatment. If the moral equivalence thesis is correct—and the same values that underlie the right to refuse life-sustaining medical

292. Timothy E. Quill, *Death and Dignity: A Case of Individualized Decision Making*, 324 NEW ENG. J. MED. 691, 692–93 (1991).

293. *Id.* at 692.

294. *Id.*

295. *Id.* at 693.

296. QUILL, *supra* note 177, at 169.

297. William Rooney, Udo Schuklenk & Suzanne van de Vathorst, *Are Concerns About Irremediableness, Vulnerability, or Competence Sufficient to Justify Excluding All Psychiatric Patients from Medical Aid in Dying?*, HEALTH CARE ANALYSIS (2017); *see also* Catherine Shaffer et al., *A Conceptual Framework for Thinking about Physician-Assisted Death for Persons with a Mental Disorder*, 22 PSYCHOL. PUB. POL’Y & L. 141, 146 (2016) (“Nevertheless, restricted access to physician-assisted dying if the individual has refused psychiatric care may be required to ensure that persons with a mental disorder that has not been adequately treated do not prematurely receive assistance with death.”).

treatment support physician-assisted suicide—then whether an effective treatment is available should not change the way we think about these cases.

2. *Unstable Preferences*

The incurability argument is connected to a second argument against permitting physician-assisted dying for people with mental disorders; namely the concern that such people are likely to have unstable preferences. Studies suggest that as many as nine out of ten people who attempt suicide and survive do not die by suicide at a later date.²⁹⁸ Anecdotal data collected from people who have attempted suicide by jumping from the Golden Gate Bridge has shown that “[s]urvivors often regret their decision in midair.”²⁹⁹ The Oregon Death with Dignity Act includes a number of cooling-off periods and procedural safeguards designed to prevent patients from making a rash decision.³⁰⁰ Yet, it stands to reason that at least some patients who choose to proceed will regret it.

Suppose you and I are at a restaurant and you order Option A from the menu. Our waiter tells you that most people who choose Option A later regret it. Indeed, nine out of ten patrons who select Option A regret it. You insist on Option A nonetheless. Option A arrives and indeed, you regret it. What is the moral significance of your regret? Does the fact of your regret at *t2* vitiate your consent, or your competence to proceed, at *t1*? Probably not. Reasonable minds will disagree over the length of time required for a cooling-off period, but if a competent person “reflects on the issue for an extended period [of time] and does not waiver in her conviction” surely her wish to die “must be counted as enduring.”³⁰¹

One might think that an important distinction between ordering an item from a menu and selecting physician-assisted dying is the irrevocable nature of the decision. However, the way to respond to that concern is to increase the threshold for establishing competence, not to ban such choices altogether.

3. *The Loss of Hope*

A third argument against physician-assisted dying in psychiatry concerns the “therapeutic significance of hope.”³⁰² According to Thomas Bilkshavn and colleagues, “[o]ne of the main tasks of the therapist is not to accept the person’s distorted thoughts and their wish to die but instead to keep hope when the patient

298. See, e.g., David Owens et al., *Fatal and Non-fatal Repetition of Self-harm*, 181 BRIT. J. PSYCHIATRY 193, 195 (2002) (finding that approximately 7% of people who attempt suicide eventually take their own lives after 9 years, range 5%–11%).

299. Tad Friend, *Jumpers: The Fatal Grandeur of the Golden Gate Bridge*, NEW YORKER (Oct. 13, 2003), <https://www.newyorker.com/magazine/2003/10/13/jumpers>.

300. OR. REV. STAT. § 127.850 § 3.08 (2017); OR. REV. STAT. § 127.845 § 3.07 (2017).

301. Young, *supra* note 267.

302. Bilkshavn et al., *supra* note 25, at 154; see also David Kissan & David Kelly, *Demoralisation, Depression and Desire for Death: Problems with the Dutch Guidelines for Euthanasia of the Mentally Ill*, AUSTRALIAN & N.Z. J. PSYCHIATRY 325, 329 (2000); Robert D. Orr & Leigh Bishop, *Why Psychiatrists Should Not Participate in Euthanasia and Physician-Assisted Suicide*, 19 AM. J. PSYCHIATRY 35, 44 (1998).

has lost it.”³⁰³ “Allying with the patient’s death wish,” the authors argue, “would render the therapeutic relation powerless or even destructive in reinforcing the patient’s lack of hope.”³⁰⁴ Certainly, however, as Bilkshavn and colleagues acknowledge, “there must be something to hope for.”³⁰⁵ Findings from the STAR*D trial, and similar investigations suggest that some patients will continue to experience a level of emotional suffering that is unbearable to them, despite the best efforts of their clinicians.

