

Physician-Assisted Suicide: Considering the Evidence, Existential Distress, and an Emerging Role for Psychiatry

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Physician-assisted suicide (PAS) is one of the most provocative topics facing society today. Given the great responsibility conferred on physicians by recent laws allowing PAS, a careful examination of this subject is warranted by psychiatrists and other specialists who may be consulted during a patient's request for PAS. In this article, recent evidence regarding the implementation of PAS in the United States and The Netherlands is reviewed. Support is found for some concerns about PAS, such as the possibility that mental illness occurs at higher rates in patients requesting PAS, but not for other concerns, such as the fear that PAS will be practiced more frequently on vulnerable populations (the slippery-slope argument). These data and common arguments for and against PAS are discussed with an emphasis on the tension between values, such as maximizing patient autonomy and adhering to professional obligations, as well as the need for additional research that focuses more directly on the patient-centered perspective. Implications of the available evidence are discussed and lead to a consideration of mental anguish in terminally ill patients including aspects of existential distress and an acknowledgment of the importance of tailoring end-of-life care to the distinct set of values and experiences that shape each patient's perspective. The article concludes with a discussion of an expanding role for psychiatrists in evaluating patients who request PAS.

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Religious condemnation and moral disapproval of suicide by society were associated with its criminalization in most societies before modern times.¹ However, views toward suicide changed during the 19th and 20th centuries, coincident with the emergence of psychiatry as an autonomous discipline in which practitioners could diagnose and treat anxiety, depression, and other ailments contributing to suicide. In addition, modern sociological theory describing suicide as a social ill reflecting widespread alienation and anomie facilitated a growing cultural sensitivity to the plight of the mentally ill. Scientific advancements in our understanding of mental illness thus implied that suicide was caused by social or psychological forces often beyond the control of individuals and contributed to the decriminalization of suicide.^{1,2}

Modern laws in the United States allowing physician-assisted suicide (PAS), defined as the practice

of a physician providing a competent patient with a prescription for medication for the patient to use with the primary intention of ending his life, are thought to have emerged from a growing dissatisfaction with the medical profession and the development of a national right-to-die movement.³ The right-to-die sentiment developed in parallel with skepticism of medical authority, beginning in 1967 with the creation of the first living will that allowed patients to make decisions about their end-of-life care years in advance.⁴

Currently, assisted suicide is legal in the United States in only four states: Oregon, Washington, Montana, and Vermont. However, it has been a source of controversy in many other states for some time, as voter initiatives for legalizing assisted suicide were introduced and defeated in California, Michigan, and Maine over a period from the early 1990s until 2000. In recent time, legislatures in Connecticut and New Jersey have proposed bills to legalize assisted suicide. These repeated recent efforts in support of assisted suicide and the strident opposition that typically results keep the question in the American public's mind as one of vital importance.

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It should be noted that the phrase physician-assisted suicide is itself not without controversy. Proponents of the practice prefer the term aid in dying to describe doctor-provided assistance to patients who want to end their lives. Although I appreciate the sentiment behind such arguments, in this article, I will use PAS to describe the practice, as it is the term predominantly used in the medical context.

As PAS implies, modern attitudes toward death and dying consider the subject of assisted suicide to fall within the purview of medical practice, despite the American Medical Association's opposition to PAS on the grounds that it is antithetical to a doctor's role as healer.⁵ U.S. physicians remain sharply divided on assisted suicide, with opposition to the practice associated with increased religiosity and certain moral and ethics-based principles.⁶⁻⁸ Oregon's Death With Dignity Act clearly delineates the role of physicians as the primary gatekeepers of assisted suicide in enumerating responsibilities for the attending physician such as ensuring that each patient who requests aid in dying is capable, acts voluntarily, makes an informed decision, and is dying of a terminal disease (defined as an incurable and irreversible disease that will produce death within six months). The grave responsibility conferred by Oregon's Death With Dignity Act suggests that psychiatrists and other physicians who may be consulted to opine on the integrity of a patient's request for aid in dying must think deeply about their views on the subject.

The impassioned debate over PAS spans a wide range of disciplines and reflects the incendiary nature of the question. Arguments for and against PAS touch on many basic moral beliefs and illustrate the tension among values such as autonomy, paternalism, fairness, and the value of human life. Although the controversy can be described in political, social, and medical terms, an individual's feelings on the subject can often be reduced to a simple moral conviction about whether a person can aid another in ending his life. Debates that turn on such basic beliefs tend to divide people deeply, and the resultant conversation is often characterized by rhetoric and ideology. Over time and with the further polarization of views, common ground and compromise often seem unlikely.

