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# ADDRESSING AND DISPELLING MISCONCEPTIONS SURROUNDING THE PHYSICIAN-ASSISTED SUICIDE CONTROVERSY

CAROL SIEGER\*

Thank you for the opportunity to include myself, as well as Choice in Dying, in part of what I hope will be an ongoing, continuing discussion regarding the issue of physician-assisted suicide.

Choice in Dying is a national, not-for-profit organization.<sup>1</sup> We are in a unique position in that it is our mission, as the oldest and only national organization devoted solely to a broad range of end of life issues, to secure the right of patients to make decisions about their end of life medical care and to promote quality care for dying patients.<sup>2</sup>

Now, the organization's work includes a professionally staffed national hotline where we respond to approximately three to five thousand individuals each month, requesting facts and counsel-

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<sup>1</sup> See Amicus Curiae Brief of Choice in Dying in Support of Neither the Petitioners or the Respondents at \*1, *Washington v. Glucksberg*, 117 S. Ct. 2258 (1997) (No. 96-110) and *Vacco v. Quill*, 117 S. Ct. 2293 (1997) (No. 95-1858), available in 1996 WL 656277. In 1976, the Euthanasia Society of America was renamed the Society for the Right to Die, and in 1991 again renamed Choice in Dying. *Id.* Choice in Dying is an organization that is well recognized for pioneering living wills. *Id.* They operate a national hotline for patients and their families. *Id.*

<sup>2</sup> See *id.* at \*1 (explaining Choice in Dying's mission which is to secure right of patients to make decisions concerning effecting their end of life medical care and to promote improving quality of care dying patients receive); see also Ann Fade, *Right to Die: New Law and Policy Issues Appear While Old Ones Remain Unresolved*, 11 No. 2 HEALTHSPAN 3, 5 (1994) (discussing broad range of services Choice in Dying provides including counseling and free legal information for families and healthcare providers concerning end of life decision making).

ing. In addition, Choice in Dying also provides public, professional and physician education and we also monitor the changes in state and federal law with regard to end of life issues.<sup>3</sup> One of my principal roles is crisis resolution.

Choice in Dying takes no position as far as the legality or the constitutionality of physician-assisted suicide.<sup>4</sup> However, the position that we do take is that this issue needs ongoing, complete debate. As part of the continuing debate, Choice in Dying did deem it crucial that the United States Supreme Court be fully informed about a number of issues. Consequently, we provided the Court with an amicus brief,<sup>5</sup> although we consider the brief to be more informational in nature.

So, you might say we are presently taking a neutral stand as public debate continues. Although we remain neutral in this debate, Choice in Dying is still able to discuss the present controversy. Presently, many factors contribute to the current controversy about medical care at the end of life.<sup>6</sup> Current medical technology can prevent or cure many diseases<sup>7</sup> and significantly improve the quality of life for those suffering from chronic disabilities.<sup>8</sup> That same technology, however, is being used to dis-

<sup>3</sup> See Amicus Curiae Brief of Choice in Dying, *supra* note 1, at \*1 (noting that in addition to patient counseling services Choice in Dying provides educational services to physicians and monitors changes in both federal and state legislation relating to end of life decision making).

<sup>4</sup> See Richard E. Coleson, *The Glucksberg and Quill Amicus Briefs: Verbatim Arguments Opposing Assisted Suicide*, 13 ISSUES L. & MED. 3, 102 n.4 (1997) (noting Choice in Dying's amicus brief did not take positions on physician-assisted suicide, however, organization's long standing involvement provided guidance to Court in deciding issue).

<sup>5</sup> See Amicus Curiae Brief of Choice in Dying, *supra* note 1, at \*1.

<sup>6</sup> See Lakshmipathi Cherulli et al., *Intensive Care for Critically Ill Elderly: Mortality, Costs and Quality of Life*, 155 ARCHIVES INTERNAL MED. 1013, 1013 (1995) (noting that factors such as reforms in organization and delivery of healthcare, changes in nation's demographics contributed to controversy surrounding physician-assisted suicide); see also John D. Lentos et al., *The Illusion of Futility in Clinical Practice*, AM. J. MED., July 1989 at 81, 82-83 (contending that disagreements among physicians concerning point at which medical treatment becomes futile has contributed to physician-assisted suicide controversy).

