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In the Laboratory of the States: The Progress of *Glucksberg*'s Invitation to States to Address End-of-Life Choice

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IN THE LABORATORY OF THE STATES: THE PROGRESS OF *GLUCKSBERG*'S INVITATION TO STATES TO ADDRESS END-OF-LIFE CHOICE

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It has now been ten years since the Supreme Court handed down Glucksberg *and* Quill, *rulings on laws that forbid "assisted suicide." In that time, normative and legal developments in the fields of law, medicine, and psychology have changed the landscape of the discourse on the choice of a mentally competent, terminally ill individual to choose to self-administer medications to bring about a peaceful death. Although the Court rejected petitioners' claims that state laws denying them the ability to end their terminal illnesses through self-administered medication violated the Constitution, it left states with the opportunity to experiment with legislation that would allow terminally ill individuals the choices they had previously sought through litigation. Oregon's experience with its Death with Dignity Act, which grants terminally ill, mentally competent individuals the choice to end their lives through self-administered medication, has proven that such laws provide comfort not only to those who, faced with the prospect of a horrible death from a terminal illness, choose to end their lives in a peaceful and dignified manner, but also to those to ultimately choose not to. Additionally, Oregon's experience shows that the fears that originally attended the "assisted suicide" debate are unfounded so long as proper procedures are in place. Because Oregon's Death with Dignity Act has proven both useful and harmless, this Article concludes that it is time for other states to follow Oregon's lead and enact their own legislation to allow their citizens an alternative to what otherwise could be a prolonged and painful death from terminal illness.*

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INTRODUCTION

Invoking continued debate, the U.S. Supreme Court concluded its 1997 decision in *Washington v. Glucksberg* with these words: "Throughout the Nation, Americans are engaged in an earnest and profound debate about the morality, legality, and practicality of physician-assisted suicide. Our holding permits this debate to continue, as it should in a democratic society."[1]

The debate has indeed continued these past ten years, and there have been two particularly significant developments worthy of close examination. First, Oregon has been implementing its Death with Dignity Act[2] ("Dignity Act") since 1997. This law empowers terminally ill, mentally competent adult Oregonians to control the timing and manner of their deaths, subject to careful procedures. A fraction of dying patients confront a dying process so prolonged and marked by such extreme suffering and deterioration that, even with excellent pain and symptom management, they determine that hastening impending death is the least-bad alternative. The data show that passing this law has harmed no one and has benefited both the relatively few patients *in extremis* who make use of it, and a great many more who draw comfort from knowing this option is available.

Second, an important evolution has occurred in the terminology used to discuss the choice of a mentally competent, terminally ill patient to self-administer medications to bring about a peaceful death. It is increasingly recognized that it is inaccurate to consider this choice to be "suicide." The Dignity Act itself states that such actions "shall not, for any purpose, constitute suicide, assisted suicide, mercy killing or homicide, under the

1. 521 U.S. 702, 735 (1997).

2. OR. REV. STAT. §§ 127.800–995 (2005).

law."[3] The Oregon Department of Human Services, which reports on the implementation of the Dignity Act, rejects referring to this as "assisted suicide" or "physician assisted suicide."

From a mental health perspective, "suicide" and the choice of a dying patient to hasten impending death in a peaceful and dignified manner are starkly different.[4] The American Psychological Association has recognized that "the reasoning on which a terminally ill person (whose judgments are not impaired by mental disorders) bases a decision to end his or her life is fundamentally different from the reasoning a clinically depressed person uses to justify suicide."[5]

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3. *Id.* § 127.880. Since it is explicit in the law that the death of a patient under the Dignity Act does not constitute "suicide," there is no basis for a suicide exemption under an insurance policy which excludes payment of benefits in cases of "suicide."

4. E. James Lieberman, Letter to the Editor, *Death with Dignity*, PSYCHIATRIC NEWS, Aug. 4, 2006, at 29. Lieberman wrote:

> The term "assisted suicide" is inaccurate and misleading with respect to the [Dignity Act]. These patients and the typical suicide are opposites:
>
> - The suicidal patient has no terminal illness but wants to die; the [Dignity Act] patient has a terminal illness and wants to live.
> - Typical suicides bring shock and tragedy to families and friends; [Dignity Act] deaths are peaceful and supported by loved ones.
> - Typical suicides are secretive and often impulsive and violent. Death in [the Dignity Act] is planned; it changes only timing in a minor way, but adds control in a major and socially approved way.
> - Suicide is an expression of despair and futility; [the Dignity Act] is a form of affirmation and empowerment.

Id.

5. Rhea K. Farberman, Am. Psychological Ass'n, *Terminal Illness and Hastened Death Requests: The Important Role of the Mental Health Professional*, 28 PROF. PSYCHOL.: RES. & PRAC. 544, 544 (1997), *quoted in* Brief of Amicus Curiae Coalition of Mental Health Professionals in Support of Respondents at 17, Gonzales v. Oregon, 546 U.S. 243 (2006) (No. 04-623); *see also* David M. Smith & David Pollack, *A Psychiatric Defense of Aid in Dying*, 34 COMMUNITY MENTAL HEALTH J. 547 (1998).

Many medical experts[6] and legal experts[7] have also come to recognize that the term "suicide" or "assisted suicide" is inappropriate when discussing the choice of a mentally competent, terminally ill patient to seek medications that he or she could consume to bring about a peaceful and dignified death. The term "assisted suicide" has been replaced with more accurate and value-neutral terms such as "aid in dying" or "physician-assisted dying."[8] The only active opponents of this evolution in terminology are opponents of the practice who continue to malign the choice for aid in dying by labeling it "suicide."

It is timely now, ten years after *Glucksberg*, to assess the lessons learned from the experience in Oregon, and to consider if the laboratory ought to and/or can be expanded beyond Oregon, as well as the likelihood that such

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6. The American Medical Women's Association's position statement *Aid in Dying* notes as follows:

> The terms "assisted suicide" and/or "physician assisted suicide" have been used in the past, including in an AMWA position statement, to refer to the choice of a mentally competent, terminally ill patient to self administer medication for the purpose of controlling time and manner of death, in cases where the patient finds the dying process intolerable. The term "suicide" is increasingly recognized as inaccurate and inappropriate in this context and we reject that term. We adopt the less emotionally charged, value-neutral, and accurate terms "Aid in Dying" or "Physician Assisted Dying".

Position Statement, Am. Med. Women's Ass'n, Aid in Dying (Sept. 9, 2007), http://www.amwa-doc.org (follow "Advocacy" hyperlink; then follow "Position Statements" hyperlink); *see also* CHARLES F. MCKHANN, A TIME TO DIE: THE PLACE FOR PHYSICIAN ASSISTANCE (1999); Joseph B. Straton, *Physician Assistance with Dying: Reframing the Debate; Restricting Access*, 15 TEMP. POL. & CIV. RTS. L. REV. 475, 475 (2006) (arguing that "the process of permitting people to actively end their lives before their disease ends their lives" ought to be referred to as "physician assistance with dying," instead of "physician-assisted suicide"); Principles Regarding Physician-Assisted Suicide, Resolution D01, Am. Med. Student Ass'n House of Delegates (March 15, 2008) (on file with author) [hereinafter AMSA Principles] (replacing the organization's use of the phrase "physician-assisted suicide" with "aid in dying" and stating that the practice "should not . . . constitute suicide, assisted suicide, mercy killing or homicide"); Position Statement, Am. Acad. of Hospice & Palliative Med., Physician-Assisted Death (Feb. 14, 2007), *available at* http://www.aahpm.org/positions/suicide.html (rejecting the term physician-assisted suicide as "emotionally charged" and inaccurate).