However, although it is often overlooked or dismissed in these cases, scientific evidence has the opportunity to inform our thinking on matters that evoke moral and ethics-related questions. While not

dispositive, evidence can characterize the conditions and consequences associated with different viewpoints. Some of the most contentious aspects of the debate over assisted suicide include fears or questions that can be illuminated with actual evidence.

In this article, I will review the recent evidence that pertains to the arguments for and against PAS and suggest avenues for future research. I will then discuss implications of the available evidence and consider mental suffering in terminally ill patients as comprising aspects of existential distress (i.e., concerns related to feelings of hopelessness, futility, and meaninglessness; anxiety about death; and disruption of personal identity), as well as acknowledge the importance of tailoring end-of-life care to the distinct set of values and experiences that shape each patient's perspective. Finally, I will explore an emerging role for psychiatrists in evaluating patients who request PAS.

Evidence

In this section I will review some of the recent data that address some of the open questions and fears regarding PAS. An important caveat is that most of the evidence is taken from studies conducted in Oregon and The Netherlands, and moreover, many of the studies involve the work of Linda Ganzini, a professor of psychiatry and medicine at Oregon Health and Science University. This is not to imply a particular bias on the part of the studies mentioned in this article, but rather to characterize the current state of evidence as limited by region and principal investigator.

Psychiatric Illness in Patients Who Request PAS

One basic question that frames the debate on assisted suicide is the extent to which patients who request PAS have a treatable psychiatric illness. Ganzini *et al.*⁹ interviewed a cross section of patients who requested a physician's aid in dying under Oregon's Death with Dignity Act and found that one in four had clinical depression. In another study, physicians in Oregon who received requests from patients for aid in dying reported that 20 percent of them were depressed.¹⁰ The results of these studies imply that a significant minority of patients who request aid in dying have depression. However, of all patients who received a prescription for a lethal drug in Oregon since 1997, just under 7 percent were referred for a psychiatric evaluation. Ganzini and colleagues also studied health care providers and family members in

Oregon and found that these groups thought that depression was rarely a factor influencing requests for PAS.^{9,11,12} Together, these findings raise the concern that clinicians and family members may fail to detect signs and symptoms of depression in these patients.

For purposes of comparison, a recent systematic review found that, in The Netherlands, the rate of depression in patients whose requests for euthanasia were honored was similar to that in the surrounding population of seriously ill patients, but that the presence of depression was a significant factor in refusals of requests for euthanasia, suggesting that the Dutch system may be successful in screening out many requests motivated by depression.¹³ Moreover, with regard to the overall prevalence of depressive symptoms in the terminally ill population, one study of terminally ill patients with cancer found that 59 percent of those with a serious and pervasive desire to die had significant symptoms of depression, versus only 8 percent of those without such a desire.¹⁴ This result is consistent with other research that has found an increased association between an expressed desire for a hastened death and symptoms of depression,¹⁵ implying a higher probability that patients who request PAS have depression. These findings suggest the importance of screening such patients carefully for evidence that mental illness may be interfering with their decision-making capacity.

Impact on Vulnerable Patients: the Slippery Slope

Another concern that can be illuminated by evidence is the question of the slippery slope that leads to abuse. Many have expressed apprehension that abusive pressures would disproportionately affect vulnerable patients, such as those whose capacities for decision-making are compromised by cognitive impairment or lack of education, those who are subject to social prejudice, or those who may have been socially conditioned to think of themselves as less deserving of care.¹⁶ Ultimately, there is concern that these pressures would result in an increased risk of death by PAS among vulnerable persons compared with the risk in other populations.

Battin *et al.*¹⁶ explored this question by examining data collected in jurisdictions where assisted dying is legal, such as Oregon and The Netherlands, and by looking for evidence that the lives of people in groups identified as vulnerable were more frequently ended with assistance from a physician than those of other

populations. Their findings were limited by substantial differences in methodologies in source studies and difficulties in determining with certainty the actual incidence of assisted dying in several of the vulnerable groups studied. However, they found no evidence of heightened risk of death by physician assistance in the elderly, women, uninsured people, the poor, racial and ethnic minorities, people with low educational status, minors, patients with psychiatric illness, and patients with chronic nonterminal illness.

Although conclusive proof about the impact of legalized assisted suicide on vulnerable patients would entail studies of higher complexity, duration, and comprehensiveness, Battin *et al.* certainly provided a first-pass look at the slippery-slope question. At this stage, there appears to be no evidence to support the fear that assisted suicide disproportionately affects vulnerable populations. Instead, the available data indicate that people who die with a physician's assistance are more likely to be members of groups with higher social, economic, educational, and professional status.