<sup>7</sup> See Michael J. Malinowski, *Capitation, Advances in Medical Technology, and the Advent of a New Era in Medical Ethics*, 22 AM. J.L. & MED. 331, 341 (1996) (noting that improvements in medical technology have decreased death rate from diseases and raised life expectancy); see also Lois Shepherd, *Sophie's Choice: Medical and Legal*, 72 NOTRE DAME L. REV. 103, 128 (1996) (contending that modern medicine has created expectation of healthier lives).

<sup>8</sup> See Terry Fielder, *The Relief Business: Treatment Efforts Targeting Previously Unmet Medical Needs*, CHI. STAR TRIB., May 4, 1997, at 1D (discussing Medicare's new emphasis on improving quality of life for those with chronic medical conditions); John Morrissey, *Outcomes, Chronic-Care Consortium Develops Living Tool to Help Integrate Services*, MODERN HEALTHCARE, Feb. 19, 1996, at 33 (stating that healthcare is shifting

tort and prolong the dying process.<sup>9</sup>

The problems raised by the misapplication of technology<sup>10</sup> and the lack of accessibility to good palliative care<sup>11</sup> are compounded by widespread public and professional confusion or ignorance.<sup>12</sup> Significant gaps still exist in the available empirical evidence concerning physician-assisted suicide. As a result, public debate is still at a comparatively formative stage.<sup>13</sup> This is evident by the fact that five years ago we might not have had this symposium.

As with any emerging body of thought and practice, there is inherent instability which augurs both progress and risk. In order to minimize the risk, Choice in Dying has felt compelled to address and resolve several areas of confusion in our amicus brief.<sup>14</sup> Some of these issues have already been discussed and I will point them out again so you understand our position.

The major point of concern is that there seems to be misinformation and misunderstanding about life sustaining treatments, including artificial nutrition and hydration.<sup>15</sup> Life sustaining

toward improving quality of life of patients with chronic illnesses like diabetes, arthritis, lung ailments, especially in elderly patients).

<sup>9</sup> See Amicus Curiae Brief of Choice in Dying, *supra* note 1, at \*8-10 (stating "imposition of artificial nutrition and hydration may actually contribute to an uncomfortable death").

<sup>10</sup> See, e.g., Charles R. Disalvo, *Genetic Discrimination; Worshipping at the Altar of Technique: Manic Aggressive Medicine and Law*, 40 VILL. L. REV. 1365, 1378 (1995) (stating that often times physicians place greater importance on utilization of medical technology at expense of best interests of patients); Patricia L. Rizzo, *Religion-Based Arguments in the Public Arena: A Catholic Perspective on Euthanasia*, Compassion in Dying v. State of Washington and Quill v. Vacco, 1 DEPAUL J. HEALTHCARE 243, 245 (1996) (stating that in many instances, medical technology has not extended life, but "merely lengthened dying process").

<sup>11</sup> See Yale Kamisar, *Against Assisted Suicide—Even a Very Limited Form*, 72 U. DET. MERCY L. REV. 735, 769 n.17 (1995) [hereinafter *Against Assisted Suicide*] (citing John D. Arras, *The Right to Die on the Slippery Slope*, 8 SOC. THEORY & PRAC. 285, 304 (1982)) (noting that euthanasia would be more attractive remedy for poor since they "lack access to mainstream medical care and the amenities of the hospice"); Anthony Szczygiel, *Long Term Care Coverage: The Rule of Advocacy*, 44 U. KAN. L. REV. 721, 755-56 (1996) (noting that although hospice care programs are being developed, they are "by no means universal").

<sup>12</sup> See Michael McCarthy, *US Patients Do Not Always Get the Best End-Of-Life Care*, THE LANCET, June 14, 1997, at 1747 (contending that medical culture tolerates, and in some cases rewards, misapplication of life sustaining technologies).

<sup>13</sup> See Ezekial J. Emanuel & Elisabeth Daniels, *Oregon's Physician-Assisted Suicide Laws: Provisions and Problems*, ARCHIVES INT. MED., Apr. 22, 1996, at 825 (asserting that lack of adequate control group of terminally-ill patients makes it impossible to differentiate between those who request and receive physician-assisted suicide and those who do not).