7. *E.g.*, James E. Dallner & D. Scott Manning, *Death with Dignity in Montana*, 65 MONT. L. REV. 309, 314–15 (2004). Dallner and Manning note:

> [T]he word "suicide" is well suited to the description of a distraught individual with his whole life ahead of him, who in a moment of despair, commits a completely senseless and utterly tragic act. In contrast, "suicide" is not well suited to describe an elderly cancer patient who in the final days of a horrible and agonizing struggle simply wishes to avoid more needless suffering and indignity. The first individual's act destroys what could be a long and productive life. The elderly cancer patient does not extinguish the hope of a bright future, but rather avoids the last uncharacteristically painful and undignified moments of a life already fully lived . . . . Use of the word "suicide" . . . arouses the images of tragic loss of life in a situation where the tragedy may be the continuation of life.

Id.

8. *E.g.*, Kevin B. O'Reilly, *Oregon nixes use of term "physician-assisted suicide"*, AM. MED. NEWS, Nov. 6, 2006, *available at* http://www.ama-assn.org/amednews/2006/11/06/prsc1106.htm ("Oregon's Dept. of Human Services announced . . . that it no longer would use the term 'physician-assisted suicide' to describe terminally ill patients who ask doctors to help them die."); Policy Statement, Am. Pub. Health Ass'n, Supporting Appropriate Language Used to Discuss End of Life Choices: Policy No. LB-06-02 (Nov. 8, 2006), *available at* http://www.compassionandchoices.org/pdfs/APHA_Policy.pdf (urging "that accurate, value-neutral terms such as 'aid in dying' or 'patient directed dying' be used to describe this choice").

expansion will occur. Part I of this Article reviews the constitutional landscape in the wake of *Glucksberg* and *Vacco v. Quill*.[9] Part II describes the Oregon statute, the legal challenges it has survived, and the record of its implementation. Finally, Part III reviews the support and opposition to aid-in-dying laws nationwide and concludes that there are substantial prospects that other states will enact laws similar to Oregon's.

I. THE CONSTITUTIONAL LANDSCAPE

A. *Where Did* Glucksberg *and* Quill *Leave Us?*

In an effort to establish that competent, dying patients have the right to openly choose a humane, physician-assisted death, laws prohibiting assisted suicide in New York and Washington were challenged on federal constitutional grounds in the cases of *Vacco v. Quill*[10] and *Washington v. Glucksberg*.[11]

In these cases, patients and physicians challenged the assisted suicide laws to the extent that they prohibited doctors from providing medications to competent, dying patients that the patients could use to hasten death if they so chose.[12] Liberty and equality guaranteed by the Fourteenth Amendment of the U.S. Constitution formed the basis of the claims.[13] Two federal courts of appeals, including the Ninth Circuit sitting en banc, agreed that statutes preventing patients from exercising this option were unconstitutional.[14] The Supreme Court reversed these decisions, but left the door open to both future legislative reform and a future successful constitutional claim.[15]

The opinions, both majority and concurring, invited legislative reform. The majority did so in the passage quoted at the beginning of this Article, and Justice Souter's concurring opinion stated an explicit preference for

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9. 521 U.S. 793 (1997).

10. *Id.*

11. 521 U.S. 702 (1997).

12. It should be noted that in these cases, it was assumed that these laws could reach the conduct of a physician prescribing medications for this purpose; this is a rather large assumption, and a compelling argument could be made that such conduct is simply outside the scope of such statutes. As noted elsewhere in this Article, there is an emerging consensus that it is inaccurate to refer to the choice of a mentally competent, terminally ill patient to seek to hasten death as "suicide"; thus it can be persuasively argued that a physician prescribing medications for such a patient does not "assist suicide."

13. These cases have been the subject of extensive commentary. A terms and connectors search for the *Glucksberg* cite in the Westlaw "law reviews and journals" database on March 1, 2008 yielded 1625 cites; a similar search with the *Quill* cite yielded 467 citations.

14. *See* Compassion in Dying v. Washington, 79 F.3d 790 (9th Cir. 1996) (en banc), *rev'd sub nom. Glucksberg*, 521 U.S. 702; Quill v. Vacco, 80 F.3d 716 (2d Cir. 1996), *rev'd*, 521 U.S. 793.

15. The fact that the door was plainly left ajar by the *Glucksberg* Court distinguishes the *Glucksberg* ruling from *Bowers v. Hardwick*, 478 U.S. 186 (1986), and the two decisions ought not be considered of a kind. *But see* Brian Hawkins, Note, *The* Glucksberg *Renaissance: Substantive Due Process since* Lawrence v. Texas, 105 MICH. L. REV. 409, 411 (2006) (arguing *Gluckberg*'s restrictive approach to due process is alive and well).

legislative action in this area. He wrote that "[t]he Court should . . . stay its hand to allow reasonable legislative consideration,"[16] and that "the legislative process is to be preferred."[17] Similarly, Justice O'Connor's concurrence demonstrated her concern that state legislatures be given the first opportunity to address the issue: "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 . . . ."[18]

In the course of these cases' movement through the courts, the subject of a dying patient's right to choose to hasten impending death by self-administering medications—prescribed by a physician for this purpose—stimulated a tremendous amount of public education and debate.[19] In support of the patients and physicians in *Glucksberg* and *Quill*, many citizens of Washington and New York shared their stories in an amicus brief to the Supreme Court, detailing the suffering of loved ones who did not have access to medications that they could self-administer to hasten death when their dying process became intolerable.[20] Countless citizens began the discussion about physician-assisted dying in the wake of the publication of these stories. Media of many varieties also addressed the issue.[21]

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16. *Glucksberg*, 521 U.S. at 789 (Souter, J., concurring).

17. *Id.* at 788.

18. *Id.* at 737 (O'Connor, J., concurring) (second and third omissions in original) (citation and internal quotation marks omitted).