Moreover, data from Belgium suggests that, for at least some psychiatric patients, the availability of physician-assisted dying provides a modicum of relief or even hope. In the study of 100 Belgian psychiatric patients by Lieve Thienpont and colleagues discussed above, 8 psychiatric patients, whose requests for euthanasia were granted decided to cancel or postpone the procedure altogether.³⁰⁶ According to the authors, “knowing [that] they had the option to proceed with euthanasia gave them sufficient peace of mind to continue their lives”³⁰⁷ A similar phenomenon has been observed in Oregon, in which patients who have received and indeed filled prescriptions for lethal medications have not used them.³⁰⁸ Much like the Belgian patients in Thienpont’s study, it seems that simply knowing that physician-assisted dying is an option gave these patients peace of mind.

IV. SAFEGUARDS AND PROCEDURES

In 1997, Oregon became the first state to legalize physician-assisted dying for terminally ill residents.³⁰⁹ With the passage of the Oregon Death with Dignity Act, opponents of physician-assisted dying feared that vulnerable patients would be “railroaded into a premature death,” by greedy relatives and profit-driven insurance companies.³¹⁰ However, the available evidence suggests that those fears are largely unfounded. Therefore, a prudent approach to implementing the proposal I have described is to build on the strengths of the Oregon Death with Dignity Act.

A. *The Oregon Death with Dignity Act*

1. *Mechanics*

The Oregon Death with Dignity Act permits terminally ill residents of Oregon who are 18 years old or older to end their lives by ingesting a lethal medication prescribed to them by a physician.³¹¹ The Oregon Death with Dignity

303. Bilkshavn et al., *supra* note 25, at 155.

304. *Id.* at 154.

305. *Id.*

306. Thienpont et al., *supra* note 94, at 1.

307. *Id.* at 5.

308. See ODDA DATA SUMMARY 2016, *supra* note 87, at 5 (finding that 204 people received prescriptions for lethal medications pursuant to the Oregon Death with Dignity Act in 2016, but only 133 of them died from ingesting those prescriptions).

309. LEWY, *supra* note 55, at 5.

310. Richard M. Doerflinger, *The Pro-Life Message and Catholic Social Teaching: Problems of Reception*, in AMERICAN CATHOLICS, AMERICAN CULTURE: TRADITION AND RESISTANCE 55 (Margaret O’Brien Steinfels ed., 2004).

311. OR. REV. STAT. § 127.805 § 2.01 (1999).

Act defines *terminal illness* as “an incurable and irreversible disease” that will “produce death within six months” based on a “reasonable medical judgment.”³¹² The patient’s attending physician must verify that the patient is capable of making health care decisions and has expressed a wish to die voluntarily.³¹³ The attending physician must also ensure that the patient is making an informed decision by apprising the patient of her diagnosis and prognosis, the risks associated with taking the medication, and “feasible alternatives” to assisted suicide, including “comfort care, hospice care and pain control.”³¹⁴

The Oregon Death with Dignity Act directs the patient’s attending physician to refer the patient to a consulting physician who can confirm that the patient meets the requirements of the statute.³¹⁵ If either physician believes that the patient is suffering from a “psychiatric or psychological disorder, or depression causing impaired judgment,” the patient must be referred to a mental health professional for counseling.³¹⁶ Neither physician may prescribe a life-ending medication until “the person performing the counseling determines that the patient is not suffering from a psychiatric or psychological disorder or depression causing impaired judgment.”³¹⁷

