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PHYSICIAN ASSISTED DEATH: FROM RHETORIC TO REALITY IN OREGON

*Arthur LaFrance**

INTRODUCTION

The topic is physician assisted death, and there is no easy way to transition into it except to say that it is a subject of importance to every person in this room, and for that matter, every person in America. We all face death at some point, and we all have friends or relatives who are either facing death or have already done so. And so this is a part of our lives. The subject of assisting people to die is particularly close to me because my state, Oregon, has adopted what is, in the world, the only legislative authorization for physicians to assist people to die.

Ten years ago, actually this month, November of 1997, Oregon's legislation became effective. It was adopted by referendum two years earlier, and as everything does, it wound its way through the courts. An injunction was dissolved in 1997 and the legislation became effective. For a second time, as well, in 1997 it was reaffirmed by yet a second referendum. Thus, on two separate occasions, we Oregonians voted that we wanted this option to be available to Oregonians who are facing a terminal illness. It is ten years this month, November of 2007, that we have been living with what is, in all the world, a unique legislative experience and experiment.

Additionally, the Oregon Department of Human Services maintains an extensive Web site detailing the nature and extent of this experiment and experience.¹ Among other resources, that Web site has eight annual reports posted to it. Those reports reflect in extensive detail all of the experience under the

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¹ See generally <http://www.oregon.gov/DHS/index.shtml> (It is a useful resource on the history of the adoption of the Oregon legislation, as well as a reference for scholarly writings on the subject. Additionally, the Department has posted eight annual reports on the practice and experience under the Death With Dignity Act, providing most of the data reflected in this paper. Because this paper, while accurate according to scholarly traditions, is not a conventional scholarly piece, many of the references one might usually find are omitted, in anticipation that the motivated reader will visit the Oregon DHHS website for further sources and validation).

legislation since its inception. That Web site also has references to scholarly articles and commentary, as well as the legislation itself. Much of this is reflected in the handout, which I hope all of you have picked up. Of course there are a number of good books, some of which I've noted towards the end of this handout.²

As we approach this subject, we will first discuss the place of death in life, then we will review the statute and the experience under it, and then we'll turn to some of the criticisms of the statute, and conclude with the present and future legal status of the Oregon legislation. In a nutshell, as I've said, the law became effective in 1997. There was a challenge that went to the United States Supreme Court which decided in favor of Oregon in 2006.³ By this year, and this month, November of 2007, two-hundred and ninety-seven [297] Oregonians have chosen to end their lives pursuant to the legislation. That is a significant number of people—about thirty [30] each year for the past ten [10] years. Perhaps more significant, of those who successfully qualify through the screening process, some twenty-five [25] percent choose *not* to go through with it.

A number of other states have considered similar laws, but those with which I am familiar have so far chosen not to enact similar legislation. There was a bill before the California Legislature this year which died in the Committee. Australia briefly had a physician assisted death statute in the Northern Territory in 1996,⁴ and the Netherlands adopted authorizing legislation in 2002. But each was different from Oregon's legislation in significant ways.⁵

² See WILLIAM H. COLBY, *LONG GOODBYE: THE DEATHS OF NANCY CRUZAN* (2003); ELISABETH KUBLER ROSS, *ON DEATH AND DYING* (2007); SHERWIN NULAND, *THE AMERICAN WAY OF DEATH*.

³ *Gonzales v Oregon*, 546 U.S. 243 (2006) (The author wrote an amicus curiae brief in that case, on behalf of two dozen law professors, presenting much of the data reflected in this speech. Most of the challenges to Oregon's law were factually grounded: that it would discriminate against the poor or ill educated or disabled; that it would be a means of abuse and over reaching; that it would go badly and lead to bad outcomes for patients; that assisting death is not properly the practice of medicine. The Amicus brief argued the contrary, relying on the facts reflected in the Annual Reports on the DHHS website and reviewed in this paper).

