

Emotional and Psychological Effects of Physician-Assisted Suicide and Euthanasia on Participating Physicians

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Abstract: This is a review and evaluation of medical and public literature regarding the reported emotional and psychological effects of participation in physician-assisted suicide (PAS) and euthanasia on the involved physicians.

Materials and Methods: Articles in medical journals, legislative investigations and the public press were obtained and reviewed to determine what has been reported regarding the effects on physicians who have been personally involved in PAS and euthanasia.

Results and Discussion: The physician is centrally involved in PAS and euthanasia, and the emotional and psychological effects on the participating physician can be substantial. The shift away from the fundamental values of medicine to heal and promote human wholeness can have significant effects on many participating physicians. Doctors describe being profoundly adversely affected, being shocked by the suddenness of the death, being caught up in the patient's drive for assisted suicide, having a sense of powerlessness, and feeling isolated. There is evidence of pressure on and intimidation of doctors by some patients to assist in suicide. The effect of countertransference in the doctor-patient relationship may influence physician involvement in PAS and euthanasia.

Conclusion: Many doctors who have participated in euthanasia and/or PAS are adversely affected emotionally and psychologically by their experiences.

The report by The New York State Task Force on Life and the Law stated: "Many physicians and others who oppose assisted suicide and euthanasia believe that the practices undermine the integrity of medicine and the patient-physician relation-ship. Medicine is devoted to healing and the promotion of human wholeness; to use medical techniques in order to achieve death violates its fundamental values. Even in the absence of widespread abuse, some argue that allowing physicians to act as 'beneficent executioners' would undermine patients' trust, and change the way that both the public and physicians view medicine." 1

The counter-argument has been expressed by Margaret Battin and Timothy Quill, editors of a book favoring legalization of PAS. These PAS advocates have stated that there is no evidence that PAS "legalization would corrupt physicians and thus undermine the integrity of the medical profession," and that "there is substantial evidence to the contrary." 2

Purpose

When new treatments or procedures in medicine are developed, they are scrutinized to determine if there are adverse or harmful effects associated with them. In the same way, physician-assisted suicide and euthanasia deserve to be evaluated to determine if they have adverse or harmful effects. Instead of focusing on the involved patients, this investigation focuses on the reported effects on the doctors who are involved in assisted suicide and euthanasia.

This investigation's focus is to determine what has been reported regarding the following questions:

- What have been the emotional and psychological effects of participation in PAS and euthanasia on the involved doctors?
- What have they expressed to others regarding their experiences?
- Are physicians being pressured, intimidated or psychologically influenced to assist in suicide or perform euthanasia?
- What has happened to doctors who have written prescriptions? Have they continued to be involved with assisted suicide with other patients after the experience with the first patient or have they stopped their involvement?

Materials and Methods

Since the passage of Oregon's assisted suicide law in 1994, the author has gathered and archived articles from medical journals, legislative investigations, and the public press regarding assisted suicide and euthanasia. This collection of articles numbers into the thousands, including dozens of books on the subject. Other articles were identified and obtained using *PubMed* and the following search words: "euthanasia, assisted suicide, physicians, responses, psychological, emotional." These publications were reviewed and analyzed to obtain information regarding the above questions.

Results and Discussion

The

Doctors in the Netherlands who have had experience with assisted suicide and euthanasia, have expressed concerns regarding the effects on doctors. A report from the Netherlands stated: "Many physicians who had practiced euthanasia mentioned that they would be most reluctant to do so again." 3

Emanuel stated that "in a television program reporting a euthanasia case, the Dutch physician who performed euthanasia noted that: "To kill someone is something far reaching and that is something that nags at your conscience. . . . I wonder what it would be like not to have these cases in my practice. Perhaps I would be a much more cheerful person." 4

The *American Medical News* reported the following comments from Pieter Admiraal, a leader of Holland's euthanasia movement: "You will never get accustomed to killing somebody. We are not trained to kill. With euthanasia, your nightmare comes true." 5