Patients' Experience of PAS

Other aspects of the debate on assisted suicide that can be informed by evidence are those related to the tension between autonomy and paternalism. In essence, paternalism presupposes that doctors are better able to act in patients' best interests than the patients are themselves. One way to examine the question of whether patients are indeed capable of making decisions about dying is to compare the quality of death and dying in patients who request PAS with that of those who do not.

Smith *et al.*¹⁷ sought to determine whether there was a difference in the quality of the dying experience, from the perspective of family members, among patients in Oregon who received lethal prescriptions, those who requested but did not receive lethal prescriptions, and those who did not pursue physician-assisted dying. Altogether, they noted few significant differences between the groups in items that measured domains such as connectedness, transcendence, and overall quality of death. However, they did observe that families reported that patients who received lethal prescriptions had higher quality ratings on items measuring symptom control (e.g., control over surroundings and control of toileting) and higher ratings on items related to preparedness

for death (e.g., saying goodbye to loved ones) than those who did not pursue physician-assisted death. Their conclusion was that the quality of death experienced by those who received lethal prescriptions was no worse than that of those who did not pursue PAS, and in some areas, family members rated it as better. In another study, Georges *et al.*¹⁸ used retrospective interviews with relatives to describe the experiences of patients who died by euthanasia (EAS) or PAS in The Netherlands and found that, according to relatives, EAS had a positive impact on the quality of the end of their loved one's life in 92 percent of cases, primarily by preventing or ending suffering.

One interpretation of the findings of these studies is that in those patients who opt for it, assisted suicide contributes favorably to the experience of their relatives. This inference is supported by evidence from other studies showing no differences in mental health outcomes in family members of patients in Oregon who had requested physician aid in dying compared with family members of patients in Oregon who died of terminal illness.¹⁹ However, although information regarding the experience of family members of patients who opt for PAS may be important in influencing social norms regarding the acceptability of PAS, these data do not speak to the central question of patient autonomy. In fact, it is arguable that the aforementioned studies are irrelevant to the patient-centered perspective, in that they do not directly assess patients' experiences of PAS. In this sense, sufficient research into this and other questions regarding PAS seems to be lacking.

Current State of Research on PAS

As mentioned earlier, most of the clinical studies performed in the United States are associated with the work of one researcher (Ganzini). The relative paucity of research on PAS compared with other areas of medicine implies that there may be a reluctance to study it. Reasons for this reluctance include the taboo associated with PAS, the small number of states that have legalized it, a reliance on using rhetoric or ideology to argue points for or against it rather than actual evidence, and finally, a fear by doctors that research may lead to changes that would restrict, rather than inform, the care that they provide. The identification of the impediments to research in this realm may itself be a consideration for future study,

as this may provide a clear path to encouraging more research on PAS.

Another important open question regarding PAS that has not been directly addressed by research to date is the quality of the dying experience of patients who opt to die in this way. Research that directly assessed the patient's experience leading up to death by PAS would clarify questions about the well-being of patients who died by this method and, in doing so, provide evidence potentially in support of PAS as a form of care. Such evidence would be vital for several reasons. For example, it could confirm the sense that physician supporters of PAS have that PAS is a valid form of health care that does indeed improve patients' well-being. Moreover, it would address fears that PAS is inconsistent with the medical dictum to "first, do no harm," for if it could be shown more clearly that PAS improves the experience of dying for patients, it could be argued that the essence of PAS is to relieve suffering rather than to kill or cause harm. Finally, data taken directly from the patient-centered perspective would address concerns that may be raised about the ability of patients to predict their future mental state accurately, as depressed patients have been shown to have more negatively biased mood predictions,²⁰ which in turn could adversely affect their ability to make decisions about end-of-life care.²¹ Evidence that patients who opt for PAS experience increased well-being up to the time of death would support the belief that, for selected patients, such end-of-life decisions could be consistent and authentic.

Discussion

The evidence reviewed offers support for some fears with regard to assisted suicide and seems to refute others. One study found no evidence to support the slippery-slope fear that assisted suicide would eventually be used prejudicially on vulnerable populations.¹⁶ Also, researchers found that families of persons who used assisted suicide felt more prepared for and accepting of their loved one's death and in other ways had mental health outcomes that were no worse than those in families of persons who died of other causes.¹⁹

However, data from multiple sources indicate that the concern that depression is often missed or overlooked in patients seeking assisted suicide may be valid. For example, although only a small percentage of patients who request assisted suicide are actually

referred to psychiatrists, around 20 percent of those who request assisted suicide have depression. Moreover, health care providers and family members underestimate the extent to which depression is a factor in requests for aid in dying.^{9–12,22} From one perspective, this finding implies a need for mandating more frequent referrals to psychiatrists to evaluate patients for evidence that mental illness may have interfered with their decision-making capacity.

