

End-of-Life Mental Health Assessments for Older Aged, Medically Ill Persons With Expressed Desire to Die

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In recent years, assisted suicide has been legalized in four states for those who are terminally ill and wish to end their lives with the assistance of lethal doses of medications prescribed by a physician. The ethics-related and legal questions raised by end-of-life suicide and decisional capacity to refuse treatment assessments are complex. In treating patients with end-stage medical conditions or disorders that severely affect the future quality of their lives, clinicians tend to engage in suicide prevention at all costs. Overriding the patient's expressed desire to die conflicts with another value, however, that of the individual's right to autonomy. We provide a framework for understanding these difficult decisions, by providing a review of the epidemiology of suicide in later life; reviewing findings from a unique dataset of suicides among the elderly obtained from the Los Angeles County Coroner's Office, as well as data from states with legalized assisted suicide; presenting a discussion of the two frameworks of suicidal ideation as a pathological versus an existential reaction; and giving a case example that highlights the dilemmas faced by clinicians addressing decisional capacity to refuse treatment in an elderly, medically ill patient who has expressed the wish to die.

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In 1965, Shneidman wrote that suicide prevention presents a minimum ever-present responsibility and that “there are no excuses for holding back on life-saving measures” (Ref. 1, p 112). Although many believe that suicide prevention is a core responsibility of mental health professionals, the ethical and legal questions raised by end-of-life suicide and decisional capacity to refuse treatment assessments are complex. When treating those with end-stage medical conditions or illnesses that will severely affect the future quality of their lives, engaging in suicide prevention at all costs and overriding the individual's expressed desire to die conflicts with another value: the right to autonomy.

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In this article, we consider two central questions: at what point are clinicians ethically and legally bound to bolster interventions that thwart the individual's desire to end his life; and, at what point can clinicians legally and ethically accept the individual's decision to end his life? We provide a framework for understanding these difficult questions through a review of the epidemiology of suicide in later life, findings from a unique dataset of elder suicides obtained from the Los Angeles County Coroner's Office occurring in a one-year period and data from states with legalized assisted suicide; a discussion of the two frameworks of suicidal ideation: pathological versus existential; and a hypothetical case example illustrating the dilemmas faced by clinicians addressing an elderly, medically ill patient's decisional capacity to refuse life-preserving treatment.

Epidemiology of Suicide in Later Life

It is well known that suicide rates increase progressively with age, with the highest rates occurring in men aged 65 and older.² In addition, physical illness plays a very important role in suicide risk, particularly for those who are aged.^{3–8} Elderly and medically ill individuals often experience other problems re-

lated to elevated suicide risk, such as social isolation, loss of physical integrity, fear of becoming a burden, cumulative life stressors, and an increased number of losses of friends and family members.^{9–15} One of the most consistent findings is that a psychiatric disorder is present in many suicides, with affective disorder as the most common psychopathology.^{11,15–18}

Stressors for older aged individuals include physical illness or functional decline, marital problems, bereavement, financial and legal concerns, and loss-related depression. However, loss of health with the attendant loss of self-esteem is a frequent stressor for older aged persons and may give rise to depression through its effects on brain function, psychological impact, or existing psychological and social factors.^{19–22} Moreover, depression and hopelessness can be precipitated by ill health and thereby influence the association between physical illness and suicide in the elderly.^{20,23–26}

Suicide of Elderly Persons in Los Angeles County

Although ill-health can precipitate suicidal ideation, there are few studies of a single cohort of completed suicides among the elderly. The Los Angeles County Coroner's Office data collected by our group provide this unique perspective of completed suicides among the elderly with medical illness within one community. Specifically, our data represent all suicide deaths of those 65 years and older occurring in one year within one of the most populous counties in the United States. Moreover, these data lend empirical support for the assertion that for some older individuals who are medically ill and experiencing depression, suicide may be perceived as a desirable alternative to continuing to live.

Our group collected data from suicide cases in the Los Angeles County Department of Coroner's files for the year 2000 (approved by the Department of Coroner's Human Subjects' Committee). The study consisted of archival review only, with removal of names and other identifying information. Identification was by code number and coroner's case number. A total of 730 persons were identified by the coroner's office as having died as a result of suicide. Of those, 713 case files were complete and available for review. The files were a rich source of information: police reports, coroner investigator's reports, deputy medical examiner's reports, toxicology reports, hospital records, medical and mental health records,

emergency medical service (EMS) records, death certificates, newspaper clippings, correspondence from next-of-kin and their legal representatives, written material left at the scene of death by decedents (e.g., suicide notes), and photographs of the decedents at the scene.

Of note, of the 713 cases reviewed, 166 (23%) involved individuals 65 years of age or older. In keeping with previous findings and as depicted in Table 1, the majority were men. The largest age group was 75–85 years old. The predominant method of death was by firearm. Most of the suicides in elderly individuals occurred in those who experienced a serious medical illness (cancer or cardiovascular disease) and some form of depression preceding death. Our data are not specific as to whether the depression was clinical or caused by sadness over loss of quality of life and loss of autonomy. However, in notes or letters left by the decedents, failing health was identified as the primary stressor.