Netherlands

In 1995-96, 405 Dutch doctors were interviewed regarding their feelings after their most recent case of euthanasia, assisted suicide, life ending without an explicit request, and alleviation of pain and other symptoms with high doses of opioids. The percentage of doctors expressing feelings of discomfort were: 75% following euthanasia, 58% following assisted suicide, 34% following life ending without an explicit request, and 18% for alleviation of pain with high doses of opioids. Fifty percent of the euthanasias and 40% of the assisted suicides were followed by "burdensome" feelings; and 48% of the euthanasia and 49% of the assisted suicide cases were followed by emotional discomfort. The willingness to perform physician-assisted death again was 95% after euthanasia and 82% for life ending without an explicit request.⁶ The doctors sought support afterwards following 43% of the euthanasia cases and following 16% of cases involving ending life without an explicit request.

Evidence reported by the British House of Lords Select Committee on the Assisted Dying for the Terminally Bill in 2005 includes the following candid responses by Dutch physicians and ethicists to questions from the committee:

Q1250 Response by Dr. Legemaate: "No physician ever likes performing euthanasia."

Q1350 Question by Baroness Finlay: "The first time that you performed euthanasia, how did you feel about it as a clinician?"

Response by Dr. Van Coevorden: "Awful."

Q 1351 Response by Dr. Mensingh van Charente: "It is not a normal medical treatment. You are never used to it."

Q1535 Question by Baroness Finlay: "Looking after complex patients can be exhausting. It can be physically and emotionally exhausting. I certainly know of a case where a patient was almost pressured by the doctor, by being offered euthanasia. I wondered if that reflected the doctor's personal distress and whether you have come across cases where the doctor is thinking of euthanasia as the only solution?"

Response by Dr. Zylicz: "I was giving consultations in several situations like this, when the GP was calling me about a patient with gastrointestinal obstruction. He said, 'The problem is that the patient is refusing euthanasia.' I said, 'What happened?' He said, 'In the past, all these kinds of situations, when people were intractably vomiting, I solved by offering euthanasia. Now this patient does not want it, and I do not know what to do.' That was really striking. Providing euthanasia as a solution to every difficult problem in palliative care would completely change our knowledge and practice, and also the possibilities that we have This is my biggest concern in providing euthanasia and setting a norm of euthanasia in medicine: that it will inhibit the development of our learning from patients, because we will solve everything with euthanasia."

Q1539 Response by Professor Jochemsen: "I know from physicians who are opposed to performing euthanasia that they are afraid of saying so when applying for jobs and trying to find a post as a physician. In certain circumstances, that will make it much more difficult for them to get a job."

Q1580 Response by Dr. Jonquiere: "When I received a request for euthanasia and I hear this also from my colleagues - when a patient said, 'Doctor, this is unbearable for me. Please help me die,' the first reaction as a doctor is, 'Oh my God! A request again!' and I will find whatever I can to prevent it."

Q1585 Response by Dr. Jonquiere: "My point is that, because doctors find the request so difficult - the most difficult request you can get as a doctor - that, in itself, is the reason why they try to find whatever way they can not to do it."

Q 1735 Question by Baroness Finlay: "The doctors who have performed euthanasia have often described it, certainly initially, as being emotionally draining, emotionally difficult, and that they have taken some time off, have perhaps not worked the next day, to have a break and then to carry on working. Has that been your experience?"

Response by Dr. de Graas: "It certainly has been, but I think that a lot is changing in that regard. The first letter of SCEN [Support Consultation Euthanasia Network] is the 's' for 'support,' and that is essential. Also as a nursing home physician confronted with euthanasia, I know that it is emotionally draining; but it is absolutely important to discuss it, not only with the SCEN doctor but with all your colleagues, to keep yourself healthy."

Q1736 Question by Baroness Finlay: "Do you think that it has become less stressful, as the process has become more developed over the time that you have had it?"

Response by Dr. de Grass: "For the individual physician it never becomes less stressful. That is absolutely impossible. What we are learning as a group, however, is that, before we become emotionally worn-out, there are a lot of possibilities to keep yourself in a good emotional state."⁷

These responses indicate the significant adverse emotional and psychological stress experienced and reported by Dutch physicians who are involved with euthanasia and PAS.

