

Psychological Distress, Mental Disorder, and Assessment of Decisionmaking Capacity Under U.S. Medical Aid in Dying Statutes

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This Article examines concepts of treatment decisionmaking capacity relevant to medical aid in dying as it is currently authorized in the United States. In order to be eligible for medical aid in dying in one of the ten jurisdictions now allowing such assistance, patients must be capable of making an informed health care decision. Under many of the governing statutes, special attention is given to whether a patient is “suffering from,” for example, “a psychiatric or psychological disorder or depression” that is causing impaired judgment.

This Article analyzes the pertinent statutory provisions, examining the meaning of terms such as “capacity” and “impaired judgment” within the context of the law of informed consent. It further considers strategies for assessing treatment decisionmaking capacity, with particular attention to the relevant scientific evidence.

This Article emphasizes the importance of avoiding presumptions that persons with mental disorders or other psychological conditions are not competent to make their own treatment decisions. It proposes reliance on criterion-relevant evaluations of decisionmaking capacity that operationalize legal standards of competence, consistent with theory and research. It recommends against a higher threshold for determining capacity to decide about medical aid in dying as contrasted with other health care decisions relating to survival near the end of life. Finally, it encourages practitioners to adopt a broad formulation of palliative care in discharging their statutory obligation to inform patients of alternatives to medical aid in dying. Such formulations of palliative and comfort care should incorporate the range of appropriate psychosocial, psychotherapeutic, and psychopharmacological interventions. Any patient experiencing psychological distress should be fully informed about, and given timely access to, interventions that may provide relief from that suffering.

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INTRODUCTION

Over a quarter of a century has passed since Oregon stunned the nation by legalizing medical aid in dying.¹ Oregon's Death with Dignity Act provides a process by which a patient diagnosed with a "terminal" (that is, "incurable and irreversible") disease, whose life expectancy does not exceed six months, can request a prescription for subsequent self-administration "for the purpose of ending his or her life in a humane and dignified manner."² Currently, a person suffering from a terminal disease who meets eligibility criteria is permitted to receive physician assistance to hasten death in ten jurisdictions within the United States (California, Colorado, Hawaii, Maine, Montana, New Jersey, Oregon, Washington, Vermont, and the District of Columbia).³ Oregon's framework provided the model for the statutes of seven states and the District of Columbia, and for patterns of practice in a tenth jurisdiction, Montana, where no statute currently regulates medical aid in dying following legalization by the state supreme court.⁴

All of those jurisdictions authorizing medical aid in dying⁵ require participating physicians to provide patients who seek authorization with full information about statutorily enumerated elements of disclosure. That is, the attending physician is required to provide patients with information including,

1. Death with Dignity Act, OR. REV. STAT. §§ 127.800–897 (2017), was passed by ballot initiative (51.31% to 48.69%) in 1994. *Oregon Measure 16, Physician-Assisted Death Initiative (1994)*, BALLOTEDIA, https://ballotpedia.org/Oregon_Measure_16_Physician-Assisted_Death_Initiative_1994; see *infra* note 22 and accompanying text.

2. OR. REV. STAT. §§ 127.800(12), 127.805 (2017).

3. As of the time of this writing, medical aid in dying is permitted by statute in California, Colorado, Hawaii, Maine, New Jersey, Oregon, Washington, Vermont, and the District of Columbia, and by state supreme court decision in Montana. The pace at which states have adopted medical aid in dying statutes has picked up in recent years. See *infra* notes 22–30 and accompanying text.

4. *Baxter v. State*, 224 P.3d 1211, 1222 (Mont. 2009). As indicated below, our research suggests that, in the absence of statutory guidance, Montana's health care professionals follow the standards and practices for medical aid in dying in Oregon. See *infra* note 30 and accompanying text.

5. The following terms have been used interchangeably: medical aid in dying, medically assisted death, physician assisted death, and physician aid in dying. In Oregon and several other jurisdictions, the term "death with dignity" refers to this option. The label "physician assisted suicide," prevalent previously, is now disfavored because experts in mental health distinguish suicide from the type of medical assistance discussed in this Article. See AM. ASS'N OF SUICIDOLOGY, STATEMENT OF THE AMERICAN ASSOCIATION OF SUICIDOLOGY: "SUICIDE" IS NOT THE SAME AS "PHYSICIAN AID IN DYING" (2017), <https://suicidology.org/wp-content/uploads/2019/07/AAS-PAD-Statement-Approved-10.30.17-ed-10-30-17.pdf>. Experts in the study of suicide assert that suicide is a form of self-destruction, and sometimes a manifestation of a mental disorder, that can interrupt a life that might otherwise have continued for an extended period of time. *Id.* at 2–4. By contrast, medical aid in dying assists persons in hastening deaths that unavoidably occur within six months due to a terminal illness. *Id.* at 2. Under the aid in dying statutes, a decision to choose medical aid in dying is a way for a patient to exert some measure of control over the timing and manner of an already-impending death. *Id.* at 2–4; see Dan Nguyen & Joe Yager, *Medical Aid in Dying: Ethical and Practical Issues for Psychiatrists*, PSYCHIATRIC TIMES (Dec. 20, 2018) <https://www.psychiatristimes.com/cme/medical-aid-dying-ethical-and-practical-issues-psychiatrists/page/0/1> ("[S]uicide is defined by the act of intentional self-inflicted death, [whereas, when patients seek medical aid in dying,] the primary (although not proximal) cause of death is from a foreseeable underlying terminal illness."); see also John Michael Bostwick & Lewis M. Cohen, *Differentiating Suicide from Life-Ending Acts and End-of-Life Decisions: A Model Based on Chronic Kidney Disease and Dialysis*, 50 PSYCHOSOMATICS 1 (2009).

but not limited to, the patient's diagnosis, prognosis, probable result of the prescribed medical aid in dying medication, and feasible alternatives including "comfort care, hospice care, and pain control."⁶ In order for a patient to be eligible under the statute, the physician must also determine that the patient is "capable" of making "an informed decision" and of "acting voluntarily."⁷ These requirements are consistent with the law governing health care decisions more generally, requiring that such decisions are made competently, voluntarily,⁸ and only after full disclosure of information material to patients' decisions.⁹

Patients who request medical aid in dying, and whose capacity to make health care decisions is questioned by the attending physician,¹⁰ must be referred to a mental health professional for further evaluation.¹¹ The statutes of several states, including Oregon, instruct physicians to identify and refer patients who "may be suffering from a psychiatric or psychological disorder or depression causing impaired judgment."¹² In New Jersey and two other states, there is no reference to mental disorder—physicians are to refer for mental health

6. See, e.g., OR. REV. STAT. § 127.815 (2017).

7. OR. REV. STAT. §§ 127.815, 127.820 (2017).

8. See Robert M. Nelson et al., *The Concept of Voluntary Consent*, 11 AM. J. BIOETHICS 6 (2011). The term "voluntariness" as a requirement for legally valid informed consent refers to a condition in which the patient's decision is made free from controlling influences, such as coercion, manipulation, or situational constraints. *Id.* at 7-10.

9. See, e.g., JESSICA W. BERG ET AL., INFORMED CONSENT: LEGAL THEORY AND CLINICAL PRACTICE 11 (2d. ed. 2001); Alan Meisel et al., *Toward a Model of the Legal Doctrine of Informed Consent*, 134 AM. J. PSYCHIATRY 285 (1977).

10. Some authors and legal sources distinguish between the terms "capacity" and "competence" (or "competency") in the context of treatment decisionmaking. See Elyn R. Saks & Stephen H. Behnke, *Competency to Decide on Treatment and Research: MacArthur and Beyond*, 10 J. CONTEMP. LEGAL ISSUES 103, 110 (1999) ("Capacity" refers to abilities relevant to performing a task, while 'competency' is a legal judgment that one has sufficient abilities to perform the task."). Yet, some medical aid in dying statutes in the United States use the term "capacity" in a manner that is analogous to "competence" above. Here, the findings of the clinical assessment performed by physicians and consulting mental health professionals determine patients' eligibility to receive a lethal prescription and operate as "competence" determinations. The statutes delegate the authority to determine competence to the health care professionals who act pursuant to the statute's authority. This transforms the findings of clinical assessments into, in effect, a legal determination, without court involvement. See THOMAS GRISSO & PAUL S. APPELBAUM, ASSESSING COMPETENCE TO CONSENT TO TREATMENT: A GUIDE FOR PHYSICIANS AND OTHER HEALTH PROFESSIONALS 11 (1998) ("Most authors distinguish between assessments of decisionmaking capacity, which health care professionals can conduct, and determination of competence, which are legal judgments left to the courts. Although technically correct, this distinction tends to break down in practice [in light of the practical consequences of clinician's judgments of capacity]."). Grisso and Appelbaum indicate that they use the term "decision-making capacities" when referring to the abilities related to the decisions, but use "competence" "to denote the state in which patients' decision-making capacities are sufficiently intact for their decisions to be honored . . . regardless of who makes that determination." *Id.* Grisso and Appelbaum's observation that the distinction between the terms breaks down in practice is apt in this context, particularly because clinicians' determinations of capacity have the effect of legal judgments of competence. *Id.*

11. See *infra* notes 12–13 and accompanying text.

12. OR. REV. STAT. § 127.825; see also CAL. HEALTH & SAFETY CODE § 443.5(a)(1)(A)(iii) (West 2020) (requiring referral for further capacity assessment to determine if the individual has the capacity to make medical decisions and "is not suffering from impaired judgment due to mental disorder").

evaluation persons whom he or she believes “may not be capable.”¹³ In Hawaii, however, *all persons* requesting medical aid in dying must undergo an evaluation with a mental health professional for the purpose of assessing capacity, even when there are no manifestations of impaired judgment.¹⁴ In all states with medical aid in dying statutes, those patients whose judgment is determined to be impaired by the mental health specialist are ineligible to receive the requested prescription.

Persons coping with the premature end to their lives as a result of a terminal illness typically experience some degree of psychological distress.¹⁵ Such distress may constitute relatively normal responses to challenging personal circumstances that should not be confused with mental disorders or related conditions.¹⁶ Yet, even when a dying person meets diagnostic criteria for a mental disorder, it does not necessarily follow that the individual’s capacity to make medical decisions is impaired. Modern legal principles categorically reject *per se* generalizations that persons who have mental disorders are not competent to make treatment decisions.¹⁷ Presumptions to the contrary are also inconsistent with the accumulated knowledge in the fields of psychology and psychiatry.¹⁸ Even persons with more severe mental disorders, including depression requiring psychiatric hospitalization, typically satisfy legal standards of competence.¹⁹

13. N.J. STAT. ANN § 26:16-8 (West 2020).

14. See *infra* note 28 and accompanying text.

15. Psychological distress has been conceptually defined as a “unique, discomfoting, emotional state experienced by an individual in response to a specific stressor or demand that results in harm, either temporary, or permanent, to the person.” Brian Kelly et al., *Measurement of Psychological Distress in Palliative Care*, 20 PALLIATIVE MED. 779, 779 (2006) (“The nature of the experience may be psychological (cognitive, behavior, emotion), social and/or spiritual, such that an individual’s ability to cope with the illness, its physical symptoms and treatment are effected.”). The terms “emotional distress,” “existential distress,” “psychological suffering” and “spiritual suffering” are also used in the palliative care literature to refer to the discomfoting psychological experiences that may accompany the dying process. Harvey Max Chochinov, *Dying, Dignity, and New Horizons in Palliative End-of-Life Care*, 56 CA: A CANCER J. FOR CLINICIANS 84, 85–86 (2006).

16. The terms “mental disorder,” “psychological condition,” or “psychiatric condition,” which are used in one or more medical aid in dying statutes, can refer to “a syndrome characterized by clinically significant disturbance in an individual’s cognition, emotional regulation, or behavior that reflects a dysfunction in the psychological, biological, or developmental processes underlying mental functioning.” AM. PSYCHIATRIC ASS’N, DIAGNOSTIC AND STATISTICAL MANUAL OF MENTAL DISORDERS 20 (5th ed. 2013) [hereinafter DSM-V] (defining mental disorder). These diagnostic terms contrast with the term “psychological distress.” See *supra* note 15. The latter term describes the *experience* of an uncomfortable emotional state, which does not necessarily cause disturbance in an individual’s functional abilities or processes. For a dying patient, the experience of psychological or existential distress is often an expression of “an expectable or culturally approved response to a common stressor or loss,” see DSM-V *supra*, and does not fall within the definition of a mental disorder. In other cases, a dying patient may also meet the criteria of a diagnosable mental disorder and the psychological distress may be part of a larger complex of symptoms. Distinguishing between the manifestations of grief frequently experienced by persons dying from terminal diseases and the symptoms of a depressive or other mental disorder can be challenging for health care professionals. See, e.g., Susan D. Block, *Assessing and Managing Depression in the Terminally Ill Patient*, 132 ANNALS OF INTERNAL MED. 209 (2000); Eric W. Widera & Susan D. Block, *Managing Grief and Depression at the End of Life*, AM. FAM. PHYSICIAN (Aug. 1, 2012), <https://www.aafp.org/afp/2012/0801/p259.html>.

17. See *infra* notes 141–143 and accompanying text.

18. See *infra* notes 143, 156–170 and accompanying text.

19. See *infra* notes 157–169 and accompanying text.

In order to ensure that patients requesting medical aid in dying are not subject to outdated presumptions of incapacity because of manifestations of psychological suffering or a diagnosis of a mental disorder, *criterion-relevant* assessments of patient capacity are necessary. That is, those assessments must be closely keyed to the applicable legal standards of capacity. None of the jurisdictions authorizing medical aid in dying rely solely on the diagnosis of a mental disorder or psychological/psychiatric condition to determine capacity. In Oregon, for example, two findings are required in order for a patient to be determined not competent: (1) the existence of the mental disorder or psychological/psychiatric condition *and* (2) evidence of “impaired judgment” *caused by* that mental disorder or condition.²⁰ Yet, what is meant by “impaired judgment,” and what standards, procedures, and assessment measures should be used in evaluating patient decisionmaking capacity for the purpose of choosing medical aid in dying? Furthermore, how high should the threshold be that distinguishes those who are competent from those who are not?

This Article addresses these questions. It examines concepts of decisionmaking capacity relevant to medical aid in dying as it is currently authorized in the United States. It analyzes pertinent statutory provisions within the context of concepts, assessment, and research related to treatment decisionmaking capacity, particularly as relevant to persons with psychological or psychiatric conditions. It recommends: (1) avoidance of any *per se* or status-based conclusions that persons experiencing psychological distress or mental disorders are not competent to make their own treatment decisions; (2) use of criterion-relevant assessments of decisionmaking capacity that operationalize legal standards of competence; (3) the same threshold for determining capacity to decide regarding medical aid in dying as is employed to determine capacity for other health care decisions related to survival near the end of life; and (4) full disclosure of, and timely access to, appropriate psychological and psychiatric palliative care for patients who request medical aid in dying and are experiencing psychological distress or a mental disorder.

Part I of this Article provides an overview of the history and current legal status of medical aid in dying in the United States and discusses the key provisions of the medical aid in dying laws in the ten U.S. jurisdictions that currently permit medical aid in dying. Part II discusses concepts of treatment decisionmaking capacity within the context of the law of informed consent, incorporating theoretical and scientific advancements of the past several decades. Part III analyzes the concept of capacity to decide about medical aid in dying. It analyzes the relevant statutory language in the jurisdictions that authorize medical aid in dying and examines scientific findings on the relationship between treatment decisionmaking capacity and mental disorders. Part III then synthesizes empirical work on the psychological status of persons requesting medical aid in dying and, more generally, persons at the end of life

20. OR. REV. STAT. § 127.825 (2017).

due to a terminal illness. Part IV sets forth recommendations for medical aid in dying capacity evaluations. It addresses procedures, competence standards and measures, the appropriate threshold for determining competence, and recommended training and expertise for those who perform competence evaluations under the medical aid in dying statutes. Part V urges attending and consulting health care professionals tasked with evaluating, educating, or counseling persons under the statutes to inform patients who are experiencing psychological distress or a mental disorder about appropriate psychological or psychiatric palliative care services. It recommends further that health care facilities and institutions make such services readily available.

This Article endorses the predominant model of treatment decisionmaking capacity supported by the scientific literature. It further recommends that the threshold for determining capacity be no higher in the context of medical aid in dying than for other end of life health care decisions relating to survival. The juxtaposition of these recommendations, together with a serious commitment to offering and providing appropriate mental health treatment to dying patients interested in such services, strikes a balance between legal and ethical principles of autonomy and beneficence.²¹ It supports the agency of persons who meet relevant legal standards of capacity and are otherwise eligible under the medical aid in dying statutes, authorizing them to make important choices regarding the manner and timing of their deaths. It also offers those persons voluntary access to interventions that may provide them with relief from their distress and symptoms. Such relief may lead a patient who is eligible to receive medical aid in dying to delay or, in some cases, forego medical aid in dying. At the same time, providing patients with knowledge of and voluntary access to appropriate psychological and psychiatric palliative care helps ensure that those who choose to go forward with medical aid in dying do so with complete understanding of alternatives that might mitigate their psychological distress.

I. MEDICAL AID IN DYING IN THE UNITED STATES: THE LEGAL LANDSCAPE

A. MEDICAL AID IN DYING: THE STATE OF AMERICAN LAW

At the time of this writing, ten jurisdictions in the United States allow eligible patients suffering from a terminal illness to receive a physician-prescribed lethal medication so that they can control the manner and timing of their deaths. Oregon's pathbreaking statute was the first of its type, passed in 1994, and implemented in 1997.²² In 2008, Washington adopted a statute

21. See *infra* notes 62–66, 274–277, 315 and accompanying text.

22. Passed by voter initiative in 1994, the implementation of Oregon's Death with Dignity Act, OR. REV. STAT. §§ 127.800–897 (2017) was delayed by injunction during the pendency of litigation challenging its constitutionality. *Lee v. State*, 107 F.3d 1382 (9th Cir. 1997), *cert. denied* *Lee v. Harcleroad*, 522 U.S. 927 (1997). The Ninth Circuit held that the plaintiffs (physicians, treatment facilities, and terminally ill patients) did not have standing to pursue these federal Constitutional claims. *Lee*, 107 F.3d at 1390–92. The injunction was lifted on Oct. 27, 1997, after the U.S. Supreme Court denied certiorari in 1997 in the federal lawsuit. *Lee*, 522

patterned after Oregon's model,²³ followed by Vermont in 2013,²⁴ California in 2015,²⁵ Colorado in 2016,²⁶ the District of Columbia in 2016,²⁷ Hawaii in 2017,²⁸ and New Jersey and Maine in 2019.²⁹

In 2009, the Montana Supreme Court legalized medical aid in dying when holding that provision of physician aid in dying in response to certain categories of patient requests does not fall within the purview of the state's criminal proscription of assisting a suicide.³⁰ To date, Montana is the only state in which

U.S. at 927. A ballot measure seeking repeal of the Oregon's Death with Dignity Act was placed on the ballot that November. *Hamilton v. Myers*, 943 P.2d 214, 220 (Or. 1997). The measure was defeated by a margin of sixty percent to forty percent. *Death with Dignity Act*, OR. HEALTH AUTH., <https://www.oregon.gov/oha/ph/providerpartnerresources/evaluationresearch/deathwithdignityact/pages/faqs.aspx> (last visited Mar. 20, 2020). In 2001, United States Attorney General John Ashcroft "issued an Interpretive Rule announcing his intent to restrict the use of controlled substances for physician-assisted suicide." *Gonzalez v. Oregon*, 546 U.S. 243, 254 (2006). This Interpretive Rule concluded that use of controlled substances did not constitute a "legitimate medical purpose" as required under the Controlled Substances Act, and therefore was in violation of federal law. *Id.* at 255. Under this interpretation, physicians who prescribed these drugs pursuant to the Oregon statute jeopardized their medical licenses. Various parties sued to enjoin enforcement of the Interpretive Rule and prevailed in 2006 when the U.S. Supreme Court held that the Interpretive Rule was inconsistent with Congressional intent and that the Attorney General had exceeded his authority in rendering this interpretation. *Id.* at 254, 268.

23. Washington's statute was passed by initiative in 2008 and became effective on March 5, 2009. Washington Death with Dignity Act, WASH. REV. CODE § 70.245 et seq. (2019).

24. In 2013, the Vermont General Assembly passed Act 39, Patient Choice and Control at the End of Life Act. VT. STAT. ANN. tit. 18, §§ 5281-93 (2019). The statute became effective May 20, 2013.

25. The California legislature passed the End of Life Option Act in 2015. The statute became effective June 9, 2016. See CAL. HEALTH & SAFETY CODE § 443 (West 2020).

26. The Colorado End-of-Life Options Act, COLO. REV. STAT. §§ 25-48-101-23 (2020), was adopted by the voters in 2016. It became effective on December 16, 2016.

27. The District of Columbia's Death with Dignity Act of 2016, D.C. LAW 21-182, was adopted by the Council of the District of Columbia and signed by the Mayor of the District of Columbia in 2016, with an effective date of February 18, 2017. The law has faced some opposition within Congress, however. Congress has appropriations powers affecting the District of Columbia budget, and has authority to review and overturn laws passed by the District of Columbia Council. For a summary of Congressional efforts, see, for example, Rachel Sadon, *House Committee Revives Fight Against D.C.'s Death with Dignity Law*, DCIST (July 14, 2017, 4:04 PM), <https://dcist.com/story/17/07/14/house-committee-death-with-dignity/>. Thus far, Congressional opponents of aid in dying have been unsuccessful in mounting sufficient support within Congress for their efforts to interfere with the District of Columbia's law. For a discussion of Congressional authority over local lawmaking in the District of Columbia, see, for example, Mary M. Cheh, *Theories of Representation: For the District of Columbia, Only Statehood Will Do*, 23 WM. & MARY BILL OF RTS. J. 65, 78 (2014). The District of Columbia has also faced challenges in making aid in dying available because few medical professionals have chosen to participate. Fenit Nirappil, *A Year After D.C. Passed Its Controversial Assisted Suicide Law, Not a Single Patient Has Used It*, WASH. POST (Apr. 10, 2018, 10:15 AM), https://www.washingtonpost.com/local/dc-politics/a-year-after-dc-passed-its-assisted-suicide-law-only-two-doctors-have-signed-up/2018/04/10/823cf7e2-39ca-11e8-9c0a-85d477d9a226_story.html?utm_term=.f0a72174ac9a.

28. The Hawaii Legislature passed the Our Care, Our Choice Act in 2018. HAW. REV. STAT. § 327L-1 (2019). The law became effective January 1, 2019.

29. The New Jersey legislature passed the Medical Aid in Dying for the Terminally Ill Act in 2019, effective August 1, 2019. N.J. REV. STAT. §§ 26:16-1 et seq. (2019). The Maine legislature passed the Maine Death with Dignity Act in 2019. ME. STAT. tit. 22, § 2140 (2019). The governor signed the legislation on June 12, 2019, and it became effective September 19, 2019.

30. In 2009, the Supreme Court of Montana held in *Baxter v. State*, 224 P.3d 1211 (Mont. 2009), that a terminally ill patient's consent to medical aid in dying constitutes a statutory defense to a charge of homicide under the Montana's criminal statutes. See MONT. CODE ANN. § 45-2-211 (2019) (setting forth statutory consent

litigation to modify criminal prohibitions in medical aid in dying has been successful.³¹ One famous challenge to a state statute prohibiting medical aid in dying culminated in the U.S. Supreme Court's decision in 1997 in *Washington v. Glucksberg*.³² The Court held that Washington's statutes criminalizing assisted suicide did not violate the Due Process Clause of the Fourteenth Amendment. The plaintiffs challenging the Washington statute asserted "the existence of a liberty interest protected by the Fourteenth Amendment," encompassing the "personal choice by a mentally competent, terminally ill adult" to receive physician assistance to hasten death.³³ Declining to apply heightened scrutiny, the Court found Washington's statute to be rationally related to legitimate government interests in preserving human life, discouraging suicide, protecting the integrity and ethics of the medical profession, and shielding vulnerable groups from "abuse, neglect, and mistakes."³⁴ In a companion case, *Vacco v. Quill*, the Court upheld the constitutionality of New York's prohibition on assisted suicide on Equal Protection grounds.³⁵ These cases effectively foreclosed subsequent challenges to state restrictions on federal constitutional grounds. Litigants in some states have argued, albeit also unsuccessfully, that the bans violate *state* constitutional provisions, or that proper construction of the statutes excludes application to medical aid in dying.³⁶

defense). The court held that medical aid in dying is not against public policy and thus the consent defense statute shielded physicians from homicide liability for assistance given to terminally ill patients through provision of a prescription for a lethal dose of medication to be self-administered by the patient. *Baxter*, 224 P.2d at 1215–16. The Montana Supreme Court did not reach the question of whether a patient has a constitutional right to die under MONT. CONST. art. II, §§ 4, 10, despite the extensive briefing of the issues by the parties. Following the *Baxter* decision, Montana legislators have made multiple unsuccessful attempts to pass statutes that would create a regulatory structure governing the practice. See S.B. 202, 2015 Leg., 64th Sess. (Mont. 2015); S.B. 220, 2013 Leg., 63d Sess. (Mont. 2013); S.B. 167, 2011 Leg., 62d Sess. (Mont. 2011). Other legislators have introduced bills to criminalize the practice, and these have not passed either. See S.B. 116, 2011 Leg., 62d Sess. (Mont. 2011). As of February 15, 2019, a bill that would criminalize medical aid in dying in Montana has passed the House and awaited action by the relevant Senate committee, although such action has not been forthcoming. See Doctor Imprisonment Bill, H.B. 284, 2019 Leg., 66th Sess. (Mont. 2019). Because no legislation has passed regulating medical aid in dying in Montana, as contrasted with the other nine jurisdictions, the practice is not governed by statutory standards or procedures, and no state-mandated data collection or record-keeping reveals how the law has been implemented. Indeed, most information about the practice of medical aid in dying in Montana is anecdotal, available primarily through communications by and with advocacy organizations or individual physicians. See, e.g., COMPASSION IN CHOICES, MT., FIVE YEARS OF DIGNITY: THE BAXTER RULING AND END-OF-LIFE FREEDOM IN MONTANA (2014), <http://compassionandchoices.org/wp-content/uploads/2018/10/Five-Years-of-Dignity.pdf>.

