

Opinions and reactions of physicians in New Jersey regarding the Oregon Death with Dignity Act

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Physician-assisted suicide (PAS) was legalized in Oregon in 1997. In the study reported here, the authors surveyed a sample of New Jersey physicians with regard to Oregon's Death with Dignity Act and to whether similar legislation should be enacted in New Jersey.

A 49-item questionnaire was sent to 563 physicians in New Jersey who were licensed in the specialties of family practice, internal medicine, surgery, psychiatry, and obstetrics/gynecology. The questionnaire contained sections pertaining to demographics, physicians' attitudes regarding PAS, and physicians' opinions on Oregon's Death with Dignity Act. A brief summary of the legislation was included in the mailing, which participants were asked to read before completing the questionnaire.

Of the 191 physicians who responded to the survey, 55% agreed with legislation that would legalize PAS, and 59% said that a law similar to that enacted in Oregon should exist in New Jersey. However, only 47% of respondents indicated that they believed PAS to be consistent with the role of a physician to relieve pain and suffering. Slightly more than half of respondents indicated that they would refuse to participate in PAS and were concerned about issues such as professional and personal liability and the potential for abuse. Physicians in New Jersey will require additional information, education, and discussion of the ethical and legal implications of PAS before a law similar to that in Oregon could be proposed or considered.

(Key words: medical ethics, physician-assisted suicide, end-of-life issues, euthanasia)

On October 27, 1997, Oregon became the first state to legalize physician-assisted suicide (PAS). The Death with Dignity Act makes it legal for a primary care physician to prescribe, if requested by a competent, terminally ill person, a medication for the sole purpose

of ending that person's life.¹ The law contains guidelines that must be carefully followed by the physician. According to the Death with Dignity Act, only competent adult residents of Oregon who are expected to live less than 6 months are eligible for PAS. The law specifies that the patient must make one written request and two subsequent oral requests. The oral requests must be at least 15 days apart. The patient's diagnosis, prognosis, and competence to make the request for PAS must be confirmed by a second physician. Referral to a mental health professional is required if the patient appears to be depressed or is experiencing any form of mental disturbance that could affect

his or her judgment. The physician must counsel the patient regarding treatment alternatives such as comfort care, hospice care, and pain medication. Physicians must report to the Oregon Health Division all prescriptions received by the patient, written for medications in amounts that are lethal. Lack of strict adherence to the guidelines stipulated in the legislation may result in the patient and the physician being subject to criminal prosecution.²

The passing of the Death with Dignity Act has prompted further debate regarding PAS. Recent studies indicate several prominent issues involved in the controversy. Slightly more than one third of physicians surveyed nationally³ and less than half of the physicians surveyed in Oregon prior to the passage of the Death with Dignity Act⁴ indicated a willingness to perform PAS if it were legal to do so. The physicians' religions appeared to be an important factor in their attitudes toward PAS.^{3,4} Concerns regarding the legality and ethics^{4,5} of the practice of PAS have been raised by many physicians, as well as the risk that patient concern with financial and caregiver burden might prompt them to seek PAS rather than available treatment alternatives.^{4,6}

The recent legalization of PAS in Oregon has created a demand for additional research regarding the consequences of this legislation on the medical community and society. The study reported here surveyed the opinions and reactions of a sample of New Jersey physicians toward Oregon's Death with Dignity Act. The responses of New Jersey physicians may be of particular importance with regard to the legalization of PAS, considering that these physicians provide medical care for the estimated 1.4 million people over the age of 60 who reside in the state.⁷ The elderly are at high risk for developing a terminal illness and have significant concerns regarding end-of-life issues.^{8,9}

Methods Subjects

The primary vehicle for data collection was a survey that included questions pertaining to demographic information, opin-

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Table 1
Characteristics of Physicians in New Jersey Who Responded to the Survey Regarding the Oregon Death with Dignity Act (N=191)