These data are disconcerting, given the violent form that characterized the last moments of these elderly individuals' lives, and raise the question of whether they would have opted for death with dignity, or assisted suicide, if given the opportunity.

States with Assisted Suicide or Death With Dignity Acts

Worldwide, there appears to be a slowly growing movement to develop a policy allowing death with dignity. In the United States, all 50 states have addressed end-of-life policies; however, it should be noted that euthanasia (in which the physician or another person administers a lethal dose of medication) is illegal in all 50 states. The states have legalized some form of advance directives or alternative provisions for end-of-life decisions (i.e., form of family consent, surrogacy, or succession laws). Only four states, Oregon, Washington, Montana, and Vermont, currently allow assisted suicide.

Oregon was the first state to pass a Death With Dignity Act. It appeared as a general referendum in November 1994. The controversial nature of death with dignity was underscored by the narrow margin, 51 to 49 percent, of passage. The law was eventually heard and upheld by the U.S. Supreme Court in *Gonzales v. Oregon*.²⁷ Currently, under the Oregon Revised Statutes,²⁸ those who are terminally ill may end their lives through voluntary self-administration of lethal medications prescribed by a physician. To

Mental Health Assessments in Persons With Desire to Die

Table 1 Suicides of 166 Persons 65 Years of Age or Older in Los Angeles County in 2000

	Aged 65–74 (<i>n</i> = 61) <i>n</i> (%)	Aged 75–84 (<i>n</i> = 82) <i>n</i> (%)	Aged 85 and older (<i>n</i> = 23) <i>n</i> (%)
Sex			
Male	49 (80.3)	71 (86.6)	18 (78.3)
Female	12 (19.7)	11 (13.4)	5 (21.7)
Race			
White	41 (67.2)	60 (73.2)	17 (73.9)
Black	6 (9.8)	2 (2.4)	1 (4.3)
Hispanic	8 (13.1)	9 (11.0)	2 (8.7)
Asian/Pacific islander	6 (9.8)	11 (13.4)	3 (13.0)
Marital status			
Married	23 (37.7)	38 (46.3)	7 (30.4)
Divorced	18 (29.5)	8 (9.8)	2 (8.7)
Widowed	11 (18.0)	20 (24.4)	14 (60.9)
Single/separated	8 (13.1)	14 (17.1)	0 (0.0)
Unknown	1 (1.6)	2 (2.4)	0 (0.0)
Means of death			
Gunshot to head	32 (52.5)	41 (50.0)	8 (34.8)
Gunshot to body	2 (3.2)	7 (8.6)	4 (17.4)
Hanging	10 (16.4)	11 (13.4)	3 (13.0)
Overdose	8 (13.1)	7 (8.5)	4 (17.4)
Fall	2 (3.2)	4 (4.9)	1 (4.3)
Other	7 (11.5)	12 (14.6)	3 (13.0)
Presence of alcohol in body*			
Yes	5 (8.2)	5 (6.1)	3 (13.0)
No	56 (91.8)	77 (93.9)	20 (87.0)
Place of death			
Home alone	21 (34.4)	36 (43.9)	13 (56.5)
Alone in garage	7 (11.5)	9 (11.0)	1 (4.3)
Alone in home but person in another room	16 (26.2)	17 (20.7)	6 (26.1)
Other location	17 (27.9)	20 (24.4)	3 (13.0)
Mental state [†]			
Depression	56 (91.8)	73 (89.0)	23 (100)
Dementia	1 (1.6)	1 (1.2)	0 (0.0)
Agitation	2 (3.3)	2 (2.4)	0 (0.0)
Alcohol intoxication	2 (3.3)	2 (2.4)	0 (0.0)
Psychosis	0 (0.0)	1 (1.2)	0 (0.0)
Unknown	3 (4.9)	6 (7.3)	0 (0.0)
Presence of physical illness*			
Yes	45 (73.8)	69 (84.1)	18 (78.3)
No	1 (1.6)	1 (1.2)	1 (4.3)
Unknown	15 (24.6)	12 (14.6)	4 (17.4)
Medical history [†]			
Cancer	16 (26.2)	22 (26.8)	5 (21.7)
Cardiovascular	10 (16.4)	14 (17.1)	6 (26.1)
COPD	4 (6.6)	8 (9.8)	3 (13.0)
Stroke	4 (6.6)	7 (8.5)	3 (13.0)
In medical or mental health treatment*			
Yes	47 (77.0)	67 (81.7)	15 (65.2)
No	1 (1.6)	3 (3.7)	3 (13.0)
Unknown	13 (21.3)	12 (14.6)	5 (21.7)
Stressor at time of suicide [†]			
Physical health	42 (68.9)	62 (75.6)	19 (82.6)
Mental health	37 (60.7)	46 (56.1)	12 (52.2)
Loss of family member or significant other	6 (9.8)	12 (14.6)	4 (17.4)
Loss of friend	2 (3.3)	0 (0.0)	1 (4.3)
Financial problems	6 (9.8)	1 (1.2)	0 (0.0)
Legal problems	2 (3.3)	2 (2.4)	1 (4.3)
Family problems	4 (6.6)	5 (6.1)	1 (4.3)
Forced retirement	2 (3.3)	1 (1.2)	0 (0.0)
Feeling like a burden	0 (0.0)	6 (7.3)	4 (17.4)

COPD, chronic obstructive pulmonary disorder.