In addition to the foregoing requirements, the Oregon Death with Dignity Act prescribes a number of procedural safeguards and “cooling off” periods. ODDA patients must make two oral requests for medication separated by at least fifteen days³¹⁸ and one of the patient’s requests must be in writing, “signed and dated by the patient and witnessed by at least two individuals” who can attest that the patient is “capable, acting voluntarily, and is not being coerced to sign the request.”³¹⁹ Physicians must offer patients an opportunity to rescind their request³²⁰ and allow at least 48 hours to elapse between the patient’s written request and writing a prescription.³²¹ Physicians and pharmacists who comply in good faith with ODDA requirements are not “subject to civil or criminal liability or professional disciplinary action.”³²²

2. Empirical Evidence

Oregon and Washington—with almost 20 years of data and 7 years of data respectively—offer the most complete picture of physician-assisted dying in the United States.³²³ First, physician-assisted dying accounts for a relatively small

312. *Id.* § 127.800 § 1.01(12).

313. *Id.* § 127.815 § 3.01(1)(a).

314. *Id.* § 127.815 § 3.01(1)(c)(A)–(E).

315. *Id.* § 127.820 § 3.02.

316. *Id.* § 127.825 § 3.03.

317. *Id.*

318. *Id.* § 127.850 § 3.08.

319. *Id.* § 127.810 § 2.02(1).

320. *Id.* § 127.845 § 3.07.

321. *Id.* § 127.850 § 3.08.

322. *Id.* § 127.885 § 4.01(1).

323. *See generally* ODDA DATA SUMMARY 2016, *supra* note 87; WASH. ST. DEP’T OF HEALTH, *supra* note 87.

number of deaths in Oregon and Washington—less than one-half of 1%.³²⁴ Only a few physicians in Oregon and Washington prescribe lethal medications pursuant to death-with-dignity statutes. According to the Oregon Division of Public Health, 204 people received ODDA prescriptions in 2016, all of them written by 102 physicians, at a rate of 1 to 25 prescriptions per physician.³²⁵ Moreover, not all ODDA patients take the medications that have been prescribed to them. In 2016, roughly 20% of the ODDA patients in Oregon and 15% of ODDA patients in Washington died of causes other than taking the ODDA medications that had been prescribed to them.³²⁶

A persistent concern voiced by opponents of physician-assisted dying is that a disproportionate number of poor, elderly, uneducated, and minority patients will elect a physician-assisted death. However, in both Oregon and Washington, most patients who received prescriptions under death-with-dignity statutes are over 65, white, and well-educated.³²⁷ Of the 133 ODDA deaths that occurred in Oregon in 2016, 96% were among white patients, and 50% of those patients had at least a baccalaureate degree.³²⁸ Although neither Oregon nor Washington collect data on income, an independent study found that people with higher annual incomes were more likely to consider physician-assisted dying than people with lower incomes.³²⁹

In Oregon and Washington, almost 78% of the patients who sought physician-assisted dying in 2016 had cancer, while less than 10% had been diagnosed with amyotrophic lateral sclerosis (ALS).³³⁰ The most common end-of-life concerns voiced by patients in both states included a diminishing ability to participate in enjoyable activities, loss of autonomy, and loss of dignity.³³¹ Similarly, a small study of Oregonians who requested physician-assisted death found that the primary reasons for expressing an interest in physician-assisted dying were a desire to “control the circumstances of death” and a desire to “die at home.”³³² Other concerns included the loss of independence, “future pain, poor quality of life, and inability to care for one’s self.”³³³

324. Emanuel et al., *supra* note 10, at 83.

325. ODDA DATA SUMMARY 2016, *supra* note 87, at 5, 7.

326. *Id.* at 3; WASH. ST. DEP’T OF HEALTH, *supra* note 87, at 1.

327. ODDA DATA SUMMARY 2016, *supra* note 87, at 4; *see also* WASH. ST. DEP’T OF HEALTH, *supra* note 87, at 1 (Of the 239 Death with Dignity Act deaths in Washington in 2016, 97% were white and 67% had at least some college education.).

328. ODDA DATA SUMMARY 2016, *supra* note 87, at 8.

329. Susan W. Tolle et al., *Characteristics and Proportion of Dying Oregonians Who Personally Consider Physician-Assisted Suicide*, J. CLINICAL ETHICS 111, 113 (2004).