19. *See* J.B. Deisher, Letter to the Editor, *Living And Dying—Suffering That Precedes Death Should Be The Real Enemy*, SEATTLE TIMES, Dec. 20, 1994, at B5; Robert A. Free et al., Op-Ed, *Compassion, Dignity In Dying—Terminal Patients Turn To Family When Living Becomes Unbearable*, SEATTLE TIMES, Jan. 12, 1997, at B5; Charlotte B. Hammond, Letter to the Editor, *Right To Die—Support For Assisted Suicide*, SEATTLE TIMES, Jan. 17, 1997, at B5; Peter M. McGough, Letter to the Editor, *Physician-Assisted Suicide—Most Patients Are Unaware of Their Treatment Options*, SEATTLE TIMES, Nov. 28, 1994, at B5; Carol M. Ostrom, *End-Of-Life Issues Prove Perplexing—'Right To Die' Raises Legal Questions*, SEATTLE TIMES, Oct. 1, 1994, at A11; Carol M. Ostrom, *Physician Survey: Suicide Aid Should Be Legal*, SEATTLE TIMES, July 14, 1994, at B1; Carol M. Ostrom, *State ACLU Proposes Assisted-Suicide Law*, SEATTLE TIMES, Nov. 16, 1994, at B3; Nancy L. Purcell, Op-Ed, *Coming To Terms With How We Treat 'The End Of Life'*, SEATTLE TIMES, Dec. 5, 1996, at B5; Brian Willoughby, *Suicide Debate Draws* 80, COLUMBIAN (Vancouver, Wash.), Aug. 9, 1994, at A1; *State's Medical Association Repeats Support For Reform*, COLUMBIAN (Vancouver, Wash.), Sept. 26, 1994, at A5; *Study: Terminally Ill Fear Loss of Independence*, COLUMBIAN (Vancouver, Wash.), Apr. 11, 1996, at A12.

20. Brief of Amicus Curiae of Surviving Family Members in Support of Physician-Assisted Dying, *Glucksberg*, 521 U.S. 702 (No. 96-110), 1996 WL 722032.

21. DVD: Ethics in America II: Three Farewells: Medicine & the End of Life (Fred Friendly Seminars 2007), *available at* http://www.learner.org/resources/series207.html; *see also Frontline: Living Old* (PBS television broadcast Nov. 21, 2006), *available at* http://www.pbs.org/wgbh/pages/frontline/livingold (depicting stories of elderly patients and their families struggling to maintain dignity as they face age and disease).

B. *Aggressive Pain and Symptom Management*

In *Glucksberg* and *Quill*, several members of the Court suggested that patients may have a right to aggressive pain management. In a concurring opinion joined by Justice Breyer, Justice O'Connor stated that "a patient who is suffering from a terminal illness and who is experiencing great pain has no legal barriers to obtaining medication, from qualified physicians, to alleviate that suffering, even to the point of causing unconsciousness and hastening death."[22] She further wrote that "[t]here is no dispute that dying patients . . . can obtain palliative care, even when doing so would hasten their deaths."[23]

Thus Justices O'Connor and Breyer answered a question that the parties had not actually posed, appearing to recognize a constitutional right to adequate pain medication—including the practice of terminal or palliative sedation.[24] In the years since the decisions issued, the practice has become steadily incorporated in end-of-life care, and authoritative literature in medical journals detailing the practice is burgeoning.[25] Where patients can expect

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22. *Glucksberg*, 521 U.S. at 736–37 (O'Connor, J., concurring).

23. *Id.* at 737–38; *see also id.* at 791 (Breyer, J., concurring) ("[The challenged statutes] do not prohibit doctors from providing patients with drugs sufficient to control pain despite the risk that those drugs themselves will kill."). Justices Ginsburg, Stevens, and Souter also suggested that they might support a right to pain medication. Justice Ginsburg supported O'Connor's opinion without joining it. *Id.* at 789 (Ginsburg, J., concurring) ("I concur in the Court's judgments . . . substantially for the reasons stated by Justice O'Connor . . . ."). Justice Stevens's statement that "there are situations in which an interest in hastening death . . . is entitled to constitutional protection" seems to contemplate aggressive treatment for pain. *Id.* at 741–42 (Stevens, J., concurring). And Justice Souter indicated "lesser concern" about the difficulty of assessing a patient's wishes "in cases involving limitations on life incidental to pain medication." Id. at 784 n.16 (Souter, J., concurring).

The practice of sedating patients with intractable pain into unconsciousness and withholding food and water until death inevitably ensues is known as terminal or palliative sedation and was endorsed as an acceptable option, indeed one seen as negating the need for assisted suicide, by the AMA and other amici in the *Quill* and *Glucksberg* cases. *See, e.g.*, Brief of the American Medical Ass'n et al. in Support of Petitioners at 6, Vacco v. Quill, 521 U.S. 793 (1997) (No. 95-1858), 1996 WL 656281. For some patients this may be an acceptable option; others (and their families) abhor the option of accepting an induced coma and a lingering demise while family members stand vigil for the week or ten days it takes for dehydration and starvation to bring about death.

24. Many commentators have observed that courts have recognized the constitutional right to adequate pain medication. *E.g.*, Robert A. Burt, *The Supreme Court Speaks: Not Assisted Suicide but a Constitutional Right to Palliative Care*, 337 NEW ENG. J. MED. 1234 (1997); David Orentlicher, *The Supreme Court and Terminal Sedation: Rejecting Assisted Suicide, Embracing Euthanasia*, 24 HASTINGS CONST. L.Q. 947, 951–54 (1997); *see also* Rob McStay, *Terminal Sedation: Palliative Care for Intractable Pain, Post* Glucksberg *and* Quill, 29 AM. J.L. & MED. 45, 52–53 (2003).

25. *E.g.*, Nat'l Ethics Comm., Veterans Health Admin., *The Ethics of Palliative Sedation as a Therapy of Last Resort*, 23 AM. J. HOSPICE & PALLIATIVE MED. 483, 484 (2007) ("There is broad professional agreement that palliative sedation is a clinically and ethically appropriate response when patients who are near death suffer severe, unremitting symptoms."); Zev D. Schuman et al., *Implementing Institutional Change: An Institutional Case Study of Palliative Sedation*, 8 J. PALLIATIVE MED. 666 app. at 672 (2005) ("In the United States, there is legal and professional support for palliative sedation. The United States Supreme Court (in *Vacco v. Quill* . . .) recognized the right of patients to receive palliative sedation if that is what is required to relieve their suffering at the end of life.") (citation omitted); *see also* Bernard Lo & Gordon Rubenfeld, *Palliative Sedation in Dying Patients*, 294 JAMA 1810 (2005).

good pain and symptom management, the argument that all that is really needed is simply better pain and symptom management[26] has little traction.[27]

II. THE OREGON EXPERIENCE: HAS THE LABORATORY SERVED ITS FUNCTION?

A decade after the Supreme Court's invitation for legislative reform, and with a decade of experience with Oregon's landmark aid-in-dying law, what have we learned? Has the laboratory envisioned by the Court served its purpose?

A. *Challenges to the Death with Dignity Act*

The Dignity Act was passed in 1994 through the initiative process. Implementation was obstructed for several years by a lawsuit arguing that the law denied the terminally ill equal protection of the laws. The Ninth Circuit dismissed the case on the grounds that the plaintiffs lacked standing.[28] Opponents also made an effort to force a repeal through another ballot initiative in 1997. That effort failed when sixty percent of Oregon voters rejected the repeal.[29] The Dignity Act began to be implemented in 1998.

Although the law became fully effective in 1998, opponents of the law continued to seek to overturn it. One strategy was to seek relief from the federal government, urging the Drug Enforcement Administration ("DEA") to take action against Oregon physicians acting in compliance with the law on the basis that such activity violated the Controlled Substances Act ("CSA").[30] The DEA initially opined that its agents could revoke the registrations of physicians who assisted in hastening deaths under the Dignity Act. However, U.S. Attorney General Janet Reno overruled this position, concluding that the CSA did not reach such conduct.[31] Reno stated that "[t]here is no evidence that Congress, in the CSA, intended to displace the states as the primary regulators of the medical profession, or to override a

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26. For an example of such an argument, see Susan M. Wolf, *Pragmatism in the Face of Death: The Role of Facts in the Assisted Suicide Debate*, 82 MINN. L. REV. 1063, 1100 (1998).