<sup>14</sup> See Amicus Curiae Brief of Choice in Dying, *supra* note 1, at \*1.

<sup>15</sup> See Maria Torrella & Carney R. Sean Morisson, *Advance Directives: When, Why*

treatments include not only artificial nutrition and hydration, but also treatment such as cardiopulmonary resuscitation (CPR), mechanical ventilation, and kidney dialysis.<sup>16</sup>

However, the Ninth<sup>17</sup> and Second<sup>18</sup> Circuit Courts seem to imply, in both their opinions, that artificial nutrition and hydration were somehow qualitatively different from the other forms of life sustaining treatment.<sup>19</sup> For example, both courts used language, such as starvation, to refer to and describe artificial nutrition and hydration.<sup>20</sup> In fact, there was a wonderful article out called *The Sloganism of Starvation*.<sup>21</sup> The problem with using the term "starvation" is it is emotion laden and it raises frightening images of hungry, otherwise healthy people who are prevented from obtaining desired food.<sup>22</sup>

It is important to any discussion of this issue to remember that artificial nutrition and hydration are medical treatments.<sup>23</sup> Consequently, artificial nutrition and hydration should not be distinguished from other forms of life sustaining treatment. In

*and How to Start Talking*, GERIATRICS, Apr. 1, 1997, at 65 (chronicling debate over life sustaining treatments).

<sup>16</sup> See THE HASTINGS CENTER, GUIDELINES ON THE TERMINATION OF LIFE-SUSTAINING TREATMENT AND CARE OF THE DYING 4 (1987) (defining life-sustaining treatment as "any medical intervention that is administered to a patient in order to forestall moment of death"); see also Council on Ethical and Judicial Affairs, *Decisions Near the End of Life*, 267 JAMA 2229, 2229 (1992) (explaining that life sustaining treatment includes "mechanical ventilation, venal dialysis, chemotherapy, antibiotics and artificial nutrition and hydration").

<sup>17</sup> *Compassion in Dying v. Washington*, 79 F.3d 790 (9th Cir. 1996), *rev'd sub nom.*, *Glucksberg v. Washington*, 117 S. Ct. 2258 (1997)

<sup>18</sup> *Quill v. Vacco*, 80 F.3d 716 (2d Cir. 1996), *rev'd*, 117 S. Ct. 2293 (1997).

<sup>19</sup> See *Compassion*, 79 F.3d at 829 (categorizing artificial nutrition and hydration as different from other life sustaining treatments); *Quill*, 80 F.3d at 729 (discussing artificial nutrition and hydration in context of starvation).

<sup>20</sup> See *Compassion*, 79 F.3d at 829 (using term starvation to refer to artificial nutrition); *Quill*, 80 F.3d at 729 (referring to artificial nutrition as starvation).

<sup>21</sup> See Judith C. Ahronheim & M. Rose Gasner, *The Sloganism of Starvation*, 335 THE LANCET 278, 315 (1990); see also *Compassion*, 79 F.3d at 823 (scrutinizing Cruzan argument that once artificial means of nutrition and hydration ended, Nancy Cruzan died from deliberate self starvation, not underlying illness); *Quill*, 82 F.3d at 729 (stating "the withdrawal of nutrition brings on death by starvation, the withdrawal of hydration brings on death by dehydration").

<sup>22</sup> See Stephen P. Von Derhoef, *In re Grant: Where Does Washington Stand on Artificial Nutrition and Hydration*, 13 U. PUGET SOUND L. REV. 197, 233 (1989) (stating that use of word "starvation" to refer to withholding of artificial nutrition conjures up emotional images of people being starved).