Characteristic	Frequency (%)
■ Sex	
☐ Male	153 (80.1)
☐ Female	38 (19.9)
■ Current professional activity	
☐ In practice full or part time	184 (96.3)
☐ Academic administration	7 (3.7)
■ Specialty	
☐ Internal medicine	75 (39.3)
☐ Family practice	33 (17.3)
☐ Surgery	32 (16.8)
☐ Psychiatry	20 (10.5)
☐ Obstetrics/gynecology	20 (10.5)
☐ Other*	11 (5.7)
■ Subspecialty	
☐ None reported	90 (47.1)
☐ Geriatrics	16 (15.8)
☐ Gastroenterology	10 (9.9)
☐ Pulmonary	8 (7.9)
☐ Nephrology	7 (6.9)
☐ Oncology	6 (5.9)
☐ Cardiology	5 (5.0)
☐ Other*	49 (25.7)
■ Main practice setting	
☐ Office-based	103 (53.9)
☐ Teaching hospital	64 (33.5)
☐ Hospital-based	20 (10.5)
☐ Other†	4 (2.1)
■ Supervise fellows, residents, or medical students	
☐ Yes	154 (80.6)
☐ No	37 (19.4)
■ Religious affiliation	
☐ Jewish	68 (36.0)
☐ Catholic	67 (36.0)
☐ Protestant	24 (12.9)
☐ Other‡	12 (6.3)
☐ None	15 (8.1)

*Other specialties included neurology, physical medicine, palliative care and unclassifiable subspecialties

†Other practice settings included nursing homes and hospice programs

‡Other religious affiliations included Muslim, Hindu, Buddhist and Greek Orthodox

ions on PAS, and reactions to the legalization of PAS in Oregon. The survey was distributed to 563 physicians currently practicing in New Jersey. Three hundred sixteen physicians were randomly selected from a listing of physicians in Morris and Somerset counties who participated in US healthcare. One hundred eight physicians were full-time faculty at the University of Medicine and Dentistry of New Jersey (UMDNJ) School of Osteopathic Medicine. One hundred thirty-nine physicians were full-time faculty at UMDNJ Robert Wood Johnson Medical School. Oregon's Death with Dignity Act defines an attending physician as "the physician who has primary responsibility for the care of the patient and treatment of the patient's terminal disease." In the study reported here, attending physicians were defined as physicians licensed in the following specialties: family practice, internal medicine, surgery, psychiatry, and obstetrics/gynecology.

Questionnaire

A questionnaire was developed based on the survey of Lee et al,⁴ which was used to study physicians' attitudes regarding PAS in Oregon prior to the passage of the Death with Dignity Act. The questionnaire contained 49 questions in 3 sections. The first section assessed demographic information through 11 multiple-choice questions. In the second section, general attitudes about PAS were determined by the degree of agreement with 9 statements (based on a 5-point Likert scale) and by 3 multiple-choice questions. The third section assessed specific opinions about Oregon's Death with Dignity Act primarily through the degree of agreement or through levels of confidence, both based on a 5-point Likert scale.

After approval by the Institutional Review Board, Committee for the Protection of Human Subjects, the survey was mailed with a cover letter that assured anonymity and confidentiality. A brief summary of Oregon's Death with Dignity Act was included, and respondents

(continued on page 355)

(continued from page 350)

were asked to read the summary before filling out the questionnaire.

Statistical analysis

The responses to the questionnaires were coded and entered into a database. After assessing the frequencies, the Likert scale ratings were collapsed into three categories: disagree/strongly disagree; neutral; and agree/strongly agree. Data are presented using descriptive statistics.

Results

Characteristics

Of the 563 physicians sent questionnaires, 191 physicians returned the questionnaire, for a return rate of 34%. The professional and demographic characteristics of the responding physicians are shown in *Table 1*. Their ages ranged from 29 to 71 years old, and their mean age was 47 years (± 10). Most (80.1%) were male. Mean years since graduation from medical school was 20.5 ± 11 (range, 0 to 46). Of those responding, 184 (96.3%) were currently in practice either part-time or full-time, and 154 (80.6%) supervised fellows, residents, or medical students. The specialties of those respondents were internal medicine (39.3%), family practice (17.3%), surgery (16.8%), psychiatry (10.5%), and obstetrics/gynecology (10.5%). Nearly half of physicians (47.1%) did not indicate a subspecialty. Thirty-six percent of physicians were Catholic, 36.6% were Jewish, and 12.9% were Protestant. The remaining physicians had another or no religious affiliation (*Table 1*).

General attitudes toward PAS

Most respondents (76.2%; 144/189) were aware prior to this questionnaire that PAS was legal in Oregon. A slight majority (54.8%; 102/186) of respondents agreed with legislation that would legalize PAS and that a law such as the Death with Dignity Act should exist in New Jersey (58.6%; 109/186). Of those responding, 47.8% (87/182) indicated that, in some cases, they might be willing to write a

Table 2
Willingness to Write a Prescription for a Lethal Dose of Medication Requested by a Terminally Ill Patient, if Physician-Assisted Suicide Were Legal (N=182)

Position	Frequency (%)
☐ I might be willing	87 (47.8)
☐ would not be willing	
morally and ethically opposed	65 (35.7)
not morally and ethically opposed, but unwilling for other reasons	30 (16.5)

prescription for a terminally ill patient who intended to use it to end his/her life if it were legal to do so (*Table 2*). The remaining respondents reported that they would not be willing to prescribe a lethal dose because of moral objections (35.7%; 65/182) or other reasons (16.5%; 30/182).