The *United* *States*
Two surveys of physicians in the United States have examined and reported on the effects on physicians of performing PAS or euthanasia.⁸

In a structured in-depth telephone interview survey of randomly selected United States oncologists who reported participating in euthanasia or PAS, Emanuel reported 53% of physicians received comfort from having helped a patient with euthanasia or PAS, 24% regretted performing euthanasia or PAS, and 16% of the physicians reported that the emotional burden of performing euthanasia or PAS adversely affected their medical practice.⁹

In a mail survey of physicians who had acknowledged performing PAS or euthanasia, Meier reported the following responses pertaining to the most recent patient who had received a prescription for a lethal dose of medication or a lethal injection among the 81 physician respondents (47% were prescriptions, 53% were injections): 18% of the physicians reported being somewhat uncomfortable with their role in writing a prescription, and 6% were somewhat uncomfortable with the lethal

injection; <1% were very uncomfortable with their role in writing the lethal prescription, and 6% were very uncomfortable with the lethal injection. 10

The State of Oregon

The first cases of legal PAS in Oregon occurred in 1998. In 2000, thirty-five Oregon physicians who had received requests for assisted suicide from patients were interviewed regarding their responses to such requests. Mixed feelings were expressed by the physicians. The authors noted: "Participation in assisted suicide required a large investment of time and had a strong emotional impact. . . . Even when they felt they had made appropriate choices, many physicians expressed uncertainty about how they would respond to requests in the future [as indicated by the responses from two physicians]:

'But my thoughts are about the fact that I know that it is a very difficult thing as a physician . . . I wonder if I have the necessary emotional peace to continue to participate.' (Physician D)

'I find I can't turn off my feelings at work as easily . . . because it does go against what I wanted to do as a physician.' (Physician I)" 11

Timothy Quill M.D., a published advocate for legalization of assisted suicide, wrote an invited editorial about this study. He noted the apparent lack of preparation for the personal emotional toll that such interactions had on the physicians.¹²

In 1998, the first year of Oregon's Death with Dignity Act, fourteen physicians wrote prescriptions for lethal medications for the fifteen patients who died from physician-assisted suicide. The annual report observed that: "For some of these physicians, the process of participating in physician-assisted suicide exacted a large emotional toll, as reflected by such comments as, 'It was an excruciating thing to do . . . it made me rethink life's priorities,' 'This was really hard on me, especially being there when he took the pills,' and 'This had a tremendous emotional impact.' Physicians also reported that their participation led to feelings of isolation. Several physicians expressed frustration that they were unable to share their experiences with others because they feared ostracism by patients and colleagues if they were known to have participated in physician-assisted suicide."¹³ This type of information regarding the emotional impact on the involved physicians has not been presented in subsequent Oregon annual reports.

A 1999 mail-survey of physicians' experiences with the Oregon Death with Dignity Act reported: "Some physicians who provided assistance with suicide under the Oregon Death with Dignity Act reported problems, including unwanted publicity, difficulty obtaining the lethal medication or a second opinion, difficulty understanding the requirements of the law, difficulties with hospice providers, not knowing the patient, or the absence of someone to discuss the situation with." "Four physicians expressed ambivalence about having provided assistance with the suicide, though two of the four noted that they had become less ambivalent over time. One of these physicians decided not to provide such assistance again."¹⁴

The emotional trauma experienced by some Oregon doctors is noted in the following responses obtained in Oregon in December 2004 by the British House of Lords committee:

Q766 Question by Baroness Finlay: "In a conversation after we had taken evidence this morning from David Hopkins, he said that, at the beginning, he had the feeling that doctors

needed to tell the whole story because they were very traumatized by having been involved, but that, in the last year, that is not happening as they have become used to it. I wondered whether you felt that was echoed within your research."

Response by Dr. Goy: "Again, anecdotally, yes. This was a monumentally difficult experience for a doctor early on, even considering changing the direction of care from preserving life and extending life to helping someone end it. For many, they have done it maybe for one patient and cannot reconcile that they have done it and they are very uncomfortable with it."

Q767 Question by Baroness Finlay: "The Dutch experience is that often doctors take the next day off because they cannot cope with taking any clinical decisions at all."