330. ODDA DATA SUMMARY 2016, *supra* note 87, at 9; WASH. ST. DEP’T OF HEALTH, *supra* note 87, at 1.

331. ODDA DATA SUMMARY 2016, *supra* note 87, at 9; WASH. ST. DEP’T OF HEALTH, *supra* note 87, at 1–2.

332. Linda Ganzini et al., *Oregonians’ Reasons for Requesting Physician Aid in Dying*, 169 ARCHIVES INTERNAL MED. 489, 489 (2009).

333. *Id.*; *see also* Linda Ganzini et al., *Experiences of Oregon Nurses and Social Workers with Hospice Patients Who Requested Assistance with Suicide*, 347 NEW ENG. J. MED. 582, 582 (2002) (finding that “the most important reasons for requesting assistance with suicide, among patients who received prescriptions for lethal medications, were a desire to

3. Problems and Controversies

a. The Role of Psychiatrists

When a person requests the assistance of a physician to hasten her death, I have said that our inquiry ought to focus on whether she is competent to consent to a physician-assisted death. However, whether and to what extent mental health professionals ought to participate in physician-assisted dying remains a matter of some controversy. In order to qualify for lethal medication through the Oregon Death with Dignity Act, a person must be capable of making and communicating healthcare decisions to providers.³³⁴ However, the Oregon Death with Dignity Act only requires a referral to a mental health professional if a physician believes that a “psychiatric or psychological disorder, or depression” might be impairing the patient’s judgment.³³⁵ The same rule applies to the consulting physician, who is required to confirm that the patient meets the requirements of the Oregon Death with Dignity Act. Yet, studies have shown that primary-care physicians often fail to notice the signs of clinical depression.³³⁶ Nor are physicians particularly adept at assessing decision-making capacity and determining whether a patient’s judgment is impaired.³³⁷

Forensic psychiatrists and psychologists, on the other hand, are routinely called upon by courts to assess competence in a wide variety of civil and criminal contexts, ranging from the capacity to contract, to fitness to stand trial, and competence to be executed.³³⁸ Many forensic psychiatrists also have extensive professional experience with competence assessments and end-of-life decisions, including competence to refuse life-sustaining medical treatment.³³⁹ Therefore, a

control the circumstances of death, a desire to die at home, the belief that continuing to live was pointless, and being ready to die”).

334. ORE. REV. STAT. § 127.815 § 3.01(1)(a) (1999).

335. *Id.* § 127.825 § 3.03.

336. Melinda A. Lee et al., *Legalizing Assisted Suicide—Views of Physicians in Oregon*, 334 NEW ENG. J. MED. 310, 312–13 (1996) (reporting that 28% of physicians surveyed “indicated that they were not confident they could recognize depression in a patient who requested a prescription for a lethal dose of medication”); Nico Peruzzi et al., *Physician-Assisted Suicide: The Role of Mental Health Professionals*, 6 ETHICS & BEHAV. 353, 354 (1996) (noting that the detection rate for clinical depression among non-psychiatrically trained physicians is alarmingly low, ranging from 20%–60%); Laura L. Sessums et al., *Does This Patient Have Medical Decision-Making Capacity?*, 306 JAMA 420, 422 (2011); *see also* Lee v. Oregon, 891 F. Supp. 1429, 1434–36 (D. Or. 1995) (criticizing the ODDA on multiple grounds, chief among them that the statute does not require an independent medical examination to determine whether the person is qualified to receive a lethal prescription under the ODDA).

337. James Werth et al., *Requests for Physician-Assisted Death: Guidelines for Assessing Mental Capacity*, 6 PSYCHOL. PUB. POL’Y & L. 348, 352 (2000).