31. See, e.g., *Sampson v. State*, 31 P.3d 88 (Alaska 2001); *Kligler v. Healy*, No. SUCV201603254F, 2017 WL 2803074 (Mass. Super. Ct. 2017); *State v. Final Exit Network*, 889 N.W.2d 296 (Minn. Ct. App. 2016); *State v. Melchert-Dinkel*, 844 N.W.2d (Minn. 2014); *Morris v. Brandenburg*, 376 P.3d 836 (N.M. 2016); *Myers v. Schneiderman*, 85 N.E.3d 57 (N.Y. 2017); see also Kathryn L. Tucker, *A Nadir of State Constitutional Jurisprudence: Failing to Protect Terminally Ill Patients' Choice for a More Peaceful Death in New Mexico*, 48 N.M. L. REV. 315 (2018) (analyzing the decision in *Morris*).

32. 521 U.S. 702 (1997).

33. *Id.* at 708.

34. *Id.* at 728–35.

35. 521 U.S. 793 (1997).

36. For a summary of state litigation, see Thaddeus Mason Pope, *Legal History of Medical Aid in Dying: Physician Assisted Death in the U.S. Courts and Legislatures*, 48 N.M. L. REV. 267, 287–99 (2018).

Legal reform, therefore, has been effectuated primarily by legislative action, or as occurred in Oregon, voter initiative. And, indeed, as the Court noted at the end of its *Glucksberg* opinion, its “holding permit[ted] this debate [about medical aid in dying] to continue” through democratic action.³⁷ In her concurrence, Justice O’Connor observed:

There is no reason to think the democratic process will not strike the proper balance between the interests of terminally ill, mentally competent individuals who would seek to end their suffering and the State’s interests in protecting those who might seek to end life mistakenly or under pressure. As the Court recognizes, States are presently undertaking extensive and serious evaluation of physician-assisted suicide and other related issues. In such circumstances, “the . . . challenging task of crafting appropriate procedures for safeguarding . . . liberty interests is entrusted to the ‘laboratory’ of the States . . . in the first instance.”³⁸

Although eight states and the District of Columbia have adopted the policy legislatively, other jurisdictions have thus far failed to pass medical aid in dying statutes.³⁹ At the time of this writing, bills that would authorize medical aid in dying are under consideration in several state legislatures.⁴⁰ While there is no way to predict the future pace of state legislative action, the pace may be picking

37. *Glucksberg*, 521 U.S. at 735.

38. *Id.* at 737 (O’Connor, J., concurring) (citation omitted) (citing *Cruzan v. Dir., Mo. Dep’t of Health*, 497 U.S. 261, 292 (1990) (O’Connor, J., concurring)). Kathryn Tucker, who represented plaintiffs in *Glucksberg*, observed in 2008 that Oregon’s Death with Dignity statute had been in force for a decade, with no evidence of the deleterious consequences cited by the Court. Kathryn L. Tucker, *In the Laboratory of the States: The Progress of Glucksberg’s Invitation to the States to Address End-of-Life Choice*, 106 MICH. L. REV. 1593 (2008). The success of Oregon’s experiment, she urged, should encourage other states to pursue a similar path. *Id.* at 1596. Although the pace was initially slow, other states have followed suit. And as the analysis of key statutory provisions in this Article observes, most states have remained strikingly close to Oregon’s model.

39. For example, in New Mexico, medical aid in dying bills were proposed 1995, 2009, 2017, and 2019: S.B. 446, 42d Leg., 1st Sess. (N.M. 1995); H.B. 814, 49th Leg., 1st Sess. (N.M. 2009); H.B. 171, 53d Leg., 1st Sess. (N.M. 2017); S.B. 252, 53d Leg., 1st Sess. (N.M. 2017); H.B. 90, 54th Leg., 1st Sess. (N.M. 2019); S.B. 153, 54th Leg., 1st Sess. (N.M. 2019). The New York legislature considered medical aid in dying bills in four sessions between 1995 and 2012. S.B. 1683, 1995–1996 Leg. (N.Y. 1995); S.B. 5024-A, 1995–1996 Leg. (N.Y. 1995); A.B. 6333, 1995–1996 Gen. Assemb. (N.Y. 1995); S.B. 4834, 1999–2000 Leg. (N.Y. 1999); S.B. 677, 2001–2002 Leg. (N.Y. 2001); A.B. 9360, 2012–2013 Gen. Assemb. (N.Y. 2012). And in every year from 2015 until the present session, except 2018, the New York legislature has considered similar bills: S.B. 3685, 2015–2016 Leg. (N.Y. 2015), and companion bill A.B. 02129, 2015–2016 Gen. Assemb. (N.Y. 2015); S.B. 5814-A, 2015–2016 Leg. (N.Y. 2015), and companion bill A.B. 5261-C, 2015–2016 Gen. Assemb. (N.Y. 2015); S.B. 7579, 2016–2017 Leg. (N.Y. 2016), and companion bill A.B. 10059, 2016–2017 Gen. Assemb. (N.Y. 2016); S.B. 3151-A, 2017–2018 Leg. (N.Y. 2017), and companion bill A. 2383-A, 2017–2018 Gen. Assemb. (N.Y. 2017); S.B. 2045, 2017–2018 Leg. (N.Y. 2017); S.B. 3947, 2019–2020 Leg. (N.Y. 2019), and companion bill A.B. 2694, 2019–2020 Gen. Assemb. (N.Y. 2019).

40. *See, e.g.*, Arizona: H.B. 2408, 54th Leg., 1st Sess. (Ariz. 2019), H.B. 2512, 54th Leg., 1st Sess. (Ariz. 2019), and S.B. 1193, 54th Leg., 1st Sess. (Ariz. 2019) (proposing addition of ARIZ. REV. STAT. ANN. § 36-3301 et seq. (2020)); Connecticut (H.B. 5898, 2019 Gen. Assemb. (Conn. 2019)); Indiana (H.B. 1184, 121st Gen. Assemb., 1st Sess. (Ind. 2019) and S.B. 300, 121st Gen. Assemb., 1st Sess. (Ind. 2019) (proposing addition of IND. CODE § 16-18-2-326.8 (2020)); Massachusetts (S.B. 1208, 191st Leg. (Mass. 2019) and H.B. 1926, 191st Leg. (Mass. 2019) (proposing addition of MASS. GEN. LAWS ch. 201G, § 1 et seq. (2020)); and New Jersey (A.B. 1504, 218th Leg. (N.J. 2018) and S.B. 1072, 218th Leg. (N.J. 2018)).

up, in that there has been an increase in successful legislative action in the last four years.

There have been significant developments in medical aid in dying in Canada. In 2015, the Supreme Court of Canada, in *Carter v. Canada*, struck down Canada's restrictions on physician assistance in dying as an unconstitutional violation of the rights of life, liberty, and security guaranteed by the Canadian Charter of Rights and Freedoms.⁴¹ The holding was limited to consenting, competent adults experiencing a "grievous and irremediable medical condition (including an illness, disease or disability) that causes enduring suffering that is intolerable to the individual in the circumstances of his or her condition."⁴² The Parliament subsequently enacted a Medical Aid in Dying statute,⁴³ consistent with the mandates of the Supreme Court of Canada's opinion. Some provisions of that statute will be discussed below.⁴⁴

B. MEDICAL AID IN DYING STATUTES IN THE UNITED STATES

The statutes in the jurisdictions that have adopted medical aid in dying have in common certain basic restrictions on the availability of this end of life choice. The important substantive criteria are virtually identical across these states. In order to be eligible for physician assistance under the statutes, patients must be diagnosed as having a terminal disease, meaning "an incurable and irreversible disease that has been medically confirmed and will, within reasonable medical judgment, produce death within six months."⁴⁵

Patients who request medical aid in dying must demonstrate *present* capacity to make treatment decisions,⁴⁶ and their requests must be *voluntary*.⁴⁷ Furthermore, the statutes do not permit patients to authorize a proxy decisionmaker to choose medical aid in dying on that patient's behalf at some future time.⁴⁸ Thus, patients may not choose medical aid in dying by means of advanced directives or powers of attorney.⁴⁹ This restriction effectively

41. *Carter v. Canada*, [2015] 1 S.C.R. 331, 334 (Can.).

42. *Id.*

43. See An Act to Amend the Criminal Code and to Make Related Amendments to Other Acts (Medical Assistance in Dying), S.C. 2016, c 3 (Can.).

44. See *infra* notes 49, 57–60 and accompanying text.

45. OR. REV. STAT. § 127.800 (12) (2017); see also CAL. HEALTH & SAFETY CODE § 443.1(q) (West 2020) ("[A terminal illness] means an incurable and irreversible disease . . . that will, within reasonable medical judgment, result in death within six months.").

46. See *infra* notes 48–49 and accompanying text.

47. See, e.g., CAL. HEALTH & SAFETY CODE §§ 443.2(a)(2); 443.3(b)(3)(B)–(C); 443.5(a)(1)(C); 443.5(a)(4); 443.8(b).

48. For example, in California, the statute specifies that the request for medical aid in dying medication "shall be made solely and directly by the individual diagnosed with the terminal disease and shall not be made on behalf of the patient, including, but not limited to, through a power of attorney, an advance health care directive, a conservator, health care agent, surrogate, or any other legally recognized health care decisionmaker." CAL. HEALTH & SAFETY CODE § 443.2(c).

49. The question of whether patients should be permitted to exercise medical aid in dying with advanced directives is undergoing serious debate in Canada. One of the provisions of the statute authorizing medical aid in dying in Canada required the Ministers of Justice Health in Canada to initiate an independent review of issues

precludes access to medical aid in dying persons whose medical condition leads to incompetence to make health care decisions prior to the statutory six-month life-expectancy window. The statutes also require that patients be *physically* capable of self-administering the lethal dose of prescribed medication.⁵⁰ This requirement effectively precludes access to medical aid in dying for persons who have lost physical capacity to self-administer the medication prior to the statutory six-month life-expectancy window.

Patients who wish to avail themselves of medical aid in dying must request assistance from a physician licensed to practice medicine in that jurisdiction.⁵¹ The statutes also contain carefully delineated procedures that incorporate a myriad of safeguards.⁵² In addition, in the United States, mental disorders cannot serve as qualifying conditions under the statutes because they are not terminal

relating to “advance requests” for medical aid in dying “no later than 180 days after the day” on which the statute was enacted. *See* S.C. 2016, c 3, § 9.1(1) (Can.). The identified ministries referred the issue to the Council of Canadian Academies, which has published a thoughtful and thorough analysis of the background and issues related to authorization of medical aid in dying through advanced directives. *See* COUNCIL OF CANADIAN ACADEMIES, THE STATE OF KNOWLEDGE ON ADVANCE REQUESTS FOR MEDICAL ASSISTANCE IN DYING (2018), <https://cca-reports.ca/wp-content/uploads/2019/02/The-State-of-Knowledge-on-Advance-Requests-for-Medical-Assistance-in-Dying.pdf>. The Canadian statute also requires the identified ministries to refer two other issues for study: whether mature minors should be permitted to consent to medical assistance in dying, and whether “requests where mental illness is the sole underlying medical condition” should be authorized under the statute. *See* S.C. 2016, c 3, § 9.1(1) (Can.). The Council of Canadian Academies has published detailed reports analyzing these issues as well. *See* COUNCIL OF CANADIAN ACADEMIES, THE STATE OF KNOWLEDGE ON MEDICAL ASSISTANCE IN DYING FOR MATURE MINORS (2018), <https://cca-reports.ca/wp-content/uploads/2018/12/The-State-of-Knowledge-on-Medical-Assistance-in-Dying-for-Mature-Minors.pdf>; COUNCIL OF CANADIAN ACADEMIES, THE STATE OF KNOWLEDGE ON MEDICAL ASSISTANCE IN DYING WHERE A MENTAL DISORDER IS THE SOLE UNDERLYING MEDICAL CONDITION (2018), <https://cca-reports.ca/wp-content/uploads/2018/12/The-State-of-Knowledge-on-Medical-Assistance-in-Dying-Where-a-Mental-Disorder-is-the-Sole-Underlying-Medical-Condition.pdf> (hereinafter WHERE MENTAL DISORDER IS THE SOLE UNDERLYING MEDICAL CONDITION).

50. *See, e.g.*, CAL. HEALTH & SAFETY CODE § 443(a)(3)(5).

51. Physicians’ participation in the medical aid in dying process is voluntary in all ten U.S. jurisdictions, as is the participation of health care organizations. The statutes provide for immunities that protect practitioners from any negative consequences for decisions to participate or not in the provision of medical aid in dying. *See, e.g.*, OR. REV. STAT. § 127.885 (2017). If, however, a health care organization chooses not to participate, those practitioners working within that setting cannot provide the service under the auspices of that organization.

52. For example, the statutes require that a “consulting physician” meet with the requesting patient and review records, confirm all of the medical findings, and the attending physician’s findings regarding capacity and voluntariness prior to the determination of the patient’s eligibility. *See, e.g.*, OR. REV. STAT. § 127.800(4) (2017) (“‘Consulting physician’ means a physician who is qualified by specialty or experience to make a professional diagnosis and prognosis regarding the patient’s disease.”); OR. REV. STAT. § 127.815 (“The attending physician shall . . . [r]efer the patient to a consulting physician for medical confirmation of the diagnosis, and for a determination that the patient is capable and acting voluntarily[.]”). The consulting physician can independently initiate the referral to the mental health professional for a capacity evaluation if he or she has concerns regarding impaired judgment. The statutes have other procedural protections, such as requirements for witnesses. *See, e.g.*, OR. REV. STAT. § 127.810 (“[A]t least two individuals who . . . attest that to the best of their knowledge and belief the patient is capable, acting voluntarily, and is not being coerced to sign the request.”). The statutes also have protections such as waiting periods. *See, e.g.*, OR. REV. STAT. §§ 127.840, 127.850 (“A qualified patient shall have made an oral request and a written request, and reiterate the oral request to his or her attending physician no less than fifteen (15) days after making the initial oral request.”).

diseases under the definition, which appears to require that the *natural* course of the patient's disease be such that it leads to death.⁵³

C. WHAT THIS ARTICLE IS NOT ABOUT

This Article does not address the question of whether the jurisdictions that authorize medical aid in dying in the United States should modify their provisions so that mental disorders can serve as qualifying conditions. As noted above, mental disorders cannot serve as qualifying conditions under the medical aid in dying statutes in the United States because such disorders are not terminal diseases that limit life expectancy to six months or less due to the natural progress of the conditions.⁵⁴ Scholars, and to a lesser extent, lawmakers, are debating the implications of allowing mental disorders to serve as *qualifying conditions* for medical aid in dying.⁵⁵ That debate is particularly lively in Canada.⁵⁶ Unlike in the United States, medical aid in dying in Canada is not restricted to persons who are not expected to survive beyond six months. The Canadian statute, adopted on June 17, 2016, requires a finding that a person is living with a “grievous and irremediable medical condition” by meeting all of the following criteria:

53. Although there is evidence that persons with mental disorders have higher risk of mortality than persons without mental disorders, see *Premature Death Among People with Severe Mental Disorders*, WORLD HEALTH ORG., https://www.who.int/mental_health/management/info_sheet.pdf (last visited Mar. 20, 2020); Elizabeth Reisinger Walker et al., *Mortality in Mental Disorders and Global Disease Burden Implications: A Systematic Review and Meta-Analysis*, 72 JAMA PSYCHIATRY 334 (2015), the disorders do not “produce” or “result in” death directly, as appears to be required under the U.S. medical aid in dying statutes. Due to a range of factors, such as poor access to preventive and treatment services for comorbid physical illnesses, and greater exposure to risk factors, persons with serious mental disorders are viewed as more vulnerable to threats to their physical health than are persons the general population. World Health Organization, *supra*; Shekhar Saxena, *Excess Mortality Among People with Mental Disorders: A Public Health Priority*, 3 LANCET PUB. HEALTH e264 (2018). The higher mortality of persons with mental disorders is due to a combination of greater susceptibility to disease and chronic conditions, a higher frequency of accidents and death by suicide, and other factors. *Premature Death, supra*; Walker et al., *supra*.

54. See *supra* notes 45, 53 and accompanying text.

55. For excellent overviews of the issues, see Candice T. Player, *Death with Dignity and Mental Disorder*, 60 ARIZ. L. REV. 115, 123–27 (2018); Catherine S. Shaffer et al., *A Conceptual Framework for Thinking about Physician-Assisted Death for Persons with a Mental Disorder*, 22 PSYCHOL. PUB. POL'Y & L. 141, 142–43, 143 tbl.1 (2016). For contrasting viewpoints, compare Paul S. Appelbaum, *Should Mental Disorders Be a Basis for Physician-Assisted Death?*, 68 PSYCHIATRIC SERVS. 315, 315–317 (2017), and Thomas Blikshavn et al., *Four Reasons Why Assisted Dying Should Not Be Offered for Depression*, 14 BIOETHICAL INQUIRY 151, 151–56 (2016), and Scott Y.H. Kim & Trudo Lemmens, *Should Assisted Dying for Psychiatric Disorders Be Legalized in Canada?* 188 CANADIAN MED. ASS'N J. E337, E337–38 (2016), and Franklin G. Miller & Paul S. Appelbaum, *Physician-Assisted Death for Psychiatric Patients—Misguided Public Policy*, 378 NEW ENG. J. MEDICINE 883, 883–85 (2018), with Justine Dembo et al., *“For Their Own Good”: A Response to Popular Arguments Against Permitting Medical Assistance in Dying (MAID) Where Mental Illness Is the Sole Underlying Condition*, 63 CANADIAN J. PSYCHIATRY 451, 452–54 (2018), and Player, *supra*, and William Rooney et al., *Are Concerns About Irremediableness, Vulnerability, or Competence Sufficient to Justify Excluding All Psychiatric Patients from Medical Aid in Dying?*, 26 HEALTH CARE ANALYSIS 326, 327–41 (2018).

56. See, e.g., WHERE MENTAL DISORDER IS THE SOLE UNDERLYING MEDICAL CONDITION, *supra* note 49, at 61–107, 148–89, <https://cca-reports.ca/wp-content/uploads/2018/12/The-State-of-Knowledge-on-Medical-Assistance-in-Dying-Where-a-Mental-Disorder-is-the-Sole-Underlying-Medical-Condition.pdf>.

(a) they have a serious and incurable illness, disease or disability; (b) they are in an advanced state of irreversible decline in capability; (c) that illness, disease or disability or that state of decline causes them enduring physical or psychological suffering that is intolerable to them and that cannot be relieved under conditions that they consider acceptable; and (d) their natural death has become reasonably foreseeable, taking into account all of their medical circumstances, without a prognosis necessarily having been made as to the specific length of time that they have remaining.⁵⁷

As instructed by the Canadian Parliament, the Ministers of Justice and Health in Canada commissioned independent reviews of several questions, including whether medical aid in dying requests “where mental illness is the sole underlying medical condition” should be permissible in Canada.⁵⁸ The report of the task force assembled to review this question published its report in December 2018.⁵⁹ Broadening of the statute to include mental disorders as qualifying conditions under some circumstances would require revision of Section (d) above, and certain other provisions.⁶⁰ Presently, a mental disorder can serve as the qualifying condition in certain European countries, such as Belgium and the Netherlands.⁶¹

57. S.C. 2016, c 3, § 241.2(2) (Can.)

58. *Id.* at § 9.1.

59. WHERE MENTAL DISORDER IS THE SOLE UNDERLYING MEDICAL CONDITION, *supra* note 49. The Working Group did not make a recommendation in favor of or in opposition to the availability of medical aid in dying to persons who wish to access this intervention when identifying a mental disorder as the sole qualifying condition. *Id.* It highlighted questions relevant to the charge, surveyed pertinent scientific work, and addressed potential implications of expansion of availability to persons under these circumstances. *Id.* In May 2019, eight members of that Working Group, referring to themselves as the “Halifax Group,” reassembled and drafted a second report under the auspices of the non-profit Institute for Public Policy Research in Canada. HALIFAX GROUP, MAID LEGISLATION AT THE CROSSROADS: PERSONS WITH MENTAL DISORDERS AS THEIR SOLE UNDERLYING MEDICAL CONDITION (2020), <https://irpp.org/wp-content/uploads/2020/01/MAiD-Legislation-at-a-Crossroads-Persons-with-Mental-Disorders-as-Their-Sole-Underlying-Medical-Condition.pdf> [hereinafter MAID LEGISLATION AT THE CROSSROADS]. The Halifax Group recommended that persons seeking medical aid in dying based on a mental disorder as a sole underlying condition should not be categorically excluded from access. *Id.* at 25.

60. Indeed, “the ‘reasonably foreseeable’ natural death and ‘end of life’ eligibility criteria were challenged by Jean Truchon and Nicole Gladu—two individuals seeking access to [medical aid in dying] but whose natural deaths were not yet reasonably foreseeable and who were not at the end of life.” MAID LEGISLATION AT THE CROSSROADS, *supra* note 59, at 4. Truchon and Gladu’s challenge to the statute were successful. In September 2019, a Quebec Superior Court struck down the challenged provisions. *Truchon v. Attorney General Canada*, 2019 CanLII 3792 (Can. Q.B. S.C.), <https://www.canlii.org/en/qc/qccs/doc/2019/2019qccs3792/2019qccs3792.pdf>. Although the plaintiffs did not cite mental disorders as the conditions they urged should qualify them for access to medical aid in dying, the decision opens the door to the potential application of the statute to persons who identify mental disorders as their sole qualifying conditions. The decision, which becomes effective in March 2020, is binding authority only in the province of Quebec. See MAID LEGISLATION AT THE CROSSROADS, *supra* note 59, at 4. At the time of this writing, the government of Quebec is seeking input from the public and the medical community in determining whether to draft an exception to the application of the *Truchon* decision that would exclude mental disorders as sole qualifying conditions. See Kalina LaFramboise, *Quebec Backtracks on Expanding Medical Aid in Dying to People with Mental Illness*, GLOBAL NEWS (Jan. 27, 2020), available at <https://globalnews.ca/news/6466641/quebec-assisted-dying-mentally-ill-backtrack/>.

61. For a discussion of these and other nations’ laws allowing medical aid in dying where a mental disorder is the sole qualifying condition, see, for example Player, *supra* note 55, at 123–27; Shaffer et al., *supra* note 55, at 143, 143 tbl.1. For more extensive analysis, see, for example, Joris Vandenbergh, *Euthanasia in Patients*

Notwithstanding the distinctions between the topic that is the focus of this Article and the question of whether a patient should have access to medical aid in dying when the sole qualifying or underlying condition is a mental disorder, some of the sources addressing the latter issue are cited within for propositions that relate more narrowly to decisionmaking capacity and mental disorder.

II. TREATMENT OF DECISIONMAKING CAPACITY: THE LAW AND THE SCIENCE

A. THE DOCTRINE OF INFORMED CONSENT

The doctrine of informed consent incorporates concepts, standards, rules, and practices governing the exercise of an individual's legal authority to make decisions about his or her own health care. According to legal and ethical principles, a patient's health care decisions must be informed, competent, and voluntary in order to be legally valid.⁶² A core value underlying and justifying the doctrine of informed consent is the principle of autonomy.⁶³ In the context of health care decisionmaking, respect for autonomy highlights our social valuing of personal choice, self-direction, and "self-rule that is free from both controlling interferences by others and . . . limitations such as inadequate understanding that prevents meaningful choice."⁶⁴ It recognizes that basic rights of bodily integrity are violated if medical tests, procedures, or interventions affecting one's body or mind proceed without consent.⁶⁵ No statement better captures the notion of autonomy in health care decisionmaking than the famous and frequently-quoted proclamation of Justice Benjamin Cardozo, writing for

with Intolerable Suffering Due to an Irremediable Psychiatric Illness: A Psychiatric Perspective, in EUTHANASIA AND ASSISTED SUICIDE: LESSONS FROM BELGIUM 150 (David Albert Jones et al. eds., 2017); see also ROBERT POOL, NEGOTIATING A GOOD DEATH: EUTHANASIA IN THE NETHERLANDS (2000).