27. *See* Kathryn L. Tucker, *The Chicken and the Egg: The Pursuit of Choice for a Human[e] Hastened-Death as a Catalyst for Improved End-of-Life Care; Improved End-of-Life Care as a Precondition for Legalization of Assisted Dying*, 60 N.Y.U. ANN. SURV. AM. L. 355, 356 (2004).

28. Lee v. Oregon, 891 F. Supp. 1429 (D. Or. 1995), *vacated*, 107 F.3d 1382 (9th Cir. 1997).

29. David J. Garrow, *The Oregon Trail*, N.Y. TIMES, Nov. 6, 1997, at A31; Kim Murphy, *Voters in Oregon Soundly Endorse Assisted Suicide*, L.A. TIMES, Nov. 5, 1997, at A1.

30. Timothy Egan, *Threat from Washington has Chilling Effect on Oregon Law Allowing Assisted Suicide*, N.Y. TIMES, Nov. 19, 1997, at A18.

31. Statement of Attorney General Reno on Oregon's Death with Dignity Act, 98 Op. Att'y Gen. 259 (1998) ("The Department has conducted a thorough and careful review of the issue .... We have concluded that adverse action against a physician who has assisted in a suicide in full compliance with the Oregon Act would not be authorized by the CSA.").

state's determination as to what constitutes legitimate medical practice in the absence of a federal law prohibiting that practice."[32]

Opponents then sought, in two successive sessions of Congress, to expand the scope of the CSA to reach the Dignity Act.[33] Both efforts failed in the face of strong opposition from the medical community, founded on the concern that the proposed measures would exacerbate physicians' fears regarding the use of controlled substances in pain management.[34]

A change in federal administration and philosophy led to a change in legal interpretation. The Bush Administration's first Attorney General, John Ashcroft, issued a directive in November 2001 (the "Ashcroft Directive"), advising that the Department of Justice had concluded that prescribing controlled substances under the Dignity Act violated the CSA.[35] The directive stated that "assisting suicide is not a 'legitimate medical purpose' within the meaning of" the regulations governing implementation of the CSA, and therefore "prescribing, dispensing, or administering federally controlled substances to assist suicide violates the [CSA]."[36] In particular, "[s]uch conduct by a physician registered to dispense controlled substances may 'render his registration . . . inconsistent with the public interest' and therefore subject to possible suspension or revocation under [the CSA]."[37]

The Ashcroft Directive was challenged in federal court by the state of Oregon, an Oregon physician, and a group of terminally ill Oregonians, who asserted that it violated the CSA, the Administrative Procedure Act, and the U.S. Constitution. The district court reached only the question of whether the directive was within the scope of the CSA. The court concluded that it exceeded the authority granted under the CSA, and a permanent injunction was entered:

> The determination of what constitutes a legitimate medical practice or purpose traditionally has been left to the individual states . . . . The CSA was never intended, and the USDOJ and DEA were never authorized, to establish a national medical practice or act as a national medical board. To allow an attorney general—an appointed executive whose tenure depends entirely on whatever administration occupies the White House—to determine

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32. *Id.*

33. Pain Relief Promotion Act of 1999, H.R. 2260, 106th Cong. (1999); Lethal Drug Abuse Prevention Act of 1998, H.R. 4006, 105th Cong. (1998).

34. *See* Marcia Angell, Editorial, *Caring for the Dying Congressional Mischief*, 341 NEW ENG. J. MED. 1923, 1923 (1999) ("If the bill becomes law, it will almost certainly discourage doctors from prescribing or administering adequate doses of drugs to relieve the symptoms of dying patients."); David Orentlicher & Arthur Caplan, *The Pain Relief Promotion Act of 1999: A Serious Threat to Palliative Care*, 283 JAMA 255, 255 (2000) ("[P]rogress in [the area of improved pain care] may be dealt a severe setback should Congress decide to enact the [PRPA] of 1999 . . . . [T]he most likely effect of PRPA would be to discourage physicians nationwide from adequately treating the suffering of their dying patients.").

35. Dispensing of Controlled Substances to Commit Suicide, Att'y Gen. Order No. 2534-2001, 66 Fed. Reg. 56,607 (Nov. 9, 2001).

36. *Id.* at 56,608.

37. *Id.* (omission in original) (citation omitted).

> the legitimacy of a particular medical practice without a specific congressional grant of such authority would be unprecedented and extraordinary.[38]

The Ninth Circuit Court of Appeals issued a ruling with much the same reasoning.[39] In January 2006, the U.S. Supreme Court affirmed, leaving Oregon's landmark law intact and the door to state experimentation with aid in dying open.[40]

B. *Implementation and Its Implications*

The Oregon Death with Dignity Act demonstrates that aid-in-dying laws can, and do, work well. The Dignity Act establishes tightly controlled procedures under which competent, terminally ill adults who are under the care of an attending physician may obtain a prescription for medication to allow them to control the time, place, and manner of their own impending death.[41] The attending physician must, among other things, determine that the patient is mentally competent and an Oregon resident, and confirm the patient's diagnosis and prognosis.[42] To qualify as "terminally ill," a person must have "an incurable and irreversible disease that has been medically confirmed and will, within reasonable medical judgment, produce death within six months."[43]

The attending physician must also inform persons requesting such medication of their diagnosis and prognosis, the risks and probable results of taking the medication, and alternatives to taking their own lives, including—although not limited to—hospice care and pain relief.[44] A consulting physician must confirm the attending physician's medical opinion.[45]

Once a request from a qualifying patient has been properly documented and witnessed, and all waiting periods have expired,[46] the attending physician may prescribe, but not administer, medication to enable the patient to end his or her life in a humane and dignified manner. The Dignity Act protects physicians and pharmacists who act in compliance with its comprehensive procedures from civil or criminal sanctions and any professional disciplinary actions based on that conduct.[47]

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38. Oregon v. Ashcroft, 192 F. Supp. 2d 1077, 1092 (D. Or. 2002), *aff'd*, 368 F.3d 1118 (9th Cir. 2004), *aff'd sub nom.* Gonzalez v. Oregon, 546 U.S. 243 (2006).

39. *Ashcroft*, 368 F.3d 1118, *aff'd sub nom. Gonzalez*, 546 U.S. 243.

40. *Gonzales*, 546 U.S. 243; *see* Kathryn L. Tucker, *U.S. Supreme Court Ruling Preserves Oregon's Landmark Death with Dignity Law*, 2 NAT'L ASS'N ELDER L. ATT'YS J. 291 (2006).

41. *See* OR. REV. STAT. § 127.805 (2005).

42. *Id.* § 127.815.

43. *Id.* § 127.800(12).

44. *Id.* § 127.800(7).

45. *Id.* §§ 127.800(4), .800(8), .820.