⁴ See A.B. LaFrance, *Physician Assisted Death: A Comparison of the Oregon and Northern Territory Statutes*, 1 *NEWCASTLE LAW REVIEW* 33 (1996) (The Australian statute was a marked contrast to Oregon's: it required the physician to be present and deliver the deadly substance and the patient to exhaust palliative care before the death event. The Australian statute thus tapped the Commonwealth tradition of public health, while—as the present text develops—the Oregon statute respects the American traditions of individual rights and autonomy).

⁵ The literature on the Netherlands is vast and troubling. Until 2002, euthanasia was practiced without explicit authorization or clear reporting and review. Since then, explicit authority has been provided, and it is reported that euthanasia has been extended to infants, with inconsistent reporting by physicians. The safeguards and limitations in the Oregon Death With Dignity Act are missing. The Oregon DHHS website provides leads for the interested reader, who will find ample recent research on the Netherlands in the *New England Journal of Medicine*.

DEATH AS A PART OF LIFE

Physician assisted death as a concept seems to put people off. But all of our lives and all our parents and grandparents lives, we have been living with death, and dealing with it in ways with which we are familiar, ways which are not entirely different from physician assisted death. Life leads to death, and death is very much a part of life.

When I was six or seven, our elderly next door neighbor, Mr. Chapman, who had read stories to us, played with our dogs, whose wife made those great Concord grape jelly jars—the ones with the funny paraffin wax on top—which as a kid I always ate before the jelly—died. And I still recall my mother saying, with sadness one day, that Mr. Chapman had died, a concept I didn't understand, but that we could say "good-bye" before he left forever. So we dressed up and went next door and there was Mr. Chapman in a casket in his home, in the front parlor of his New Hampshire house, where I had visited any number of times. And he didn't look exactly like Mr. Chapman, but he looked a lot like Mr. Chapman, and we paused and we passed, and we said "good-bye" to Mr. Chapman.

I've always been happy that I had that experience. It's stayed with me all these uncounted years since. I mentioned it to my sister the other day, in preparation for this presentation, and she recalled the occasion vividly and thankfully, as do I. Yet in those post-war years, America was already beginning to build the huge hospital industrial complex of today, so that the opportunity to include death in life has been compromised or lost, and more and more, dying has become something that is done in hospitals. Somewhere between eighty [80] and eighty-five [85] percent of Americans die in a hospital—a foreign place, a place that is necessarily sterile, regulated, staffed by strangers; no matter how well done, no matter how well supported, far removed from the place where we lived our lives.

But the practice of assisting people to die, whether to die at home or in hospital, remains quite commonplace and we've lived with it for decades. A "D.N.R." is a "do not resuscitate" notation, which is a common order in hospitals for people who are facing terminal illness. It is a notation that, should the person expire, he or she should not be resuscitated. The team that races out in E.R. or Gray's Anatomy should *not* race out and clap those paddles around and shock somebody back to life. We also, when somebody is hooked up to life support, understand that the person may be unhooked from the ventilator or that tubes and nutrition and hydration may be withdrawn. That's a practice with which we're well familiar.

These are familiar practices in critical settings. As well, there is also a term called "futility," a common sense concept, that when care and treatment cease to have the probability or possibility of success, then treatment becomes futile and we should stop. We should end efforts which are unavailing. Pointless care can

become cruelty. For those of us who remember the Terry Schiavo controversy of a few years ago, futility was at the center of the debate.

So, in a hospital, assisting someone to die is a well understood practice in various forms. Legally, for those of us who do estate planning or do elder law, tools like advanced directives and health care powers of attorney are for people to execute in advance of a life crisis—in advance of becoming incompetent and facing death. These then become the context for the hospital to respect in assisting a patient to die, by withholding the heroic measures the patient has chosen against.

Finally, increasingly in America, the good news is that hospice care is available in almost every community, not only in the United States, but throughout the world. With hospice, people are towards the end of life and may receive support and care in their dying days or dying weeks. There is a hospice just over in Cheyenne, which my students and I have visited, built with a gift of over \$8,000,000, as comfortable and welcoming a place as anyone could choose for a vacation . . . or for dying. I have visited hospices all the way from Houston, to Christchurch, New Zealand, to Houston, and points in between. Hospice is a philosophy, as well as a methodology, as well as a place, and it offers hope and comfort for people who are dying. It is one of the important tools that we should have available to us, but physician assisted death is as well, another such tool.

