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THE IMPLEMENTATION OF OREGON'S DEATH WITH DIGNITY ACT

Reassuring, But More Data Are Needed

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Undoubtedly, empirical data from Oregon will play a key role for academics, legislators, judges, and the public as debate over the legalization of physician-assisted suicide continues. A central issue in the debate is whether a right to assisted suicide can be limited to only the truly compelling cases, or whether it will in practice be provided to patients who choose it out of depression, coercion, or misunderstanding. Empirical research can provide critical insights into this question.

The absence or presence of data from the United States has played a major role in shaping right-to-die law. When the U.S. Supreme Court rejected a constitutional right to physician-assisted suicide in 1997,¹ the Justices expressed their concern about the risks of abuse and about the lack of empirical data by which they could assess the ability of legal safeguards to protect against abuse. The physician-assisted suicide cases were brought before there was any experience in this country with a right to suicide under state statutory or common law. Studies from the Netherlands have been cited widely in discussions about assisted suicide, and those studies were available to the Court. However, there is legitimate disagreement whether the Dutch experience with assisted suicide and euthanasia is transferable to a country like the United States, with its different demographics and different health care system.²

The empirical uncertainty strikingly contrasts with the circumstances that preceded the Supreme Court's 1990 decision in the *Cruzan* case that there is a constitutional right to refuse life-sustaining treatment.³ When the Court recognized such a right, it could look for reassurance to nearly a decade-and-a-half of experience with a right to refuse treatment under state constitutional and common law.⁴ The *Cruzan* Court knew that, for 14 years since the New Jersey Supreme

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¹Washington v. Glucksberg, 521 U.S. 702 (1997); *Vacco v. Quill*, 521 U.S. 793 (1997).

²Barney Sneiderman, *Euthanasia in the Netherlands: A Model for Canada?*, 8 HUMAN MED. 104, 108–9 (1992).

³*Cruzan v. Director, Missouri Department of Health*, 497 U.S. 261 (1990).

⁴David Orentlicher, *The Supreme Court and Terminal Sedation: Rejecting Assisted Suicide, Embracing Euthanasia*, 24 HASTINGS CONST. L. Q. 947, 949–50 (1997).

Court recognized a right to refuse treatment in the *Quinlan* case,⁵ physicians, patients, and families had made hundreds of thousands of decisions to withdraw or withhold life-sustaining treatment. The Court also knew that the decisions had generally been made responsibly.

Accordingly, when other states decide whether to follow the lead of Oregon, or the Justices of the Supreme Court reconsider their assisted-suicide decisions in legalizing physician-assisted suicide, they will look to studies from Oregon. If Oregon's experience indicates that assisted suicide can be limited to appropriate cases, legislators and courts will likely become more willing to grant a legal right to assisted suicide. Conversely, if it appears that assisted suicide in Oregon is regularly used by patients who are not terminally ill,⁶ who are depressed, or who otherwise do not fall within the Oregon law's guidelines, we can expect a waning of support for a legal right to assisted suicide.⁷

The empirical data to date are reassuring. As the article by Coombs Lee and Werth in this issue⁸ and the reports from Oregon in the *New England Journal of Medicine*⁹ indicate, implementation of Oregon's assisted suicide law seems to be proceeding according to design, with little evidence of abuse. For example, despite fears that there would be a high rate of assisted suicide as a result of the law, it apparently is infrequently used, with an estimated 0.09% of deaths in Oregon taking place by assisted suicide.¹⁰ By any measure, this is a low rate, and it is especially low in comparison with data from the Netherlands. In that country, assisted suicide occurs 4 times more frequently and euthanasia 26 times more frequently than does assisted suicide in Oregon.¹¹ In addition to being used

⁵*In re Quinlan*, 355 A.2d 647 (N.J. 1976).

⁶To be sure, even if Oregon's guidelines are not followed strictly on this requirement, support for physician-assisted suicide may persist. There are patients who are not terminally ill, but who are seriously and irreversibly ill, and for whom the public may believe that assisted suicide is a legitimate option. We currently permit people who are seriously and irreversibly but not terminally ill to refuse ventilators, dialysis, and other life-sustaining treatments.

⁷We might also see that people disagree whether Oregon's law is being abused, just as we see profoundly different views about the experience in the Netherlands with euthanasia and physician-assisted suicide. Indeed, there already are disagreements about the interpretation of the Oregon experience. Compare Kathleen Foley & Herbert Hendin, *The Oregon Report: Don't Ask, Don't Tell*, 29(3) HASTINGS CTR. REP. 37 (1999); Herbert Hendin, Kathleen Foley, & Margot White, *Physician-Assisted Suicide: Reflections on Oregon's First Case*, 14 ISSUES IN LAW & MED. 243 (1998); and Wesley J. Smith, *Dependency or Death? Oregonians Make a Chilling Choice*, WALL ST. J., February 25, 1999, at A18; with Arthur E. Chin, Katrina Hedberg, Grant K. Higginson, & David W. Fleming, *Legalized Physician-Assisted Suicide in Oregon—The First Year's Experience*, 340 NEW ENG. J. MED. 577 (1999).