* At time of death.

[†] More than one category per person may apply.

participate, one must be 18 years of age or older, a resident of Oregon, capable of making and communicating health care decisions for oneself, and have a diagnosed terminal illness that would lead to death within six months. It is up to the attending physician (MD or DO) to determine whether the criteria are met.

Oregon law addresses whether a psychiatric or psychological condition or depression impairs the individual's decision to end his life in this manner. If the attending or consulting physician believes the patient has a psychiatric or psychological disorder that impairs judgment, the patient must be referred for a psychiatric or psychological consultation. No end-of-life medication can be prescribed until the psychiatrist or psychologist concludes that the patient is capable and has no psychiatric or psychological disorder causing impaired judgment.

The state of Washington passed a Death With Dignity Act²⁹ as a voter initiative in November 2008; it became law on March 4, 2009, and is similar to Oregon's Death with Dignity Act. As in Oregon's Act, a psychiatric or psychological evaluation is not required unless the patient is suspected to have a mental disorder that impairs judgment.

In Montana, assisted suicide was legally upheld in *Baxter v. Montana*.³⁰ Mr. Baxter had lymphocytic leukemia and other symptoms of debilitation and wanted his physician to prescribe a lethal dose of medication for him to self-administer at a time of his choosing. The Montana Supreme Court found that physician assistance in dying is not against public policy and that Montana's code, Rights of the Terminally Ill,³¹ entitles patients to autonomous end-of-life decisions, even if it involves direct acts by a physician.

On May 20, 2013, the governor of Vermont signed into law a legislative bill that legalized assisted suicide for terminally ill patients.³² The law is very similar to Oregon's Death with Dignity Act.

Table 2 shows a comparison of Oregon's and Washington's experiences with their Death With Dignity Acts, showing data that were derived from reports published by each state.^{33,34} These data offer a picture of the types of individuals who choose death with dignity. Of note, most of the cases in Oregon and Washington involved persons of older age who had serious medical illness that compromised the quality of their lives. The most frequently expressed end-of-life concerns were those of loss of autonomy

(~90%), less ability to engage in life's enjoyable activities (88%), and loss of dignity (>75%). The data suggest an interaction between the effect of the medical condition and age that causes an erosion of the senses of self-efficacy and self-reliance. The data from Los Angeles County also underscored that, among the elderly who committed suicide, debilitating health and its accompanying stressors were prominent factors in their decision to end their lives. The assisted suicide data from Washington and Oregon imply that the decision to end life was driven by reduced quality of life and was not the apparent by-product of distorted thinking influenced by depression. These data, in particular, suggest an alternate viewpoint to the prevailing psychopathological representation of why older aged, medically ill individuals may want to end their lives.

Death and Existential Concerns

Existential psychologist Rollo May observed more than 55 years ago that there was a, "growing awareness on the part of some psychiatrists and psychologists that serious gaps exist in our way of understanding human beings" (Ref. 35, p 3). May asked whether the clinician is, "...seeing the patient as he really is, knowing him in his own reality; or are we seeing merely a projection of our own theories about him?" (Ref. 35, p 3) Individuals wishing to end their lives may be vulnerable to the clouding of the lens of observation by clinicians' theoretical prejudices. That is, the predominant viewpoint of suicide among mental health professionals is one where such expression is a symptom of a mental disorder, frequently that of clinical depression.^{11,14,15} This clinical viewpoint considers suicidal ideation as uniformly pathological and psychiatrically abnormal, therefore requiring intervention. However, an alternate view, from an existential approach, argues that there may be plausible reasons for contemplating suicide. Those with a medical illness who consider suicide or assisted suicide may do so because of an impaired quality of life. This decision does not come from a pathological or distorted perspective, but is based on a cost-benefit analysis of the quality of life as opposed to quantity. A medically ill person contemplating death may well have a realistic view of his situation and future; viz., that his life-threatening illness will not improve and in fact will get worse. Such a self-assessment of quality of life may not be a facet of depression. Although the literature describes older

