Just the Medical Facts: An Argument in Support of the Continued Ban on Physician-Assisted Suicide

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Thank you very much; it is a pleasure to be here. Assisted suicide is a complex topic, as the first speaker has certainly demonstrated in his survey of opinions in ethics, morality and the law. Assisted suicide is an intersection not only of those concepts, but also of medicine, compassion, and society's atti-
tude toward the terminally ill and the disabled. 4

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

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

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

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7 See Lee v. Oregon, 107 F.3d 1382, 1386 (9th Cir. 1997) (dismissing challenge to Oregon's Measure 16 on grounds that plaintiffs did not have standing), cert. filed, 65 U.S.L.W. 3783 (1997); see also Thomas Maier, Death By Choice: Oregon Voters Back MD-Aided Suicides, NEWSDAY, Nov. 6, 1997, at A5 (reporting that voters in Oregon approved law allowing prescription of life-ending drugs to terminally ill patients); Jeff Mapes, Suicide Law Ruling May Shake up Fall Vote, PORTLAND OREGONIAN, June 16, 1997, at A1 (describing opinion of James Bopp as chief attorney for Measure 16 Opponents regarding appeal to Supreme Court); Mark O'Keefe et al., Legislators May Refer Suicide Law to Voters, PORTLAND OREGONIAN, Mar. 1, 1997, D1 (discussing Bopp's plan to appeal to Supreme Court if Ninth Circuit refused to reconsider decision); Mark O'Keefe, Measure 16 Foes Keep Using Courts to Stall Law, PORTLAND OREGONIAN, Apr. 16, 1997, at B11 (discussing Bopp's reaction to Ninth Circuit's denial of reconsideration of February ruling).
with terminal illnesses of the protection of Oregon law against assisted suicide. Furthermore, as president of the National Legal Center for the Medically Dependent & Disabled, I helped coordinate, as our organization was the national coordinator, the amicus curiae briefs filed in support of the anti-assisted suicide laws in New York and Washington.

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

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


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

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


Geriatric Society\textsuperscript{16} and many, many others. The sole exception from the unanimous view of the healthcare organizations was the National Student Medical Association, which filed a brief for the opposing side.\textsuperscript{17} I think that proves the old adage: Students know only enough to be dangerous.

In addition to the healthcare professions, there were organizations representing people with disabilities,\textsuperscript{18} the United States Catholic Conference,\textsuperscript{19} the National Right to Life Committee\textsuperscript{20} and the Clinton Administration\textsuperscript{21} that all supported the notion that laws against assisted suicide should be upheld by the Supreme Court.

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


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


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

\textsuperscript{23} See Sanford Levinson, Fan Letters: Holmes & Frankfurter: Their Correspondence, 1912-1934, 75 TEX. L. REV. 1471, 1483 (1997) (discussing Brandeis as inventor of "Brandeis brief" who was extremely fact-oriented, as evidenced by his opinions while Supreme Court Justice). See generally BLACK'S, supra note 22, at 188 (noting "Brandeis brief" takes its name from Louis D. Brandeis, former Associate Justice of Supreme Court, who used this tactic while practicing law).
sought to advise a court of the societal consequences of a potential ruling by setting forth extensive relevant facts, outside the record that the court has before it, to inform and assist judges in coming to a correct result. Such briefs often play a major role in the decisions that courts make.

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

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

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


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

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

29 See AMA Brief, supra note 14, at 5-6, Washington v. Glucksberg, 117 S. Ct. 2258 (1997) (No. 96-110) (finding that it was implicit in Second Circuit’s decision that those requesting suicide do so to avoid excruciating pain); Coleson, Verbatim Arguments, supra note 12, at 9.
patients are condemned to face unmitigated torture before they die.30 "Implicit in the [court's] holding [are] the view[s] that [many of] those who request suicide do so to avoid excruciating pain and that health care professionals can do nothing compassionate in response other than" to assist in suicide.31