338. MICHAEL L. PERLIN ET AL., *COMPETENCE IN THE LAW: FROM LEGAL THEORY TO CLINICAL APPLICATION* (2008).

339. *See, e.g.*, Linda Ganzini et al., *Evaluation to Consent to Assisted Suicide: Views of Forensic Psychiatrists*, 157 AM. J. PSYCHIATRY 595 (2000).

psychologist or psychiatrist with forensic training is perhaps best suited to determine competence to consent to physician-assisted death.³⁴⁰

A competency evaluation is a necessary procedural safeguard for anyone seeking medical assistance in dying. Nonetheless, some scholars continue to question the wisdom of mandatory competence assessments. Some are reluctant to add an additional burden to terminally ill patients.³⁴¹ Others, including Mark Sullivan, fear that competence evaluations will lend a misleading veneer of objectivity to decisions about physician-assisted dying:

We are concerned that this “safeguard” inappropriately uses a technical clinical procedure to disguise our society’s ambivalence about suicide itself. By making every patient who requests physician-assisted suicide jump the hurdle of psychiatric evaluation, we shift responsibility for a troubling moral decision from the . . . shared decisionmaking of patient, family, and primary physician to an outside specialist.³⁴²

Objections along these are well taken but overstated. The involvement of a clinician who has been trained to perform a competence evaluation does not “shift” the moral responsibility for such a weighty decision away from the patient. To say that a person is competent to elect a physician-assisted death is not to *endorse* physician-assisted dying. The moral responsibility for electing a physician-assisted death always, and necessarily, rests with the patient.

To say that a competency evaluation is a necessary precondition for access to physician-assisted dying is not to say that such evaluations are not fraught. Studies have shown that the personal histories and characteristics of clinicians can influence their decisions. For example, a recent study of licensed psychologists found that whether someone in the clinician’s personal life had ever attempted suicide and whether the clinician was willing to support a family member’s interest in physician-assisted dying influenced whether the clinician was also likely to declare a patient competent to consent to physician-assisted dying.³⁴³ However, the way to handle such biases is not to discard competence evaluations, but rather to encourage clinicians to be mindful of their biases and encourage them to refrain from performing competence assessments when they are unable to do so objectively. Another approach would be to develop a network of mental health professionals

340. Catherine S. Shaffer et al., *A Conceptual Framework for Thinking About Physician-Assisted Death for Persons with a Mental Disorder*, 22 PSYCHOL. PUB. POL’Y & L. 141, 148 (2016).

341. LEWY, *supra* note 55, at 54.

342. Mark D. Sullivan, Linda Ganzini & Stuart J. Younger, *Should Psychiatrists Serve as Gatekeepers for Physician-Assisted Suicide?*, 28 HASTINGS CTR. REP. 24, 24 (1998).

343. Shara M. Johnson, *What Patient and Psychologist Characteristics Are Important in Competency for Physician-Assisted Suicide Evaluations?*, 21 PSYCH. PUB. POL’Y & L. 420, 428 (2015); *see also* Linda Ganzini et al., *Attitudes of Oregon Psychiatrists Toward Physician-Assisted Suicide*, 153 AM. J. PSYCHIATRY 1469, 1469 (1996) (“Only 6% of psychiatrists were very confident that in a single evaluation they could adequately assess whether a psychiatric disorder as impairing the judgment of a patient requesting assisted suicide.”).

with expertise in competence assessments, similar to SCEN—the network of physicians created by the Royal Dutch Medical Association to improve the quality of end-of-life care in the Netherlands.

b. “Doctor Shopping”

A further objection concerns the specter of doctor shopping. We know very little about psychiatric patients who end their lives through physician-assisted dying or euthanasia. However, a study of 66 psychiatric patients by Scott Kim and colleagues (discussed above) found that many of these patients were euthanized by physicians who were not previously known to them.³⁴⁴ The physicians who performed the procedure were affiliated with a mobile euthanasia practice called the End-of-Life Clinic. Typically in the Netherlands, euthanasia is performed by general practitioners; however, as Dr. Petra de Jong, the founder of the End-of-Life Clinic remarked, “people are dependent on their doctors, and when you have a doctor who doesn’t want to do it, sometimes you have no one to turn to.”³⁴⁵ To that end, an important purpose of the End-of-Life Clinic is to provide access to physician-assisted dying or euthanasia for patients who are unable to find a willing physician. The End-of-Life Clinic provides a mobile service consisting of a nurse and a doctor for people who want to die at home.³⁴⁶

