

Is the Legalization of Physician-Assisted Suicide Compatible with Good End-of-Life Care?

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ABSTRACT *Many have held that there is some kind of incompatibility between a commitment to good end-of-life care and the legalization of physician-assisted suicide. This opposition to physician-assisted suicide encompasses a cluster of different claims. In this essay I try to clarify some of the most important of these claims and show that they do not stand up well to conceptual and empirical scrutiny.*

Introduction

Many have held that there is some kind of incompatibility between a commitment to good end-of-life care and the legalization of physician-assisted suicide. We can gain an initial sense of this way of thinking simply from the titles of three recent anti-PAS essays: ‘Competent care for the dying instead of physician-assisted suicide’ (Foley, 1997); ‘Pain management rather than assisted suicide: the ethical high ground’ (Orr, 2001); ‘The proposed Assisted Dying Bill negates end-of-life care’ (Robinson, 2004).¹

These worries about PAS are unfounded. There is no incompatibility between a commitment to good end-of-life care and the legalization of physician-assisted suicide.

Opposition to the legalization of physician-assisted suicide (or PAS) based on its relationship to end-of-life care encompasses a cluster of different claims.² In what follows I try to clarify some of the most important of these claims and show that they do not stand up well to conceptual and empirical scrutiny.

In section 1, I address the claim that better end-of-life care eliminates requests for PAS. In section 2, I address the claim that requests for PAS are often due to depression, which end-of-life care should aim to treat. In section 3, I address the claim that physical pain is the only legitimate reason for PAS, and that good end-of-life care can relieve physical pain. In section 4, I address the claim that many requests for PAS are illegitimate because they are based in hopelessness. In section 5, I address the claim that PAS is incompatible with hospice care. And in section 6, I address the claim that PAS is incompatible with the value end-of-life care ought to place on a natural death.

Before I begin, however, let me note what I will *not* try to do. I will not try to show that PAS is a fully justifiable course of action or that, all things considered, we ought to legalize PAS. I will try to show only that the principles of good end-of-life care do not imply the unjustifiability of PAS; that the goals of end-of-life care do not constitute a reason not to allow PAS; that the legalization of PAS is compatible with a commitment to good end-of-life care.

1. Will Better End-of-Life Care Eliminate Requests for PAS?

Some who hold the anti-PAS view claim that terminally ill people who would otherwise seek PAS will not seek it once they learn about the full range of end-of-life options that can be made available to them. As Lee has put it, ‘If we were to do a better job of responding to suffering individuals in a loving, caring manner, physician-assisted suicide would in all likelihood be an option rarely, if ever, chosen’.³ Orr maintains, ‘Patients who are receiving good end-of-life care rarely request that their physicians hasten death’ (Orr op. cit.). Stoddard writes, ‘[P]eople who are comfortable, secure and lovingly cared for *do not want* to commit suicide’.⁴ Hendin says, ‘The appeal of assisted suicide and euthanasia is a symptom of our failure to develop a better response to death and the fear of intolerable pain or artificial prolongation of life’.⁵ And Robinson contends that assisted suicide should remain illegal because ‘there is no suffering that cannot be relieved or removed if patients have the opportunity for expert clinical support and care by trained staff. Our efforts should be focused on raising the levels of skill among the healthcare team to relieve suffering, not getting rid of the problem by assisting in the elimination of the patient’ (Robinson op. cit.). Those who make this claim believe ‘that adequate palliative care can prevent people from requesting euthanasia’ (Hermsen & ten Have op. cit.). They believe that PAS is a tragically defeatist response to problems that good end-of-life care can solve.⁶

If this claim were true, we should expect to find that patients receiving good end-of-life care almost never request PAS — that the availability of good end-of-life care virtually eliminates requests for PAS. Numerous studies have found, however, that even among patients receiving good end-of-life care, there is still a consistently non-negligible percentage who request PAS or evince a wish to hasten death. In a 1998 study of 140 AIDS patients with attentive and supportive caregivers, it was found that 12.1% used medications ‘to hasten death’.⁷ In a 2000 study of 92 terminally ill cancer patients at a palliative care hospital in New Jersey, it was found that 17% had ‘a high desire for hastened death’.⁸ In a 2000 study of 92 terminally ill cancer patients at a palliative care hospital in New York, it was found that 16.3% had ‘a high desire for death’.⁹ In a 2000 study of 70 terminally ill patients receiving palliative care for advanced cancer, 12% would have requested PAS if it had been legal.¹⁰ In a 2002 study of 279 ALS patients in the Netherlands, it was found that 20% died as a result of euthanasia or PAS, and that these patients were ‘similar to patients who died from other causes in terms of the receipt of hospice care and professional home care’.¹¹ In a 2003 study of 256 terminally ill cancer patients at hospice and palliative care facilities in Australia, it was found that 14% reported a ‘high wish to hasten death’.¹² In a 2005 study of 80 ALS patients at the Gehrig ALS Research Center at Columbia University, it was found that 18.9% ‘wished to die’.^{13,14}

We can see, then, that the empirical evidence strongly suggests that a non-negligible percentage of terminal patients — somewhere between 12% and 20% — will continue to express interest in PAS or evince a desire for hastened death even when they are receiving good end-of-life care.¹⁵ Of course good end-of-life care may lead some people who would otherwise seek PAS not to seek it, and this is a compelling reason to make such care available to all. Indeed, we should perhaps consider legalizing PAS only in those places where good end-of-life care is widely available, as it is uncontroversially regrettable for a person to commit suicide only because she is not receiving proper

end-of-life care; it is uncontroversially regrettable if a person commits suicide but would not have done so if her end-of-life care had been better.¹⁶ But the evidence of the last paragraph implies that the availability of such care will not come close to eliminating requests for PAS altogether. Somewhere between 12 and 20% of the terminally ill have reasons for considering hastening death that persist even when they are receiving good end-of-life care.

2. Depression and Requests for PAS

The second anti-PAS claim I want to examine is this: requests for PAS often result from depression, but good end-of-life care should aim to alleviate depression rather than accede to the self-destructive wishes that arise from it.

The claim that requests for PAS often result from depression seems initially to have strong empirical support. Emanuel *et al.*, for instance, claim, 'One of our most striking findings is that patients who had seriously considered and prepared for euthanasia or physician-assisted suicide were significantly more likely to be depressed'.¹⁷ And Breitbart says that depression is one of the 'two strongest predictors of desire for hastened death' (Breitbart *et al.* 2000 *op. cit.*).

Other studies, however, claim to have found that depression is *not* a major factor in the desire for PAS. Ganzini *et al.* (2002) report that 'depression and other psychiatric disorders' were 'relatively unimportant' factors in requests for PAS¹⁸ and that 'there was no difference in the prevalence of depression between the patients who would consider taking a lethal dose of medication and those who would not'.¹⁹ Pearlman *et al.* claim, 'Depression and hopelessness were not significant issues for our sample'.²⁰ And Albert *et al.* say, 'Our findings suggest caution in concluding that the desire to hasten dying is simply a feature of depression' (Albert *et al.* *op. cit.*).

What are we to make of these apparently divergent conclusions about the correlation between depression and requests for PAS? The first thing to note is that different studies drew samples from different patient populations. Some studied AIDS patients; some studied cancer patients; some studied ALS patients. We should, therefore, take seriously the possibility that requests for PAS from people with certain diseases are more closely correlated with depression than requests for PAS from people with other diseases. There is evidence, for instance, that the correlation with depression is higher when the patient requesting PAS has AIDS or cancer than when the patient requesting PAS has ALS.