⁸Barbara Coombs Lee & James L. Werth Jr., *Observations on the First Year of Oregon's Death With Dignity Act*, 6 PSYCHOL. PUB. POL'Y & LAW 268–290 (2000).

⁹Chin et al., *supra* note 7; Amy D. Sullivan, Katrina Hedberg, & David W. Fleming, *Legalized Physician-Assisted Suicide in Oregon—The Second Year*, 342 NEW ENG. J. MED. 605 (2001).

¹⁰Sullivan et al., *Oregon 1998–2000*, *supra* note 9, at 605.

¹¹Paul J. van der Maas, et al., *Euthanasia, Physician-Assisted Suicide, and Other Medical Practices Involving the End of Life in the Netherlands, 1990–1995*, 335 NEW ENG. J. MED. 1699, 1701 (1996) (reporting that 0.4% of all deaths occurred by assisted suicide and 2.3% of all deaths by euthanasia in the Netherlands in 1995).

sparingly in Oregon, the right to a legalized form of suicide has not encouraged suicide among young people in the state.¹²

It is also reassuring that physicians have complied with the requirements of the Oregon law¹³ and that decisions to die by assisted suicide are apparently not being driven by poor education, lack of insurance, or inadequate palliative care.¹⁴

Still, as critics of assisted suicide have observed, there may be abuses lurking in the Oregon data. We do not know whether patients in Oregon undergo an adequate psychiatric evaluation,¹⁵ whether physicians know their patients well enough to judge the voluntariness of their decisions,¹⁶ or how careful Oregon physicians are in adhering to the law's requirement that the patient be terminally ill to qualify for assisted suicide. We need to look at additional data to fill out the picture.

Moreover, even if the initial data from Oregon were more comprehensive, it would be premature to reach any definitive conclusions about the consequences of legalizing assisted suicide in the United States. Clearly, we need more than a few years of data from the state.

I suggest three other important sources of empirical data that would improve our understanding of assisted suicide in the United States.

Getting Better Data

A Controlled Study of Physician-Assisted Suicide

Some of the weaknesses in the empirical data so far reflect the methods used. For example, the study of Oregon's first year of assisted suicide relied solely on information provided to the Oregon Health Division by physicians who wrote prescriptions under the act, and there were no interviews of patients or their families.¹⁷ The study by Coombs Lee and Werth was limited by the data-gathering practices of Compassion in Dying, which did not include, for example, whether patients were referred for psychological evaluation.¹⁸

As with other new treatments that carry a promise of improved patient welfare but also may pose serious risks, important empirical information about assisted suicide can be obtained by studying the practice in a rigorous research trial. By subjecting assisted suicide to a trial with close supervision, we can test the value of assisted suicide without unduly jeopardizing patient welfare. That is, rather than simply collecting data as assisted suicide is implemented by physicians

¹²Coombs Lee & Werth, *supra* note 8, at text accompanying notes 53–54.

¹³Coombs Lee & Werth, *supra* note 8, at text accompanying note 19. One physician, however, submitted an incomplete informed consent form. Sullivan et al., *Oregon, 1998–2000*, *supra* note 9, at 605.

¹⁴Chin et al., *supra* note 7, at 582; Sullivan et al., *Oregon—The Second Year*, *supra* note 9, at 602.

¹⁵Coombs Lee & Werth, *supra* note 8, at text accompanying note 34; Hendin, et al., *supra* note 7, at 251–254.

¹⁶Smith, *supra* note 7.

¹⁷Chin et al., *supra* note 7, at 578; Smith, *supra* note 7. For its second-year study, Oregon did include interviews with physicians and family members. Sullivan et al., *Oregon—The Second Year*, *supra* note 9, at 600–602.