The statement that competent patients with a terminal illness have a right to make the decision to commit suicide was endorsed by 67.7% of the respondents (128/189). Sixty percent (114/189) said that PAS would be ethical in some cases, and 47.4% (90/190) agreed that writing a lethal prescription for a terminally ill patient who requested one was consistent with the physician's role of relieving pain and suffering. Almost 43% (81/190) said that writing a lethal prescription violated professional ethics, 42.1% (80/190) said that it would be immoral, and 36.4% (69/190) felt that writing a lethal prescription would violate religious beliefs (*Table 3*).

When analyzed according to religion, 67% of the Catholic physicians (45/67) and 78% of the Protestant physicians (19/24) indicated they would not participate in PAS even if legal. Only 33% of the Jewish physicians (22/68) reported that they would not participate in PAS if it were legal. Of those not willing to participate in PAS, 78% of the Catholic physicians (35/45), 79% of the Protestant physicians (15/19), and 55% of the Jewish physicians (12/22) refused to participate because of moral and ethical beliefs (*Table 4*).

A majority of the physicians surveyed (75.0%; 135/180) replied that if PAS were legal in New Jersey, they would

either refer a patient who requested a prescription for a lethal dose of medication to a willing provider (44.4%; 80/180) or comply with the request personally after exploring the patient's areas of concern and therapeutic alternatives (30.6%; 55/180). Eighteen percent (33/180) indicated that after listening to the patient's concerns and exploring other therapeutic alternatives, they would inform the patient that they could neither write a prescription nor refer the patient to a physician who might consider doing it.

Issues of concern

When asked how confident they were about recognizing depression in a patient who requested a lethal prescription, only 45.4% of respondents (84/185) felt confident. Forty-two percent of the physicians (78/184) were not confident about predicting that a patient had less than 6 months to live, and half (50.5%; 92/182) were not confident about prescribing a correct dose of medication for the purpose of ending a life. Thirty-one percent of the physicians (57/184) did not feel confident about determining that the patient was making a voluntary request for a lethal prescription (*Table 5*).

When asked about practical issues regarding writing a lethal prescription, 52.5% (95/181) of the respondents were concerned that the patient's family might pursue legal action, and 52.4% (96/183) were concerned about the possible harm if an attempt failed or a complication developed. Fifty-six percent (100/178) indicated they would feel uncomfortable writing a lethal prescription if the health-care system of which they were a member

Table 3
Attitudes of New Jersey Physicians Toward
Physician-Assisted Suicide

Attitude	Respondents (%)		
	Agree	Neutral	Disagree
☐ Competent patients with a terminal illness have a right to commit suicide	67.7	9.5	22.8
☐ Would be ethical in some cases	60.3	7.4	32.3
☐ Is consistent with the physician's role of relieving pain and suffering	47.4	14.7	37.9
☐ Violates professional ethics	42.6	3.2	44.2
☐ Would be immoral	42.1	13.7	44.2
☐ Would violate my religious beliefs	36.4	6.3	47.4

Table 4
Willingness to Write a Prescription for a Lethal Dose of Medication
Requested by a Terminally Ill Patient, if Physician-Assisted Suicide
Were Legal, According to Religious Affiliation

Variable	Religion			
	Catholic (%)	Protestant (%)	Jewish (%)	Other* (%)
■ Respondents	36	13	36	15
■ Position				
☐ might be willing	33	22	67	77
☐ would not be willing				
morally and ethically opposed	52	61	8	0
not morally and ethically opposed, but unwilling for other reasons	5	7	5	23

*Other religious affiliations included Muslim, Hindu, Buddhist, Greek Orthodox, and none.

refused to participate, and 35.6% (64/180) were concerned that it might lead to sanctions by hospitals. A concern indicated by 42.6% (78/183) of physicians was that someone other than the patient might use the lethal prescription, and 20.2% (37/183) did not know what to prescribe. Finally, 15% (27/180) indicated that if the lethal prescription did not lead to a timely death, they would choose to end the patient's life by lethal injection (Table 6).