Mental Health Assessments in Persons With Desire to Die

Table 2 Data on the Death with Dignity Act for Oregon and Washington

	Oregon 1998–2011 (<i>n</i> = 596) <i>n</i> (%) [*]	Washington 2009–2011 (<i>n</i> = 213) <i>n</i> (%) [*]
Sex		
Male	308 (51.7)	111 (52.1)
Female	288 (48.3)	102 (47.9)
Age, years		
18–34	6 (1.0)	0 (0)
35–44	14 (2.3)	3 (1.4)
45–54	44 (7.4)	19 (8.9)
55–64	123 (20.6)	45 (21.1)
65–74	170 (28.5)	67 (31.5)
75–84	168 (28.2)	47 (22.1)
85+	71 (11.9)	32 (15.0)
Race		(<i>n</i> = 189) [†]
White	579 (97.6)	180 (95.2)
Hispanic or non-white	14 (2.4)	9 (4.8)
Unknown	3	0
Marital status		(<i>n</i> = 189) [†]
Married	271 (45.7)	90 (47.6)
Widowed	134 (22.6)	41 (21.7)
Divorced	139 (23.4)	42 (22.2)
Never married	49 (8.3)	16 (8.5)
Unknown	3	0
Underlying Illness		
Cancer	480 (80.9)	166 (77.9)
Neurodegenerative disease (including ALS)	44 (7.4)	22 (10.3)
Respiratory disease (including COPD)	25 (4.2)	9 (4.2)
Heart Disease	10 (1.7)	10 (4.7)
HIV/AIDS	8 (1.3)	Not noted
Other illnesses	26 (4.4)	6 (2.8)
Unknown	3	0
End-of-life concerns [‡]	<i>n</i> = (592) [§]	(<i>n</i> = 202)
Losing autonomy	538 (90.9)	183 (90.6)
Less able to engage in activities that make life enjoyable	523 (88.3)	179 (88.6)
Loss of dignity	386 (82.7)	151 (74.8)
Losing control of bodily functions	318 (53.7)	105 (52.0)
Burden on family, friends/caregivers	214 (36.1)	78 (38.6)
Inadequate pain control or concern about it	134 (22.6)	70 (34.7)
Financial implications of treatment	15 (2.5)	8 (4.0)
Health care provider present when medication ingested	(<i>n</i> = 526) [¶]	(<i>n</i> = 157) [#]
Prescribing physician or other provider	331 (82.1)	87 (62.6)
No provider	72 (17.9)	52 (37.4)
Unknown	123 ^{**}	18
At time of death		
Prescribing physician or other provider	343 (66.7)	Not noted
No provider	171 (33.3)	Not noted
Unknown	12 ^{††}	Not noted

The totals for some categories are less than the number of people who died in Washington, because not all data had been received or reported at the time the report was written. Data are expressed as *n* (%), unless otherwise noted. COPD, chronic obstructive pulmonary disorder; ALS, amyotrophic lateral sclerosis.

^{*} Unknowns are excluded when calculating percentages.

[†] Data available for 87 of the 94 participants who died in 2011, 61 of the 72 who died in 2010, and 41 of the 47 who died in 2009.

[‡] Participants may have noted more than one concern; therefore, total percentage may be more than 100% for both Oregon and Washington.

[§] Data unavailable for 4 participants in 2001.

^{||} Data available for 91 of the 94 participants who died in 2011, 67 of the 72 who died in 2010, and 44 of the 47 who died in 2009.

[¶] Data are reported for 2001–2011.

[#] Of those participants who ingested the medication and died, data are available for 70 in 2011, 51 in 2010, and 36 in 2009.

^{**} A procedure revision in Oregon, adopted mid-year 2010, accepts information only when a physician or other health care provider is present at time of death; thus, resulting in a larger number of unknowns beginning in 2010.

^{††} Noted for 2001–2010.

people as having depression, it may be that more of them are experiencing sadness and grief. They are sad because they want to continue to live, but can no longer tolerate their lives or are unhappy about how their illness may be affecting others. Sadness and grief are not equivalent to depression, but rather are normal emotional reactions to the recognition that the end of one's life is approaching.

Suicide or such expressed ideation (i.e., the desire to die), therefore, for some individuals may actually be a response to existential concerns at the end of life. There may be both spiritual and existential drives toward an individual's desire to die rather than prolong a painful life. A developmental model by Erickson³⁶ conceptualized the last phases of life as resolving the conflict of integrity versus despair in the face of bodily deterioration. Despair may be the end product of an assessment that the consequences of living will be protracted physical debility and pain, that one's sense of self, as defined by autonomy and self-efficiency, will give way to an existence defined by pain. Frankl³⁷ conceptualized a similar process, that of an existential vacuum in which the individual experiences suffering as meaningless and therefore despairs. Although Frankl's perspective would not have supported suicide, because end-of-life physical suffering would be viewed as an opportunity to contemplate the meaning of physical debilitation in the context of one's life, both of these models underscore May's point of understanding the individual from his perspective rather than through clinical dogma.

Refusal of Treatment as Passive Suicidal Ideation

Existential concerns are relevant to psychological and psychiatric assessments of the capacity to refuse treatment in older persons who are medically hospitalized. Suicidal ideation in medically ill, elderly individuals may reflect a complex interaction of pain, functional impairment, and affective disorder. Those elements, in conjunction with one another, may contribute to the refusal of treatment. When such refusal can lead to death, it could be considered passive suicidal intent; that is, the surface expression of a loss of the will to live precipitated by clinical depression. Alternatively, passive suicidal ideation could represent existential concerns that are human reactions related to dying rather than psychiatric symptoms.

All states legally recognize that people have the capacity to choose between alternatives of treatment.

Such capacity is assumed unless otherwise determined to be lacking by health professionals, and if necessary, by the court. The crux of the matter is whether the refusal of treatment represents a means of suicide. Typically, people are allowed to make choices that can result in the hastening of death, such as refusing a respirator (saying that they would rather die than be supported by a machine, no matter how temporary), declining to undergo open heart surgery (saying they would rather die than go through the postoperative pain), or refusing cancer treatments (preferring an earlier death to a prolonged dying process). These choices, however, are reserved generally for those with terminal diseases where, with or without treatment, it is likely that the individual would die of the disease process.