<sup>23</sup> See *Cruzan v. Harmon*, 760 S.W.2d 408, 412 (Mo. 1988) (stating that artificial nutrition, as well as hydration, are medical life sustaining treatments); see also Edward R. Grant & Cathleen A. Cleaver, *A Line Less Reasonable: Cruzan and the Looming Debate Over Active Euthanasia*, 2 MD. J. CONTEMP. LEGAL ISSUES 99, 1182 (1991) (reiterating that according to American Medical Association, artificial nutrition and hydration are medical treatments).

addition, there is no evidence that individuals who are dependent upon artificial nutrition and hydration, whether alert and aware, or partially or severely neurological impaired, would experience discomfort if these treatments were foregone.<sup>24</sup> In fact, extensive, indirect evidence indicates that foregoing artificial nutrition and hydration could actually facilitate a natural death without discomfort.<sup>25</sup>

Another source of concern for Choice in Dying is the blurring of the distinction between the withholding or withdrawing of life sustaining treatment and physician-assisted suicide.<sup>26</sup> There are important distinctions between the two<sup>27</sup> and it is critical, from a healthcare perspective and as far as our organization is concerned, that these distinctions be maintained. I do not want to go through another analysis regarding informed consent, bat-

24 See *In re Estate of Longeway*, 549 N.E.2d 292, 295 (Ill. 1989) (declaring that it is doubtful that patients in persistent vegetative state could experience pain and discomfort from withholding artificial nutrition and hydration); Mark Strasser, *Assisted Suicide and the Competent Terminally Ill: On Aiding Treatments and Extraordinary Policies*, 74 OR. L. REV. 539, 589 (1995) (stating that some believe that death by starvation, as well as by dehydration, may be painful but if patient is insensate, he may not feel anything). But see *Brophy v. New England Sinai Hosp.*, 497 N.E.2d 626, 641 (Mass. 1986) (Lynch, J., dissenting) (contending that pain and suffering as result of starvation or dehydration could be prolonged because death may take time); Robert L. Lapointe, *The Removal of Feeding Tubes: Has the Right to Die Reached Its Limits*, 24 NEW ENG. L. REV. 185, 209 (1989) (stating that death by starvation and dehydration is slow, as well as uncomfortable).

25 See *In re Conroy*, 486 A.2d 1209, 1236 (N.J. 1985) (recognizing that artificial nutrition and hydration to prolong life may be more painful or stressful than dehydration or starvation); *In re Grant*, 747 P.2d 445, 453 (Wash. 1987) (contending that it is no longer clear that dehydration and malnourishment will always be painful to terminally ill patients); see also *Nancy Dies, Outlived By Debate Over Right to Die*, N.Y. TIMES, Dec. 27, 1990, at 1 (stating that Nancy Cruzan's parents claimed she was peaceful throughout removal of feeding tubes, showing no sign of discomfort).

26 See *Cruzan v. Missouri Dep't of Health*, 497 U.S. 261, 296-297 (1990) (Scalia, J., concurring) (stating action-inaction distinction is irrelevant because cause of death in both cases is patient's conscious decision to put end to own life); *In re Gardner*, 534 A.2d 947, 955 (Me. 1987) (stating that decision to refuse artificial life-sustaining treatment does not constitute suicide); *McKay v. Bergstedt*, 801 P.2d 617, 627 (Nev. 1990) (declaring "substantial difference" between person desiring to terminate their life and person deciding not to interfere with natural consequences of their condition); *In re Coyer*, 660 P.2d 738, 743 (Wash. 1983) (stating that death results from natural causes when life sustaining equipment is removed).

27 See *Cruzan*, 497 U.S. at 280 (stating "the majority of states in this country have laws imposing criminal penalties on one who assists another to commit suicide. We do not think a state is required to remain neutral in the face of an informed and voluntary decision by a physically able adult to starve to death."); see also Yale Kamisar, *The "Right To Die": On Drawing (and Erasing) Lines*, 35 DUQ. L. REV. 481, 512-13 (1996) [hereinafter *Right to Die*] (questioning how rationale of *Quill* and *Compassion in Dying* to limit physician-assisted suicide to terminally ill patients will be upheld in Supreme Court); David Orentliker, *The Legalization of Physician-Assisted Suicide: A Very Modest Revolution*, 38 B.C. L. REV. 443, 444 (1997) (distinguishing suicide assistance and treatment withdrawal by arguing that only latter is morally acceptable).

tery and the common law, however, I will just briefly discuss the distinctions.