PHYSICIAN ASSISTED DEATH

Qualifying Under the Statute

Let me then talk about physician assisted death. What does it add to the other techniques of assisting people to die—DNRs, and withdrawal of support, and the concept of futility, and the support methods of hospice? In essence, and perhaps this is obvious, physician assisted death enables people to choose, independently of professionals or even family, when and where they will die; it creates the real possibility of moving death back into the home, as a part of life.

First of all, significantly, the Oregon Death With Dignity Act is available only for Oregon residents. There was in the debate, the assertion that Oregon would become “death tourists” site of choice, bringing new meaning to the term, “destination resort.” I’m not sure that that would be a bad thing, but it’s not a possible thing under the Oregon statute.⁶

⁶ The Oregon Death With Dignity Act is set out in full at the DHHS website, and, as well, may be found in the Oregon Revised Statutes at ORS § 127.800-995. As my discussion proceeds in the text, I will not provide, contrary to the usual custom, frequent section references. These may easily be found and consulted by the interested reader.

Secondly, a person must have received a terminal diagnosis—that is, the best medical judgment is that he or she in all probability will be dead within six [6] months. That has to be confirmed. The initial diagnosis is by an attending physician and then the second is by a consulting physician. Almost always at least one of these is an oncologist; eighty [80] to ninety [90] percent of these patients have cancer of varying kinds.

The next step is the person must be competent—that is defined in the statute, but it is a term that is familiar to all of us—able to make a choice, understanding what he or she faces, and what another choice available might be. Moreover, the attending physician has to conclude that there is not a clinical depression. If there is, then there has to be a referral to a specialist either to deal with the depression or to report back that the person simply does not qualify to proceed under the physician assisted death statute. Early on there were a number of these, I'm thinking about twenty [20] percent, but over the last few years the numbers have dwindled to about five [5] to ten [10] percent. Most of those who are so classified, that is depressed, are simply shunted out of the process—they do not ultimately qualify for prescription.

Those patients who are competent and have a terminal diagnosis make two oral requests and a written request. The written request is on a form on the Department of Health Web site. It is fairly plain vanilla for such an important subject that's readily understandable. Fifteen [15] days have to pass between the two [2] oral requests. What the person is basically saying to the physician is "I've been given a diagnosis, what I want to do is to be assisted in dying and I would like a prescription from you to make that happen." The attending physician advises of the alternatives and requests that the person notify the next-of-kin. There's no requirement that the person do that, which was the subject of some controversy. Our American tradition is one of autonomy, and choice, and privacy. And so, for those of us who have problematic relatives, not having to notify them at a problematic time is an option well worth having available.

The prescription is written within the fifteen [15] days of the last request. Since 1999 the pharmacist must be told the purpose of the prescription. The prescription will be of a barbiturate which will be prescribed for a number of purposes, Secobarbital or Pentobarbital. The pharmacist is told the purpose so that he or she may opt out—it's sort of a conscience clause for those who do not want to participate. Again, this is the subject of some controversy, but it is there and it is part of the process.

The last point about the statute is that there is extensive reporting. The forms that the physicians fill out on every patient are on the DHS Web site and are gathered in the routine. One point I should mention is that the patient's names are submitted to the Department of Health, but the Department of Health says they are nowhere recorded. The only purpose is to check them against the death

certificate that is ultimately filed, which reflects the underlying cause of death as the disease, cancer, or ALS or HIV. It does not reflect that the person has availed of this statute. The notes of the names are destroyed after a year's time.

Some Distinctions

Many people confuse the Oregon approach with euthanasia, or the practices in the Netherlands, or the work of Doctor Kevorkian. It is quite narrower and safer, and practices elsewhere would be illegal in Oregon, as they would be here in Wyoming.