When is it legally, morally, and ethically permissible to conclude that a patient has the capacity to refuse treatment when he presents with a loss of will to live? If the precipitant of the lack of will to live is pain, the fact that some of the medical problems are reversible, by such methods as enhanced pain medication in cancer or other clinical conditions with pain, becomes notable. In addition, depression among the elderly is vulnerable to under-recognition. The reason for the failure to recognize warning signs of suicide among elderly or ill individuals is that both the person and family may view depressive symptoms and suicidal ideation as a normal aspect of aging and an expected side effect of the physical illness. Older people are frequently seen in primary care settings and may be hesitant or unable to report psychiatric symptoms, even when asked. Primary care physicians may not be trained to elicit or recognize symptoms of depression or be able to treat it adequately. Under such circumstances, untreated depression may worsen to the point of suicide. On the other hand, the older or medically ill individual may assess the quality of life realistically as poor and consequently may have the understandable reaction of wanting to die. Therefore, the role of the psychiatric clinician is represented by an adequate assessment of suicide risk and a recommendation of appropriate interventions in cases where it is opined that the capacity to make treatment decisions is undermined by an untreated psychiatric disorder.

However, in cases where the line between a psychiatric disorder and an existential condition is blurred, or where the lack of will to live is a realistic reaction to a poor quality of life, how does the psy-

chiatrist render an ethics-based assessment? The failure to assess the possibility of suicide adequately may render the clinician vulnerable to a malpractice suit. The failure to acknowledge the human condition of pain, poor quality of life, and a sense of being a burden are among some concerns that may raise the possibility of the ethics violation of ignoring the individual's right to choose. Clinicians face two competing demands: liability for inadequate suicide assessment versus respecting the individual's right to refuse medical treatment.

Legal and Moral Aspects of Assisted Suicide in the United States

A century ago, the right to choose was articulated by U.S. Supreme Court Justice Benjamin Cardozo in *Schloendorff v. Society of New York Hospital*, where he wrote, "every human being of adult years and sound mind has a right to determine what shall be done with his own body" (Ref. 38, p 93). Underscoring the fundamental value of an individual's right to choose (where to live, whom to marry, how to worship, and type of medical treatment) is the capacity to refuse treatment. In Western medical systems, the principles of individual autonomy and informed consent have been emphasized increasingly, along with direct end-of-life planning that stresses personal choices and medical decisions (e.g., advance directives and physician's orders for life sustaining treatment, or POLST paradigm³⁹). In addition, since the 1980s, psychiatric advance directives (PADs) have provided a mechanism for psychiatric patients to retain some level of choice as to psychiatric treatment during periods of incapacity. Swanson *et al.*⁴⁰ noted that PADs do not guarantee that a patient's wishes will be followed, as clinicians may legally override directives when they are considered to be contrary to accepted standards of care.

An essential underpinning of a patient's right to refuse is the patient's (or a surrogate's) right to understand and be informed about all medical conditions and procedures, including medication. Courts have concluded that physicians have an obligation to disclose the risks, so that the patient is provided the information needed to make an informed decision.⁴¹ Moreover, disclosure should not be based on a reasonable-medical-practitioner standard, because patients have the right of self-determination and therefore have to be able to understand the medical information (reasonable-patient standard). In-

formed-consent information must include: the inherent and potential risks of the proposed treatments; the alternatives to that treatment, if any; and the result likely if the patient remains untreated. However, in some cases, a patient's cognitive or emotional condition may be such that a question is raised about his ability to make an informed treatment decision. Appelbaum⁴² noted that physicians are frequently unaware of patients' lack of decisional capacity or, if they are aware, may not know what standard to apply. Consequently, he and others have argued for a systematic approach to determining capacity to consent to treatment, which includes four core criteria⁴²⁻⁴⁴: the ability to communicate a choice, understand the relevant information, appreciate the situation and its consequences, and reason about treatment options.

In the rights-driven model, autonomy and protection of the patient's right to determine the course of treatment is viewed as a primary goal. Competent patients have the right to refuse treatment, whereas only the treatment refusals of those deemed incompetent may be overridden. Lack of competency may be due to cognitive or emotional deficits. Although it is beyond the scope of this commentary, it is important to note that there have been several landmark cases in psychiatry, *Rogers v. Okin*,⁴⁵ *Rogers v. Commissioner of Department of Mental Health*,⁴⁶ and *People v. Medina*,⁴⁷ that reflect a rights-driven model, where a competent patient's right to refuse the forcible administration of psychotropic medication was supported. In contrast to an absolute rights-driven model, the case of *Rennie v. Klein*⁴⁸ exemplifies the treatment-driven model that allows a patient's refusal of such (psychiatric) medications to be overridden when his safety or that of others is compromised by nontreatment.