Response by Ms. Glidewell: "Sometimes they are overwhelmed by the impact of this which is contrary to what they normally do."¹⁵

Dr. Peter Reagan's description of his experience with "Helen" was the first individual account in the medical literature of assisted suicide in Oregon.¹⁶ His account reveals his emotional and psychological concerns. As Helen was dying from his prescribed lethal medication "[t]he three of us [Dr. Reagan and Helen's son and daughter] sat around her bed talking quietly about the emotional struggle we'd each been through."¹⁷ Regarding his thoughts and emotions leading up to writing the lethal prescription, Dr. Reagan wrote:

I had to accept that this really was going to happen. Of course I could choose not to participate. The thought of Helen dying so soon was almost too much to bear, and only slightly less difficult was the knowledge that many very reasonable people would consider aiding in her death a crime. On the other hand, I found even worse the thought of disappointing this family. If I backed out, they'd feel about me the way they had about their previous doctor, that I had strung them along, and in a way, insulted them.¹⁸

This is an example of a doctor feeling intimidated and coerced by the family and patient to participate in assisted suicide.

In writing about Helen's expressed appreciation for his role in the assisted suicide, Dr. Reagan wrote, "I thanked her and then turned away with my tangle of emotions." "That afternoon. . . I wrote the prescription for the 90 secobarbital. I hesitated at the signature and stared out the window. . . . I tried to imagine deciding to die. . . . Whenever I tried, I experienced a sadness much more profound than what I saw in her." "I slept badly."¹⁹

The extent of Dr. Reagan's personal concerns is exemplified by his editorial inclusion of the following: "Experience in the Netherlands suggests that doctors are profoundly affected by an act of physician-assisted suicide. Gerrit Kimsma, a Dutch family physician and medical ethicist, writes with colleagues that some professionals become dysfunctional and may require a lot of time to recover."²⁰

Further insight into Dr. Reagan's experience is found in an earlier newspaper reporter's interview in 1998 of a then anonymous doctor whose story, matches that of "Helen" and Dr. Reagan:

Q: What did you learn from the experience?

A: I think the most important thing is for doctors to understand how huge of an experience it's going to be for them and that they must have ways of dealing with it for themselves.

Q: How did you feel the day that your patient planned to use the medication?

A: I would look out the window that day and try to imagine what it would feel like to take leave of the Earth that day - and it was a pretty nice day - and the sadness that that thought induced in me and I couldn't find it in my patient. And that was a profound experience.

Q: What about the death was a struggle for you?

A: A big piece is grief. A big piece is a funny sort of ambivalence where a person says, 'Really nice to have met you. Really nice to have gotten to know you a little better. Where's the medicine?' I have a feeling of responsibility that I can't say I'm entirely proud of. I did what I felt was right, given bad choices. But frankly, maybe I'm kidding myself a little bit, but it's better to not feel good about this. . . . I have to admit, I am blown away by how different this felt than a natural death. And I am still not clear on what to make of that. . . . Just the suddenness of it. It's shocking to have somebody go from telling a family story to being dead. It's a strange, strange, strange transition.²¹

Later in 1998, the same reporter noted, "Reagan still grapples with his experience. He has declined other requests from patients who weren't qualified. But if he meets another patient who is qualified, he will help. To him, it would feel like abandonment if he didn't."²² Dr. Reagan is expressing that he would have "no choice" and is an example of a doctor feeling intimidated by the patient and family to participate in assisted suicide.

In a newspaper interview in 2001, the same reporter wrote, "Dr. Peter Reagan, the primary physician in the first publicly described case in 1998, said the experience changed his feelings about assisted suicide. If he were dying, 'I made a commitment that I wouldn't ask my own doctor to help in this way,' Reagan said, 'because it's a lot to ask.'" ²³Dr. Reagan described his troubled feelings in the reversal of his role as a healer, to his role in assisting Helen in her suicide. There is a sense of isolation. In Dr. Reagan's first comments to the public and press, he was concealed by anonymity. It was difficult for him to find others with whom to discuss his troubling experience.