The foregoing of life sustaining treatment refers to the avoidance of medical treatment that is necessary to sustain life.<sup>28</sup> Since these life sustaining treatments artificially postpone natural death, the withholding or withdrawing of these treatments remove that obstacle to death.<sup>29</sup> In addition, the right to withhold or withdraw life sustaining treatment is not limited to the terminally-ill, nor to competent adults because limiting such a right to terminally-ill competent patients, may be constitutionally impermissible.<sup>30</sup>

Finally, as a way of contrasting analogy, another way to look at this topic is to examine the result of a failure to comply with an individual's wishes. If a failure to comply with the request for withholding or withdrawing life sustaining treatment would subject an individual to unwanted treatment, then such failure would make him or her basically a virtual prisoner of medical technology.<sup>31</sup> The imposition of life support often involves highly invasive equipment and procedures, and that is a more serious interference with personal liberty.<sup>32</sup>

<sup>28</sup> See Amy Haddad, *Ethics in Action (Ethical Questions Regarding Assisted Suicide)*, RN, Mar. 1, 1997, at 17 (stating that forgoing life sustaining treatments simply means declining intervention).

<sup>29</sup> See *Washington's Natural Death Act*, WASH. REV. CODE. § 70.122.020(4) (1985) (defining life sustaining treatment as any procedure or intervention which utilizes mechanical or artificial means to sustain, restore or supplant vital functions, however, nutrition and hydration is only defined as life sustaining treatment if it serves to postpone death); see also Elizabeth Helene Adamson, *The Right to Refuse Life Sustaining Medical Treatment and the Noncompetent Nonterminally Ill Patient: An Analysis of Abridgment and Anarchy*, 17 PEPP. L. REV. 461, 470 (1990) (stating that most life sustaining procedures serve to delay moment of death by excluding medication or procedure to alleviate pain).

<sup>30</sup> See *The Right to Die*, *supra* note 27, at 511 (contending that because of Equal Protection Clause there is no reason why non-terminally ill person who made voluntary, informed decision to die, should be denied right to have assistance to achieve death).

<sup>31</sup> See *Cruzan*, 497 U.S. at 287 (O'Connor, J. concurring) (stating "[a] seriously ill or dying patient whose wishes are not honored may feel captive of the machinery required for life sustaining measures or other medical interventions. Such forced treatment may burden that individual's liberty interests as much as any state concern. . ."); see also Nancy Watkins Anderson, *Life and Death in Washington State After Cruzan v. Director, Missouri Department of Health*, 16 U. PUGET SOUND L. REV. 249, 317 n.264 (1992) (arguing that allowing physicians to refuse to take patient off life sustaining treatment makes patient prisoner to technological advances).

<sup>32</sup> See *Cruzan*, 497 U.S. at 281 (describing decision to withdraw life support is "deeply personal" decision which is protected by Due Process Clause); see also Alan Meisel, *The Debate Is Not Over, Supreme Court's Ruling Just Puts Question Back to Court of Public Opinion*, PORT. OREGONIAN, June 27, 1997, at B09 (asserting that decision of terminally ill patients to forgo life sustaining treatments is private, intimate de-

A failure to comply with the request for physician-assisted suicide, on the other hand, would restrict patient autonomy, but would not amount to a bodily invasion.<sup>33</sup> The cases of *Compassion in Dying*<sup>34</sup> and *Quill*<sup>35</sup> once again call upon the United States Supreme Court to address the limits of governmental power and the scope of individual autonomy.

There is another blurring of the distinction between physician-assisted suicide and the potential double effect of pain medication in certain circumstances.<sup>36</sup> The term "double effect" refers to the administration of pain medication with the intention of providing relief from suffering, with the possible secondary effect of hastening death.<sup>37</sup>

It is important to understand that hastening of death is theoretical. Therefore, it is impossible to determine whether the disease or the medication is responsible for the precise moment of death.<sup>38</sup> There is widespread consensus, among ethicists and

cision to be made by patient without governmental interference).

33 See Tom L. Beauchamp, *The Justification of Physician-Assisted Suicide*, 29 IND. L. REV. 1173, 1188-91 (1996) (analogizing physician's refusal to assist in suicide to refusal to prescribe requested narcotics where physicians feel it is inappropriate); see also *The Right to Die*, *supra* note 27, at 492 (stating that to deny patient's request for physician-assisted suicide will certainly restrict patient's self determination but it does not amount to bodily invasion or medical imprisonment).