But secondly, none of the recent studies gives us grounds for thinking that effective treatment of depression in the terminally ill will eliminate most requests for PAS. For even in the recent studies that emphasize the correlation between depression and requests for PAS, the data reveal that over half of those who requested PAS were not depressed.²¹ While some of the terminally ill who request PAS may be depressed, most are not. So even by the lights of those studies that emphasize the correlation between depression and requests for PAS, there is no reason to think that excellent (one hundred percent effective) treatment for depression at the end of life would reduce requests for suicide by as much as half.

Some might worry, however, that a higher rate of depression among those who request PAS makes it more likely if PAS is legalized a mentally incompetent person

will receive physician assistance to commit suicide, and that it is significantly morally worse to assist a mentally incompetent person commit suicide than not to assist some mentally competent people to commit suicide. In response, we should recall that the Oregon PAS law requires a psychological evaluation, and that a mentally incompetent person — which would include someone who is clinically depressed — would not qualify for PAS under that law. Of course there is a possibility that a person will be mistakenly passed on the psychological evaluation even though she is incompetent and so receive a lethal prescription despite the law's intentions. But it is not clear that the possibility of this kind of mistake is in and of itself enough to justify not allowing any competent person to seek assistance in committing suicide. Such issues would, in any event, have to be carefully discussed in a full treatment of the question of whether PAS should be legal. My purpose in this section is only to argue that the salutary idea that end-of-life care should do everything possible to treat depression in the terminally ill does not imply that PAS is always illegitimate or should never be allowed. For the evidence suggests that most of the terminally ill who request PAS are not depressed, and we can implement measures to try to ensure that those who are depressed do not have their requests for PAS granted.

3. Does Our Ability to Control Physical Pain Make PAS Illegitimate?

The third anti-PAS claim I want to examine is this: physical pain is the only legitimate reason for PAS, but good end-of-life care can relieve physical pain. This position is arrived at in three steps. First, we draw a distinction between two types of suffering people with terminal disease face, physical pain and psychological distress. Second, we maintain that while the desire to eliminate dire physical pain can give rise to a justifiable reason for PAS, the desire to eliminate psychological distress cannot. And third, we point out that improved palliative care can now control the physical pain most people experience at the end of life (see, for instance, Emanuel, 1996 op. cit. and 2000 op. cit.; Jansen, 2003;²² Kaverny, 1997²³). From this line of reasoning it follows that when good palliative care is available, the only reasons that can be offered for PAS are unjustified because they will be based solely on the desire to eliminate psychological distress. Such an argument is clearly present in Cohn and Lynn,²⁴ who maintain, 'The argument that physician-assisted suicide is necessary to serve the needs of patients who are suffering terribly . . . quickly fails when we understand that patients do not have to suffer.' For it is clear that Cohn and Lynn mean only that patients do not have to suffer physical pain — they write, 'Virtually all patients with serious illness can be *physically* comfortable' — and that the fact that such patients may continue to suffer psychological distress is not a legitimate reason for PAS (Cohn & Lynn op. cit., p. 245).

The central normative idea here is that there is a crucial normative difference between cases of PAS that are intended to eliminate physical pain and cases of PAS that are intended to eliminate psychological distress. Jansen articulates this idea well when she contends that reasons based on 'damage or assault to the patient's underlying physiological condition' warrant taking steps to end a patient's life while reasons based on psychological suffering 'such as depression, anxiety, loneliness, or despair' do not warrant it (Jansen, 2003).²⁵ Emanuel has argued that a majority of the general public believes that 'only when patients want euthanasia or physician-assisted suicide and

simultaneously have physical, rather than psychological, burdens that cannot be relieved by conventional medical interventions, are euthanasia or physician-assisted suicide acceptable' (Emanuel, 1996 op. cit.; see also Emanuel, 2000 op. cit.). And Kaverny has shown how the Supreme Court's 1997 ruling that there is no constitutionally-protected right to PAS involved the idea that the desire to eliminate physical pain is a normatively superior reason to seek PAS than the desire to eliminate psychological distress. Kaverny writes, 'As a justification for assisted suicide, [O'Connor, Ginsburg, and Breyer] put the desire to eliminate severe, unremitting physical pain in a class by itself' (Kaverny op. cit.). As Justice Breyer put it, '[T]he avoidance of severe physical pain (connected to death) would have to comprise an essential part of any successful claim [for PAS]' (Breyer, 1997).²⁶ And as Kamisar describes O'Connor's position, 'Justice O'Connor's overall view appears to be that *so long as a state erects no legal barriers to obtaining pain relief* (even when the analgesics may hasten death or cause unconsciousness), the state's interests in protecting those who are not truly competent or whose wish to commit suicide is not truly voluntary . . . are sufficiently strong to uphold a total ban against physician-assisted suicide' (Kamisar, 2002).²⁷

Why is it held that the desire to eliminate physical pain gives rise to a more legitimate reason for PAS than the desire to eliminate psychological suffering? A large part of the explanation seems to be that PAS opponents take reasons based on the desire to eliminate psychological distress to be afflicted by a dubious kind of subjectivity that reasons based on the desire to eliminate physical pain are not (see Kass, 2002, pp. 23–24; Callahan, 2002 op. cit., pp. 57–60).²⁸ Someone with a terminal disease may experience a great deal of psychological distress even when the best end-of-life care is available to her. Such a person may think that her life is not worth living because she cannot work, or because she can no longer exert control over herself and her environment, or because she is a burden to her loved ones, or because she is humiliated by the daily care she has to receive in order to perform basic bodily functions. But another person with the very same terminal disease — another person with the same medical condition — may think that she has every reason to continue to live. This second person might have a sense of self or religious conviction that makes her take her life to be of absolute value regardless of how much control she can exert or whether she can go to work in the morning. Far from thinking that her loved ones will be better off with her dead, she might believe that living for as long as she can is the best thing she can do for them. She might not be at all embarrassed by the daily care she receives. And, according to this line of thinking, the existence of these differences between the first and second persons and the sameness of their medical conditions reveals that the reasons the first person has for wanting to die are not based on her medical condition itself. It reveals that her reasons are based on her attitudes towards her medical condition, on her subjective dispositions. But reasons based on the desire to eliminate physical pain are not subjective in this way. We do not need to know anything about a person's sense of self, religious convictions, conception of value, personal relationships, or fastidiousness to conclude that she has a reason to take action that will prevent her from feeling physical pain. That something causes physical pain is an objective reason to eliminate it. It's a reason based on what pain is, not on an individual's idiosyncratic attitudes or subjective dispositions.

Those who hold this anti-PAS view also contend that a *reductio ad absurdum* argument can be advanced to show that the subjectivity of psychological distress makes it

an illegitimate reason for PAS (Callahan, 1992;²⁹ and 2002 op. cit., p. 62; Safrenek, 1998;³⁰ Arras, 1997³¹). Some physically healthy people experience psychological distress that makes them think their lives are not worth living. People invest all sorts of things — romantic attachments, career advancement, etc. — with great subjective value. And, according to this argument, if we held that PAS is a legitimate remedy for one person who had psychologically-based reasons for thinking her life not worth living, then we would be committed to holding that PAS is legitimate for anyone who has psychologically-based reasons for thinking her life not worth living. But it is obviously unacceptable for a perfectly healthy person to receive physician assistance to commit suicide, no matter how upset she may be about a romantic disappointment, a financial setback or whatever. So we must conclude that PAS is not a legitimate remedy for anyone — terminal or healthy — who has merely psychologically-based reasons for thinking that her life is not worth living. (I explain why this *reductio ad absurdum* argument fails in the next section of this paper and in Gill, 2005.³²)

According to the third anti-PAS claim, then, proper palliative care can alleviate the objective reasons terminal patients can have for seeking PAS. Some terminal patients might still have subjective reasons for seeking PAS. Those subjective reasons may be very intense, and care-givers should certainly try to help patients overcome the distress that gives rise to them. That some people have these subjective reasons cannot make PAS legitimate, however, for healthy people can also have subjective reasons to request PAS, but it is clear that we should not honour those requests.