First of all, methodology is limited to prescription. The choice could have been injection, a fatal injection, as was permitted in Australia or is now allowed in the Netherlands. But the point of having a prescription is simply to enhance the patient's autonomy. He or she makes the choices of when and where, takes the medication, and nobody else need be present. The distinction is an important one. The physician need not be present, although in fact physicians are present in about thirty [30] percent of the cases. In fifty [50] percent of the cases another provider is present.⁷ Almost never are the patients alone; often times there are a number of people present with them when they take the medication.

The patient need not take the prescription—it's an important point. About sixty [60] prescriptions are written each year and about forty [40] people take them. That means about one-quarter [1/4] to one-third [1/3] of the people are not taking them. When I talked about this in New Zealand a member of the audience said "this stuff is sitting in someone's medicine cabinet, it could be sold to children on elementary playgrounds!" And I said, "Well, you know, it could be. But I don't think it is. These patients have six [6] month diagnoses; in all likelihood, their medicine cabinets will be cleaned out when their homes are cleaned out, after their deaths." The truly significant aspect of this is that people are making choices at each point along the way, even at the very end.

Another important point, truly crucial, is that any other method or any other agent is homicide. For those of us who remember Jack Kevorkian, Michigan's Doctor Death, recently released from prison, who was involved in administering death by injections and convicted of homicide—he would be prosecuted for homicide in Oregon as well. The only permitted technique in Oregon is orally taking the medication; and the actor is the patient himself or herself. No physician may do it to or for the patient, nor may anyone else.

⁷ Perhaps this need not be said, but the text discussion of the statistics and practices and patients under the Oregon DWDA are based on the eight annual reports on the DHHS website. The interested reader will probably find all she or he needs by consulting the Eighth Annual Report, since it is cumulative. One might also find there references to articles based on the Reports by Hedberg et al., in the *New England Journal of medicine* over the past ten years.

Finally I want to distinguish the Netherlands which for two to three decades had what could properly be characterized as euthanasia—that is to say, physicians in the Netherlands were killing patients, and were doing so pursuant to an unwritten understanding that they would not be prosecuted criminally. In 2002, the Netherlands adopted explicit authorization for physicians there to put people to death. That is in fact euthanasia. Oregon does not practice euthanasia.

The most recent reports from the Netherlands, I think, are quite scary because while they had previously been focusing chiefly on the elderly, physicians in the Netherlands are now putting to death young infants born with massive disabilities or birth complications.⁸ It's not clear that they're doing so with the knowledge or consent of the parents. And, it is absolutely clear that in the Netherlands they do not have the extensive system of reporting we have in Oregon; the controls are missing. We should be concerned about the Netherlands.

THE EXPERIENCE

The Practice

Starting in 1997, there were twenty-three [23] prescriptions written for patients with a terminal diagnosis. The annual number has been slowly moving up to about sixty [60] to sixty-five [65] a year.⁹ This means that a person has gone through all the stages I described earlier, and the physician has concluded that he or she should receive a prescription to use for purposes of hastening death. The prescriptions consumed amount to about two-thirds [2/3] on the average. The last report for the year 2006, recited that thirty-five [35] out of sixty-five [65] took the prescriptions. Nineteen [19] died of the underlying disease, eleven [11] are still alive, but eleven [11] in 2006 took prescriptions from 2005.

Forty [40] M.D.s participated in 2006—that number has been pretty consistent over the years. Several write prescriptions for two [2] or three [3] patients. As I recall, the maximum is one physician who in one year, dealt with seven patients. It is not a specialty that physicians are fighting for, and it is a problem to find physicians who are willing to participate since, like all other practitioners, they really entered the medical profession to keep people alive. Assisting people to die is not an attractive undertaking. It's also, for physicians, in some settings, a source of criticism and stigma. But about forty [40] physicians regularly participate.

⁸ In the United States, of course, these conditions and practices would trigger protections and sanctions of the Americans with Disabilities Act, 42 U.S.C. § 12101 (1990). Concerns that the disabled would be victimized by the Oregon DWDA prompted disabilities groups to file Amicus in the United States Supreme Court, challenging the Oregon Act.