34 *Compassion in Dying v. Washington*, 79 F.3d 790 (9th Cir. 1996), *rev'd sub nom.*, *Washington v. Glucksberg*, 117 S. Ct. 2258 (1997).

35 *Quill v. Vacco*, 80 F.3d 716 (2d Cir. 1996), *rev'd*, 117 S. Ct. 2293 (1997).

36 See *Compassion*, 79 F.3d at 823-24 (arguing that there is little difference for constitutional or ethical purposes between providing medication with double effect and providing medication for single effect because both hasten death); *The Right to Die*, *supra* note 27, at 485 (contending that court in *Compassion in Dying* belittled distinction between physician-assisted suicide and double effect of medication); see also Leon R. Kass & Nelson Lund, *Physician-Assisted Suicide, Medical Ethics and the Future of the Medical Profession*, 35 DUQ. L. REV. 395, 422-423 (1996) (contending that double effect has blurred distinction between physician-assisted suicide and double effect of medication).

37 See Susan R. Martyn & Henry Bourguignon, *Physician-Assisted Suicide: The Lethal Flaws of the Ninth and Second Circuit Decisions*, 85 CALIF. L. REV. 371, 399 (1997) (stating that double effect phenomenon differs from physician-assisted suicide in that the former supports the patient's life while recognizing that treatment or medication necessary to relieve suffering risks hastening death of patient while latter relieves suffering by ending the patient's life); see also Derrick Augustus Carter, *Knight in the Duel with Death: Physician-Assisted Suicide and the Medical Necessity Defense*, 41 VILL. L. REV. 663, 719 (1996) (stating that "aggressive medical treatment that has the double effect of alleviating pain as well as the collateral effect of causing death"); Peter G. Daniels, *An Illinois Physician-Assisted Suicide Act: A Merciful End to a Terminally Ill Criminal Tradition*, 28 LOY. U. CHI. L.J. 763, 767-68 (1997) (stating that physicians' participation in double effect results from the belief that sometimes the obligation to alleviate suffering surpasses the unnatural prolonging of life).

38 See Carter, *supra* note 37, at 699 (contending that basic premise of double effect theory is that disease kills not the medication); see also Lance K. Stell, *Stopping Treatment on Grounds of Futility: A Role for Institutional Policy*, 11 ST. LOUIS U. PUB. L. REV.

within the law, that the double effect is a morally acceptable risk in the context of the great suffering of the terminally-ill.<sup>39</sup> In addition, we do have technology available for managing pain and other symptoms associated with terminal illness.<sup>40</sup>

One of the big concerns is that such technology is not routinely provided.<sup>41</sup> For example, even though we have a wonderful hospice program, only about 15% of the terminally ill are actually made part of the hospice program. That phenomenon is due to a number of different factors.<sup>42</sup>

It is important to note, in light of similar language in the Ninth Circuit,<sup>43</sup> that it is a misconception that severe discomfort is invariably associated with the final stages of a terminal illness.<sup>44</sup> Pain and other physical symptoms, in most circum-

481, 497 (1992) (stating that "any medical intervention has reasonably expectable death-postponing effect," so this medical intervention "almost totally eclipses natural course of disease").

39 See Carter, *supra* note 37, at 719 (referring to Minnesota's statute that bans assisted suicide but permits, along with Catholic Church, exemption for administration of medication to relieve another person's pain or suffering); see also Robert A. Sedler, *Are Absolute Bans on Assisted Suicide Constitutional? I Say No*, 72 U. DET. MERCY L. REV. 725, 729 (1995) (stating that since government has no valid interest in prolonging death, terminally ill people continue to suffer).

40 See Robert A. Burt, *Constitutionalizing Physician-Assisted Suicide: Will Lightening Strike Thrice?*, 35 DUQ. L. REV. 159, 181 (1996) (stating that pain management has recently improved both through development of better techniques and enhanced care delivery of hospice); see also Edward R. Grant & Paul Benjamin Linton, *Relief or Reproach? Euthanasia Rights in the Wake of Measure 16*, 74 OR. L. REV. 449, 537 n.306 (1995) (contending that advances in pain management have made cases of intolerable, untreatable pain rare).