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

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

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

30 See AMA Brief, supra note 14, at 5-6, Washington v. Glucksberg, 117 S. Ct. 2258 (1997) (No. 96-110) (discussing fallacy that physicians' only compassionate response to extreme pain is suicide); Coleson, Verbatim Arguments, supra note 12, at 9.
32 See AMA Brief, supra note 14, at 6, Washington v. Glucksberg, 117 S. Ct. 2258 (1997) (No. 96-110)(arguing that there is no evidence supporting view that increasing numbers of patients die in severe pain); Coleson, Verbatim Arguments, supra note 12, at 9.
33 See AMA Brief, supra note 14, at 6, Washington v. Glucksberg, 117 S. Ct. 2258 (1997) (No. 96-110) (noting that management of pain has improved with better techniques and advanced technology).
34 Id. (discussing development of improved pain management) (quoting AMA Council on Scientific Affairs, Good Care of the Dying Patient, 275 JAMA 474, 475 (1996)).
36 See Bopp & Coleson, supra note 8, at 242 (stating that most people seeking suicide suffer from depressive illness, or some other psychiatric or emotional problem); Herbert
predictor of the desire for death."37 What are we talking about when we talk about depression? We are not talking about the term as we commonly use it; that is, being in a sad mood. What we are talking about is the psychiatric illness of depression, which triggers suicidal wishes. It is a psychiatric illness that renders one incapable of rational decision making.38 It is often triggered by major negative life events, such as a divorce, death, loss of a job, loss of a family member, or the onset of a terminal illness.39

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


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


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

41 See generally Amiram Elwork, *Depression's Devastation: Occupational Stress Can Contribute to Depression*, 56-May OR. ST. B. BULL. 39, 39 (1996) (noting symptoms of depression include sadness, fear of rejection and failure, guilt and anger); Elizabeth Emmett, *Depression: Research Sheds Light On a Dark Illness*, 31-Fall ARK. L.W. 4, 4
sive mood. One survey indicates that ninety-five percent of those who attempt suicide have the psychiatric illness of depression.42

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

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

The American Suicide Foundation argued in its brief:

No sound scientific or clinical basis exists for distinguishing

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

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

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

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

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

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

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

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

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


Most depression, just like most delirium, is not recognized or treated in current practice. The risks of involving persons with diminished capacity in [physician-assisted suicide] are substantial.\(^5\)

Medical fact number five: Elderly and ill patients are subject to undue influence and coercion and many will not seek assisted suicide voluntarily.\(^5\) The American Geriatric Society also addressed this issue:\(^5\)

Proponents of a constitutional right to [physician-assisted suicide] expect the practice to be limited to persons who are acting voluntarily, without undue influence or coercion. The image is that of an independent, capable person thoughtfully evaluating his or her options, unaffected by biased third parties or other circumstances. This is so far from the experience of dying as to be fanciful. Dying persons are often very weak, prone to strong emotions, and vulnerable to the suggestions, expectations, and guidance of others. In this context, pressure or encouragement from family, friends, and caregivers may cloud or overwhelm the patient’s independent judgment and thus amount to inappropriate coercion.\(^5\)

Medical fact number six: Pressure to contain healthcare costs will cause people to seek suicide.\(^5\) The American Medical Asso-
Pressure to contain health care costs exacerbates the problem. Even if, as one would expect, health care insurers would consciously seek to avoid suggesting to patients or physicians that they consider financial costs in making a decision to hasten death, the continuing pressure to reduce costs can only constrain the availability and quality of palliative care and support services that patients and families need. These limitations on the availability of proper care clearly can place pressure on patients to express a wish for suicide that they might not otherwise feel.

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

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

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

To offer [physician-assisted suicide] at this time does not merely offer an option but also affirms feelings of worthless-
ness or devaluation. Since, when comfortable and comforted, most patients feel that this was an unexpectedly important time, encouraging supportive care and discouraging suicide seems well within the purview of wise public policy.\(^{60}\)

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

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


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

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

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

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


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


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

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

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

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

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

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

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

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

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

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

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