¹⁸Coombs Lee & Werth, *supra* note 8, at text accompanying notes 34–35.

acting individually under Oregon's law, researchers should undertake a carefully designed, prospective study.¹⁹

The conditions for the trial might be as follows: It could take place at a major medical center that has expertise in the care of dying patients. Many of the study's requirements would be defined by Oregon's assisted suicide statute. For example, patients would have to be irreversibly ill, with no more than 6 months to live. In addition, the patients would have to be mentally competent to choose assisted suicide, and they would have to request assisted suicide voluntarily and consistently over a 15-day period. Other requirements could be added to ensure that a choice of suicide would reflect a genuine and competent expression of autonomy. For example, maximum palliative care should be made available and encouraged, and, as recommended in formal guidelines developed in Oregon, a psychiatrist or psychologist would have to certify that the patient is mentally competent and not suffering from a treatable depression.²⁰ Steps could be taken to help ensure that enough data were gathered about the use of assisted suicide. For example, patients and their families could be asked to keep diaries during the process, with structured questions provided to guide their writing, and discussions about assisted suicide between physicians and patients could be recorded and transcribed.

A clinical trial would help answer some important questions that have been raised in the assisted suicide debate and that are not likely to be adequately answered by current data being generated in Oregon. Are terminally ill patients driven to seek suicide because nothing can be done for their suffering, because they have not received adequate care, or because they have a treatable depression? To what extent are the anxieties of patients and families relieved by the assisted suicide process, and to what extent do patients express discomfort with their decision or indicate difficulties with explicit or implicit pressure to choose suicide? Are diagnoses of terminal illness made on the basis of sufficiently reliable information? Do patients adequately understand their prognosis and their therapeutic alternatives? What leads some patients to fill their prescription and take the lethal dose of medication and other patients to leave the prescription unfilled or the drugs untaken?

Regardless of whether there are formal clinical trials, assisted suicide will continue to occur in Oregon. Nevertheless, carefully designed trials will improve our understanding of the assisted suicide process, indicate whether changes need to be made in Oregon's law, and provide guidance on whether other states would do well to follow Oregon's model.

Comparative Data From Decisions to Withdraw Life-Sustaining Treatment

There are legitimate concerns about possible abuses from a right to assisted suicide. Yet, the same potential for abuse exists with a right to refuse life-

¹⁹It may be the case that such a study is already underway.

²⁰Linda Ganzini & Tony Farrenkopf (1998). *Mental Health Consultation and Referral*, in B. Reagan (Ed.), *THE OREGON DEATH WITH DIGNITY ACT: A GUIDEBOOK FOR HEALTH CARE PROVIDERS*. PORTLAND, OR: THE TASK FORCE TO IMPROVE THE CARE OF TERMINALLY ILL OREGONIANS. (For updates, see <http://www.ohsu.edu/ethics/contents.htm>.)

sustaining treatment. For example, many commentators observe that there may be compelling cases in which assisted suicide would be appropriate. However, they also believe that assisted suicide in practice would not be limited to only the compelling cases but would be extended to patients who are not appropriate candidates for suicide.²¹ Although this concern is legitimate, the same risks of abuse exist with respect to a right to refuse life-sustaining treatment. Life-sustaining treatment might be withdrawn from incompetent patients, for example, on the basis of decisions by family members who are driven by their self-interest rather than by the wishes of the patients. Indeed, all of the "slippery slope" arguments made for prohibiting assisted suicide are also arguments for prohibiting the withdrawal of life-sustaining treatment.²²

Before we decide whether to make assisted suicide widely available, it would be very helpful to know how the practice of assisted suicide compares with the practice of treatment withdrawal. Accordingly, it would be important not only to study the assisted suicide process but also to study withdrawals of life-sustaining treatment in the same way. We might find that assisted suicide is abused more, the same, or less than withdrawals of treatment.²³ If assisted suicide is no more abused than treatment withdrawal, and the risks of treatment withdrawal are viewed as tolerable by society, then it follows that the risks of assisted suicide should be viewed as tolerable by society.

To see how the risks of abuse are the same, consider the following examples of potential abuse:

*Requests for assisted suicide may reflect inadequate treatment of pain or fears that suffering will become intolerable in the future.*²⁴ The appropriate response, it is argued, should be better palliative care that will relieve discomfort and provide reassurance to patients that future suffering will also be alleviated. Without doubt, greater attention must be paid to the care of the dying. Nevertheless, the inadequacy of palliative care can also drive patients to refuse life-sustaining treatment. Indeed, the Nevada Supreme Court concluded that Kenneth Bergstedt had the right to have his ventilator withdrawn because he feared that his life would become intolerable once his terminally ill father died and was no longer able to care for him.²⁵

It might be too dangerous to allow assisted suicide in a health care system run by managed care. With insurers rewarding physicians and hospitals for spending less on patients, fewer resources will be available for the kinds of supportive care needed to relieve a dying patient's suffering. Patients will choose suicide when

²¹Yale Kamisar, *Physician-Assisted Suicide: The Problems Presented by the Compelling Heartwrenching Case*, 88 J. CRIM. L. & CRIMINOLOGY 1121, 1124-1127 (1998).