Let me now explain what I take to be three flaws with the reasoning behind this third claim.

First, some people with terminal disease continue to experience extreme pain even when the best palliative care is available. As it was put by Diane Pretty, the Briton dying of motor neuron disease who unsuccessfully sought assistance to commit suicide, ‘Whilst palliative care makes a great difference to many people, it is not the solution for all. Some terminal pain and other distressing symptoms cannot be fully controlled, even with the best care — I know!’³³ Pretty’s death bore out her observation. ‘She struggled on,’ it was reported of her final days, ‘in increasing pain, and at last developed fatal breathing difficulties, and died in hospital in early May. Doubtless she received what palliative care was possible, but her pain was intense and her cries heart-rending’ (Warnock, 2002).³⁴ In response to stories such as Pretty’s, some PAS opponents maintain that the existence of a few exceptional cases in which a request for PAS appears to be legitimate should not on its own be taken to justify the legalization of PAS (see Hendin op. cit.; Steinbock op. cit.; Arras op. cit.). This is a reasonable and important point. When we are thinking about whether to legalize PAS we should consider the effect such legislation would have on society as a whole, and such considerations may reveal that even if a few people do have legitimate reasons for seeking PAS, those reasons are overridden by other more powerful reasons for keeping PAS illegal. But our discussion here is focused on whether some of the terminally ill will still have legitimate reasons to request PAS even when good end-of-life care is available to them, a question that has to be answered prior to addressing the much larger issue of what position on the legalization of PAS a full consideration of all the relevant factors implies. It is, moreover, unclear that the desire to avoid physical pain is as exceptional a reason to request PAS as PAS opponents sometimes suggest. Some studies have concluded that physical pain is a very minor factor in requests for PAS (Emanuel, 1996 op. cit.; Breitbart *et al.*,

1996; Breitbart *et al.*, 2000 *op. cit.*; Kelly *et al. op. cit.*). But another study has found that the desire to avoid pain was an ‘influential . . . motivation’ in 14 out of 35 cases in which terminal patients ‘seriously pursued hastened death’ (Pearlman *et al. op. cit.*). And yet another study found that 38% of patients requesting PAS were in ‘severe pain’ (Meier *et al. op. cit.*). As Quill and Byock have explained, despite the presence of palliative care some patients still develop ‘intolerable’ or ‘severe, unrelievable end-of-life suffering’ (Quill & Byock, 2000).³⁵

Secondly, physical pain narrowly construed is not the only ‘damage or assault to the patient’s underlying physiological condition’ (Jansen *op. cit.*) that the terminally ill have to contend with. There are numerous other physical conditions that can cause the terminally ill to wish for hastened death and yet cannot be consistently relieved by palliative medicine. In Pearlman’s study, 24 out of 35 subjects cited as influential in their desire to pursue hastened death factors such as shortness of breath, extreme fatigue and weakness, diarrhoea, and nausea (Pearlman *et al. op. cit.*; see also Quill & Byock *op. cit.*). In Meier’s study, 42% of those who requested PAS had experienced ‘severe discomfort other than pain’ (Meier *et al. op. cit.*). In Veldink’s study, ALS patients cited dyspnoea and choking as significant factors in their desire for hastened death (Veldink *et al. op. cit.*). And Stephany describes numerous physical conditions impeding a ‘comfortable death’ that are ‘beyond our control despite the finest symptom management’ — conditions such as ‘toes that turn black and fall off; the cancer that eats through the patient’s face, exposing jawbones and sockets; the blood that spurts out of friable, irradiated skin; and the inhuman secretions that ooze from head and neck cancers’ (Stephany, 1994).³⁶ These are not psychological conditions, like ‘depression, anxiety, loneliness, or despair’. They are, rather, features of the patient’s ‘physiological condition’. So if the desire to eliminate the cause of pain gives rise to a legitimate reason to seek PAS because pain is physical rather than psychological, then it seems as though the desire to avoid shortness of breath, extreme fatigue and weakness, diarrhoea, nausea and the various other conditions Stephany describes gives rise to a legitimate reason to seek PAS as well. But end-of-life care cannot be expected to eliminate such conditions.

Thirdly, the distinction between objective reasons for PAS (i.e. those based on the desire to prevent physical pain) and subjective reasons (i.e. those based on the desire to prevent psychological distress) cannot sustain the moral weight PAS opponents place on it. To see the problematic nature of this distinction, we need to distinguish between physical pain and psychological distress as general classificatory categories and physical pain and psychological distress as specific, actual causes of physical pains and specific, actual causes of psychological distress. If we are talking about physical pain and psychological distress as general classificatory categories, then they both appear to give rise to objective reasons: the statement ‘All other things being equal, the fact that an action will eliminate psychological distress is a reason to perform it’ is just as objectively true as the statement ‘All other things being equal, the fact that an action will eliminate physical pain is a reason to perform it’. And if we are talking about specific, actual causes of physical pains and specific, actual causes of psychological distress, then both give rise only to subjective reasons for PAS. People have vastly different pain thresholds as well as vastly different attitudes toward physical pain, as evidenced by the fact that the physical pain caused by a disease may lead one person to require massive doses of opiates while the physical pain caused by the same disease may

lead another person to seek no medicine stronger than acetaminophen. The normative distinction between the objectivity of pain and the subjectivity of psychological distress looks to be plausible only when we take physical pain to be a general classificatory category and psychological distress to be a specific, actual mental state. But that is an unfair comparison, if not a category mistake. If when we compare physical pain and psychological distress we take them both to be general classificatory categories, then both turn out to give rise to objective reasons. And if when we compare physical pain and psychological distress we compare specific actual instances of each, both turn out to give rise to merely subjective reasons.

This problem with this attempt to privilege reasons based on physical pain over reasons based on psychological distress points to a more general problem with the way the anti-PAS position is sometimes presented. PAS opponents sometimes suggest that the judgment that a life remains worth living is evaluatively neutral while the judgment that a life is no longer worth living is evaluatively loaded — that the idea that life is worth living rests on objective, universally accepted considerations that do not involve controversial value-judgments, while the idea that a life is not worth living does involve substantive value-judgments about which there is considerable disagreement (Callahan, 2002 *op. cit.*, pp. 57–8; Pellegrino, 2002³⁷). But no such evaluative asymmetry exists. That human life in general is valuable is a virtually universally accepted claim. But that pain and distress in general are disvaluable — that it is good to eliminate the causes of pain and distress — is also a virtually universally accepted claim. It is not, however, at these very general value judgments that the battle over whether there are legitimate reasons to seek PAS is joined. The battle is joined where the continuation of specific, actual human lives conflicts with the elimination of specific, actual causes of pain and distress — where instantiations of one universally accepted general value conflict with instantiations of another universally accepted general value. And each side of this battle must rely on substantive value judgments about which there is quite a lot of disagreement.

That is not to say that just because people *disagree* about whether the desire to eliminate psychological distress is a legitimate reason to seek PAS, it is in fact the case that the desire to eliminate psychological distress *is* a legitimate reason to seek PAS. It's possible that the value judgments on the anti-PAS side of this question are the ones we should endorse and that the value judgments on the other side are untenable. My point at this stage is just that such judgments do need to be made and defended. The case against psychological distress's being a legitimate reason for PAS cannot be won simply by drawing a quick conceptual or meta-ethical distinction between one (putatively objective or morally neutral) type of reason and another (putatively subjective or morally loaded) type of reason.