46. *Id.* §§ 127.840–850. The Dignity Act requires a fifteen day waiting period between the patient's initial oral request and the writing of the prescription, and a forty-eight hour waiting period between the patient's written request and the writing of the prescription. *Id.* § 127.850.

47. *Id.* § 127.885(1)–(2).

The Dignity Act requires healthcare providers to file reports with the state documenting their actions.[48] Oregon's experience with aid in dying has therefore been extensively documented and studied. To date, the Oregon Public Health Division and Department of Human Services have issued nine annual reports that present and evaluate the state's experience with the Dignity Act.[49] Related reports and articles have also been published in leading medical journals.[50] These reports constitute the only source of reliable data regarding actual experience with legal, regulated physician-assisted dying in America.

C. *The Laboratory Has Served Its Function*

In invoking the laboratory of the States, the Court in *Glucksberg* contemplated that one courageous state could address this controversial issue, and other states could watch and learn. This is exactly what has happened in Oregon.

The experience in Oregon has demonstrated that a carefully drafted law does not place patients at risk.[51] In a report examining the Oregon experience to assess whether vulnerable populations were put at risk, the researchers concluded that there was no evidence supporting this concern.[52] The Oregon experience has caused even staunch opponents to admit that

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48. *Id.* § 127.865.

49. Or. Dep't of Human Servs., Death with Dignity Act Annual Reports, http://oregon.gov/dhs/ph/pas/ar-index.shtml (last visited Jan. 19, 2008) [hereinafter Annual Reports].

50. *E.g.*, 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 (2007); Andrew I. Batavia, *So Far So Good: Observations on the First Year of Oregon's Death With Dignity Act*, 6 PSYCHOL. PUB. POL'Y & L. 291 (2000); Arthur E. Chin et al., *Legalized Physician-Assisted Suicide in Oregon—The First Year's Experience*, 340 NEW ENG. J. MED. 577 (1999); David Orentlicher, *The Implementation of Oregon's Death With Dignity Act: Reassuring, But More Data Are Needed*, 6 PSYCHOL. PUB. POL'Y & L. 489 (2000) (stating that implementation of Oregon law has so far been limited to terminally ill patients with a clear, persistent, and voluntary request for hastened death); Amy D. Sullivan et al., *Legalized Physician-Assisted Suicide in Oregon—The Second Year*, 342 NEW ENG. J. MED. 598 (2000); *see also* Straton, *supra* note 6; Timothy E. Quill & Christine K. Cassel, *Professional Organizations' Position Statements on Physician-Assisted Suicide: A Case for Studied Neutrality*, 138 ANNALS INTERNAL MED. 208 (2003).

51. Battin et al., *supra* note 50; *see also*, Quill & Cassel, *supra* note 50 (urging that medical associations adopt a position of neutrality on assisted dying laws); Linda Ganzini et al., *Oregon Physicians' Attitudes About and Experiences With End-of-Life Care Since Passage of the Oregon Death with Dignity Act*, 285 JAMA 2363 (2001) (reviewing Oregon's experience with its Death With Dignity Act and concluding no harm occurred to vulnerable populations); Melinda A. Lee & Susan W. Tolle, *Oregon's Assisted Suicide Vote: The Silver Lining*, 124 ANNALS INTERNAL MED. 267 (1996); Straton, *supra* note 6.

52. Battin et al., *supra* note 50, at 591. The American Medical Student Association took note of the Battin study and findings in reaching its own policy to support aid in dying. AMSA Principles, *supra* note 6 ("WHEREAS the Oregon data showed 'no evidence of heightened risk for the elderly, women, the uninsured . . . people with low educational status, the poor, the physically disabled or chronically ill, minors, people with psychiatric illnesses including depression, or racial or ethnic minorities . . . .'" (quoting Battin, *supra*)).

continued opposition to such a law can only be based on personal, moral, or religious grounds.[53]

The Oregon reports have shown the dire predictions of those initially opposed to the Dignity Act to have been unfounded. The data demonstrate that the option of physician-assisted dying has not been unwillingly forced upon those who are poor, uneducated, uninsured, or otherwise disadvantaged.[54] In fact, the studies show just the opposite. For example, the eighth annual report found that a higher level of education is strongly associated with the use of physician-assisted dying; those with a baccalaureate degree or higher were 7.9 times more likely than those without a high school diploma to choose physician-assisted dying.[55] The report found that 100% of patients opting for physician-assisted dying under the Dignity Act had either private health insurance, Medicare, or Medicaid, and 92% were enrolled in hospice care.[56] Furthermore, the reports demonstrate that use of physician-assisted dying is limited. During the first nine years in which physician-assisted dying was a legal option, only 292 Oregonians chose it.[57] And although there has been a gradual increase in the rate of those opting for physician-assisted dying, the overall rate remains low: the 38 terminally ill adults who chose this option in 2005 represented only 12 deaths for every 10,000 Oregonians who died that year.[58] A 2000 survey of Oregon physicians found that they granted 1 in 6 requests for aid in dying, and that only 1 in 10 requests resulted in hastened death.[59] Roughly one-third of those patients who complete the process of seeking medications under the Dignity Act do not go on to consume the medications. These individuals derive com-

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53. *See* Daniel E. Lee, *Physician-Assisted Suicide: A Conservative Critique of Intervention*, HASTINGS CENTER REP., Jan.–Feb. 2003, at 17.

54. *E.g.*, CTR. FOR DISEASE PREVENTION & EPIDEMIOLOGY, OR. HEALTH DIV., DEP'T OF HUMAN RES., OREGON'S DEATH WITH DIGNITY ACT: THE FIRST YEAR'S EXPERIENCE 7 (1999), *available at* http://oregon.gov/dhs/ph/pas/docs/year1.pdf ("Patients who chose physician-assisted suicide were *not* disproportionately poor (as measured by Medicaid status), less educated, lacking in insurance coverage, or lacking in access to hospice care."); *see also* Battin et al., *supra* note 50; Kant Patel, *Euthanasia and Physician-Assisted Suicide Policy in the Netherlands and Oregon: A Comparative Analysis*, 19 J. HEALTH & SOC. POL'Y 37 (2004) (finding no empirical evidence of a slippery slope in Oregon, but more potential for a slide in the Netherlands).

55. OFFICE OF DISEASE PREVENTION & EPIDEMIOLOGY, OR. DEP'T OF HUMAN SERVS., EIGHTH ANNUAL REPORT ON OREGON'S DEATH WITH DIGNITY ACT 12 (2006), *available at* http://oregon.gov/dhs/ph/pas/docs/year8.pdf [hereinafter EIGHTH ANNUAL REPORT].

56. *Id.* at 23.

57. OR. PUB. HEALTH DIV., OR. DEP'T OF HUM. SERVS., DEATH WITH DIGNITY ANNUAL REPORTS: YEAR 9 – 2006 SUMMARY (2007), http://oregon.gov/dhs/ph/pas/docs/year9.pdf [hereinafter NINTH ANNUAL REPORT]. Some commentators have observed that legal medical interventions that will bring about death, such as removal of feeding tubes, are reluctantly taken, and have reasoned from this that if aid in dying were legal it would also be rare. *See* David Orentlicher & Christopher M. Callahan, *Feeding Tubes, Slippery Slopes, and Physician-Assisted Suicide*, 25 J. LEGAL MED. 389 (2004). The Oregon data supports this contention.