In the United States, as in the Netherlands, although a sizeable percentage of the population supports physician-assisted dying, many physicians have serious moral reservations about the practice, which can make it difficult for patients to find doctors who are willing to write a prescription for a lethal medication. In the Netherlands, patients find physicians who are willing to assist them through SCEN. In the United States, terminally ill patients frequently find physicians who are amenable to physician-assisted dying through right-to-die organizations like Compassion and Choices. In this respect, Dutch psychiatric patients who seek physician-assisted dying through organizations like the End-of-Life Clinic are not unlike people with terminal illnesses who seek assistance through right-to-die organizations in the United States. Dr. Quill has argued, quite rightly, that “physician-assisted suicide should only be carried out in the context of a meaningful doctor patient relationship”; however, a “preexisting relationship” should not be a requirement.³⁴⁷ Although a meaningful relationship must develop over time, a meaningful relationship need not be a long-term relationship. What matters instead is whether the physician has performed a scrupulous evaluation of the patient’s request.

c. Voluntary Active Euthanasia

Thus far, I have argued that the primary moral arguments advanced in favor of physician-assisted dying for people with terminal illnesses can support physician-

344. For a more thorough discussion, see *supra* Section I.D.

345. Ben Brumfield, *Dutch Euthanasia Clinic Offers Mobile Service*, CNN (Mar. 9, 2012), <http://www.cnn.com/2012/03/07/world/europe/netherlands-euthanasia-clinic/index.html>.

346. *Id.*

347. QUILL, *supra* note 177, at 171.

assisted dying for at least some people with mental disorders. In the United States, proponents of physician-assisted dying have supported the legalization of physician-assisted dying, but stopped short of advocating for the legalization of euthanasia on the ground that requiring patients to perform the final act is an important indicator of voluntariness.³⁴⁸ However, in Belgium and the Netherlands, patients who qualify for physician-assisted dying may choose euthanasia.³⁴⁹

The Oregon Death with Dignity Act explicitly prohibits euthanasia,³⁵⁰ and as a result, most patients receive prescriptions for oral doses of secobarbital or pentobarbital, along with a medication to prevent vomiting.³⁵¹ Although physician-assisted dying is seen as more politically palatable than euthanasia, oral administration of barbiturates includes a risk of regurgitation. According to a 2008 report produced by the Oregon Department of Human Services based on 10 years of ODDA data, “in 19 cases (5.7%) patients regurgitated some of the medication” that had been prescribed.³⁵² “In 2005, one patient regained consciousness 65 hours after ingesting the medication, and subsequently died from the underlying illness two weeks after awakening.”³⁵³

In contrast to the United States where physicians are not required to be present when patients consume the lethal medications they have prescribed, in the Netherlands, the Dutch Regional Euthanasia Review Committees encourage physicians to “stay with their patients until death occurs.”³⁵⁴ Dutch physicians are also permitted to use a lethal injection, in the event of a complication such as vomiting or regaining consciousness.³⁵⁵ For similar reasons, access to medically assisted dying in Canada includes both physician-assisted suicide and euthanasia.³⁵⁶ Voluntariness is a legitimate concern, but it is only one concern of many. Others include safe administration of the drug. Patients should have the option to select either physician-assisted suicide or euthanasia.

V. TIRED OF LIFE

In this Article, I have argued that when a person requests the assistance of a physician to hasten her death, our inquiry should focus on competence. Moreover, because our inquiry ought to focus on competence, I have argued that people with mental disorders should not be disqualified, *per se*, and at least some people who have been diagnosed with mental disorders will be able to meet even a very high threshold set by lawmakers. Still, if access to physician-assisted dying hinges, in

348. See, e.g., Oral Argument at 29:14, *Washington v. Glucksberg*, 521 U.S. 702 (1997) (No. 96-110), <https://www.oyez.org/cases/1996/96-110>.