So how should we go about assessing the claim that the psychologically-based reasons terminally ill people have for requesting PAS are unreasonable or illegitimate? The first thing we must do is determine what kinds of reasons such people do in fact offer. A number of studies have undertaken this task, and from them a list of overlapping reasons has emerged. This list includes: aversion to becoming dependent, desire to control the circumstances of one's death, hopelessness, loss of dignity, loss of interest or pleasure in activities, loss of identity or sense of self, meaninglessness, pointlessness, poor quality of life, and readiness to die. I cannot discuss in detail all the items on this list, so in the next section I will focus instead on only one: hopelessness, which has

been shown to be one of the strongest predictors of requests for PAS and wishes to hasten death (Albert *et al.* op. cit., Breitbart 1996 *et al.* 1996 op. cit.; Breitbart *et al.* 2000 op. cit.; Ganzini *et al.*, 1998 op. cit.; Wilson *et al.* op. cit.).³⁸

4. Hopelessness as a Reason for PAS

Is hopelessness a reasonable ground for a terminally ill person to request PAS? To see why it can be, we need to distinguish between two ways in which someone might be said to be hopeless. The first kind of hopelessness is a mental state that antecedently colours how a person perceives her situation. To say someone is hopeless in this first sense is to say that her thinking about what her future life has to offer is unduly influenced by a pessimistic attitude — that she is possessed of a negative affect that precedes and prejudices (i.e. pre-judges) her thinking. The second kind of hopelessness, in contrast, is a mental state that is preceded by and results from a person's perception of her situation. To say someone is hopeless in this second sense is to say that her thinking about her situation has led her to a negative conclusion about her future prospects. This second kind of hopelessness does not necessarily involve prejudicial thinking. It can be based on accurate perceptions of what the future has to offer.

Undoubtedly, some of the terminally ill whom the studies label 'hopeless' are hopeless in the first sense of the term. But it seems intuitively plausible that others may be hopeless in the second sense. And when we examine one of the most common methods used for making this determination, it appears to be even more likely that this second sense is sometimes the relevant one.

This common method for determining whether a terminal patient is hopeless is to administer the Beck Hopelessness Scale (or BHS), which consists of twenty Yes or No questions (Beck & Weissman, 1974).³⁹ Here are some of those questions:

All I can see ahead of me is unpleasantness rather than pleasantness. (1 point for Yes, 0 points for No)

I look forward to the future with hope and enthusiasm. (0 points for Yes, 1 point for No)

I have enough time to accomplish the things I most want to do. (0 points for Yes, 1 point for No)

In the future, I expect to succeed in what concerns me most. (0 points for Yes, 1 point for No)

When I look ahead to the future, I expect I will be happier than I am now. (0 points for Yes, 1 point for No)

I can look forward to more good times than bad times. (0 Points for Yes, 1 point for No)

If a healthy person who has every reason to believe she will live for many more years receives a high BHS score, we may have good grounds for holding that her thinking about her situation has been unduly influenced by a prejudicially pessimistic attitude. But we will not have similarly good grounds for holding that a person who is suffering

from a terminal illness — someone with advanced ALS, for instance, who has been told she has less than six months to live — is suffering from prejudicial thinking just because she receives a high BHS score.⁴⁰ What we call the hopelessness of a person with late-stage ALS might be preceded by, and result from, a reasonable assessment of the facts of her situation. Her hopelessness might rest on perceptions that are factually accurate.

What features of her situation might such a person's high-scoring BHS answers rest on? Three features in particular — each of which has been frequently cited by patients who have requested PAS or evinced a wish to hasten death (Ganzini *et al.* 1998 *op. cit.*; Veldink *et al.* *op. cit.*; Pearlman *et al.* *op. cit.*; Wilson *et al.* *op. cit.*) — stand out.⁴¹ One is the prognosis of having less than six months to live, which could certainly bear on a patient's judgment of whether she has 'enough time to accomplish the things I most want to do' (see BHS question 5 [Beck & Weissman *op. cit.*]). A second is the difficulty and need of assistance in performing the most basic of hygienic and bodily functions, which could certainly bear on a patient's judgment of the amount of 'unpleasantness' and 'bad times' she can expect in the future (see BHS questions 11 and 19 [Beck & Weissman *op. cit.*]). A third is the inability to participate in activities (e.g. working, playing sports, playing a musical instrument, spending time in nature, reading, talking) that constituted the bulk of what she used to choose to do and that made her life enjoyable, which could certainly bear on the patient's judgment of how much 'pleasantness' she has ahead of her, of what she can 'accomplish' or 'succeed' in, of how many 'good times' she can 'look forward to' (see BHS questions 5, 6 and 19 [Beck & Weissman *op. cit.*]).

Note that these three features connect a patient's physical condition to her BHS diagnosis of hopelessness. An ALS patient's limited life expectancy, loss of function, and inability to participate in activities such as walking and talking are clearly caused by physiological aspects of her disease, and it is just those aspects that can lead her to give some of the answers to the BHS that result in her being labelled hopeless. Her hopelessness — at least insofar as we mean by that her high BHS score — may not rest on the floor of her psyche but sit atop her awareness of the facts of her physical state. Improvements in end-of-life care may, consequently, do little to reduce her hopelessness. For improvements in end-of-life care may not extend her life expectancy, restore her bodily function, or enable her to work, play sports, spend time in nature, or engage in other such activities.

When we note how an ALS patient's hopelessness can sit atop her awareness of the facts of her physical state, we can also see why one very common anti-PAS argument fails. As we noted in the previous section (when discussing the *reductio ad absurdum* against PAS), PAS opponents argue that there must be something unreasonable or illegitimate about psychologically-based reasons for PAS because a perfectly healthy person could also have psychologically-based reasons for requesting PAS but such a request from a healthy person would obviously be unreasonable or illegitimate. But insofar as an ALS patient's hopelessness sits atop features of her situation that are themselves directly caused by her disease, the equivalency between her reasons for PAS and the reasons a healthy person has for PAS does not hold. Taking the hopelessness of a person with ALS to be a reasonable response to her situation does not commit us to taking the hopelessness of a healthy person to be a reasonable response to his situation, for the former response can be connected to the person's underlying physiological condition in ways that the latter is not.⁴²

That is not to say that it would be reasonable for everyone with late-stage ALS to seek PAS. Some people place great value on activities, abilities, and goals that are not compromised by late stage ALS, and the reasonable thing for them to do may be to try to live for as long as they can. But that two people respond differently to the same disease does not imply that either of them is unreasonable. That it is reasonable for one person with a late-stage cancer to eschew pain medication does not imply that it is unreasonable for another person with the same late-stage cancer to seek pain medication. That one person who holds certain religious and spiritual beliefs reasonably chooses to discontinue life-sustaining treatment does not imply that it is unreasonable for another person with different religious and spiritual beliefs to continue treatment.

I have been focusing here on hopelessness, but the same points can be made about other psychologically-based reasons commonly offered by terminally ill people who request PAS — reasons such as poor quality of life, readiness to die, loss of interest or pleasure in activities, and loss of sense of self. In the case of each of these, we can distinguish between a prejudicial attitude that unduly influences a person's assessment of her situation and a non-prejudicial attitude that is preceded by and results from a person's awareness of the facts of her situation. And while we should acknowledge that some of the terminally ill who request PAS possess the former prejudicial attitude, it seems very plausible that others possess the latter non-prejudicial attitude instead. It seems very plausible that some of the terminally ill who, for instance, believe they have a very poor quality of life or who are ready to die have come to this conclusion in light of an assessment of what their remaining days have to offer that is factually accurate and consistent with the values and priorities that have guided their conduct throughout their lives.