²²David Orentlicher, *The Legalization of Physician-Assisted Suicide: A Very Modest Revolution*, 38 BOSTON COLLEGE L. REV. 443, 459-460 (1997).

²³Because assisted suicide is performed by a competent patient, and life-sustaining treatment can be withdrawn from incompetent patients, it is quite possible that it is less susceptible to abuse than treatment withdrawal. Assisted suicide may be less susceptible to abuse also because by law in Oregon it is limited to terminally ill persons, while treatment can be withdrawn from any person, regardless of prognosis.

²⁴Mark E. Chopko & Michael F. Moses, *Assisted Suicide: Still a Wonderful Life?*, 70 NOTRE DAME L. REV. 531-532 (1995).

²⁵McKay v. Bergstedt, 801 P.2d 617 (Nev. 1990).

better care would have caused them to change their mind.²⁶ Yet, resource constraints are even more likely to cause premature withdrawals of life-sustaining treatment. Patients dependent on ventilators or dialysis consume more resources than patients who are not so dependent, and patients can live for many years, even decades, while being sustained on artificial life supports. When physicians at Hennepin County Medical Center objected to ventilatory treatment for Helga Wanglie because of her persistent vegetative state, they observed that insurance payments for her health care came to \$700,000 for 18 months of hospitalization.²⁷

Patients choosing assisted suicide will do so because of a treatable psychiatric depression. Physicians often are not adequately trained to distinguish a rational desire for suicide from an irrational one.²⁸ As important a concern as this is, it is also just as much a concern when patients refuse life-sustaining treatment. Those refusals may also arise out of a treatable but undiagnosed depression.

*Physicians may misdiagnose patients as being terminally ill.*²⁹ People may choose suicide on the mistaken impression that they have only a few months to live. This too is an important concern, but it is just as much a concern for withdrawals of treatment. Imprecise diagnoses are also a problem for patients deciding whether to continue on a ventilator or accept other life-prolonging therapies. Patients may refuse life-sustaining treatment because they have been told mistakenly that they will be dependent on artificial life support for the rest of their lives or because they have been told mistakenly that they are terminally ill.

We do need to worry about the risks of abuse with assisted suicide. However, we have a long experience with exactly the same concerns when patients refuse life-sustaining treatment. What we have done in that context is adopt careful safeguards to protect against abuse, and this gives us good reason to think that careful safeguards can also protect against abuse with assisted suicide. As Oregon has done, assisted suicide can be limited to terminally ill patients who have made a clear, persistent, and voluntary request for suicide assistance. It may be that other safeguards are needed, such as mandatory evaluation by a psychiatrist, but it may also be the case that the same safeguards are needed for withdrawals of treatment. The important point is that we can do more than continue making these arguments back and forth. Empirical data from a comparison of assisted suicide and treatment withdrawal can help us advance our understanding and possibly resolve this part of the assisted suicide debate.

Comparative Data From Dr. Jack Kevorkian's Experience With Assisted Suicide

The two kinds of studies I have already suggested will not yield data for some time. A more immediate way to get a sense of the Oregon experience would be

²⁶Daniel P. Sulmasy, *Managed Care and Managed Death*, 155 ARCHIVES INTERNAL MED. 133 (1995); Susan Wolf, *Physician-Assisted Suicide in the Context of Managed Care*, 35 DUQ. L. REV. 455 (1996).

²⁷Steven H. Miles, *Informed Demand for "Non-Beneficial" Medical Treatment*, 325 NEW ENG. J. MED. 512, 513 (1991).

²⁸Yeates Conwell & Eric D. Caine, *Rational Suicide and the Right to Die: Reality and Myth*, 325 NEW ENG. J. MED. 1100, 1101 (1991).

²⁹Eric Chevlen, *The Limits of Prognostication*, 35 DUQ. L. REV. 337 (1996).

to compare it with the experience of illegal assisted suicide in Michigan at the hands of Dr. Jack Kevorkian. For example, are there important differences between assisted suicide patients in Oregon and assisted suicide patients in Michigan? We can imagine that, of those dying patients who meet the Oregon guidelines, only a small percentage truly want to end their lives by assisted suicide.³⁰ Among those patients, some would turn to a Kevorkian, but most would not be willing to violate the law. In other words, assisted suicide patients in Oregon and Michigan might differ only in their tolerance for law breaking. On the other hand, it also might be the case that Kevorkian would assist patients with suicide when other physicians would conclude that suicide is inappropriate, either because the patient is not seriously ill enough,³¹ because the patient is acting out of treatable depression, or for other reasons, such as the sense that the patient is acting in response to undue coercion by family members. Kevorkian used some safeguards to protect against abuse but eschewed others.³² For example, he did not limit his assistance to terminally ill persons. This raises an important question: To what extent does the evidence indicate that the kinds of legal safeguards in Oregon play an important role in protecting against abuse? Are certain safeguards seemingly more important than other safeguards? For example, is it critical to have psychiatric evaluation and to limit assisted suicide to terminally ill persons, but not as critical to have a 15-day waiting period?