Leon Cass stated that "the psychological burden of the license to kill (not to speak of the brutalization of the physician-killers) could very well be an intolerably high price to pay for physician-assisted euthanasia."²⁴

The author of an investigation of "the euthanasia underground" reported:

The personal cost of involvement in illegal euthanasia was a central theme in interviews, and one emphasized throughout this book. 'I hate it', says one doctor, 'my partner hates it, because [she] feels that I'm going to be really horrible to be around . . . afterwards.' Another emphasized the 'emotionally demanding and draining' nature of involvement, adding 'there's only a finite amount of times you can do it' and 'I think I've almost reached the expiry date.' These are typical comments.²⁵

Intimidation of and anger towards doctors who block access to PAS
Hamilton and Hamilton reviewed the first case of legal assisted suicide in Oregon that was reported

in the press.²⁶ The physician who helped the ill woman end her life described the woman's tenacity and determination in her decision. "It was like talking to a locomotive. It was like talking to Superman when he's going after a train."²⁷ The Hamiltons' psychiatric analysis of this case was that the doctor felt helpless when faced with the challenge of containing a patient who elicited images of locomotives, or of attempting to make a therapeutic intervention when talking with the patient seemed, as he put it, like "talking to Superman when he's going after a train."²⁸ The doctor was expressing powerlessness on his part.

This intimidation of doctors by patients who request assisted suicide is also described in an analysis of in-depth personal interviews of thirty-five Oregon physicians who received a request for a lethal prescription.²⁹ The article portrays a daunting situation for the doctors. These doctors describe very forceful patients who persevered in their requests for assisted suicide, even when the doctors were unwilling to participate. One doctor quoted a patient as saying, "I am going to come in and I am going to try to convince you."³⁰ Another doctor said, "I learned very quickly that the patient's agenda is to get the medication. When I tried to talk them out of it, or to really assess their motivations, then they perceived me as obstructionist and became quite resentful of that."³¹

Emotional experiences for psychiatrists who are called upon to evaluate potential assisted suicide patients' mental competency, appear to be more profound when they disqualify patients. Dr. Linda Ganzini described the painful experience of two patients whom she [as the evaluating psychiatrist] disqualified for the option of Oregon's assisted suicide law.³² She stated: "These disqualifications resulted in extraordinary pain and anger for both of the patients and their families, which interfered with much-needed opportunities to resolve other emotional issues."³³ Pain and anger is directed towards and felt by the evaluating psychiatrist. Such anger was energetically expressed by Kate Cheney, an Oregon PAS patient, whose evaluating psychiatrist told her, "You can't make a decision for yourself and your life, because you are not in your right mind."³⁴ Kate Cheney's angry response was "Get out of my house. I can't believe you can tell me something like this."³⁵ The significant anger towards the evaluating psychiatrist who disqualified her from PAS continued in Kate Cheney's daughter, who reported this experience.³⁶

What is known regarding the frequency of and numbers of assisted suicide cases per physician?

Meier reported in a national survey of physicians, that the median number of assisted suicide cases since entering practice was two (range 1-25) for the 3.3% of surveyed physicians who had written a prescription for a patient to use with the primary intention of ending his or her own life.³⁷ The median number of euthanasia (lethal injection) cases since entering practice was also two (range 1-150) for the 4.7% of surveyed physicians who had ever given a patient a lethal injection.³⁸

Questions regarding physician involvement in assisted suicide in Oregon

After seven years of legalized assisted suicide in Oregon, we should have answers to the following questions:

- What is the total number of physicians who have written prescriptions under Oregon's PAS law?
- What has been the pattern of prescribing? How many physicians have written only one prescription, and how many have written multiple prescriptions?

- Most importantly, are there physicians who have written prescriptions in earlier years, who are not now writing prescriptions? Why have they changed their minds, and are not now involved in assisted suicide?

The basic Oregon PAS data for the early years has been destroyed, as noted in the following personal communication: "Unfortunately, we are unable to provide any additional information than is currently available in our Annual Reports. Prior to 2001, we did collect the names of physicians who were participating. However, because of concerns about maintaining the confidentiality of participating physicians, we began using a numeric coding system in 2001. When we implemented this coding system, we destroyed the identifying data from the earlier years."³⁹ This was also documented in the responses to Q592-4 by members of the Oregon Department of Human Services to the British House of Lords Select Committee in December 2004.⁴⁰

Because this basic Oregon data was destroyed by personnel in the state agency, the answers to the above questions will never be known.