Undoubtedly, many will still hold that there must be something regrettable about a person with terminal disease deciding to commit suicide because she thinks further life will be of poor quality or because she is ready to die — and that if a patient reaches such a state we must conclude that her end-of-life care has failed her in some way. I believe, however, that the tenacity of this idea results at least partly from an illegitimate conflation of a terminal patient's situation with that of healthy people who think their lives will continue to be of poor quality or are ready to die. Such healthy people are characterized by negative affect. They are liable to lament their fate. They're sad. But terminal patients who believe that further life will be of poor quality or who are ready to die do not necessarily possess the same negative affect. Some of these terminal patients are sad and take their situations to be lamentable, but some of them do not. Some of them say the things that lead them to be labelled hopeless or ready to die not because wrenching emotional pain has made them feel that they can't go on but because they have drawn a certain conclusion ('I want to die by taking a lethal dose of drugs next week rather than die after being in a ten-day semi-conscious stupor two months from now') on the basis of perceptions of their situation that we cannot find factual fault with. As Stephany puts it, 'In my practice, a patient's request for assisted suicide, the plea of "... please, I've had enough," has *not* been about poor pain or symptom control ... The patients simply prefer death to the life they are left with ... [Such patients] are just realistic. They know what lies ahead and they'd rather not continue with it' (Stephany *op. cit.*). And Veldink at least partially corroborates Stephany's personal observations, finding that among patients with ALS the choice of PAS is 'negatively associated with ... the presence of anxiety before death' and that

those who choose PAS have no greater frequency ‘of feelings of pain, despair, fear [or] anger’ than those who do not (Veldink *et al.* op. cit.).

An 84-year-old woman in hospice once calmly told me, ‘It’s time for me to go, and I don’t see the point of waiting around any longer’. And it certainly did not seem to me that she was sad about her situation, or that she thought that lamentations were in order. Her affect was nothing like what one would expect in a 25-year-old who wants to kill himself because of a romantic disappointment or financial setback. She seemed to have reached the conclusion that it was time for her to go through reasonable reflection on her past and her future. Most importantly for our purposes, it is very hard to see how the quality of her end-of-life care could have been expected to have altered the thought processes that led her to the decision that it was time for her to go. Maybe integral to her decision was a set of values that others do not endorse; maybe she paid little attention to religious or spiritual matters that others take to be of profound importance.⁴³ But these aspects of her decision-making were utterly consistent with how she had lived her entire adult life. Unless we hold that end-of-life care should aim to induce conversion experiences in patients such as these, I don’t see how we can hold that improvements in end-of-life care bear one way or another on the reasonability of such persons’ requests for PAS.

5. Is PAS Incompatible with Hospice Care?

When Oregon voters chose to legalize physician-assisted suicide in 1994, there was a great deal of consternation within the hospice community. Hospice care had ‘historically been viewed as an alternative to physician-assisted suicide’ (Woolfrey, 1998).⁴⁴ And many in the hospice community took as a ‘cornerstone principle of hospice’ the idea that it was wrong to postpone *or hasten* death (Campbell & Hare, 1995).⁴⁵ Aggressive high-tech curative measures for the terminally ill violate the hospice philosophy because they artificially postpone death. But PAS, according to this view, violates the hospice philosophy just as clearly because it artificially hastens death. Some also believed that the focus on legalizing physician-assisted death could shift attention away from the benefits hospice could provide, as well as discourage people opposed to PAS from seeking hospice care.

At the same time, others in the hospice community maintained that the hospice philosophy could and should be modified to accommodate PAS — that opposition to PAS was a ‘moral relic’ — and that the expertise of hospice staff made them particularly well-suited to deal with requests for PAS (Campbell & Hare op. cit.). Moreover, even those who thought PAS was incompatible with hospice’s opposition to postponing or hastening death also acknowledged that another cornerstone principle of hospice care was to respect patients’ wishes at the end of life and never to abandon them. So how could a hospice worker *not* become involved in PAS when some of those under her care chose to avail themselves of their legal right to it?

As it has turned out, a large majority of Oregonians who have used the provisions of the PAS law to commit suicide — 87% — have been enrolled in hospice (Eighth Annual Report on Oregon’s Death with Dignity Act 2006).⁴⁶ There is, however, no indication that the hospice movement in general has been impeded by Oregon’s legalization of PAS, or that Oregon hospices in particular have suffered any negative

fallout from their involvement. From 1998 (when the Oregon law began to take effect) until 2004, the percentage of deaths in the US as a whole that occurred in hospice rose from 19% to 45%, and the percentage of deaths in Oregon that occurred in hospice rose from 31% to 54%.⁴⁷ Indeed, 30% of Oregon physicians report that they have increased their referrals to hospice as a result of the PAS law (perhaps because they wanted to make sure that everything that could be done to forestall patients from availing themselves of PAS was done) (Ganzini *et al.* 2001 op. cit.).⁴⁸ In addition, studies have been conducted of Oregon's hospice physicians (Ganzini *et al.*, 2003),⁴⁹ chaplains (Carlson, 2005),⁵⁰ nurses and social workers (Ganzini *et al.*, 2002 op. cit.), and they have consistently found that hospice care-givers have not experienced any great difficulty combining their commitment to hospice care with involvement in PAS.

Some might hold, however, that even if hospice enrolment has not declined as a result of the legalization of PAS and even if hospice care-givers have found a way to accommodate patients who seek PAS, hospice and PAS are still deeply philosophically incompatible nonetheless. PAS might violate hospice's core principles even if the practical implications of that violation are hard to measure and quantify. Specifically, PAS might conflict with the value hospice places on *natural death*. But because endorsements of this value are not unique to hospice, and because not everyone within the hospice community takes this value to imply opposition to PAS, let us address the issue in a separate section.

6. PAS and Natural Death

Is PAS wrong because it is incompatible with the value end-of-life care ought to place on a natural death? Dame Cicely Saunders, one of the founders of the hospice movement in the UK, thought so (Saunders, 1995).⁵¹ She wrote that hospice care must be 'guided by the principle that life is of value until its "natural" end' (Saunders, 1995). Daniel Callahan's belief that when thinking about end-of-life care we should take 'nature as a guide' has anti-PAS implications that are very similar to Saunders' position (Callahan, 1993).⁵²

There are many different reasons one might have for placing special value on natural death. But one reason particularly relevant to our discussion is based on the idea that one of the most important goals of end-of-life care should be to help patients accept their situation, to help patients come to peace with their fates. But, according to this way of thinking, so long as patients' minds are occupied by the prospects of controlling what happens to them — so long as they focus their energies on trying to ensure that things go according to their own plans — they'll not be able to attain that acceptance and peace. Their plans, moreover, will inevitably come to grief as nature will always win out in the end. So, because end-of-life care should help patients bring themselves into harmony with the inevitable running of nature's course, end-of-life care should discourage attempts to control the circumstances of death.

It is, however, very problematic to hold that those receiving end-of-life care ought to avoid attempts to control how they die. For by the time a person receiving end-of-life care qualifies for PAS under the Oregon law, she will almost certainly have exerted quite a lot of control over her dying already.