An adequate comparison of the experience in Oregon with the experience in Michigan may be hampered by an unavailability of important information from many of Kevorkian's assisted suicides. On the other hand, he and family members of his patients may be more forthcoming with researchers who have a genuine interest in assessing his practices.

While I have been unable to do a complete comparison myself, I can offer a preliminary comparison between the early experience in Oregon and the early experience of Kevorkian in Michigan. In comparing the two experiences, I have relied more on the data reported from Oregon by Chin et al. in the *New England Journal of Medicine* rather than on the data from Coombs Lee and Werth in this issue because Chin et al.'s report covers a larger group of patients who died by assisted suicide (15 vs. 10).³³ With regard to Kevorkian, I will be considering data primarily from his first 20 patients.³⁴

³⁰Ezekiel J. Emanuel, Diane L. Fairclough, & Linda L. Emanuel, *Attitudes and Desires Related to Euthanasia and Physician-Assisted Suicide Among Terminally Ill Patients and Their Caregivers*, 284 JAMA 2460, 2463 (2000); finding that less than 11% of terminally ill patients surveyed had thought seriously about requesting euthanasia or assisted suicide.

³¹This in fact appeared to be the case with Kevorkian.

³²It also appears that he does not follow his own guidelines in every case. Kirk Cheyfitz, *He Breaks His Own Rules: Kevorkian Rushes to Fulfill His Clients' Desire to Die*, DETROIT FREE PRESS, March 3, 1997, at 7A.

³³The Oregon data from both reports also include patients who received a prescription but had not used it and patients who had expressed an interest in assisted suicide but had not received a prescription. Because these patients may be different in important ways from those who ended their lives by assisted suicide, and because Kevorkian likely has been approached by people who ultimately did not choose to commit suicide with this assistance, I will use only the data for the people who actually died by assisted suicide in Oregon.

³⁴The sources for the data are listed in an Appendix to this article.

The data. In terms of demographics, we find a number of differences. In Oregon, the average age of assisted suicide patients was 69 years.³⁵ Kevorkian's patients were more than a decade younger, averaging 57.1 years.³⁶ The difference in average age cannot be explained by Kevorkian's willingness to provide assisted suicide to people who were not terminally ill. Among his terminally ill patients, the average age was 57–58; for his patients who were not terminally ill, the average age was 56–57.³⁷

The patients in Oregon also differed from the Kevorkian patients by sex but not by race. Among the Oregon patients, 47% were women³⁸ compared with 60% of Kevorkian's patients.³⁹ All of the patients were White for both Oregon and Kevorkian.⁴⁰

Kevorkian's patients were somewhat better educated. In Oregon, 27% had a college degree and 80% were high school graduates;⁴¹ some 35% of Kevorkian's patients had completed their undergraduate studies and 90% had earned a high school diploma.⁴² As already mentioned,⁴³ the data show no difference in educational status between assisted suicide patients in Oregon and matched controls, suggesting that poorly educated persons are not placed at special risk by a right to assisted suicide. The Michigan data reinforce that finding. Indeed, they further suggest that a right to assisted suicide is the kind of right that is more important to well-educated persons than to poorly educated persons. As some commentators have observed,⁴⁴ people of lower socioeconomic status (and education correlates highly with economic status) need to worry more about whether they can get medical care to keep them alive rather than whether they can get medical care to die, and there is greater support in the public for a right to assisted suicide among persons of higher socioeconomic status.

As to marital status, of the Oregon patients, 13% were married, 33% were

³⁵Chin et al., *supra* note 7, at 580. After 3 years, the average age has been 70 years. Sullivan et al., *Oregon, 1998–2000*, *supra* note 9, at 606.

³⁶The average age of Kevorkian's patients is a mean age; the average age from the Oregon article is a median age.

³⁷The ranges for average age reflect the fact that it was not clear whether one of the patients, Hugh Gale, was terminally ill.

³⁸Chin et al., *supra* note 7 at 579. For all 3 years, women have accounted for 49% of those committing assisted suicide. Sullivan et al., *Oregon, 1998–2000*, *supra* note 9, at 606.

³⁹The gender differential widened over time with Kevorkian's patients. Whereas 60% of his first 20 patients were female, 68% of his first 47 patients were female. Brian Dickerson, *Death Express: Acquitted, Kevorkian Speeds Through 13 Suicides in Three Months*, DETROIT FREE PRESS, March 3, 1997, at 6A.