On the other hand, psychiatrists and physicians in general may be overly inclined to pathologize suicidal ideation and depression in patients who request aid in dying. Most people with major depression retain competence to make medical decisions,²³ and the legalization of PAS reflects an acceptance that active hastening of death can be a valid choice in terminal illness, implying that PAS can be a valid choice despite the presence of depression.¹³ It follows that, although the expression of suicidal ideation may indeed be pathologic in most settings in which it is observed, the conditions that characterize terminal illness may truly be distinct, as patients can reasonably interpret such a diagnosis as a death sentence. One would anticipate that no matter how psychologically healthy a patient might be, it would be understandable for that person to experience feelings of despair, demoralization, and existential distress (i.e., concerns related to feelings of hopelessness, futility, or meaninglessness; anxiety about death; and a disruption of personal identity) in response to receiving a diagnosis of terminal illness.

The Evaluation and Treatment of Existential Distress

Researchers have explored the concept of existential distress in terminally ill patients and have found that their concerns are often related to themes such as loss of control, loss of continuity, and acceptance and preparation.²⁴ Some have resolved to address the plight expressed by these patients by emphasizing the importance of finding “meaning” at the end of life. Breitbart and colleagues²⁵ describe psychotherapeutic approaches intended to explore spiritual and existential themes through a meaning-oriented approach that encourages the dying patient to find meaning and purpose in living until death and promotes a patient’s personal agency and responsibility.

Chochinov and colleagues²⁶ have studied the psychological experience of terminally ill patients and have proposed that a fractured sense of dignity can be

diagnosed, quantified, associated with a decreased quality of life, and treated with dignity-conserving therapies, such as maintaining autonomy by participating in decisions about care or contributing to something that might serve as a lasting legacy.

Although these researchers have offered therapies that promote continued life, their findings also imply alternative solutions to the existential dilemma facing the terminally ill. For example, important values such as autonomy and dignity would appear to be served with the practice of assisted suicide as well. In fact, assisted suicide might plausibly be a choice that resolves the existential dilemma of terminal illness and its attendant helplessness and hopelessness. Choosing the time and manner of one’s death could be a way of symbolically wresting back the reins of the course of one’s life. After all, if the healthy among us face up to our finite lives by making choices about how to live, it may also be reasonable for those facing their imminent demise to determine the conditions of their death.

The use of assisted suicide to resolve the existential distress of the terminally ill gains additional support from the work of Chochinov *et al.*²⁶ on the concept of dignity in this population. They found that, although there were many common elements shared in different patients’ definitions of dignity, there were also important distinctions. For example, some patients valued a “fighting spirit” and “railing against their illness,” whereas others valued acceptance. Some patients spoke of their distress at the thought of having to rely on others for their care, whereas others raised fears related to the anticipation that their death would cause their loved ones pain.

The findings of Chochinov *et al.* highlight the diverse set of values and manifold experiences within the terminally ill population and imply that treatments aiming to improve these patients’ well-being would have to take into account their various desires and perspectives. After deep consideration and reflection on his goals and wishes, as well as careful evaluation to rule out the possibility that pathologic motivations (such as severe mental illness) may be playing a role in his decision, a patient may ultimately decide that assisted suicide is the best way to end his life.

A Role for Psychiatry

These findings imply a potential role for psychiatrists in evaluating patients who request PAS. How-

ever, this perspective, too, is not without its complications. Psychiatrists themselves are divided in their support for assisted suicide, with surveys indicating that about two-thirds of U.S. psychiatrists believe that it should be permitted in certain circumstances.^{27,28} Moreover, most psychiatrists believe that a single independent psychiatric examination would be insufficient to determine a patient's capacity to decide on PAS,²⁸ especially given previously mentioned concerns about the general difficulty humans have in accurately forecasting their future mental state.^{20,21}

It must be acknowledged that mandated or multiple independent psychiatric examinations would have the effect of increasing the labor and time associated with ensuring the integrity of a patient's request for PAS, which in turn may serve as an impediment to the overall process. Moreover, terminally ill patients may feel stigmatized by being mandated to undergo a psychiatric examination. In Australia, Kissane *et al.*²⁹ found that mandated psychiatric assessments for patients requesting euthanasia or PAS sometimes leads them to withhold key information because they see the psychiatric assessment as a legal hurdle to be overcome, suggesting also that mandated psychiatric assessments may compromise the relationship between psychiatrist and patient.