When people favour the natural over the artificial, they may be thinking that we can identify some natural baseline — some state the patient would be in if no artificial means had been used — and that this natural baseline possesses some elevated normative status. But for most of those who qualify for PAS under the Oregon law, going back to a natural baseline may not be a viable option at all. Many salient features of their current situation may obtain only because they chose to use medical technology in the past, and all of the viable courses of action available to them may be equally non-natural in that all of them are available only because of those past choices to use medical technology. Consider, for instance, a person with cancer, which is the most common disease of those who have used Oregon's PAS law. There are, of course, many different kinds of cancer. But let's focus on the following plausible scenario. A woman contracts breast cancer. She undergoes months of radiation and chemotherapy. As a result, her cancer goes into remission. Then, several years later, there is a recurrence, and this time treatment turns out to be futile. She is told she has less than six months to live. The woman is now dying, but were it not for past medical interventions she would have been dead years ago. The end-of-life experiences she now faces — the pain and suffering as well as the opportunities for interpersonal connection and personal growth — owe their existence to the prolonged life past medical interventions have helped provide. Or consider ALS, which is the second most common disease of those who have used Oregon's PAS law. Most ALS patients today who are diagnosed as having less than six months to live have already had their lives significantly extended by medical technology as ALS often involves respiratory ailments that used to kill patients early in the course of the disease but can now be controlled. But this also means that many ALS patients now have to contend with severe disability and discomfort that ALS patients naturally would not have experienced. By the time they qualify for PAS under the Oregon law, all of the moral terrain many of the people with such diseases face will bear the mark of past choices to use artificial means to alter how they die.

Even when attempts to prolong life have been abandoned, moreover, end-of-life care still typically involves the choice to use various types of artificial measures. Helping a terminal patient to accept her fate does not usually involve having her forgo all medical and technological assistance in her final months of life. Patients receiving non-curative end-of-life care are usually given medication for pain and distress. Their conditions are often monitored by high-tech machines. Some of them use breathing apparatus. Indeed, those who argue for a greater emphasis on end-of-life care usually do so by pointing to the many things that can now be done to ease and comfort patients during the dying process. To no longer make use of curative medicine is not to no longer make use of medicine at all. That is not to say that there are no morally significant reasons to favour one way of going through the dying process over others. But it is to say that these morally significant reasons will support one non-natural course of action over other non-natural courses of action. To die in an entirely natural way — to forswear all medical artifice — would be to spend one's final months in a non-medicated, non-technologically-assisted state that bears little resemblance to the situation of many of those who receive the kinds of treatment champions of end-of-life care rightly trumpet.

Traditional discussions of suicide often imply that there is virtue in accepting the fate that nature (or nature's Author) has bestowed on us. But the way most of us use

medical technology has obliterated that purely natural fate long ago. The distinction between the right course of action and the wrong one does not track the distinction between what is natural and what is unnatural. Most of us, by the time we face end-of-life decisions, will already be in a situation that artifice has played an essential role in creating. When facing these decisions, we will not be considering whether to accept nature's plan or to alter it. We will be considering whether to opt for one kind of alteration or another.

One of the most commonly reported reasons for requesting PAS is the desire for control (Albert *et al.* op. cit.; Ganzini *et al.* 1998 op. cit.; Ganzini *et al.* 2002 op. cit.; Wilson *et al.* op. cit.; Veldink *et al.* op. cit.). Now I expect that someone like Callahan would take the prevalence of this control-based reason to be symptomatic of the wrong-headedness of the Oregon law. For Callahan has poured scorn on the idea that we can exercise complete control over the dying process.⁵³ But the idea that we cannot exercise *any* control over how and when we die is also risible. We can and do prolong life, not always of course and never indefinitely, but in many cases and for significant periods of time. We also can and do use the tools of modern medicine to ease and comfort people through the dying process. It is thus arbitrary, illegitimately *ad hoc*, to claim that it is wrong for someone to avail herself of PAS because PAS constitutes an artificial death or an attempt to exert control over her dying. For some element of artifice and control is inextricably built into all of modern medicine — including end-of-life care.

Nor is there any reason to think that allowing a terminal patient to choose whether or not to attain a lethal prescription need make it more difficult for her to achieve a peaceful reconciliation to her fate. No one seems to think that the availability of many other options to control the circumstances of one's dying — all the options that end-of-life care can offer — is incompatible with that kind of peaceful reconciliation. Indeed, a terminal patient's choice to hasten death by discontinuing life-sustaining treatment can be, and often is, characterized by calm acceptance. So why think a terminal patient's choice to seek PAS cannot be characterized by the same kind of calm acceptance? If a healthy person decides to kill himself because of a romantic disappointment or financial setback, it will be reasonable to surmise that there is some crucial and regrettable respect in which he has failed to come to grips with his situation. But the mental state of a terminal patient who requests PAS may not be at all similar to that of the healthy suicide. The mental state of a terminal patient who requests PAS may be much more similar to that of a terminal patient who chooses to discontinue life-sustaining treatment.⁵⁴

There may be good reasons not to make PAS available to people with terminal disease. But for those who avail themselves of modern medicine — including many aspects of end-of-life care — the fact that PAS is unnatural is not one of them.

Let me close by stating once again that I have not tried to show that PAS is a fully justifiable course of action or that there are decisive grounds for its legalization. What I have tried to show is more limited: that PAS is not in conflict with the goals of good end-of-life care, that the principles of good end-of-life care do not imply the unjustifiability of PAS. One can consistently both respect patients' requests for PAS and promote the very best care for patients at the end of life.

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NOTES

- 1 K. M. Foley, 'Competent care for the dying instead of physician-assisted suicide', *New England Journal of Medicine* 336 (1997): 53–58; R. D. Orr, 'Pain management rather than assisted suicide: the ethical high ground', *Pain Medicine* 2 (2001): 131–137; V. Robinson, 'The proposed assisted dying bill negates end-of-life care', *British Journal of Nursing* 13 (2004): 240.
As Callahan has put it, 'The movement to legalize euthanasia and assisted suicide . . . draws part of its strength from the failure of modern medicine to assure us that it can manage our dying with dignity and comfort': D. Callahan, 'Reason, self-determination, and physician-assisted suicide,' in K. Foley & H. Hendin (eds) *The Case Against Assisted Suicide* (Baltimore, MD: Johns Hopkins Press, 2002), pp. 53–54.
- 2 For helpful overviews and extensive bibliographies of the issue of whether there is an incompatibility between end-of-life care and PAS, see S. A. Hurst & A. Mauron, 'The ethics of palliative care and euthanasia: exploring common values', *Palliative Medicine* 20, 2 (2006): 107–12; and M. A. Hermsen & H. A. ten Have, 'Euthanasia in palliative care journals', *Journal of Pain and Symptom Management* 23 (2002): 517–525.
- 3 D. E. Lee, 'Physician-assisted suicide: a conservative critique of intervention', *Hastings Center Report* 33 (2003): 17–19.
- 4 S. Stoddard, 'Terminal, but not hopeless', *New York Times* 1991 August 31.
- 5 H. Hendin, 'Selling death and dignity', *Hastings Center Report* 25, 3 (1995): 19–23.
- 6 A forerunner of this view was Cicely Saunders, the founder of the hospice movement in Britain, who said in 1971, 'If you relieve a patient's pain and if you can make him feel like a wanted person, which he is, then you are not going to be asked about euthanasia . . . I think that euthanasia is an admission of defeat, and a totally negative approach. One should be working to see that it is not needed': C. Saunders, 'The moment of truth: care of the dying patient', in F. G. Scott & R. M. Brewer (eds) *Confrontations of Death: A Book of Readings and a Suggested Method of Instruction* (Corvallis, OR: A Continuing Education Book, 1971), p. 119.
- 7 M. Cooke, L. Gourlay, L. Collette, A. Boccellari, M. A. Chesney & S. Folkman, 'Informal caregivers and the intention to hasten AIDS-related death', *Archives of Internal Medicine* 158 (1998): 69–75.
- 8 W. Breitbart, B. Rosenfeld, H. Pessin, M. Kaim, J. Funesti-Esch, M. Galietta, C. J. Nelson & R. Brescia, 'Depression, hopelessness, and desire for hastened death in terminally ill patients with cancer', *Journal of American Medical Association* 284 (2000): 2907–2911.
- 9 B. Rosenfeld, W. Breitbart, M. Galietta, M. Kaim, J. Funesti-Esch, H. Pessin, C. J. Nelson & R. Brescia, 'The schedule of attitudes toward hastened death: measuring desire for death in terminally ill cancer patients', *Cancer* 88 (2000): 2868–2875.
- 10 K. G. Wilson, J. F. Scott, I. D. Graham, J. F. Kozak, S. Chater, R. A. Viola, B. J. de Faye, L. A. Weaver & D. Curran, 'Attitudes of terminally ill patients toward euthanasia and physician-assisted suicide', *Archives of Internal Medicine* 160 (2000): 2454–2460.
- 11 J. H. Veldink, J. H. J. Wokke, G. van der Wal, V. de Jong & L. H. van den Berg, 'Euthanasia and physician-assisted suicide among patients with amyotrophic lateral sclerosis in the Netherlands', *New England Journal of Medicine* 346 (2002): 1638–44.
- 12 B. Kelly, P. Burnett, D. Pelusi, S. Badger, F. Varghese & M. Robertson, 'Factors associated with the wish to hasten death: a study of patients with terminal disease', *Psychological Medicine* 33 (2003): 75–81.
- 13 S. M. Albert, J. G. Rabkin, M. Del Bene, T. Tider, I. O'Sullivan, L. P. Rowland & H. Mitsumoto, 'Wish to die in end-stage ALS', *Neurology* 65 (2005): 68–74.
- 14 The differences in percentages of those requesting PAS might be due to the different diseases the people in question have. Those with ALS, for instance, seem to request PAS more frequently (about 20%) than those with cancer or AIDS.
- 15 In Oregon, where PAS is legal, the percentage of terminally ill people who have died by PAS is lower than these studies might have led us to expect — only about one tenth of one percent (S. W. Tolle, V. P. Tilden, L. L. Drach, E. K. Fromme, N. A. Perrin & K. Hedberg, 'Characteristics and proportion of dying Oregonians who personally consider physician-assisted suicide', *The Journal of Clinical Ethics* 15, 2 (2004): 111–118). It is notable, however, that 17% of the terminally ill in Oregon have requested or considered requesting PAS — a number that is in line with the studies cited above. It seems likely that many terminally ill people derive benefit simply from having the legal option of requesting PAS, whether or not they actually end up committing suicide. It's also possible that there are barriers to PAS in Oregon that prevent some competent terminally ill people from acquiring a lethal prescription even though they desire