⁴⁰After 3 years in Oregon, 97% of patients have been White and 3% have been Asian. Sullivan et al., *Oregon, 1998–2000*, *supra* note 9, at 606.

⁴¹Chin et al., *supra* note 7, at 580. For all 3 years in Oregon, 43% were college graduates and 89% had graduated from high school. Sullivan et al., *Oregon, 1998–2000*, *supra* note 9, at 606.

⁴²The educational status of Kevorkian's patients is not clear for a number of his patients. The 35% and 90% figures are based on the educational status of the 40 of his first 47 patients for whom their educational status is known. Dickerson, *supra* note 36.

⁴³See text accompanying *supra* note 14.

⁴⁴Susan M. Wolf, *Shifting Paradigms in Bioethics and Health Law: The Rise of a New Pragmatism*, 20 AM. J. L. & MED. 395, 402 (1994).

widowed, 27% were divorced, and 27% never married.⁴⁵ For Kevorkian's patients, 40% were married, 5% were widowed, 40% were divorced, and 15% never married. This may seem surprising. If one believes that Kevorkian preys on vulnerable persons, one might guess that more of his patients would be living alone, without an adequate support system.⁴⁶ Yet 40% of his patients were married at the time of death, compared with 13% of the Oregonians. One possible explanation is that married persons are in fact more vulnerable to the extent that they feel pressure to consider the emotional and financial burdens that they place on their spouses.⁴⁷ After 3 years, Oregon's data are similar to those of Kevorkian. Forty-six percent of the assisted suicide patients from 1998–2000 were married at the time of death.⁴⁸

In addition to the demographic differences, there were also striking differences in terms of the patient's underlying disease. Among the 15 Oregonians, 87% were dying of cancer, whereas the remaining 13% were split between congestive heart failure and chronic obstructive lung disease.⁴⁹ Among Kevorkian's first 20 patients, 50% were dying of cancer, 15% suffered from amyotrophic lateral sclerosis (ALS, or Lou Gehrig's disease), and another 15% from multiple sclerosis (MS); 10% had both congestive heart failure and chronic obstructive lung disease, 5% had early Alzheimer's disease, and 5% experienced severe pelvic pain of unknown origin. These differences in underlying diagnosis are clearly linked to another striking difference. Whereas all of the Oregon patients were apparently terminally ill, as required by Oregon law, only 55–60% of Kevorkian's first 20 patients were terminally ill.⁵⁰ Among Kevorkian's 10 patients with a malignancy, 9 were terminally ill. Among his 10 patients with a diagnosis other than cancer, only 2 or 3 were terminally ill.⁵¹

It is difficult to compare the two groups of patients in terms of their reasons for dying because the report from Oregon gives more precise reasons for the patients' choice of assisted suicide. Common reasons for assisted suicide in Oregon were the loss of autonomy (80%), the inability to participate in activities (67%), and the loss of control of bodily functions (53%).⁵² Common reasons

⁴⁵Chin et al., *supra* note 7, at 580.

⁴⁶The 40% figure for marriage was not simply an anomaly of Kevorkian's first 20 patients. Of his first 47 patients, 40% were living with a spouse (36%) or partner (4%). Dickerson, *supra* note 36.

⁴⁷The greater likelihood of marriage among Kevorkian's patients does not seem to reflect their younger age compared with the assisted suicide patients in Oregon. Although the average age of Kevorkian's patients was 57, the average age of his married patients was 64.

⁴⁸Sullivan et al., *Oregon, 1998–2000*, *supra* note 9 at 606.

⁴⁹Chin et al., *supra* note 7, at 579. A leading type of chronic obstructive lung disease is emphysema.

⁵⁰For one of Kevorkian's patients, there was not sufficient information available regarding his life expectancy at time of death. See *supra* note 35.

⁵¹After 3 years, cancer was responsible for 74% of underlying illnesses in Oregon, down from 87% in the first year, and a broader range of diagnoses was responsible for the other 26%, though still not as broad a range of illness as seen in Kevorkian's patients. Sullivan et al., *Oregon, 1998–2000*, *supra* note 9, at 606; Sullivan et al., *Oregon—The Second Year*, *supra* note 9, at 600.

⁵²Chin et al., *supra* note 7, at 581. The corresponding percentages for all 3 years were 83% loss of autonomy, 77% inability to participate in activities, and 66% loss of control of bodily functions. Sullivan et al., *Oregon 1998–2000*, *supra* note 9, at 606.

for suicide by Kevorkian's patients were that there was too much suffering and the patient could not go on any longer (40%), life was meaningless or hopeless (30%), there was uncontrolled pain (25%),⁵³ and the patient did not want to suffer like other family members had suffered when they died (20%). It is worth noting a similarity between the report by Coombs Lee and Werth in this issue and the data on Kevorkian's patients. A Compassion in Dying patient was quoted as expressing a typical feeling: "She had progressed to the point that she was 'no longer living, but just existing.'"⁵⁴ This was also a common sentiment among Kevorkian's first 20 patients.