41 See *Against Assisted Suicide*, *supra* note 11, at 769 (asserting that high cost of pain management makes its availability limited to small number of patients with adequate health insurance); see also Susan Block & Andrew Billings, *Patients Requests to Hasten Death: Evaluation and Management in Terminal Care*, 154 ARCH. INTERN. MED. 2039, 2040 (1994) (stating that other symptoms of terminal illness are often inadequately controlled by physicians who lack expertise in palliative care or fail to take aggressive position toward assuring patient's comfort); see generally Burt, *supra* note 40, at 181 (contending that doctors do not inform patients about pain alleviation or provide palliative care).

42 See, e.g., Joanne Lynn et al., *Defining the "Terminally Ill": Insights From Support*, 35 DUQ. L. REV. 311, 312-14 (1996) (noting that Medicare hospice benefits only extend to patients that are deemed to only have life expectancy not exceeding six months).

43 See *Compassion in Dying v. Washington*, 79 F.3d 790, 818 (9th Cir. 1996), *rev'd sub nom.*, *Washington v. Glucksberg*, 117 S. Ct. 2258 (1997).

44 See *Compassion*, 79 F.3d at 818 (discussing belief that patients who are terminally ill may be subjected to unnecessary pain and discomfort when their lives are mechanically extended with no medical benefits in return); see also Carter, *supra* note 37, at 718 (noting that doctors say that terminally ill patients, dying of lack of nutrition, do not suffer in stereotypical image of parched person scrambling in desert for water); *Undying Pain: Relieving Death's Pain Will Reduce Calls for Help to Die*, HOUSTON CHRONICLE, Jan. 19, 1997, at 2 (stating that many people drift into final sleep without significant discomfort).

stances, can be appropriately controlled within the confines of standard medical practice.<sup>45</sup> Although potent medications can sometimes reduce alertness, there are psychostimulant medications that are available that might ameliorate this problem.<sup>46</sup>

There are misconceptions both by the public and professionals about the management of pain, in addition to pain and suffering.<sup>47</sup> Such misconceptions distort the current debate about physician-assisted suicide. Most individuals with terminal illness do not have to experience undue suffering.<sup>48</sup> The Ninth Circuit's opinion reflected the prevailing feeling, by both the public and professionals, that extreme pain and physical symptoms are inevitably associated with terminal illness.<sup>49</sup> Public education and continuing debate are critical to dispelling these misconceptions. In addition, enhanced professional education is certainly necessary to ensure that competent pain management is available and accessible to all individuals.

One of the criteria for physician-assisted suicide is that the individual be terminal.<sup>50</sup> There has been much discussion by reasonable minds who differ as to whether or not one can accurately predict whether an individual is terminal.<sup>51</sup>

45 See Grant & Linton, *supra* note 40, at 537 n.306 (noting that improvements in pain control have made cases of intolerable, untreatable pain rare); see generally Nancy J. Osgood, *Assisted Suicide & Older People—A Deadly Combination: Ethical Problems in Permitting Assisted Suicide*, 10 ISSUE L. & MED. 415, 428 (1995) (discussing terminally ill patients and availability of palliative care).

46 See *Abstracts*, 11 ISSUES L. & MED. 459, 462 (1996) (detailing use of psychostimulant drugs for controlling depression, as well as sedation, in terminally ill patients).

47 See Burt, *supra* note 40, at 166. Medical technology exists that will provide relief for terminally ill patients suffering from excruciating pain. *Id.* Often times, however, physicians neither utilize such measures nor discuss such techniques with their patients. *Id.* Moreover, this technology is sometimes not prescribed to those patients in need due to physicians' insufficient knowledge concerning pain management and state and federal restrictions on availability of controlled substances. *Id.* at 167.

48 See, e.g., *A Growing Move to Treat Chronic Pain Seriously*, USA TODAY, Apr. 16, 1997, at 6D (noting that with the proper treatment, terminally ill patients' pain can be controlled).

49 See *Compassion*, 79 F.3d at 818 (noting Washington legislature's recognition that those terminal patients dependent on life sustaining medical technology experience extreme pain when their lives are extended by such means).