Regarding mental health, 76.3% (142/186) of the respondents felt that depression would impair competency,

and 45.9% (85/186) believed that all mental disorders and psychologic disturbances also impaired competency. Furthermore, 71.8% (132/185) indicated that all patients who requested a lethal prescription should consult with a mental health professional (Table 7).

In response to notifying a family member, 67.7% (126/186) agreed that all patients who requested a lethal prescription should be required to inform a family member, but only 28% (52/185) agreed that writing a prescription for a fatal overdose might cause guilt or anger in the patient's family. Physicians were

almost unanimous in agreeing that some terminally ill patients might request a lethal prescription because of concerns about placing a care (95.7%; 179/187) or financial (94.6%; 175/185) burden on others. Nearly three fourths of physicians (74%; 137/185) agreed that family members who were motivated by the desire to escape the burdens of caregiving or to preserve the estate may too easily facilitate a plan for PAS (Table 8).

Comment

The statement that competent patients with a terminal illness have a right to end

Table 5
Confidence Levels of Physicians Regarding Oregon's Death with Dignity Act

Attitude	Respondents (%)		
	Confident	Somewhat confident	Not confident
☐ Recognizing depression in a patient who requests a lethal prescription	45.4	37.6	16.7
☐ Determining that the patient is making a voluntary request for a lethal prescription	37.5	31.5	31.0
☐ Prescribing a correct dose of medication for the purpose of ending a life	26.0	21.4	50.5
☐ Predicting that a patient has less than 6 months to live	23.3	34.2	42.4

Table 6
Issues of Concern About the Lethal Prescription Regarding Oregon's Death with Dignity Act

Attitude	Respondents (%)		
	Agree	Neutral	Disagree
☐ Healthcare system of which I am a member refuses to participate	95.1	25.4	17.4
☐ Family might sue me if the attempt fails or some complication develops	92.5	27.6	9.9
☐ Patient might suffer worse harm if the suicide attempt fails	92.4	25.1	22.4
☐ Someone other than the patient might use it	42.6	27.9	29.6
☐ My hospital might sanction me	35.6	33.3	31.1
☐ Do not know what to prescribe	20.2	27.9	51.9
☐ If necessary, would choose to end the patient's life by lethal injection	15.0	25.6	59.5

their life was endorsed by 67.7% of New Jersey physicians who responded to the survey. Although a preponderance of physicians felt that a patient has a right to end his or her life, when further questioned about the Oregon Death with Dignity Act, several concerns regarding the application of the Act were discovered.

Forty-two percent of respondents were not confident about predicting that a patient had less than 6 months to live. It has been reported that in the case of terminal illness, physicians may frequently be inaccurate in predicting the exact course of a patient's illness and predicting a

patient's life expectancy.¹⁰ Furthermore, while the Death with Dignity Act requires the physician to determine that the patient has a terminal disease, defined as having a condition with less than 6 months to live, the results of this study indicate that physicians were not confident in their ability to make this prediction.

The Death with Dignity Act requires that the attending physician determine that the patient does not have a mental health condition that would impair judgment. Only 45.4% of New Jersey physicians who participated in this study responded that they were confident about

being able to recognize depression. Many primary care physicians are unable to diagnose underlying depression a significant amount of the time.¹¹ Almost 72% of the current respondents agreed that all patients who requested a lethal prescription should consult with a mental health professional; however, this is not a requirement of the Death with Dignity Act. With regard to mental health consultation, the law specifies that "if in the opinion of the attending physician or the consulting physician a patient may be suffering from a psychiatric disorder, or depression causing impaired judgment,

Table 7
Issues of Concern About Mental Health
Regarding Oregon's Death with Dignity Act

Attitude	Respondents (%)		
	Agree	Neutral	Disagree
☐ Presence of depression will impair competency	76.3	11.3	12.4
☐ All patients should consult with a mental health professional	71.8	5.8	2.5
☐ All mental disorders impair competency	45.9	16.8	37.3

Table 8
Issues of Concern About the Patient's Family
Regarding Oregon's Death with Dignity Act