Yet, the push for more extensive evaluations by psychiatrists in this context is understandable. Concerns about a patient's capacity to make reasoned decisions about treatment are likely to be raised in circumstances where a patient expresses a desire for an intervention with unfavorable outcomes and high risk.³⁰ In addition, some physicians may feel uncomfortable participating in PAS without a more comprehensive evaluation.²⁸ Thus, in instances where a patient's capacity is in serious question, multiple independent evaluations from consulting psychiatrists over time may be indicated.

For the purpose of guiding a psychiatrist's evaluation of a patient who has requested PAS, Muskin³¹ emphasized a psychodynamic approach to exploring the complexity contained in a patient's request to die, which could be interpreted as a communication to the patient's doctor, a method of control over aspects of the patient's life or death, rage or revenge, an expression of hopelessness, or even an expression of guilt, self-punishment, or atonement. A psychiatrist's role as expert in exploration would also include evaluating the effect of psychiatric or medical disease

on a patient's decision-making capacity, as well as clarifying communications among treatment team, family, and patient to minimize the possibility of undue influence on a patient's ultimate decision. Finally, a psychiatrist may simply bear witness to and acknowledge the validity of the patient's emotional experience, thereby offering relief by way of empathy. The expertise of psychiatrists in these important areas thus suggests that they would be well suited to provide careful guidance to a patient as he explores his feelings, desires, and values in the service of making authentic decisions about end-of-life care.

In the final analysis, however, a psychiatrist's impressions of the integrity of a patient's request for PAS may turn on the psychiatrist's conception of rational suicide. Thus, it seems critical for psychiatrists to ponder the psychological constituents of rational suicide. Muskin's article³¹ is useful in summarizing the questions necessary for a sufficient exploration of a patient's request for PAS, but additional work is warranted to delineate the essential features of rational suicide. The conception set forth by Tomasini³² of rational suicide as instrumentally rational, autonomous, born of stable goals, and not due to mental illness offers a potential starting point, but in its brevity, it also implies that patients who possess these basic qualities may differ greatly. The challenge will then be for consulting psychiatrists to immerse themselves in a patient's psychological experience with the goal of ensuring that the request is emotionally appropriate, purposive, free of undue influence, and consistent over time with the patient's stated goals, values, and preferences.

Conclusion

Although the arguments and evidence reviewed herein may influence some to change their views on assisted suicide, there are undoubtedly those who will remain steadfast in their beliefs. That strong arguments can be made on both sides of the debate and strident disagreement continues suggests that the question of assisted suicide may touch on something deeper than any single ideology.

In medicine, it may be especially difficult to feel comfortable with helping a patient commit suicide, given that some may equate PAS with killing rather than healing. For this and other reasons, which may be religiously or philosophically derived, certain physicians may feel that it is against their code of ethics to participate in assisted suicide. The question of as-

sisted suicide can also raise feelings of personal failure, as if medicine has nothing left to offer patients, although as implied by the arguments outlined in this article, assisted suicide could instead function as a vital form of care for someone who is suffering.

Indeed, for our purposes in medicine, it is this latter perspective that forms the *raison d'être* of PAS. Rather than merely seeking to maximize patient autonomy in some abstract sense, physicians are experts in the service of patients' health and are therefore obligated to practice PAS only when it is deemed to be in the interest of patients' well-being and not solely in the service of patient autonomy or preference satisfaction. This approach obviates the absurd implication of prioritizing maximization of autonomy over our professional obligations and moreover serves as a useful framework with which to deny the practice of PAS in other conditions, such as chronic, nonterminal illness, in which physicians would feel that PAS would not constitute appropriate care.

In fact, the fear that assisted suicide could eventually be used in such cases is fundamentally unsettling to many. When the philosopher Albert Camus³³ said, "There is but one truly serious philosophical problem and that is suicide," he was identifying one of the most basic fears that humans can have. Camus' statement highlights the fact that, at one point or another in our lives, we all must confront our mortality and the question of whether life is worth living. As fellow humans and in psychiatry in particular, we hope that each person is able to resolve this dilemma in a way that allows him to live life in a satisfying, meaningful way. Assisted suicide seems to flout that basically pro-life view, but on closer examination, its purpose is instead to relieve suffering in imminently terminal cases where it is thought that no other treatment could reasonably hope to do the same. Our charge as physicians is to encourage an honest, scientific inquiry into the questions raised by PAS that is commensurate with the ideological fervor that surrounds the debate and, as psychiatrists, to ensure that patients struggle valiantly and honestly before making a decision in that direction.

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Physician-Assisted Suicide

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