349. Thienpont et al., *supra* note 94; LEWY, *supra* note 55, at 34.

350. OR. REV. STAT. § 127.880 § 3.14 (1999).

351. LEWY, *supra* note 55, at 139.

352. *Id.*

353. *Id.*

354. *Id.*

355. *Id.*

356. *Medical Assistance in Dying*, GOV'T OF CAN., <https://www.canada.ca/en/health-canada/services/medical-assistance-dying.html#> (last visited Jan. 30, 2018).

large part on competence, as it does in my view, what should we say about someone who is neither medically ill, nor mentally ill, but instead requests a physician-assisted death because he is simply “tired of life?”

In April 1998, Dr. Philip Sutorius helped his patient, 86-year-old Edward Brongersma, end his life by supplying him with “a lethal cocktail of drugs.”³⁵⁷ Brongersma, a lawyer and former senator, had an active life but in later years as his physical condition began to decline, he complained of social isolation.³⁵⁸ According to Sutorius, Brongersma was “lonely” and suffering from “feelings of senseless, physical deterioration, and a long-standing wish to die, not associated with depression.”³⁵⁹ After several discussions with Brongersma, Sutorius granted his request and reported his death to the police.³⁶⁰ Sutorius was prosecuted and found guilty of assisting a suicide.³⁶¹ The Dutch Supreme Court held that existential suffering, of the kind experienced by Brongersma, is not a medical ailment; therefore, a doctor who assists such a patient in suicide cannot avail himself of the necessity defense.³⁶²

Because of *Brongersma*, Dutch law limits euthanasia to patients whose suffering has a medical or psychological dimension.³⁶³ However, a proposal before the Dutch Parliament would allow older people, who are neither medically ill nor mentally ill, to access euthanasia if they believe they have “completed life.”³⁶⁴ The government has taken the position that new legislation is needed to address the concerns of older people “who, in their opinion no longer have any life prospects and have as a result developed a *persistent, active desire to die*.”³⁶⁵ In a letter to

357. *Dutch Court Upholds Euthanasia Rules*, BBC NEWS (Dec. 24, 2002), <http://news.bbc.co.uk/2/hi/europe/2603709.stm>.

358. GRIFFITHS ET AL., *supra* note 23, at 35; see also Tony Sheldon, *Dutch GP Cleared After Helping to End Man’s “Hopeless Existence,”* 321 BRIT. MED. J. 1174, 1174 (2000) (noting that one month before he committed suicide, Brongersma said that “death had ‘forgotten’ him . . . [H]is friends and relatives were dead, and he experienced a ‘pointless and empty existence’”).

359. GRIFFITHS ET AL., *supra* note 23, at 36.

360. *See id.* at 35.

361. Tony Sheldon, *Being “Tired of Life” is Not Grounds for Euthanasia*, 316 BRIT. MED. J. 71, 71 (2003).

362. Brongersma, HR 24 Dec. 2002 (LJN AE8772); see also Ubaldus der Vries, *A Dutch Perspective: The Limits of Lawful Euthanasia*, 13 ANNALS HEALTH L. 365, 383–86 (2004).

363. REGIONAL EUTHANASIA REVIEW COMMITTEES, *supra* note 70, at 13.

364. Dan Bilefsky, *Dutch Law Would Allow Assisted Suicide for Healthy Older People*, N.Y. TIMES (Oct. 13, 2016), <https://www.nytimes.com/2016/10/14/world/europe/dutch-law-would-allow-euthanasia-for-healthy-elderly-people.html>; see also *Plenary Session about Citizens Initiative “Completed Life,”* TWEEDE KAMMER, DER STATEN-GENERAAL, <https://www.houseofrepresentatives.nl/news/plenary-session-about-citizens-initiative-%E2%80%98completed-life%E2%80%99> (last visited Feb. 15, 2018).