Information regarding physicians' participation in physician-assisted suicide from Oregon Health Division reports

From 1998 through 2004, 326 prescriptions for lethal drugs have been written and 208 have died under Oregon's PAS law.⁴¹

The only report from the state that has given the number of doctors prescribing from one year to the next was reported for the 1999 year: "In 1999, 22 physicians legally prescribed the 33 lethal doses of medication. Six of them also prescribed in 1998."⁴² This information has not been included in subsequent annual Oregon state reports.

Of the forty physicians who wrote prescriptions during 2004, twenty-eight wrote one prescription, nine wrote two prescriptions, one wrote three prescriptions, one wrote four prescriptions, and one wrote seven prescriptions.⁴³ This was the first year that this type of information was provided in the state's annual report.⁴⁴ However, a year earlier, a reporter from *The Oregonian* newspaper publicly reported the following information for the 2003 year, which he had personally obtained from the Oregon Department of Human Services: "Of the 42 doctors who wrote prescriptions for assisted suicide in 2003, 27 wrote one prescription, eight wrote two, six wrote three, and one doctor wrote 6 prescriptions."⁴⁵ This information was not in the Oregon state annual report for that year.

Specific deficiencies in data from the annual Oregon reports are listed in Table 1. This missing information makes it impossible to provide answers to the previously noted questions.

During the first four years of legalized PAS in Oregon the prescribing physician was present at the time the patient took the lethal medication for 52% of the assisted suicides.⁴⁶ However during the 2004 year, the prescribing physician was present for only 16% of the patients.⁴⁷ Why are the physicians withdrawing from being present at the time of the assisted suicide?

The effect of countertransference in physician-assisted suicide

Countertransference is defined as a phenomenon referring "to the attitudes and feelings, only partly conscious, of the analyst towards the patient,"⁴⁸ Regarding the "rational" decision of physicians to

assist in the ending of a person with a terminal illness, Dr. Glen O. Gabbard, a noted psychiatrist, has written:

Those decisions made by medical professionals, including psychiatrists, can never be entirely free of what we would broadly call countertransference issues. The doctor's own anxiety in the face of death, and even the hatred of the patient who does not want treatment or will not allow the doctor to be helpful, can influence a supposedly scientific or "rational" decision.⁴⁹

Table 1
Information (and missing information) about assisted suicide in Oregon

Year	# of prescriptions written	# of doctors writing prescriptions for lethal drugs	# of these doctors (prior column) who had written prescriptions for lethal drugs in prior year/s	# of PAS deaths	# of doctors writing prescriptions for those who died from ingesting lethal drugs	# of these doctors (prior column) who had written prescriptions for lethal drugs in prior year/s
1998	24	*	No prior year	16	14 of 15 deaths in 1st years report	no prior year
1999	33	22	6	27	*	*
2000	39	*	*	27	22	*
2001	44	33	*	21	*	*
2002	58	33	*	38	*	*
2003	68	42	*	42	30	*
2004	60	40	*	37	* 26**	*
Total	326	*	*	208	*	*

* Information missing from reports.

** Personal communication, March 10, 2005.⁵⁰

From the published annual reports, Oregon Department of Human Services, Office of Disease Prevention and Epidemiology. 51

The involvement of countertransference with assisted suicide has been evaluated by Varghese and Kelly.⁵² They report that:

[T]he subjective evaluation by a doctor of a patient's 'quality of life' and the role of such an evaluation in making end-of-life decisions of themselves raise significant countertransference issues. Inaccurately putting oneself 'in

the patient's shoes' in order to make clinical decisions and evaluations of quality of life leave the patient vulnerable to the doctor's personal and unrecognized issues concerning illness, death and disability.⁵³

They state that "[f]ortunately, the ethical code prohibits certain actions on the part of the doctor. In the absence of these prohibitions, the doctor's countertransference feelings about patients could put the public in grave danger."⁵⁴ They conclude "Psychopathological factors in the doctor, including reactions to illness, death, and the failure of treatment, can influence the dying patient's end-of-life decision."⁵⁵