62. GRISSO & APPELBAUM, *supra* note 10, at 7–11; Meisel et al., *supra* note 9, at 286–87.

63. For a review of commentary addressing the role of autonomy as the foundation of the doctrine of informed consent, see Tom L. Beauchamp, *Autonomy and Consent*, in THE ETHICS OF CONSENT: THEORY AND PRACTICE 55, 58–61 (Franklin G. Miller & Alan Wertheimer eds., 2010); see also TOM L. BEAUCHAMP & JAMES F. CHILDRESS, PRINCIPLES OF BIOMEDICAL ETHICS 101, 121 (7th ed. 2012); GERALD DWORKIN, THE THEORY AND PRACTICE OF AUTONOMY 108–12 (1988); WILLARD GAYLIN & BRUCE JENNINGS, THE PERVERSION OF AUTONOMY: COERCION AND CONSTRAINTS IN A LIBERAL SOCIETY 28–29 (2003); Bruce Jennings, *Autonomy*, IN THE OXFORD HANDBOOK OF BIOETHICS 72, 77–78 (Bonnie Steinbock ed., 2009).

64. BEAUCHAMP & CHILDRESS, *supra* note 63, at 101; see also *The Belmont Report*, NAT'L COMM'N FOR PROTECT. HUM. SUBJECTS BIOMED. & BEHAV. RES. (Apr. 18, 1979), https://www.hhs.gov/ohrp/sites/default/files/the-belmont-report-508c_FINAL.pdf ("To respect autonomy is to give weight to autonomous persons' considered opinions and choices while refraining from obstructing their actions unless they are clearly detrimental to others."). For further discussion of a range of formulations of the concept of autonomy, see, for example, BEAUCHAMP & CHILDRESS, *supra* note 63, at 61–65; DWORKIN, *supra* note 63, at 3–61; GAYLIN & JENNINGS, *supra* note 63, at 27–46. For a provocative challenge to the dominant role that traditional notions of autonomy play in end-of-life health care decisionmaking, see Megan S. Wright, *End of Life and Autonomy: The Case for Relational Nudges in End-of-Life Law and Policy*, 77 MD. L. REV. 1062 (2018).

65. See, e.g., BERG et al., *supra* note 9, at 11. See DWORKIN, *supra* note 63, at 112–13. Gerald Dworkin asserts that autonomy plays a special role in the context of health care decisionmaking. He notes that decisions about one's health, such as "what form of treatment to undergo, the probabilities of cure and of side effects, judgments about how the body will look to others after various forms of surgery, whether to spend one's last days in a hospital or at home – these are not technical, medical judgments." *Id.* at 113.

New York's highest court in *Schloendorff v. Society of New York Hospital*: "Every human being of adult years and sound mind has a right to determine what shall be done with his own body[.]"⁶⁶

Over the past decades, the law of informed consent has been shaped by sources and events in the field of bioethics (including scholarly analyses,⁶⁷ documents produced by numerous ethics commissions,⁶⁸ formal codes of ethics,⁶⁹ ethical analyses or opinions by professional organizations),⁷⁰ tort law principles governing health care practitioner liability,⁷¹ constitutional law relevant to specific health care decisions,⁷² and specialized statutes and regulations governing informed consent in particular contexts.⁷³

66. *Schloendorff v. Soc'y of N.Y. Hosp.*, 105 N.E. 92, 93 (N.Y. 1914). In this case, the court determined that a physician could be liable for complications of a surgical procedure to which the patient did not consent. While cases such as *Schloendorff* adjudicate tort liability of medical practitioners or institutions, they also articulate a common law principle of autonomy in the context of medical procedures, contributing to the development of the modern doctrine of informed consent.

67. See, e.g., BEAUCHAMP & CHILDRESS, *supra* note 63, at 101–49 (providing one of the earliest analyses of bioethical issues relevant to health care decisionmaking in its first edition); BERG et al., *supra* note 9, at 11; RUTH R. FADEN & TOM L. BEAUCHAMP, *A HISTORY AND THEORY OF INFORMED CONSENT* (1986) (providing an overview and theoretical, historical, doctrinal, and empirical analysis of the concept of informed consent in ethics, law, and clinical practice from the time of Hippocrates to the date of publication); JAY KATZ, *THE SILENT WORLD OF DOCTOR AND PATIENT 171–72*, 205 (1986) (providing an early critical analysis of the doctrine of informed consent and the gap between ethical ideals and clinical practice).

68. 1 PRESIDENT'S COMM'N FOR THE STUDY OF ETHICAL PROBLEMS IN MED. AND BIOMED. AND BEHAVIORAL RESEARCH, *MAKING HEALTH CARE DECISIONS: THE ETHICAL AND LEGAL IMPLICATIONS OF INFORMED CONSENT IN THE PATIENT-PRACTITIONER RELATIONSHIP 15–51* (1982) [hereinafter PRESIDENT'S COMM'N]; *The Belmont Report*, *supra* note 64.

69. See, e.g., NUREMBERG CODE, *reprinted in 2 TRIALS OF WAR CRIMINALS BEFORE THE NUREMBERG MILITARY TRIBUNALS UNDER CONTROL COUNCIL LAW 181*, 181–82 (1949) (articulating the requirements for permissible medical experiments); *Ethical Principles of Psychologists and Code of Conduct*, AM. PSYCHOL. ASS'N, <https://www.apa.org/ethics/code/> (last visited Mar. 20, 2020).

70. See, e.g., *Informed Consent: Code of Medical Ethics Opinion 2.1.1*, AM. MED. ASS'N, <https://www.ama-assn.org/delivering-care/ethics/informed-consent> (last visited Mar. 20, 2020).

71. See, e.g., Jaime S. King & Benjamin W. Moulton, *Rethinking Informed Consent: The Case for Shared Medical Decision-Making*, 32 J.L. & MED. 429, 438–40 (2006).

72. The federal and state constitutional implications of informed consent doctrine have arisen in cases concerning rights to refuse unwanted treatment and to access to specific treatment interventions. For example, the U.S. Supreme Court has held that adults have a Fourteenth Amendment right to refuse lifesaving interventions, see, e.g., *Cruzan v. Dir., Mo. Dept. of Health*, 497 U.S. 261, 278 (1990), and forcible administration of psychotropic medications, see, e.g., *Washington v. Harper*, 494 U.S. 210, 221–24 (1990). The Court has held that certain state statutory provisions violated individuals' Fourteenth Amendment rights to access contraception, see, e.g., *Carey v. Population Servs. Int'l*, 431 U.S. 678, 685 (1977); *Eisenstadt v. Baird*, 405 U.S. 438, 453 (1971); *Griswold v. Connecticut*, 381 U.S. 479, 485–86 (1965), or abortion, see, e.g., *Planned Parenthood of Se. Pa. v. Casey*, 505 U.S. 833, 851 (1992); *Roe v. Wade*, 410 U.S. 113, 152–53 (1973). State court holdings have, at times, supplemented federal decisions, grounding protections in state constitutional provisions. See, e.g., *Conservatorship of Wendland*, 28 P.3d 151, 158–60 (Cal. 2001) (citing state constitutional protection of autonomy in health care decisionmaking).

73. For example, most states have passed statutes governing end-of-life decisionmaking, including provisions for advanced directives and surrogate decisionmaking. See, e.g., ALA. CODE 1975 § 22-8A-4 (2019); COLO. REV. STAT. § 15-14-504 (2019). States have also passed specialized statutes regulating consent for interventions such as surgical sterilization, see, e.g., COLO. REV. STAT. §§ 25.5-10-231–35; VA. CODE ANN. §§ 54.1-2974–80 (2019), and breast cancer surgery, see, e.g., CAL. HEALTH & SAFETY CODE § 109275 (West 2020); FLA. STAT. § 458.324 (2019); see also federal regulations governing human participation in

Scholarship and policy analyses examining the doctrine of informed consent frequently identify the following as fundamental goals: (1) protecting patients' interests in personally choosing whether to accept or reject health care treatments, procedures, diagnostic tests, and related interventions and (2) facilitating *meaningful* exercise of autonomy interests by providing patients with the information essential to making knowledgeable and well-reasoned decisions.⁷⁴ In order to achieve its promise of promoting autonomy in patients' health care decisions, the doctrine must concern itself with satisfaction of a range of requirements.⁷⁵ The requirement that consent be *informed* mandates that health care practitioners disclose to prospective patients, in a comprehensible manner, the information necessary to make the treatment decision. That information should describe, consistent with the best available knowledge: (1) the nature of the condition, illness, disorder, or symptoms for which treatment is recommended; (2) the likely consequences of failure to treat the condition, illness, disorder, or symptoms; (3) the nature of the proposed or recommended treatment, and of alternative treatments; and (4) the possible benefits, risks, discomforts, and side effects of each identified treatment and its alternatives, as well as their anticipated likelihood.⁷⁶

The *competence* requirement underscores that patients must have the *capacity* to understand and reason about the information provided. Below, I review modern competence constructs and their articulation in U.S. medical aid in dying statutes.⁷⁷ Finally, the doctrine of informed consent also requires that patients' decisions regarding treatment be made *voluntarily*, that is, at a minimum, free from coercive or controlling influences.⁷⁸

B. THE HISTORY, THEORY, AND SCIENCE OF EVALUATING CAPACITY TO MAKE TREATMENT DECISIONS

Competence to make treatment decisions—one of the three requirements for legally and ethically valid informed consent by a patient—first received

research, Protection of Human Subjects, 45 C.F.R. §§ 46.101–.505 (2019), which also include specific informed consent requirements. See 45 C.F.R. § 46.116.

74. See, e.g., PRESIDENT'S COMM'N, *supra* note 68, at 15–51; see also BEAUCHAMP & CHILDRESS, *supra* note 63, at 114–125; BERG et al., *supra* note 9, at 3–74; FADEN & BEAUCHAMP, *supra* note 67, at 23–43; KATZ, *supra* note 69, at 38–74.

75. King & Moulton, *supra* note 71, at 463–80; see *infra* notes 76–101 and accompanying text.

76. This summary consolidates themes drawn from multiple sources. See BEAUCHAMP & CHILDRESS, *supra* note 63, at 124–25; *Informed Consent: Code of Medical Ethics Opinion 2.1.1*, *supra* note 70 (“[The physician should inform the patient of] 1. The diagnosis (when known)[,] 2. The nature and purpose of recommended interventions[,] 3. The burdens, risks, and expected benefits of all options, including foregoing treatment.”); Alan Meisel, *The “Exceptions” to the Informed Consent Doctrine: Striking a Balance Between Competing Values in Medical Decisionmaking*, 1979 WIS. L. REV. 413, 421; Meisel et al., *supra* note 9, at 286–87; Alan Meisel & Lisa D. Kabnick, *Informed Consent to Medical Treatment: An Analysis of Recent Legislation*, 41 U. PITT. L. REV. 407, 421–37 (1980).

77. See *infra* notes 79–82, 95–122 and accompanying text.

78. See Paul S. Appelbaum et al., *Voluntariness of Consent to Research: A Conceptual Model*, 39 HASTINGS CTR. RPT. 30, 32 (2009); Nelson et al., *supra* note 8, at 6.

attention in law and bioethics, and from the health and mental health professions, during the 1970s.⁷⁹ California, for example, provides the following definition of health care decisionmaking capacity. “‘Capacity’ means a person’s ability to understand the nature and consequences of a decision and to make and communicate a decision, and includes in the case of proposed health care, the ability to understand its significant benefits, risks, and alternatives.”⁸⁰ An interdisciplinary group of scholars supported by the MacArthur Foundation identified four standards of competence⁸¹: (1) ability to communicate a choice, (that is, ability to “clearly indicate [a] preferred treatment option”); (2) ability to understand relevant information (that is, to “grasp the fundamental meaning of information communicated by” the practitioner); (3) ability to reason about treatment options (that is, to “engage in a process of rational manipulate[ion of] the relevant information”); and (4) ability to appreciate the situation and its likely consequences (that is, to “acknowledge medical condition and likely consequences of treatment options,” particularly as applied to their own situation).⁸²

The theoretical and empirical work of the MacArthur Treatment Competence Study team further advanced our conceptualizations of, and ability to evaluate, patients’ capacity to make legally valid treatment decisions.⁸³ This work had been initiated a decade earlier by a first generation of treatment decisionmaking capacity scholars and researchers, at the University of Pittsburgh, Alan Meisel, Loren Roth, and Charles Lidz.⁸⁴ Indeed, the University

79. Two of the most influential early papers on the topic, providing initial conceptualizations that influenced subsequent initiatives. See Meisel et al., *supra* note 9; Loren H. Roth et al., *Tests of Competency to Consent to Treatment*, 134 AM. J. PSYCHIATRY 279 (1977). Despite the implication from the term “informed consent” that the doctrine focuses primarily on facilitating “consents,” the doctrine of informed consent encompasses *refusals* as well as consents. Meisel et al., *supra* note 9, at 286; Roth et al., *supra*, at 282. Indeed, modern concepts place greater emphasis on the *process* of decisionmaking, as contrasted with the outcome. Meisel et al., *supra* note 9, at 288; Roth et al., *supra*, at 283.

80. CAL. PROB. CODE § 4609 (West 2020).

81. See GRISSE & APPELBAUM, *supra* note 10, at 31–60. The initial empirical work of the MacArthur Treatment Competence researchers included: Paul S. Appelbaum & Thomas Grisso, *The MacArthur Treatment Competence Study I: Mental Illness and Competence to Consent to Treatment*, 19 LAW & HUM. BEHAV. 105 (1995) (hereinafter Applebaum & Grisso, *MacArthur I*); Thomas Grisso et al., *The MacArthur Treatment Competence Study II: Measures of Abilities Related to Competence to Consent to Treatment*, 19 LAW & HUM. BEHAV. 127 (1995) (hereinafter Grisso et al., *MacArthur II*); Thomas Grisso & Paul S. Appelbaum, *The MacArthur Treatment Competence Study III: Abilities of Patients to Consent to Psychiatric and Medical Treatments*, 19 LAW & HUM. BEHAV. 149 (1995) (hereinafter Grisso & Applebaum, *MacArthur III*).

82. See, e.g., Paul S. Appelbaum, *Assessment of Patients’ Competence to Consent to Treatment*, 357 NEW ENG. J. MEDICINE 1834, 1836 tbl.1 (2007).

83. See *MacArthur I*, *supra* note 81; *MacArthur II*, *supra* note 81; *MacArthur III*, *supra* note 81; see also GRISSE & APPELBAUM, *supra* note 10; Appelbaum, *supra* note 82; Jessica Wilen Berg et al., *Constructing Competence: Formulating Standards of Legal Competence to Make Medical Decisions*, 48 RUTGERS L. REV. 345 (1996); MACARTHUR RESEARCH NETWORK ON MENTAL HEALTH AND THE LAW, THE MACARTHUR TREATMENT COMPETENCE STUDY: EXECUTIVE SUMMARY, http://www.macarthur.virginia.edu/treatment.html#N_1_ (last visited Mar. 20, 2020).

84. See Meisel et al., *supra* note 9; Roth et al., *supra* note 79; see also PAUL APPELBAUM ET AL., INFORMED CONSENT: LEGAL THEORY AND CLINICAL PRACTICE (1987); CHARLES W. LIDZ ET AL., INFORMED CONSENT: A STUDY OF DECISIONMAKING IN PSYCHIATRY (1984). The University of Pittsburgh group’s work also served as

of Pittsburgh group's synthesis of concepts of treatment decisionmaking competence served as a core building block for the MacArthur group's work.⁸⁵ The work of the MacArthur group has been extremely influential in modern formulations and assessment of treatment decisionmaking capacity in law, ethics, research, and clinical practice. The MacArthur group also developed standardized measures that can be used by health care practitioners (the MacArthur Competence Assessment Tool for Treatment, or MacCat-T)⁸⁶ or researchers (the MacArthur Competence Assessment Tool for Clinical Research, or MacCAT-CR).⁸⁷ The measures allow evaluators to customize the assessment of capacity for each treatment or research decisionmaking context.

The MacArthur group's work was largely completed in the 1990s, although the researchers have continued to produce important writings on the subject.⁸⁸ Their analyses and studies have influenced a third generation of researchers, who have extended, adapted, applied, and critiqued this foundational work.⁸⁹ In addition to the proposal and development of alternative measures and assessment strategies, discourse has focused on a number of themes, including the need for improved training of health and mental health practitioners

the foundation for other empirical studies of competence conducted prior to the MacArthur group's work. *See, e.g.,* Lois A. Weithorn & Susan B. Campbell, *The Competency of Children and Adolescents to Make Informed Treatment Decisions*, 53 *CHILD DEV.* 1589 (1982). For other "first-generation" discussions of the doctrine of informed consent, see FADEN & BEAUCHAMP, *supra* note 67; KATZ, *supra* note 67, at 171.

85. Roth et al., *supra* note 79.

86. THOMAS GRISSO & PAUL S. APPELBAUM, *MACARTHUR COMPETENCE ASSESSMENT TOOL FOR TREATMENT (MACCAT-T)* (1998) [hereinafter *MACCAT-T MANUAL*].

87. PAUL S. APPELBAUM & THOMAS GRISSO, *MACCAT-T: THE MACARTHUR COMPETENCE ASSESSMENT TOOL FOR CLINICAL RESEARCH* (2001).

88. *See, e.g.,* Appelbaum, *supra* note 82.

89. For summary and discussion of instruments and approaches to evaluating treatment competence, see AM. BAR ASS'N & AM. PSYCHOLOGICAL ASS'N, *ASSESSMENT OF OLDER ADULTS WITH DIMINISHED CAPACITY: A HANDBOOK FOR PSYCHOLOGISTS* 56–58 (2008), <https://www.apa.org/pi/aging/programs/assessment/capacity-psychologist-handbook.pdf>; THOMAS GRISSO, *EVALUATING COMPETENCIES: FORENSIC ASSESSMENTS AND INSTRUMENTS* 404–60 (2d ed. 2003); SCOTT Y. H. KIM, *EVALUATION OF CAPACITY TO CONSENT TO TREATMENT AND RESEARCH* 55–66 (2010); JENNIFER MOYE ET AL., *ASSESSMENT OF THE CAPACITY TO CONSENT TO TREATMENT: (ACCT): ADMINISTRATION AND TECHNICAL MANUAL* 14–21 (2007); Laura B. Dunn et al., *Assessing Decisional Capacity for Clinical Research or Treatment: A Review of Instruments*, 163 *AM. J. PSYCHIATRY* 1323 (2006); Adam Gerstenecker et al., *Enhancing Medical Decision-Making Evaluations: Introduction of Normative Data for the Capacity to Consent Treatment Instrument*, 23 *ASSESSMENT* 232 (2015); Scott Lamont et al., *Assessing Patient Capacity to Consent to Treatment: An Integrative Review of Instruments and Tools*, 22 *J. CLINICAL NURSING* 2387 (2013); Jennifer Moye et al., *Assessment of the Capacity to Consent to Treatment: Challenges, the "ACCT" Approach, Future Directions*, 31 *CLINICAL GERONTOLOGIST* 37 (2007); Jennifer Moye et al., *Empirical Advances in the Assessment of the Capacity to Consent to Medical Treatment: Clinical Implications and Research Needs*, 26 *CLINICAL PSYCHOLOGY REV.* 1054 (2006); Barton W. Palmer & Alexandria L. Harmell, *Assessment of Healthcare Decision-Making Capacity*, 31 *ARCHIVES CLINICAL NEUROPSYCHOLOGY* 530 (2016); Laura L. Sessums et al., *Does This Patient Have Medical Decision-Making Capacity?*, 306 *JAMA* 420 (2011); Edward D. Sturman, *The Capacity to Consent to Treatment and Research: A Review of Standardized Assessment Tools*, 25 *CLINICAL PSYCHOLOGY REV.* 954 (2005); Astrid Vellinga et al., *Instruments to Assess Decision-Making Capacity: An Overview*, 16 *INT'L PSYCHOGERIATRICS* 397 (2004); Irma M. Hein et al., *Accuracy of Assessment Instruments for Patients' Competence to Consent to Medical Treatment or Research*, *COCHRANE DATABASE OF SYSTEMATIC REVIEWS*, <https://www.cochranelibrary.com/cdsr/doi/10.1002/14651858.CD011099.pub2/epdf/full> (last visited Mar. 20, 2020).

conducting capacity evaluations,⁹⁰ the challenges of lack of agreement in clinician assessments,⁹¹ further development, refinement, revision, or critique of the categories and criteria of treatment decisionmaking capacity,⁹² and consideration of the relative roles that standardized measures versus clinical judgment should play in the assessment of capacity.⁹³ Despite the important expansion of empirical and theoretical work on assessment of treatment decisionmaking capacity, the template laid out by the MacArthur group remains the “gold standard,” and therefore will be relied upon in this Article.

III. CAPACITY TO DECIDE ABOUT MEDICAL AID IN DYING

A. DEFINITIONS OF CAPACITY UNDER MEDICAL AID IN DYING STATUTES IN THE UNITED STATES

All jurisdictions authorizing medical aid in dying by statute require that, as a precondition for access to this assistance, the prescribing physician, a consulting physician, and in some instances also, a mental health specialist, certify that the patient has capacity to make health care decisions.⁹⁴ The substantive definitions and procedures relating to the evaluation of decisional capacity are fairly consistent across the jurisdictions that regulate medical aid in dying by statute. For example, Oregon and four other jurisdictions provide the following generic definition of decisionmaking capacity: “the ability to make and communicate health care decisions to health care providers[.]”⁹⁵ While the meaning of “ability to make . . . health care decisions” is not specified initially, more detail is provided in a subsequent section defining “informed decision.”⁹⁶ The Oregon statute indicates that an “informed decision” means a decision:

[T]o request and obtain a prescription to end his or her life in a humane and dignified manner, that is *based on* appreciation of the relevant facts and after being fully informed by the attending physician of: (a) His or her medical diagnosis; (b) His or her prognosis; (c) The potential risks associated with taking the medication as prescribed; (d) The probable result of taking the

90. Lisa Seyfried et al., *Assessment of Decision-Making Capacity: Views and Experiences of Consultation Psychiatrists*, 54 *PSYCHOSOMATICS* 115, 117 (2013).

91. See, e.g., Scott Y. Kim et al., *Variability of Judgments of Capacity: Experience of Capacity Evaluators in a Study of Research Consent Capacity*, 52 *PSYCHOSOMATICS* 346 (2011).

92. Lisa Eckstein & Scott Y.H. Kim, *Criteria for Decision-Making Capacity: Between Understanding and Evidencing a Choice*, 24 *J.L. & MED.* 678, 683–85 (2017); Christopher Slobogin, “Appreciation” as a Measure of Competency: *Some Thoughts About the MacArthur Group’s Approach*, 2 *PSYCHOLOGY PUB. POL’Y & L.* 18, 24–27 (1996).

93. KIM, *supra* note 89, at 93–95.

94. See *infra* notes 95–123 and accompanying text.

95. See COLO. REV. STAT. § 25-48-102(10) (2019) (defining “mental capacity”); D.C. CODE § 7-661.01(2) (2019) (defining “capable”); ME. STAT. tit. 22, § 2140(2)(C) (2019) (defining “competent”); N.J. STAT. ANN. § 26:16-3 (West 2019) (defining “capable”); OR. REV. STAT. ANN. § 127.800 § 1.01(3) (2017); VT. STAT. ANN. tit. 18, § 5281(2) (2019); WASH. REV. CODE § 70.245.010(3) (2019) (defining “competent”). The states further define “informed decision,” by specifying that the individual has “based” the decision “on an understanding and acknowledgement of the relevant facts” See COLO. REV. STAT. § 25-48-102(5)(b).

96. See, e.g., COLO. REV. STAT. § 25-48-102(5).

medication to be prescribed; and (e) The feasible alternatives, including, but not limited to, comfort care, hospice care, and pain control.⁹⁷

The definition of capacity contained in California's End of Life Option Act initially provides a bit more guidance to evaluators regarding the relevant criteria for treatment decisionmaking capacity under the Act.⁹⁸ Evaluating professionals are to determine that "the individual has the ability to understand the nature and consequences of the health care decision, the ability to understand its significant benefits, risks, and alternatives, and the ability to make and communicate an informed decision to health care providers."⁹⁹ California's statute further defines an "informed decision" as one that is "based on an understanding and acknowledgement of the relevant facts, and that is made after being fully informed by the attending physician" of a similar list of elements of disclosure laid out in the Oregon statute, including "the possibility that the individual may choose not to obtain the drug or may obtain the drug but may decide not to ingest it."¹⁰⁰ Hawaii's definition follows California's lead with some minor changes in language.¹⁰¹

These initial definitions of capacity found in the codes are incomplete however, if not viewed together with the additional criteria found in the sections of the statutes addressing referrals to mental health practitioners. If there are indications that the patient may not have decisional capacity, and the patient still wishes to pursue the request, the physician must refer the patient to a mental health professional for further assessment of capacity.¹⁰² In Oregon, the statute reads: "If in the opinion of the attending physician . . . a patient may be suffering from a psychiatric or psychological disorder or depression causing impaired judgment," a referral to a consulting mental health professional is made, with no life-ending drugs provided until that consultant "determines that the patient is not suffering from a psychiatric or psychological disorder or depression causing impaired judgment."¹⁰³ Maine, Washington, and the District of Columbia have

97. OR. REV. STAT. ANN. § 127.800(7) (emphasis added). Most states provide a similar recitation of information that must be disclosed to the patient, and upon which the patient must base his or her decision. *See, e.g.*, N.J. STAT. ANN. § 26:16-3 (West 2019) ("(1) the patient's medical diagnosis; (2) the patient's prognosis; (3) the potential risks associated with taking the medication prescribed; (4) the probable result of taking the medication prescribed; and (5) the feasible alternatives to taking the medication, including, but not limited to, concurrent or additional treatment opportunities, palliative care, comfort care, hospice care, and pain control.").