365. Letter from the Minister of Health, Welfare and Sport and the Minister of Sec. and Justice, to the House of Representatives on the Government Position on “Completed Life,” (Oct. 12, 2016), <https://www.government.nl/binaries/government/documents/>

Parliament, the Health Minister added: “People who have come to a well-considered decision that their life is completed and who are suffering from life, without prospect of improvement, must be allowed to end their life with dignity.”³⁶⁶

How should we think about this? From the perspective of soft paternalism, what matters is not whether the cause of a person’s suffering is medical or existential, but rather whether the person has consistently and voluntarily expressed a well-considered decision to die. The right to determine the time and manner of one’s death with the assistance of a physician falls squarely within the domain of personal sovereignty, whether the cause of the person’s suffering is the “despair beyond despair” of clinical depression, or the existential suffering of an elderly man who is simply tired of life. Courts have held that competent adults have the right to refuse life-sustaining medical treatment. Under the rule announced in *Brongersma*, the law would allow Brongersma to hasten his death by refusing to eat and drink or refusing life-sustaining medical treatment, but prohibit him from achieving the same result, more humanely, with the help of a physician.

The tired-of-life cases, perhaps even more so than the other cases discussed in this Article, force us to consider the nature of the state’s interest in preserving life. In early cases, courts endeavored to balance the right to refuse treatment against the state’s interest in preserving life, and in doing so, suggested that the right to refuse treatment could only be exercised by patients who are terminally ill or by a surrogate acting on behalf of patients who are comatose.³⁶⁷ However, more recent cases have not included this limitation. In *Matter of Conroy*, for example, the New Jersey Supreme Court observed that “competent persons generally are permitted to refuse medical treatment, even at the risk of death,” nor is a patient’s right to refuse treatment “affected by her medical condition or prognosis.”³⁶⁸ Justice Brennan arrived at a similar conclusion in *Cruzan*: “The only state interest asserted here is a general interest in the preservation of life. But the State has no legitimate general interest in someone’s life, completely abstracted from the interest of the person living that life, that could outweigh the person’s choice to avoid medical treatment.”³⁶⁹

Competent adults have the right to refuse unwanted medical treatment for good reasons or bad reasons, whether they are medically ill or mentally ill. The right of a competent adult to refuse unwanted medical treatment does not hinge on the nature of the patient’s medical condition. Nor does it matter whether the person has a spouse or dependent children, or whether the treatment is minimally invasive and can restore the person to good health. As Justice Brennan remarked in *Cruzan*, the state has no legitimate interest in someone’s life, abstracted from that person’s

letters/2016/10/12/the-government-position-on-completed-life/government+position+on+%27completed+life%27.pdf.

366. *Id.*

367. *In re Quinlan*, 355 A.2d 647, 664 (N.J. Sup. Ct. 1976) (noting that the state interest in preserving life “weakens and the individual’s right to privacy grows as the degree of bodily invasion increases and the prognosis dims”).

368. 486 A.2d 1209, 1225 (N.J. Sup. Ct. 1985).

369. *Cruzan ex rel. Cruzan v. Dir., Mo. Dep’t of Health*, 497 U.S. 261, 313 (1990).

interest in living her life, that could outweigh her right to refuse unwanted medical treatment. If the moral equivalence thesis is correct then, just as Mr. Brongersma can refuse unwanted medical treatment for good reasons or bad reasons, he may also hasten his death through physician-assisted dying or euthanasia for good reasons, or bad reasons, or no reason at all.

CONCLUSION

By 2050, demographers expect the number of Americans who are 65 years old or older to double, when they will comprise more than one-fifth of the nation's population.³⁷⁰ As the population ages, lawmakers will be forced to reconsider (the largely political) boundaries that have been drawn around physician-assisted dying in the United States. In this Article, I have argued that when a person seeks the assistance of a physician to end her life, our inquiry ought to focus not on whether she is medically ill or mentally ill, but rather on whether she is competent to consent to physician-assisted dying.

With its emphasis on competence, an argument of the kind I have outlined necessarily extends even beyond people with mental disorders. However, the specter of physician-assisted dying for healthy adults who are merely "tired of life" does not undermine my central contention. When a person requests the assistance of a physician in hastening her death, our only question should be whether she is competent to avail herself of a physician-assisted death. A person can be depressed and form a desire to die that we are obligated to respect, whether the source of the person's suffering is clinical depression or the existential depression of elderly adults who are tired of life.

370. Timothy Williams, *Graying of America Is Speeding, Report Says*, N.Y. TIMES (May 6, 2014), <https://www.nytimes.com/2014/05/07/us/graying-of-america-is-speeding-report-says.html>.