Conclusion

Physician participation in assisted suicide or euthanasia may have a profound harmful emotional toll on the involved physicians. Doctors must take responsibility for causing the patient's death. There is a huge burden on conscience, tangled emotions and a large psychological toll on the participating physicians. Many physicians describe feelings of isolation. Published evidence indicates that some patients and others are pressuring and intimidating doctors to assist in suicides. Some doctors feel they have no choice but to be involved in assisted suicides. Oregon physicians are decreasingly present at the time of the assisted suicide. There is also great potential for physicians to be affected by countertransference issues in dealing with end-of-life care, and assisted suicide and euthanasia.

These significant adverse "side effects" on the doctors participating in assisted suicide and euthanasia need to be considered when discussing the pros and cons of legalization.

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40 SELECT COMMITTEE ON THE ASSISTED DYING FOR TERMINALLY ILL BILL, *supra* note 7, at 262.

41 Chin, *supra* note 13; A. D. SULLIVAN ET AL., OREGON'S DEATH WITH DIGNITY ACT: THE SECOND YEAR'S EXPERIENCE (OREGON HEALTH DIV., 2000); OREGON HEALTH DIV., OREGON'S DEATH WITH DIGNITY ACT: THREE YEARS OF LEGALIZED PHYSICIAN-ASSISTED SUICIDE (2001); OREGON DEPARTMENT OF HUMAN SERVICES, OFFICE OF DISEASE PREVENTION AND EPIDEMIOLOGY, FOURTH ANNUAL REPORT ON OREGON'S DEATH WITH DIGNITY ACT (2002); OREGON DEPARTMENT OF HUMAN SERVICES, OFFICE OF DISEASE PREVENTION AND EPIDEMIOLOGY, FIFTH ANNUAL REPORT ON OREGON'S DEATH WITH DIGNITY ACT (2003); OREGON DEPARTMENT OF HUMAN SERVICES, OFFICE OF DISEASE PREVENTION AND EPIDEMIOLOGY, SIXTH ANNUAL REPORT ON OREGON'S DEATH WITH DIGNITY ACT (2004); OREGON DEPARTMENT OF HUMAN SERVICES, OFFICE OF DISEASE PREVENTION AND EPIDEMIOLOGY, SEVENTH ANNUAL REPORT ON OREGON'S DEATH WITH DIGNITY ACT (2005).

42 SULLIVAN, *id.*, at 9.

43 SEVENTH ANNUAL REPORT, *supra* note 41 at 14.

44 *Id.*

45 D. Colburn, *Assisted Suicide Total Edges Higher in 2003*, OREGONIAN, Mar. 10, 2004, at E1.

46 FOURTH ANNUAL REPORT, *supra* note 41, at 16.

47 SEVENTH ANNUAL REPORT, *supra* note 41, at 24.

48 PSYCHOANALYTIC TERMS AND CONCEPTS 29 (B. Moore & B. Fine, eds., 1968).

49 *Foreward*, 18:1 COUNTERTRANSFERENCE ISSUES IN PSYCHIATRIC TREATMENT: REVIEW OF PSYCHIATRY xiii-xvi (G. O. Gabbard, ed. 1999).

50 Personal e-mail from D. Niemeyer to author (Mar. 10, 2005) (on file with author).

51 Chin, *supra* note 13; SULLIVAN, OREGON HEALTH DIVISION SECOND ANNUAL REPORT, *supra* note 41; OREGON HEALTH DIV., *supra* note 41; FOURTH ANNUAL REPORT, *supra* note 41; FIFTH ANNUAL REPORT, *supra* note 41; SIXTH ANNUAL REPORT, *supra* note 41; SEVENTH ANNUAL REPORT, *supra* note 41.

52 F. T. Varghese & B. Kelly, *Countertransference and Assisted Suicide*, in 18:1 COUNTERTRANSFERENCE ISSUES IN PSYCHIATRIC TREATMENT: REVIEW OF PSYCHIATRY 85 (G. O. Gabbard, ed. 1999).

53 *Id.* at 92.

54 *Id.* at 106.

55 *Id.* at 112.

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