Interpreting the data. There are real limits to what we can learn from a comparison of data from Oregon and Michigan, partly because we do not have complete information about assisted suicides in the two states, and partly because Kevorkian often did not follow his own safeguards. For example, in many cases, he did not have patients examined by a psychiatrist to exclude the possibility of a treatable depression, nor did he always undertake a detailed review of the patient's medical records.⁵⁵ Accordingly, we cannot know whether abuses in Kevorkian's practice tell us more about Kevorkian or more about the inability of strict safeguards to protect against abuse. It may be that other physicians, as suggested by the data of Coombs Lee and Werth,⁵⁶ will be conscientious in adhering to the requirements of assisted suicide law and that a right to assisted suicide will be no more abused than a right to refuse life-sustaining treatment. It may also be the case, as critics of assisted suicide have argued, that regulation of assisted suicide cannot adequately prevent abuse.⁵⁷

There is telling evidence, however, that a requirement of terminal illness is a very important safeguard against abuse. For example, recall that women were more likely than men to use Kevorkian's services. There may be innocent explanations for this disparity, but it also raises concern that something may be awry. For example, to the extent that women are less powerful and more vulnerable than men in society, women might be more likely to die inappropriately by assisted suicide. If we look just at the patients of Kevorkian who were terminally ill, though, the Michigan data look much more like the data from Oregon. Of Kevorkian's terminally ill patients, 6 out of 11 (or 7 out of 12)⁵⁸ were men. In other words, just as 53% (8 out of 15) of the Oregon assisted suicides involved men,⁵⁹ 55% (or 58%) of Kevorkian's assisted suicides involved men.

A requirement of terminal illness also addresses two other important concerns. There have been charges that, because Kevorkian does not adequately

⁵³Only 7% of the Oregon patients complained of uncontrolled pain. Chin et al., *supra* note 7, at 581. For the first 3 years, 17% of Oregon patients reported inadequate pain control or indicated that they were concerned about the possibility of poorly controlled pain. Sullivan et al., *Oregon, 1998–2000*, *supra* note 9, at 606.

⁵⁴Coombs Lee & Werth, *supra* note 8, at text accompanying notes 29–30.

⁵⁵Cheyfitz, *supra* note 30.

⁵⁶Coombs Lee & Werth, *supra* note 8, at text accompanying note 19.

⁵⁷Daniel Callahan & Margot White, *The Legalization of Physician-Assisted Suicide: Creating a Regulatory Potemkin Village*, 30 U. RICHMOND L. REV. 1 (1996).

⁵⁸For one patient, it was not clear whether he was terminally ill. See, *supra*, note 35.

⁵⁹Chin et al., *supra* note 7, at 580. Or 51% were male in Oregon after 3 years, Sullivan et al., *Oregon, 1998–2000*, *supra* note 9, at 606.

evaluate his patients before assisting their suicides, he has helped end the lives of some persons who did not suffer from serious and irreversible illness but suffered from despondency over matters other than their health.⁶⁰ A requirement that patients be terminally ill would have avoided suicide in those cases.

A requirement of terminal illness also helps protect against fallible evaluations by physicians acting more conscientiously than Kevorkian. Even with referral for careful evaluation by a psychiatrist, there is a real risk that the patient will be misjudged as making a competent decision to commit suicide. As with any kind of medical testing, psychological evaluation will have "false positive" results, and we want to be especially careful to avoid cases in which we wrongly think that the patient has autonomously chosen death. By requiring that the patient be terminally ill, we have an objective measure to reassure us that the patient's decision to die is grounded in a genuine expression of self-determination.⁶¹ When a patient is terminally ill, it is much more likely that a choice to die reflects a rational trade-off between quality of life and length of life than when a person is not terminally ill.⁶²

Conclusion

More information is almost always better, and the assisted suicide debate is no exception. The data from Oregon are reassuring in their indication that the law is being implemented according to its requirements and that assisted suicide is not being extended to patients who do not qualify for the statutory right.

On the critical question whether assisted suicide can be permitted in the compelling cases without opening up the door to a slippery slope of abuse, the data support the view that Oregon's law contains adequate safeguards. Still, without more data, the question remains open. There may be undetected abuses, and the early experience may not be reflective of future practices. To enhance our understanding of assisted suicide, we need data from more patients than we currently have. We also should go beyond the kinds of studies that have so far been performed to include (a) a more rigorously controlled trial of assisted suicide, (b) a study comparing assisted suicide with treatment withdrawal, and (c) a comprehensive study comparing the experience in Oregon with the experience in Michigan with Dr. Kevorkian.