58. EIGHTH ANNUAL REPORT, *supra* note 55, at 4–5.

59. Linda Ganzini et al., *Physicians' Experiences with the Oregon Death with Dignity Act*, 342 NEW ENG. J. MED. 557, 557 (2000) (finding that the availability of palliative care led some, but not all, patients to change their mind about hastened death).

fort from having the option to control the time of death yet ultimately die of their disease without exercising that control.[60]

Outside observers, after carefully studying implementation of the aid-in-dying law in Oregon, have concluded that the law poses no risk to patients. For example, a report prepared for the Vermont legislature, after thoroughly reviewing the Oregon experience, concluded that "it is quiet [sic] apparent from credible sources in and out of Oregon that the Death with Dignity Act has not had an adverse impact on end-of-life care and in all probability has enhanced the other options."[61] Leading scholars have come to conclusions such as this: "I worried about people being pressured to do this . . . . But this data confirms . . . that the policy in Oregon is working. There is no evidence of abuse or coercion, or misuse of the policy."[62]

Indeed, rather than posing a risk to patients or the medical profession, the Dignity Act has galvanized significant improvements in the care of the dying in Oregon. Oregon doctors report that since the passage of the Dignity Act, efforts have been made to improve their ability to provide adequate end-of-life care.[63] These efforts include improving their knowledge of the use of pain medications for the terminally ill, improving their ability to recognize depression and other psychiatric disorders, and more frequently referring their patients to hospice programs.[64] One survey of Oregon physicians on their efforts to improve end-of-life care since 1994 found that 30% of respondents increased their number of referrals to hospice care and 76%

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60. *See* Annual Reports, *supra* note 49; NINTH ANNUAL REPORT, *supra* note 57 (showing number of prescription recipients each year compared to number of deaths from use of prescriptions).

61. VT. LEGISLATIVE COUNCIL, OREGON'S DEATH WITH DIGNITY LAW AND EUTHANASIA IN THE NETHERLANDS: FACTUAL DISPUTES § 3E (2004), *available at* http://www.leg.state.vt.us/reports/05Death/Death_With_Dignity_Report.htm.

62. William McCall, *Assisted-suicide cases down in '04*, COLUMBIAN (Vancouver, Wash.), Mar. 11, 2005, at C2 (quoting Arthur Caplan, director of the Center for Bioethics at the University of Pennsylvania School of Medicine); *see also* Straton, *supra* note 6, at 480–82.

63. U.S. GEN. ACCOUNTING OFFICE, REPORT TO THE HONORABLE RON WYDEN, U.S. SENATE, END-OF-LIFE CARE 17 (2007). According to the report:

> Representatives of a hospice-based palliative care provider in Oregon stated that the physicians they work with are more comfortable discussing end-of-life issues with their patients since the 1997 enactment in Oregon of the Death with Dignity Act, which focused attention in the state on end-of-life care and the options available to individuals. Representatives of a palliative care program operated by a health care system we interviewed stated that passage of this act helped create an environment in Oregon where end-of-life issues are discussed more openly.

Id.

64. *See* Ganzini et al., *supra* note 51; *see also* Lee & Tolle, *supra* note 51, 268–69; Lawrence J. Schneiderman, *Physician-Assisted Dying* 293 JAMA 501, 501 (2005); Quill & Cassel, *supra* note 50, at 209. Schneiderman notes that

> one of the unexpected yet undeniable consequences of Oregon's Death with Dignity Act permitting physician aid-in-dying is that "many important and measurable improvements in end-of-life care" occurred following the Act's implementation. Rather than becoming the brutal abattoir for hapless patients that some critics predicted, the state is a leader in providing excellent and compassionate palliative care.

Schneiderman, *supra*, at 501 (reviewing and quoting PHYSICIAN-ASSISTED DYING: THE CASE FOR PALLIATIVE CARE AND PATIENT CHOICE (Timothy E. Quill & Margaret P. Battin eds., 2004)).

made efforts to increase their knowledge of pain medication.[65] A survey of hospice nurses and social workers in Oregon reveals that they observed, during a period from 1998 to 2003, an increase in physicians' knowledge of palliative care and willingness both to refer and to care for hospice patients.[66]

In addition to the improvement of end-of-life care, the legal option of aid in dying has psychological benefits for both the terminally ill and the healthy. The availability of the option of aid in dying gives the terminally ill autonomy, control, and choice, which physicians in Oregon have identified as the overwhelming motivational factor behind the decision to request assistance in dying.[67] Healthy Oregonians know that if they ever face a terminal illness, they will have control and choice over their manner of death.

The data demonstrate that, far from posing any hazard to patients or the practice of medicine, making the option of assisted dying available has galvanized improvements in end-of-life care and benefited all terminally ill Oregonians. A central argument against allowing patients access to aid in dying has been that risks would arise if the option were available.[68] Actual experience demonstrates that these risks do not, in fact, exist. And the lack of these risks undermines the argument against aid in dying.[69] This has led some major medical organizations to conclude that passage of Oregon-type aid-in-dying laws is good policy and to adopt policy supporting passage of such laws.[70]

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65. Ganzini et al., *supra* note 51, at 2363.

66. Elizabeth R. Goy et al., *Oregon Hospice Nurses and Social Workers' Assessment of Physician Progress in Palliative Care Over the Past 5 Years*, 1 PALLIATIVE & SUPPORTIVE CARE 215 (2004).

67. Kathy L. Cerminara & Alina Perez, *Therapeutic Death: A Look at Oregon's Law*, 6 PSYCHOL. PUB. POL'Y & L. 503, 512–13 (2000) (acknowledging possible negative effects of legalized aid in dying, but concluding that the data from Oregon in one year justifies an optimistic view); *see also* Linda Ganzini et al., *Experiences of Oregon Nurses and Social Workers with Hospice Patients who Requested Assistance with Suicide*, 347 NEW ENG. J. MED. 582 (2002) (reporting that nurses and social workers rated desire to control circumstances of death as the most important reason for requesting aid in dying); Linda Ganzini et al., *Oregon Physicians' Perceptions of Patients Who Request Assisted Suicide and Their Families*, 6 J. PALLIATIVE MED. 381 (2003) (finding physicians receiving requests for lethal medication perceive patients as wanting to control their deaths).

68. *See, e.g.*, Washington v. Glucksberg, 521 U.S. 702, 732 (1997) ("We have recognized . . . the real risk of subtle coercion and undue influence in end-of-life situations.").