- to obtain one (L. Ganzini & S. K. Dobscha, 'Clarifying distinctions between contemplating and completing physician-assisted suicide', *The Journal of Clinical Ethics* 15, 2 (2004): 119–122). Moreover, during the first six years that PAS was legal in Oregon, 171 people did die by PAS, and it seems that most of these people had good end-of-life care, which once again implies that while good end-of-life care almost certainly leads some who would commit suicide not to do so, it does not come close to eliminating the desire to commit suicide altogether.
- 16 It is far from clear, however, that we should wait until the very best end-of-life care becomes available to all of a given population before considering legalizing PAS for that population. For the evidence from Oregon suggests that the legalization of PAS may be one of the most effective catalysts to improvements in end-of-life care (L. Ganzini, H. D. Nelson, M. A. Lee, D. T. Kraemer, T. A. Schmidt & M. A. Delorit, 'Oregon physicians' attitudes about and experiences with end-of-life care since the passage of the Oregon Death with Dignity Act', *Journal of the American Medical Association* 285, 18 (2001): 2363–9).
 - 17 J. E. Emanuel, D. L. Fairclough, E. R. Daniels & B. R. Clarridge, 'Euthanasia and physician-assisted suicide: attitudes and experiences of oncology patients, oncologists, and the public', *The Lancet* 347 (1996): 1805–1810; see also J. E. Emanuel, D. L. Fairclough & L. L. Emanuel, 'Attitudes and desires related to euthanasia and physician-assisted suicide among terminally ill patients and their caregivers', *Journal of the American Medical Association* 284 (2000): 2460–2468.
 - 18 L. Ganzini, T. A. Harvath, A. Jackson, E. Goy, L. L. Miller & M. A. Delorit, 'Experiences of Oregon nurses and social workers with hospice patients who requested assistance with suicide', *New England Journal of Medicine* 347 (2002): 582–8.
 - 19 L. Ganzini, W. S. Johnston, B. H. McFarland, S. W. Tolle & M. A. Lee, 'Attitudes of patients with amyotrophic lateral sclerosis and their care givers toward assisted suicide', *New England Journal of Medicine* 339 (1998): 967–73.
 - 20 R. A. Pearlman, C. Hsu, H. Starks, A. L. Back, J. R. Gordon, A. J. Bharucha, B. A. Koenig & M. P. Battin, 'Motivations for physician-assisted suicide: patient and family voices', *Journal of General Internal Medicine* 20 (2005): 234–9.
 - 21 Breitbart *et al.* 1996, for instance, report that among 'the 117 patients with high levels of depressive symptoms, 67% (N = 78) considered physician-assisted suicide as an option, whereas 50% (N = 131) of the 261 less depressed subjects considered physician-assisted suicide as an option' (W. Breitbart, B. D. Rosenfeld & S. D. Passik, 'Interest in physician-assisted suicide among ambulatory HIV-infected patients', *American Journal of Psychiatry* 153 (1996): 238–242). So according to Breitbart *et al.* 1996, 131 of the 209 people who expressed interest in PAS were not depressed. Breitbart *et al.* 2000 *op. cit.* reports that of 15 cancer patients who were depressed, '7 (47%) were classified as having a high desire for hastened death and 8 (53%) were not. Conversely, among the 74 patients who were not depressed, 9 (12%) had a high desire for hastened death while 65 (88%) did not'. So according to Breitbart *et al.* 2000, nine of the sixteen people who had a high desire for hastened death were not depressed. Foley claims that 'more than the majority' of terminal patients who evinced a desire to hasten death were influenced by 'significant psychiatric morbidity' (K. M. Foley, 'The relationship of pain and symptom management to patient requests for physician-assisted suicide', *Journal of Pain and Symptom Management* 6 (1991): 289–297). But so far as I know, none of the studies from the last ten years (Foley was writing in 1991) concludes that such a large percentage of those who request PAS are depressed. Meier *et al.* come closest in holding that 'nearly half' of those requesting PAS were described by their physicians as depressed (Meier *et al.*'s data were based on surveys of physicians and not on direct contact with patients): D. E. Meier, C. A. Emmons, A. Litke, S. Wallenstein & R. S. Morrison, 'Characteristics of patients requesting and receiving physician-assisted death', *Archive of Internal Medicine* 163 (2003): 1537–1542.
 - 22 L. A. Jansen, 'The moral irrelevance of proximity to death', *The Journal of Clinical Ethics* 14 (2003): 49–58.
 - 23 M. C. Kaverny, 'Assisted suicide, the supreme court, and the constitutive function of the law', *Hastings Center Report* 27 (1997): 29–33.
 - 24 F. Cohn & J. Lynn, 'Practical rejoinders to claims in favor of legalizing PAS', in K. Foley & H. Hendin (eds) *The Case Against Assisted Suicide* (Baltimore, MD: Johns Hopkins Press, 2002) pp. 238–260.
 - 25 Jansen *op. cit.*; I should note that Jansen's topic is terminal sedation and not PAS.
 - 26 S. Breyer, Concurrence in *Washington v. Glucksberg*, United States Supreme Court, 1997.
 - 27 Y. Kamisar, 'The Rise and Fall of the "Right" to Assisted Suicide', in K. Foley & H. Hendin (eds) *The Case Against Assisted Suicide* (Baltimore, MD: Johns Hopkins Press, 2002) at p. 79.
 - 28 A forerunner of the view (present in L. R. Kass, "'I will give no deadly drug": why doctors must not kill', in K. Foley & H. Hendin (eds) *The Case Against Assisted Suicide* (Baltimore, MD: Johns Hopkins Press,