98. CAL. HEALTH & SAFETY CODE § 443.1(e) (West 2020) (citing to CAL. PROB. CODE § 4609 (West 2020)).

99. CAL. HEALTH & SAFETY CODE § 443.1(d).

100. CAL. HEALTH & SAFETY CODE § 443.1(i).

101. "'Capable' means that . . . a patient has the ability to understand the patient's choices for care, including risks and benefits, and make and communicate health care decisions to health care providers." HAW. REV. STAT. § 327L-1 (2019).

102. As noted below in *infra* notes 103–113, Hawaii departs from this procedure in that it requires *all* patients who request medical aid in dying to be evaluated by a mental health professional. *See infra* notes 114–116.

103. *See, e.g.*, OR. REV. STAT. § 127.825 (2017).

adopted Oregon's language verbatim.¹⁰⁴ California's language is similar, focusing the mental health consultation on whether "the individual has the capacity to make medical decisions and is not suffering from impaired judgment due to a mental disorder."¹⁰⁵ These formulations define a two-pronged test. The capacity evaluation must examine: (1) whether the patient is experiencing a psychiatric, psychological, or mental disorder, or depression; *and* (2) whether any such observed disorder or condition is causing impaired judgment. Existence of a mental disorder is not sufficient to render the patient incompetent under the statute if judgment is not impaired.¹⁰⁶

Colorado, New Jersey, and Vermont also require the attending physician to refer to a mental health specialist under certain circumstances. Yet, notably, these three states do not specify presence of mental, psychiatric, or psychological disorder, or depression, as a triggering feature and basis for referral and subsequent evaluation. Colorado focuses solely on the need for further assessment of decisionmaking capacity if the attending physician believes the patient "may not be mentally capable of making an informed decision."¹⁰⁷ New Jersey also grounds the referral on the attending physician's judgment that the patient "may not be capable."¹⁰⁸ Vermont highlights the need for confirmation of whether the patient is capable and does not have impaired judgment.¹⁰⁹ These latter approaches are superior to those that cite to depression or mental disorder as the basis for a more in-depth capacity evaluation because of the focus on observations of the patient's *functioning* relative to the capacity standards,¹¹⁰ rather than on the existence of a mental disorder or psychological or psychiatric conditions or symptoms.¹¹¹

The existence of a mental disorder has historically led to presumptions of legal incompetence in a range of spheres.¹¹² While the presumptive approach no longer prevails in the law, generalizations about the capacities of persons with mental disorders persist in practice. Language such as that in the Colorado, New Jersey, and Vermont statutes avoid undue focus on a diagnosis of mental disorder and may reduce the likelihood of inappropriate generalizations about

104. D.C. CODE § 7-661.01(4) (2019); ME. STAT. tit. 22, § 2140(8) (2019); WASH. REV. CODE § 70.245.010(5) (2019).

105. CAL. HEALTH & SAFETY CODE §§ 443.1(k); 443.5(a)(1)(iii) (West 2020).

106. For a discussion of what is meant by "impaired judgment," see *infra* notes 117–123 and accompanying text.

107. COLO. REV. STAT. § 25-48-106(1)(f) (2019) ("The attending physician shall . . . [r]efer the individual to a licensed mental health professional . . . if the attending physician believes that the individual may not be mentally capable of making an informed decision."); § 25-48-108(2) (same).

108. N.J. STAT. ANN. § 26:16-8 (West 2019).

109. VT. STAT. ANN. tit. 18, § 5283(a)(8) (2019).

110. See, e.g., KIM, *supra* note 89, at 11 (referring to the "functionalist model of competence" as meaning that "a person's capacity status is determined by his demonstrable abilities" rather than a diagnosis or label).

111. Stephen J. Morse, *Mental Disorder and Criminal Law*, 101 J. CRIM. L. & CRIMINOLOGY 885, 895 (2011) ("Mental disorder per se is not a sufficient criterion for special legal treatment. All mental health laws require further legally relevant behavior, which is in fact the law's primary concern.").

112. See *infra* notes 144–145 and accompanying text.

the relationship between such conditions and capacity. Furthermore, they may alert evaluators to the possibility that factors other than mental disorder may affect capacity. As discussed below, research indicates that neurocognitive conditions, the effects of physical illness, and the effects of treatments such as chemotherapy and radiation may impair capacity.¹¹³ Although there are insufficient data to draw definitive conclusions, it is possible that in the population of persons who are medically eligible to request medical aid in dying in the United States, these latter factors constitute greater risks to decisionmaking capacity than do mental disorders.

Hawaii departs from the other states in procedure and substantive criteria relating to mental health consultation. Hawaii requires the involvement of a mental health professional in all cases to provide a consulting capacity evaluation.¹¹⁴ The mental health practitioner provides a judgment as to whether the patient's decision has been made voluntarily, whether "the patient is capable, and that the patient does not appear to be suffering from undertreatment or nontreatment of depression or other conditions which may interfere with the patient's ability to make an informed decision."¹¹⁵ Hawaii's language is novel in its emphasis on the adequacy of treatment of conditions affecting treatment decisionmaking capacity rather than solely on the presence of the conditions.¹¹⁶ This shift also has the benefit of focusing evaluators on the patient's *demonstrated* functional capacity rather than solely on the existence of a diagnosis of a mental disorder.

Only Vermont explicitly defines the term "impaired judgment" in its statute.¹¹⁷ The relevant provision states that impaired judgment is manifest when "a person does not sufficiently understand or appreciate the relevant facts necessary to make an informed decision." In other words, in Vermont, a

113. See *infra* notes 212–243 and accompanying text.

114. HAW. REV. STAT. § 372L-4(a)(4) (2019). The University of California at San Francisco Medical Center has opted to refer all otherwise-qualified requesting patients for a capacity evaluation with mental health specialists, even though not required to do so under the California statutes. See, e.g., James A. Bourgeois et al, *Physician-Assisted Death Psychiatric Assessment: A Standardized Protocol to Conform to the California End of Life Option Act*, 39 PSYCHOSOMATICS 441 (2018). For an alternative perspective, see, for example, Linda Ganzini, *Psychiatric Evaluations for Individuals Requesting Assisted Death in Washington and Oregon Should Not be Mandatory*, 36 GEN. HOSP. PSYCHIATRY 10, 10 (2014).

115. HAW. REV. STAT. §§ 327L-1; 372L-6.

116. Hawaii statutes impose the same obligation as do other states' medical aid in dying laws to inform the patient of alternatives to medical aid in dying "including but not limited to comfort care, hospice care, and pain control." HAW. REV. STAT. § 327L-4(a)(3)(F) (2019). Ideally, if a practitioner determines that the patient has impaired judgment from a mental disorder or psychological condition that has not been effectively treated, that patient should be offered appropriate treatment for that mental health condition. One might speculate that, if such treatment is effective in treating a condition that impairs capacity, the patient can request reevaluation of capacity for the purpose of demonstrating eligibility under the medical aid in dying statute. The concept that an impaired legal capacity may be "restored" with treatment is a familiar one in the context of criminal adjudication, see, e.g., Debra A. Pinals, *Where Two Roads Meet: Restoration of Competence to Stand Trial from a Clinical Perspective*, 31 NEW ENG. J. ON CRIM. & CIV. CONFINEMENT 81, 85 (2005); Patricia A. Zapf & Ronald Roesch, *Future Directions in the Restoration of Competency to Stand Trial*, 20 CURRENT DIRECTIONS PSYCHOL. SCI. 43, 44 (2011), and may be equally applicable to this context.

117. VT. STAT. ANN. tit. 18, § 5281(5) (2019).

determination that a patient's judgment is impaired is a finding that the patient has not satisfied one of the applicable legal standards of competence. A similar meaning of "impaired judgment" can be inferred from the language of the other states' statutes as well. When referring to capacity, the legislatures clearly focus on patients' abilities to *make and communicate* a treatment decision. It is therefore highly unlikely that the legislatures would have inserted the term "impaired judgment" to refer to something *other than* impairment in the ability to effectively employ one's mental faculties in making such a decision. The core concern regarding capacity, as laid out in those statutes, is whether the patient is able to make a decision "based on an understanding . . . of the relevant facts . . . after being fully informed by the attending physician" of the elements of disclosure laid out in the statute.¹¹⁸

It is useful to consider which of the standards of competence identified and studied by the MacArthur group are cited in the statutes. The terms "understanding" and "appreciation" appear in the statutes. Yet, there is no explicit mention of the concept of "reasoning." Some jurisdictions' statutes indicate that an "informed decision" is one that is *based on* the information provided by the attending physician. This language implies that patients must *use* the information in some way in order to demonstrate capacity. Does the concept of "making" an informed decision under the statutes necessarily require *reasoning about* the information provided, such as, for example, a weighing or balancing of risks and benefits?¹¹⁹

The lack of legislative clarity on this matter does not indicate that reasoning is irrelevant to capacity determinations under the statutes. Clinicians tasked with evaluating capacity "*to make health care decisions*" must carry out that mandate consistent with ethical and professional standards. Those standards require professionals to avail themselves of the "established scientific and professional knowledge of the discipline."¹²⁰ "Reasoning" is generally recognized as a component of human thinking essential to effective decisionmaking.¹²¹ In addition, in the decades since the publication of the MacArthur group's work, the health and mental health disciplines have generally endorsed the identified standards of competence. In light of these factors, and the important consequences of a determination of patient competence in this context, it may be appropriate for clinicians to strive to obtain a relatively comprehensive

118. CAL. HEALTH & SAFETY CODE § 443.1(i) (West 2020).

119. The Mac-CAT-T rating criteria identify four forms of Reasoning on which patients must be scored: Consequential Reasoning (identifying specific treatment effects that may follow from the choice), Comparative Reasoning (articulating some form of comparison between at least two options), Generating Consequences (considering at least two reasonable everyday consequences of the treatment choices), and Logical Consistency (demonstrating a logical relationship between the choice and the reasons articulated supporting that choice). See MACCAT-T MANUAL, *supra* note 86.

120. *Ethical Principles of Psychologists and Code of Conduct*, *supra* note 69.

121. *See, e.g.,* Jonathan St. B. T. Evans, *The Cognitive Psychology of Reasoning: An Introduction*, 46A Q. J. EXPERIMENTAL PSYCHOL. 561, 561 (1993) ("Reasoning is the central activity in intelligent thinking. It is the process by which knowledge is applied to achieve most of our goals . . . It is not surprising, therefore, that the study of reasoning has become the central focus in cognitive science.").

picture of patient decisionmaking that incorporates assessment of reasoning as well as understanding and appreciation.¹²² In the event that a patient manifests variability in performance across standards, clinicians must confront difficult decisions about how to interpret those findings in deciding the ultimate legally relevant question of competence.¹²³

None of the statutes identifies the presence of a mental disorder as dispositive of capacity. There must be evidence that the disorder or condition is causing impaired judgment (that is, interfering substantially with those mental functions that reveal effective understanding and appreciation of and, possibly also reasoning about, the disclosed treatment information). As such, states that focus on whether a psychological condition may be impairing judgment are, in effect, asking the same question as jurisdictions that simply instruct physicians and consulting mental health professionals to determine whether or not a patient is capable of making the treatment decision. All states appear to view capacity consistent with widely accepted criteria for treatment competence laid out by the MacArthur group. The existence of a mental disorder or other psychological condition, where mentioned in the statute, serves either as a trigger for more careful scrutiny of capacity, or as an explanatory factor when functional capacities are found to be impaired. It does not, however, serve as an independent basis for a finding of incapacity.

B. TREATMENT DECISIONMAKING CAPACITY AND PERSONS WITH MENTAL DISORDERS

Because of the statutory reference to “psychiatric or psychological disorder or depression causing impaired judgment,”¹²⁴ or “impaired judgment due to a mental disorder,”¹²⁵ this Subpart addresses the law, theory, and research related to the treatment decisionmaking competence of persons with mental disorders. It begins with a brief review of arguments that some have advanced suggesting that the decisional capacities of persons with mental disorders or depression should receive special scrutiny under the medical aid in dying statutes. Notably, however, modern American law presumes the competence of adults, even if those adults have mental disorders. Thus, as noted below, consistent with the provisions of U.S. medical aid in dying statutes, competence evaluations must assess the functional abilities relevant to the law rather than focus primarily on diagnostic formulations.

122. The breadth of the capacity evaluation does not, however, necessarily translate into a *higher threshold* for the demarcation of competent versus incompetent decisionmaking. See *infra* notes 266–289 and accompanying text for a discussion of this factor.

123. The fourth standard of competence assesses whether the patient can identify and communicate a treatment decision. The state statutes require that patients personally request medical aid in dying orally and in writing in order to commence the formal process for consideration of their requests. See, e.g., CAL. HEALTH & SAFETY CODE § 443.3 (a), (b) (West 2020). As such, patients’ ability to comply with these statutory requirements will inform the question of competence under the first standard.

124. See, e.g., OR. REV. STAT. § 127.825 (2017).

125. CAL. HEALTH & SAFETY CODE §§ 443.1(k), 443.5(a)(1)(iii) (West 2020).

1. *Rationales for Additional Scrutiny of Treatment Decisionmaking Capacity of Persons with Mental Disorders or Depression*

Given that medical aid in dying facilitates the hastening of death, jurists, policymakers, health care professionals, advocacy groups, and others articulate a need to protect potentially vulnerable patients from “abuse, neglect and mistakes” resulting from “subtle coercion and undue influence in end-of-life situations.”¹²⁶ In *Glucksberg*, the U.S. Supreme Court cited concerns about persons whose autonomy and well-being were compromised by factors such as “membership in a stigmatized social group.”¹²⁷ Recognizing this concern, states authorizing medical aid in dying have incorporated a range of substantive and procedural protections to protect against discrimination, abuses, and impediments to voluntary decisionmaking.¹²⁸ Empirical findings from the states reveal that, under the current statutory frameworks for medical aid in dying in the United States, deleterious impacts on disadvantaged or vulnerable subgroups have not been observed.¹²⁹

In addition to concerns about vulnerability of persons with mental disorders to coercion or abuse, or the devaluation of their lives by some in society, some observers may have questions about the capacities of persons with mental disorders to make legally competent decisions. Such questions may be grounded in inaccurate generalizations about the functioning of persons with mental disorders. Alternatively, the questions may be more narrowly and appropriately focused, consistent with scientific findings revealing that a subset of individuals with severe mental disorders demonstrate impairments in treatment decisionmaking capacity.¹³⁰

The specific reference to depression in some medical aid in dying statutes may reflect a concern that those persons who are dying from a terminal disease

126. See, e.g., *Washington v. Glucksberg*, 521 U.S. 702, 731–32 (1997); Browne Lewis, *A Deliberate Departure: Making Physician-Assisted Suicide Comfortable for Vulnerable Patients*, 70 ARK. L. REV. 1, 51 (2017) (asserting that current medical aid in dying statutes in the U.S. do not sufficiently protect vulnerable patients). But see Margaret P. Battin et al., *Legal Physician-Assisted Dying in Oregon and the Netherlands: Evidence Concerning the Impact on Patients in “Vulnerable” Groups*, 33 J. MED. ETHICS 591, 591–92 (2007) [hereinafter Battin et al., *Legal Physician-Assisted Dying*] (discussing commonly raised concerns and concluding that current statutes do not place vulnerable patients at risk); Margaret P. Battin, *Physician-Assisted Dying and the Slippery Slope: The Challenge of Empirical Evidence*, 45 WILLAMETTE L. REV. 91, 151 (2008) [hereinafter Battin, *Slippery Slope*] (same).

127. 521 U.S. at 732.

128. See *supra* note 45–52 and accompanying text; see also Thaddeus Pope, *Implementation and Practice of Physician-Assisted Death: Safeguards*, in THE NAT’L ACADEMIES OF SCI., ENG’G, AND MED., *PHYSICIAN-ASSISTED DEATH: SCANNING THE LANDSCAPE* 76, 77 (2018) [hereinafter NAS, *PHYSICIAN-ASSISTED DEATH*].

129. See Battin et al., *Legal Physician-Assisted Dying*, *supra* note 126, at 591–92; Battin, *Slippery Slope*, *supra* note 126, at 151. Indeed, to the contrary, some commentators express concern that many of the laws’ protections operate like barriers—making it difficult for many patients to access medical aid in dying—and that such barriers have disproportionate impacts on persons with limited resources, education, and medical sophistication. Courtney Campbell, *Implementation and Practice of Physician-Assisted Death: Access*, in NAS, *PHYSICIAN-ASSISTED DEATH*, *supra* note 128, at 79; Alicia Ouellette, *Barriers to Physician Aid in Dying for People with Disabilities*, 6 LAWS, no. 4, 2017, at 1, 4–7.

130. See *infra* Subpart III.B.4.

may be more prone to depression than are those in the general population,¹³¹ and that persons who are depressed are less likely to have decisional capacity.¹³² Some authors express a concern that persons with depression who elect medical aid in dying might be acting on a desire to commit suicide that is driven by psychopathology.¹³³ Unfortunately, the distinction may not always be clear between a desire to die grounded in the psychopathology of depression and a desire to die grounded in physical, emotional, and spiritual suffering caused by the terminal illness, the dying process, and associated interventions.¹³⁴ The diagnostic complexity in individual cases, or variations in the ways in which scholars and practitioners conceptualize desires to hasten death contribute to this lack of clarity.¹³⁵

131. See, e.g., *Glucksberg*, 521 U.S. at 730 (asserting a higher incidence of depression among those who are terminally ill); see *infra* note 138 and accompanying text for discussion regarding whether persons experiencing terminal illnesses reveal higher rates of mental disorders, including depression.

132. See *infra* Subpart III.B.2 and accompanying text for discussion of the research evaluating the treatment decisionmaking capacities of persons diagnosed with depression.

133. See, e.g., *Glucksberg*, 521 U.S. at 730–31 (citing research that “uncontrolled pain” at the end of life can increase the likelihood of depression, and that many persons who request aid in dying withdraw requests if pain and depression are treated); Ellen H. Moskowitz, *Mental Illness, Physical Illness, and the Legalization of Physician-Assisted Suicide*, 24 *FORDHAM URB. L.J.* 781, 791 (1997) (expressing concern that medical aid in dying laws will facilitate suicides by some terminally ill patients with mental disorders). *But see* COUNCIL ON PSYCHIATRY & LAW, *APA RESOURCE DOCUMENT ON PHYSICIAN ASSISTED DEATH 16–18* (2017) (addressing diagnostic and conceptual complexity of determining the relationship between desire for hastened death and depression).

134. Keith G. Wilson et al., *Desire for Euthanasia or Physician-Assisted Suicide in Palliative Cancer Care*, 26 *HEALTH PSYCHOL.* 314, 321 (2007) (noting that “the influence of depressive symptoms in motivating” requests for hastened death is unclear). COUNCIL ON PSYCHIATRY & LAW, *supra* note 133, at 15–18; Wendy G. Lichtenthal et al., *Do Rates of Mental Disorders and Existential Distress among Advanced Stage Cancer Patients Increase as Death Approaches?*, 18 *PSYCHO-ONCOLOGY* 50, 59–60 (“The challenge clinicians often face distinguishing normative distress from psychopathology is only exacerbated at end of life, a time during which patients are expected to experience some distress and in addition, suffer numerous overlapping physical symptoms.”). Elizabeth Goy, Linda Ganzini, and Tony Farrenkopf observe:

Even for mental health professionals, diagnosing a major depressive disorder in terminally ill patients can be difficult. What appear to be depressive vegetative symptoms such as weight loss and loss of energy may be due to the underlying disease . . . Mild psychological symptoms such as sadness, hopelessness, and difficulty experiencing pleasure may be realistic responses to a terminal prognosis and the limitations of severe medical illness.

Elizabeth Goy et al., *Mental Health Consultation*, in *THE OREGON DEATH WITH DIGNITY ACT: A GUIDEBOOK FOR HEALTH CARE PROFESSIONALS* (2008).

135. Various studies have investigated the relationship between the desire to die and the diagnosis of depression, revealing patterns of findings that underscore the complexities of this area of investigation. William Breitbart et al., *Depression, Hopelessness, and Desire for Hastened Death in Terminally Ill Patients with Cancer*, 284 *J. AM. MED. ASS’N* 2907, 2907 (2000) (reporting that depression and hopelessness are the strongest predictors in study examining desire for hastened death in terminally ill cancer patients); Harvey Max Chochinov et al., *Desire for Death in the Terminally Ill*, 152 *AM. J. PSYCHIATRY* 1185, 1190 (1995); Kyriaki Mystakidou et al., *Desire for Death Near the End of Life: The Role of Depression, Anxiety and Pain*, 27 *GEN. HOSP. PSYCHIATRY* 258, 262 (reporting that psychological distress and an interaction between depression and pain medications are the strongest predictors of desire for hastened death); Keith G. Wilson et al., *supra* note 134, at 321; Keith G. Wilson et al., *Mental Disorders and the Desire for Death in Patients Receiving Palliative Care for Cancer*, 6 *BMJ SUPPORTIVE & PALLIATIVE CARE* 170, 173 (2016) (reporting a higher proportion of palliative care patients with a depressive or anxiety-based mental disorder who expressed a serious desire for death than

The Canadian Parliament requested that a Canadian Academies group address questions relating to medical aid in dying and patients with mental disorder.¹³⁶ The panel summarized the concerns about the relationship between mental disorder and requests to hasten death:

In some instances (e.g., certain neurocognitive disorders like dementia, neurodevelopmental disorders and intellectual disabilities, and some cases of schizophrenia), there is a clear decline in the cognitive abilities needed to understand and appreciate information. In other instances (e.g., depressive, bipolar, and anxiety disorders), a person's capacity for making decisions can be impaired by the disorder's impact on their mood and emotions. For example, depression can impair one's ability to deliberate about the future . . . or to maintain a minimal concern for self[.] Furthermore, some disorders, such as bipolar disorder, may be characterized by manic, depressive, or mixed states, in which the impact of emotion on capacity will vary.¹³⁷

The legally relevant question, of course, with respect to mental health assessments under the medical aid in dying statutes is whether the patient's treatment decisionmaking capacity is impaired.¹³⁸ Persons with mental disorders, by definition, experience some variant of atypical functioning in

patients with no such disorder). *But see* COUNCIL ON PSYCHIATRY & LAW, *supra* note 133, at 15–18 (discussing the complex relationship of depression and the desire to die at the end of life and attendant diagnostic challenges); Linda Ganzini et al., *The Effect of Depression Treatment on Elderly Patients' Preferences for Life-Sustaining Medical Therapy*, 151 AM. J. PSYCHIATRY 1631, 1634 (1994) (reporting that treatment of depression did not alter mild to moderately depressed patient's preferences to terminate life-sustaining treatment, but did alter the preferences of some more severely depressed patients); Lichtenhal et al., *supra* note 134, at 59 (reporting data that do not support the "common speculation that rates of depressive and anxiety disorders increase as patients approach death"); Ashok J. Bharucha et al., *The Pursuit of Physician-Assisted Suicide: Role of Psychiatric Factors*, 6 J. PALLIATIVE MED. 873, 873, 881-82 (2003) (reporting results from an empirical study examining the relationship of depression, decisionmaking capacity, and the desire for hastened death, and highlighting "the importance of avoiding reductionist understanding of the role of psychiatric illnesses in contributing to the serious pursuit of" medical aid in dying).

136. WHERE MENTAL DISORDER IS THE SOLE UNDERLYING MEDICAL CONDITION, *supra* note 49, at 64 (citations omitted). For additional discussion of the possible impacts of mental disorder on treatment decisionmaking in the context of medical aid in dying, see, for example, Goy et al., *supra* note 134; COUNCIL ON PSYCHIATRY & LAW, *supra* note 133, at 15–18 (focusing on the relationship between the presence of depression and a desire to die in the population of persons experiencing terminal illnesses).

137. WHERE MENTAL DISORDER IS THE SOLE UNDERLYING MEDICAL CONDITION, *supra* note 49, at 64 (citations omitted). For additional discussions of the possible impacts of mental disorder on treatment decisionmaking in the context of medical aid in dying, see, for example, Goy et al., *supra* note 134; COUNCIL ON PSYCHIATRY & LAW, *supra* note 133, at 15–18 (focusing on the relationship between the presence of depression and a desire to die in the population of persons experiencing terminal illnesses).

138. After reviewing the relevant research, psychologist James Werth Jr. stated, in language still appropriate today:

[W]hether clinical depression is present in a given individual tells us very little about that person's true desire for death, capacity to decide to hasten death, or whether a desire for death is or is not rational, reasonable, or impaired; depression is only one piece of a much larger puzzle related to a particular person's desire to die.