⁹ For reasons that are not clear, the total number of people using the DWDA has stabilized at about sixty [60] or so. One would think that the number would continue to climb, as the population increases, and the aged increase in number.

The terminal diagnosis about ninety [90] percent of the time is cancer, of a number of different kinds. The balance is A.I.D.S. and A.L.S. Those two are interesting. Obviously H.I.V. is a terrible source of disease and death, but because of success in treating them, over the past five [5] to ten [10] years, the percentage of people with H.I.V. using physician assisted death is relatively small, of all of those with H.I.V. On the other hand, A.L.S. is a relatively small population, but about fifty [50] percent of those in Oregon with A.L.S. avail themselves of physician assisted death. I think it is simply because they understand they are facing a slow, wasting, horrific death and there simply is no treatment.

In 2006, there were forty [40] to fifty-four [54] days from the final request to death, less than two months. On the average, death came within twenty-nine [29] minutes from the taking of the medication. Folks are unconscious within five [5] minutes of taking the medication. These are averages. One fellow after a passage of twelve [12] to fourteen [14] hours woke up and said, “What the hell, I’m supposed to be dead!” And then followed through and did achieve that objective. But on the average, most are gone within thirty [30] minutes.

In terms of complications, the only complication which is recurring is simply nausea and vomiting from the medications themselves. I will come to talk about a case where a woman volunteered to be recorded and interviewed and so her entire experience is available to anybody who’d like to read it. One of the things she said was “The stuff just tastes awful.” So I think she had to wash it down with Gatorade or something else.

Insurance covers it. The statute specifically says that insurance shall be unaffected by somebody taking the medication. So if, for example, an insurance policy had an exclusion for suicide, physician assisted death would not be excluded from life insurance. Medicaid in Oregon will cover assisted death, but only with state funds. For those of us who know about Medicaid, about fifty [50] to seventy [70] percent of the funding is federal, so the state has to be very careful to track the monies involved. The monies involved here are not huge: going to see a doctor, you’ve got cancer, you’ve had your diagnosis, you pick up a prescription. Lots of us pick up prescriptions regularly, Lipitor for example, and the costs are within that range.

One of the criticisms as the legislation was being debated was that you cannot trust the M.D.s—who will they be? What specialties will be involved? There will be pressures on them to engage in malpractice and the like. There hasn’t been a single instance of that reported. There have been reports to the Board of Medical Examiners of physicians inadequately filling out the reports, which are quite extensive. Each of those has been corrected and there have been no sanctions physically. So, the performance of the M.D.s has been within the professional norm.

The Patients

Ninety-three [93] percent of the patients die at home. Now, home may be a friend's home, or a friend's apartment, but they're at a home. In the definition of "home" as the reports use it, a hospice may also qualify. About three-quarters [3/4] of these folks are dying in hospice. This practice of hospice varies from community to community. In hospice in Christchurch, fewer than half [1/2] of the patients die in the hospice facility. That was surprising to me. In hospices in Houston, Texas, about ninety [90] percent of the patients die in the facility. They would come in about a week before they would die and that was the chief function of the hospice facility. In Cheyenne, patients dying in hospice take on average fourteen [14] to eighteen [18] days.

Most hospices do not participate in assisted death, simply because the practice is limited to Oregon. But of course, they support people who are dying, while they die. In Oregon, as I have said, about three-quarters [3/4] of these folks, who qualify for assisted death, go to hospice and they die there. Of those present at the death event, most are family member and friends; M.D.s are present about thirty [30] percent of the time, another provider about fifty [50] percent.

The majority of the patients are in their sixties. The median age in 2006 was seventy-four [74], which is up significantly from previous years. They are educated: forty-one [41] percent have a Bachelor of Arts degree. They tend to be employed and insured: sixty-four [64] percent have private insurance, one-third [1/3] have Medicaid. Fifty-four [54] percent are male, and of them, forty-six [46] percent are married. Of the balance, half [1/2] were divorced, and half [1/2] were either widowed or had never been married.