Courts have concluded that the mere presence of a diagnosed (or severe) mental illness does not preclude a patient's right to refuse medical treatment.⁴⁹ Highlighting the right to choose is the concept that substituted judgment (in the case of an incompetent patient, a surrogate who is legally allowed to determine what the patient would do if competent) may be used to refuse certain medical interventions on behalf of the patient. However, substituted judgment by family members with regard to the withdrawal of life support should reflect the person's prior stated or known preferences.^{50,51}

Ethics Guidelines Related to Assisted Suicide and End of Life

In 1997, assisted suicide was appealed to the U. S. Supreme Court, which held in two cases (*Vacco v. Quill*,⁵² and *Washington v. Glucksberg*⁵³) that it was not a constitutionally protected right and that the states should determine its legality. Aware of these considerations, the American Psychological Association (APA) had assembled a working group earlier that year to explore the question and create a brief. In 2000, the group released the document, "Report of the APA Working Group on Assisted Suicide and End-of-Life Decisions."⁵⁴ The arguments that the APA articulated in support of assisted suicide included self determination and a desire to preserve dignity and personhood; that no one should endure terminal suffering that is unremitting, unbearable, or prolonged; that a person may feel abandoned by a physician who fails to assist in this endeavor; and that models should be enacted that contain safeguards to protect people from abuse. Arguments opposing support for assisted suicide included concern about certain persons whose autonomy may be compromised because of, among others, poverty or membership in a stigmatized group, thus opening the possibility of coercion into assisted suicide; that killing is wrong, even if a person agrees to have his life ended; that civil suit may result if premature or unnecessary termination of life results after a diagnostic error or an incorrect prognosis; that cost could play into the consideration (either by the family or the medical care institution); and that assisted suicide is not congruent with the physician's traditional role as healer. In the end, the APA Working Group took no position either endorsing or opposing assisted suicide. A second resolution, "APA Policies on End-of-Life Issues and Care: APA Resolution on Assisted Suicide,"⁵⁵ was published in January 2009, and again, no position was taken.

The American Medical Association (AMA) stated in their most recent code of medical ethics "Opinion 2.21 Euthanasia":

It is understandable, though tragic, that some patients in extreme duress—such as those suffering from a terminal, painful, debilitating illness—may come to decide that death is preferable to life. However, permitting physicians to engage in euthanasia would ultimately cause more harm than good. Euthanasia is fundamentally incompatible with the physician's role as healer, would be difficult or impossible to control, and would pose serious societal risks [Ref. 56, p 1].

While the AMA proscribes physician involvement in euthanasia, there appears to be no clear directive regarding assisted suicide. Moreover, the American Psychological Association does not offer clear ethics guidelines for psychologists, in that it neither endorses nor opposes assisted suicide. Assisted suicide, as established in the Washington, Oregon, Montana, and Vermont laws, as well as the end-of-life legislation found in all 50 states, provide a role for mental health professionals that is not in the realm of euthanasia, but is in that of end-of-life dialogue.

Physician-administered lethal medication (i.e., euthanasia) is different from having a physician prescribe medication that the patient then self-administers (i.e., assisted suicide). A recent survey of physician members of the National Hospice and Palliative Medicine Society, involving a final sample of 663 physicians (53% response rates), was conducted.⁵⁷ Over one-half of the respondents reported at least one example where a patient's family, another physician, or another health care professional characterized palliative (comfort) care management as euthanasia, murder, or killing. Twenty-five percent of the clinicians stated that at least one friend, family member, or patient had characterized their treatments similarly. Interventions such as palliative sedation or stopping artificially delivered hydration and nutrition presented the greatest risks of being misperceived as euthanasia. Use of opiates, benzodiazepines, and barbiturates for symptom management represented the lowest risk of such a portrayal. However, four percent (25 physicians) in this sample had been investigated (none found guilty) at one time or another for hastening the death of a patient when it was not the physician's intention. Specifically, in 13 of the 25 cases, the intervention under investigation was the use of opiates for symptom relief; in six cases it was the use of medications while discontinuing mechanical ventilation. The authors of the survey noted that continuing efforts are needed to educate colleagues and patients about well-accepted, ethical, and legal practices in end-of-life care. However, it could be argued that what is considered acceptable and ethical is subject to debate.

We now present the difficult challenges and the broader elements of ethics and legal concerns in end-of-life cases for the mental health professional in a hypothetical case example. Three core questions are addressed: what is the clinician's responsibility from the viewpoint of professional ethics? What is their

responsibility legally? What is their responsibility from a human perspective?

Case Illustration

This example is not reflective of a specific case. Rather, it is meant to be representative of topics found in the palliative care mental health literature and what is encountered in consultation-liaison clinical practice. The case is constructed to address whether it is legally, ethically, and morally justifiable to characterize treatment refusal as passive suicidal ideation and insist on treating such end-of-life reactions as a psychiatric illness.

The patient, an 88-year old man, had a medical history of hypertension, congestive heart failure, and pulmonary tuberculosis status post left upper lobectomy. He was initially admitted to the hospital after a myocardial infarction and underwent a three-vessel CABG (coronary artery bypass graft). His postoperative course was complicated by respiratory failure after tracheostomy and renal failure that required temporary hemodialysis. He presented with intermittent altered mental status after surgery. There were some periods of waxing and waning cognition when attempting to wean him from the ventilator. During lucid periods, he made repeated statements, through mouthing and gesturing, that he did not wish to be kept alive by life support.