James L. Werth, Jr., *Clinical Depression and the Desire for Death Among Persons with Terminal Illnesses*, 5 SOC. PATHOLOGY 22, 33 (1999).

cognitive, emotional, or behavioral domains.¹³⁹ Thus, the decisionmaking capacity of some subset of those persons might be deleteriously affected. Categorical presumptions of incapacity of persons with mental disorders are legally disfavored today. Yet, there remains greater scrutiny of the decisionmaking capacities of persons with mental disorders in a range of contexts. Statutes in states like Vermont or New Jersey reflect a substantial advance away from presumptive classification of persons with mental disorders, in that they do not identify mental disorders or depression specifically as a possible basis for incapacity, but require a referral for further evaluation of decisionmaking capacity based on initial determination that such capacities may be impaired.¹⁴⁰

2. *Diagnosis of Mental Disorder or Depression and Presumption of Incapacity*

Under modern legal standards, adults are presumed competent to make treatment decisions. In the United States, modern law recognizes “a rebuttable presumption affecting the burden of proof that all persons have the capacity to make decisions and to be responsible for their acts or decisions.”¹⁴¹ A diagnosis of a mental or physical disorder does not create a presumption of incompetence.¹⁴² MacArthur researchers Thomas Grisso and Paul Appelbaum assert that the “most fundamental, important, and uncontroversial maxim [they] can offer about the modern concept of legal competence is that [the] presumption” that persons with mental disorders, mental disabilities, or cognitive impairments are *per se* incompetent to make treatment decisions “is obsolete.”¹⁴³

Prior to the latter decades of the 20th Century, persons with mental disorders were considered *de facto* incompetent relative to most legal capacities, including relative to treatment decisionmaking capacity.¹⁴⁴ Despite the shift in

139. According to the DSM-V, a “mental disorder is a syndrome characterized by clinically significant disturbance in an individual’s cognition, emotion regulation, or behavior that reflects a dysfunction in the psychological, biological, or developmental processes underlying mental functioning.” DSM-V, *supra* note 16, at 20.

140. See *supra* notes 108–111 and accompanying text.

141. CAL. PROB. CODE § 810(a)–(b) (West 2020) (“A person who has a mental or physical disorder may still be capable of contracting, conveying, marrying, making medical decisions, executing wills or trusts, and performing other actions.”); CAL. WELF. & INST. CODE § 5331 (West 2020) (“No person may be presumed to be incompetent because he or she has been evaluated or treated for mental disorder or chronic alcoholism, regardless of whether such evaluation or treatment was voluntarily or involuntarily received.”).

142. GRISSO, *supra* note 89, at 392 (“The mere fact of mental illness, disability, or involuntary hospitalization does not create a presumption of incompetence to consent to or refuse most treatments.”).

143. GRISSO & APPELBAUM, *supra* note 10, at 18–19 (“Courts across the land have made it consistently clear that the presence of mental illness, mental retardation, or dementia alone does not render a person incompetent.”).

144. “Courts often accepted a clinician’s diagnosis of mental illness as all that was required to settle the matter” of a person’s competence to consent to treatment. *Id.* The presumption that persons with “serious mental illness” were *per se* incompetent to consent to treatment was generally recognized by both mental health practitioners and actors in the legal system. *Id.*; see also Celia B. Fisher, *A Goodness-of-Fit Ethic for Informed*

the formal status of persons with mental disorders regarding presumptions of capacity, there remain legal actors and medical and mental health professionals who assume that mental disorders or psychological conditions render an individual *per se* incompetent to make treatment decisions.¹⁴⁵ In the context of medical aid in dying, evidence of this bias can be found in a national survey of mental health practitioners conducted shortly after the passage of Oregon's Death with Dignity statute. It revealed that, for example, a substantial proportion of respondents viewed a diagnosis of one of several depressive disorders as a *per se* basis for a determination of incompetence to choose medical aid in dying.¹⁴⁶ Yet, in another study,¹⁴⁷ when study participant licensed psychologists were provided with vignettes of hypothetical patients requesting medical aid in dying, and the patient characteristics included scores on a clinical measure of depression *and* scores on a measure operationalizing legal standards of treatment decisionmaking competence,¹⁴⁸ the participants prioritized the competence data in evaluating treatment decisionmaking capacity.¹⁴⁹ This finding may indicate that, in the presence of clinical data more relevant to the legal criteria than diagnosis, practitioners focus on the former, minimizing the impact of *a priori* presumptions about the relationship of depression and decisionmaking competence.¹⁵⁰ There is, however, a need for additional research addressing the

Consent, 30 FORDHAM URB. L.J. 159, 159 (2002) (“Historically, adults with known mental disorders were presumed incompetent and restricted from opportunities to make decisions for themselves.”); Bruce J. Winick, *The Side Effects of Incompetency Labeling and the Implications for Mental Health Law*, 1 PSYCHOL. PUB. POL’Y & L. 6, 12 (1995) (observing, in the 1990’s, that the law often regarded persons with mental disorders as legally incompetent).

145. Bruce J. Winick, *The MacArthur Treatment Competence Study: Legal and Therapeutic Implications*, 2 PSYCHOL. PUB. POL’Y & L. 137, 151, 153 (1996) (“In the 19th century, mental illness was regarded as . . . invariably destroy[ing] decision-making ability. . . . Modern American mental health law has been moving in the direction of a presumption in favor of competence. Yet, 19th-century notions equating mental illness with incompetence continue to influence legal rules and practices in this area.”) (footnotes omitted).

146. See, e.g., Linda Ganzini et al., *Evaluation of Competence to Consent to Assisted Suicide: Views of Forensic Psychiatrists*, 157 AM. J. PSYCHIATRY 595, 599 tbl.4 (2000). In a national survey of forensic psychiatrists, fifty-eight percent of respondents viewed diagnosis of a major depressive disorder as dispositive of incompetence. *Id.* Approximately one-third of respondents also viewed a patient’s diagnosis with several less serious depressive disorders, including “adjustment disorder with depressed mood,” as providing conclusive evidence of incompetence to choose medical aid in dying. *Id.*

147. Shara M. Johnson et al., *What Patient and Psychologist Characteristics Are Important in Competency for Physician-Assisted Suicide Evaluations?*, 21 PSYCHOL. PUB. POL’Y & L. 420, 421 (2015).

148. For discussion of the measure, the MacCAT-T and its development, see *supra* 84–87 and accompanying text.

149. Johnson et al., *supra* note 147, at 428.

150. Alternatively, or in addition, the differential findings of this study and the reporting may reflect differences between the disciplines of practitioners, increasing sophistication about assessment of treatment decisionmaking capacity within the mental health professions, and shifts in attitudes about the acceptability of medical aid in dying. Ganzini et al., *supra* note 146, at 600. Ironically, however, Johnson and colleagues’ own commentary regarding this finding is somewhat puzzling:

Clinicians were provided with a [Beck Depression Inventory] score for the patient in the vignette as one means of manipulating competence and in an effort to gauge the importance of depressive symptoms in a competence evaluation [for medical aid in dying] Despite the emphasis placed on depressive disorders by the statute, the perceived importance of the [Beck Depression Inventory]

ways in which clinicians tasked with performing mental health evaluations under the medical aid in dying statutes incorporate data regarding mental disorder and depression.

3. *Determination of Psycholegal Capacities Through Assessment of Functional Abilities*

One of the most important research contributions to our understanding of legal competencies is the core principle that determinations of individual's capacities must be based on direct assessment of the *functional abilities* that are required under the applicable legal standard.¹⁵¹ The existence of a mental disorder, cognitive impairment, or other condition should not, in itself, trigger a suspicion of incompetence.¹⁵² By contrast, the observed *effects* of a mental disorder, cognitive impairment, or other condition on an individual's functioning in a sphere relevant to a legal competency can, and often should, lead a legal actor or health care professional to inquire as to a person's capacity relative to the applicable legal standard.¹⁵³ Such suspicions about capacity are not dispositive evidence of legal competence. Rather, they can serve as a basis of a referral for a *criterion-relevant* assessment that incorporates operationalization of the applicable legal standard.

Only in a very limited subset of cases will individuals manifest pervasive and global incapacity across functional spheres.¹⁵⁴ Because each type of legal competence is defined by functional criteria relevant to *that* legal context, assessments of each type of competence must track those situation-specific functional criteria.¹⁵⁵ Therefore, impairments affecting capacity in one legal

scores was unrelated to competence decisions, complicating the importance of depressive symptoms in [medical aid in dying] competence evaluations. . . . [T]he disconnect between the null influence of [depression inventory] scores and the fact that depression is specifically cited *in* the law is potentially troublesome.

Johnson et al., *supra* note 147, at 428. My interpretation of Johnson and colleagues' findings regarding the relationship between clinical evaluations of competence in the context of evidence of depression and MacCAT-T scores differs. The study participants appear to be *properly* interpreting the statutory requirement that—in the absence of impairments in decisionmaking capacity due to a mental disorder or depression—the presence of a mental disorder, including depression, does not lead to a finding of incapacity.

151. See, e.g., KIM, *supra* note 89, at 11 (referring to the “functionalist model of competence” as meaning that “a person's capacity status is determined by his demonstrable abilities” rather than a diagnosis or label).

152. Morse, *supra* note 111, at 895 (“Mental disorder per se is not a sufficient criterion for special legal treatment. All mental health laws require further legally relevant behavior, which is in fact the law's primary concern.”).

153. GRISSE & APPELBAUM, *supra* note 10, at 19–20 (observing that there can be a relation between impaired mental states and legal incompetence in that those conditions can increase the risk that one's functioning in the realm of treatment competence may be affected).

154. “Until recent years, the law tended to perceive individuals simply as incompetent or competent for all [legal] purposes.” *Id.* at 21.

155. GRISSE, *supra* note 89, at 9 (“No single legal criterion or test applies across all legal competencies. Each legal competence refers to somewhat different abilities.”). “Unfortunately, many writers and professionals—including, but not limited to . . . policymakers and health care personnel—fail to differentiate among the various legal competencies.” Lois A. Weithorn, *Children's Capacities in Legal Contexts*, in 4 CHILDREN, MENTAL HEALTH, & THE LAW 25, 49 (N. Dickon Reppucci et al. eds., 1984). The legal, and therefore

sphere do not necessarily predict capacity in another legal sphere and do not obviate the necessity to perform focused criterion-relevant assessments of capacity targeted to any other legal question of interest.

4. *Empirical Research on Capacities of Persons with Mental Disorders to Make Treatment Decisions*

The MacArthur Treatment Competence Study incorporated into its landmark work an ambitious assessment and comparison of the decisionmaking capacities of groups of hospitalized patients with psychiatric and medical conditions and non-hospitalized persons in the community.¹⁵⁶ Recently hospitalized patients diagnosed with schizophrenia or schizoaffective disorder, major depression, or ischemic heart disease, and a non-ill community group were compared on measures of all four standards of treatment competence. The findings revealed substantial heterogeneity within and across the two groups of patients with mental disorders, with “impairments in performance . . . more pronounced and more consistent across measures for the schizophrenia patients than for patients with depression.”¹⁵⁷ The investigators observed statistically significant differences between patients with mental disorders and other groups, particularly those patients with schizophrenia.¹⁵⁸ Approximately 25% of the schizophrenic group scored in the “impaired” range on each measure of capacity, compared with 5-7% of the heart disease patients and 2% of the community group.¹⁵⁹ At the same time, according to the researchers, approximately one-half of the schizophrenia group and three-quarters of the depression group “performed in the ‘adequate’ range . . . across all decisionmaking measures.”¹⁶⁰ The authors further point out that “the rate of adequate performance rose to roughly 75% for patients with schizophrenia and to approximately 90% or more for patients with depression” when examining the results from the single standard of competence that is relied upon in many jurisdictions (that is, “understanding”).¹⁶¹

Subsequent studies report consistent results.¹⁶² For example, David Okai and colleagues review a series of studies and conclude that research comparing

also psychological, standards for competence to make treatment decisions differ from competence to testify or competence to stand trial. *Id.* at 49–50. Furthermore, even in the context of the same legal standard, situational variables may present patients with more challenging, or more emotionally charged, information to process and apply in one context versus another. For expanded discussion of such additional relevant factors, see, for example, GRISSO & APPELBAUM, *supra* note 10, 21–24.

156. Grisso & Applebaum, *MacArthur III*, *supra* note 81, at 150.

157. *Id.* at 169.

158. *Id.* at 171.

159. *Id.*

160. *Id.*

161. *Id.*

162. David Okai et al., *Mental Capacity in Psychiatric Patients: Systematic Review*, 191 BRITISH J. PSYCHIATRY 291, 291 (2007); see also KIM, *supra* note 89, at 58–59; Vanessa Raymont et al., *Prevalence of Mental Incapacity in Medical In-Patients and Associated Risk Factors: Cross-Sectional Study*, 134 LANCET 1421, 1425–26 (2004).

the decisionmaking capacities of hospitalized psychiatric patients and medical patients typically found most patients in the former group to be competent and did not observe substantial differences between the groups.¹⁶³ The authors note the striking consistency of findings across studies.¹⁶⁴ In an excellent analysis of the empirical literature on the impact of mental and cognitive disorders on treatment capacities, Scott Kim emphasizes the variations in patients' assessed treatment decisionmaking capacities within diagnostic categories.¹⁶⁵ He observes, for example, that while chronic psychotic disorders present a risk of incompetence, "there is tremendous heterogeneity in that group," with many such patients performing quite well on competence measures initially, and others improving performance with supportive interventions to promote competence.¹⁶⁶ Studies have also revealed that mild and moderately depressed individuals generally meet competence standards, as do most severely depressed persons.¹⁶⁷ Only a minority of persons with severe depression reveal impairments that interfere with treatment decisionmaking capacity.¹⁶⁸

The findings support several conclusions. First, some patients with mental disorder may experience impairments in treatment decisionmaking capacity, particularly those patients with the most severe disorders that affect cognitive processes, such as schizophrenia. Many of the empirical studies assessing treatment capacities of persons with mental disorders focus primarily on psychiatric inpatients or persons who typically fall on the higher end on the continuum of severity of symptoms. Even in this population, many patients are found competent to make their treatment decisions. Most patients seeking medical aid in dying that are diagnosed with a mental disorder are not likely to

163. Okai et al., *supra* note 162, at 295.

164. *Id.*

165. KIM, *supra* note 89, at 37–54.

166. *Id.* at 45–48.

167. *Id.* at 49–50.

168. *Id.* For several views of the relationship between depression and medical aid in dying, see, for example, Thomas Hindmarch et al., *Depression and Decision-Making Capacity for Treatment or Research: A Systematic Review*, BMC MED. ETHICS, Dec. 13, 2013, at 2; Barry Rosenfeld, *Assisted Suicide, Depression, and the Right to Die*, 6 PSYCHOL. PUB. POL'Y & L. 467, 474 (2000); James L. Werth, Jr., *supra* note 138, at 33. Hindmarch and colleagues suggest that, of the four competence standards, the one most likely to be affected by clinical depression is "appreciation," particularly to the extent that the depression interferes with a patient's ability to understand the "situation-dependent, personal implications of that decision" for herself. Hindmarch et al., *supra*, at 2–3. They further emphasize that, while treatment decisionmaking capacity is framed as relying on cognitive abilities, there is an "interplay between cognition, emotion, and [decisionmaking capacity]." *Id.* at 6. This interplay is particularly evident when decisionmaking capacity is impaired by feelings of helplessness, hopelessness, guilt, or worthlessness often associated with severe depression, which may limit the ability to "appreciate future possibilities" or interfere with the ability to "maintain a minimal concern for self." *Id.* at 6–8; see also Ian H. Gotlib & Jutta Joormann, *Cognition and Depression: Current Status and Future Directions*, 6 ANN. REV. CLINICAL PSYCHOL. 285, 286 (2010). For critiques and alternatives to the conceptualization of appreciation encompassed within the MacArthur standards, see, for example, Elyn R. Saks et al., *The California Scale of Appreciation: A New Instrument to Measure the Appreciation Component of Capacity to Consent to Research*, 10 AM. J. GERIATRIC PSYCHIATRY 166, 166–67 (2002); Christopher Slobogin, "Appreciation" as a Measure of Competency: Some Thoughts About the MacArthur Group's Approach, 2 PSYCHOL. PUB. POL'Y & L. 18, 19 (1996).

manifest the levels of severity experienced by psychiatric inpatients.¹⁶⁹ Given the heterogeneity in decisionmaking capacities observed in the groups studied in the research reported above, focused criterion-based competence assessments are essential when persons who seek medical aid in dying are referred for a mental health consultation.

Second, the findings of the MacArthur study and subsequent research reveal that the modern legal position that competence should be presumed for adults with or without mental disorders is consistent, from a statistical standpoint, with the functional abilities of many persons who fall into these two groups.¹⁷⁰ Therefore, it is appropriate to maintain this presumption until clinical evidence of incapacity leads to its rebuttal for individual patients.

Third, and related to another component of the empirical literature, patients often perform better on competence measures if they are given the opportunity to “learn” the information that is relevant to the treatment decision, either through repeated exposure, or through efforts to “teach” the information to those who do not demonstrate competence first-time around.¹⁷¹ This latter observation reinforces the more modern recognition that, at times, patients’ lack of understanding and apparent incompetence is sometimes related to deficits in communication of the health care information by practitioners.¹⁷² Thus, many scholars and health policymakers have focused attention on the need to improve such communications in order to promote patients’ understanding, reasoning, and decisionmaking regarding treatment choices.¹⁷³ Furthermore, health care practitioners must take affirmative steps to “enhance the capacity of the

169. See *infra* notes 193–200, 244–248 and accompanying text.

170. In applying a legal presumption, a court assumes that what is most likely to be true is true, unless sufficient evidence is introduced to rebut the presumption. See e.g., Jason R. Bent, *The Telltale Sign of Discrimination: Probabilities, Information Asymmetries, and the Systemic Disparate Treatment Theory*, 44 U. MICH. J.L. REFORM 797, 822 (2011); James J. Vedder & Brittney M. Miller, *Presumptions in Paternity Cases: Who Is the Father in the Eyes of the Law?*, 40 FAM. ADVOC. 26, 26 (“Legal presumptions are a useful and efficient way to deal with legal questions. A legal presumption is essentially a legal shortcut. It allows the court to reach a conclusion once a specific set of facts is established. The burden of proof then shifts to the other party to rebut the presumption.”) (citing FED. R. EVID. § 301).

171. KIM, *supra* note 89, at 47–48; William T. Carpenter, Jr. et al., *Decisional Capacity for Informed Consent in Schizophrenia Research*, 57 ARCHIVES GEN. PSYCHIATRY 533, 537 (2000); Grisso & Appelbaum, *MacArthur III*, *supra* note 81, at 173.

172. See e.g., Thaddeus Mason Pope, *Certified Patient Decision Aids: Solving Persistent Problems with Informed Consent Law*, 45 J.L. MED. & ETHICS 12, 22 (2017).

173. For summary and analysis of empirical research findings and recommendations on improving health information communication, see, for example, FOOD & DRUG ADMIN., COMMUNICATING RISKS AND BENEFITS: AN EVIDENCE-BASED USER’S GUIDE 1–2 (Baruch Fischhoff et al. eds., 2011); THE ROUTLEDGE HANDBOOK OF HEALTH COMMUNICATION 37 (Teresa L. Thompson et al. eds., 2d ed. 2003); Austin S. Babrow et al., *Managing Uncertainty in Illness Explanation: An Application of Problematic Integration Theory*, in EXPLAINING ILLNESS: RESEARCH, THEORY & STRATEGIES 41, 41 (Bryan B. Whaley ed., 2000); Ellen Peters et al., *The Functions of Affect in Health Communications and in the Construction of Health Preferences*, 56 J. COMMUNICATION S140, S156 (2006).

individual to meaningfully participate in his/her healthcare decision-making,” regardless of the initial observed level of capacity.¹⁷⁴

Substantial attention now has been directed toward the science of health information communication as an independent area of inquiry and research, as well as a component of the “shared decisionmaking” model.¹⁷⁵ This has led to development of a range of innovative strategies, including availability of “decision aids.”¹⁷⁶ Even patients with no impairments due to medical disorder can benefit from presentation of health care information in a manner that facilitates comprehension and cognitive and emotional processing by the recipient. Persons with psychological impairments are likely to benefit even more substantially from such strategies. Modern frameworks have reconceptualized communications about health care information between practitioners and patients.¹⁷⁷ Such communications are increasingly viewed as dialogues that may occur over time in multiple meetings. This contrasts with the traditional one-time and one-way interaction in which the practitioner discloses information to be received by the patient. This interactive model, frequently discussed within the “shared decisionmaking” literature, is likely to enhance patient decisionmaking capabilities and improve patients’ responses to their overall health care situation.¹⁷⁸ Patients are likely to benefit as well from

174. Barton W. Palmer & Alexandra L. Harmell, *Assessment of Healthcare Decision-Making Capacity*, 31 ARCHIVES CLINICAL NEUROPSYCHOL. 530, 537 (2016).

175. For more information about this model, see, for example, Emily Oshima Lee & Ezekiel J. Emanuel, *Shared Decision Making to Improve Care and Reduce Costs*, 368 N. ENG. J. MEDICINE 6, 6 (2013); see also DARTMOUTH-HITCHCOCK, CENTER FOR SHARED DECISION MAKING, https://med.dartmouth-hitchcock.org/csdm_toolkits.html (last visited Mar. 20, 2020); NAT’L LEARNING CONSORTIUM, SHARED DECISION MAKING (2013), www.healthit.gov/sites/default/files/nlc_shared_decision_making_fact_sheet.pdf (last visited Mar. 20, 2020).

176. See e.g., AGENCY FOR HEALTHCARE RESEARCH & QUALITY, IMPACT OF CANCER-RELATED DECISION AIDS 2–3 (2002); Annette M. O’Connor et al., *Toward The “Tipping Point”: Decision Aids and Informed Patient Choice*, 26 HEALTH AFF. 716, 717 (2007); Palmer & Harmell, *supra* note 89, at 537 (noting empirical findings on the benefits to patients of multimedia decision aids for a range of medical conditions and decision types); Pope, *supra* note 172, at 21–25 (summarizing effectiveness of patient decision aids in promoting patient understanding); Dawn Stacey et al., *Decision Aids for Patients Facing Health Treatment or Screening Decisions*, COCHRANE DATABASE OF SYSTEMATIC REVIEWS, https://www.cochrane.org/CD001431/COMMUN_decision-aids-help-people-who-are-facing-health-treatment-or-screening-decisions (last visited Mar. 20, 2020). These instruments, which may include written materials with pictorial images, videos and other multimedia modalities, or computer-based interactive approaches, take advantage of newer understandings about human learning, and have the potential to render health care information accessible to patients for whom standardized written or oral disclosures are insufficient to promote comprehension.

177. See generally BETTER DOCTORS, BETTER PATIENTS, BETTER DECISIONS: ENVISIONING HEALTH CARE 2020 (Gerd Gigerenzer et al. eds., 2011); ADRIAN EDWARDS & GLYN ELWYN, SHARED DECISION-MAKING IN HEALTH CARE: ACHIEVING EVIDENCE-BASED PATIENT CHOICE (2d ed. 2009).

178. Indeed, providing patients with information about the possible courses of their medical problems and treatment options has been shown to improve their coping, reduce anxiety, and diminish other aversive reactions. See, e.g., Erling A. Anderson, *Preoperative Preparation for Cardiac Surgery Facilitates Recovery, Reduces Psychological Distress, and Reduces the Incidence of Acute Postoperative Hypertension*, 55 J. CONSULTING & CLINICAL PSYCHOL. 513, 516–18 (1987); Paul G. Greene et al., *Preparation for Cesarean Delivery: A Multicomponent Analysis of Treatment Outcome*, 57 J. CONSULTING & CLINICAL PSYCHOL. 484, 484 (1989); Jerry Suls & Choi K. Wan, *Effects of Sensory and Procedural Information on Coping with Stressful Medical Procedures and Pain: A Meta-Analysis*, 57 J. CONSULTING & CLINICAL PSYCHOL. 372, 377–78 (1989). In

involvement of trusted family members and significant others in some of these informational sessions.¹⁷⁹ It is critical that any assessments of patient capacities in the context of medical aid in dying occur *only after* the evaluating practitioner ensures that patients have been adequately educated about the material elements of information in a manner most likely to facilitate competent decisionmaking.

Research reveals that the treatment decisionmaking capacities of patients who are seriously ill— a subset of whom may request medical aid in dying— may shift over time due to fluctuations in their medical condition, emotional state, and treatment effects.¹⁸⁰ Therefore, repeated assessment of competence may be warranted when the initial evaluation reveals impairments in decisionmaking skills.¹⁸¹ Such a practice increases the likelihood that evaluators will obtain a more comprehensive picture of these patients' abilities.