The reasons given for seeking assisted death were fairly consistent, year to year: dignity and autonomy with some fear of pain. Significantly in 2006, forty-four [44] people said they were motivated by the fear of pain at the end of life with cancer. The previous years the numbers had been around twenty-two [22]. So for whatever reason, in 2006, many more people were concerned with pain at the end of life than previously.

The average length of the relationship with the physician had been about twelve [12] weeks or three [3] months. Now that will be with the physician who wrote the prescription. There will also have been other physicians typically in the picture. The average experience of the physician was about twenty [20] plus years in practice. On average, they were in their forties, and were family doctors, internists or oncologists.

Still on the human dimension, it helps to put a human face on these patients. This is difficult, because of the guaranties of privacy and the respect due those who are dying and pursuing the difficult path of death with dignity. But the

Portland Oregonian newspaper was recently able to follow one such patient, with her full cooperation, as she prepared to die and in fact did so, by means of physician assisted death.¹⁰ Lovelle Svart died September 30th, perhaps a month or six [6] weeks ago. For somebody here who would like to get a feeling for the feeling of this experience, her contribution is extraordinary because she agreed, after she got her diagnosis of six [6] months terminal cancer, to be video taped, to be interviewed, and to have the final events taped with a reporter present. This is uncommon courage and uncommon commitment to the community. But she was an uncommon lady—a very feisty lady who the afternoon of the death event danced the polka with a counselor, George Eighmey, from Compassion and Choices, who has devoted his career to assisting people to die.

Lovelle Svart had lung and throat cancer; chemo and radiation failed; in June she got a six [6] month diagnosis. July 1st, she filled out the form. August 7th, Lovelle fills the script. The morning of the event she bought food, she visited a park, she actually had the battery of her car charged because the car was going to the son of a friend, and she wanted to make sure the car was operating well. She visited with friends privately in her bedroom, took the pills and went to the bedroom with her mother, came back danced the polka, had a hugging line, she had one last cigarette, then she went to bed. She took the liquid, went to sleep, and in five [5] hours she was dead. Her case obviously took much longer than the average of thirty [30] minutes, but there was little about Lovelle Svart that was average in life or death.

Reading the Oregonian articles, and visiting the Web site, are both journeys well worth undertaking.

The Critics and the Criticism

So, this is the human dimension. Let us now turn to the polemics, the critics and the criticism.¹¹

The criticisms, first of all, were that physician assisted death would discriminate against people; the poor, the disabled, the elderly, the poorly educated. The demographics of the State of Oregon Reports indicate that this has simply not happened. As well, interviews with family members support the conclusion

¹⁰ Video Diary: Living to the End, *available at* http://blog.oregonlive.com/multimedia/living_to_the_end/.

¹¹ The literature on assisted death is vast and the critics numerous. For ease of manageability, the reader might find most informative reviewing the briefs of the parties and the amici in *Gonzales v. Oregon*, 546 U.S. 243 (2006), where the critics were forced to focus and substantiate, as best they could, their criticism. The briefs are all available on the Supreme Court website or through Westlaw.

that the feared discrimination has not happened.¹² There was a fear as well of imposition for financial concerns. But the participants themselves list financial concerns as a very minor position in their choosing to go through with this. The remarkable thing with most of these folks is that they have enough to support themselves, both by way of insurance and their own personal resources. There was also a fear that there would be misfire or malfunctioning—that somebody would be rendered brain dead or in a persistent vegetative state or in a coma, due to maladministration of the medication. There is not one instance of that.

Most tellingly, I think, the critics have advanced palliative care as an alternative. They argue that if someone is approaching the end of life and experiencing pain, there is palliative care available—ultimately Morphine or increasing dosages of Morphine or some other pain killer so that the person need not be hastened to the end, and may in fact live out somewhat close to a natural span. Other people respond differently to this, that surviving in a heavily sedated state is not living or dying with dignity. My own response is I think it's important for palliative care to be available as a choice, and I think equally that physician assisted death should also be available as a choice.