The hospital ethics committee was requested to comment about the patient's refusal to accept the percutaneous endoscopic gastrostomy (feeding) tube and related capacity issues (refusal to consent to lifesaving measures). He did not have an advance directive on record. His family did not want to accept his request to be removed from life support and asked repeatedly for all measures to be taken to keep him alive. However, they also acknowledged that the patient told them that he would never want to be kept alive on a machine. He had pulled out his tracheostomy (breathing) and nasogastric tubes, both of which had been reinserted against his will. In addition, he was observed by the attending medical staff to make gun-to-the-temple gestures and mouth words that expressed his wish to die. Consequently, a psychiatrist was consulted to evaluate the patient for suicidal risk as well as his capacity to refuse treatment.

During the psychiatric assessment, the patient's sense of hopelessness and suffering related to his potentially terminal and painful illness could only be assessed indirectly, through his gestures (gun to head), his behaviors (pulling out the breathing and nasogastric tube), and his desire for death, which the patient expressed repeatedly by mouthing and gesturing. His life could be maintained with artificial ventilation and feedings, and he was bedbound, alert, and stable. The medical team believed that aggressive intervention was necessary to determine whether he was unable to be weaned from the ventilator. In this case, the patient was kept on life support for further determination of his capacity to refuse treatment and whether he was reversibly depressed. Whereas he regarded the life support measures as intrusive and assaultive, the treatment team continued to believe it was important to assess the transience of symptoms. The evaluating psychiatrist assessed the patient as

having some waxing and waning capacity (related to the attempts to wean him from the respirator), but generally as being very cognizant (assessed by nonverbal means), interactive, logical, and coherent, despite his inability to talk. In the psychiatrist's opinion, the patient had the capacity to understand the implications of removing the tracheostomy and nasogastric tubes, had expressed the desire not to have his life prolonged, and had mouthed that he did not want to live in his current painful state.

However, the psychiatrist also believed that the patient was depressed and viewed his expressed desire to die as suicidal ideation and his removal of the tracheostomy tube as a suicide attempt. Consequently, the patient was placed on an involuntary psychiatric hold as a danger to self (the detainment was later upheld by a court hearing) and started on antidepressant medications. Five months after he was admitted for myocardial infarction, the patient was still hospitalized, intubated, and receiving tube feedings and antidepressant medications. His family remained adamant in wanting to continue all medical interventions that would keep him alive. His mood was unchanged by medications, and he persisted in requesting that he be removed from the ventilator and tube feedings so that he could die.

What Is the Clinician's Responsibility From a Professional Ethics Viewpoint?

Requests by primary care for mental health evaluations for the elderly are often framed around whether the patient has the capacity to refuse treatment. Sometimes other factors pollute such refusals, including the cost of the medical decisions; involvement of the patient's significant others; and at times, cultural factors. A recent magazine article by Konigsberg⁵⁸ focused on Refuseniks, defined as those individuals who, in the face of life-threatening illness, reject doctors' life-prolonging recommendations. Surveys of patients who reject treatment have found that such refusals occur more often among the elderly, are a distinct phenomenon of those at the end of their lives, and occur in the beginning phases of treatment.⁵⁹ In our case example, however, the patient refused life support in the latter stages of the treatment process.

In this instance, the autonomy of our patient came into conflict with beneficence, as he disagreed with the medical team's recommendations, which were believed to be in the patient's best interest. The psychiatric assessment further complicated the matter. There was a need to be sure that the patient's desire to die, or expressed suicidal ideation, was not the result of a treatable mental disorder. The psychiatrist could identify that the patient had symptoms of clinical depression: hopelessness, sad mood, limited response when approached by staff, a lack of interest in interacting with family, and a preoccupation with want-

ing to end his life. The psychiatrist diagnosed clinical depression.

Questions of ethics raised in this case involve the patient's right of self-determination as well as provider beneficence versus maleficence. The thorny task for the evaluating psychiatrist was to differentiate between the patient's request to die, as a reflection of a reasonable reaction to the very poor quality of his life (including the unwanted touching involved in invasive life support), and suicidal ideation due to a clinical condition such as depression.

In addition, the capacity assessment suggests another ethics-related concern. Should the patient's right to self-determination be overridden by questions of his capacity as related to the waxing and waning mentation noted only during periods when he was not on the ventilator? Quality of life, personal dignity, and independence are factors that appeared to drive this patient's refusal of medical treatment, a finding similar to the refusal of chemotherapy in a patient described by Konigsberg,⁵⁸ who found that doctors may view refusal of treatment as troubling and thus focus the discussion with the patient on changing his mind. That process, in part, may be driven by fears that failure to do so will result in subsequent lawsuits against the physician by surviving family members. Konigsberg raised the question as to whether a new paradigm, that of collaboration between the doctor and patient, is possible. The collaboration would center on the patient's length of survival and quality of life and not on litigation-driven assessments that so often document the physician's review of the treatment options and the patient's capacity to refuse treatment. The patient in our example remained on life support despite his doctor's and family's awareness of his wishes not to be subjected to invasive measures. A concern may have been the family's staunch refusal to agree to his wishes, thus motivating the physicians' reluctance to remove life-support and face possible internal investigation and lawsuit.