Attitude	Respondents (%)		
	Agree	Neutral	Disagree
☐ Some terminally ill patients might request a lethal prescription because of concerns about placing a care burden on others	95.7	2.7	1.6
☐ Some terminally ill patients might request a lethal prescription because of concerns about placing a financial burden on others	94.6	3.2	2
☐ Family members who are motivated by desire to escape the burdens of caregiving or preserve the estate may too easily facilitate a plan for physician-assisted suicide	74.0	14.1	11.9
☐ Patients requesting a lethal prescription should be required to notify a family member	67.7	6.7	5.6
☐ I object to writing a lethal prescription partly because a fatal overdose by a terminally ill patient could cause guilt and/or anger in the patient's family	28.0	34.6	37.3

either physician shall refer the patient for counseling" to a licensed psychiatrist or licensed psychologist.¹ In a survey of Oregon mental health professionals, few psychiatrists and psychologists indicated that they were comfortable determining that a person's request for a lethal prescription was not the result of a mental illness, particularly if they were only seeing the patient for one visit.¹² In addition, while 76.3% of physicians in the study reported here agreed that depression would impair the patient's competency to make decisions of this magnitude, others have shown that the presence of depression does not necessarily mean that the

patient's ability to make important decisions is impaired.¹³

In the current study, half (50.5%) of the respondents were not confident about prescribing a correct dose of medication for the purpose of ending a life. All published reports concerning specific drug combinations for PAS are anecdotal, and none of these drugs or drug combinations has been studied in a controlled manner for efficacy in providing swift, certain death.¹⁴ Chin et al² determined that the lethal medication being prescribed since the legalization of PAS in Oregon has been consistent, most likely as a result of the information provided by advocacy

groups. All but one patient documented in the reported cases of PAS received a prescription for 9 g of secobarbital or pentobarbital and an antiemetic agent.² Concern with this issue was evident by the responses of New Jersey physicians that failed attempts by a patient to end his or her life might bring on a lawsuit (52.5%) or cause the patient to suffer worse harm (52.4%). Furthermore, the Death with Dignity Act states that in the event of a failed attempt, the physician may not end a patient's life by lethal injection. In the Netherlands and in Australia's Northern Territory, physicians are expected to be present at the time the patient ingests

the medication and are permitted to administer a lethal injection if the oral dose does not result in death.¹⁵ The results of the current study as well as those of Lee et al⁴ suggest that inadequate consideration has been given to these issues.

The majority (67.7%) of physicians who responded to the survey believed that all patients who requested a lethal prescription should be required to inform a family member. This is supported by a previous report that found that 83% of patients who received a lethal prescription had family or friends involved at the time of the request.³ The Oregon legislation requires that the attending physician ask the patient to notify a family member, but the patient may decline to do so. There are several reasons why involving a patient's family throughout the suicide process is beneficial for everyone involved. It has been shown that a patient's desire to hasten death is often influenced by the perception that they are burdening or financially hurting the family.¹⁶ Involvement of family members may lead to an understanding that this is a false perception.¹⁷ Discovery of the suicide after it has occurred may complicate the grieving process of the family. Long-term health risks for surviving family members of suicide victims include unresolved grief, illness, depression, anxiety, and an increased risk of suicide.¹⁸ If family members are not told, they may become involved in the suicide process accidentally by finding the patient, still alive but unconscious, after they have ingested the lethal dose of medication.¹⁹ The family may call for emergency medical services, which could lead to an undesired interruption of the suicide process. Finally, the family can become a center for love and support for the patient, averting the request for PAS, only if they are aware of the patient's concerns.¹⁴

One of the criticisms of the legalization of PAS is the potential for abuse.²⁰ Almost three fourths of respondents in this study agreed that family members who were motivated by the desire to escape the burdens of caregiving or to preserve the estate may too easily facilitate a plan for PAS. Others report that

approximately one half of the requests for a lethal injection were made by a family member or significant other.³ By contrast, during the first year of legalized PAS in Oregon, the decision to request a lethal prescription was associated with patients' concerns regarding personal autonomy and control. A fear of abuse was not a concern raised by patients who requested PAS.²

Although a slight majority (58.6%) of physicians agreed that the Death with Dignity Act should exist in New Jersey, results of this study suggest that the specific legislation should be studied more carefully. Many New Jersey physicians seem to disagree with many aspects of the legislation, including the lack of requirement for family notification and the lack of mandatory psychiatric consult. Also, considering the difficulty physicians have in diagnosing depression and predicting a terminal state, it is surprising that so many physicians would support the legislation for New Jersey. This suggests that the physicians' acceptance of the legislation may not be carefully thought out. Instead, their response may be based purely on emotions, or a lack of education about the implications of the law. Furthermore, the practical concerns that this study has examined, as well as the potential for abuse inherent in the law, leaves the future of the Death with Dignity Act in New Jersey still questionable.

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