C. THE POPULATION: WHO SEEKS MEDICAL AID IN DYING IN THE UNITED STATES?

1. Data from the States

The most substantial body of data about the persons who seek medical aid in dying in the United States can be found on the website of the Health Authority of the State of Oregon.¹⁸² Since the inception of Oregon's policy, prescriptions for lethal medication were provided under the statute for 2217 people. Of these 1459 or 65.8% are known to have died from ingesting the medication.¹⁸³ The rate of the statute's usage has increased gradually throughout the twenty years that the option for medical aid in dying has been available.¹⁸⁴ The cumulative 20-year data reveals that patients who have used the prescription to hasten their deaths present a distinct demographic profile. They are predominantly age 65 and older (72.8%) with a median age of 72 years, 96.4% White, and most (73%)

addition, open, responsive, and interactive communication improves the rapport and relationship between the practitioner and patient. See Jennifer Fong Ha et al., *Doctor-Patient Communication: A Review*, 10 OSCHSNER J. 38, 38–39 (2010); John M. Traveline, et al., *Patient-Physician Communication: Why and How*, 105 J. AM. OSTEOPATHIC ASS'N. 13, 14 (2005).

179. For a discussion of the importance of relationships to promoting effective end-of-life decisionmaking and enhancing decisionmaking capacity, see Wright, *supra* note 64.

180. NANCY BERLINGER ET AL., *THE HASTINGS CENTER GUIDELINES FOR DECISIONS ON LIFE-SUSTAINING TREATMENT AND CARE NEAR THE END OF LIFE* 53 (2d ed. 2013) (citing as “reversible” factors affecting capacity of medical patients: “fatigue, metabolic factors, overmedication, undertreatment of pain, or delirium induced by the stress of hospitalization”).

181. See Palmer & Harnell, *supra* note 174, at 537–38 (emphasizing the importance of *reassessment* of capacity when a patient does not initially test as capable, in light of factors such as fatigue, anxiety, fluctuations in health status, or need for further education).

182. The state publishes an annual report, which contains cumulative information dating back to the implementation of the law in 1998. See, e.g., OREGON HEALTH AUTHORITY, *OREGON DEATH WITH DIGNITY ACT: 2018 DATA SUMMARY* 4 (2019).

183. *Id.* at 5.

184. *Id.* at 4 fig.1. The year 2018 saw the highest usage, with 249 requests for prescriptions granted and 157 deaths from ingesting the medication. *Id.* at 5. Forty-eight persons are known not to have ingested the medication, while the ingestion status of another forty-three patients is not yet known. *Id.*

have had at least some college education.¹⁸⁵ Most (90.2%) were enrolled in hospice, and almost all (98.8%) were covered by either private or public insurance.¹⁸⁶ The qualifying medical condition for 76% of the patients was some form of cancer, 11% were diagnosed with a neurological disease such as amyotrophic lateral sclerosis (ALS), 9.5% were diagnosed with cardiac disease, and 7.7% were diagnosed with respiratory disease.¹⁸⁷ Oregon regularly collects data on the end of life concerns that lead patients to choose medical aid in dying. Patients can cite multiple reasons. The twenty-year data reveal that the most significant motivators are psychological and psychosocial: loss of autonomy (95.5%), lessened ability to engage in life activities (94.6%), and loss of dignity (79.4%).¹⁸⁸ Other concerns cited focus on loss of control of bodily functions (56.5%), possible burdens on family, friends and caregivers (51.9%), worries regarding inadequate pain control (29.8%) and financial implications of treatment (4.7%).

Oregon reports how many of the patients who ultimately died from ingestion of lethal prescriptions had been referred for mental health evaluation (4.5% over twenty years).¹⁸⁹ Clearly, if those patients were approved for receipt of the lethal prescription, compliance by the prescribing health care professional requires that those patients were determined to be competent by the consulting mental health professional. Yet, there are several other groups of patients for whom data are not available. Oregon does not provide data on whether patients who received prescriptions, but did not take the medication, had been referred for a mental health evaluation. It also does not report data on patients who requested medical aid in dying, were referred for mental health evaluation, and were found not to be competent.¹⁹⁰ Thus, we must rely on data obtained independently by other researchers to learn about the mental health status of patients seeking medical aid in dying who did not die from the lethal prescriptions.

Washington's statute has been operative since 2009, and the state's data summaries report statistics through 2017.¹⁹¹ The findings from Washington and the other states issuing reports, including California, present a fairly similar picture, demographically, and with respect to underlying medical conditions, to that reported by Oregon.¹⁹² As in Oregon, the state-reported data tell us nothing

185. *Id.* at 8 tbl.1. The percentage of persons using medical aid in dying in Oregon who have completed college or have graduate degrees is 43.8. *Id.*

186. *Id.* at 10 tbl.1.

187. *Id.* at 11 tbl.1.

188. *Id.* at 12 tbl.1.

189. *Id.* at 11 tbl.1.

190. There are other subsets of patients for whom data regarding mental health status is also not available, such as patients who were referred for a mental health evaluation, but became too ill to proceed, or died prior to completing the process.

191. WASH. STATE DEP'T OF HEALTH, 2018 DEATH WITH DIGNITY ACT REPORT 5 (2019), <https://www.doh.wa.gov/Portals/1/Documents/Pubs/422-109-DeathWithDignityAct2018.pdf>.

192. For example, in 2017, 74% of patients who hastened their deaths under the provisions of the Washington statute were age 65 or older; 94% were White, 75% had some college, and almost all were insured.

about patients' capacity. We can assume, of course, that those patients described in the data were determined to be competent, either by the attending physician (who did not refer for a mental health evaluation) or by the consulting mental health practitioner.

Other researchers have investigated a number of variables relating to patients seeking medical aid in dying in Oregon. According to some studies, a subset of patients who request and receive medical aid in dying appear to their physicians to be depressed or meet certain clinical criteria of depression.¹⁹³ One researcher concluded from these data that “the current practice of legalised [sic] aid in dying may allow some potentially ineligible patients to receive a prescription for a lethal drug.”¹⁹⁴ Yet, the relationship between depression and potential ineligibility for medical aid in dying is perhaps less clear than is implied here. The existence of depression—even where the condition meets criteria for a diagnosable mental disorder—does not lead to a finding, *or even a presumption*, of incompetence. This important principle not only guides modern legal formulations regarding treatment competence more generally, but also reflects the legislative intent of the drafters of the statutes of all states permitting medical aid in dying. In order to find a patient ineligible due to incapacity in Oregon and other states, the evaluator must make *two findings*. He or she must find not only that there is a mental disorder or depression, but also that such a condition is *causing impaired judgment*.¹⁹⁵

The empirical research on the capacities of patients with depressive disorders suggests that most will meet legal standards for treatment decisionmaking capacity—or in the language of the statutes—would not manifest impaired judgment.¹⁹⁶ Such capacity must be evaluated directly with a

Id. at 6 tbl.1. The distribution of categories of underlying disease and concerns motivating use of medical aid in dying track the Oregon data fairly closely. *Id.* at 6, 8 tbl.1. Even California, with its ethnic diversity, reports that 88.9% of persons hastening their deaths through medical aid in dying were White, and 72.7% had some college education. CAL. DEP'T OF PUB. HEALTH, CALIFORNIA END OF LIFE OPTION ACT 2017 DATA REPORT 4 (2018), <https://www.cdph.ca.gov/Programs/CHSI/CDPH%20Document%20Library/2017EOLADataReport.pdf>. Data collected Vermont, and Colorado also present a consistent picture. See VT. DEP'T OF HEALTH, REPORT CONCERNING PATIENT CHOICE AT THE END OF LIFE (2018), <https://legislature.vermont.gov/assets/Legislative-Reports/2018-Patient-Choice-Legislative-Report-12-14-17.pdf>; COLORADO DEP'T OF PUB. HEALTH & ENV'T, COLORADO END-OF-LIFE OPTIONS ACT, YEAR TWO, 2018 DATA SUMMARY, WITH UPDATES TO 2017 DATA (2018), <https://www.deathwithdignity.org/wp-content/uploads/2015/10/2018-CO-End-of-Life-Options-Act-Annual-Report.pdf>. Hawaii, the District of Columbia, New Jersey, and Maine have not yet published data reports.

193. Diane E. Meier et al., *Characteristics of Patients Requesting and Receiving Physician-Assisted Death*, 163 ARCHIVES INTERNAL MED. 1537, 1538 (2003). Linda Ganzini et al., *Prevalence of Depression and Anxiety in Patients Requesting Physicians' Aid in Dying: Cross Sectional Survey*, BMJ, Aug. 2018, at 1.

194. *Id.* at 3.

195. The pertinent provisions of the Oregon statute read: “If in the opinion of the attending physician . . . a patient may be suffering from a psychiatric or psychological disorder or depression causing impaired judgment,” a referral to a consulting mental health professional is made, with no life-ending drugs provided until that consultant “determines that the patient is not suffering from a psychiatric or psychological disorder or depression causing impaired judgment.” OR. REV. STAT. § 127.825 (2017).

196. See *supra* Subpart III.B.4.

functional assessment using criterion-relevant measures or techniques.¹⁹⁷ Thus, while it is troubling that there is a dearth of data as to what proportion of patients *requesting* medical aid in dying might be disqualified because of mental disorders impairing judgment, we must also be cautious about questioning the eligibility of depressed patients who were found capable. Without more information, we do not know whether physicians were applying the statutory requirements correctly—requiring both findings—or whether other factors led to the inclusion of some persons viewed or diagnosed as depressed.¹⁹⁸ Dr. Diane Meier and colleagues observe:

While our respondents were less likely to honor a request for assistance in dying from a depressed patient, nonetheless physicians did assist some individuals whom they believed were depressed at the time of their request. . . . [P]hysicians may reason that it is normal to be depressed or may be unable to distinguish depression from sadness under circumstances of terminal illness, may believe that depression in this clinical context is untreatable, or may have tried and failed to treat their patient's depression. It is also possible that they believed that depression was not interfering with decisional capacity and was not the primary reason for the request, and was therefore of less salience in their decision to honor it.¹⁹⁹

Meier and colleagues recommend education of physicians regarding the prevalence and treatability of depression in the population of persons experiencing a terminal illness.²⁰⁰

While it is important not to presume incapacity based on the presence of a mental disorder, psychological symptoms, or depression, it is also important that the psychological suffering and mental health challenges of persons requesting medical aid in dying be identified when they exist. To the extent that these experiences and conditions impair capacity to decide regarding medical aid in dying, such information is relevant to that person's eligibility under the statutes. Yet, even for persons who meet statutory capacity requirements, whether or not they meet criteria for diagnosis of a mental disorder, the medical aid in dying request provides an opportunity for health care personnel to offer support and services that might ease such suffering.²⁰¹

197. *See supra* Subpart IV.B.

198. Ironically, the researchers administered the MacArthur competence assessment tool to determine if the individual was competent to consent to the *research* participation. Ganzini et al., *supra* note 193, at 2. All participants were determined to be competent. *Id.* at 1. While capacity to consent to the research study and capacity to consent to medical aid in dying will differ because the types of information to be understood, appreciated, and reasoned about are not identical, there is substantial similarity in competence to consent to treatment and to research. *Id.* at 2. The competence of the participants to consent to research may provide some support for the hypothesis that these individuals' depressive symptoms had minimal impact on those facets of their judgment necessary to satisfy the competence standards. *See id.* at 2.

199. Meier et al., *supra* note 193, at 1541.

200. *Id.*

201. *See infra* Part V.

2. *Psychological and Neurocognitive Factors Affecting Persons at the End of Life Due to a Terminal Illness*

a. *Psychological Distress or Mental Disorder*

There is general agreement in the scientific literature that persons in the later stages of terminal disease experience emotional suffering to a greater extent than do persons in the general population.²⁰² “A life-threatening illness has widespread ramifications affecting a person’s physical, emotional, social, and spiritual well-being.”²⁰³ There is somewhat more debate, however, as to whether there is indeed a higher prevalence of *mental disorder* among those with such serious diseases. For example, Wendy Lichtenthal and colleagues found that “patients closer to death reported increased existential distress without a parallel increase in rates of psychiatric disorders.”²⁰⁴ By contrast, another study found that “about 50% (or more) of patients with advanced cancer meet criteria for a psychiatric disorder.”²⁰⁵ The investigators of this latter study caution however, that this statistic relies on the inclusion of “the diagnosis of adjustment disorder.”²⁰⁶ Adjustment disorders are typically viewed as less serious mental disorders, and are identified by the presence of certain psychological symptomatology accompanying an individual’s reaction to a stressful life event.²⁰⁷ The challenge of coping with a life-threatening disease would certainly qualify as such a stressful life event. Thus, while most studies report increased psychological distress at the end of life, reported prevalence of diagnosable mental disorders varies widely from study to study.²⁰⁸ These discrepant findings may result in part from a failure to distinguish between more and less severe

202. See, e.g., Harvey Max Chochinov, *Psychiatry and Terminal Illness*, 45 CAN. J. PSYCHIATRY 413, 146–48 (2000); Wendy Lichtenthal et al., *Do Rates of Mental Disorders and Existential Distress Among Advanced Stage Cancer Patients Increase as Death Approaches?* 18 PSYCHO-ONCOLOGY 50, 54 (2009); Alex J. Mitchell et al., *Prevalence of Depression, Anxiety, and Adjustment Disorder in Oncological, Haematological, and Palliative-Care Settings: A Meta-Analysis of 94 Interview-Based Studies*, 12 LANCET ONCOLOGY 160, 167 tbl.2 (2011).

203. Katherine LeMay & Keith Wilson, *Treatment of Existential Distress in Life Threatening Illness: A Review of Manualized Interventions*, 28 CLINICAL PSYCHOL. REV. 472, 472 (2008).

204. Lichtenthal et al., *supra* note 134, at 58.

205. Michael Miovic & Susan Block, *Psychiatric Disorders in Advanced Cancer*, 110 CANCER 1665, 1666 (2007).

206. *Id.*; see also Mitchell et al., *supra* note 202, at 170 (discussing importance of distinguishing among “major and minor depression, dysthymia, adjustment disorder, and anxiety disorder” and reporting results of a meta-analysis, revealing a rate of up to 38.2% of emotional disorder, including “all types of depression and adjustment disorder” in adults with cancer in palliative care settings).

207. See DSM-V, *supra* note 16, at 286–89.

208. See Robert L. Fine, *Depression, Anxiety, and Delirium in the Terminally Ill Patient*, 14 BAYLOR U. MED. CTR. PROC. 130, 130 (2001) (citing reports of incidence of major depression in terminally ill patients ranging from 25% to 77%); Chong Guan Ng et al., *Psychiatric Comorbidity Among Terminally Ill Patients in General Practice in the Netherlands: A Comparison Between Patients with Cancer and Heart Failure*, BRITISH J. GEN. PRAC. e63, e63, e66, e67 (2013) (citing prior estimated rates of psychiatric disorder in patients with cancer of 20 to 60 percent and reporting high use of psychotropic drugs at end of life).

conditions. Another factor explaining inconsistent results across studies may be variations in sampling, such as differences in the stage of disease progression of patients included in the estimates.²⁰⁹ Finally, variations in reports may result from the challenges of distinguishing between the presence of a mental disorder and the psychological distress attendant to the grief, loss, and suffering that often accompanies the process of dying from a terminal disease.²¹⁰

Persons who meet the medical qualifications for aid in dying in the United States may be at a higher risk than are persons in the general population for a range of manifestations of psychological distress, whether or not those experiences and symptoms satisfy diagnostic requirements for a mental disorder. Clinicians assessing competence under the medical aid in dying statutes must be attuned to these symptoms and determine whether these symptoms impair decisionmaking capacity. Furthermore, as discussed below, clinicians must also consider whether there are psychological or psychopharmacological treatment interventions that might mitigate the patient's distress, symptoms, or disorder. Informing patients of these treatment options falls within the charge of health care professionals under the medical aid in dying statutes, encompassed within the requirement to inform patients of alternative treatments, such as palliative or comfort care.²¹¹

b. Neurocognitive Impairments

Although the medical aid in dying statutes direct attention to mental disorders and psychological conditions like various forms of depression, persons who meet the medical qualifications for medical aid in dying may be more likely to experience impairments in decisionmaking capacity due to neurocognitive challenges. Several factors place the population of persons who might qualify for medical aid in dying at greater risk than the general population for neurocognitive impairment.

A high percentage of such patients who request medical aid in dying are over age sixty-five.²¹² And, while persons over age sixty-five do not necessarily experience cognitive declines that affect treatment decisionmaking, there is a higher incidence of cognitive impairment in persons over age sixty-five than in younger persons, and that incidence increases with age.²¹³ A recent study

209. Ng et al., *supra* note 208, at e66.

210. Susan D. Block, *Assessing and Managing Depression in the Terminally Ill Patient*, 132 ANNALS INTERNAL MED. 209, 209–10 (2000); Eric W. Widera & Susan D. Block, *Managing Grief and Depression at the End of Life*, 86 AM. FAM. PHYSICIAN 259, 259 (2012).

211. Such professionals should also facilitate access to such treatment where the patient so requests. While some patients may choose to forego mental health interventions, others may elect to receive treatment, perhaps while still considering hastening death under the medical aid in dying statute. Others may decide to delay or forego medical aid in dying. Of course, patients who do not qualify for medical aid in dying because a mental disorder impairs decisionmaking judgment should also be offered appropriate mental health interventions.

212. *See supra* notes 185, 192 and accompanying text.

213. According to one report: "Dementia incidence increases exponentially with age between the ages of 65 and 90 years and doubles approximately every 5 years." María M. Corrada et al., *Dementia Incidence Continues to Increase with Age in the Oldest Old: The 90+ Study*, 67 ANNALS NEUROLOGY 114, 114 (2010). *See generally*

estimated the rate of dementia in persons age seventy-one and older to be 13.9%.²¹⁴ There is a growing body of literature examining the treatment decisionmaking capacity of older persons, although much of that literature focuses on persons who have already been diagnosed as having a condition that affects neurocognitive functioning.²¹⁵ Clinicians tasked with evaluating capacity under medical aid in dying statutes must not, of course, substitute presumptions related to age or diagnosis of a neurocognitive condition for a criterion-relevant evaluation of capacity. Stereotypes and presumptions have historically characterized social and clinical expectations of the functional abilities of older persons and must be avoided.²¹⁶

Substantial individual variability in decisionmaking capacities has been observed across patients diagnosed with neurocognitive disorders in those studies that have assessed such capacities in the context of consent to participate in treatment or research.²¹⁷ Even within the population of persons diagnosed as having a form of dementia, such as Alzheimer's Disease, "there is sufficient heterogeneity such that one cannot simply equate dementia with incapacity."²¹⁸ Jennifer Moye and colleagues have found that "most individuals with mild dementia can participate in decision making as defined by legal standards for competency," particularly with additional supports to compensate for areas in which there may be deficits.²¹⁹ Furthermore, studies indicate that some decisionmaking domains are affected to a greater extent than others in mild to moderate neurocognitive conditions.²²⁰ Clinicians involved in medical aid in dying capacity assessments should be knowledgeable about possible age-related changes and neurocognitive conditions that might affect evaluated patients. Such background will promote sensitivity to potential deficits. It may also facilitate practitioner enhancement of capacity with cognitive and memory supports.

Shannon M. Foster et al., *Cognitive Changes Across the Life Span*, in CHANGES IN DECISION-MAKING CAPACITY IN OLDER ADULTS: ASSESSMENT AND INTERVENTION 25 (Sarah Honn Qualls & Michael A. Smyer eds., 2007).

214. B.L. Plassman et al., *Prevalence of Dementia in the United States: The Aging, Demographics, and Memory Study*, 29 NEUROEPIDEMIOLOGY 125, 125 (2007).

215. For a summary of studies and issues relevant to research and clinical assessment, see, for example, KIM, *supra* note 89, at 40–44; Scott Y.H. Kim et al., *Current State of Research on Decision-Making Competence of Cognitively Impaired Elderly Persons*, 10 AM. J. GERIATRIC PSYCHIATRY 151, 159–60 (2002); Jennifer Moye et al., *Assessment of Capacity in an Aging Society*, 68 AM. PSYCHOLOGIST 158, 158, 167 (2013); Jennifer Moye & Daniel C. Marson, *Assessment of Decision-Making Capacity in Older Adults: An Emerging Area of Practice and Research*, 62B J. GERONTOLOGY P3, P7–P8 (2007).

216. See Michael A. Smyer, *Aging and Decision-Making Capacity: An Overview*, in CHANGES IN DECISION-MAKING CAPACITY IN OLDER ADULTS: ASSESSMENT AND INTERVENTION, *supra* note 213, at 3, 6.

217. KIM, *supra* note 89, at 42–44; Moye & Marson, *supra* note 215, at P7.

218. KIM, *supra* note 89, at 42.

219. Jennifer Moye et al., *Capacity to Consent to Treatment: Empirical Comparison of Three Instruments in Older Adults with and Without Dementia*, 44 GERONTOLOGIST 166, 174–75 (2004).

220. See, e.g., KIM, *supra* note 89, at 42–43; Jason Karlawish, *Measuring Decision-Making Capacity in Cognitively Impaired Individuals*, 16 NEURO SIGNALS 91, 97 (2008); Moye et al., *supra* note 219, at 171–72.

Studies reveal that patients with certain terminal illnesses may be at higher risk than the general population of experiencing impairments in cognition.²²¹ Some of these effects may be caused by the progress of the disease itself. Certain cancers interfere with facets of brain functioning.²²² Patients with advanced heart failure may experience altered supply of oxygen and other nutrients to the brain, leading to cognitive deterioration.²²³ It is commonly recognized that powerful chemotherapeutic agents used in the treatment of some cancers can have a deleterious impact on cognitive functioning.²²⁴ Radiation treatment may also affect cognitive functioning.²²⁵ Finally, other concomitants of terminal illness such as fatigue, cognitive overload, demands of treatment regimens and medical decisions, financial worries, efforts devoted to putting “affairs in order,” and concerns about loved ones may take a cumulative toll on cognitive functioning. Studies reveal a wide range of possible impairment, both in severity and in the aspects of functioning affected.²²⁶ The effects of all of the phenomena just cited vary substantially across patients.

Some studies have revealed manifestations of cognitive impairment in hospice patients in cases where clinical staff have not diagnosed or treated such conditions.²²⁷ The “relationships between cognitive impairment and the nature and quality of decision making in various domains among hospice patients” have not been the subject of investigation until recently.²²⁸ Thus, little is known about “whether and to what degree cognitive impairment fluctuates over time and what the effects of such fluctuations are on . . . decision making[.]”²²⁹

Two studies by Elissa Kolva and colleagues provide a bit more data.²³⁰ In one study, the researchers evaluated a sample of persons in a palliative care

221. See, e.g., Moises Gaviria et al., *Cognitive Impairment in Patients with Advanced Heart Failure and Its Implications on Decision-Making Capacity*, 17 CONGESTIVE HEART FAILURE 175, 175 (2011); J. Cara Pendergrass et al., *Cognitive Impairment Associated with Cancer: A Brief Review*, 15 INNOVATIONS CLINICAL NEUROSCI. 36, 36 (2017); Brooke Myers Sorger et al., *Decision-Making Capacity in Elderly, Terminally Ill Patients with Cancer*, 25 BEHAV. SCIS. & L. 393, 393 (2007).

222. Pendergrass et al., *supra* note 221, at 38.

223. Gaviria et al., *supra* note 221, at 176.

224. Pendergrass et al., *supra* note 221, at 37 (citing reports in the literature that between 13 and 70 percent of patients receiving chemotherapy experience some level of cognitive impairment); see also Ian F. Tannock et al., *Cognitive Impairment Associated with Chemotherapy for Cancer: Report of a Workshop*, 22 J. CLINICAL ONCOLOGY 2233, 2233 (2004).

225. Pendergrass et al., *supra* note 221, at 38.

226. *Id.* at 39–40.

227. Cynthia Z. Burton et al., *Undetected Cognitive Impairment and Decision-Making Capacity in Patients Receiving Hospice Care*, 20 AM. J. GERIATRIC PSYCHIATRY 306, 306 (2012); S.A. Irwin et al., *Unrecognised Cognitive Impairment in Hospice Patients: A Pilot Study*, 22 PALLIATIVE MED. 842, 842 (2008).

228. Irwin et al., *supra* note 227, at 846.

229. *Id.* at 846.

230. Elissa Kolva et al., *Assessing Decision-Making Capacity at End of Life*, GEN. HOSP. PSYCHIATRY, July–Aug. 2014, at 1, 1 [hereinafter Kolva et al., *End of Life*]; Elissa Kolva et al., *Assessing the Decision Making Capacity of Terminally Ill Patients with Cancer*, 26 AM. J. GERIATRIC PSYCHIATRY, May 2018, at 1, 1 [hereinafter Kolva et al., *Terminally Ill Patients*].

hospital with a diagnosis of a terminal illness and life expectancy not to exceed six months.²³¹ Administering the MacCAT-T,²³² the researchers found:

[S]tudy participants demonstrated a range of decision-making abilities across the MacCAT-T subscales. . . . However, a surprisingly large proportion of participants (75%) did not evidence significant decisional impairment on any of the MacCAT subscales. These findings echo the results found in studies in other medically ill populations including Alzheimer's disease, malignant glioma, and mild cognitive impairment; merely having a life-limiting illness is not pathognomonic for impaired decisional capacity. However, when present, decisional impairment may impact treatment choice.²³³

Of particular note, the researchers found no "significant association between MacCAT subscales and measures of depression and anxiety."²³⁴

Kolva and colleagues found higher levels of impairment in decisionmaking capacity of terminally ill patients with cancer in a palliative care hospital in a second study.²³⁵ In this study, the ill subjects were compared with demographically matched healthy volunteers from the community.²³⁶ The comparisons revealed statistically significant differences between the groups, and deficits in patients that varied across competence standards.²³⁷ In this sample, approximately half of the patient participants manifested impairment on the Understanding and Appreciation scales, while 85.4% revealed impairment on the Reasoning scale.²³⁸ The researchers hypothesized that outpatient palliative care patients would likely perform better on these measures than did the inpatient sample in the instant study.²³⁹ They also reported poor agreement between clinician judgments of decisionmaking capacity and the MacCAT-T, with the measures more sensitive to impairments.²⁴⁰

While patients in the age and illness demographics most commonly associated with requests for medical aid in dying may be at greater risk than persons in the general population of experiencing a cognitive impairment affecting treatment decisionmaking capacity, the findings of Kolva and her colleagues' suggest that substantial variability in cognitive capacity exists within this population. If there are deleterious effects on treatment decisionmaking capacity due to age, neurocognitive deficits, or deterioration in medical status, the effects will likely vary in severity across patients. Individual patients may also vary in capacity across the treatment decisionmaking domains measured by four competence standards. On the other hand, we cannot discern from the studies cited above how comparable these research samples are to the narrow

231. Kolva et al., *End of Life*, *supra* note 230, at 2.

232. See MacCAT-T Manual, *supra* note 86.

233. Kolva et al., *End of Life*, *supra* note 230, at 4 (footnotes omitted).

234. *Id.* at 5.