This case also illustrates two competing concerns: the hospital's and physicians' wish to abide by moral protection of life (and to avoid lawsuits or criminal prosecution for wrongful death) and the growing movement and acceptance of the right to death with dignity. A fundamental value in ethics is individual autonomy and the right to choose whether to initiate or continue life-preserving medical treatment. Caregiver beneficence may cross the boundary into pater-

nalism when physician directives for treatment interfere with a competent patient's choices.

What Is the Clinician's Legal Responsibility?

When the patient's interests conflict with the physician's assessment of the patient's welfare, different jurisdictions and clinicians settle the conflict in a variety of ways. Generally, medical teams defer to the wishes of mentally competent patients to make their own decisions, even in cases where the medical team believes that patients are not acting in their own best interests. The requisites for competent autonomy include the capacity to reason and manipulate information. The decisions must be made voluntarily and without coercion. The patient must also have a clear understanding of the risks and benefits of the proposed treatment alternatives and those of forgoing treatment, along with a reasonable understanding of the nature of the disease and the prognosis.⁶⁰

Is there a legally defined right to die? The landmark U.S. Supreme Court decision in *Vacco v. Quill*⁶² outlined important parameters for an individual's right to die. The Court ruled that a New York ban on physician-assisted suicide is constitutional. Doctors can be prohibited by the state from assisting in their patients' death, regardless of whether the individual is terminally ill or in great pain. The Court wrote that the intent of the physician's intervention was at the core of its decision. The withdrawal of life support at the request of the patient respects the patient's wishes. The Court distinguished this from the physician who helps effect the death of a patient when the patient makes a request to end life, as this intervention's intent is to assist in a suicide. The key difference between the two instances is that the patient is potentially dying of the underlying disorder in the first case, whereas in the assisted suicide scenario, the patient will not die immediately from the underlying disorder, but from the medical intervention. In practice, this difference may at times be subtle. However, the Supreme Court affirmed the state's interest in determining policy with regard to assisted suicide.

The U.S. Supreme Court also affirmed a patient's right to refuse life support; thus, protecting a common law right to preserve individual autonomy and retain bodily integrity and prevent "unwanted touching." There is no right to hasten death. The Court's decision supports the right to palliative care. By making the ruling, it has been noted that "by

authoritatively pronouncing that terminal sedation intended for symptomatic relief is not assisted suicide, the Court has licensed an aggressive practice of palliative care” (Ref. 61, p 1234). However, others, such as Orentlicher,⁶² have argued that terminal sedation is a poor substitute for assisted suicide and that the Court came to this decision for symbolic purposes, to support those terminally ill people who require heavy doses of pain relief that may hasten death. Orentlicher also interpreted the Court’s decision as “rejecting assisted suicide but embracing euthanasia” and as ethically more problematic than assisted suicide or voluntary euthanasia, because it posed risks for abuse and did not fully serve the purposes of the right-to-die law.

What Is the Clinician’s Responsibility From a Human Perspective?

Our patient’s expressed desire to die could be interpreted as a reflection of an existential concern related to the quality and meaning of his life, as opposed to a symptom of a pathological clinical condition such as depression. From a human perspective, the concept of *primum non nocere* (first, do no harm) is relevant in this case, because medical treatment was unable to reverse his respiratory and tube feeding dependence. The medical care system was therefore arguably prolonging his ongoing suffering by keeping him alive. Ultimately, he was kept alive by chronic ventilation and tube feedings. He remained awake, aware, and desirous of death. It could be argued that, in this case, harm was committed because the physicians did not honor the U.S. Supreme Court’s determination that a person has a right to refuse treatment and be free from unwanted touching.

Traditional psychiatry and psychology may tend to neglect the spiritual aspect of the human experience in favor of the pathological view. Palliative mental health care for those at the end of their lives, perhaps analogous to medications given for comfort care and not toward prolonging life, may involve allowing the patient to engage in a dialogue that addresses frankly the rational aspect of the person’s wish to die. That process could include a life review and discussion of death in terms of personal values. This type of dialogue with a patient may be controversial, in that it represents a departure from traditional mental health interventions that focus on moving a person away from the decision to end his

life; rather, it allows the patient to discuss the decision to die.

Conclusions

The argument that society has a moral duty to protect and preserve life was modified when assisted suicide was legalized in four states and when some physicians employed an adjusted form of palliative care. The practice of assisted suicide continues to remain controversial. The role of the physician in hastening a patient’s death can vary greatly based on ethics, as well as legal, societal, and personal factors. The absence of clear guidelines fosters the development of a gray area. As the data from Los Angeles County suggest, many of these older persons were physically ill and experiencing depression; these factors may well have influenced them to end their lives by committing suicide. With our aging population and increasing medical advancements, the evaluation and treatment dilemmas facing medical and mental health professionals are likely not only to continue but to multiply.

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