69. *See* Tucker, *supra* note 27. Other reasons that put to rest the fear that passage of aid-in-dying laws will put patients at risk have been offered. For example, one commentator studied the reluctance of patients and providers to withdraw feeding tubes, an option legal in every state. *See* Orentlicher & Callahan, *supra* note 57, at 390. He concluded that the data show that feeding tubes are overutilized and argues that this demonstrates reluctance to take steps that will precipitate death and that such reluctance will apply in the context of aid in dying. *Id.*

70. *See, e.g.*, AMSA Principles, *supra* note 6 ("The American Medical Student Association[] supports passage of aid in dying laws that empower mentally competent, terminally ill patients to hasten what might otherwise be a protracted, undignified, or extremely painful death."); Jay Cohen, *CAPG Supports AB 374: The Compassionate Choices Act*, CAPG UPDATE (Cal. Ass'n of Physician Groups, L.A., Cal.), Mar. 2007, at 9, *available at* http://www.capg.org/docs/capg_update--march_2007.pdf (supporting passage of an Oregon-type aid-in-dying law in California); Position Statement, Am. Med. Women's Ass'n, *supra* note 6 ("AMWA supports the passage of aid-in-dying

III. ARE OTHER STATES READY FOR AN ASSISTED DYING LAW?

The arguments against aid in dying are unpersuasive. Once those arguments are dismissed, the question remains: given the successful experience in Oregon, can and should other states adopt laws permitting aid in dying?

A. *Support and Opposition*

Since 1991, when Washington voters were the first in the nation to consider the question of legalizing physician-assisted dying, the issue has been in the public eye. In early 1993, Compassion in Dying, now called Compassion & Choices, was formed as a non-profit public interest organization. This group provides direct counseling to patients confronting end-of-life decisionmaking and advocates for improved end-of-life care and expanded choices for terminally ill patients, including aid in dying. This group has been operating since 1993, advancing the public dialogue on this subject, speaking in public forums, and counseling thousands of individuals and their families in states across the nation.

Though Oregon is the only state yet to have legalized the option of physician aid in dying, support for the option is widespread nationwide. A poll released by the Pew Research Center in January 2006 found that 60% of Americans "believe a person has a moral right to end their life if they are suffering great pain and have no hope of improvement," an increase of nearly 20 percentage points since 1975, and 53% "believe a person has a moral right to end their life if suffering from an incurable disease."[71] A Harris poll published in January 2002 found that 65% of respondents supported legalization of the right to physician-assisted dying, and 61% favored implementation of a version of the Dignity Act in their own states.[72] Another group of studies found that between 63% and 90% of people with a terminal illness supported a right to physician-assisted dying and would like to have the option available to them.[73] In California, surveys in February 2005 and February 2006 found that 70% of California residents supported the idea

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laws which empower mentally competent, terminally ill patients and protect participating physicians, such as . . . the Oregon Death with Dignity Act.").

71. News Release, Pew Research Ctr. for the People & the Press, More Americans Discussing—and Planning—End-of-Life Treatment: Strong Public Support for Right to Die, at 8 (Jan. 5, 2006), *available at* http://people-press.org/reports/pdf/266.pdf.

72. Humphrey Taylor, *2-to-1 Majorities Continue to Support Rights to Both Euthanasia and Doctor-Assisted Suicide*, HARRIS POLL, Jan. 9, 2002, http://www.harrisinteractive.com/harris_poll/index.asp?PID=278.

73. Andrew I. Batavia, *The Relevance of Data on Physicians and Disability on the Right to Assisted Suicide: Can Empirical Studies Resolve the Issue?*, 6 PSYCHOL. PUB. POL'Y & L. 546, 553 (2000) (citing William Breitbart et al., *Interest in Physician-Assisted Suicide Among Ambulatory HIV-Infected Patients*, 153 AM. J. PSYCHIATRY 238, 240 (1996), and Brett Tindall et al., Letter to the Editor, *Attitudes to Euthanasia and Assisted Suicide in a Group of Homosexual Men with Advanced HIV Disease*, 6 J. ACQUIRED IMMUNE DEFICIENCY SYNDROME 1069, 1069 (1993)).

that "incurably ill patients have the right to ask for and get life-ending medication."[74]

Support is also strong among physicians. A national survey conducted in February 2005 found that 57% of the 1088 physicians polled believed it is ethical for a physician to assist a competent, dying patient to hasten death.[75] A 2001 survey published by the *Journal of the American Medical Association* found that 51% of responding physicians in Oregon supported the Dignity Act and legalization of physician-assisted dying.[76] A nationwide survey published in 2001 in the *Journal of General Internal Medicine* found that 45% of responding physicians believed that physician-assisted death should be legal, whereas only 34% expressed views to the contrary.[77] Some medical associations have adopted policies supporting passage of aid-in-dying laws,[78] while others, recognizing the division within the medical community on the question, have opted to embrace a position of neutrality on the question of legalizing physician-assisted dying.[79] Women's health advocates also support legalization of aid in dying. For example, the National Women's Law Center and the National Women's Health Network endorsed passage of the aid-in-dying law ("AB 374")[80] proposed in California in 2007. The National Women's Law Center drew a connection to the issue of reproductive rights:

> As an organization that supports reproductive rights, the Center is committed to making sure that the religious beliefs of some individuals or entities do not impose barriers to health care quality or access. We have seen tremendous opposition to certain care at the end of life from the same forces that oppose women's right to reproductive health care. Because these two issues implicate similar interests of privacy, autonomy, bodily integrity, and respect for the patient's conscience and beliefs, we feel compelled to support AB 374. . . . This bill would place California, along with Oregon, at the forefront of efforts to respect individuals' right to consult with their

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74. Mark DiCamillo & Mervin Field, *Continued Support for Doctor-Assisted Suicide. Most Would Want Their Physician to Assist Them If They Were Incurably Ill and Wanted To Die*, FIELD POLL (Field Research Corp., S.F., Cal.), Mar. 15, 2006, at 1, 2, *available at* http://www.field.com/fieldpollonline/subscribers/RLS2188.pdf.

75. Jewish Theological Seminary, Physician-Assisted Suicide Survey, http://www.jtsa.edu/x5533.xml (last visited Jan. 19, 2008).

76. Ganzini et al., *supra* note 51, at 2365 tbl.2.

77. Simon N. Whitney et al., *Views of United States Physicians and Members of the American Medical Association House of Delegates on Physician-Assisted Suicide*, 16 J. GEN. INTERNAL MED. 290, 292–93 (2001). An additional nationwide survey, published in the *New England Journal of Medicine* in 1998, focused on doctors who practiced in one of the ten medical specialties identified as likely to encounter dying patients (e.g., cardiology, geriatrics, neurology). Of the responding physicians, 36% said that, if it were legal to do so, they would be willing to hasten death by medication, and 24% stated that they would be willing to do so by injection. Diane E. Meier et al., *A National Survey of Physician-Assisted Suicide and Euthanasia in the United States*, 338 NEW ENG. J. MED. 1193, 1199 tbl.6 (1998).

78. *See supra* note 70.

79. *See, e.g.*, Position Statement, Am. Acad. of Hospice & Palliative Med., *supra* note 6.