235. *Id.* at 1.

236. Kolva et al., *Terminally Ill Patients*, *supra* note 230, at 2–3.

237. Kolva et al., *End of Life*, *supra* note 230, at 5–6.

238. Kolva et al., *Terminally Ill Patients*, *supra* note 230, at 5.

239. *Id.* at 3.

240. *Id.* at 7–8.

and self-selected population of patients who actually seek medical aid in dying. One expert observed that the process of obtaining a prescription under the medical aid in dying law is a “marker of fortitude.”²⁴¹ That is, the legislatively mandated procedural steps require substantial proactivity and perseverance, manifested at a time when such efforts are likely highly burdensome in light of a patient’s physical and psychological limitations. Thus, persons with severe cognitive (and other psychological) impairments will be less likely to proceed down this path and successfully follow through with the multiple statutory requirements. Thus, while Kolva and colleagues’ findings are illuminating and underscore the need for careful evaluation of persons requesting medical aid in dying, they do not necessarily predict findings in the population of persons seeking medical aid in dying.

As in the case of mental disorders, a criterion-relevant assessment is essential to address the question of whether a neurocognitive limitation impairs treatment decisionmaking capacity. Even diagnosis of a neurocognitive condition does not necessarily render an individual unable to meet competence standards.²⁴² Incapacity should not be presumed from a clinical diagnosis but must be evaluated with criterion-relevant measures. Depending on the source of the impairment, assessment at a different time of day, or after certain medications have cleared from the patient’s system, may allow for a less-impaired manifestation of the patients’ decisionmaking abilities. Finally, it is possible that supportive interventions, such as educational or pharmacological interventions, may improve decisionmaking capacity.²⁴³

c. Early Data from University of California, San Francisco Medical Center

The University of California San Francisco Medical Center (UCSFMC) has developed an evidence-based assessment protocol to conduct mental health evaluations of persons requesting lethal prescriptions under California’s End of Life Option Act.²⁴⁴ UCSFMC opted to require all patients who seek medical aid in dying to be evaluated by the mental health team. Although California law does not require this step for all patients, UCSFMC made this policy decision “because of psychiatry’s expertise in assessment of decisional capacity in

241. Laura A. Petrillo et al., *How California Prepared for Implementation of Physician-Assisted Death: A Primer*, 107 AM. J. PUB. HEALTH 883, 886 (2017) (quoting a conference presenter).

242. Persons with some neurocognitive dementias, such as Alzheimer’s Disease, may not be eligible for medical aid in dying in the United States because they are typically not within six months of the expected ends of their lives when the conditions are mild enough for patients to qualify as *psychologically* capable of making the decision to choose aid in dying. By contrast, a person with mild dementia due to Alzheimer’s Disease who suffers from a comorbid qualifying medical condition, such as cancer, and whose life expectancy is not greater than six months, might satisfy both medical and psychological requirements.

243. See, e.g., Laura B. Dunn & Dilip V. Jeste, *Enhancing Informed Consent for Research and Treatment*, 24 NEUROPSYCHOPHARMACOLOGY 595, 595 (2001).

244. Bourgeois et al., *supra* note 114, at 441; see *infra* notes 245–248, 257–258, 263, 297 and accompanying text.

general” and because of the centrality of this assessment to the statutory requirements.²⁴⁵ While some may critique this decision as unduly burdensome on patients who do not require a mental health assessment under the statute,²⁴⁶ the process will allow for a more comprehensive picture of the mental health status of all persons seeking medical aid in dying at UCSFMC. Five of the first six persons evaluated were determined to be capable under the statute; the sixth person was not found to be capable.²⁴⁷ The authors draw the following conclusions:

As reflected in the case vignettes, the impact of psychiatric illness and psychiatric status regarding [medical aid in dying] requests in our cases was dimensional, not categorical. Mild to moderate depressive disorder typically does not affect cognitive status so profoundly as to render a patient incapable of decisional capacity, even for [medical aid in dying]. Similarly, mild cognitive impairment . . . may be compatible with intact decisional capacity for [medical aid in dying].²⁴⁸

IV. CONSIDERATIONS IN THE ASSESSMENT OF CAPACITY TO DECIDE REGARDING MEDICAL AID IN DYING

The statutes of jurisdictions that have enacted medical aid in dying laws in the United States provide some initial guidance as to the meaning of key terms. Some observers have concluded that the criteria laid out in the statutes are “incomplete,” “provid[ing] insufficient guidance for [health care professionals] in their assessment of the patient’s decisionmaking process.”²⁴⁹ Kim characterizes the statutory language in some jurisdictions as “tautological or empty definition[s] of incapacity” that tell us no more than that incapable patients are those who lack “the ability to make and communicate health care decisions.”²⁵⁰ Yet, the statutes are sufficiently clear in establishing that mental disorder, psychological symptomatology, or depression are not disqualifying without further demonstration of impaired decisionmaking about medical aid in dying. While further delineation of the competence standards would be helpful, the drafters may have chosen instead to allow health care practitioners to rely on the scientific literature, clinical training, and guidance from their disciplines and institutions when conducting competence evaluations.²⁵¹ In this Part, I briefly

245. Bourgeois et al., *supra* note 114, at 444–45.

246. See, e.g., Linda Ganzini, *Psychiatric Evaluations for Individuals Requesting Assisted Death in Washington and Oregon Should Not Be Mandatory*, 36 GEN. HOSP. PSYCHIATRY 10, 10 (2014).

247. Bourgeois et al., *supra* note 114, at 445–46.

248. *Id.* at 449.

249. David Orentlicher et al., *Clinical Criteria for Physician Aid in Dying*, 19 J. PALLIATIVE MED. 259, 259 (2016).

250. Scott Kim, *Concepts and Terms in Physician-Assisted Death: Competency, Decision-Making Capacity, and Voluntariness*, in NAS, PHYSICIAN-ASSISTED DEATH, *supra* note 128, at 10, 11.

251. It is not uncommon for the scientific and clinical literatures and professional guidelines to assist practitioners in interpreting and applying legal definitions in forensic evaluations. See, e.g., AM. PSYCHIATRY ASS’N, TEXTBOOK OF FORENSIC PSYCHIATRY (Liza H. Gold & Richard L. Frierson eds., 3d ed. 2018); GARY B. MELTON ET AL., PSYCHOLOGICAL EVALUATIONS FOR THE COURTS: A HANDBOOK FOR MENTAL HEALTH PROFESSIONALS AND LAWYERS (4th ed. 2018).

survey some of the guidance that has emerged and integrate it with the findings discussed in this Article.

A. EVALUATION PROCEDURES

There is a broad consensus in the scientific and clinical literatures that evaluations of capacity to make treatment decisions must incorporate data from multiple sources.²⁵² This consensus exists both generally and with specific reference to medical aid in dying.²⁵³ Medical aid in dying decisional capacity evaluations should assess the individual's functioning with enough breadth to allow causal inferences about how any observed functional deficits in the relevant statutorily required capacities relate to underlying psychological or medical conditions.²⁵⁴ The broader picture of the individual's functioning may facilitate strategies to enhance capacity, where needed, and may assist practitioners in offering patients targeted mental health services, where appropriate.

Although medical aid in dying is still a relatively new and infrequent intervention in U.S. jurisdictions, the scientific and clinical literature addressing mental health consultation consists of a solid and growing body of resources,²⁵⁵ complemented by documents developed by professional task forces and advisory groups.²⁵⁶ The literature includes reports by those directly involved with the implementation of the medical aid in dying laws in the authorizing jurisdictions.²⁵⁷ For example, the UCSFMC has developed an evidence-based

252. See, e.g., GRISSO, *supra* note 89, at 474–75; Am. Psychological Ass'n, *Specialty Guidelines for Forensic Psychology*, 68 AM. PSYCHOLOGIST 7, 15 (2013) (“Forensic practitioners ordinarily avoid relying solely on one source of data, and corroborate important data whenever feasible.”); MACCAT-T MANUAL, *supra* note 86, at vi, 2 (emphasizing the importance of integrating MacCAT-T findings with other clinical and background data). Furthermore, embedding a focused, criterion-relevant assessment keyed to legal standards in a more comprehensive assessment of mental health or psychological functioning is consistent with recommended practice for forensic evaluations more generally.

253. Goy et al., *supra* note 134, at ch. 9 (recommending use of a mini-mental status examination and other evaluation measures, as needed, to assess factors such as mental disorders, delirium, and dementia, that may limit decisionmaking capacity).

254. See GRISSO, *supra* note 89, at 29.

255. See, e.g., NAS, PHYSICIAN-ASSISTED DEATH, *supra* note 128; Cameron Stewart et al., *A Test for Mental Capacity to Request Assisted Suicide*, 37 J. MED. ETHICS 34 (2010); Richard B. Stuart & Stephen Thielke, *Protocol for the Assessment of Patient Capacity to Make End-of-Life Treatment Decisions*, 19 JAMDA 106 (2018); James L. Werth Jr. et al., *Requests for Physician-Assisted Death: Guidelines for Assessing Mental Capacity and Impaired Judgment*, 6 PSYCHOL. PUB. POL'Y & L. 348 (2000).

256. See, e.g., CAL. PSYCHOLOGICAL ASS'N, CALIFORNIA'S END OF LIFE OPTION ACT: CPA GUIDANCE FOR PSYCHOLOGISTS 9 (2017), <https://cdn.ymaws.com/www.cpapsych.org/resource/resmgr/DPA/EndOfLifeOptionAct.pdf>; COUNCIL ON PSYCHIATRY & LAW, *supra* note 133.

257. See, e.g., CINDY L. CAIN, IMPLEMENTING AID IN DYING IN CALIFORNIA: EXPERIENCES FROM OTHER STATES INDICATES THE NEED FOR STRONG IMPLEMENTATION GUIDANCE (2016) (California); Bourgeois et al., *supra* note 114 (California); Linda Ganzini et al., *Physicians' Experiences with the Oregon Death with Dignity Act*, 342 NEW ENG. J. MEDICINE 557 (2000) (Oregon); Elizabeth Trice Loggers et al., *Implementing a Death with Dignity Program at a Comprehensive Cancer Center*, 368 NEW ENG. J. MEDICINE 1417 (2013) (Washington); Meier et al., *supra* note 193 (Oregon); Petrillo et al., *supra* note 241 (California). See generally NAS, PHYSICIAN-ASSISTED DEATH, *supra* note 128 (transcribing National Academies of Sciences conference

Psychiatric Assessment Protocol for evaluation of requests under the California End of Life Option Act, which incorporates the MacArthur competence standards as well as other clinical and diagnostic data.²⁵⁸ The care and transparency that has characterized the development and implementation of the standards and procedures at UCSFMC and other institutions can guide those who do not have the benefit of similar institutional resources.

One practical limitation to conduct of comprehensive mental health evaluations has been observed.²⁵⁹ Patients requesting medical aid in dying are often experiencing significant debilitation and discomfort. Participating in the basic medical aid in dying eligibility evaluation can be quite burdensome for these patients, and many are unable to complete it. The mental health evaluation superimposes another layer of time-consuming appointments on that basic qualification process. Therefore, mental health professionals must balance comprehensiveness with concessions to the realities of the patient's situation. Otherwise, the mental health evaluation process risks creating insurmountable barriers to access for some patients.²⁶⁰

B. COMPETENCE STANDARDS AND MEASURES

Subpart III.A. above interprets the language of medical aid in dying statutes. The statutes appear to define capacity as the ability to make and communicate a decision regarding medical aid in dying. More specifically, the statutes require patient understanding of the information provided by the attending practitioner, and appreciation of the meaning of that information. Less clarity exists, however, as to whether the statutes require evidence of a logical reasoning process in patients' use of that information. One might infer that the legislatures intended that the capacity evaluation examine patient reasoning because many statutes indicate that an informed decision is one that is *based on* the information provided. Even if not explicitly mentioned in the statutes, a logical reasoning process may be implicit in the broader mandate to assess patients' "capacity to make medical decisions,"²⁶¹ particularly in light of the importance of reasoning ability to effective decisionmaking.

In the context of medical aid in dying, there is substantial consensus in the professional and scientific literature, and in recommendations of advisory

proceedings with reports from researchers on the implementation of medical aid in dying in the authorizing jurisdictions).

258. Bourgeois et al., *supra* note 114, at 446, 446 tbl. 3.

259. *See, e.g.*, COUNCIL ON PSYCHIATRY & LAW, *supra* note 133; Stewart et al., *supra* note 255.

260. *See* COUNCIL ON PSYCHIATRY & LAW, *supra* note 133, at 15 ("The strength of the depth of [Werth et al.'s] approach is . . . that it is expected to prevent erroneous granting of lethal prescriptions to [persons without decisional capacity]. However, the specificity and depth of the requirements may have the opposite effect of limiting the availability of [medical aid in dying] to those who are held to too high a standard of capacity . . ."); *see also* Charles H. Baron, *Competency and Common Law: Why and How Decision-Making Capacity Criteria Should Be Drawn from the Capacity-Determination Process*, 6 PSYCHOL., PUB. POL'Y, & L. 373, 375 (2000) (critiquing Werth et al.'s proposed guidelines as placing too heavy a burden on patients to demonstrate capacity).

261. CAL. HEALTH & SAFETY CODE §§ 443.1(k), 443.5(a)(1)(A)(iii) (West 2020) (emphasis added).

groups and task forces, that capacity evaluations should incorporate criterion-relevant assessment on all four of the standards included in the MacArthur group's work. For example, in one of the earliest and most frequently cited discussions of capacity evaluations under the Oregon statute, James Werth and colleagues recommend that all four standards be evaluated, despite the lack of explicit reference to "reasoning" in the Oregon statute.²⁶² Documents disseminated by the California Psychological Association and the American Psychiatric Association highlight consideration of all four standards of competence in capacity assessments.²⁶³

These sources typically avoid prescribing particular measures, while referencing the MacCAT-T or other instruments as examples of tools that can facilitate the assessment of the four dimensions of treatment decisionmaking capacity. One of the strengths of the MacCAT-T is that it provides a template that allows evaluators to customize the assessment inquiry and to tailor the interview questions and scoring guidelines to each treatment decisionmaking context (and each unique fact pattern that characterizes each patient's health care situation and choices). Yet, this flexibility also increases the likelihood that there may be variability in how individual examiners use the tool. The use of the MacCAT-T by clinicians might be enhanced with the development of standard items targeting assessment of capacity to decide about medical aid in dying. Such a tool could be used as an adjunct to the examiner-customized application of the MacCAT-T. Evaluators still must face the question of how high the scores must be on the various scales in order to find a patient competent. This issue is discussed in detail below.²⁶⁴

The evaluative criteria used by examiners focus primarily on cognitive decisionmaking skills. Yet, there may be substantial emotionality associated with a patient's decision to request medical aid in dying. Furthermore, when a patient experiences a mental disorder, emotional factors may have an impact on cognition. The assessment, however, must remain focused on the impact of any such factors on the cognitive tasks required for competence. Analysis of the causative role of emotional factors can assist in the explanation for any observed deficits in capacity.²⁶⁵

262. Werth Jr. et al., *supra* note 255, at 358–61, 366; *see also* Alyson L. Kepple et al., *Decision-Making Capacity at the End of Life*, 23 *PROGRESS PALLIATIVE CARE* 133, 133–35 (2015); Stewart et al., *supra*, note 255.

263. *See* CAL. PSYCHOLOGICAL ASS'N, *supra* note 256; *see also*, COUNCIL ON PSYCHIATRY & LAW, *supra* note 133. In implementing the End of Life Option Act (EOLOA) at the University of California San Francisco Medical Center (UCSF), the institution required all persons requesting medical aid in dying to be evaluated by a mental health professional. Bourgeois et al., *supra* note 114, at 444–45 (explaining that this policy is based in part on the expertise of mental health professionals in assessing capacity). The UCSF team indicated that the four MacArthur standards would be adapted for the medical aid in dying context, but also with "fidelity with the usual procedures to assess decisional capacity for all other clinical interventions." Bourgeois et al., *supra* note 114, at 445.

264. *See infra* notes 266–289 and accompanying text.

265. *See supra* note 139 and accompanying text; *see also* Gotlib & Joormann, *supra* note 168, at 287.

C. THE “THRESHOLD”: THE LINE BETWEEN COMPETENCE AND INCOMPETENCE

Identification of the substantive areas of functioning that are the focus of capacity evaluations does not resolve the problem of where to draw the line between competence and incompetence. While one of the standards, expression of choice, is a dichotomous variable, the scales measuring the other three standards are continuous variables.²⁶⁶ How high must the levels of understanding, appreciation, and reasoning be to lead to a conclusion that the patient meets the legal criterion of capacity under the statute? In developing the MacCAT-T, Grisso and Appelbaum expressly declined to set such thresholds, recognizing that such decisions are *policy* matters that reflect a number of considerations relevant to each treatment context or decision.²⁶⁷

Some scholars emphasize the importance of examining the *consequences* of a particular treatment decision when setting the threshold for competence.²⁶⁸ Some have focused on what they characterize as the “gravity” of the choice, that is, the seriousness of the consequences of the decision.²⁶⁹ This latter factor seems to argue for a higher threshold of competence for life and death decisions such as a request for physician aid in ending one’s life. Yet, on second look, focusing solely on the possibility that death may result from a patient’s choice is insufficiently nuanced. Not all life and death choices are the same. For example, the choice of death by a person who rejects a treatment with low risk that offers an excellent prognosis for a long, relatively healthy life is not the same as the choice of death by a person who is suffering greatly and for whom there is a six-month life expectancy and no available life-saving treatment. The *consequences* of a decision cannot be viewed as determined solely by the fact that death is the outcome of one of the choices.

While simple formulas are unlikely to capture the complexity of individual treatment scenarios, Kim correctly observes that “it is widely accepted that the level of abilities required—the threshold for competence—increases as the risk-to-benefit ratio increases.”²⁷⁰ In elaborating upon this “sliding scale” model, Grisso and Appelbaum point out that “[a]s a general rule, a *lower* threshold for competence is set when a patient is *accepting* a treatment option” with a high benefit, low risk profile.²⁷¹ By contrast, “a somewhat *higher* threshold for

266. See ALLEN E. BUCHANAN & DAN W. BROCK, DECIDING FOR OTHERS: THE ETHICS OF SURROGATE DECISION MAKING 26 (1990); Hindmarch et al., *supra* note 168, at 54 (observing that “impairment” of treatment decisionmaking abilities “lie on continua,” while the judgment of whether a patient is competent is “binary” and “normative,” requiring one to address the question of “how much ability a patient” must demonstrate to be determined competent).

267. MACCAT-T MANUAL, *supra* note 86, at 2.

268. GRISSO & APPELBAUM, *supra* note 10, at 24–26; KIM, *supra* note 89, at 34.

269. BEAUCHAMP & CHILDRESS, *supra* note 60, at 119 (describing, although not necessarily endorsing, the view that “[i]f the consequences to welfare are grave, the need to certify that the patient possesses the requisite capacities increases,” with particular attention to “serious risk of death” as such a grave consequence).

270. KIM, *supra* note 89, at 34–35.

271. GRISSO & APPELBAUM, *supra* note 10, at 25.

competence may be required for patients who are *refusing* high benefit-low risk treatments.²⁷² Grisso and Appelbaum propose the mirror image thresholds for low benefit-high risk treatment scenarios. Of course, some fact patterns are murkier. Some risk-benefit ratios fall somewhere in between high benefit-low risk and low benefit-high risk. Sometimes high risks are paired with high benefits, and low risks with low benefits. Sometimes the certainty regarding the risks, benefits, and outcomes is less clear. And sometimes there is disagreement in the medical community as to these factors. The complexity of the analysis varies from situation to situation but will often turn on more than the fact that death is an outcome of an option.

Why is the risk-benefit profile of a choice a factor in determining the threshold at which we determine competence or incompetence? Ruth Faden and Tom Beauchamp articulate the tensions that are inherent in our society's regulation of patients' health care decisions:

The selection of abilities, thresholds, and tests will depend on moral and policy questions closely related to the concerns that shape the selection of requirements for informed consent Central issues include the number of moral principles to be balanced and the weight to be given to each principle in different circumstances. In determinations of the competence of patients[,] . . . the evaluative tradeoff is usually between two principles—the principle of respect for autonomy, on the one hand, and that of beneficence, on the other.²⁷³

The doctrine of informed consent is grounded on the notion that each of us has the right to govern what happens to our own bodies.²⁷⁴ This concept is an expression of the foundational moral, ethical, and legal notion of autonomy,²⁷⁵ now embedded as well in constitutional concepts of liberty.²⁷⁶ Yet, in our society, the state's *parens patriae* interest in our welfare (and in particular, those amongst us who may be more vulnerable and less capable), provides it with authority to interfere in our lives to promote our best interests. The bioethical concepts of beneficence and nonmaleficence encompass such paternalistic regulation.²⁷⁷

Governmental regulation of every health care decision expresses a reconciliation of the inherent tensions in balancing autonomy and beneficence. Decisions regarding which competence standards to include in an evaluation, and the thresholds to be used in applying those standards, are often

272. GRISSO & APPELBAUM, *supra* note 10, at 25.

273. FADEN & BEAUCHAMP, *supra* note 67, at 291; *see also* Ganzini et al., *supra* note 146, at 599 (“Thresholds for levels of incompetence vary by situation and may reflect social goals in tension—the degree to which society seeks to strike a balance between self-determination and protection of the patient. Standards and thresholds develop through discussion, debate, consensus, and legal decisions about competence to make particular decisions or to perform specific acts.”).

274. *See supra* notes 63–66 and accompanying text.

275. BEAUCHAMP & CHILDRESS, *supra* note 63, at 101–02, 121–25.

276. *See, e.g.*, Planned Parenthood of Se. Pa. v. Casey, 505 U.S. 833, 846–50 (1992); Cruzan v. Dir., Mo. Dept. of Health, 497 U.S. 261, 278 (1990); Washington v. Harper, 494 U.S. 210, 221–24 (1990).

277. BEAUCHAMP & CHILDRESS, *supra* note 63, at 150–54, 202–06.

manifestations of that reconciliation. Indeed, the modern history of states' policies regarding medical aid in dying demonstrates an evolution in the way these interests have been reconciled over time.

In 1997, in *Washington v. Glucksberg*, the U.S. Supreme Court concluded that Washington's asserted "unqualified interest in the preservation of human life" could constitutionally guide that state's policy choice to criminalize aid in dying for terminally ill persons in the state.²⁷⁸ The Court contrasted the policy choice made by the state of Washington with a "sliding-scale" approach that would have allowed its interest in preserving life to be balanced against the autonomy interests of those with terminal illnesses.²⁷⁹ By 2008, however, the state of Washington reversed its policy choice, adopting that sliding-scale approach and allowing the autonomy interests of those who meet certain narrow statutory requirements to override the state's interest in preserving life.²⁸⁰ In so doing, the legislature also provided some indication of where it placed the threshold for competence.

Tracking the language in the Oregon statute, the Washington legislature defined competence as "the ability to make and communicate an informed decision to health care providers."²⁸¹ As in the ordinary health care context, the legislature characterized an "informed decision," as one that "is based on an appreciation of the relevant facts and after being fully informed" of the basic elements of disclosure.²⁸² In the context of medical aid in dying, those elements include disclosures regarding the patient's condition, prognosis, risks, benefits, and alternatives to medical aid in dying. The legislature provided for greater scrutiny of capacity in the medical aid in dying context by requiring the assessment of capacity by a mental health specialist when an attending physician or consulting physician believes the patient "may be suffering from a psychiatric or psychological disorder or depression causing impaired judgment."²⁸³ In such cases, the legislature required certification from that mental health professional that the patient "is not suffering from a psychiatric or psychological disorder or depression causing impaired judgment."²⁸⁴ The legislature could have, but did not, distinguish the level of capacity needed to demonstrate competence from that required for other health care decisions or other decisions made at the end of life relating to survival. Its focus was, instead, on attaining a higher level of *certainty* about the patient's competence. In particular, it sought to achieve that heightened level of certainty through assessment by a specialist that any depression or mental disorder experienced by a patient was not impairing that patient's ability to render a competent treatment decision.