Response to the Commentary by Callahan and White

In their commentary on the Oregon experience, Callahan and White point to several concerns with legalized physician-assisted suicide. They are legitimate concerns, yet the concerns also exist with respect to the right to refuse life-

⁶⁰Cheyfetz, *supra* note 30.

⁶¹Richard A. Epstein, MORTAL PERIL: OUR INALIENABLE RIGHT TO HEALTH CARE? 300-305 (Reading, MA: Addison-Wesley, 1997); David Orentlicher, *The Alleged Distinction Between Euthanasia and the Withdrawal of Life-Sustaining Treatment: Conceptually Incoherent and Impossible to Maintain*, 1998 U. ILL. L. REV. 837, 851-853.

⁶²To be sure, there are people with severe, nonterminal illnesses who might rationally choose death, but there are also many more people with nonsevere, nonterminal illnesses who are at risk for suicide that no one would consider appropriate.

sustaining treatment. If we respond to concerns with life-sustaining treatment by regulating the practice, why should we respond to the same kinds of concerns with assisted suicide by prohibiting that practice? Unfortunately, Callahan and White do not answer this question.

Callahan and White remind us that Dutch physicians fail to follow official guidelines when performing euthanasia. In about 25–30% of cases involving euthanasia or assisted suicide, patients did not make an explicit and contemporaneous request to have their life ended.⁶³ Whether this represents abuse is not clear. The requirement of an explicit and contemporaneous request helps assure us that the patient's death truly reflects the patient's wishes. Nevertheless, the absence of a contemporaneous request does not automatically mean that the patient's death is inconsistent with the patient's wishes. In some cases, patients had expressed their desire for euthanasia but were no longer able to communicate at the time of their death.⁶⁴ In these cases, euthanasia may well have been exactly what the patient wanted.

However, even assuming that the failure to comply with official guidelines represents abuse, we still have the same problem when life-sustaining treatment is withheld or withdrawn. For example, in a prospective study of the extent to which physicians carry out a patient's living will, researchers found that physicians overrode patient preferences 25% of the time. Moreover, physicians withheld desired treatment in 75% of the overrides.⁶⁵ Other studies have documented failures by physicians to follow guidelines for writing do-not-resuscitate (DNR) orders, including the writing of DNR orders after discussions with the family rather than with the patient.

We should be worried about noncompliance by physicians when they assist a patient's suicide. However, we should respond to the risk of noncompliance with assisted suicide regulations in the same way that we respond to the risk of noncompliance with treatment withdrawal regulations, unless there is some other reason to treat the two practices differently. Callahan and White suggest other reasons, but those reasons also do not distinguish assisted suicide from treatment withdrawal.

For example, Callahan and White observe that "it is impossible to effectively regulate PAS [physician-assisted suicide]. Doctor-patient relationships are private and cannot be monitored, and what cannot be monitored cannot be regulated." True enough, but withdrawals of treatment emerge from the same private doctor-patient relationships.

Callahan and White also reject assisted suicide because they "believe that PAS represents a corruption of the practice of medicine, one of whose aims is to save and protect life, not help that life be taken." Yet turning off a ventilator also contributes to the ending rather than the preserving of a life.

Finally, Callahan and White express concern that the desire for assisted suicide is not about the pain or suffering imposed by illness but about loss of

⁶³Van der Maas et al., *supra* note 11, at 1700–1701.

⁶⁴*Id.* at 1701–1702.

⁶⁵Marion Danis, et al., *A Prospective Study of Advance Directives for Life-Sustaining Care*, 324 NEW ENG. J. MED. 882, 884–885 (1991).

control. They also observe that when distinguishing dying patients who choose assisted suicide from those who do not so choose, we seem to find that the key variable is the extent to which control and autonomy matter to the patient. I suspect that Callahan and White are correct about the role of desire for control in decisions to choose assisted suicide. I also suspect, however, that the same desire for control is critical in decisions to refuse life-sustaining treatment. Thus, if dissatisfaction with the loss of control is not a legitimate justification for assisted suicide, how can it be a legitimate justification for refusing life-sustaining treatment?

I agree with Callahan and White that assisted suicide poses real concerns for patients, physicians, and society. However, we have weathered the same concerns well with legalized refusal of life-sustaining treatment by regulating treatment withdrawals carefully. This experience indicates that we should be able to protect against abuse with assisted suicide by regulating it carefully.

Appendix

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