80. California Compassionate Choices Act, Assemb. 374, 2007–08 Leg., Reg. Sess. (Cal. 2007).

doctors to make the health care decisions they deem best, and perhaps encourage other states to do the same.[81]

One might conclude that, with such strong support for legalizing aid in dying, other states would be passing laws similar to Oregon's. However, certain groups remain staunchly opposed. These include the so-called "right to life" lobby[82] and the Catholic Church.[83] In addition, a vocal segment of the disability rights community has raised arguments in opposition to passage of such laws, contending that legalization of aid in dying for competent, terminally ill patients would somehow put persons with disabilities into jeopardy. These arguments have been addressed and shown to be without foundation by a number of scholars.[84]

B. *The Back Alley: Facing the Reality of Leaving Aid in Dying Unregulated*

Although legal only in Oregon, physicians throughout the country report that they regularly receive requests for assistance in dying. A significant percentage of primary care physicians and an even larger percentage of oncologists in the United States report having been asked for their assistance in a patient's hastened death; one quarter of them complied.[85]

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81. Memorandum from Judy Waxman, Vice President of Health, Nat'l Women's Law Ctr., to Members of the Cal. State Assembly (May 15, 2007) (footnotes omitted) (on file with author). A footnote in the memorandum's text refers readers wishing to obtain more information on the Center's Religious Restrictions Project to http://www.nwlc.org/details.cfm?id=252&section=health.

82. That this advocacy community has turned its attention to end-of-life issues was made abundantly clear in the sensationalized case involving Terri Schiavo, where so-called right to life groups sought to prevent the patient's wishes from being implemented and to force continued tube feeding on a woman who had permanently lost all cognitive function and was in a permanent vegetative state. For extended discussion of who these groups were and how they are funded, see JON B. EISENBERG, USING TERRI: THE RELIGIOUS RIGHT'S CONSPIRACY TO TAKE AWAY OUR RIGHTS (2005), and RELIGIOUS COAL. FOR REPROD. CHOICE, THE MEDICAL RIGHT: REMAKING MEDICINE IN THEIR IMAGE (2007), *available at* http://www.rcrc.org/pdf/MedicalRight_fullreport.pdf (examining the concerted effort of the religious right to inject religious values into the practice of medicine).

83. In California, Catholic bishops and their political arm have been at the forefront of opposition to AB 374. Cardinal Roger Mahony led the attack, charging those who support the bill with participating in a "culture of death." *See* Jim Sanders, *Cardinal scolds Núñez on death aid*, SACRAMENTO BEE, Apr. 3, 2007, at A1.

84. *See, e.g.*, Battin et al., *supra* note 50, at 594–95; Alicia Ouellette, *Disability and the End of Life*, 85 OR. L. REV. 123 (2006); *see also* Lois Shepherd, *Terri Schiavo: Unsettling The Settled*, 37 LOY. U. CHI. L.J. 297, 320–26 (2006); Kathryn L. Tucker et al., *The Sky is Not Falling: Disability and Aid-in-Dying*, *in* END OF LIFE ISSUES AND PERSONS WITH DISABILITIES (Timothy H. Lillie & James L. Werth eds., 2007).

85. A recent study reports that 18–24% of primary care physicians and 46–57% of oncologists have been asked for aid in dying. Elizabeth M. Arnold et al., *Consideration of Hastening Death Among Hospice Patients and Their Families*, 27 J. PAIN SYMPTOM MGMT. 523 (2004). When patients must go underground for medical care, the risk of encountering a provider who does not practice competent, ethical medicine is greatly increased. The most well known "back alley" provider for patients seeking control over their own death may be Jack Kevorkian, the Michigan pathologist who assisted patients with chronic and terminal conditions to end their lives, often in the back of an old Volkswagon van. Kevorkian was ultimately convicted of homicide in the death of Thomas Youk. After serving part of his prison sentence, Kevorkian was granted parole and released on June 1, 2007. *See* Monica Davey, *Kevorkian Freed After Years in Prison for Aiding Suicide*, N.Y. TIMES, June 2, 2007, at A8.

When aid in dying occurs outside of Oregon—in covert, underground practice—complications are more likely to occur. For example, there is a much higher chance of an extended time until death after consuming lethal medications under covert practice.[86] Moreover, the stress and anxiety for the patient and family is much higher when no physician can legally be involved to counsel the patient and family and provide the prescription for medications.[87]

This situation is reminiscent of the era when women could not legally choose to terminate an unwanted pregnancy and had to resort to the "back alley," where a rusty hanger could be the implement used to end the pregnancy, resulting in countless injuries, deaths, and trauma.[88] Thus, the question is not whether aid in dying will occur, but whether it will occur in a regulated and controlled fashion with safeguards and scrutiny or covertly, in a random, dangerous, and unregulated manner.

C. *The California Effort*

Efforts to pass laws similar to the Oregon Death with Dignity Act have been launched in other states, including a recent effort in California. The California Compassionate Choices Act ("CCCA"), introduced in 2007, was modeled after Oregon's Death with Dignity Act and would have allowed a mentally competent, terminally ill patient with a prognosis of three months or less to obtain a prescription to bring about hastened death.[89] The CCCA, while modeled after the Oregon law, was more restrictive in certain respects, as a result of amendments sought and accommodated in the legislative process. For example, the CCCA would permit use of the law only when a patient has up to three months life expectancy,[90] rather than six months as permitted in Oregon.[91] In addition, the CCCA explicitly required that the patient self-administer the medications, whereas in Oregon this is implicit.[92] Thus, the already stringent limitations of the Oregon model were made even more stringent by California legislators seeking to devise a measure that addresses public concerns while still providing comfort and relief to dying patients who find their situation intolerable. Notwithstanding the strong

86. *See* Helene Starks et al., *Family Member Involvement in Hastened Death*, 31 DEATH STUD. 105 (2007).

87. *Id.* at 112–17.

88. *Cf.* Douglas R. Miller, *The Alley Behind First Street, Northeast: Criminal Abortion in the Nation's Capital, 1872–1973*, 11 WM. & MARY J. WOMEN & L. 1 (2004) (detailing history of criminal abortion in Washington, D.C., before *Roe v. Wade*).

89. California Compassionate Choices Act, Assemb. 374, 2007–08 Leg., Reg. Sess. (Cal. 2007).

90. *Id.* § 7196(g).

91. OR. REV. STAT. §§ 127.800(12), 127.805 (2005).

92. California Compassionate Choices Act § 7197.7.

public support for the CCCA[93] and the many safeguards and restrictions in the measure, it did not pass and was not reintroduced in 2008.[94]

CONCLUSION

Ten years after *Glucksberg*, it is timely, prudent, and humane for other states to enact laws to empower terminally ill, mentally competent adult citizens to control the timing and manner of their deaths by enabling them to obtain medications from their physician that could be self-administered to bring about a peaceful and humane death, subject to careful procedures.

Even with excellent pain and symptom management, a fraction of dying patients confront a dying process so prolonged and marked by such extreme suffering and deterioration that they determine that hastening impending death is the least-bad alternative. Passage of aid-in-dying laws harms no one and would benefit both the relatively few patients *in extremis* who would make use of the option and a great many more who would draw comfort from knowing this is available should their dying process become intolerable.

Any state now considering the issue does so with a decade of data from the state of Oregon, which firmly puts to rest the concern that a legal option of aid in dying poses risk to patients or physicians. The question, finally, is simply this: is a state sufficiently compassionate to allow the choice of aid in dying to terminally ill, competent patients who are receiving state-of-the-art end-of-life care but are still suffering?

93. *See supra* notes 74, 80 and accompanying text.

94. Legislative Counsel of California, AB 374 Assembly Bill—History, http://www.leginfo.ca.gov/pub/07-08/bill/asm/ab_0351-0400/ab_374_bill_20080204_history.html (last visited Mar. 16, 2008).