Finally there are those that simply object to the statute because it involves the inflicting of harm and the ending of life and we ought not to do that, we should leave death in God's hands. I cannot really respond to that except to say that if these choices and these tools are made available to us, then maybe that is part of the natural order as well. Indeed, the Roman Catholic view is that increasing sedation is permissible even if it will ultimately hasten death,¹³ under the principle of double effect.

LEGAL STATUS

Homicide

I've already distinguished the Oregon practice of assisted death from euthanasia. It is a permissible medical practice, although the medical community is much divided about whether physicians should be participating in this practice.

¹² It is important to note, on behalf of the critics, that what we know about the motivations and independence of the patients was largely gathered by their caregivers. Few patients were interviewed, due to privacy concerns, as to their motivations and feelings and freedom of choice. Hence, critics would argue that much of the supposed data was gathered by the very people who might most profit by the person's death.

¹³ The Roman Catholic Church has a highly developed set of principles, codified as THE ETHICAL AND RELIGIOUS DIRECTIVES ON HEALTHCARE, supported by commentary and frequently updated. These guide the Catholic Church's opposition to Oregon's DWDA, and were the basis of the Church's continuing opposition, despite the principle of double effect. The ERDs are available on the Church's website, at <http://www.usccb.org/bishops/directives.shtml>.

The statute specifically relieves practitioners of criminal and civil liability. The key point is that the physician does not administer the death agent; only the patient does do. It is not euthanasia, which would, in fact, be homicide in Oregon, as elsewhere.

While I was teaching this spring in New Zealand, I attended meetings there of groups advocating legislation similar to Oregon's. There had been cases where family had assisted people to die. The prime mover, a remarkable woman named Lesley Martin,¹⁴ had in fact smothered her own mother, after injecting morphine, as she lay in pain, dying of cancer. There had been other cases. However compelling and sympathetic such stories may be, the result there and here is the same: the act is homicide, and any compassion we may feel is reflected only in a light sentence, usually around two years in prison.

Continued Validity

It seems clear that Oregon will continue to authorize physicians to write prescriptions assisting terminal patients to choose the time and place of their deaths. We have twice done so by state-wide referenda. The leading advocate in Oregon, an extraordinary nurse practitioner and attorney, and a former student of mine, Barbara Coombs Lee, Executive Director of Compassion and Choices, recently told me that the main opponents have now accepted physician assisted death as a part of the Oregon healthcare landscape.

The chief threat comes from without, from conservatives in Washington, both Congress and the White House. Congressional critics have been unsuccessful because of the uniquely unanimous support of Oregon's Congressional delegation, Republican and Democrat. But the Bush Administration persists in its opposition, and has sought to terminate Oregon's practice by withdrawing the Drug Enforcement Administration (D.E.A.) licenses of participating Oregon physicians. These licenses are essential to medical practice of participating physicians, such as family doctors, internists and oncologists, whose practices would simply shut down without them. So the Bush Administration's approach is hugely, and disproportionately, punitive, punishing the physicians, not simply blocking the assistance to thirty or forty Oregonians annually. The *in terrorem* effect alone would prospectively and totally shut down Oregon's legislation.

The Drug Enforcement Agency ranks medications and has a list of those which are simply unavailable—marijuana for example. There is another list of medications which are available for general practice and the medications used in assisted death, Secobarbital and Pentobarbital, are on that list. They are regularly

¹⁴ Ms. Martin has written two books about her experience.

used as pain killers and anti-nausea treatments and occasionally to help people sleep. Their use in assisting death is not due to their properties, but to the size of the prescribed dosage.