278. *Washington v. Glucksberg*, 521 U.S. 702, 728–29 (1997).

279. *Id.* at 729.

280. WASH. REV. CODE § 70.245.020 (2019).

281. *Id.* at § 70.245.010(3).

282. *Id.* at § 70.245.010(7).

283. *Id.* at § 70.245.060.

284. *Id.*

It is noteworthy that the Washington statute, and statutes of other states, do not characterize the inquiry as assessing capacity *to make decisions regarding physician aid in dying*. They focus more generically on the capacity *to make health care decisions*.²⁸⁵ These legislatures, therefore, signaled their intent that the assessment of treatment decisionmaking capacity in this context should apply the same standards used to assess capacity for other health care decisions and a similar threshold in drawing the line between capacity and incapacity.

Indeed, by narrowing the eligible population of patients to those whose illnesses are expected to cause a natural death within six months, the legislature has identified a subset of individuals whose autonomy interests are given greater weight when balanced against the state's interests in preserving life. The legislature's policy choice does not value the lives of those who are closer to death any less than the lives of other citizens.²⁸⁶ Rather, in light of the inevitability and proximity of eligible patients' deaths, it grants those patients weightier autonomy rights in decisions regarding the timing and manner of their deaths. This elevates those patients' authority to make personal choices of when and how to die. Yet, in a critical expression of the state's *parens patriae* interests in protecting those who are vulnerable, it restricts this exercise of decisionmaking autonomy to those patients who are competent, with special attention to whether a patient's decisionmaking capacities are impaired by mental disorder or other psychological symptomatology.

The risk-benefit profile of a treatment decision becomes relevant in setting the threshold for competence under the sliding-scale model because ethical values instruct us to be particularly mindful of protecting those who are not capable of exercising autonomy when the risks to their welfare from particular choices are great. In other words, we scrutinize patient decisionmaking more carefully when a person whose competence is uncertain makes a choice that entails serious risks.²⁸⁷ Kim asserts that:

[T]he goal of conducting a capacity evaluation is not simply to ensure that a patient's right to self-determination is preserved, but also to protect the incompetent from harm. Thus, a capacity determination must incorporate welfare considerations. What this shows is not that the welfare-sensitive sliding scale disregards the autonomy principle but rather that, from a societal point of view, when it comes to decisionally impaired persons (whose capacity status is uncertain), there is a strong societal interest in making sure that their welfare is protected to the extent consistent with their [capacity for] self-determination.²⁸⁸

The drafters of the Washington statute and the statutes of other jurisdictions permitting medical aid in dying made several choices with the goal of protecting the welfare of patients. One such choice is the limitation of access to medical

285. WASH. REV. CODE § 70.245(3).

286. The Court in *Washington v. Glucksberg* implied that allowing such persons to end their lives with physician assistance would have expressed such devaluation. See 521 U.S. 702, 729 (1997).

287. KIM, *supra* note 89, at 36.

288. KIM, *supra* note 89, at 36.

aid in dying to patients who are within six months of the end of their lives due to a terminal illness. Another such choice is incorporation of procedures likely to maximize the certainty of capacity determinations. Not only do two physicians evaluate the patient according to a range of statutory qualifications, but patients must be referred for a mental health consultation when there are concerns about capacity, with special attention to the possible effect that mental disorder or psychological symptomatology might be having on decisionmaking capacity. It does not appear that these legislatures intended that, in addition to these protections, a higher threshold for capacity would be applied than is employed in other important decisions made by those whose illnesses bring them close to the end of life.²⁸⁹

D. EXPERTISE AND TRAINING TO PERFORM TREATMENT DECISIONMAKING CAPACITY ASSESSMENTS

One team of health care professionals, in discussing the challenges to the implementation of California's End of Life Option Act, observed that the statute assumed "that all physicians are skilled at assessing decisionmaking capacity."²⁹⁰ Yet, available research indicates "a lack of education in [decisionmaking capacity assessment, which leads] to calls for compulsory training for physicians."²⁹¹ It is unlikely that the average health care practitioner is aware of the available evidence-based decisionmaking capacity assessment strategies and tools. Most clinicians are likely to be unfamiliar with the debates, challenges, and pitfalls relevant to the conduct of such evaluations. Even mental health professionals, as a group, may be unprepared to perform these evaluations. Indeed, one survey of psychiatrists in Oregon revealed that very few were confident about their ability to evaluate the capacity of patients under the medical aid in dying statute.²⁹²

289. As the analysis in Part C indicates, I conclude that the legislatures did not intend to apply a different threshold for capacity determinations for medical aid in dying as contrasted with other end of life decisions relating to survival. Yet, I recognize that some bioethicists, health care practitioners, and others characterize refusals of life-sustaining treatment decisions as ethically distinct from affirmative provision of a means to hasten death by medical professionals. For a discussion of the distinction between "killing and letting die," see BEAUCHAMP & CHILDRESS, *supra* note 63, at 174-86. Some might view medical aid in dying as ethically unsupportable because of the affirmative role played by health care professionals in assisting patients to hasten death. Others might view this intervention as permissible, yet require a demonstration of higher level of decisionmaking capacity in the aid in dying context. I do not elaborate on these positions here because, in the jurisdictions that authorize medical aid in dying, the policy choices implicit in these positions have been made by the legislatures of those states, reflecting a social consensus of those states' citizens.

290. Petrillo et al., *supra* note 241, at 884-86.

291. Lesley Charles et al., *Physician Education on Decision-Making Capacity Assessment*, 63 CANADIAN FAM. PHYSICIAN e21, e25 (2017) (footnotes omitted). In one study, physicians and other health care professionals working in long-term care and hospital settings revealed that their training on performing such assessments had been minimal. See Andrea K. Shreve-Neiger et al., *Assessing the Need for Decision-Making Capacity Education in Hospitals and Long Term Care (LTC) Settings*, 34 EDUC. GERONTOLOGY 259, 365-67 (2008).

292. Linda Ganzini et al., *Attitudes of Oregon Psychiatrists Toward Physician-Assisted Suicide*, 153 AM. J. PSYCHIATRY 1469, 1473-74 (1996).

Those who take on responsibility for performing decisionmaking capacity assessments under the statutes of their respective states require training beyond that necessary to be competent for general practice in their fields. Attending physicians serve as the gatekeepers for medical aid in dying in most states. Patients will not be referred to a consulting mental health professional unless the attending physician identifies concerns about the possible impairment of the patient's decisionmaking capacity.²⁹³ (Only in Hawaii are all requesting patients referred to a mental health consultant for a capacity assessment.²⁹⁴) Thus, specialized training for attending practitioners who perform this gatekeeper function is necessary to enhance their ability to make such determinations consistent with the principles discussed throughout this Article.

Several areas of expertise are required. First, practitioners must become familiar with the theory and scientific foundations of assessment of treatment decisionmaking capacity and the relevant evaluation techniques and strategies. Knowledge of the MacArthur tools, alternative instruments, and complementary clinical strategies will promote more reliable and valid assessments. Without adequate and consistent training, agreement among evaluators who perform decisional capacity assessments is poor.²⁹⁵ Furthermore, practitioners' values regarding the ethicality of medical aid in dying laws may affect the stringency or leniency of their interpretation of legal standards when performing clinical assessments in a potentially value-laden area of practice such as medical aid in dying.²⁹⁶ The tendencies of personal values to influence clinical determinations of capacity have been found to be greater when the standards and procedures for such clinician assessments are uncertain.²⁹⁷ Without formal training and knowledge of the empirical literature on the relationship between treatment decisionmaking capacity and mental disorder, clinicians may presume that presence of a mental disorder predisposes patients to incapacity.

Second, evaluators should have expertise in working with patients who are at the end of life and grappling with issues relating to death and dying.²⁹⁸ Such expertise is essential so that the evaluator can appreciate the medical features of the patient's situation and how those features might be influencing patients'

293. See, e.g., OR. REV. STAT. § 127.825 (2017); D.C. CODE § 7-661.01(4) (2019); ME. STAT. tit. 22, § 2140(8) (2019); WASH. REV. CODE § 70.245.010(5) (2019).

294. HAW. REV. STAT. § 372L-4(a)(4) (2019).

295. See, e.g., James Armontrout et al., *Do Consultation Psychiatrists, Forensic Psychiatrists, Psychiatry Trainees, and Health Care Lawyers Differ in Opinion on Gray Area Decision-Making Capacity Cases? A Vignette-Based Survey*, 57 *PSYCHOSOMATICS* 472, 475 (2016); Kim et al., *supra* note 91; Daniel C. Marson et al., *Consistency of Physician Judgments of Capacity to Consent in Mild Alzheimer's Disease*, 45 *J. AM. GERIATRICS SOC'Y* 453, 456 (1997).

296. Ganzini, *supra* note 146, at 597.

297. See Bourgeois et al., *supra* note 114, at 442–43 (expressing concern that, without training on a “clearly defined clinical method” for assessing treatment decisionmaking capacity in the context of medical aid in dying, it was possible that “psychiatrists’ own views on the ethics of [medical aid in dying] impact the ultimate decision to allow [medical aid in dying]”).

298. James L. Werth, Jr., *When is a Mental Health Professional Competent to Assess a Person's Decision to Hasten Death?*, 9 *ETHICS & BEH.* 141, 146–47 (1999).

choices. In addition, practitioners should have a baseline of experience regarding the range of psychological responses patients may have to terminal illness and impending death, and to the physiological effects of the condition and treatment interventions on the patients' functioning.

Third, evaluators must be experienced in identifying and evaluating mental disorders. Attending physicians likely require a level of sophistication to enable them to screen patients for the purposes of making referrals for mental health consultation. Mental health consultants require substantial expertise not only in generic mental health assessment, but importantly, on distinguishing between the desire to die grounded in depression or mental disorder and a desire to die grounded in physical, emotional, and spiritual suffering caused by the terminal illness, the dying process, and associated interventions.²⁹⁹ Sophistication and expertise in the assessment of these phenomena are essential not only in evaluating the impact of these experiences on capacity, but in identifying the opportunities for enhancement of decisionmaking capacities where relevant.³⁰⁰ Enhancement interventions may be most effective if they are designed with recognition of the underlying cause of the skills deficit.

Fourth, in order to execute the functions I discuss in Part V below, practitioners must have knowledge of psychotherapeutic, psychosocial, and psychopharmacological interventions potentially helpful to persons who are in the later phases of dying from a terminal disease. In that Part, I discuss the importance of informing patients seeking medical aid in dying about their other options, including palliative care interventions that can address the patients' psychological and existential distress and symptoms of a mental disorder.³⁰¹ Many health care practitioners are not knowledgeable about the range of palliative care interventions that may be available. Therefore, in order to ensure that the recommendations discussed in Part V can be implemented, clinicians involved in the medical aid in dying consultation process must become knowledgeable about such interventions.

V. INCORPORATING PSYCHOSOCIAL, PSYCHIATRIC, AND PSYCHOPHARMACOLOGICAL PALLIATIVE CARE RECOMMENDATIONS INTO MEDICAL AID IN DYING MENTAL HEALTH EVALUATIONS

Medical aid in dying statutes in the United States require that attending physicians inform patients of various elements of disclosure, such as "feasible alternatives or additional treatment opportunities, including, but not limited to, comfort care, hospice care, palliative care, and pain control."³⁰² At a conference convened in California in 2015 to address important issues in the

299. *See supra* notes 204–210 and accompanying text.

300. *See supra* notes 171–179 and accompanying text.

301. *See supra* notes 302–314 and accompanying text.

302. CAL. HEALTH & SAFETY CODE § 443.1(i)(5) (West 2020). The language in the other states is fairly similar, although some refer primarily to "comfort care, hospice care, and pain control." *See, e.g.,* OR. REV. STAT. § 127.815(E) (2017).

implementation of that state's then newly passed End of Life Option Act, participants observed that the statute does not require that participating health care practitioners "be proficient in responding to patients' end-of-life needs."³⁰³ In the context of patients who may be suffering from psychological distress or a mental disorder, proficiency in responding to patients' end-of-life care needs requires that health care providers recognize that the terms "palliative care" and "comfort care" do not refer exclusively to provision of relief for *physical* pain and discomfort associated with illnesses toward the end of life.³⁰⁴ Rather, the terms also encompass intervention designed to promote relief from psychological suffering.

Palliative care "is a broad term that refers to care provided at any point in the trajectory of an illness for the purpose of alleviating physical and psychosocial-spiritual suffering, enhancing quality of life, effectively managing symptoms, and offering comprehensive, interdisciplinary support to the patient and family throughout the course of illness."³⁰⁵ Palliative care, as contrasted with other forms of treatment, does not seek to treat the underlying disease that is threatening the patient's life. Rather, "[i]ts primary goals are to provide comfort and care for those with life-limiting illnesses and their families."³⁰⁶

The California conference presenters underscored that "providers must explore, acknowledge, and address issues that may be contributing to patients' unbearable suffering, including spiritual or physical distress, or lack of social support. . . . Providers may need training to develop these skills."³⁰⁷ Even among those who deliver palliative care services, there may be inadequate focus on psychological needs. Brian Kelly and colleagues observe that "[d]espite its ubiquitous nature, . . . psychological distress in palliative patients tends to be under-diagnosed and under-treated."³⁰⁸ Scholars and practitioners who specialize in providing palliative care emphasize the essential interrelationship of physical and psychological distress, and the need to target both sets of symptoms.³⁰⁹ In the ideal world, those patients who meet the terminal disease requirement for medical aid in dying in U.S. jurisdictions would already be

303. Petrillo et al., *supra* note 241, at 886.

304. In addition, the terms "palliative care" or "comfort care" are not synonymous with hospice care. While palliative care can be provided at any point in the trajectory of an illness, and individuals need not be dying to be considered appropriate recipients of such services, hospice "refers to an aspect of palliative care devoted to alleviating symptoms and enhancing quality of life during the last six months of life for patients who accept that disease-directed therapy can no longer benefit them." Julia E. Kasl-Godley et al., *Opportunities for Psychologists in Palliative Care: Working with Patients and Families Across the Disease Continuum*, 69 AM. PSYCHOLOGIST 364, 365 (2014).

305. *Id.*

306. Chochinov, *supra* note 15, at 85.

307. Petrillo et al., *supra* note 241, at 886.

308. Kelly et al., *supra* note 15, at 780; *see also* Mystakidou et al., *supra* note 135, at 261 (emphasizing "the importance of incorporating mental health care into traditional models of palliative care").

309. Chochinov, *supra* note 15, at 84; Robin B. Rome et al., *The Role of Palliative Care at the End of Life*, 11 OCHSNER J. 348, 348-49 (2011) (discussing the concept of "total pain," viewing the patient's "physical, psychological, social, and spiritual pain" as an interrelated phenomenon requiring coordinated intervention).

receiving palliative care from an interdisciplinary team that incorporates interventions targeting the patient's psychological distress and any mental health conditions or symptoms. Yet, many patients who are within six months of their predicted end of life might not be receiving integrated palliative care targeting the range of their physical and psychological needs. They may not even have been evaluated by a mental health professional. As such, a referral to a mental health professional under the medical aid in dying statutes presents an opportunity to further identify the patient's need for relief of suffering and to provide essential services.

Those patients who are referred for mental health evaluation—whether or not they are found to be competent under the medical aid in dying statutes—deserve the opportunity to receive palliative care services that address not only their physical pain and discomforts, but also their psychological suffering. Such referrals, ideally to palliative care specialists, should become a formal component of mental health evaluations performed under the statute. The statutory obligation for health care practitioners to inform patients of their feasible alternatives should, without question, incorporate a sophisticated discussion of the palliative care options that might alleviate psychological suffering and assist the patient and his or her family in coping with the impending death. Patients found to be ineligible to receive medical aid in dying due to decisional incapacity may be experiencing relatively severe mental health symptoms. Referral to those who can provide psychological or psychiatric palliative care is imperative. In addition, some competent patients might choose to delay hastening death by means of medical aid in dying if made aware that such interventions might provide some relief from their suffering.³¹⁰ Only with

310. While there has not been substantial empirical work directly examining this hypothesis, the research literature provides some support. One study found that treatment of depression did not alter mild to moderately depressed patients' preferences to terminate life-sustaining treatment, but did alter the preferences of some more severely depressed patients. Linda Ganzini et al., *The Effect of Depression Treatment on Elderly Patients' Preferences for Life-Sustaining Medical Therapy*, 151 AM. J. PSYCHIATRY 1631, 1631, 1635 (1994). More generally, there are studies that indicate that cancer patients can, in some instances, receive relief from psychological distress and symptoms of mental disorder with mental health intervention. See, e.g., Nathan Fairman & Scott A. Irwin, *Palliative Care Psychiatry: Update on an Emerging Dimension of Psychiatric Practice*, 15 CURRENT PSYCHIATRY REP. 374, 374 (2013); Jessica J. Fulton et al., *Psychotherapy Targeting Depression and Anxiety for Use in Palliative Care: A Meta-Analysis*, 21 J. PALLIATIVE MED. 1024, 1034–35 (2018); Miovic & Block, *supra* note 205, at 1665; Nat'l Insts. of Health State-of-the-Sci. Panel, *National Institutes of Health State-of-the-Science Conference Statement: Symptom Management in Cancer: Pain, Depression, and Fatigue, July 15-17, 2002*, 95 J. NAT'L CANCER INST. 1110, 1113 (2003); Timothy A. Newby, et al., *Interventions That May Reduce Depressive Symptoms Among Prostate Cancer Patients: A Systematic Review and Meta-Analysis*, 24 PSYCHO-ONCOLOGY 1686, 1692 (2015); G. Rodin et al., *Treatment of Depression in Cancer Patients*, 14 CURRENT ONCOLOGY 180, 186 (2007); Emily Kathryn Stagg & Mark Lazenby, *Best Practices for the Nonpharmacological Treatment of Depression at the End of Life*, 29 AM. J. HOSPICE & PALLIATIVE MED. 183, 191–92 (2012). There are also studies that suggest a relationship between a desire for death in terminally ill patients and diagnosis of depression or other mental disorders. See *supra* note 135 and accompanying text. Without question, further empirical investigation is necessary to address the question of whether the desire to hasten death of terminally ill patients who suffer from psychological distress or a diagnosed mental disorder can be reduced with mental health intervention targeting treatment of their psychological distress or mental disorder.

a full understanding of the ways in which palliative care interventions might assist them can patients truly make an informed choice.³¹¹ Finally, patients who decide to go forward with medical aid in dying may still benefit from such interventions before they take the lethal prescription.

A growing database reveals the efficacy of psychological, psychosocial, and psychopharmacological interventions in persons referred for palliative care.³¹² Yet, patients seeking medical aid in dying who experience psychological distress or symptomatology will not have the opportunity to consider these interventions unless the practitioner gatekeepers take seriously the importance of fully and meaningfully informing patients of such options and their possible impact on the patients' suffering.³¹³ In addition, the necessary array of palliative services must be available without undue delay in order to benefit persons whose time is rapidly diminishing. Some observers have emphasized that, in order to meet this challenge, jurisdictions must upgrade the availability of integrated palliative care resources.³¹⁴

CONCLUSION

In the past fifty years, the law governing patients' choices regarding their own medical care has shifted dramatically. Although Justice Cardozo uttered his famous words—“[e]very human being of adult years and sound mind has a right to determine what shall be done with his own body”³¹⁵—over one hundred years ago, patients' rights to refuse life-saving or life-sustaining treatment were not formally recognized until late into the 20th Century. Justice Cardozo's words embody what has become a core value in American bioethics and law: the principle of autonomy. Yet, as his language emphasizes, the *right* to make

311. One commentator suggests that states add a requirement of consultation with a palliative care specialist before patients receive a prescription under the U.S. medical aid in dying laws. Benjamin Shibata, *An Ethical Analysis of Euthanasia and Physician Assisted Suicide: Rejecting Euthanasia and Accepting Physician-Assisted Suicide with Palliative Care*, 37 J. LEGAL MED. 155, 163–64 (2017). In light of the burdensome nature of the multiple consultations for patients who are experiencing physical limitations and distress at the end of life, seamlessly integrating such information provision into the existing consultations and procedures would be ideal.

312. See *supra* note 310 and accompanying text.

313. See Sophie Dilworth et al., *Patient and Health Professional's Perceived Barriers to the Delivery of Psychosocial Care to Adults with Cancer: A Systematic Review*, 23 PSYCHO-ONCOLOGY 601, 609 (2014) (highlighting the role of inadequate information and communication as key barriers to access of cancer patients to psychosocial interventions).

314. See Petrillo et al., *supra* note 241, at 887. The authors point to special challenges in California, where many rural communities lack access to palliative care. See Laura A. Petrillo et al., *California's End of Life Option Act: Opportunities and Challenges Ahead*, 31 J. GEN. INTERNAL MED. 828, 828 (2016). Petrillo and colleagues note as well that the implementation of medical aid in dying statutes in Oregon was accompanied by a “silver lining,” of improvements in the end-of-life care options available as alternatives to patients who approach practitioners about obtaining a lethal prescription. Petrillo et al., *supra* note 241, at 887 (citing Melinda A. Lee & Susan W. Tolle, *Oregon's Assisted Suicide Vote: The Silver Lining*, 124 ANNALS INTERNAL MED. 267 (1996)). One study of California hospitals' policies regarding offering services related to the End of Life Option Act revealed that participating facilities were more likely to have comprehensive palliative care services than non-participating facilities. Cindy L. Cain et al., *Hospital Responses to the End of Life Option Act: Implementation of Aid in Dying in California*, 179 JAMA INTERNAL MED. 985, 986 (2019).

315. *Schloendorff v. Soc'y of N.Y. Hosp.*, 105 N.E. 92, 93 (N.Y. 1914).

personal health care decisions depends on one's *capacity* to make those choices. Without capacity, the value of autonomy is questionable, and the state's interest in protecting those who cannot decide wisely for themselves becomes weightier.

Although competent adult patients have generally been authorized to refuse or terminate life-sustaining treatments since the late 20th Century, the right to receive the assistance of willing medical professionals to hasten death was denied until Oregon passed and implemented its Death with Dignity Act. None of the ominously predicted dire consequences have materialized during Oregon's experiment over the past quarter century. One by one, nine other jurisdictions have joined Oregon to be part of a growing minority of places within the United States where competent patients with terminal diseases can receive medical assistance to choose the timing and manner of their deaths.

There are many substantive and procedural safeguards written into these laws. One of the most important is the requirement that only patients who are competent will be permitted to access medical aid in dying. The statutes create a framework that seeks to avoid excessive obstacles to patient choice while screening out those patients with decisional impairments. By restricting access to medical aid in dying to a narrow subset of ill patients—those who are not expected to survive beyond six months due to a terminal disease—jurisdictions offering this option to patients have balanced the state's interest in preserving life with the patient's autonomy interests.

There is no indication that the legislators in these states intended to require demonstration a "higher" level of competence to choose medical aid in dying as compared with the threshold applied to other end of life decisions relating to survival. The legislatures adopting medical aid in dying statutes established the procedural requirement of a referral to a mental health specialist to provide greater *certainty* as to the competence of patients, particularly those viewed as being at greater risk of experiencing impairments in capacity. Ironically, while some statutes suggest greater scrutiny of persons with depression, empirical data reveal that such persons are not generally at greater risk of experiencing impaired judgment in health care decisionmaking when evaluated with criterion-relevant capacity measures. Rather, persons experiencing cognitive deficits in the months before death appear to be at greater risk of decisional incapacity.³¹⁶ Further research is needed to better understand the relationships among decisional capacity and the range of factors that lead to cognitive challenges in persons who meet medical eligibility for medical aid in dying.

Research reveals that there is insufficient attention to the integrated psychological and physiological needs of persons at the end of life.³¹⁷ Regardless of the ultimate determination of eligibility for medical aid in dying, persons who are experiencing a level of psychological distress or symptomatology sufficient to trigger the mental health referral procedure under the medical aid in dying

316. See *supra* notes 212–243 and accompanying text.

317. See *supra* notes 303–309 and accompanying text.

statutes deserve attention to their psychological suffering. Providers must adopt a broad formulation of palliative care that incorporates psychosocial, psychiatric, and psychopharmacological interventions where it is determined that such modalities are appropriate to treat psychological distress, psychiatric symptomatology, or a mental disorder. Education of patients about these options is inherent in the mandate requiring practitioners to disclose alternatives to patients seeking aid in dying. Such disclosure should be coupled with relatively rapid access to services for interested patients.

These recommendations strike a balance between legal and ethical principles of autonomy and beneficence. Persons satisfying medical criteria for medical aid in dying who are experiencing psychological distress or diagnosed mental disorders and meet relevant legal standards of capacity are entitled to choose the manner and timing of their deaths without confronting unfair and outdated presumptions of incapacity. At the same time, practitioners must validate, and offer help for, the psychological suffering that can accompany serious illness and impending death. When patients are educated about, and given access to, interventions that may provide them with relief from their psychological distress and symptoms, we can be more confident that those who choose to hasten death have exercised a choice that is grounded in meaningful knowledge of alternatives to that decision.