50 See *id.* (noting that holding in *Compassion* would limit right to physician-assisted suicide to terminally ill competent adults); *Quill v. Vacco*, 80 F.3d 716, 717 (2d Cir. 1996) (discussing physician-assisted suicide in limited context of terminally ill person's rights), *rev'd*, 117 S. Ct. 2293 (1997).

51 See Daniel Callahan & Margot White, *The Legalization of Physician-Assisted Suicide: Creating A Regulatory Potemkin Village*, 30 U. RICH. L. REV. 1, 44-45 (1996) (discussing difficulty of finding consistent definition of "terminal condition"); Stephen L. Mikachik, *Assisted Suicide and Disabled People*, 46 DEPAUL L. REV. 987, 987 (1997) (referring to ABA Commission on Legal Problems' notion that term "terminal" is without

I can tell from my personal experience, with Choice in Dying and with nursing homes, hospitals and physicians, that there is profound disagreement among professionals and others concerning whether an individual meets a certain definition of terminal illness. This is evident by the fact that the word "terminal" is described in different ways in various statutes.<sup>52</sup>

The advanced directive statutes illustrate that there are at least seven different commonly used definitions of terminal illnesses. As a result, defining terminal illness might not be as easy as it initially seems.<sup>53</sup>

Lastly, one of the cornerstones of the regulation of physician-assisted suicide is to ensure that physicians and their patients communicate clearly regarding not only physician-assisted suicide, but all of their treatment choices.<sup>54</sup> Choice in Dying's experience, as well as mine, indicates that, at least in the area of withholding life sustaining treatment, patients frequently receive unwanted medical treatments that prolong their lives.<sup>55</sup> Such conflict often continues between providers and patients. In fact, from the last report that we did, among the 922 case calls received during a 30 month period at Choice in Dying, sixty-five percent of such calls involved concerns over unwanted treat-

truly operational definition).

<sup>52</sup> See GA. CODE ANN. § 31-7-172 (1983) (stating that therapeutic intervention is no longer appropriate if patient's medical prognosis is one with life expectancy of six months or less); MICH. COMP. LAWS § 333.5653 (West 1997) (describing terminal illness as condition in which a patient's death is anticipated within six months); MINN. STAT. § 62A.616 (1996) (interpreting terminal illness to be diagnosis certified by physician that person has less than six months to live); NEB. REV. STAT. § 20-403 (1993) (defining terminal illness as incurable, irreversible condition that without life sustaining system, will cause death within relatively short time); N.J. STAT. ANN. § 26:2-96 (West 1996) (stating that terminal illness is defined as illness for which there is unknown cure, which ultimately ends in death, and is certified as such by two physicians licensed to practice medicine and surgery); OKLA. STAT. tit. 63, § 3101.3 (West 1996) (stating that terminal illness means incurable, irreversible condition that even with administration of life-sustaining treatment, will in attending physician's, in addition to another physician's, opinion result in death within six months); WIS. STAT. § 50.90 (1993) (defining terminal illness as medical prognosis that individual's life expectancy is less than twelve months).

<sup>53</sup> See Coleson, *supra* note 4, at 60-63 (exploring three approaches to defining "terminally ill": (1) subjective determination; (2) statistical determination; and (3) disease threshold).

<sup>54</sup> See Donald E. Spencer, *Practical Implications for Healthcare Providers in a Physician-Assisted Suicide Environment*, 18 SEATTLE U. L. REV. 545, 554 (1995) (explaining importance of physician/patient communication).

<sup>55</sup> See Donald C. Dilworth, *Dying Wishes Are Ignored By Hospitals, Doctors*, TRIAL, Feb. 1, 1996, available in 1996 WL 13323062 (noting that many times physicians ignore patients' wishes not to be kept alive with life sustaining procedures, resulting in prolongation of patients suffering through receipt of unwanted medical treatment).

ment. Seventy-four percent of those instances involved a dispute, usually between the patient or the patient's family and the healthcare provider, over the use of life sustaining treatment. Choice in Dying and I are concerned that this lack of communication, reflected in the withholding or withdrawal of life sustaining treatment, will carry over into any discussion between the healthcare provider and the patient regarding physician-assisted suicide.

The above concerns need to be addressed and they need to be part of this continuous public debate. In fact, one of the reasons that we are all here today is to ensure that this essential public debate continues.

Thank you.