What the D.E.A. was trying to do was to sanction physicians for appropriately prescribing a licensed medication, but for what the D.E.A. considered impermissible purposes. The short of it is, that the U.S. Supreme Court rejected the challenge, in *Gonzales v. Oregon* and the practice as it is currently undertaken in Oregon is legal and constitutionally permissible. I should add, however, that the grounds of the Supreme Court's decision were that Congress had not authorized the D.E.A. to determine what the proper practice of medicine is. Should Congress do so, then the constitutional issues would be squarely raised: can Congress' Interstate Commerce powers regulate the local practice of medicine? Can the First Amendment protect the doctor-patient relationship? Does a patient have a right to die?¹⁵

These are fundamental, difficult issues, which the Supreme Court typically avoids reaching unnecessarily. And Congress would be reluctant to force them on the Court. So, I think with a presently liberal majority in Congress, Oregon's legislation is secure for the foreseeable future. But if the issues were to come before the presently conservative Court, the outcome is in doubt. On the one hand, conservatives believe in deference to states under the doctrine of federalism; on the other, they tend to have an expansive view of Congress' authority. And the balance would turn on how the then majority of the Court would view the individual rights at issue . . . the right to death, with dignity . . . to autonomy and choice . . . as an aspect of the First Amendment or the Due Process Clause.

CONCLUSION

This is the conclusion:

My friends who are constitutional law scholars tell me that Oregon's legislation would lose in a frontal challenge in the Supreme Court. But I'm not so sure. In the end, Court nominees are selected in part because of their human qualities. And they, and we, are all growing older, and fear the kind of isolated, inhumane death that awaits us in hospital ICUs. I bank on that as a tipping factor in motivating Justices, as with voters.

¹⁵ Obviously, these are complex questions and there is abundant case law from a number of courts on them. See among others, *In re Quinlan* 70 N.J. 10, 355 A.2d 647 (1976); *Bouvia v. Superior Court*, 255 Cal. Rptr. 297, 300 (Ct. App. 1986); *Cruzan v. Director, MDH*, 497 U.S. 261 (1990); *Planned Parenthood v. Casey*, 505 U.S. 833 (1992). These case names on Westlaw will provide an easy to guide to abundant commentary in the JLR database.

When I speak to audiences such as this, comprised of voters, I am often asked why more states haven't adopted Oregon's approach. Legislative reform efforts have failed in other states and I've talked with people who've been involved with them and there are just differing reasons, but the short of it is that assisting people to die is a troubling practice and people in different states have different demographics and different political makeups. Oregonians tend to be, I think, a lot like the folks who live here in Wyoming—independent minded and thoughtful in ways that, let's say, Massachusetts or California, may be missing.

One consideration is the Netherlands specter and people are concerned about a slippery slope—if we do this, then maybe we'll do this next, and it's a legitimate fear, but I think the safeguard is simply that you don't slide down the slippery slope! You establish safeguards or fail-safes. Oregon has done that, to avoid abuses.

The hospitals and pharmaceutical industries are very powerful forces in resisting change in American health care, and they dig in their heels in resisting assisted death because they fear liability and lawsuits. The hospice and palliative care movements are also in opposition, because they take away some of the apparent necessity for the Oregon approach.

One other consideration that is hard to capture or express is the difference between fearing the general but supporting the specific. Those who fear abuses if assisting death is authorized might well understand and support it in specific cases where the need and circumstances are compelling, as with the case of Lovelle Svart or Lesley Martin. And the truth is, as with Lesley Martin, we have a way of accommodating to individual cases, by labeling them homicide and giving light, compassionate sentences, or—as in the Netherlands for decades—simply not prosecuting. The trouble with this approach is that it is too hit-or-miss, and people may be treated very unevenly, or be deterred by uncertainty from acting at all, even in extreme, compelling cases.

But two things that I think work in favor of other states considering Oregon's approach are demographics and common sense. The demographics are clear and they're simple. We have an aging population in the United States. More of the middle class are contemplating the possibility of high tech death and it's ugly. The option of a more comforting and comfortable death is attractive. The more we immediately face this, the more urgent becomes the need to have physician assisted death as an option.

Finally, I truly do believe there is something about dignity and humanity in a process empowering a person, who is ultimately going to die like all of us will die, but will die soon, predictably and possibly without dignity. I think there's something about dignity and humanity in permitting that person to make a choice that brings death into life and blends the two together. Call it the legacy of Mr. Chapman.