- 2002, and Callahan 2002 op. cit.) that physical pain is a normatively legitimate reason for ending life because it is objective and that psychological distress is normatively illegitimate because it is subjective was Paul Ramsey, one of the most influential early bioethicists. In 1978 he formulated the ‘medical indications policy’, which held that choosing to die for medical or ‘objective’ reasons is morally acceptable while choosing to die for psychological or ‘subjective’ reasons is morally unacceptable (P. Ramsey, *Ethics at the Edges of Life* (New Haven, CT: Yale University Press, 1978), pp. 153–60). I should note, however, that neither Kass nor Callahan nor Ramsey have ever supported physician-assisted suicide even in cases of physical pain. They are against physician-assisted suicide in all cases. My point here is simply that they have drawn a distinction between the ‘objectivity’ of reasons to end physical pain and the ‘subjectivity’ of reasons to end at least certain kinds of psychological suffering. For expressions of the view that this distinction makes reasons for ending life to avoid physical pain more legitimate than reasons for ending life to avoid psychological distress, see Emanuel *et al.* 1996 op. cit.; and Kaverny op. cit.
- 29 D. Callahan, ‘When self-determination runs amok’, *Hastings Center Report* 22 (1992): 52–55, at p. 54.
- 30 J. P. Safrenek, ‘Autonomy and assisted suicide: the execution of freedom’, *Hastings Center Report* 28, 4 (1998): 32–36 at p. 35.
- 31 J. D. Arras, ‘Physician-assisted suicide: a tragic view’, *Journal of Contemporary Health Law and Policy* 13 (1977): 360–389, at p. 369.
- 32 M. B. Gill, ‘A moral defense of Oregon’s physician-assisted suicide law’, *Mortality* 10, 1 (2005): 53–67.
- 33 This quotation comes from B. Steinbock, ‘The case for physician-assisted suicide: not (yet) proven’, *Journal of Medical Ethics* 31 (2005): 235–41, where it is attributed to a website that has since been altered.
- 34 M. Warnock, ‘Death where is thy sting?’ *Counsel: The Journal of the Bar of England and Wales* August (2002): 14–15. Steinbock op. cit. provides this quotation.
- 35 T. E. Quill & I. R. Byock, ‘Responding to intractable terminal suffering: the role of terminal sedation and voluntary refusal of food and fluids’, *Annals of Internal Medicine* 132 (2000): 408–414, at p. 408; see also p. 409.
- 36 T. M. Stephany, ‘Assisted suicide: how hospice fails’, *American Journal of Hospice and Palliative Care* 11 (1994): 4–5.
- 37 E. D. Pellegrino, ‘Compassion is not enough’, in K. Foley & H. Hendin (eds) *The Case Against Assisted Suicide* (Baltimore, MD: Johns Hopkins Press, 2002), at p. 48.
- 38 Hopelessness is taken to be distinct from depression. For discussion of this distinction, see Ganzini *et al.* 1998 op. cit.; and Breitbart *et al.* 2000, op. cit.
- 39 A. T. Beck & A. Weissman, ‘The measurement of pessimism: the hopelessness scale’, *Journal of Consulting and Clinical Psychology* 42 (1974): 861–865. The BHS was used by Albert *et al.* op. cit.; Breitbart *et al.* 1996 op. cit.; Breitbart *et al.* 2000, op. cit.; Ganzini *et al.* 1998 op. cit.; C. McClain, B. Rosenfeld & W. Breitbart, ‘Effect of spiritual well-being on end-of-life despair in terminally-ill cancer patients’, *The Lancet* 361, 9369 (2003): 1603–1607; and Rosenfeld *et al.* 2000 op. cit., pp. 2868–2875.
- 40 There is good reason to question whether the BHS is an appropriate test to put to terminal patients who have requested PAS. For the test seems to have been designed to assure a high correspondence between high hopelessness scores and attempts at suicide. As Beck writes when describing the ‘reliability’ of his scale, ‘A population of 294 hospitalized patients who had made recent suicide attempts provided the data for determination of the internal consistency of the HS [Hopelessness Scale]’ (Beck & Weissman op. cit., p. 862).
- 41 Recall as well, Stephany’s description of physical conditions that can afflict other kinds of terminal patients — toes that blacken and fall off, exposed jawbones and sockets, secretions, etc. (Stephany op. cit.).
- 42 In Gill op. cit., I explain in more detail what I take to be the moral difference between a request for PAS from a healthy person and a request for PAS from a person with a terminal disease.
- 43 Numerous studies have found that one of the strongest predictors of a person’s *not* requesting PAS is religious commitment (Albert *et al.* op. cit.; Breitbart *et al.* 1996 op. cit.; Emanuel *et al.* 1996 op. cit.; Emanuel *et al.* 2000 op. cit.): 2460–2468; Ganzini *et al.* 1998 op. cit.; McClain *et al.* op. cit.; Veldink *et al.* op. cit.; Wilson *et al.* op. cit.
- 44 J. Woolfrey, ‘What happens now?’, *Hastings Center Report* 28 (1998): 9–17.
- 45 S. Campbell & J. Hare, ‘Conflicts of conscience: hospice and assisted suicide’, *Hastings Center Report* 25 (1995): 36–44.
- 46 <http://www.oregon.gov/DHS/hp/pas/docs/year8.pdf>
- 47 This information comes from personal correspondence with Ann Jackson, Executive Director of the Oregon Hospice Association.

- 48 Ganzini *et al.*, 2001 *op. cit.* also reports that as a result of the Oregon PAS law, 76% of Oregon physicians 'made efforts to improve their knowledge of the use of pain medications in the terminally ill'.
- 49 L. Ganzini, S. K. Dobscha, R. T. Heintz & N. Press, 'Oregon physicians' perceptions of patients who request assisted suicide and their families', *Journal of Palliative Medicine* 6 (2003): 381–390.
- 50 B. Carlson, N. Simopolous, E. R. Goy, A. Jackson & L. Ganzini, 'Oregon hospice chaplains' experience with patients requesting physician-assisted suicide', *Journal of Palliative Medicine* 8 (2005): 1160–1166.
- 51 C. Saunders, 'In Britain fewer conflicts of conscience', *Hastings Center Report* 25 (1995): 44–45.
- 52 D. Callahan, *The Troubled Dream of Life: Living with Mortality* (New York: Simon & Schuster, 1993).
- 53 See, for instance, chapter 1 of Callahan, 1993 *op. cit.*: 'The First Illusion: Mastering our Medical Choices' and Callahan 2002 *op. cit.* See also Zylicz, who says that almost all the people who continue to seek PAS after good end-of-life care has been made available to them are 'control freaks' (Z. Zylicz, 'Dutch hospice and euthanasia', in D. C. Thomasma *et al.* (eds) *Asking to Die: Inside the Dutch Debate about Euthanasia* (Dordrecht: Kluwer Academic Publishers, 1998)).
- 54 As I noted above, Veldink found that among patients with ALS the choice of PAS was 'negatively associated with . . . the presence of anxiety before death' and that those who chose PAS had no greater frequency 'of feelings of pain, despair, fear [or] anger' than those who did not (Veldink *et al.* *op. cit.*).